Promise Health Plan

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

Report Year 2024

Responsible Health Equity Office Staff

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

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

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

Executive Summary

The Quality Improvement Health Equity Transformation Program (QIHETP) Annual Evaluation Report Year (RY) 2024 documents the annual review and formal assessment of Blue Shield Promise Health Plan's Health Equity Advancements Resulting in Transformation, or lovingly called the HEART program. This evaluation serves as the foundation for the ongoing QIHETP activities described in the 2023 Quality Improvement Equity Committee Work Plan and conforms to the 2023-2024 Quality Improvement Health Equity Transformation Program Description.

Our 2023-2024 QIHET program goals and objectives support the QIHETP program principles that will seek to implement the Health Equity Office milestones.

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

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

2023-2024 QIHET Program Outcomes and Accomplishments:

- Successful formation of the Health Equity Office led by Blue Shield Promise' Chief Health Equity Officer.
- Convened a Quality Improvement Health Equity Committee and governance structure.
- Development of a QIHETP strategic plan.
- Finalization of 2023 program documents.
- Facilitation of Health Equity Transformation Program roadshow and activities.
- Define a Health Equity Measure Set.
- Finalized the 2023 QIHET Program Description.
- Successful implementation of the I Have HEART Advocate Program.

Table of Contents

Executive Summary....2
I. Overview....4
II. Data Sources....5
III. Quality Improvement Health Equity Transformation Program Activities....6
a. Goal #1: Sound Infrastructure and Operations....6
b. Goal #2: Equity embedded in everything we do....15
c. Goal #3: Information in Action....19
d. Goal #4: Interventions that Matter....30
IV. Key Findings....37
V. Action Plan....38
VI. Stakeholder Engagement....39
VII. Annual Evaluation Reporting and Oversight....41
VIII. References....42
VIII. Appendices....43

I. Overview

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

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

Blue Shield Promise' HEART program is comprised of activities, procedures, investments, member engagement, clinical programs, and provider partnerships that will help drive transformation of the health care system, improving quality, expanding access, and ensuring equity for all members.

The QIHETP Annual Evaluation Report will address the Plan's initial Action Plan Goals and Objectives as outlined in the 2023-2024 QIHET Program Description including:

QIHET Program Objectives	
Goal	Objective
Information in Action	Blue Shield Promise will develop a HEART Measure Set with key functional area leaders and out by end of the year 12/31/2023.
Sound Infrastructure and Operations	Blue Shield Promise Quality Improvement Health Equity Transformation (QIHET) program documents will be reviewed and approved by the governance process by 7/1/2023.
Equity embedded in everything we do	Blue Shield Promise Health Equity Office (HEO) will conduct at least five health equity presentations and/or trainings within the organization to embed equity in everything we do by 12/31/2023.
Sound Infrastructure and Operations	Blue Shield Promise HEO will facilitate the first inaugural Quality Improvement Health Equity Committee (QIHEC) meeting by 3/31/2023.
Sound Infrastructure and Operations	Blue Shield Promise HEO will facilitate the first inaugural Health Equity Oversight Committee (HEOC) meeting by 6/20/2023.
Interventions that Matter	Blue Shield Promise will prioritize interventions for at least 3 populations of focus by 12/31/2023.

Table 1. QIHET Program Goals and Objectives

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

<u>Data Sources/Sets</u>

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

Surveys and Studies

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

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

II. Data Sources

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

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

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

Data Sources/Sets

1. Appeals data: Cultural, linguistics, or discrimination related appeals suggestive of disparity from the measurement year.
2. Beneficiary Demographics: California Department of Health Care Services 834 enrollment data.

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

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data: CAHPS® survey conducted in calendar year 2023.
2. Community Advisory Committee (CAC), held in the calendar year 2023.
3. Provider Advisory Committee (PAC), held in the calendar year 2023.
4. Joint Operations Meeting (JOM), held in the calendar year 2023.
5. Quality Improvement and Health Equity Committee (QIHEC), held in calendar year 2023.

III. Quality Improvement Health Equity Transformation Program Activities

Blue Shield of California seeks to advance health equity by implementing activities supporting the health plan mission to transform its health care delivery system into one that is worthy of families and friends and sustainably affordable. As aforementioned, Blue Shield Promise HEO operationalized program activities to meet the four program goals and objectives.

a. Goal #1: Sound Infrastructure and Operations

1. Objective #1: Blue Shield Promise HEO will facilitate the first inaugural QIHEC meeting by 3/31/2023.

As part of our health plan operational readiness, Blue Shield Promise Health Plan formulated the HEO. The Blue Shield Promise HEO is comprised of the Chief Health Equity Officer, Health Equity Principal Program Manager, Health Equity Business Analyst, Chief Executive Officer, Chief Medical Officer, Senior Director of Quality, and Director of Quality. Further, the HEO established the operational governance and framework in accordance with Blue Shield Promise current operating model and alignment with regulatory requirements.

Governance

In 2023, Blue Shield Promise softly launched the QIHEC. The QIHEC included membership from Interdepartmental participants across multiple cross-functional areas such as Marketing, Grievances, Utilization Management, Quality Improvement, Community Engagement, Health Education and Cultural and Linguistics, Behavioral Health, and other medical health services. The committee launched on 3/17/2023 and held quarterly meetings thereafter. In preparation for 2024, the HEO focused efforts on recruiting external partners for committee membership and onboarded members hosting orientation prior to the first QIHEC meeting. QIHEC external partners represent twelve (12) voting members and their back-up point person, totaling eighteen (18) individuals from eleven (11) diverse organizations across our Medi-Cal service Areas in Los Angeles and San Diego counties. The organizations include Federally Quality Health Centers, Individual Physician Associations and/or Medical Groups, physicians, and county partners. The QIHEC inaugural meeting with internal and external partnership launched on 3/21/2024 and has held up to five meetings to date.

Blue Shield Promise has established committees, such as the implementation and maintenance of the QIHEC responsible for creating the QIHETP Annual Plan, the Community Advisory Committee, Provider Advisory Committee, and other committees as identified by leadership and the community.

Blue Shield Promise' QIHEC is charged with reviewing all Health Equity related activities and documents. The QIHEC reports to the HEOC and QMC, both report to the Quality Oversight Committee (QOC). The QOC then reports directly to the Board Quality Improvement Committee (BQIC).

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

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

The responsibilities of the QIHEC include the following:

1. Review and approve annual QI and Health Equity plan. The Annual QIHETP workplan was reviewed and approved on March 17, 2023.
2. Develop, implement, maintain, and periodically update policies and procedures to ensure compliance with health equity requirements. The QIHEC reviewed and approved policies and procedures for the QIHETP including Policy # HEQ-001 QIHETP, HEQ-002 QIHEC, and HEQ-003 Diversity, Equity, and Inclusion (DEI) Training Program Requirements.
3. Analyze and evaluate the results of QI and health equity activities, including but not limited to, the annual review of the results of performance measures, utilization data, consumer satisfaction surveys or CAHPS®, and the findings and activities of other Blue Shield Promise committees such as the CAC and incorporating results into the design of quality improvement and health equity activities were reviewed in 2023 and incorporated as findings in this report.
4. Institute actions to address performance deficiencies, including policy recommendations as identified by committee members.
5. Ensure appropriate follow-up of identified performance deficiencies.
6. Implement and maintain a charter including the role, structure, and function of the QIHEC.
7. Continuously monitor, review, evaluate and improve quality and health equity of covered services including clinical care services, case management, coordination and continuity of services provided to all members.
8. Review and provide feedback on Blue Shield Promise Health Equity Accreditation activities, reports, and policies.

The Blue Shield Promise Health Equity Office (HEO) identified an opportunity to enhance the governance structure. The Medi-Cal Committee of the Board will be convened in 2024. The Medi-Cal Committee will be responsible for reviewing and approving the QIHETP and annual work plan. The Committee will also direct modifications to the plan and program. The HEO will prepare written progress reports that include a summary of findings and recommendations, actions taken, progress in objectives and improvements made.

Reporting

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

1. The Blue Shield Promise CHEO or designee provided a written summary of QIHEC activities, findings, recommendations, and actions following each meeting to BQIC and

to DHCS upon request. On behalf of the CHEO, the HEO's designated staff submitted the first written summary due to the state DHCS on March 31, 2024.

2. The Blue Shield Promise CHEO or designee provided a written summary of the QIHEC activities and made these available publicly on the Plan's website post QIHEC meeting. The summary was made available in April 2024. On behalf of the CHEO, the HEO's designated staff will continue to post the written summary at least on a quarterly basis following each QIHEC meeting.
3. The Blue Shield Promise CHEO will produce an annual Promise Health Equity report to the QIHEC and DHCS upon request in Quarter 2, 2024.
4. The HEO will continue to track designated staff to provide annual copies of all final reports of independent accrediting agencies to DHCS.
5. The HEO will post the annual Quality Improvement and Health Equity Plan to the Blue Shield Promise public website in Quarter 2, 2024.

Membership Composition

Further, the Blue Shield Promise QIHEC membership includes:

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

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

Accreditation

The Blue Shield Promise HEO works closely with the Blue Shield of California Quality Accreditation Department to plan, develop, and implement NCQA Health Equity

Accreditation (HEA) guidelines and activities per DHCS contract requirements to obtain formal accreditation.

In 2023, the HEO worked to create a Customer Care Conversation Guide Using Sexual Orientation and Gender Identity (SOGI) Inclusive Language Over the Telephone script for member-facing staff in our Customer Experience Department. The script meets regulatory requirements for NCQA Health Equity 2, which requires that Blue Shield of California gather individuals' race/ethnicity, language, gender, identity, and sexual orientation data that helps provide culturally and linguistically appropriate services (CLAS). As well as Assembly Bill (AB) 133 requires all "specified entities" to "exchange health information or provide access to health information to and from" other specified entities in real-time, as defined in the bill.

The SOGI script will assist Customer Care staff interaction with members who are encouraged to use members' preferred pronouns to enhance engagement with members, and create a safe space, welcoming environment, and speak respectfully to our members using their preferred language (Reference Appendix 8. Using SOGI Inclusive Language Over the Telephone). To pair the SOGI script training with enhanced training, the Blue Shield Promise HEO also worked in collaboration with the Quality Accreditation Department and Blue Shield of California HEO to develop a robust training on Diversity, Equity, Inclusion and Cultural Sensitivity that was provided to all member-facing staff to complete in May 2024 entitled *2024 Advancing Health Equity: Training to Support Members Interactions*.

Blue Shield Promise will continue to work toward obtaining NCQA HEA in accordance with DHCS contractual requirements and report on NCQA HEA activity status to QIHEC quarterly meetings.

2. Objective #2: Blue Shield Promise QIHET program documents will be reviewed and approved by the governance process by 7/1/2023.

a. QIHET Program Description

As part of building a sound infrastructure and operations Blue Shield Promise QIHET program documents were reviewed and approved by the governance process by 7/1/2023. Blue Shield Promise established the QIHET Program Description at the QIHEC Quarter 2 2023 meeting held on 6/5/2023.

The document was submitted to the QIHEC meeting for formal review and approval by the committee. The document outlines the QIHETP, defines the strategy and framework needed to advance health equity efforts across the organization in accordance with the requirements set forth by the California Department of Health Care Services (DHCS).

Blue Shield Promise included an introduction of the QIHETP program levers Transform, Heal, Build, Partner, and Champion activities to support the drive to eliminate disparities

among populations served are detailed in the document. It summarizes the health equity lens that has been applied to the health equity guiding principles to create a unique set of Health Equity Strategies.

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

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

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

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

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

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

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

b. QIHETP Work Plan

Blue Shield Promise established the QIHETP Work Plan at the QIHEC Quarter 1 2023 meeting held on 3/17/2023 and brought forward to committee members for formal review and approval quarterly thereafter.

The HEO developed the QIHETP Work Plan which outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the QIHEC and committee governance structure (Reference Appendix 1, 2023 QIHEC Work Plan).

The QIHETP Work Plan is a fluid document, updated as needed throughout the program year and referenced for comprehensive assessment of QIHETP activities. The scope of the annual work plan includes the following:

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

The Workplan is revised at least quarterly to meet changing priorities, regulatory requirements, and identified areas for improvement. And submitted for review and approval by QIHEC voting members. The status of QIHETP Work Plan items is reported as appropriate to the QIHEC, QOC and the BQIC.

A written summary of the QIHETP and QIHEC activities, findings, recommendations, and actions will be prepared after each QIHEC meeting and submitted to the BQIC and DHCS

upon request. Blue Shield Promise will make the written summary of the QIHEC and QIHETP activities publicly available on the Blue Shield Promise website at least on a quarterly basis.

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

c. Policies and Procedures

Blue Shield Promise QIHETP policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to:

1. Marketing strategy
2. Medical and other health services policies
3. Member and provider outreach
4. Community Advisory Committee
5. Quality Improvement activities
6. Grievance and Appeals
7. Utilization Management

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

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

As part of building a sound infrastructure and operations, Blue Shield Promise QIHET program documents were reviewed and approved by the governance process prior to 7/1/2023 as mentioned in the objective. Blue Shield Promise established the QIHET Program policies and procedures at the QIHEC Quarter 1 2023 meeting held on 3/17/2023. The HEO office will continue to follow the established process for health plan policies and procedures.

d. Reports

In 2023 and beginning 2024, the HEO conducted at least four (4) program reports, including the following:

1. Health Equity Assessment providing an overview of the need for applying the health equity lens across cross-functional areas to identify health disparities and/or inequities across vulnerable populations, a QIHET Program Description in Quarter 2 2023. The report highlights building on evidence based existing equitable practices, developing a health equity measure set, and uncovering priority populations of focus. Findings noted the need for the HEO to conduct comprehensive health equity assessments periodically throughout the year to evaluate utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, and establish collaborative partnerships (Reference Appendix 2. 2023-2024 QIHET Program Description).

2. Health Equity Assessment provides quality and bold goals disparity analysis of quality outcomes for the measurement year (MY) 2022 in Quarter 3 2023. The assessment provides a baseline report of performance relative to the DHCS Bold Goals. Key findings included recommendations for statistical significance between groups to identify disparities, especially since the total of eligible members per category ranged significantly. The report includes a complete analysis of the DHCS Managed Care Accountability Set (MCAS) and intersection with health equity (Reference Appendix 3. Health Equity Assessment - Quality and Bold Goals Disparity Analysis).

3. Health Equity Recommendations Report contains an assessment and recommendations to ensure Provider Network Capacity to meet ethnic, cultural, and linguistic needs of members in Quarter 4 2023. The Report highlights recommendations for cross collaboration across the enterprise, the need for workgroups to review the report and prepare a strategic action plan that considers the recommendations outlined in the report (Reference Appendix 4. Health Equity Recommendations Report - Provider Network Capacity).

4. Health Equity Assessment an Introduction to Equity and the Redetermination Process in Quarter 1 2024. The report highlights Blue Shield Promise's redetermination retention rate among Spanish speaking members of 81%, generalized to the Latino population; and Blue Shield Promise's redetermination retention rate among children and families of 83%. With Blue Shield Promise ending with a total 48,000 members favorable to the Plan (Reference Appendix 5. Health Equity Assessment - Redeterminations Report).

3. Objective #3: Blue Shield Promise HEO will facilitate the first inaugural HEOC meeting by 6/20/2023.

In 2023, Blue Shield Promise' QIHEC reported up to the QMC, QOC, and BQIC. The Health Equity Office focused its efforts, in 2023, to work closely with the Health Equity Office and strategically plan to align health equity goals and objectives enterprise-wide prior to convening the inaugural HEOC meeting. Continuous efforts are being made in 2024 to plan and implement the HEOC in partnership with Blue Shield of California, or the Classic Health Equity Office who has direct oversight of Commercial, Medicare, and Individual and Family Plans. Blue Shield Promise Health Equity Office will continue to meet governance committee structure compliance by reporting all QIHEC activities through the appropriate governance structure as it has until the inaugural HEOC meeting is launched.

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

1. Objective #1: Blue Shield Promise HEO will conduct at least five health equity presentations and/or trainings within the organization to embed equity in everything we do by 12/31/2023.

To meet the second goal to embed equity in everything we do, the HEO focused to conduct at least five health equity presentations in the calendar year 2023. The following are activities the HEO conducted throughout the year.

Health Equity Roadshow

As part of building awareness and centering health equity in everything we do, Blue Shield of California Promise Health Equity Office conducted a series of introductory health equity presentations, or Health Equity Roadshow presentations. The Health Equity Office CHEO met with several functional areas, including Quality, Behavioral Health, CalAIM, Community Engagement, Customer Experience Clinical Access, Grievance and Appeals, Health Education and Cultural and Linguistics, Maternal Health Equity, Population Health Management, Provider Network and Contracting. The Roadshow presentations served to engage functional areas in health equity planning and oversight.

The roadshow experience between the Health Equity Office and functional area leaders helped facilitate the importance of embedding health equity, partnership and advancing health equity while meeting contractual requirements. Furthermore, as part of the Roadshow presentations, identification of select health equity measures allowed for planning in recognition of the intersection between health equity in various functional areas. The goal of the roadshows was to discuss opportunities for health equity integration and identify specific health equity measures to monitor disparities. These multi-disciplinary measures comprise the HEART Measure Set (Reference Appendix 6. HEART Measure Set). The HEART Measure Set was built based on the adoption of the California Health Care Foundation (CHCF) and NCQA Health Equity Measurement framework, using a standardized approach to health equity measurement to that allows for Blue Shield Promise to systematically identify disparities, track progress over time and assess performance.

The framework has six domains, that informs development of quality improvement programs, helps us focus resources on programs and/or interventions most likely to contribute to improving health equity, and provide an opportunity to align quality and performance strategies with equity centered approaches to address disparities and close gaps in health care and health outcome (CHCF and NCQA, 2022).

In 2023, the HEO monitored data for the selected measures and identified initial findings. Integrated data results and outcomes were shared at the quarterly QIHEC meeting to provide transparent information sharing for cross-collaboration and understanding. Although further tracking and trending of these measures are needed, the intent is to continue to monitor the data, and in partnership with the cross functional areas at the direction of the CHEO, will implement initiatives to resolve the known health disparities, gaps, and opportunities.

Health Equity Department Presentations

Concurrently, the new HEO was building momentum, and an important topic various teams wanted to learn about. For example, the HEO regularly meets with the PHM Department and touch base on various PHM/HE related discussions. An opportunity arose when the PHM Department was building their team and wanted to learn how to identify great candidates using a health equity lens. The PHM Department, who worked closely with the Human Resources Talent Acquisition team, invited the HEO office to present on the topic. A meeting was held to introduce health equity, the mission and vision of the enterprise, a brief health equity program overview, as well as, an overview of the PHM Department, the need for candidates with lived experience, and how to assess candidates for cultural competency. The presentation was well received, and Talent Acquisition adopted the tools and resources the HEO provided.

Additional Departments requested an introductory health equity presentation, including PHM Department team meeting, Quality, and Information Technology (IT). Each presentation covered the very basis of what is health equity, why health equity matters, provided a brief health equity exercise applying the equity lens, provided a summary of DHCS contract requirements, the intersection of health equity in their respective Departments and how to operationalize health equity, along with a few key health equity takeaways, with a call to action.

Each meeting held with the teams was successful. Each Department felt better equipped with the health equity learnings and how to apply the health equity lens in their own individual work and functional area. Each Department was provided with tools and resources including furthering their education and knowledge on the topic by taking internal

trainings offered such as the Health Equity Foundations Course, Foundations of Diversity Equity, Inclusion and Belonging, and Cultural Competency and Humility Training.

I have HEART Advocate Program

The HEO was provided with great feedback from internal Departments and those that were introduced to the work, including the development of the I have HEART Advocate Program to assist the HEO in advancing health equity within the organization.

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

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

The I Have HEART Advocate team launched with leadership support, and a team of energized, inspired Advocates who created a workplan of activities to implement over the course of the 6-month program. The workplan detailed activities aimed at increasing knowledge, awareness, networking, and exposure to real-life scenarios. This working document allows Advocates to proactively sign up for activities, which support personal interests and professional goals and leverage expertise and skillsets amongst the team. Advocates volunteered to Lead, Contribute, or Participate. Leaders planned meetings, led teams, facilitated collaboration across functional areas, and served as Project Manager of a given activity. Contributors supported the Leader, contributing ideas or helping execute tasks. Participants attended training and events hosted by the various Leaders.

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

1. Advocates completed a series of health equity-related trainings within a safe space to discuss sensitive topics such as systemic racism, implicit bias, and health

disparities. A training on Bias and Gender Affirming Care was prepared by one of our Advocate.

2. Drafted a Charter, describing goals, responsibilities, and other logistical details outlining participation for Advocates. The Charter clearly details frequently asked questions and serves as a tool for Advocates when describing the I Have HEART Advocate program.
3. Planned and facilitated a tour and focus group for Advocates at the Pomona Community Resource Center. The focus group assessed community and member needs. This resulted in a partnership with a Consulting firm who prepared a document outlining the Member Journey with identified pain points and opportunities to improve the member experience.
4. Procurement of a team of industry experts in the field of Artificial Intelligence and facilitated a panel discussion with the Advocates talking about AI and the Future of Healthcare.
5. Spearheaded a coffee chat with peers to provide a forum for sharing memorable member stories that have deeply impacted our roles and ignite our desire to serve. This information will be used to maximize member engagement, increase member satisfaction, and support planning value-added benefits.
6. Hosted a virtual, interactive Cost of Poverty Experience (COPE) event with over 40 participants in attendance. This event which is designed to deepen understanding of the social determinants of health, impacting healthcare delivery and outcomes, and provide learning from communities that are most affected by inequities in health and social conditions, Participating in COPE created novel ways of thinking about what it takes to lift individuals and families out of poverty. This simulation allowed participants to explore the lived experiences and impact of poverty, firsthand through the eyes of people in their personal journey.
7. Many Advocates expressed interest in gaining exposure to teams and roles in which they would not typically interact with in their daily role. Advocates were invited to attend the quarterly Promise Quality Improvement and Health Equity Committee. Each quarter, a representative presents a summary of the I Have HEART Advocate program. This affords opportunities to interact with Promise Leaders, learn about Committee operations, and learn updates and outcomes on Promise's HEART program.
8. The development of a Framework and presented the Framework to Promise's Quality Improvement and Health Equity Committee. This will be used to codify planning and operations for subsequent cohorts.

This voluntary, peer-led, and equity-focused collaborative is new and requires HR and Executive support recognizing the importance of centering an equity lens in our daily roles and operations. Second, because this program was new, there was no structure, resulting in the team designing a formal structure, from finalizing a program Charter, to preparing a

framework for continuation into subsequent cohorts. Valerie worked to overcome challenges with lean resources, inspiring others to lead activities, use their time judiciously, and hold individual meetings to make vital connections. The planning was especially organic as Advocates' skills and interests emerged. Advocates went above and beyond the expectations of their current role, raising their hand, leaning in, with a cooperative mindset and member-centered approach.

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

Most notably, the HEO recruited from the Advocate team and filled an open position within the HEO. In 2024, the HEO will assess the success of the program and plan for a second I have HEART Program cohort.

c. Goal #3: Information in Action

1. Objective #1: Blue Shield Promise will develop a HEART Measure Set with key functional area leaders and out by end of the year 12/31/2023.

HEART Measure Set

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

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

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

The framework six domains are as follows:

Figure 1. Health Equity Measurement Framework for Medicaid Accountability Domains

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.

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

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

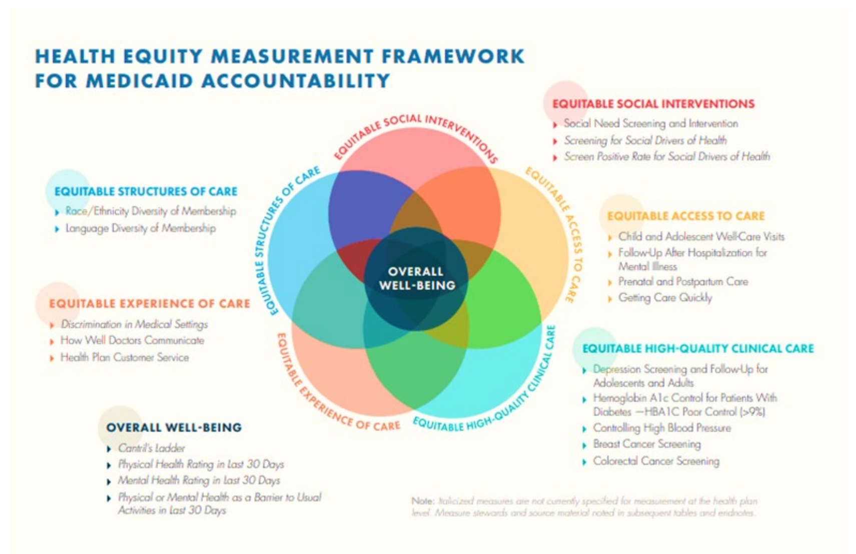


Figure 2. Health Equity Measurement Framework for Medicaid Accountability Summarized

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

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

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

1. Quality HEDIS® measures

2. Grievances and Appeals, Behavioral Health
3. Provider Relations and Contracting
4. Health Education
5. Cultural and Linguistics
6. CalAIM and subsidiary population health management functional area
7. Customer Experience
8. Clinical Access Programs
9. Maternal Health
10. Utilization Management

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

Below is a detailed list of the health equity measures set selection by Department. Oversight of the health equity measure set outcomes and/or performance results are following the continuous quality improvement (CQI) process. The HEO has defined an overall Health Equity Score, the number of measures from the HEART Measure Set that are meeting the target. The health equity measure set is monitored at least quarterly and reported to the QIHEC. Reference Appendix 6 for the complete HEART Measure Set by Department.

A. Customer Experience

The member experience is critical to member engagement, satisfaction, and can influence member utilization of services. The HEO and Customer Experience Department selected specific regulatory measures that meet both regulatory and health equity intent and purposes. Customer Experience will focus on call center metrics including tracking Blue Shield Promise Customer Experience and vendor requested interpreter service calls by the member's preferred language. Tracking and trending the total number of multi-cultural/multilingual staff to ensure our Customer Experience member-facing staff are representative of our entire membership. If identified, the Customer Experience team notes any notable operational challenges that impact health equitable structures and access to care.

B. Appeals and Grievances

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

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

The HEO and Appeals and Grievances Department selected specific measures that meet both regulatory and health equity intent and purposes. Measures include, the percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period, and percentage of Discrimination grievances based on all grievances received during the measurement period.

C. CalAIM

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

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

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

D. Quality

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

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

E. Behavioral Health

The scope of the Health Equity Transformation Program extends into the delivery of behavioral health services. The HEO and Behavioral Health Department have monitored the recently released CalAIM metrics related to behavioral health and DHCS bold goals required for monitoring. These metrics are stratified by the REGAL dataset. Additionally, the Behavioral Health Department tracks the total number of prenatal and postpartum depression screenings. This will help us to identify any disparate populations within our prenatal and/or postpartum membership and identify any other populations that may be impacted by mental illness specifically among our most vulnerable populations including adolescents, homeless, and lesbian, gay, bisexual, transgender and queer, (LGBTQ+) members for select measures. Reference Appendix 6 for the complete HEART Measure Set as it relates to behavioral health.

F. Provider Contracting and Relations

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

Furthermore, Blue Shield Promise will ensure Network Providers complete the new Diversity, Equity, Inclusion (DEI) Training Program that includes topics such as cultural competency, sensitivity, health equity, and diversity training and provided for employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees) and All Plan Letter Diversity, Equity, Inclusion Training Program Requirements (APL) 23-025.

The CHEO will collaborate with Blue Shield staff to ensure that the Network Provider bi-annual mandatory training includes information on all member rights specified in Exhibit A, Attachment III, Section 5.1 (Member Services), and DEI training (sensitivity, diversity, communication skills, and cultural competency training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training) and APL 23-025.

This process includes an educational program for Network Providers regarding health needs to include but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health

Service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and Children with special health care needs. Training includes Social Drivers of Health and disparity impacts on members' health care. Attendance records will be reviewed and maintained by Blue Shield Promise staff. The Provider Contracting and Relations Department will work closely with the HEO, and Health Education and C&L Department to track provider training.

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

G. Health Education and Cultural and Linguistics

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

H. Maternal Health

The Maternal Health Department supports the delivery of perinatal services. In 2023, the HEO and Maternal Health team monitored existing metrics to measure health disparate populations including metrics that directly address the DHCS bold goals. The Maternal Health functional area will track rate of maternal morbidity, and c-section rates stratified by REGAL where possible to identify any disparate trend within our population. In partnership with the Behavioral Health Department, the Maternal Health functional area also track maternal mental health screening and positive mental health screening results by REGAL and the total rate of members with a positive maternal mental health screening referred to behavioral health services. The selection of these metrics is sound and evidence-based to have determined disparate populations most seen among our Black, African American, and Hispanic or Latino populations. The Maternal Health Equity team structured under the Office of the Chief Medical Officer will finalize a comprehensive strategic plan for implementation in 2024-2025. The plan will be presented to the QIHEC in 2024.

I. Clinical Access Programs

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

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

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

HEART Measure Set Monitoring Data Report

The HEO identified initial observations and emerging trends by measure domain over the course of monitoring the HEART Measure Set from Q2 2023 into Q12024. The following are some results by measure domain.

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

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

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

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

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

Table 3. Depression Screening Follow-Up Measure

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

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

Table 4. Interpreter Service Utilization

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

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

Table 5. Childhood Immunization Measure

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

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

The HEO's initial observations have led to recommendations per metric, including planned or current activities. For example, the SDOH reporting metric, the Quality team is leading SDOH incentives for Providers. The program has been officially submitted to the DHCS and is under desk review for approval. For Childhood Immunization Status, we need to assess the root causes for why our measures are low among African American and White populations, could it be vaccine hesitancy vs. access issues. For the DSF measure, we would like to continue to track the next 6 months' worth of data to confirm the geographical variance trend we're seeing now. Regarding the bilingual calls managed by call center, our initial observation is to ensure call center agents can meet the need of our Spanish-speaking members. We did reach out to Call Center leadership who confirmed they are prioritizing recruitment of bilingual Call Center staff; 21 of 29 recent hires are bilingual. For interpreter service utilization, we saw a higher request service for ASL utilization when compared to other languages. We have requested membership data to identify people with disabilities, and ASL category across all HEART measures to assess health outcomes for people with disabilities, specifically among our hard of hearing members.

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

Table 6. Opportunities and/or Next Steps

Additionally, The HEO is also working in partnership with the IT and Data Analytics teams to enhance reporting, automation, and a health equity dashboard build to improve tracking and trending of data over time.

Health Equity Integration Plan

In collaboration with impacted functional areas, the HEO will continue to meet with each department and build upon the Integrated Health Equity Measurement Set to ensure the measure set is all encompassing and includes all Departments. The HEO will optimize use of the Health Equity Measurement Framework to identify disparities and inequities occurring between populations and inform data-driven activities.

Furthermore, the roadshow experience exacerbated the need to focus our efforts on vulnerable priority populations that would also align with the DHCS bold goals, including maternal health, child health, justice-involvement, homelessness, LGBTQ+, members with open care gaps identified health disparate inequities, member experience as indicated by the CAHPS ® survey, and utilization management over- and under-utilization of services.

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

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

demonstrate they are integrating and prioritizing health equity into program plans and operations.

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

d. Goal #4: Interventions that Matter

1. Objective #1: Blue Shield Promise will prioritize interventions for at least 3 populations of focus by 12/31/2023.

In collaboration with cross-functional departments, the HEO spotlighted 3 interventions during the 2023 QIHEC quarterly meetings. The following interventions below include findings, interventions, and outcomes presented by each department.

Community Well Child Visit Events

To improve performance on Well Child Visits (WCV), the Medi-Cal Quality Team partnered with the Community and Provider Engagement (CAPE) team to hold well child visit clinics at YMCAs and Boys and Girls Clubs in San Diego, and the Blue Shield Promise Informational Resource Center in Huntington Park. The services conducted at the WCV events included the WCV for children ages 0-20 years, lead screening, developmental screenings, topical fluoride application, and depression screenings.

The Quality Department conducted a thorough event process that included identifying members who have open care gaps, examine high density areas with low well child visit rates to hold clinics, and targeted older children who are less likely to be seen for a well-child visit. The Quality Department then worked to collaborate with community-based groups to identify facilities in areas of need, availability dates, and secure event dates. There was also a pre-purchase membership for members participating in the event.

The Quality Department conducted outreach activities encouraging members to attend the events. Offered language/interpreter services, transportation if needed, member incentives for completing services, and addressed any barriers or challenges that may have impeded attendance at the events. The Quality Department also conducted reminder calls prior to the events to confirm attendance.

The events were launched. Quality Health Partners' clinicians conducted the visit, addressed member questions and needs, ensured member knew who their Primary Care Provider (PCP) is for follow-up, and ensured that the member established with a Dentist. After the visits, the visit notes were submitted to the member's PCP; referrals to PCPs for follow-up, and ancillary services such as Social Services, Care Management, and Health Education Departments were submitted as well.

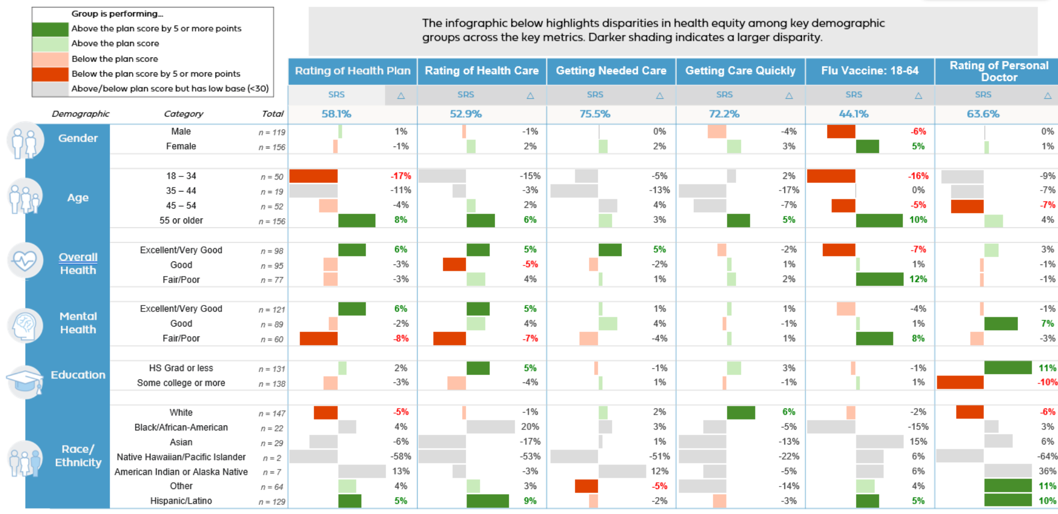
The WCV Events resulted in lessons learned, barriers and next steps for the Quality Team. Overall, members are interested in being seen in familiar community settings. A total of 400 members were seen. Some members expressed more comfort in this setting and the offered flexibility of hosting the events at the weekend hours. The event garnered the opportunity to use non-traditional settings for member-facing interaction to encourage preventive care and to see their PCP. Members responded favorably to the added incentive of the YMCA membership to promote fitness/exercise and mental wellbeing. As a result of the events, Blue Shield Promise Medi-Cal Product Department is working on a value-added benefit for YMCA and Boys and Girls Club membership offering in calendar year 2024 for Blue Shield Promise Medi-Cal members.

The Quality Department continued to offer well child visit events in non-traditional settings, holding 3 events in December 2023 at the Information Resource Center and 2 events in the Boys and Girls Club in January 2024. The Quality Department continues to explore conducting these events at Blue Shield Promise and Los Angeles (LA) Care Health Plan Community Resource Centers (CRC) throughout Los Angeles County, and plans to expand the events to Head Start, Early Head Start and State Preschool (MAAC Project) in San Diego County for calendar year 2024.

CAHPS® Outreach Activities

The Blue Shield Promise Medi-Cal Quality team conducts an annual CAHPS® Adult and Child Survey to Los Angeles and San Diego County members. The CAHPS® data results specific to health equity key demographic groups across metrics were presented to the QIHEC in Q4 2024. The CAHPS® survey is completed via a multi-channel approach including live telephone calls and mailings.

Data presented at the QIHEC were based on a summary of key metrics as demonstrated below.

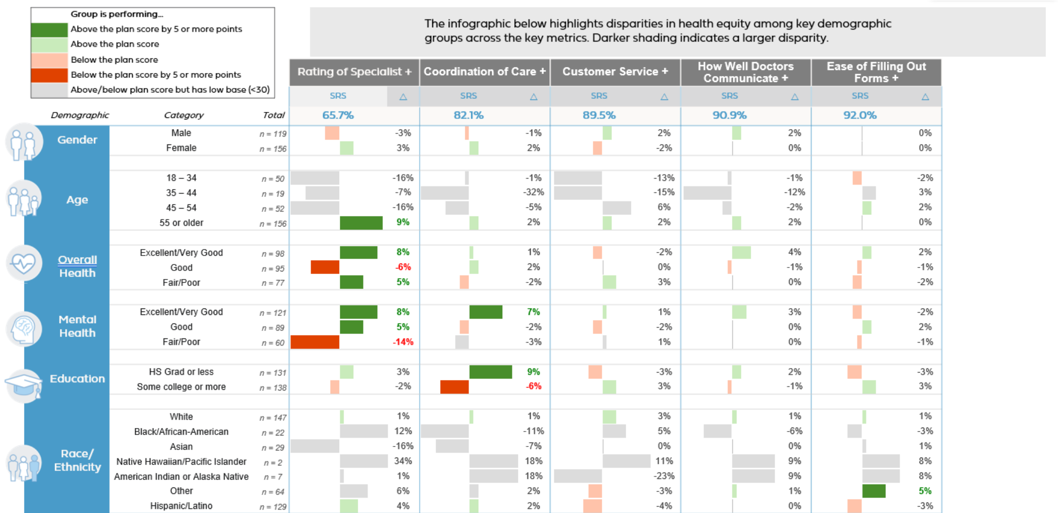


Group is performing…
- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	Category	Total	Rating of Health Plan △	Rating of Health Care △	Getting Needed Care △	Getting Care Quickly △	Flu Vaccine: 18-64 △	Rating of Personal Doctor △
		SRS	58.1%	52.9%	75.5%	72.2%	44.1%	63.6%
Gender	Male	n = 119	1%	-1%	0%	-4%	-6%	0%
	Female	n = 156	-1%	2%	2%	3%	5%	1%
Age	18 – 34	n = 50	-17%	-15%	-5%	2%	-16%	-9%
	35 – 44	n = 19	-11%	-3%	-13%	-17%	0%	-7%
	45 – 54	n = 52	-4%	2%	4%	-7%	-5%	-7%
	55 or older	n = 156	8%	6%	3%	5%	10%	4%
Overall Health	Excellent/Very Good	n = 98	6%	5%	5%	-2%	-7%	3%
	Good	n = 95	-3%	-5%	-2%	1%	1%	-1%
	Fair/Poor	n = 77	-3%	4%	1%	2%	12%	-1%
Mental Health	Excellent/Very Good	n = 121	6%	5%	1%	1%	-4%	-1%
	Good	n = 89	-2%	4%	4%	-1%	1%	7%
	Fair/Poor	n = 60	-8%	-7%	-4%	1%	8%	-3%
Education	HS Grad or less	n = 131	2%	5%	-1%	3%	-1%	11%
	Some college or more	n = 138	-3%	-4%	1%	-1%	1%	-10%
Race/ Ethnicity	White	n = 147	-5%	-1%	2%	6%	-2%	-6%
	Black/African-American	n = 22	4%	20%	3%	-5%	-15%	3%
	Asian	n = 29	-6%	-17%	1%	-13%	15%	6%
	Native Hawaiian/Pacific Islander	n = 2	-58%	-53%	-51%	-22%	6%	-64%
	American Indian or Alaska Native	n = 7	13%	-3%	12%	-5%	6%	36%
	Other	n = 64	4%	3%	-5%	-14%	4%	11%
	Hispanic/Latino	n = 129	5%	9%	-2%	-3%	5%	10%

Figure 3. Reporting Year 2023 San Diego Adult Results - Health Equity Metrics



Group is performing…
- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	Category	Total	Rating of Specialist + △	Coordination of Care + △	Customer Service + △	How Well Doctors Communicate + △	Ease of Filling Out Forms + △
		SRS	65.7%	82.1%	89.5%	90.9%	92.0%
Gender	Male	n = 119	-3%	-1%	2%	2%	0%
	Female	n = 156	3%	2%	-2%	0%	0%
Age	18 – 34	n = 50	-16%	-1%	-13%	-1%	-2%
	35 – 44	n = 19	-7%	-32%	-15%	-12%	3%
	45 – 54	n = 52	-16%	-5%	6%	-2%	2%
	55 or older	n = 156	9%	2%	2%	2%	0%
Overall Health	Excellent/Very Good	n = 98	8%	1%	-2%	4%	2%
	Good	n = 95	-6%	2%	0%	-1%	-1%
	Fair/Poor	n = 77	5%	-2%	3%	0%	-2%
Mental Health	Excellent/Very Good	n = 121	8%	7%	1%	3%	-2%
	Good	n = 89	5%	-2%	-2%	0%	2%
	Fair/Poor	n = 60	-14%	-3%	1%	0%	-1%
Education	HS Grad or less	n = 131	3%	9%	-3%	2%	-3%
	Some college or more	n = 138	-2%	-6%	3%	-1%	3%
Race/ Ethnicity	White	n = 147	1%	1%	3%	1%	1%
	Black/African-American	n = 22	12%	-11%	5%	-6%	-3%
	Asian	n = 29	-16%	-7%	0%	0%	1%
	Native Hawaiian/Pacific Islander	n = 2	34%	18%	11%	9%	8%
	American Indian or Alaska Native	n = 7	1%	18%	-23%	9%	8%
	Other	n = 64	6%	2%	-3%	1%	5%
	Hispanic/Latino	n = 129	4%	2%	-4%	0%	-3%

Figure 4. Reporting Year 2023 San Diego Adult Results - Health Equity Metrics

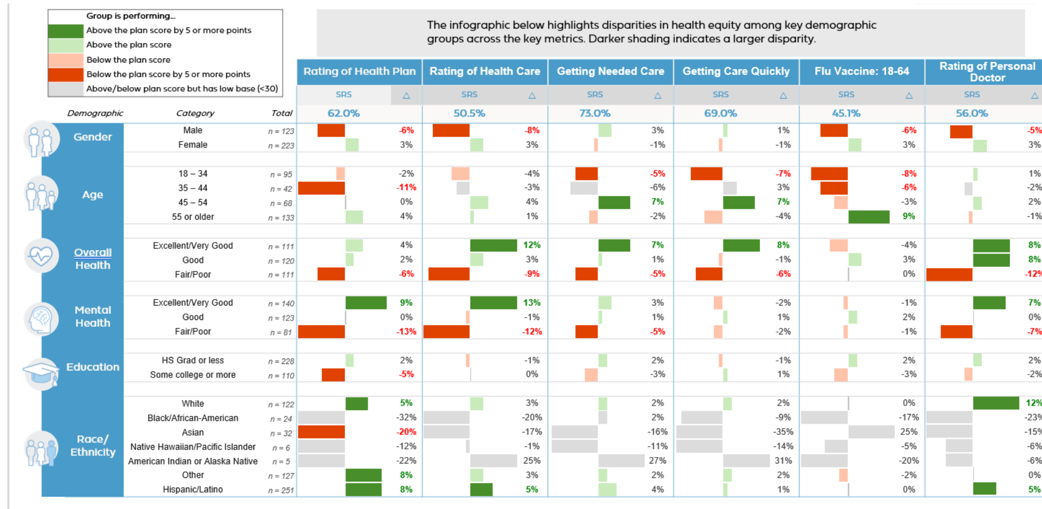


Figure 5. Reporting Year 2023 Los Angeles Adult - Health Equity Metrics

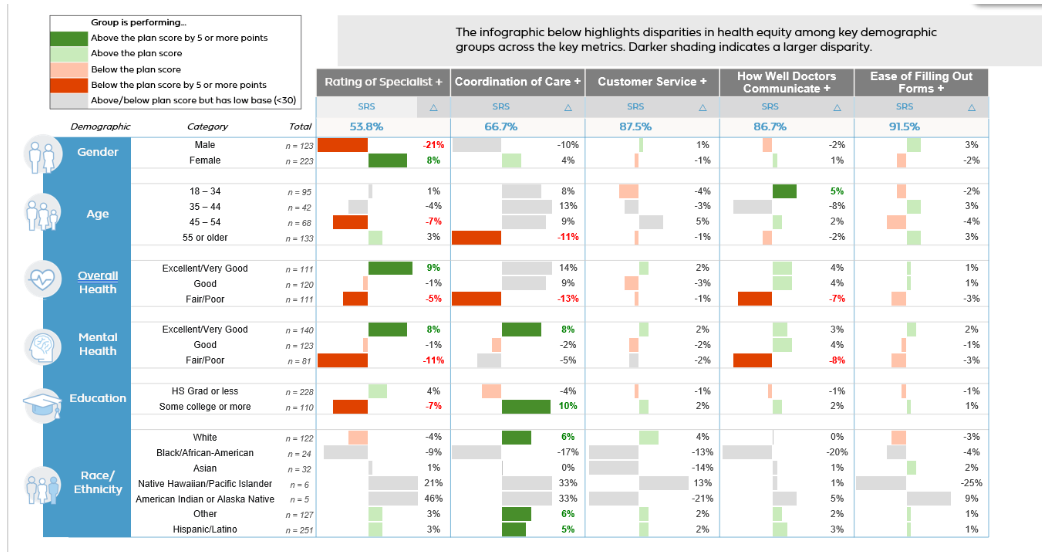


Figure 6. Reporting Year 2023 Los Angeles Audit - Health Equity Metrics

Overall summary results and data indicated that the CAHPS® health plan rating based on age remained consistent year-over-year and the data shows that older health plan members are reporting a better experience and are happier with their health plan. It also shows that 18- to 34-year-olds report being less satisfied with their health plan. Also noted, the self-reported mental health status correlates with health plan ratings. Another key takeaway is that the Hispanic and Latino population are shown to be happy with their health plan and the care they are receiving. The same trends are shown with the Net Promoter Scores (NPS). The Medi-Cal Quality team reviewed the mental health results in Los Angeles County stating that in race and ethnicity categories, Asian and Black or African American members are shown more in the data outcomes.

As a result of the outcomes, interventions taking place include a pre-CAHPS push with outreach via mailers and phone calls. This push supplements the year-round outreach. New decision point tools are planned to be implemented to include new call scripts, new mailers, better member segmenting, more detailed profile of member and other health equity factors. Different age ranges will be targeted each month and health equity data is being used. An online platform is available that takes available data for the call representatives to access. This can determine social needs, transportation issues, or the last time a member accessed care. A mock CAHPS® is completed year-round, and results are available monthly. This mock survey does not provide much data, so a shorter survey is being considered. Additionally, member newsletter content is derived from CAHPS® and NPS data. In 2024, there are plans to develop an Access to Care Health Education mailer.

Redetermination Process

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

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

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

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

- Income, expenses, deductions
- Address

- Review and update household information
- Supporting documents

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

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

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

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

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

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

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

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

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

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

Health Equity Spotlight Interventions: Summary Outcomes				
Spotlight	Finding	**Source**	**Intervention**	**Outcome**
Community Well Child Visit Events	Low Well Child Visit (WCV) rates	Report	Boys and Girls Club	Onsite WCV services offered; 400 members seen; community-based organization (CBO) partnership; referral for PCP follow-up and health plan ancillary services; opportunity for 5 additional events and expansion with other CBO's and LA County CRC's
CAHPS® Outreach Activities		Report	Outreach Telephone calls	Older health plan members are reporting a better experience and are happier with their health plan. 18- to 34-year-olds report being less satisfied with their health plan. Self-reported mental health status correlates with health plan ratings. Hispanic and Latino members are shown to be happy with their health plan and the care they are receiving. Mental health results in Los Angeles County among Asian and Black or African American members are shown more in the data outcomes.
Redetermination Outreach Activities	Redetermination Rate favorable to plan	Report	Algorithm to prioritize multi-channel outreach to populations at disproportionate risk for disenrollment based on select criteria developed by the Provider and Community Engagement Department	48,000 members favorable to plan, and nearly 290,0000 (55%) of members completed redetermination process. Plan achieved 80% redetermination rate, higher rate compared to State, Los Angeles County, San Diego County and LA Care Redetermination rate among Spanish Speaking members is 81%; and among children and families 83% compared to only 50% of people who disenrolled from Medi-Cal among the Latino population as reported by the Los Angeles Times.

Table 7. Health Equity Spotlight Interventions

Blue Shield Promise will continue to spotlight health equity interventions, monitor the HEART Measure Set to continue to develop data-driven customized interventions that

drive Quality and Health Equity in Medi-Cal, in partnership with key cross functional areas and in alignment with the DHCS Bold Goals: 50x2025 initiative, a strategy introduced in the DHCS Comprehensive Quality Strategy (DHCS, 2022).

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

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

IV. Key Findings

The following list highlights key findings the HEO has identified throughout the calendar year 2023 and beginning 2024.

- Blue Shield Promise will continue to work toward obtaining NCQA HEA in accordance with DHCS contractual requirements and report NCQA HEA activities and status to QIHEC quarterly meeting.
- Continual efforts to plan and implement the HEOC in partnership with Blue Shield of California, or the Classic Health Equity Office who has direct oversight of Commercial, Medicare, and Individual and Family Plans.
- There is an identified need to conduct additional comprehensive health equity assessments periodically throughout the year to evaluate utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, and establish collaborative partnerships (Reference Appendix 2. 2023-2024 QIHET Program Description).
- The HEO will act on key findings and recommendations that resulted from the Health Equity Assessment – Quality and Bold Goals Disparity Analysis report. Included in the recommendations, is the need to enhance existing data reports to include statistical significance and analysis to identify disparities between groups (Reference Appendix 3. Health Equity Assessment - Quality and Bold Goals Disparity Analysis).
- The need for the HEO to cross collaborate across the enterprise. There is a need to conduct additional workgroups to review the written Health Equity Recommendations Report – Provider Network Capacity Report conducted and prepare a strategic action plan that

considers the recommendations outlined in the report (Reference Appendix 4. Health Equity Recommendations Report - Provider Network Capacity).

- Continual monitoring of the HEART Measure set over time is needed. Initial observations drew limited data inferences. The HEO will follow up on initial observations and recommendations made as outlined in Table 6. Opportunities and/or Next Steps.
- Overall, the HEO needs more time to confirm data variance trend across the metrics, while concurrently, working in partnership with the IT and Data Analytics teams to enhance existing reports, automation, and a health equity dashboard build to improve tracking and trending of data.
- The roadshow experience exacerbated the need to focus our efforts on vulnerable priority populations that would also align with the DHCS bold goals, including maternal health, child health, justice-involvement, homelessness, LGBTQ+, members with open care gaps identified health disparate inequities, member experience as indicated by the CAHPS ® survey, and utilization management over- and under-utilization of services.

V. Action Plan

In 2024, the HEO will seek to meet a set of objectives that contribute to accomplishing the QIHETP goals. Objectives are established by the HEO on an annual basis and revised as needed. Progress is assessed routinely and reported to the QIHEC. Results are incorporated into the QIHETP Annual Evaluation and reported to the QIHEC and other committees per the established governance structure.

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

Table 8. QIHET Program Goals and Objectives

Furthermore, the QIHETP Action Plan lists all actions and milestones needed to formally build and implement Blue Shield Promise QIHETP. The Action Plan is managed by the HEO (Reference Appendix 7. 2024-2025 QIHETP Action Plan).

The initial goal for the QIHETP is to at minimum meet all state requirements and achieve DHCS Request for Proposal (RFP) content for implementation readiness. The QIHETP Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the QIHEC, HEOC, QOC and BQIC.

VI. Stakeholder Engagement

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

a. Community Advisory Committee

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

In 2023, Blue Shield Promise CAC meetings were engaged to learn about the new QIHETP and had an opportunity to provide input on how they would like to learn more about the program. The HEO attended Quarter 3, 2023 meetings in both Los Angeles and San Diego counties to invite members and community-based organizations to be part of the QIHEC. Attendees proposed ideas for how to recruit membership including posters, flyers, social media such as Instagram, TikTok, and Facebook. Community-based organizations present added, to incentivize members to increase membership and promote the incentive where possible. Additional feedback including recruiting members from clinic site locations using posters, videos, brochures, or leveraging local grocery stores to market the new committee. The HEO took the committee’s feedback and collaboratively worked with the Community and Provider Engagement Department to develop a flyer, create short excerpts to be included in Blue Shield Promise’ public website and member handbook. The excerpts encourage the reader to join the QIHEC membership. The result of the feedback garnered, the HEO also created their own email address and inbox inviting both members and providers to message the department directly to join the newly formed QIHEC.

b. Provider Advisory Council

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

Provider Advisory Council meetings, including Quarter 2 2023 Los Angeles and San Diego County meetings to introduce the QIHETP and Quarter 3 2023 Los Angeles and San Diego County meetings to summarize what we talked about health equity in Quarter 2.

The CHEO introduced the QIHETP to the committee in Quarter 2 2023 and the newly formed HEO comprised of the Blue Shield Promise Chief Executive Officer (CEO) and President, CMO, CHEO, and Quality leadership. The HEO briefly discussed how the QIHETP will be responsible for the development of the QIHETP strategy and drive program development and implementation. The CHEO reviewed Blue Shield of California's Health Equity Vision for all and applying the equity lens in everything we do; provided an overview of the Health Equity Transformation Program Requirements and priority focus areas as we implement the program; reviewed the Health Equity program design and the five (5) tenets to drive the health equity work; walked through the QIHETP implementation roadmap, including all the activities to meet program requirements; reviewed the Health Equity Program initial monitoring plan, focused populations, and health equity board reports to include stratified race, ethnicity, gender, age, language (REGAL) data; and introduced health equity program opportunities for committee participation to support and partner in our health equity program efforts.

The HEO received great feedback from the PAC including top recommendations to integrate into strategic planning such as diversifying the Provider Network to ensure the network meets the membership needs' served and best practice offered by Family Health Centers of San Diego (FHCSD); a pipeline program needed to build capacity and skills to meet diverse population needs, for example, Community Health Workers, Clinicians, scholarship opportunities, and school partnerships; scale the internal HEART Advocate program and invest in current staff by building cultural competency skills; offer provider practice training and train providers on health equity concepts, basic health equity terms, and share the importance of why this health equity work is important and needed. The FHCSD CEO commended the Blue Shield Promise CHEO for bringing forward an "Energetic and well thought out presentation. This doesn't look like a program that is going to occupy shelf space."

In 2024, the HEO will continue to bring forward pertinent QIHETP topics to upcoming meetings to garner Network Provider feedback toward the development and/or enhancement of health plan programs.

c. Joint Operations Meeting

The Blue Shield Promise HEO also participated in 2023 Joint Operations Meetings and met with several individual provider associations (IPAs) and medical groups. The HEO had the opportunity to present on the topic of health equity with 23 IPAs and medical groups over the calendar year. The HEO formally introduced the Blue Shield Promise HEO, the new DHCS QIHETP contract requirements along with our approach to addressing health equity as a health plan. A representative from the HEO introduced the QIHETP tenets, for which the program is built on detailed activities. The HEO also informed JOM attendees what the initial focus would be for the

first year, provided an overview of our governance structure, new DHCS requirements and activities that will impact our Provider Network. The HEO also had the opportunity to recruit attendees that were at the JOM meetings for the QIHEC and successfully recruited new members who are officially a part of the QIHEC membership.

In 2024, the HEO will continue to bring forward pertinent QIHETP topics and updates to upcoming meetings to garner feedback toward the development and/or enhancement of health plan programs.

VII. Annual Evaluation Reporting and Oversight

Results and key findings of the QIHETP Annual Evaluation will be presented to the QIHEC in Quarter 2 2024. The Health Equity Principal Program Manager will manage the 2024-2025 QIHETP Action Plan updating outcomes as they become available. An executive summary will be presented to the QIHEC, HEOC, QMC, QOC, BQIC, 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 RY 2024 QIHETP Annual Evaluation as applicable. The QIHETP Annual Evaluation will be posted on the Plan's public website. Notification of the website and program updates will be transmitted via the member newsletter, Member Handbook (Evidence of Coverage), Provider Manual.

VIII. References

1. Agency for Healthcare Research and Quality (2023). Frequently asked questions about CAHPS. Retrieved from https://www.ahrq.gov/cahps/faq/index.html
2. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Committee Charter.
3. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Committee Policy.
4. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Transformation Program Policy.
5. California Department of Managed Health Care (DMHC) APL 22-028 Health Equity and Quality Measure Set and Reporting Process retrieved from https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
6. California Health Care Foundation (CHCF) and National Committee for Quality Assurance (NCQA) (2022). White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid. Retrieved from https://www.ncqa.org/wp-content/uploads/2022/10/NCQA-CHCF-EquityFrmwrkMedicaid-Sep22_FINAL.pdf.
7. DHCS Medi-Cal Managed Care Plans Blue Shield of California Promise Health Plan Contract 22-20516.
8. National Committee for Quality Assurance (NCQA) 2023 Health Equity Accreditation Standards retrieved from https://www.ncqa.org/programs/health-equity-accreditation/.

VIII. Appendices

Appendix 1. 2023 QIHEC Work Plan

Appendix 2. 2023-2024 QIHET Program Description

Appendix 3. Health Equity Assessment - Quality and Bold Goals Disparity Analysis

Appendix 4. Health Equity Recommendations Report - Provider Network Capacity

Appendix 5. Health Equity Assessment - Redeterminations Report

Appendix 6. HEART Measure Set

Appendix 7. 2024-2025 QIHETP Action Plan

Appendix 8. Using SOGI Inclusive Language Over the Telephone

Quality Improvement and Health Equity Committee Workplan

Item No.	Regulatory Standard (e.g., CMS DMHC, DHCS and NCQA, Office of Affordability)	Item	Responsible Person/Owner(s)	Reporting Frequency	Goal	Objective	Action Steps	Q1	Q2	Q3	Q4	Reporting Date(s)	Status	Risk	Comments
1	DHCS	Quality Improvement and Health Equity Transformation Program (QIHETP) Policy	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Develop the QIHETP Policy to meet DHCS compliance by February 15, 2023 and submit to QIHEC by March 17, 2023.	Annual Review and Approval	X				3/17/2023	Complete	Low	
2	DHCS	Quality Improvement and Health Equity Committee Policy	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Develop the QIHEC Policy to meet DHCS compliance by February 15, 2023 and submit to QIHEC by March 17, 2023.	Annual Review and Approval	X				3/17/2023	Complete	Low	
3	DHCS	Quality Improvement and Health Equity Committee Charter	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Develp the QIHEC Charter and submit to QIHEC for review and approval by March 17, 2023.	Annual Review and Approval	X		X		3/17/2023 9/28/2023	Complete	Low	9/28/2023: Updates made to member composition section.
4	DHCS	Quality Improvement and Health Equity Transformation (QIHET) Program Description	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Develop the written QIHET Program Description and submit to QIHEC for review and approval by June 5, 2023.	Annual Review and Approval		X			6/5/2023	Complete	Low	
5	DHCS	Quality Improvement and Health Equity Transformation Program Evaluation	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Assess the QIHET Program Evaluation and submit to QIHEC for review and approval by 9/28/2023.	Annual Review and Approval			X		9/28/2023	Complete	Low	
6	DHCS, DMHC, NCQA	Health Equity Requirements: Appeals and Grievances	Lorraine Graywitt Valerie Martinez	Quarterly	Embed Equity and Advance Information in Action	Introduce the health equity requirements for Appeals and Grievances and health equity analysis to QIHEC by March 17, 2023 and updates quarterly thereafter.	Analysis of quarterly reports to identify HE trend and remediate issues.	X	X	X	X	3/17/2023 6/5/2023 9/28/2023 12/4/2023	Ongoing	Medium	DHCS requires Medi-Cal Plans to *integrate Health Equity into Appeals and Grievances operations*. HEO and AGD partnering to source demographic data that is needed to meet DHCS health equity requirements via our quarterly HEART Measure Set Monitoring Report.
7	DHCS, NCQA	Quality Measure Equity Stratification Dashboard (MCAS Health Equity Assessment)	Christine Nguyen	Quarterly	Embed Equity and Advance Information in Action	Submit the Quality Measure Equity Stratification Dashboard to QIHEC by June 5, 2023 and quarterly thereafter for tracking and trending.	Analysis of quarterly reports to identify HE disparities.		X	X	X	6/5/2023 9/28/2023 12/4/2023	Ongoing	Low	6/5/2023: share data set 9/28/2023: share analysis
8	DHCS, NCQA	Health Equity Advancement Resulting in Transformation (HEART) Measure Set for Approval	Valerie Martinez	Quarterly	Embed Equity and Advance Information in Action	Submit the HEART Measure Set to QIHEC by June 5, 2023 and quarterly thereafter for tracking and trending.	Approval of measure set.		X	X	X	6/5/2023 9/28/2023 12/4/2023	Ongoing	Low	6/5/2023: share data set 9/28/2023: share analysis
	DHCS, NCQA	Health Equity Advancement Resulting in Transformation (HEART) Measure Set Monitoring Report	Valerie Martinez	Quarterly	Embed Equity and Advance Information in Action	Submit the HEART Measure Set monitoring report to track and trend notable health disparities to QIHEC by September 28, 2023 and quarterly thereafter.	Analysis of quarterly reports to identify HE disparities.			X	X	9/28/2023 12/4/2023	Ongoing	Medium	6/5/2023: share data set 9/28/2023: share analysis
9	DHCS	Health Equity Spotlight Report	Various Functional Leads	Quarterly	Embed Equity	Submit a Health Equity Spotlight Report to demonstrate health equity integration in everything we do by March 17, 2023 and quarterly thereafter.	Spotlight and report a health equity initiative.	X	X	X	X	3/17/2023 6/5/2023 9/28/2023 12/4/2023	Ongoing	Low	
10	DHCS	Community Resource Center (CRC) and Health Equity Strategic Planning Session, Focus Groups	Valerie Martinez	Quarterly	Listening Deeply Center Community in our Strategy Embed Equity Reimagine the member experience	Engage internal functional area(s) and experiences to embed health equity in everything we do by September 28, 2023.	Informational and report out to QIHEC.			X	X	9/28/2023 12/4/2023	Ongoing	Low	
11	DHCS	I have HEART Advocate Program	Valerie Martinez	Quarterly	Build Sound Infrastructure and Operations Cultivate a culture of Equity	Introduce the I have HEART Advocate Program to QIHEC by September 28, 2023, and updates quarterly thereafter.	Informational and report out to QIHEC.			X	X	9/28/2023 12/4/2023	Ongoing	Low	
12	DHCS	Health Equity Recommendations Provider Network Capacity Report	Valerie Martinez	Quarterly	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Submit a Health Equity Recommendations Provider Network Capacity Report to align and organize DHCS readiness cultural and linguistics program workgroup efforts and demonstrate how the HEO will advance information in action by December 04, 2023.	Informational and report out to QIHEC.				X	12/4/2023	Planned	Medium	
13	DHCS	Health Equity Assessment Quality MCAS Report	Valerie Martinez Christine Nguyen	Quarterly	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Submit a Health Equity Assessment Quality MCAS Report to demonstrate how the HEO is tracking and trending notable health disparities and advancing information in action by September 28, 2023.	Informational and report out to QIHEC.			X		9/28/2023	Complete	Low	
14	DHCS	Population Health Management (PHM) Framework: Integrate Health Equity into Program Operations and Planning	Valerie Martinez Ayesha Sharma Lillien Chen	Quarterly	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Develop a PHM Framework that integrates health equity into program operations and planning by December 4, 2023.	Informational and report out to QIHEC.			X	X	9/28/2023 12/4/2023	Planned	Low	

15	DHCS	Health Equity and Talent Acquisition Training: PHM Program Talent Recruitment	Valerie Martinez Marco Martinez Lillien Chen	Quarterly	Embed Equity Build Sound Infrastructure and Operations	Develop a Health Equity and Talent Acquisition Training to identify culturally competent candidates as part of our efforts to build a sound infrastructure and operations within the PHM team.	Informational and report out to QIHEC.			X		9/28/2023	Complete	Low	
16	DHCS	CalAIM and Health Equity Strategic Planning Session	Valerie Martinez Dr. Manisha Sharma Paige Brogan	Quarterly	Embed Equity Build Sound Infrastructure and Operations		Informational and report out to QIHEC.				X	12/4/2023	Planned	Low	
17	DHCS	APL 23-025: Diversity, Equity, and Inclusion Training Program Requirements	Valerie Martinez Linda Fleischman Angelica Matsuno Melinda Kjer	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Development of DEI training, implementation and monitoring by January 1, 2025.	DEI training development updates for informational purposes and report out to QIHEC.			X	X	9/28/2023	Ongoing	Low	

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

Summary of Changes	
Status	**Definition**
MM/DD/YYYY	*Briefly explains item changes*
6/5/2023	Establishment of original document
9/28/2023	Added activities, updated responsible owners and quarterly activities completed.
12/4/2023	Updated responsible owners and quarterly activities completed.

Promise Health Plan

2023-2024
Quality Improvement Health Equity Transformation Program Description Medi-Cal Product

Responsible Health Equity Office Staff

Name: James Cruz, MD
Title: Chief Medical Officer
Email: james.cruz@blueshieldca.com

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

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

Contents

I. Introduction and Background ... 3
II. Blue Shield Promise Health Plan's Health Equity Mission ... 6
III. Blue Shield Promise Quality Improvement Health Equity Transformation Program Values ... 7
IV. Quality Improvement Health Equity Transformation Program Levers ... 7
V. Guiding Principles ... 9
VI. Health Equity Keywords ... 10
VII. Quality Improvement Health Equity Transformation Program Structure ... 10
VIII. Quality Improvement Health Equity Committee ... 11
IX. Executive Leadership ... 13
X. Quality Improvement Health Equity Transformation Program Goals and Objectives ... 17
XI. Blue Shield Promise Internal Key Functional Areas and Responsible Departments ... 25
XII. Health Equity Integration ... 27
XIII. National Committee for Quality Assurance Health Equity Accreditation ... 34
XIV. Monitoring and Oversight ... 35
XV. Quality Improvement Process ... 36
XVI. Annual Review of the Health Equity Transformation Program Description ... 38
XVII. Quality Improvement and Health Equity Work Plan ... 39
XVIII. Annual Evaluation ... 40
XIX. Data Sources ... 41
XX. Confidentiality and Information Security ... 42
XXI. Resources ... 43
XXII. Appendices ... 45

I. Introduction and Background

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

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

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

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

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

Figure 1. California Department of Health Care Services Bold Goals

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

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

D. DHCS All Plan Letter 19-011 Population Needs Assessment (PNA).

The PNA identifies member health status and behaviors, member health education and cultural and linguistics (C&L) needs, health disparities, and gaps in services related to these issues. The goal of the PNA is to improve health outcomes for our members and ensure that

BSCPHP is meeting the needs of all our Medi-Cal members by identifying member health needs and health disparities; evaluating health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns; implementing targeted strategies for health education, C&L, and QI programs and services.

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

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

The HEQMS will be effective Measurement Year (MY) 2023 through at least MY 2027. BSCPHP will comply with Assembly Bill (AB) 133 as implemented by this APL and future DMHC guidance, consistent with applicable law, including Health and Safety Code section 1399.872. Pursuant to AB 133, the DMHC will promulgate regulations to codify these requirements by 2026.

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

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

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

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

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

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

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

BSCPHP's Health Equity Office will integrate health equity throughout the organization. The health plan has adopted the California Health Care Foundation (CHCF) and National Committee Quality Assurance (NCQA) recommended measurement framework for accountability in Medicaid to advance health equity. This framework represents an effort to centralize health equity in quality measurement through a set of domains to track progress over time and assess performance.

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

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

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

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

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

BSCPHP is a licensee of the Blue Cross Blue Shield Association and is an affiliate of BSCPHP holds Health Plan Accreditation and Multicultural Health Care Distinction for its Medicaid product line

from the National Committee for Quality Assurance (NCQA) and will be pursuing Health Equity Accreditation from NCQA in 2024.

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

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

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

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

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

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

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

IV. Quality Improvement Health Equity Transformation Program Levers

BSCPHP seeks to eliminate disparities within the organization, counties, and members served. Therefore, BSCPHP's' HEO will embed health equity into everything we do across the enterprise.

The HEO will establish a process and framework for embracing the program values, solidifying a culture and a practice of equity across the organization, and in accordance with regulatory requirements. The HEO will work to implement the Quality Improvement Health Equity Transformation (QIHETP) program levers and activities to support the drive to eliminate disparities among populations served (Reference figure 2).

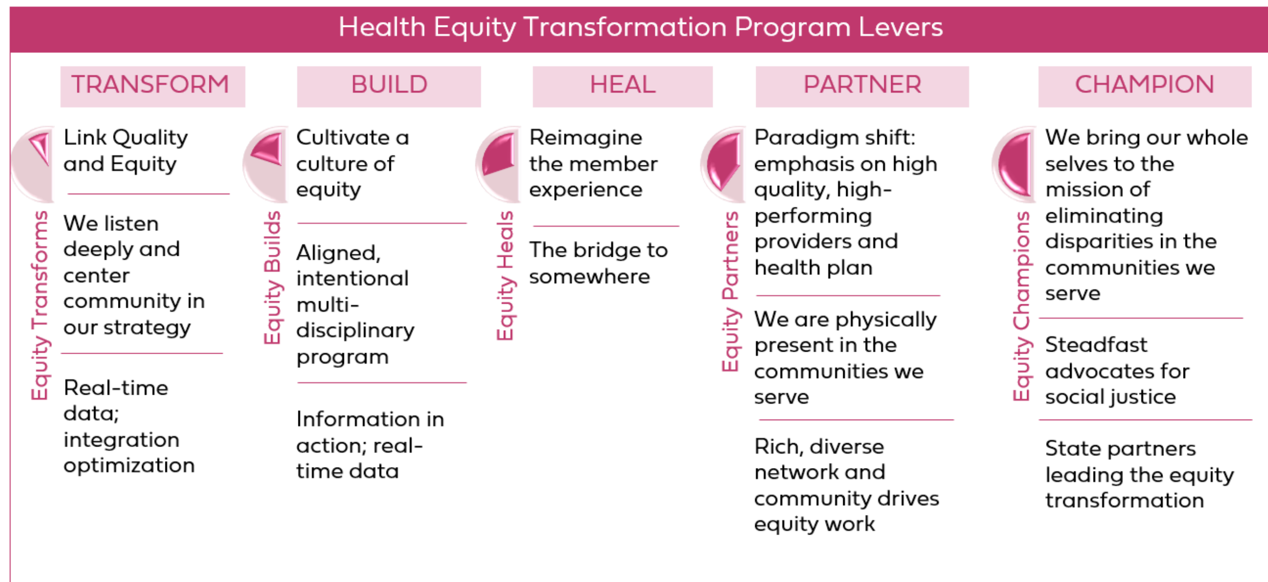


Figure 2. Health Equity Transformation Program Levers

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

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

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

C. Heal. BSCPHP will not only be equipped to best identify a member's needs but will facilitate coordination of care to address social drivers of health. Most importantly, BSCPHP will also confirm members are obtaining needed care, placing additional emphasis on members in most need. DHCS has issued several mandates requiring health plans to initiate health disparity work. Such mandates include requirements to identify specific member needs via the DHCS All Plan Letter 19-011: Population Needs Assessment (PNA), CalAIM program requirements (DHCS CalAIM, 2022), and stratified reporting of HEDIS® data for specific measures as outlined in the DHCS Comprehensive Quality Strategy 2022 report. These requirements will be integrated into this Health Equity program. BSCPHP is fully committed to launching the new Health Equity Office and will support disparity work as needs are identified.

D. Partner. BSCPHP will support providers and operations to maximize health care delivery, understanding that equity work extends beyond the four walls of an exam room. BSCPHP will not only support the member journey, but will also rely on partners, ensuring they are equipped to meet the unique needs of each and every member. BSCPHP will work diversify our provider network, supporting cultural competency, health equity training, attempting to dismantle systemic racism and teach skills to reduce implicit bias, all lending to an improved member experience while facilitating optimal outcomes.

E. Champion. BSCPHP is committed to bringing our whole selves to the mission of eliminating health disparities. We believe in the ability to catalyze lasting change. To reach health equity, we recognize that we must be steadfast advocates for social justice and be successful state partners leading health equity transformation. As we look ahead toward the future state, building the capacity of individuals, internal, and external stakeholders will be essential in reaching health equity.

V. Guiding Principles

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

Guiding Principle	Health Equity Strategy
Doing what's right	Actively working on correcting systemic inequities in our health and social systems to address member needs and deliver a high-quality experience and integrate an internal culture of diversity, inclusion, and equity (DEI)
Being a trusted and reliable partner	Collaborating with community-based organizations, other managed care plans and all levels of government to implement tools, exchange information for the benefit of all, bring healthcare

	into the digital age and ensure the accountability and long-term affordability of health care
Keeping our members first	Driving whole person, person-centered care that meets that health needs of all members, addresses SDOH, reduces disparities, and gives every member the opportunity to attain their full health potential
Community engagement	Aligning with community-based organizations, public plans, and county partners to improve community health and meet members where they are born, live, work, worship, and play with innovative programs to improve health outcomes
Provider collaboration	Helping providers focus on delivering quality care by providing technology and resources that remove barriers, inefficiencies, and administrative burden
Continuous improvement	Developing innovative advancements powered by leading edge technology, grounded in comprehensive, real-time data designed to improve care integration, outcomes, and delivery of health care services
Creating a personal, high-quality experience	Integrate shared opportunities to meet the needs of the members served across departments to create a personal high-quality experience at various touchpoints across the organization.
Serving more people	Understand that health equity is intersectional, and diversity exists within the communities and members served. Ensuring all employees, contracted staff and providers take an annual sensitivity, diversity, cultural competency, and health equity training with the goal to change behavior with interpersonal interactions and address all people inclusively, accurately, and respectfully (CDC, 2021).
Being a great place to do meaningful work	Actively recruit employees who represent the ethnic and cultural community groups we serve or who have extensive experience working with diverse populations.

Table 1. Guiding Principles and Health Equity Strategies

VI. Health Equity Keywords

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

VII. Quality Improvement Health Equity Transformation Program Structure

The Blue Shield Board of Directors (Board) is comprised of community and provider leaders and is ultimately responsible for the Quality Program. The Board approves the Quality Strategy, and is presented with related goals, metrics, and recommendations for BSCPHP. The Board provides oversight on performance against quality goals, including ensuring compliance and regulatory

requirements are met. The Board has delegated oversight of all quality activities to the Board Quality Improvement Committee (BQIC).

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

1. BSCPHP's Governing Board maintains oversight of the Quality Improvement and Health Equity Committee (QIHEC) and participates in the QIHETP planning.
2. QIHETP activities are supervised by BSCPHP's Medical Director or the Medical Director's designee, in collaboration with BSCPHP's CHEO.
3. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of QIHETP development and performance review.

VIII. Quality Improvement Health Equity Committee

BSCPHP's QIHEC is charged with reviewing all Health Equity related activities and documents. The QIHEC reports to the Health Equity Oversight Committee (HEOC) and Quality Management Committee (QMC), both report to the Quality Oversight Committee (QOC). The QOC then reports directly to the BQIC.

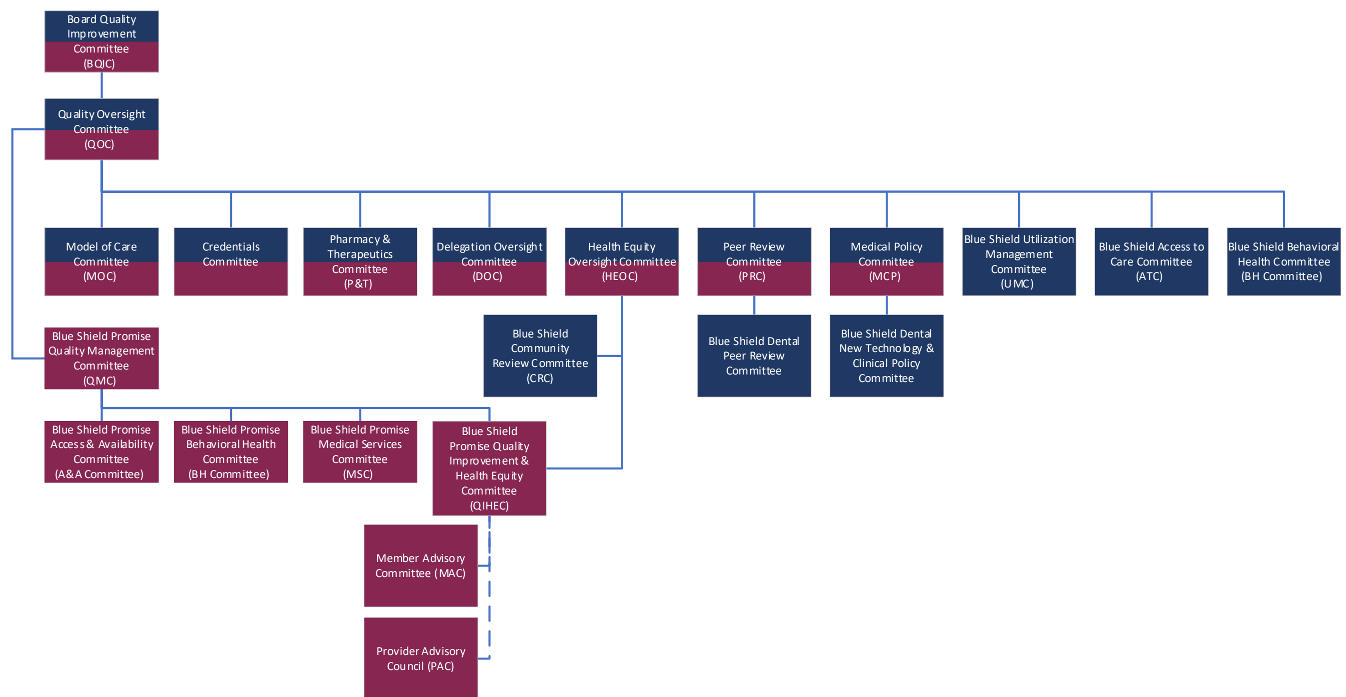


Figure 3. Quality Improvement Health Equity Committee Reporting Structure

BSCPHP's QIHEC is responsible for Quality Improvement and Health Equity activities. The QIHEC is charged with reviewing and approving health equity activities. The QIHEC reviews Culturally and Linguistically Appropriate Services (CLAS), Population Needs Assessment (PNA), Consumer

Assessment of Healthcare Providers & Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS) results as related to health equity, results of the Health Equity Advancements Resulting in Transformation (HEART) Measure Set, and the review, feedback, and approval of the annual written evaluation of the QIHETP.

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

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

Reporting

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

Membership Composition

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

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

IX. Executive Leadership

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

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

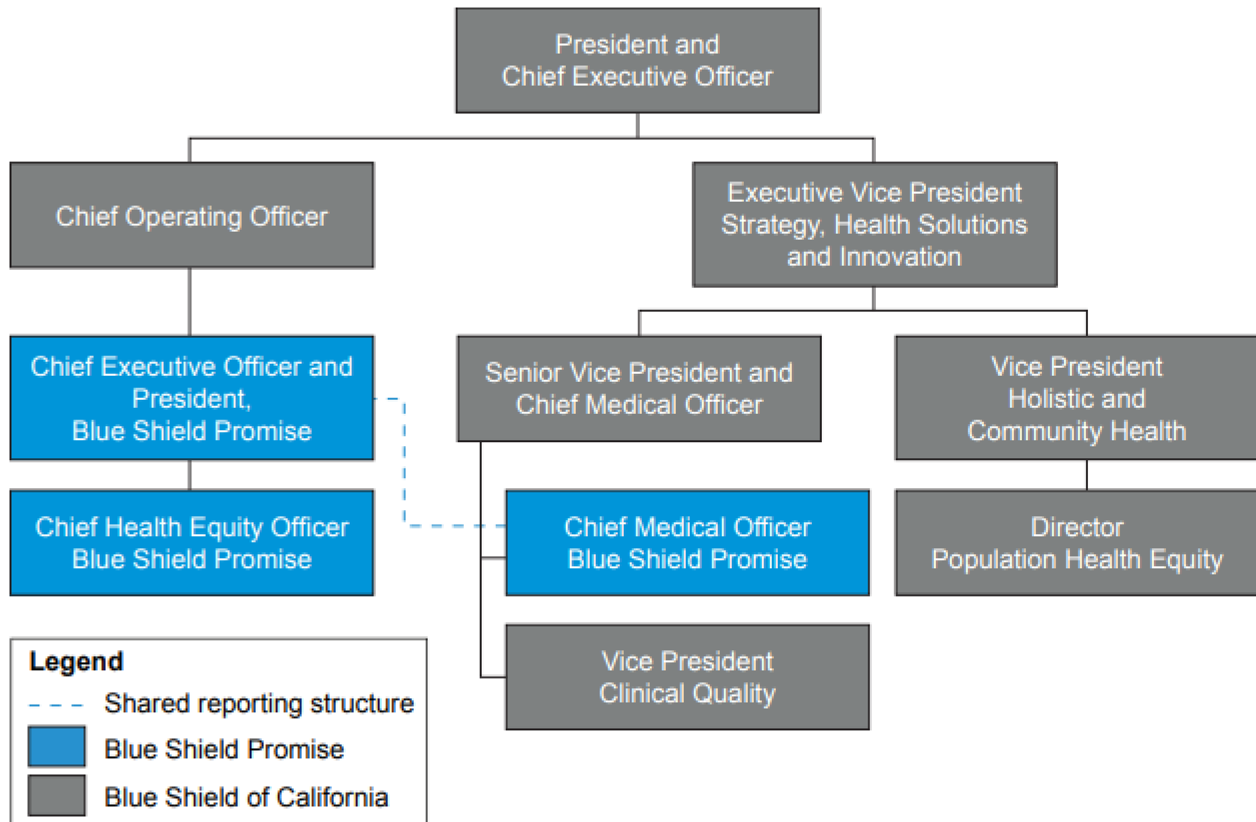


Figure 4. Organizational Chart BSCPHP Leadership

The HEO is comprised of the following BSCPHP leaders:

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

The following officers report up through the leadership of Blue Shield of California and support health equity efforts across the enterprise as described below.

A. President and Chief Executive Officer, Blue Shield of California: The Blue Shield of California President and Chief Executive Officer (CEO) supports the quality program through oversight and ultimate supervision of individuals participating in Quality programs and is responsible for implementation of the Quality program. The CEO also coordinates allocation of resources and reports to the Board.
B. Chief Operating Officer, Blue Shield of California: The Chief Operating Officer (COO) reports to the Blue Shield CEO with responsibility for all business operations, including member services, growth, marketing, government affairs, strategy, planning and operations.
C. Executive Vice President, Strategy, Health Solutions and Innovation, Blue Shield of California: The EVP, Strategy, Health Solutions, and Innovation reports to the Blue Shield CEO, with the responsibility for healthcare services, healthcare transformation, and driving more affordable care.
D. Vice President, Holistic and Community Health, Blue Shield of California: The VP, Holistic and Community Health, reports to the EVP, Strategy, Health Solutions, and Innovation, and is responsible for the development and execution of community/holistic health programs and payment, Health Equity, and clinical innovation initiatives including population health management programs.
E. Senior Vice President and Chief Medical Officer, Blue Shield of California: The SVP, CMO is responsible for the healthcare services organization, with functional responsibilities comprised of Clinical Quality, Medical Care Solutions (consisting of utilization, care, and disease management), Pharmacy Services, and MindBody Medicine.
F. Vice President, Clinical Quality, Blue Shield of California: The VP, Clinical Quality reports to the SVP/CMO and has direct operational accountability of the Clinical Quality department for BSCPHP. Functional responsibilities include quality assurance, clinical quality improvement, quality analytics, clinical quality review, and clinical quality member experience.
G. Population Health Equity Director, Blue Shield of California: The Population Health Equity (PHE) Director is responsible for the design, implementation, and adoption of Blue Shield's population health strategy. The PHE Director partners with the CHEO, Clinical Quality, Medical Care Solutions, Utilization Management, and other teams to ensure regulatory requirements are met, and to evaluate, create and advocate for the delivery of equitable, high-quality, cost-effective, patient-centered medical care via the networks and platforms through which all Blue Shield's members are served.

Blue Shield Promise CEO & President

Chief Medical Officer dual report Promise Health Plan/BSC CMO

VP Growth

VP Operations

Chief Health Equity Officer

Enterprise & External Engagement

BSCA Health Equity Teams

Marketing

Human Resources

Government Affairs

Board Engagement

External Stakeholders

- Local Health departments - collaborate on data collection and opportunities for cross-functional interventions
- Engagement with community-based organizations
- Engagement with local governments to drive effective policy development

Diagram outlines how the CHEO will interact across corporate functions

— — /——— Depicts reporting relationships

- - - - - - - - - Depicts interactions between CHEO and various functions

Figure 5. Organization and Administration of Plan| Chief Health Equity Officer

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

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

health departments, community-based organizations, and our members to drive towards the most effective quality and health equity programs.

X. Quality Improvement Health Equity Transformation Program Goals and Objectives

A. Quality Improvement Health Equity Transformation Program Goals

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

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

BSCPHP has established the subsequent QIHETP program goals and will seek to implement the milestones listed (Reference figure 6).

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

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

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

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

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

Figure 6. 2023-2025 QIHETP Goals

The QIHETP goals align with the QIHETP levers in section IV, to transform, build, heal, partner and champion. For example, Advancing Information in Action activities integrate data and analytics platforms to generate actionable, meaningful information. Data will be used to identify disparities and develop data-driven, customized interventions that sustainably address health inequities linking quality and equity. Sound Infrastructure and Operations are the building blocks of the QIHETP. Establishing a HEO that champions integration and transformation that drives Quality and Health Equity in Medi-Cal. The HEO will establish regular reporting and information flow/data analysis expectations across functional departments. Embedding Equity in everything and everywhere is part of our strategic approach to both healing and championing health equity, serving as a catalyst for change. Finally, the HEO will develop customizable interventions that target equitable whole-person care in marginalized populations and/or communities. This member-centric approach will provide the HEO with the opportunity to partner with cross functional departments and external community and provider partners.

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

1. **Advance Information in Action**

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

quality data is critical for key functions like Social Services, Enhanced Care Management (ECM), Population Health Management (PHM) to facilitate delivery of individualized and equitable care to members.

BSCPHP has committed to the following Information in Action strategies:

a. Develop a Comprehensive Data Strategy for Stratification and Analysis of Health Disparities.
b. Capture/Validate Health Equity-Related Demographic Data.
c. Enable a simplified reporting and analytics platform that enables delivery of equitable whole-person care for BSCPHP members.
d. Institute processes to close gaps in care and maintain ongoing data accuracy.
e. Enable demographic data capture along each member-facing touchpoint.
f. Develop and/or update internal staff and Provider trainings for BSCPHP (e.g., Navigators, Community Health Advocates, Care Managers, etc.) and network providers to include responsibilities and evidence-based best practices for capturing key demographic data.
g. Define scope and milestones for enabling real-time user-customizable reporting and analysis (e.g., drop down menus, etc.) and advanced member segmentation/analytics that address health-equity focused questions, including establishing a clear understanding of the reporting needs for different functional areas and Subsequent development of the necessary health equity dashboards.
h. Assess the value of third-party data and/or analytics, integrating where able.
i. Define scope and milestones for accessing actionable data and analytics that address health equity-focused questions and allow our internal teams to:
    i. Surface insights regarding complex health issues, ex. severe maternal morbidity or primary care deserts.
    ii. Highlight disparities in health outcomes and access to healthcare.
    iii. Run custom, targeted analysis looking at a wide range of utilization measures, selected HEDIS measures, and provider access measures.
    iv. Run custom, targeted analysis using community-level social determinants of health data at zip code and census tract level.
    v. Access provider-level and hospital-level reporting data for analysis.
j. Develop a cross-functional process that enables organization-wide access to actionable data and analytics that address health equity focused questions.
    i. Identify areas where health disparities exist as seen by open care gaps.
    ii. Track performance of ongoing outreach activities.
    iii. Plan member outreach activities through a health equity lens.
    iv. Display characteristics of members who did not engage in past outreach activities.
    v. A wide range of HEDIS® and Align Measure Perform (AMP) program measures.
    vi. Community-level social determinants of health data at zip code and census tract level.

vii. Provider group-level reporting.
viii. Use SDOH data to understand the unique journeys and challenges of members.

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

2. Sound Infrastructure and Operations

Integration

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

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

Health Equity Office

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

The HEO is comprised of the following BSCPHP staff (Reference figure 7):

a. President and Chief Executive Officer
b. Chief Medical Officer
c. Chief Health Equity Officer
d. Senior Director of Clinical Quality

e. Director of Clinical Quality
f. Health Equity Principal Program Manager

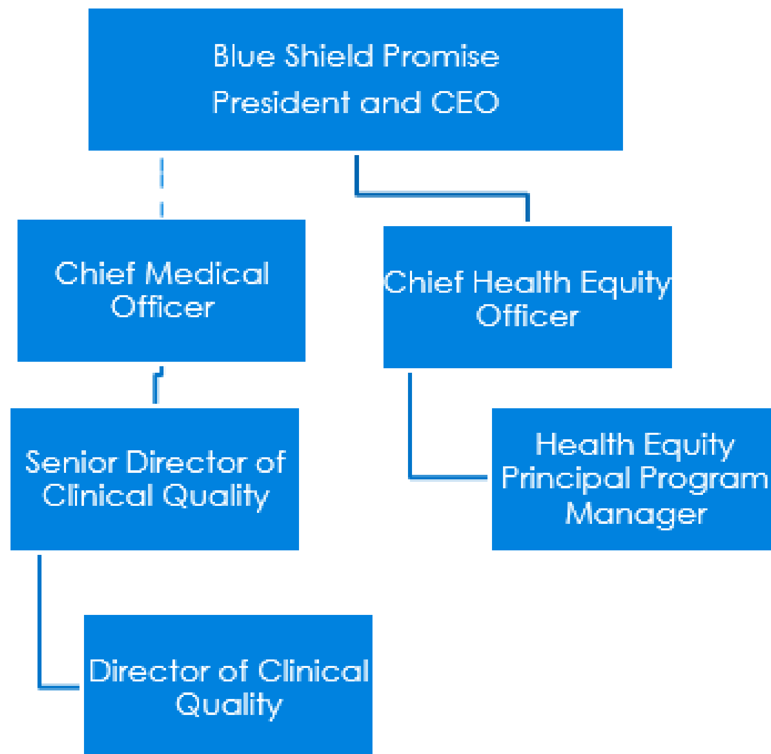


Figure 7. BSCPHP Health Plan Health Equity Office Organizational Chart

The President and CEO of BSCPHP reports to the Chief Operating Officer (COO) of Blue Shield and is responsible for providing strategic leadership for BSCPHP by working with the Board and other management to establish long-range goals, strategies, plans and policies. The CEO provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes.

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

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

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

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

Governance

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

Policies and Procedures

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

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

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

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

Monitoring and Oversight

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

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

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

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

Accreditation

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

3. Equity Embedded

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

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

4. Interventions that Matter

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

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

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

B. QIHETP Objectives

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

QIHET Program Objectives	
Goal	Objective
Information in Action	BSCPHP will develop a HEART Measure Set with key functional area leaders and out by end of the year 12/31/2023
Sound Infrastructure and Operations	BSCPHP's QIHET program documents will be reviewed and approved by the governance process by 7/1/2023
Equity embedded in everything we do	BSCPHP HEO will conduct at least five health equity presentations and/or trainings within the organization to embed equity in everything we do by 12/31/2023.
Sound Infrastructure and Operations	BSCPHP HEO will facilitate the first inaugural QIHEC meeting by 3/31/2023.
Sound Infrastructure and Operations	BSCPHP HEO will facilitate the first inaugural HEOC meeting by 6/20/2023.
Interventions that Matter	BSCPHP will prioritize interventions for at least 3 populations of focus by 12/31/2023.

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

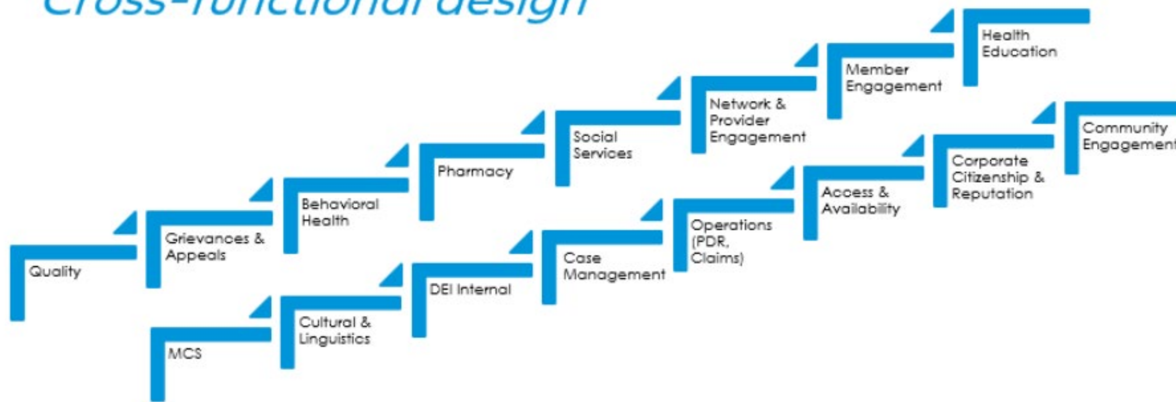
Health Disparities transcends across departments impacting multiple cross-functional areas, thus, BSCPHP's policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to the following cross functional areas: Marketing strategy,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

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

The HEO seeks to engage functional areas in health equity planning and oversight. The roadshow experience between the Health Equity Office and functional area leaders facilitates identification of select health equity measures and allows for planning in recognition of the intersection between health equity in various functional areas. The goal of the roadshows is to discuss opportunities for health equity integration and identify specific health equity measures to monitor disparities. These multi-disciplinary measures comprise the HEART Measure Set. The HEO will then monitor the data for the selected measures and identify disparities and/or trends over time. Integrated data results and outcomes will be shared at the quarterly QIHEC meeting to provide transparent information sharing for cross-collaboration and understanding. Based on this analysis, and in partnership with the cross functional areas at the direction of the CHEO, will implement initiatives to resolve the known health disparities, gaps, and opportunities (Reference figure 8).

Figure 8. Building Blocks of QIHETP Integration Across Departments

Building Blocks of HETP Integration
Cross-functional design



- ❖ Disparities transcend departments impacting multiple cross-functional areas
- ❖ Apply a Health Equity lens to program oversight across each functional area
- ❖ Monitor metrics to identify disparities and trends in each department (360 assessment) Implement initiatives, sharing results, outcomes, and lessons learned
- ❖ Health Equity efforts will be integrated, targeting wide range of inequities - populations, measures, access to care, utilization, satisfaction, engagement, DEI etc.
- ❖ Transparent information sharing for cross-collaboration and understanding

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

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

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

XII. Health Equity Integration

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

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

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

The framework six domains are as follows:

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

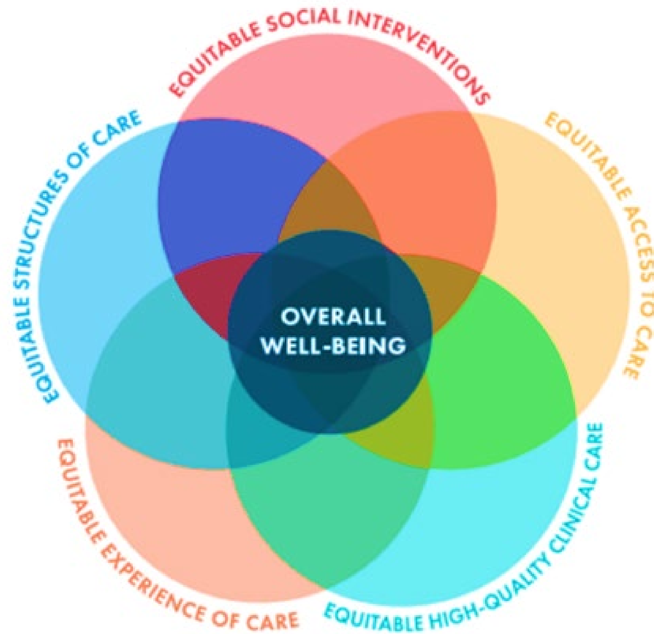


Figure 9. Health Equity Measurement Framework for Medicaid Accountability Domains

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

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

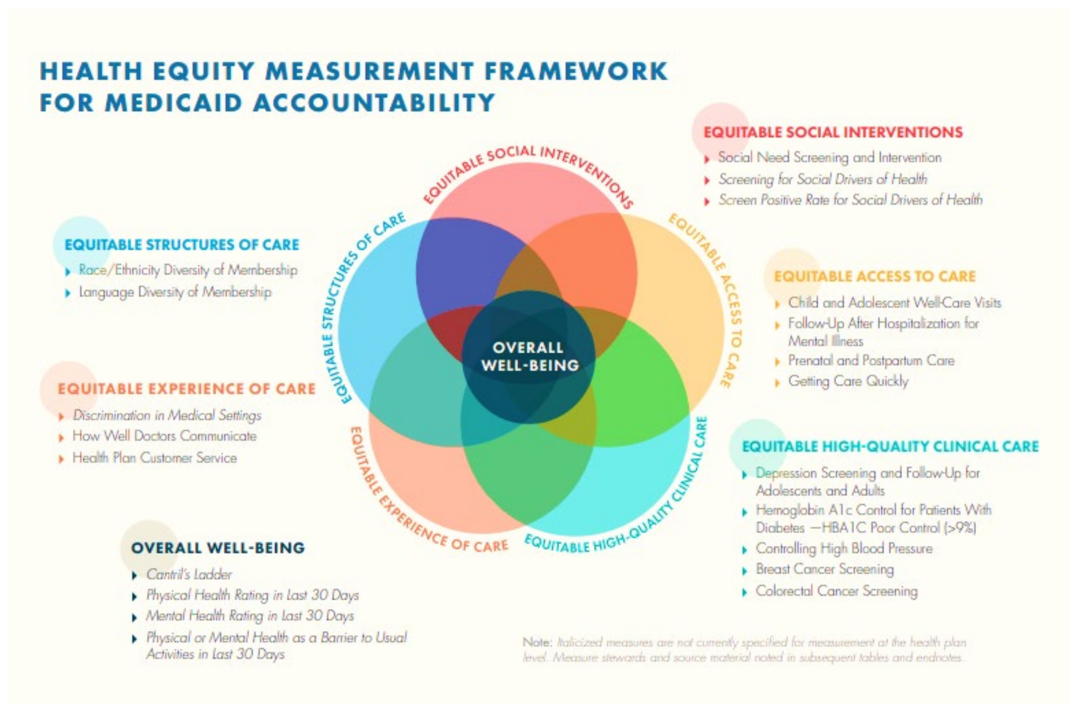


Figure 10. Health Equity Measurement Framework for Medicaid Accountability Summarized

Health Equity is integrated across the organization disparities transcend departments impacting multiple cross-functional areas and. BSCPHP will apply a health equity lens to program oversight across each functional area. As figure 10 demonstrates, data and analytic sets extend beyond HEDIS® measures. The six domains extend across cross functional departments throughout BSCPHP.

Select measures outlined in the HEART Measure Set will be stratified and analyzed for health disparities. When possible, metrics must be stratified by race, ethnicity, gender, age, and language spoken (REGAL) to inform health equity initiatives and mitigate health disparities. Key measures or metrics for each data set will need to be selected by the HEO in collaboration with each functional area. Reporting and dashboards will need to be designed for each data set and/or use case to monitor metrics and identify disparities and trends in each department. Identifying where the health disparities are will facilitate strategic implementation of targeted initiatives and sharing of results, outcomes, and lessons learned. Health equity efforts will be integrated targeting a wide range of inequities and will allow a cross sharing of transparent information for collaboration and understanding across departments providing insight into potential underlying reasons for variations (Reference figure 8).

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

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

- Health Education
- C&L
- CalAim and subsidiary population health management functional area
- Customer Experience
- Clinical Access Programs
- Maternal Health
- Utilization Management

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

Below is a detailed list of the health equity measures set selection by department. Oversight of the health equity measure set outcomes and/or performance results will follow the continuous quality improvement (CQI) process. The HEO will define an overall Health Equity Score, the number of measures from the HEART Measure Set that are meeting the target. The health equity measure set will be monitored at least quarterly and reported to the QIHEC. Reference Appendix 3 for the complete HEART Measure Set by department.

A. Customer Experience

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

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

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

C. Appeals and Grievances

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

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

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

- Grievance category stratified by race and ethnicity for all grievances received during the measurement period.
- The percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period.
- Percentage of Discrimination grievances based on all grievances received during the measurement period.
- Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period.

D. Cal Aim

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

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

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

E. Quality

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

Further, select MCAS measures also intersect with the CalAim program. These measures will be monitored to assess for disparities and differences between populations, especially among populations of focus. Additionally, the Quality Department will also track the CAHPS® Getting Care Quickly measure by REGAL.

F. Behavioral Health

The scope of the Health Equity Transformation Program extends into the delivery of behavioral health services. The HEO and Behavioral Health Department will monitor the recently released CalAim metrics related to behavioral health and DHCS bold goals required for monitoring. These metrics will be stratified by the REGAL dataset. Additionally, the Behavioral Health Department will track the total number of prenatal and postpartum depression screenings. This will help us to identify any disparate populations within our prenatal/postpartum membership and identify any other populations that may be impacted by mental illness specifically among our most vulnerable populations including adolescents, homeless, and LGBTQ+ members for select measures. Reference Appendix 3 for the complete HEART Measure Set as it relates to behavioral health.

G. Provider Contracting and Relations

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

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

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

This process includes an educational program for Network Providers regarding health needs to include but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health Service needs,

members with substance use disorder needs, members with intellectual and developmental disabilities, and Children with special health care needs. Training includes Social Drivers of Health and disparity impacts on members' health care. Attendance records will be reviewed and maintained by BSCPHP staff. The Provider Contracting and Relations Department will work closely with the Health Education and C&L Department to track health equity provider training.

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

H. Health Education and Cultural and Linguistics

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

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

I. Maternal Health

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

J. Clinical Access Programs

The Clinical Access Programs department supports the delivery of clinical programs including the Facility Site Review program, Initial Health Assessments, and the Early, Preventive, Screening and Development Treatment (EPSDT) program. The HEO and Clinical Access Programs selected specific metrics across various areas managed by the Department. The HEART measure set for this functional area will support identification of any health disparities among the EPSDT population and provider network through the medical record review and facility site review audits. The Clinical Access Programs functional area will:

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

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

XIII. National Committee for Quality Assurance Health Equity Accreditation

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

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

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

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

XIV. Monitoring and Oversight

Ongoing monitoring is a key mechanism to evaluate progress of quality activities, as outlined in the Work Plan, and are submitted to the Health Equity Oversight Committee (HEOC), Quality Oversight Committee (QOC), and Board Quality Improvement Committee (BQIC) for review and approval at least quarterly. Quality reports are submitted to DHCS on a quarterly basis.

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

BSCPHP's BQIC coordinates with the QIHEC to approve the overall QIHETP and the annual plan of the QIHETP. The BQIC will regularly receive written QIHEC progress reports describing actions taken, progress in meeting QIHETP objectives, and future opportunities for improvement. A comprehensive assessment and list of all QIHETP activities is presented in a fluid QIHETP work plan.

As part of the initial monitoring plan, the QIHETP work plan will integrate required reporting that addresses regulatory intensive requirements and tracks and trends the HEART Measure Set. The work plan activities will support a data driven strategy to inform resources and initiatives to reduce disparities. BSCPHP's HEO in partnership with cross-functional areas and/or departments will continuously collaborate to build a robust health equity measure set, identify priority populations, and focus areas, and prioritize initiatives to address disparities and inequities.

A. Priority Populations and Focus Areas

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

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

8. Housing insecurity

These clinical focus areas are designed to complement the significant CalAIM initiatives that are targeted at specific high-risk and align with the vulnerable populations as outlined by the DHCS' Comprehensive Quality Strategy, 2022. The HEO will conduct comprehensive assessments to assess utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, establish collaborative partnerships, etc. Addressing the needs for these vulnerable populations will help reduce disparities and inequities that may exist for vulnerable populations (Reference Appendix 2).

B. HEART Measure Set

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

The HEART Measure Set is fluid and may change over time. The HEO and designated area will work together to conduct a comprehensive assessment and analysis of the health equity measure set. Each measure will be stratified, at a minimum, by race, ethnicity, age, gender, and/or language. Oversight of the health equity measure set, outcomes and performance results will follow the CQI process. The health equity measure set will be monitored at least quarterly and reported to the QIHEC and other relevant workgroups. Reference Appendix 3 for the complete HEART Measure Set by department.

XV. Quality Improvement Process

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

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

BSCPHP recognizes that quality and health equity are deeply intertwined, and we cannot have a high-quality plan without equity. BSCPHP's HEO and Quality team collaborates to conduct quality improvement and health equity activities in all areas and dimensions of clinical and non-clinical member care and service. BSCPHP annually develops a QIHETP work plan steeped in health equity

that outlines quality improvement activities for the year and focuses on reducing health disparities. The plan is reviewed by the CHEO and CMO and submitted to the QIHEC, QOC, and BQIC for review, comment, and approval.

BSCPHP seeks to meet the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS and meet health disparity reduction targets for specific populations and measures as identified by DHCS. BSCPHP applies the principles of CQI to all aspects of service delivery through analysis, evaluation, and systematic enhancements as related to health equity, including quantitative and qualitative data collection and data-driven decision-making, using up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field, incorporate feedback provided by members, families, and Network Providers in the design, planning, and implementation of its CQI activities, and incorporate other issues identified by BSCPHP, DHCS, DMHC, and/or NCQA (Reference figure 11).

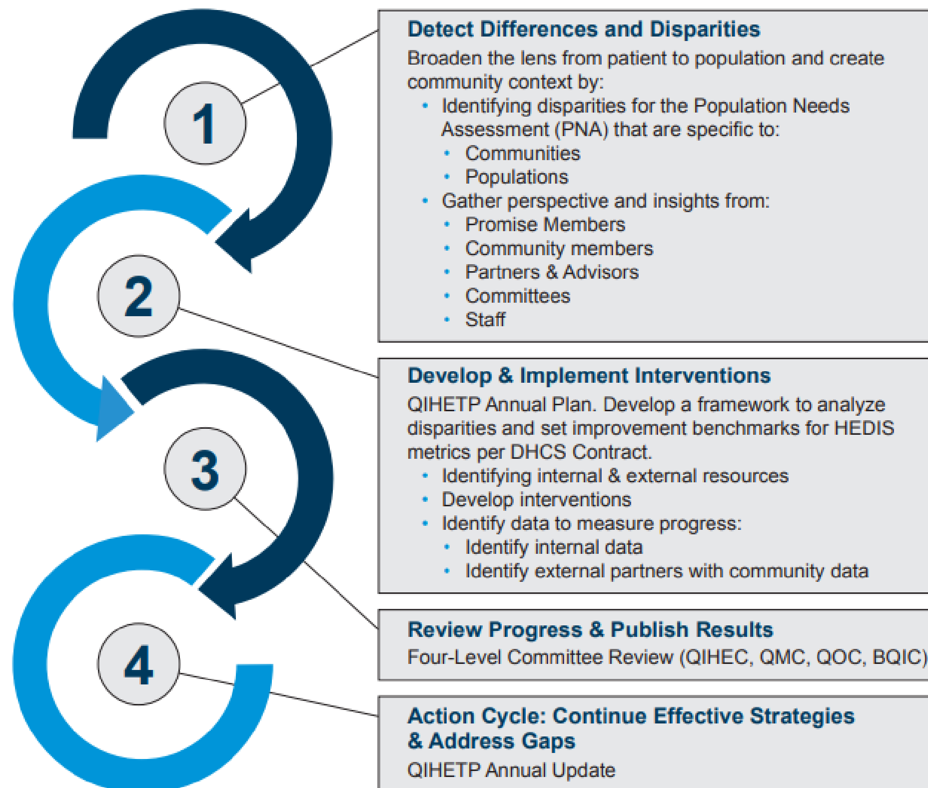


Figure 11. Principles of Continuous Quality Improvement in Action

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

- analyzing data to identify differences in quality of care and utilization, as well assessing as the underlying reasons for variations in the provision of care to its members;

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

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

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

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

XVI. Annual Review of the Health Equity Transformation Program Description

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

XVII. Quality Improvement and Health Equity Work Plan

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

The initial goal for the QIHETP is to at minimum meet all state requirements and achieve DHCS Request for Proposal (RFP) content for implementation readiness. The QIHETP Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the QIHEC, HEOC, QOC and BQIC.

The QIHETP Work Plan is a fluid document, updated as needed throughout the program year. BSCPHP prepares a comprehensive assessment of QIHETP activities no less than 12 months apart that includes. The scope of the annual work plan includes the following:

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

15. Summarizes community engagement with commitment to member and family focused care, and uses MAC findings, member listening sessions, focus groups/surveys, and uses information to inform policies.
16. Incorporates PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management and Coordination of Care).
17. Uses Performance Improvement Project (PIP) findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.
18. Track and trend the HEART Measure Set.
19. Monitor interventions targeting priority populations and focus areas.

The Workplan is revised as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement. The status of QIHETP Work Plan items is reported as appropriate to the QIHEC, QOC and the BQIC.

A written summary of the QIHETP and QIHEC activities, findings, recommendations, and actions will be prepared after each QIHEC meeting and submitted to the BQIC and DHCS upon request. BSCPHP shall make the written summary of the QIHEC and QIHETP activities publicly available on the BSCPHP website at least on a quarterly basis.

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

XVIII. Annual Evaluation

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

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

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

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

An executive summary is presented to the QIHEC, HEOC, QOC and BQIC for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An

informational summary of the annual evaluation is available to members, member representatives, and providers.

XIX. Data Sources

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

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

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

17. Race, Ethnicity, Gender, Age, and Language (REGAL) data: data collection on a member's race, ethnicity age, and language preferences.
18. Sexual Orientation and Gender Identity (SOGI) data: data collection on a member's sexual orientation and gender identity preferences.
19. Vendor performance data: competency assessment results for language assistance, and behavioral health data

XX. Confidentiality and Information Security

All information related to the QIHETP process is considered confidential. All data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews are stored in designated, secured locations, and access is granted based on minimum necessary standards. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee. All QIHETP program activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889, and the Health Insurance Portability and Accountability Act (HIPAA) for patient's confidentiality. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

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

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

XXI. Resources

1. Agency for Healthcare Research and Quality (2023). Frequently asked questions about CAHPS. Retrieved from https://www.ahrq.gov/cahps/faq/index.html
2. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Committee Charter.
3. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Committee Policy.
4. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Transformation Program Policy.
5. California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-011: Population Needs Assessment retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
6. California Department of Managed Health Care (DMHC) APL 22-028 Health Equity and Quality Measure Set and Reporting Process retrieved from https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
7. California Health Care Foundation (CHCF) and National Committee for Quality Assurance (NCQA) (2022). White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid. Retrieved from https://www.ncqa.org/wp-content/uploads/2022/10/NCQA-CHCF-EquityFrmwrkMedicaid-Sep22_FINAL.pdf.
8. California Health and Human Services Agency (CHHS, 2022). Guiding Principles and Strategic Priorities. Retrieved from https://www.chhs.ca.gov/wp-content/uploads/2022/03/CalHHS-Guiding-Principles_condensed_R1.pdf.
9. Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity (2023). retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/health-equity-programs/cms-framework-for-health-equity.
10. DHCS APL 21-009: Collecting Social Determinants of Health Data retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx .
11. DHCS California Advancing and Innovating Medi-Cal (CalAIM) Guide (2023) retrieved from https://www.dhcs.ca.gov/calaim.
12. DHCS Comprehensive Quality Strategy 2022 retrieved from https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf.
13. DHCS Medi-Cal Managed Care Plans Blue Shield of California Promise Health Plan Contract 22-20516.
14. Kaiser Family Foundation (KFF) (2022). Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Maternal%20and%20infant%20health%20disparities,outcomes%20for%20people%20of%20color.
15. KFF (2021). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. Retrieved from https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/
16. Medicaid and CHIP Payment and Access Commission (MACPAC) (2022). Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with

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

17. National Alliance to End Homelessness (2023). Homelessness Statistics. California.
18. National Committee for Quality Assurance (NCQA) 2023 Health Equity Accreditation Standards retrieved from https://www.ncqa.org/programs/health-equity-accreditation/.
19. United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC) (2021). Health Equity Guiding Principles for Inclusive Communication Retrieved from https://www.cdc.gov/healthcommunication/HealthEquityGuidingPrinciples.pdf.

XXII. Appendices

Appendix 1. Health Equity Keywords

Appendix 2. Health Equity Assessment

Appendix 3. Health Equity Advancement Resulting in Transformation (HEART) Measure Set

Appendix 4. Quality Improvement Health Equity Transformation Program Action Plan

Appendix 1: Health Equity Keywords

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

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

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

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

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

2023 Health Equity Assessment

Date: May 9, 2023
Prepared By: Brigitte Lamberson, Health Equity Principal Program Manager

Introduction and Background

Blue Shield of California Promise Health Plan (BSCPHP) conducted its first annual health equity assessment to advance the organization's health equity work and strengthen our commitment to identifying health disparities and inequities that exist among the members we serve in Los Angeles and San Diego counties.

BSCPHP acknowledges that health disparities transcend across departments impacting multiple cross-functional areas such as Marketing, Grievances, Utilization Management, Quality Improvement, Community Engagement, Health Education and Cultural and Linguistics, Behavioral Health, and other medical health services. Thus, we are committed to coordinating with functional areas to identify and address disparities. Applying a health equity lens to program oversight across each functional area in identifying health disparities and/or inequities across vulnerable populations.

Conducting a health equity assessment allowed for our organization to build on evidence based existing equitable practices, develop a health equity measure set, and uncover priority populations of focus for the upcoming year.

Health Equity Roadshow Experience

BSCPHP recognizes the existence of an intersection between health equity in various functional areas. As a result, BSCPHP's Health Equity Office (HEO) sought to engage with key functional areas in health equity planning and oversight and facilitated a health equity roadshow experience between the HEO and functional area leaders. The HEO met with the following functional areas including Customer Experience, Appeals and Grievances, CalAIM, Population Health Management, Quality Improvement, Behavioral Health, Provider Relations and Contracting, Health Education and Cultural and Linguistics, Maternal Health, Social Services, Community Engagement and Clinical Access Programs. The health equity roadshow experience was facilitated from February to April 2023. The goal of the roadshows was to discuss opportunities for health equity integration and identify specific health equity measures to monitor disparities. The health equity roadshow experience served as the forum to gather consensus and commitment to identifying measures that are most applicable.

The health plan has adopted the California Health Care Foundation (CHCF) and NCQA recommended measurement framework for accountability in Medicaid to advance health equity.

Specifically, the measurement framework will support a robust, comprehensive approach to monitoring for disparities that may exist when assessing various health plan operations and data sources.

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

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

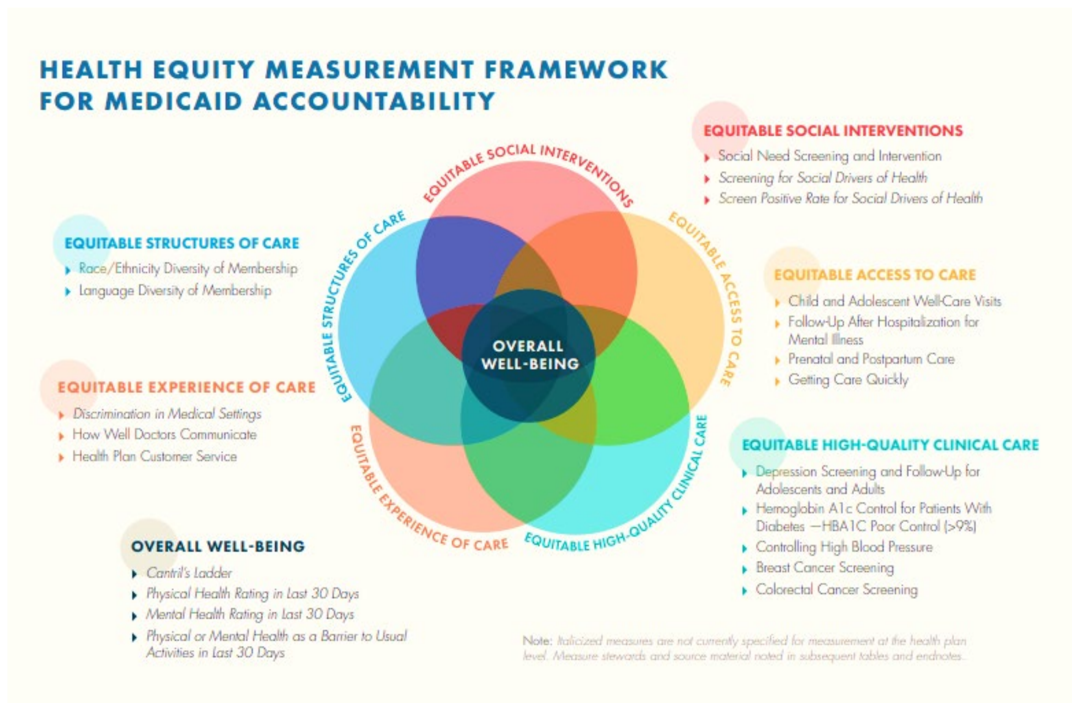


Figure 1. Health Equity Measurement Framework for Medicaid Accountability Summarized

The framework six domains are as follows:

1. Equitable Social Interventions. Measures of unmet social needs and the interventions and services designed to address them.

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

The measures identified in collaboration with the HEO and functional areas were built upon the evidence-based California Health Care Foundation (CHCF) and NCQA recommended measurement framework, and then categorized under the most applicable domain.

These multi-disciplinary measures comprise the Health Equity Advancements Resulting in Transformation (HEART) Measure Set (Reference Appendix 1). The HEO will monitor the data for the selected measures and identify disparities and/or trends over time. Integrated data results and outcomes will be shared at the quarterly Quality Improvement and Health Equity Committee (QIHEC) meeting to provide transparent information sharing for cross-collaboration and understanding. Based on this analysis, and in partnership with the cross functional areas at the direction of the CHEO, will implement initiatives to resolve the known health disparities, gaps, and opportunities

Health Equity Priority Populations of Focus

The health equity assessment would include a thorough review of the California Department of Health Care Services (DHCS) Comprehensive Quality Strategy and Bold Goals. As the HEO met with cross functional departments to identify a HEART Measure Set using the CHCF and NCQA framework, the HEO and team leads identified the need to align with the DHCS bold goals and newly released CalAIM and Population Health Management (PHM) measures. The roadshow experience exacerbated the need to focus our efforts on vulnerable priority populations that would align with the DHCS, including:

1. Maternal health
2. Child health
3. Justice-involvement
4. Homelessness
5. Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+)
6. DHCS Managed Care Accountability Sets (MCAS), members with open care gaps identified health disparate inequities
7. Member experience as indicated by the CAHPS ® survey
8. Utilization Management over- and under-utilization of services

These clinical focus areas are designed to complement the significant CalAIM initiatives that are targeted at specific high-risk and align with the vulnerable populations as outlined by the DHCS' Comprehensive Quality Strategy, 2022.

The following summarizes why these priority populations are important to BSCPHP, what we are doing to identify disparities, and the programs planned to support these populations.

1. Maternal Health

   Racial disparities in maternal and infant health in the U.S. have persisted for decades despite the continual advancements in medical care. The COVID-19 pandemic exacerbated the already persisting racial disparities for people of color the longstanding inequities in maternal and infant health (KFF, 2022).

   Black and American Indian and Alaska Native (AIAN) women have higher rates of pregnancy-related death compared to White women. Pregnancy-related mortality rates among Black and AIAN women are over three and two times higher, respectively, compared to the rate for White women (41.4 and 26.2 vs. 13.7 per 100,000). Black, AIAN, and Native Hawaiian and Other Pacific Islander (NHOPI) women also have higher shares preterm births, low birthweight births, or births for which they received late or no prenatal care compared to White women. Infants born to Black, AIAN, and NHOPI people have markedly higher mortality rates than those born to White women. Maternal death rates increased during the COVID-19 pandemic and racial disparities widened for Black women (KFF, 2022).

   BSCPHP is committed to reducing the racial and health disparities that exist among our membership population by developing programs that will help address the existing issues. BSCPHP recognizes the crisis in maternal and child health inequities and takes an integrated approach to improving the outcomes for pregnant members and their babies. Our prenatal risk assessment strategy fits into a larger, targeted maternal health equity strategy aimed at improving health outcomes in alignment with DHCS's 50 by 2025: Bold Goals initiative for maternity care. We use a data-driven, quality improvement approach to identify health inequities, plan interventions, adjust interventions, and measure impact. Our Maternal Health Equity Dashboard that is part of our Health Equity Insights Platform stratifies maternal health measures, such as: severe maternal morbidities (SMM) and C-section rates, by race/ethnicity, geographic location, area deprivation index, and delivery hospital. The dashboard enables us to target interventions in areas with the highest health disparities. Review of prenatal assessments are prioritized, and once we identify disparities, we conduct a root cause analysis, and prioritize interventions.

   BSCPHP, in collaboration with a diverse set of healthcare partners across the state, is representing California in the Institute for Medicaid Innovation's (IMI) three-year midwifery learning collaborative. The goal of the collaborative is to develop sustainable, equity-centered initiatives to advance midwifery-led models of care for the Medi-Cal population while facilitating opportunities for stakeholders to engage with each other in partnership. Early efforts will focus on Los Angeles County to build a blueprint to scale to the rest of

California. BSCPHP is committed to offering access to doula services. Our CMs can refer members directly to a partnering non-profit doula organization and providers can find additional doula organizations through community resource referral platforms such as Unite Us and San Diego 211 Community Information Exchange. BSCPHP launched payor-agnostic doula pilot programs in Los Angeles, and San Diego counties. Different doula organizations offer culturally congruent, trauma-informed services to help ensure birthing people are heard, supported, and informed during their perinatal experience. In San Diego County, we are working with For the Village which provides free doula services to all families in San Diego County with an emphasis on marginalized groups, such as people of color, LGBTQ+, and low-income families. In Los Angeles County, we are working with CBOs, including Black Wellness and Prosperity Center, Diversity Uplift, and Her Health First to provide training curriculum for doulas and connect members to family-centered services, emergency funds, and maternal supplies. To date, the pilot has demonstrated objective positive maternal child health outcomes, including a high proportion of full-term births, few C-sections and pre-term births, and improved depression scores. Our current work with doulas sets a strong community-based foundation for implementing the Medi-Cal doula benefit that is currently planned for January 2023.

BSCPHP will continue to analyze prenatal and postpartum data to identify disparate populations and inequities that exist in our own membership. We will deliver excellent programs that are already in flight such as the Doula program, enhanced care management, and community supports programs that offer prenatal and postpartum care services.

2. Child Health

It is inarguably true that a child's first years of life are the most important in terms of their overall physical and behavioral well-being. Unfortunately, not all children have the same positive experiences or opportunities, which lead to disparities. A child's social, economic, and environmental factors shape their overall well-being and are closely linked to health disparities (CDC, 2016). In fact, according to the Centers for Disease Control and Prevention, research demonstrates that many disparities in overall health and well-being are rooted in early childhood (2016).

For example, young children who live in poverty are more likely to be at more risk for leading causes of illness and death. They experience an overall poor quality of life (CDC, 2016). Low levels of neighborhood trust and cohesion are related to higher rates of criminal activity in disadvantaged neighborhoods. There exists a high correlation between low household income levels and rates of property crime, such as burglary. The combination of high crime rates and other social factors associated with low-income neighborhoods creates barriers to healthy behaviors limits walking and playground use puts children at risk for poor educational, emotional, and health outcomes makes children more likely to become victims or perpetrators of violent crime.

According to the Children's Environmental Health Network (CEHN), "as of 2016, 19% of all children in the United States live in poverty. By race and ethnicity, this amounts to 34% of black children and 28% of Hispanic children, compared with 12% of white children. Mounting evidence indicates that additional issues related to poverty, such as lack of access to quality health care, malnutrition or undernutrition, and prolonged periods of adversity or toxic stress, can compound the harmful effects of environmental exposures on children's health."

Further statistics confirm health disparities exist among this vulnerable child population. Despite progress in immunization rates, 300 children in the United States die each year from vaccine-preventable diseases. In California, students entering kindergarten must show proof of immunizations, African American kindergarteners have fallen behind all other racial or ethnic groups in immunization rates. Moreover, inadequate progress has been made to improve environmental health for African American children who are 4 times more likely to be hospitalized for asthma compared with White children, and urban African American; or Latino children who are 2 to 6 times more likely to die from asthma than White children.

BSCPHP acknowledges that the statistics are only the surface of health disparities highlighted by research and more complex disparities exist among this population to reach a positive overall well-being. Most notably, the inability to make adequate progress due to the underlying issues of structural racism which perpetuate wealth and health disparities for children of color.

BSCPHP will focus on reducing health disparities among our child membership population by developing interventions that are directly aligned to the DHCS Bold Goals to close racial/ethnic disparities in well-child visits and immunizations by 50%, improve adolescent depression screening by 50%, and ensure BSCPHP exceeds the 50th percentile for all children's preventive care measures. We will analyze child health data to identify the disparities and inequities that exist in our membership and build interventions that support healthy development in early childhood reduce disparities, have lifelong positive impacts, and are prudent investments. Addressing these disparities effectively offers opportunities to help children and benefits our society.

3. Justice Involved

The COVID-19 pandemic has also magnified the pre-existing health disparities that exist for the justice-involved populations. For example, COVID-19 infection rates among incarcerated populations were higher than the overall infection rates in nearly all states across the United States. Justice-involved individuals are disproportionately low-income and often have complex and/or chronic conditions, including behavioral health needs.

According to the Kaiser Family Foundation, one analysis conducted Inmates incarcerated between 2009 and 2013 found that in the first full year after release from incarceration, only 55% of individuals had any reported earnings and among those with jobs, median earnings were only $10,090. In the 39 states (including DC) that have adopted Medicaid expansion under the Affordable Care Act, nearly all adults with incomes up to 138% of the federal

poverty level (FPL) ($17,774 for an individual in 2021) are eligible for Medicaid; however, eligibility for adults remains very limited in the remaining 12 states (KFF, 2021).

BSCPHP is committed to reducing the pre-existing health disparities that exist among our justice-involved membership population by developing programs that will help address the existing issues. We will analyze justice involved data to identify disparities and inequities that exist in our own membership. We will deliver the CalAim justice-involved program in flight to connect our justice-involved populations to Medicaid coverage and care as necessary.

4. Homelessness

An estimated 130,000 people are homeless in California, according to the last statewide count conducted by the National Alliance to End Homelessness (2023). In BSCPHP' service areas, Los Angeles County has nearly 50,000 homeless people, and San Diego County has over 8,500 homeless people (National Alliance to End Homelessness, 2023). Virtually all may qualify for Medi-Cal; however, data and statistics do not show a clear count of how many have enrolled and are receiving care. The limited data available, coupled with anecdotal evidence, show that enrollment rates vary from region to region, depending on local agency practices and county priorities.

BSCPHP is committed to our homeless members. Blue Shield will conduct an in-depth analysis monitoring utilization data for members eligible for Enhanced Care Management and Community Supports Enhanced Care Management and identify our homeless population by stratifying available data, identifying health disparities and inequities among our populations and areas served. We will deliver the CalAim ECM program to connect our homeless population to Medicaid coverage and provide health care services providing a whole-person approach to care and include expanded benefits to address clinical and non-clinical needs to our homeless members including housing support services, delivered by community-based providers, providing needed services to individuals experiencing homelessness to support their health, housing stability, and overall well-being.

5. LGBTQ+

According to the Medicaid and CHIP Payment and Access Commission (MACPAC) *Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with Accessing Medical and Behavioral HealthCare*, there are about 1.2 million lesbian, gay, bisexual, and transgender (LGBT) adults covered by Medicaid. Of those, it is estimated that about 12.7% (n=152,000) identify as transgender. In 2017, about 2 million youth ages 13-17 identify as LGBT, and it is estimated that about 0.7% (about n= 150,000) of youth ages 13-17 identify as transgender (2022).

Research has also shown that there are disparities in access to and use of physical and mental health services among those who identify as LGBTQ+ (MACPAC, 2022).

There are many factors that contribute to these disparities, including but not limited to provider discrimination, lack of provider knowledge about LGBTQ+ health care needs, and state health insurance coverage policies, including health insurance exclusions for gender-affirming care (MACPAC, 2022).

This issue brief is an analysis of the 2015-2018 National Health Interview Survey (NHIS) data and 2015-2019 National Survey on Drug Use and Health (NSDUH) data to compare the demographics, health status, and difficulties accessing medical and behavioral care between heterosexual and LGB adult Medicaid beneficiaries.

Overall results of the study conducted highlighted that the majority of Medicaid-covered Lesbian, Gay, and Bisexual (LGB) adults had a usual source of care and similar rates of physical health care service use as Medicaid-covered heterosexual adults. However, LGB adults were significantly more likely than heterosexual adults to report having a mental illness and to not receive needed treatment for their mental illness in the past 12 months. Similarly, LGB adults reported significantly higher rates of substance use disorder compared to heterosexual adults, and LGB adults were significantly more likely than heterosexual adults to have reported not receiving needed alcohol or drug treatment in the past 12 months.

The study found that the overall health and mental health status reported by transgender and gender diverse (TGD) adults covered by Medicaid was more similar to those who were uninsured than those with private insurance. Regarding access to services, TGD adults covered by Medicaid reported similar rates of access to providers for both routine and most gender-affirming health care as those covered by private insurance, but those covered by Medicaid were more likely to report not being able to find in-network providers to provide gender-affirming surgery.

Additionally, a higher proportion of those covered by Medicaid compared to those with private insurance reported having negative experiences with their providers, such as having to teach their provider about TGD people to get the appropriate care, and not being able to change their name and gender in their records.

These notable disparities in access to and use of physical and mental health services among those who identify as LGBTQ+ has driven BSCPHP' commitment to identify the disparities among our LGBTQ+ members, plan and implement targeted interventions to address identified opportunities. The HEO will work collaboratively with the Behavioral Health Department to conduct an analysis of HEDIS® and DHCS priority behavioral health measures such emergency department visits for mental illness, opioid use disorder, follow up after emergency department visit for substance use by REGAL stratification.

BSCPHP will also work diligently to enhance current cultural competency, sensitivity diversity, inclusion, and equity training available to our network providers, subcontractors, and downstream subcontractors which will include providing gender affirming care.

6. DHCS Managed Care Accountability Sets (MCAS)

   Per Supplement to the DHCS All Plan Letter 19-017 Quality and Performance Improvement Requirements, DHCS selects a set of performance measures, referred to as MCAS measures to evaluate the quality of care delivered by a Managed Care Plan (MCP) to its beneficiaries. The MCAS measures are comprised of select Centers for Medicare and Medicaid Services' (CMS) Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets). Many of these measures are also part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®).

   BSCPHP will conduct a data analysis of the MCAS measures and focus on analyzing for health disparate populations among the HEDIS® priority measures that each MCP is held accountable for to the minimum performance level (MPL). The MPL is based on the CA DHCS MCAS measurement year. BSCPHP may also complete a data analysis of additional measures that may contribute to the identification and findings of health disparities population(s).

   Such analysis will support BSCPHP' CQI promise for identifying health disparate populations during the measurement year and plan to develop targeted interventions for identified populations using the Plan-Do-Study-Act cycle (PDSA).

7. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

   The CAHPS® surveys ask consumers and patients to report on their experiences with health care services in different settings. The surveys are a product of the Agency for Healthcare Research and Quality's CAHPS program, which is a public-private initiative to develop and maintain standardized surveys of patients' experiences with ambulatory and facility-level care (AHRQ, 2023). The CAHPS® Survey is used to accurately capture customer feedback and expand on the scope of information gathered relative to quality-of-care issues.

   The CAHPS® surveys member satisfaction with questions related to health education and promotion, language, or cultural needs. For example, if the member has access to practitioners who speak their language and understand their culture, or supplemental questions that ask members if they need an interpreter were they able to access one. Results from the CAHPS® survey will provide BSCPHP with a member understanding of our member's overall experience and identify any disparities. BSCPHP continuously monitors member satisfaction survey results to track progress towards goals and identifying opportunities for improvement. We use the Plan-Do-Study-Act method to conduct qualitative and quantitative data and barrier analysis, develop interventions, implement quality initiatives, assess impact of interventions, and modify initiatives as needed. Our quality committees review performance on CAHPS® measures, analyze and evaluate the progress and outcomes of our activities to support performance improvement, and provide input on strategies. We also have a dedicated team under the Senior Manager, Clinical Quality Member Experience, to support member experience and to improve member satisfaction and experience. This team analyzes CAHPS® data, grievances and appeals,

health equity data, member experience reports, and ethnographic research to improve member experience.

The CAHPS® is conducted at least annually by BSCPHP, compiles the results and reports this to the state DHCS and NCQA regulators. The CMS also requires the DHCS, through their contracts with managed care plans, measure, and report on performance to assess the quality and appropriateness of care and services provided to members. The DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care program (MCMC) members as part of its process for evaluating the quality of health care services provided by Medi-Cal managed care health plans (MCPs) and population-specific health plans (PSPs) to MCMC members.

CAHPS® survey results are also incorporated and reported in the Population Needs Assessment to the DHCS as part of the DHCS All Plan Letter (APL) 19-011: Population Needs Assessment requirement.

8. Utilization Management

The HEO will analyze data gathered for the utilization management (UM) measures to identify health disparities reflected in differences in utilization or outpatient and preventive services. Utilization Management (UM) stratifies members' utilization by race, ethnicity, sexual orientation, and gender to identify areas for health interventions and inform our Health Equity Insights platform.

This enhances our understanding of why certain members do not engage in critically important prevention services. While we understand that there is no "one size fits all" for Medi-Cal, there are certain trainings, incentive programs and intervention programs that can be adapted across the communities and counties we serve. The Health Equity Insights Platform is an analytics platform that combines data from diverse sources and uses intelligent analytics to generate unique whole person-based insights impacting health equity. There are different public data sets that look at social risks based on the zip code, economics, education, housing, food, transportation, language spoken, etc. With this aggregate data, we can risk stratify populations based on social factors to supplement clinical risk which helps inform strategies to improve our care delivery and health interventions.

BSCPHP will also conduct a utilization review of outpatient, mental Health, emergency department, immunizations and well child visits to analyze and assess utilization and stratify by REGAL categories. BSCPHP will track year-over-year change to identify any statistically significant data trends in all categories. Furter, assessment of REGAL stratification will reveal any health disparities and inequities.

Next Steps

The HEO will conduct comprehensive health equity assessments periodically throughout the year to evaluate utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, and establish collaborative partnerships. The HEO will follow up on recommendations from prior assessments.

Recognizing that we have a lot of work to do in the health equity space and are unable to approach all at the same time, our approach is to prioritize where to focus our efforts. Addressing the needs for these vulnerable populations will help reduce disparities and inequities that may exist for vulnerable populations. This will be presented to the QIHEC for approval to focus on the recommended priority populations.

Resources

1. Centers for Disease Control and Prevention (2016). Addressing Health Disparities in Early Childhood.
2. Children's Environmental Health Network (2016). Children and Health Disparities. Retrieved from https://cehn.org/our-work/policy/policy-factsheets/children-and-health-disparities/
3. Kaiser Family Foundation (KFF) (2022). Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Maternal%20and%20infant%20health%20disparities,outcomes%20for%20people%20of%20color.
4. KFF (2021). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. Retrieved from https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/
5. Medicaid and CHIP Payment and Access Commission (MACPAC) (2022). Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with Accessing Medical and Behavioral Health Care. Retrieved from https://www.macpac.gov/wp-content/uploads/2022/06/Access-in-Brief-Experiences-in-Lesbian-Gay-Bisexual-and-Transgender-Medicaid-Beneficiaries-with-Accessing-Medical-and-Behavioral-Health-Care.pdf
6. Mehta N. K., Lee H., Ylitalo K. R. (2013). Child health in the United States: Recent trends in racial/ethnic disparities. Social Science & Medicine, 95, 6–15. https://doi.org/10.1016/j.socscimed.2012.09.011
7. National Alliance to End Homelessness (2023). Homelessness Statistics. California.

Promise Health Plan

Appendix 1 Health Equity Advancement Resulting in Transformation (HEART) Measure Set

HEART Measure Set											
No.	Measure Description	Measure Definition	Measure Acronym	Measure Steward	Health Equity Framework Domain	Responsible Functional Area	Responsible Owner	Report Source	Reporting Frequency	Baseline	Target
1	ED Utilization	Members who had more ED visits than primary care visits within a 12-month period by REGAL during the measurement period	ED UTIL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
2	PCP Utilization	Members who had a primary care visit within a 12-month period by REGAL during the measurement period	PCP UTIL	DMHC, DHCS CalAIM, EPSDT, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
3	Preventive Care Access	Percentage of members with no ambulatory or preventive visit within a 12-month period	PREV UTIL	DMHC, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
4	Disnerollment by REGAL	Voluntary disenrollment by REGAL during the measurement period	DISENR REGAL	DHCS	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
5	Redetermination Rate by REGAL	Redetermination rate of members reinstated by REGAL during the measurement period	REDET REGAL	DHCS	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
6	CRC Reach	Number of Blue Shield members served Community Resource Centers during the measurement period	CRC REGAL	NEW	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
7	Interpreter service utilization	Number of Language line interpreter service requests by language during the measurement period	INT SVC UTIL	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Access to Care	Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
8	Translated documents	Number of translated documents by language or alternative format during the measurement period	TRNSLTD DOCS	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Access to Care	Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
9	Physical Accessibility	Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period	PARS	DHCS	Equitable Access to Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
10	IHA Completion	IHA completion rate stratified by REGAL during the measurement period	IHA	DHCS	Equitable Access to Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
11	DPP Enrollment by REGAL	DPP enrollment by REGAL during the measurement period	DPP REGAL	DHCS	Equitable Access to Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
12	Getting Needed Care	Getting Needed Care by REGAL during the measurement period	GNC REGAL	NCQA	Equitable Access to Care	Quality	Alyson Spencer; Christine Nguyen	CAHPS	Quarterly	TBD	TBD
13	Getting Care Quickly by (REGAL)	Getting Care Quickly by REGAL during the measurement period	GCQ REGAL	NCQA	Equitable Access to Care	Quality	Alyson Spencer; Christine Nguyen	CAHPS	Quarterly	TBD	TBD
14	Grievances stratified by race and ethnicity	Grievance category stratified by race and ethnicity for all grievances received during the measurement period	GRV-RE	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt	834 file + Grievance	Quarterly	TBD	TBD

								universe file			
15	Cultural competency-related grievances	Percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period	CULT COMP GRV	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
16	Discrimination-related grievances	Percentage of Discrimination grievances based on all grievances received during the measurement period	DISC GRV	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
17	C&L grievances	Percent of C&L grievances (discrimination-related, interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period	C&L GRV	DMHC, DHCS	Equitable Experiences of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
18	Overturned appeals stratified by race and ethnicity	Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period	APP-RE	NCQA	Equitable High Quality Clinical Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
19	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Behavioral Health; CalAIM	David Bond; Paige Brogan	Inovalon (Late 2023)	Quarterly	TBD	TBD
20	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Behavioral Health; CalAIM	David Bond; Paige Brogan	Inovalon	Quarterly	TBD	TBD
21	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Behavioral Health; CalAIM	David Bond; Paige Brogan	Inovalon	Quarterly	TBD	TBD
22	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life stratified by REGAL	WCV REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
23	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
24	Colorectal Cancer Screening by REGAL	Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified by REGAL	COL REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
25	Hemoglobin A1c Control for Patients with Diabetes by REGAL	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year	HBD REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD

26	Controlling High Blood Pressure by REGAL	Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL	CBP REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
27	Asthma Medication Ratio by REGAL	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL	AMR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
28	Child and Adolescent Well Care Visits by REGAL	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL	AWC REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
29	Childhood Immunization Status by REGAL	Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday during the measurement period strafied by REGAL	CIS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
30	Immunizations for Adolescents by REGAL	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates during the measurement period stratified by REGAL	IMA REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
31	Plan All-Cause Readmissions by (REGAL)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission during the measurement period stratified by REGAL	PCR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
32	Potentially Preventable 30-day Post-Discharge Readmission by (REGAL)	Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL	PPR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD

33	Prenatal and Postpartum Care: Postpartum Care by (REGAL)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL	PPC POST REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
34	Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL)	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL	PPC TIME REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
35	EPSDT Preventive Utilization Gap	Percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period stratified by REGAL	EPSDT UTIL GAP	DMHC, DHCS CalAIM, EPSDT	Equitable High-Quality Clinical Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
36	EPSDT PCP Utilization	Members ages 0-20 who had a primary care visit within a 12-month period by REGAL during the measurement period	EPSDT UTIL	DMHC, DHCS CalAIM, EPSDT	Equitable High-Quality Clinical Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
37	C-section rates by REGAL	C-section rates by REGAL during the measurement period	CSCTN	DMHC, DHCS	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
38	Maternal Morbidity	Rate of Maternal morbidity by REGAL during the measurement period	MAT MORB	DHCS	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
39	Transitions and Care Manager Interaction	Transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge. by REGAL during the measurement period	TOC	DMHC, DHCS CalAIM, NCQA	Equitable Social Interventions	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
40	Maternal Mental Health Screening Referral	Rate of members with positive maternal mental health screening referred to behavioral health services during the measurement period	MMH REF	DMHC, DHCS	Equitable Social Interventions	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
41	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
42	Populations of Focus	Percent of members stratified into each populations of focus	POF	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
43	Community Support utilization	Community support utilization by category	CS UTIL	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
44	CCM Enrollment	Members eligible for CCM who are successfully enrolled in the CCM program by REGAL during the measurement period	CCM ENR	DMHC, DHCS CalAIM, NCQA	Equitable Structures of Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
45	Enrollment Growth by REGAL	Enrollment growth stratified by REGAL during the measurement period	ENR REGAL	DHCS	Equitable Structures of Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
46	Bilingual calls managed by Call Center	Call center number of internal bilingual calls by member's preferred language during the measurement period	CALL CTR BLNGL	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Structures of Care	Customer Experience	Vivian Husband Phillips		Quarterly	TBD	TBD

47	Multi-lingual staff	Total number of multi-cultural/multi-lingual staff during the measurement period	MUL STAFF	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Structures of Care	Customer Experience	Vivian Husband Phillips		Quarterly	TBD	TBD
48	PCP Staff Training	Compliance rate for all FSRs completed assessing FSR section "Site personnel receive training on member rights" performed during measurement period	PCP TRNG	DHCS	Equitable Structures of Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
49	Cultural Competency Training	Cultural competency training – internal completion rate by member-facing staff	CULT COMP TRNG	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
50	Health Education Materials	Health Education materials available in all threshold languages during the measurement period	HEALTH ED	DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
51	Member-facing staff representative of membership	Rate of bilingual member-facing health plan staff by language is representative of membership during the measurement period	BLNGL STF	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
52	Provider Network by Threshold Language	Percent of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area – i.e. X% speak threshold languages (per geographic area)	PROV NTWK LANG	DHCS	Equitable Structures of Care	Provider Contracting	Melinda Kjer		Quarterly	TBD	TBD
53	Depression Screening and Follow up for Adolescents and Adults by REGAL	Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period	DSF REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Overall Well-Being	Behavioral Health; Quality; CalAIM	David Bond; Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
54	Perinatal Depression Screening	Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period	PND	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond	Inovalon	Quarterly	TBD	TBD
55	Postpartum Depression Screening and follow-up	Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. during the measurement period	PDS	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond	Inovalon	Quarterly	TBD	TBD
56	Positive maternal mental health screening	Positive maternal mental health screening results by REGAL during the measurement period	MMH POS	DMHC, DHCS	Overall Well-Being	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD

HEART Measure Set

No.	Measure Description	Measure Definition	Measure Acronym	Measure Steward	Health Equity Framework Domain	Responsible Functional Area	Responsible Owner	Report Source	Reporting Frequency	Baseline	Target
1	ED Utilization	Members who had more ED visits than primary care visits within a 12-month period by REGAL during the measurement period	ED UTIL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
2	PCP Utilization	Members who had a primary care visit within a 12-month period by REGAL during the measurement period	PCP UTIL	DMHC, DHCS CalAIM, EPSDT, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
3	Preventive Care Access	Percentage of members with no ambulatory or preventive visit within a 12-month period	PREV UTIL	DMHC, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
4	Disenrollment by REGAL	Voluntary disenrollment by REGAL during the measurement period	DISENR REGAL	DHCS	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
5	Redetermination Rate by REGAL	Redetermination rate of members reinstated by REGAL during the measurement period	REDET REGAL	DHCS	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
6	CRC Reach	Number of Blue Shield members served Community Resource Centers during the measurement period	CRC REGAL	NEW	Equitable Access to Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
7	Interpreter service utilization	Number of Language line interpreter service requests by language during the measurement period	INT SVC UTIL	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Access to Care	Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
8	Translated documents	Number of translated documents by language or alternative format during the measurement period	TRNSLTD DOCS	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Access to Care	Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
9	Physical Accessibility	Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period	PARS	DHCS	Equitable Access to Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
10	IHA Completion	IHA completion rate stratified by REGAL during the measurement period	IHA	DHCS	Equitable Access to Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
11	DPP Enrollment by REGAL	DPP enrollment by REGAL during the measurement period	DPP REGAL	DHCS	Equitable Access to Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
12	Getting Needed Care	Getting Needed Care by REGAL during the measurement period	GNC REGAL	NCQA	Equitable Access to Care	Quality	Alyson Spencer; Christine Nguyen	CAHPS	Quarterly	TBD	TBD
13	Getting Care Quickly by (REGAL)	Getting Care Quickly by REGAL during the measurement period	GCQ REGAL	NCQA	Equitable Access to Care	Quality	Alyson Spencer; Christine Nguyen	CAHPS	Quarterly	TBD	TBD
14	Grievances stratified by race and ethnicity	Grievance category stratified by race and ethnicity for all grievances received during the measurement period	GRV-RE	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt	834 file + Grievance universe file	Quarterly	TBD	TBD
15	Cultural competency-related grievances	Percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period	CULT COMP GRV	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
16	Discrimination-related grievances	Percentage of Discrimination grievances based on all grievances received during the measurement period	DISC GRV	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
17	C&L grievances	Percent of C&L grievances (discrimination-related, interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period	C&L GRV	DMHC, DHCS	Equitable Experiences of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
18	Overturned appeals stratified by race and ethnicity	Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period	APP-RE	NCQA	Equitable High Quality Clinical Care	Appeals and Grievances	Lorraine Greywitt		Quarterly	TBD	TBD
19	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Late 2023)	Quarterly	TBD	TBD
20	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
21	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
22	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life stratified by REGAL	WCV REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
23	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
24	Colorectal Cancer Screening by REGAL	Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified by REGAL	COL REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
25	Hemoglobin A1c Control for Patients with Diabetes by REGAL	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year	HBD REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
26	Controlling High Blood Pressure by REGAL	Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL	CBP REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
27	Asthma Medication Ratio by REGAL	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL	AMR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon (Q4 2023)	Quarterly	TBD	TBD
28	Child and Adolescent Well Care Visits by REGAL	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL	AWC REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD

29	Childhood Immunization Status by REGAL	Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday during the measurement period stratifed by REGAL	CIS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
30	Immunizations for Adolescents by REGAL	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates during the measurement period stratified by REGAL	IMA REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
31	Plan All-Cause Readmissions by (REGAL)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission during the measurement period stratified by REGAL	PCR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
32	Potentially Preventable 30-day Post-Discharge Readmission by (REGAL)	Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL	PPR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
33	Prenatal and Postpartum Care: Postpartum Care by (REGAL)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL	PPC POST REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
34	Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL)	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL	PPC TIME REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High-Quality Clinical Care	Quality; CalAIM	Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma		Quarterly	TBD	TBD
35	EPSDT Preventive Utilization Gap	Percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period stratified by REGAL	EPSDT UTIL GAP	DMHC, DHCS CalAIM, EPSDT	Equitable High-Quality Clinical Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
36	EPSDT PCP Utilization	Members ages 0-20 who had a primary care visit within a 12-month period by REGAL during the measurement period	EPSDT UTIL	DMHC, DHCS CalAIM, EPSDT	Equitable High-Quality Clinical Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
37	C-section rates by REGAL	C-section rates by REGAL during the measurement period	CSCTN	DMHC, DHCS	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
38	Maternal Morbidity	Rate of Maternal morbidity by REGAL during the measurement period	MAT MORB	DHCS	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
39	Perinatal Immunization Status - Flu	Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date; or Deliveries where members had an influenza virus vaccine adverse reaction any time during or before the Measurement Period.	PERINATAL IZ FLU	NCQA	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
40	Perinatal Immunization Status - Tdap	Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or Deliveries where members had any of the following: • Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. • Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis) any time during or before the Measurement Period.	PERINATAL IZ Tdap	NCQA	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
41	NICU Admits	Rate of newborns of babies born during the measurement period to prenatal care patients aditted to the Neonatal Intensive Care Unit upon birth	NUCI ADMITS	New Measure	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
42	Pre term birth	Pre term birth before 37 weeks of pregnancy of babies born during the measurement period	PRETERM BIRTH	New Measure	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
43	Low birth weight	Birthweight of babies born during the measurement period (<1,00 grams; 1,500-2,499 grams; >2,500 grams)	LBW	New Measure	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
44	Breast feeding rates	Rate of breastfeeding at least 6 months following birth from all deliveries occuring during the measurement period	BRFDNG	New Measure	Equitable High-Quality Clinical Care	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
45	Transitions and Care Manager Interaction	Transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge. by REGAL during the measurement period	TOC	DMHC, DHCS CalAIM, NCQA	Equitable Social Interventions	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
46	Maternal Mental Health Screening Referral	Rate of members with positive maternal mental health screening referred to behavioral health services during the measurement period	MMH REF	DMHC, DHCS	Equitable Social Interventions	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD
47	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
48	Populations of Focus	Percent of members stratified into each populations of focus	POF	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
49	Community Support utilization	Community support utilization by category	CS UTIL	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria		Quarterly	TBD	TBD
50	CCM Enrollment	Members eligible for CCM who are successfully enrolled in the CCM program by REGAL during the measurement period	CCM ENR	DMHC, DHCS CalAIM, NCQA	Equitable Structures of Care	Cal AIM	Paige Brogan		Quarterly	TBD	TBD
51	Enrollment Growth by REGAL	Enrollment growth stratified by REGAL during the measurement period	ENR REGAL	DHCS	Equitable Structures of Care	Community Engagement	Sandra Rose		Quarterly	TBD	TBD
52	Bilingual calls managed by Call Center	Call center number of internal bilingual calls by member's preferred language during the measurement period	CALL CTR BLNGL	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Structures of Care	Customer Experience	Vivian Phillips Husband		Quarterly	TBD	TBD
53	Multi-lingual staff	Total number of multi-cultural/multi-lingual staff during the measurement period	MUL STAFF	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Structures of Care	Customer Experience	Vivian Phillips Husband		Quarterly	TBD	TBD

54	PCP Staff Training	Compliance rate for all FSRs completed assessing FSR section “Site personnel receive training on member rights” performed during measurement period	PCP TRNG	DHCS	Equitable Structures of Care	Clinical Access Programs	Jesse Brennan-Cooke		Quarterly	TBD	TBD
55	Cultural Competency Training	Cultural competency training – internal completion rate by member-facing staff	CULT COMP TRNG	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
56	Health Education Materials	Health Education materials available in all threshold languages during the measurement period	HEALTH ED	DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
57	Member-facing staff representative of membership	Rate of bilingual member-facing health plan staff by language is representative of membership during the measurement period	BLNGL STF	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman		Quarterly	TBD	TBD
58	Provider Network by Threshold Language	Percent of providers that reflect the needs of the Medi-Cal population in the Contractor’s Service Area – i.e. X% speak threshold languages (per geographic area)	PROV NTWK LANG	DHCS	Equitable Structures of Care	Provider Contracting	Melinda Kjer		Quarterly	TBD	TBD
59	Depression Screening and Follow up for Adolescents and Adults by REGAL	Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period	DSF REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Overall Well-Being	Behavioral Health; Quality; CalAIM	David Bond; Alyson Spencer; Christine Nguyen; Paige Brogan; Ayesha Sharma	Inovalon	Quarterly	TBD	TBD
60	Perinatal Depression Screening	Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period	PND	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond; Kim Bower	Inovalon	Quarterly	TBD	TBD
61	Postpartum Depression Screening and follow-up	Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. during the measurement period	PDS	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond; Kim Bower	Inovalon	Quarterly	TBD	TBD
62	Positive maternal mental health screening	Positive maternal mental health screening results by REGAL during the measurement period	MMH POS	DMHC, DHCS	Overall Well-Being	Maternal Health	Katie Abbott; Kim Bower; Nicole Evans		Quarterly	TBD	TBD

Equitable Social Interventions

Measure	Measure Steward	Data Source	Abbreviated Description
Social Need Screening and Intervention (HEDIS)	NCQA	Electronic Clinical Data Systems	The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using prespecified instruments and, if screened positive, received a corresponding intervention.
Screening for Social Drivers of Health	The Physician's Foundation	Clinical data	Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Screen Positive Rate for Social Drivers of Health	The Physician's Foundation	Clinical data	Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.

Equitable Access to Care

Measure	Measure Steward	Data Source	Abbreviated Description
Child and Adolescent Well-Care Visits (HEDIS)	NCQA	Administrative Data	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Follow-Up After Hospitalization for Mental Illness (HEDIS)	NCQA	Administrative Data	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
Prenatal and Postpartum Care (HEDIS)	NCQA	Administrative or hybrid data	Assesses access to prenatal and postpartum care: • Timeliness of Prenatal Care. The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.
Getting Care Quickly (CAHPS)	AHRQ	Survey data	The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed. • Respondent got care for illness/ injury as soon as needed. • Respondent got non-urgent appointment as soon as needed.

Equitable High-Quality Clinical Care

Measure	Measure Steward	Data Source	Abbreviated Description
Depression Screening and Follow Up for Adolescents and Adults (HEDIS)	NCQA	Electronic Clinical Data Systems	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates: Screening and Follow-Up.
Hemoglobin A1c Control for Patients With Diabetes—HBA1C Poor Control (>9%) (HEDIS)	NCQA	Administrative or hybrid data	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c poor control (>9.0%) indicator.
Controlling High Blood Pressure (HEDIS)	NCQA	Administrative or hybrid data	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Breast Cancer Screening (HEDIS)	NCQA	Administrative Data	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Colorectal Cancer Screening (HEDIS)		Administrative Data	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Equitable Experience of Care

Measure	Measure Steward	Data Source	Abbreviated Description
Discrimination in Medical Settings	NA	Survey data	Asks respondents to indicate whether the following events have happened to them in medical settings: • Treated with less courtesy or respect than other people. • Received poorer service than others. • A doctor or nurse acts as if they think you are not smart, as if they are afraid of you, as if they are better than you or that they are not listening to what you were saying. A follow-up question asks respondent to identify what they think is the main reason for these experiences. Response options include: Ancestry or National Origins, Gender, Race, Age, Religion, Height, Weight, Some other Aspect of Physical Appearance, Sexual Orientation, Education or Income Level
How Well Doctors Communicate Composite (CAHPS)	AHRQ	Survey data	This question asks enrollees how often their personal doctor explained things clearly, listened carefully, showed respect and spent enough time with them. • Doctor explained things in a way that was easy to understand. • Doctor listened carefully to enrollee. • Doctor showed respect for what enrollee had to say. • Doctor spent enough time with enrollee

Health Plan Customer Service (CAHPS)	AHRQ	Survey data	This measure asks enrollees how often customer service staff were helpful and treated them with courtesy and respect. • Customer service gave necessary information/help. • Customer service was courteous and respectful.
Equitable Structures of Care			
Measure	**Measure Steward**	**Data Source**	**Abbreviated Description**
Race/Ethnicity Diversity of Membership (HEDIS)	NCQA	Member-reported and enrollment data	This measure assesses the count and percentage of members enrolled at any time during the measurement year by race and ethnicity.
Language Diversity of Membership (HEDIS)	NCQA	Member-reported and enrollment data	This measure assesses the count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and for written materials.
Measures in Overall Well-Being			
Measure	**Measure Steward**	**Data Source**	**Abbreviated Description**
Cantril's Ladder	NA	Survey data	This measure is an assessment of well-being, which asks respondents to imagine a ladder with steps numbered from 0 at the bottom to 10 at the top, where the top and bottom of the ladder represent the best and worst possible life. Respondents are asked to indicate where on the ladder they feel they stand now, and where they think they will stand 5 years from now. Respondents are then categorized as follows: Thriving: 7 or higher currently, 8 or higher in 5 years Suffering: 4 or lower currently and in 5 years Struggling: in the middle or inconsistent
Physical health rating in last 30 days (BRFSS)	CDC	Survey data	Asks respondents to think about their physical health, including physical illness and injury, and for how many days during the past 30 days was their physical health not good.
Mental health rating in last 30 days (BRFSS)	CDC	Survey data	Asks respondents to think about their mental health, including stress, depression, and problems with emotions, and for how many days during the past 30 days was their mental health not good.
Physical or mental health as a barrier to usual activities in last 30 days (BRFSS)	CDC	Survey data	Asks respondents to report about how many days during the past 30 days did poor physical or mental health keep them from doing their usual activities, such as self-care, work, or recreation.

Appendix 4: Quality Improvement Health Equity Transformation Program Action Plan

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

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

Task	Comments	Contract Requirement	Due Date	Collaboration	Status
Chief Health Equity Officer position	CHEO started 9/26/2022	Yes	10/1/2022	HEO	Closed
Health Equity Organizational Chart	Submitted and approved by the DHCS on 04/11/2023	Yes	3/14/2023	HEO	Closed
Health Equity Office Structure	Submitted and approved by the DHCS on 04/11/2023	Yes	3/14/2023	HEO	Closed
Medi-Cal Readiness Deliverable: 2.2. QIHETP	Submitted on 3/30/2023 to the DHCS; pending approval by the DHCS	Yes	3/30/2023	HEO	Open
Identify DHCS Health Equity contractual requirements	Will need to review Medi-Cal Managed Care Health Plan Contract and develop a gap analysis; will also need to include any NCQA and/or DMHCS requirements cross walk	No	5/31/2023	HEO Compliance Medi-Cal Growth Office	Open
5-year strategic plan, Maturation Model	Completed and presented to executive leadership	No	3/1/2023	HEO	Closed
QIHETP Description	Draft in progress due to QIHEC Q2 meeting	Yes	6/5/2023	HEO	Open
QIHETP Policy	Submitted and approved by the DHCS on 03/09/2023	Yes	2/10/2023	HEO Compliance Medi-Cal Growth Office	Closed
QIHEC Policy	Submitted on 3/30/2023 to the DHCS; pending approval by the DHCS	Yes	2/10/2023	HEO Compliance Medi-Cal Growth Office	Closed
QIHEC Charter	Completed and submitted to QIHEC Q1 for review and approval; Approved by committee on 3/6/2023	Yes	3/6/2023	HEO	Closed
HEOC Charter	In progress for submission to HEOC Q2 for committee review and approval	Yes	6/8/2023	BSC Health Transformation Lab BSP- HEO	Open
QIHETP Workplan	In progress for submission to QIHEC Q2 for committee review and approval	Yes	6/5/2023	HEO	Open

HEOC Workplan	In progress for submission to HEOC Q2 for committee review and approval	Yes	6/8/2023	BSC Health Transformation Lab BSP- HEO	Open
Health Equity Workgroup	Ongoing workgroups to address open gaps enterprise-wide. NCQA gap analysis, owner identification BSC vs. BSP. IT/Data system builds enhancements needed e.g., FACETS REAL/SOGI data available to first contact Customer Experience member facing staff	Yes	6/12/2023	BSC- Health Transformation Lab BSP- HEO Quality NCQA Accreditation Medi-Cal Growth Office Strategic and Performance	Open
QIHEC (introduction emails/committee member recruitment, agenda, slide deck, meeting minutes)	QIHEC Q1 completed; QIHEC Q2, Q3 and Q4 are scheduled	Yes	3/5/2023 6/5/2023 9/13/2023 12/4/2023	HEO	Open
Health Equity Oversight Committee (agenda, slide deck, meeting minutes)	HEOC Q2 inaugural committee meeting scheduled HEOC Q3 and Q4 are scheduled	Yes	6/12/2023 9/11/2023 12/8/2023	BSC- Health Transformation Lab BSP- HEO	
DEI training for BSP staff	Enhance current cultural competency training; exploring internal resources and/or external vendors for sourcing, as needed	Yes	1/1/2024	HEO HE/CL	Open
Develop HEART Measure Set	Identify all impacted departments, facilitate meetings	Yes	5/15/2023		Open
Health Equity Measure Set Roadshow Experience	Share strategic plan, facilitate collaboration, establish partnerships between HEO and functional area leaders	No	4/30/2023		Open
Stratified reporting of HEDIS®/ Health Equity Measure Set	Many data sets must be stratified and analyzed for disparities for the very first time- key measures will need to be selected for each data set. With this, development of a separate roadmap and strategy is needed to ensure that Promise can meet DHCS requirement timelines, but also operationalize high quality health equity work.	Yes	9/13/2023	HEO A&G BH CalAim PHM Customer Experience Clinical Services (FSR) HE/CL Maternal Health Provider Contracting Quality Corporate Citizenship and Reputation	Open

				Social Services Management Community Engagement	
Update global policies and procedures with health equity lens	Need to review all policies and procedures with a health equity lens. Need to connect with Sylvona Boler for P&P operational process as presented in April 2023 MPOD meeting	Yes	12/31/2023	HEO Compliance Medi-Cal Growth Office	Open
QIHETP Annual Evaluation Report	Need to draft QIHETP Annual Evaluation Report	Yes	4/30/2024	HEO	Open
Review Marketing Plan and identify HE activities	CHEO to review Marketing Plan and identify HE activities in collaboration with Community Engagement Department	Yes	6/1/2023	Community Engagement HEO	Open
Population Needs Assessment and Population Health Management Strategy	Support draft and use findings to guide program activities None	Yes	TBD	BSC- Health Transformation Lab HEO	Open
BSP Population Needs Assessment	Support draft and use findings to guide program activities None	Yes	6/30/2023	HE/CL HEO	Open
BSP Population Health Management Strategy	support draft and use findings to guide program activities	Yes	TBD	PHM HEO	Open
Provider Health Equity training	No known training. Need to develop content and implement. Systems to track provider compliance unknown.	Yes	1/1/2024	HEO Provider Relations HE/CL	Open
Assess health equity pilots	Need to assess current health equity pilots, projects, programs – part of 5-year strategic planning and maturation model.	Yes	1/1/2024	HEO A&G BH CalAim PHM Customer Experience Clinical Services (FSR) HE/CL Maternal Health Provider Contracting Quality Corporate Citizenship and Reputation Social Services Management Community Engagement	Open
Committee involvement (QIHEC, MAC, PAC, PPC)	CHEO representation in committee involvement. Co-chairing QIHEC with CMO	Yes	6/7/2023	HEO Community Engagement	Open

	CHEO provide updates as MAC, PAC, PPC Member and Provider feedback needed to build QIHETP for required written reports				
Provider involvement in Health Equity – APM, VBC	No existing mechanisms to assess provider HE competence (possibly incorporated into z-code training). Roadmap and timeline needed for journey to HE related APMs and VBC after CHEO is hired. Unclear whether Salesforce (or any other platform) will have functionality to track or facilitate selection of partners for interventions.	Yes	1/1/2024	BSC – Health Transformation Lab BSP- HEO and Quality	Open
NCQA Health Equity Accreditation in 2025	Need to Identify owners for all HEA standards and elements; IT policies need to be updated to include NCQA data; Data REAL/SOGI collection systems implementation needed; report writing needed	Yes	12/31/2025	HEO NCQA Accreditation HE/CL IT Other - TBD	Open

Promise Health Plan

Health Equity Assessment: Quality Outcomes 2022 Measurement Year

Responsible Health Equity Office Staff

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

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

Contents

I. Introduction and Background 4
II. Key Findings 5
III. Measurements of Health Disparities 6
HEDIS® 6
DHCS Managed Care Accountability Set (MCAS) 6
DHCS Bold Goals 7
DMHC Health Equity and Quality Measure Set 7
IV. Methodology 8
A. Member Profiles 9
Gender. 9
Age. 9
Language 10
Education and Literacy Characteristics 11
B. HEDIS® Results 11
Child and Adolescent Well Care Visits 11
Immunizations for Adolescents – Combination 2 14
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7 day 16
Follow-Up after emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30 day 18
Follow-Up after Emergency Department Visit for Mental Illness - 7 day 21
Follow-Up after Emergency Department Visit for Mental Illness - 30 day 23
Depression Screening and Follow-Up for Adolescents and Adults (Screening) 26
Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up) 28
Prenatal and Postpartum Care – Postpartum Care 31
Prenatal and Postpartum Care – Timeliness of Prenatal Care 33
Hemoglobin A1c Control for Patients with Diabetes - <8% 35
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9) 37
Controlling Blood Pressure 40
Childhood Immunization Status – Combination 10 Immunizations 42

C. Disparity Analysis 47
Race 48
Language 48
Age 48
Gender 48
D. Analysis of DHCS' Bold Goals 53
Close racial/ethnic disparities in well-child visits by 50%. 53
Close maternity care disparity for Black and Native American persons by 50%. 53
Improve maternal and adolescent depression screening by 50%. 53
Improve follow up for mental health and substance use disorder by 50%. 54
Ensure all health plans exceed the 50th percentile for all children's preventive care measures. 54
Conclusion 55
XXII. References 56

I. Introduction and Background

Racial and ethnic disparities in health and health care remain a persistent challenge in the United States (Kaiser Family Foundation, 2023). While inequities in access to and use of health care contribute to disparities in health, inequities across broader social and economic factors that drive health, often referred to as social drivers of health, also play a major role. Disparities occur across many demographic categories, including race, ethnicity, economic status, age, place of residence, gender, disability status, language, and sexual orientation.

All Californians should have access to the high-quality health care they need to lead long and healthy lives (California Health Care Foundation, 2021). The Blue Shield of California Promise Health Plan (BSCPHP) Health Equity Office (HEO) supports this vision and facilitates a strategy to transform the health care system, improving quality, expanding access, and ensuring equity for all members.

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

BSCPHP seeks to create a healthcare system that is worthy of our family and friends and is sustainably affordable. BSCPHP has defined a set of health plan strategies to achieve this goal. One of the health equity strategies developed for the 2023-2024 Quality Improvement and Health Equity Transformation Program is to link quality and equity. This Assessment supports that strategy, as the Health Equity Office seeks to accomplish the following program goals:

1. Advance Information in Action: BSCPHP will integrate data and analytics platforms to generate valid, actionable, and meaningful information to increase quality and health equity. This assessment was designed using data generated for reporting of the NCQA HEDIS® measures. The HEO can assess quality performance and health outcomes using a validated dataset.
2. Design Interventions that Matter: BSCPHP will embed equity-focused initiatives across the enterprise to consistently prioritize addressing health disparities and in accordance with regulatory requirements and strategies. Results of this assessment will be used to design interventions that matter.

Using data to identify disparities and the factors that drive them is important for developing interventions and directing resources to address them as well as for assessing progress toward achieving greater equity over time (California Health Care Foundation, 2021). As such, BSCPHP's HEO has designed a strategic approach to assess health disparities and inequities that may exist among BSCPHP membership.

The following assessment includes a comprehensive assessment of the results of the Measurement Year (MY) 2023 National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data

and Information Set (HEDIS®) results stratified by race, ethnicity, gender, age, and language (REGAL). Measures included in this Assessment are aligned with the Department of Healthcare Services (DHCS) Managed Care Accountability Set (MCAS) and the Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set.

This Assessment presents an equity analysis of measures, where data was stratified by REGAL in accordance with NCQA, DHCS, and DMHC reporting guidelines for HEDIS® MY 2022.

II. Key Findings

- The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups. Statistical analysis is necessary to identify significant disparities, especially since the total number of eligible members per category ranged significantly, with some denominators having 1+ eligible member.
- This assessment provides a baseline report of performance relative to the DHCS Bold Goals.
- Disparities or difference between populations were identified for Black or African American and American Indian or Alaskan Native populations having completed well-child visits.
- The White demographic accounts for 16.66% of total membership yet reports the lowest rates for the most (9 of 15) HEDIS® measures when comparing to the highest performing Races.
- Similarly, the total number of lowest compliance rates per measure were observed for the following groups. These are not relative to total membership - Black or African American (9.06%), Asian (4.19%), Native Hawaiian or Pacific Islander (3.17%), and American Indian or Alaskan Native (0.12%). Further statistical analysis is needed to confirm significant differences between Race.
- Common disparities for disparate racial groups include immunizations for children and adolescents, prenatal and postpartum care, Behavioral Health management, and diabetes management.
- The Tagalog (0.1% of total membership) demographic reports the lowest rates for the most (8 of 15) HEDIS® measures when comparing to the highest performing Languages, followed by Arabic (0.2% of total membership), Vietnamese (0.4% of total membership), and Russian (0,2%) with 4 or more disparities identified per group. This is indicative of a disparity as members whose preferred language accounts for a small portion of total membership.

III. Measurements of Health Disparities

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® data is used to report the quality performance of health plans.

For health plans, HEDIS® ratings are very important. The scores on measures allow the health plan to better understand the quality of care being delivered to their members in a standard, nationally recognized manner for some of the most common chronic and acute illnesses. Higher scores help the plan compete more effectively in various markets. The DHCS uses performance rates to compare MCPs and publishes a Quality Scorecard in which Plans are ranked in order of performance.

HEDIS® results are used to monitor performance on important dimensions of utilization and care. BSCPHP monitors against goals such as National Averages, and/or NCQA benchmarks. BSCPHP also seeks to meet the Minimum Performance Levels (MPL) for all state priority measures outlined in the MCAS which is currently set at the HEDIS® 50th percentile.

DHCS Managed Care Accountability Set (MCAS)

The MCAS measures are comprised of select Centers for Medicare and Medicaid Services' (CMS) Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets). Many of these measures are adopted from NCQA as the measure steward.

This set provides DHCS with a standardized method to objectively evaluate an MCP's delivery of services. MCPs must annually collect and report rates for MCAS measures. The published MCAS for MY 2022 contains 39 measures, of which many are HEDIS® measures.

The MCAS metrics support the assessment of utilization, preventive care screening, and management of chronic health conditions. BSCPHP's Quality Department closely monitors the MCAS Quality and health equity intersect as related to disparities that exist between reported MCAS results. Further, select MCAS measures intersect with health equity. These measures will be monitored to assess disparities and differences between populations, especially among populations of focus.

DHCS Bold Goals

DHCS published the Comprehensive Quality Strategy (CQS) in 2022. The CQS introduced DHCS' Bold Goals: 50x2025 4 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025. To achieve DHCS' vision of eliminating health care disparities, DHCS has defined needed improvements in data collection and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts.

This Assessment is aligned to identify disparities related to the Bold Goals and serves as a baseline report in assessing disparities or differences between populations among Promise members.

Figure 1 DHCS Bold Goals

DMHC Health Equity and Quality Measure Set

The DMHC has established the Health Equity and Quality Measure Set (HEQMS) and measure stratification requirements, which are provided in All Plan Letter (APL) 22-028. The HEQMS were recommended with the goal of addressing long-standing health inequities and ensure the equitable delivery of high-quality health care services across all market segments, including the individual, small and large group markets, and the Medi-Cal Managed Care program. Benchmark rates were not established at the time of this report.

Per the 2022 Health Equity and Quality Committee Recommendations Report, key implementation dates of the HEQMS include:

- By March 1, 2022: The DMHC convened the Health Equity and Quality Committee.
- MY 2023: Health plans begin collecting data on health equity and quality measures.
- 2024: Health plans submit MY 2023 data to the DMHC.
- 2025: The DMHC publishes the Health Equity and Quality Compliance Report for MY 2023.
- 2026: The DMHC promulgates regulations to codify the Health Equity and Quality measures and benchmarks.
- January 1, 2026: Health plans required to obtain NCQA Health Plan Accreditation (HPA).

The initial set of measures will be collected and reported beginning in MY 2023 through at least MY 2027. After five years, the DMHC may reconvene the Committee to adjust or revise the measure set.

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

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

Although the NCQA requires health plans to stratify by race and ethnicity for only nine of the measures on the DMHC's HEQMS, the DMHC will require stratification by race and ethnicity for all 13 of the HEQMS measures beginning in MY 2023. The NCQA follows the Office of Management and Budget (OMB) Standards for stratification, which define minimum standards for collecting and presenting data on race and ethnicity for all Federal data reporting. **This Assessment contains a comprehensive, stratified report of these* measures as they are aligned with NCQA and DHCS Quality measures.**

IV. Methodology

This analysis examines variances in outcomes between populations as stratified by REGAL. Data sources include:

- Blue Shield of California Promise Health Plan 2022 Population Needs Assessment
- 2022 Healthcare Effectiveness Data and Information Set

Data is presented for 8 racial groups: White, Asian or Pacific Islander, Hispanic, Black, or African American, American Indian, and Alaska Native, Race Detail Unknown, Some Other Race, and Two or More Races. People of Hispanic origin may be of any race but are classified as Hispanic for this analysis. Age groups are presented as specified per measure. Gender is reported as Male and Female. Language is presented for English, Spanish, Non-English, Not Selected, Chinese, Vietnamese, Armenian, Arabic, Korean, Tagalog, Russian, Khmer, Farsi, and Hmong.

Differences described between groups are statistically significant at the $p<0.05$ level. Data used for the analysis include validated results as submitted to the NCQA for the 2022 MY.

A. Member Profiles

Membership

In 2022, Blue Shield Promise had a total membership of 413,740 continuously enrolled members.

Gender

Females represent the majority gender and comprise 54.1% of the population, compared to males that make up the remaining 45.9%.

Gender	Number	Rate
Female	223,833	54.1%
Male	189,907	45.9%

Figure 2 BSCPHP Membership by Gender

Age

The average age of Promise's membership is 25.4 with over half of members being infants, children, or adolescents. The largest group of Blue Shield Promise's Medi-Cal membership falls into the 20-44 age range at 33%.

Of the total members, age is distrusted as follows. The 20-44 age band represented the highest proportion of Members (33%), followed by 2-11 (25.6%), 12-19 (22.3%), 45-64 (15.5%), 0-1 (3.2%) and 65 and older (0.4%).

Age Band	Percent of Population
0-1	3.2%
2-11	25.6%
12-19	22.3%
20-44	33.0%
45-64	15.5%
65+	0.4%

Figure 4 BSCPHP Membership by Age

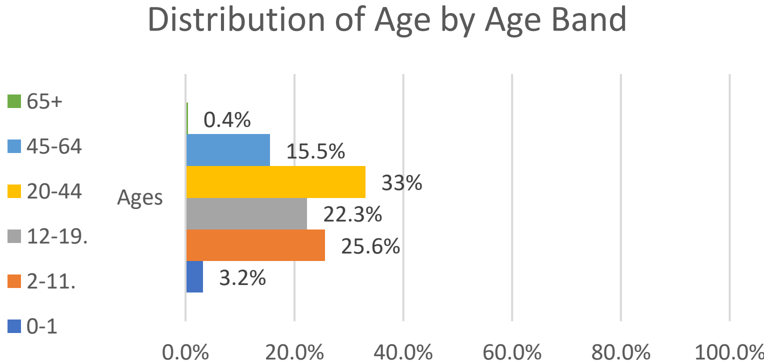


Figure 3 BSCPHP Membership by Age

Race/Ethnicity

Based on self-reported data and imputed race data, the largest racial group among Blue Shield Promise members in 2022 was White (16.66%). This excludes the 66.72% of the population that have been grouped as unknown or "some other race." The next largest racial group is Black or African American (9.06%). The Asian group made up 4.19% while the Native Hawaiian and Other Pacific Islander group made up 3.17%. The smallest racial group was American Indian or Alaskan Native (0.12%). Of note, 40.11% of Blue Shield Promise members in 2022 did not identify their ethnicity.

Among those who did report ethnicity, 33.63% identified as Hispanic or Latino while 26.26% identified as not Hispanic or Latino.

Ethnicity	Percent of Population
Hispanic or Latino	33.63%
Not Hispanic or Latino	26.26%
Unknown	40.11%

Figure 6 BSCPHP Membership by Ethnicity

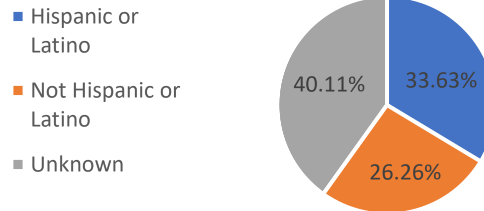


Figure 5 BSCPHP Membership by Ethnicity

Race	Percent of Population
Some Other Race	66.72%
White	16.66%
Black of African American	9.06%
Asian	4.19%
Native Hawaiian and Other Pacific Islander	3.17%
American Indian or Alaskan Native	0.12%
Two or More Races	0.07%
Race Detail Unknown	0.01%

Figure 8 BSCPHP Membership by Race

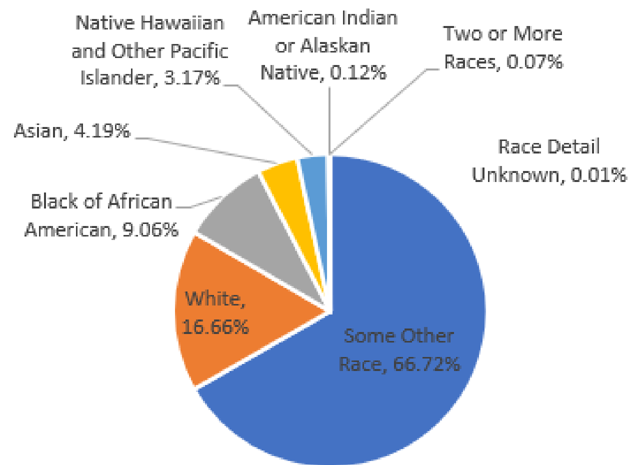


Figure 7 BSCPHP Membership by Race

Language

The largest language group among Blue Shield Promise members in 2022 was English (51.72%). The second largest group was Spanish (34.38%). 11.31% of the population did not select a language and 0.32% selected a language that was not considered a threshold language. The next largest language group was Chinese (0.71%). Each other threshold language represents less than half a percent of the population.

Language	Total	Percent of Total
English	213,967	51.7%
Spanish	142,240	34.3%
Non-English	1,318	0.3%
None Selected	46,793	11.3%
Chinese	2,383	0.7%

Vietnamese	1,943	0.4%
Armenian	1,047	0.2%
Arabic	962	0.2%
Korean	627	0.1%
Tagalog	755	0.1%
Russian	1,057	0.2%
Farsi	137	0.3%
Hmong	11	0.0%
Total	413,740	100%

Figure 9 BSCPHP Membership by Language

Education and Literacy Characteristics

Limited health literacy is associated with poor health status and quality of life in our as compared to individuals with a higher health literacy and education. According to the U.S. Department of Health and Human Services, limited health literacy has been linked to poor health outcomes, higher hospitalizations, and less use of preventive services. Blue Shield Promise is comprised of the populations most likely to experience low health literacy such as older adults, racial and ethnic minorities, people with less than a high school degree or GED certificate, people with low-income levels, Limited English Proficient (LEP) adults, and people with compromised health status. Education, language, culture, access to resources, and age are all factors that affect a person's health literacy skills.

This overview of Promise's Medi-Cal membership is relative to the MCAS Assessment because these members meet eligibility criteria for the various HEDIS® measures and population data will be used to assess relativity among potential disparities identified. Further, these member demographics (i.e., Language and/or ethnicity) lend to health equity and social drivers of health that impact care gap closures as stratified in this report. This demographic data can be used as a reference point for context or relativity when designing programs or quality improvement efforts.

B. HEDIS® Results

The following HEDIS® measures are reported for MY 2022 for San Diego County. Los Angeles (LA) Care Health Plan did not have stratified reporting available at the time of this report.

Child and Adolescent Well Care Visits

Child and Adolescent Well-Care Visits (WCV) is a combination measure that replaces the former "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" and "Adolescent Well-Care Visits" HEDIS measures. This measure assesses the percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

The overall rate for MY 2022 was 44.66%, below the 50th percentile MPL at 48.93%. The following graphs depict stratified outcomes reported by Race, Ethnicity, Age, Gender, and Language. The

top 5 racial and ethnic groups with the highest compliance rate are: Hispanic (48.16%); Native Hawaiian (43.72%); Other (41.67); Asian (39.76%); White (38.85%). Adversely, **the racial and ethnic groups with the lowest compliance rates included: Two or More Races (20.0%) and American Indian and Alaska Native (26.92%).** Males ages 3-11 have the highest compliance rate with 53.4% having completed a well-care visit. **Males ages 19-21 have the lowest WCV compliance rate at 16.1%.** Females ages 3-11 trail closely behind with 51.4% having completed a well-care visit. Females ages 19-21 have the lowest compliance rate at 23.4%. Compliance rates by language reveal variation among 13 different categories. The top 5 languages with the highest compliance rates included: Chinese (57.1%); Spanish (51.3%); Arabic (50.0%); Russian (49.0%); and Vietnamese (45.8%). Adversely, the **languages with the lowest WCV compliance rates are: Cambodian (12.5%); Non-English (30.6%); and Korean (33.3%).** Of note, several groups did meet the MPL including Females and Males ages 3-11 (51.4% and 53.4%, respectively); and members whose preferred language was Chinese (57.1%), Spanish (51.3%), Arabic (50.0%), and Russian (49.0%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

MY 2022 Health Equity Measure Performance – San Diego

R/E group did not meet 50th Percentile and/or lowest performance

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Child and Adolescent Well Care Visits	11258	25,209	44.66%	48.93%	Ethnicity	Hispanic/Latino	5264	10931	48.16%	1577	3293	47.89%
					Ethnicity	Not Hispanic/Latino	1865	4852	38.44%	1103	2655	41.54%
					Ethnicity	Unknown-Ethnicity	-	-	-	1449	3447	41.67%
					Ethnicity	Asked-No Answer	0	1	0.00%	-	-	-
					Race	American Indian & Alaska Native	14	52	**26.92%**	2	6	33.33%
					Race	Asian	297	747	**39.76%**	0	0	0.00%
					Race	Black	436	1196	**36.71%**	189	515	36.70%
					Race	Native Hawaiian/ Other Pacific Islander	87	199	**43.72%**	386	865	44.62%
					Race	Other	5	12	41.67%	7164	14907	48.06%
					Race	Two or More Races	2	10	20.00%	19	32	59.38%
					Race	White	1036	2667	**38.85%**	1617	4001	40.41%
					Race	Asked - No Answer	0	0	0.00%	-	-	-
					Race	Unknown –Race	-	-	-	0	0	0.00%

Figure 10 Child and Adolescent Well-Care Visits by Race and Ethnicity

MY 2022 Health Equity Measure Performance – San Diego

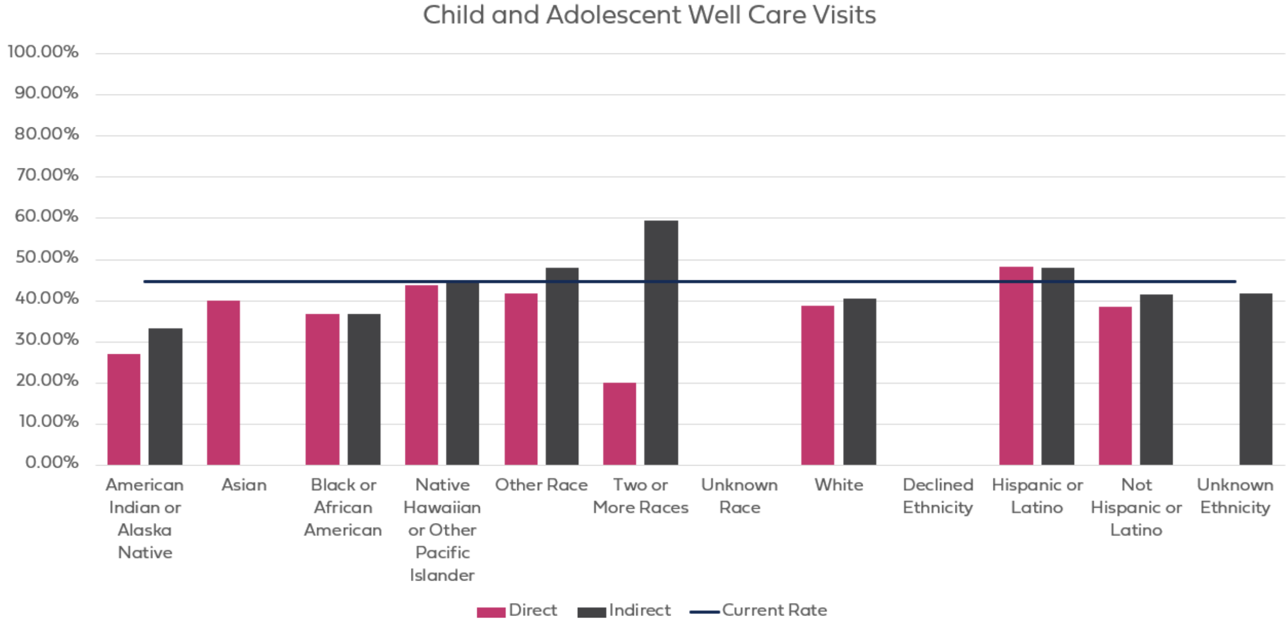


Figure 11 Child and Adolescent Well-Care Visits by Race and Ethnicity

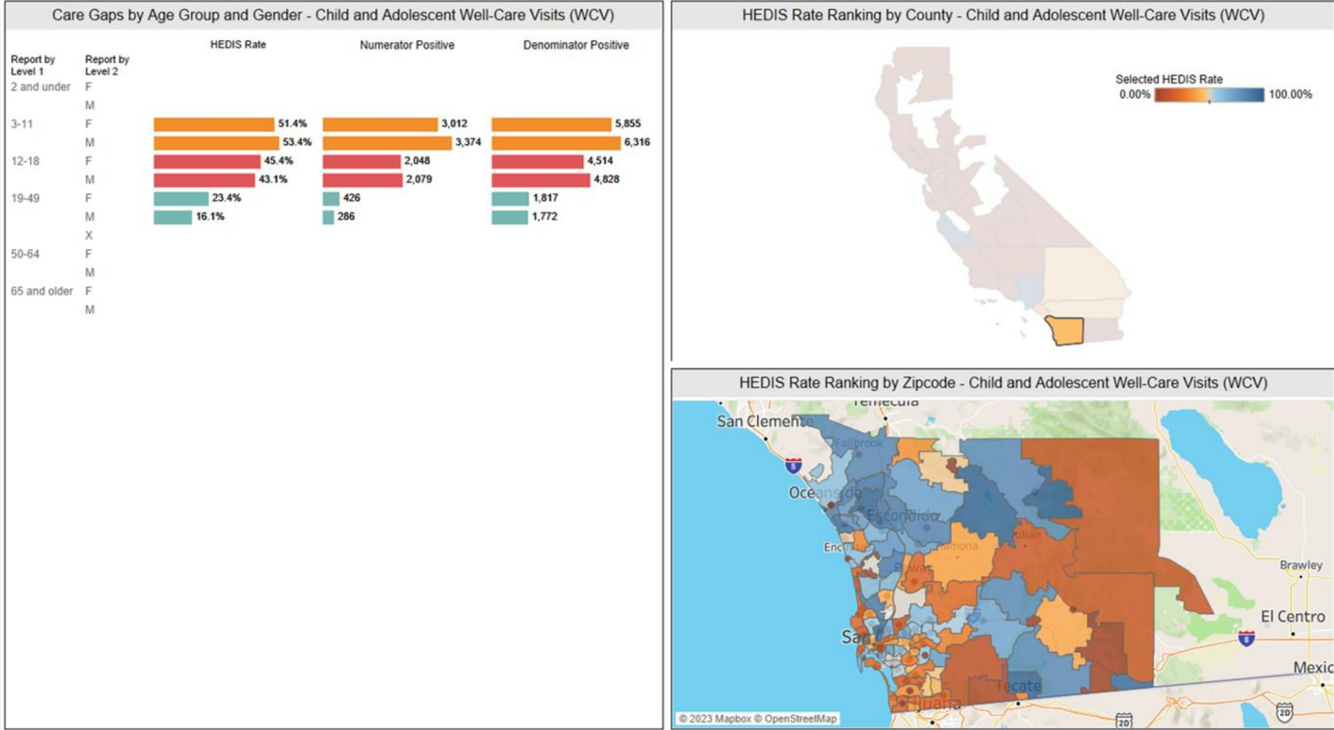


Figure 12 Child and Adolescent Well-Care Visits by Age, Gender, County, and Zip Code

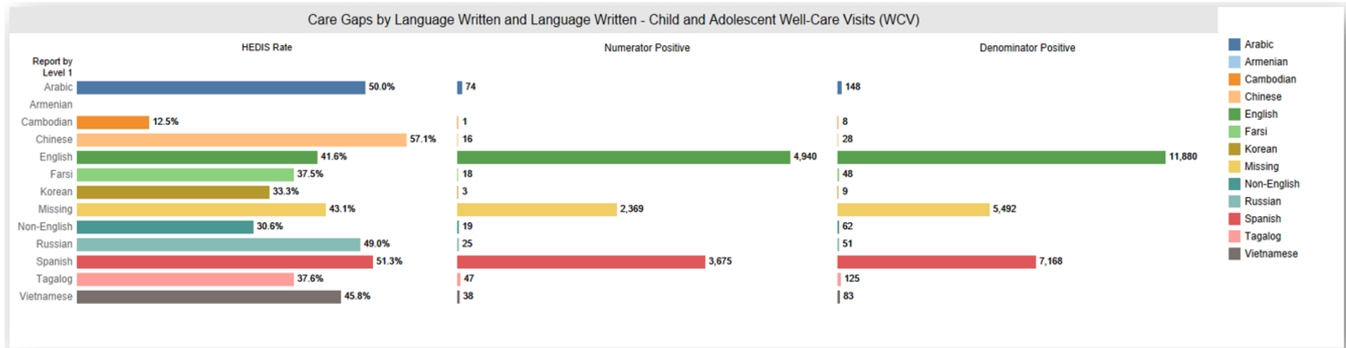


Figure 13 Child and Adolescent Well-Care Visits by Written Language

Immunizations for Adolescents – Combination 2

Immunizations for Adolescents – Combination 2 (IMA-2) measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

The overall IMA-2 rate for MY 2022 was 34.00%, below the 50th percentile MPL at 35.04%. The following graphs depict stratified outcomes reported by Race, Ethnicity, Gender, and Language. The top racial and ethnic groups with the highest IMA-2 compliance rate included: Hispanic (40.31%) and Asian (34.69%). Adversely, **the racial and ethnic groups with the lowest IMA-2 compliance rates are: Black (15.28%) and Native Hawaiian/Other Pacific Islander (20.0%)**. IMA compliance rates by language reveal variation among 13 different categories. Data was stratified by gender and then sorted by language. The top 5 languages by gender with the highest IMA-2 compliance rates included: Females/Chinese (100%); Males/Farsi (100%); Females/Vietnamese (66.7%); Males/non-English (50.0%); Females/Spanish (47.5%); and Males/Spanish (45.1%). **Adversely, the lowest IMA-2 compliance rates by gender/language included: Females/Farsi (05%); Females/Tagalog (0%); Females/English (26.6%); and Males/English (28.0%).**

Of note, several groups did meet the IMA-2 MPL including: Hispanic/Latino (40.31%); Asian (34.69%); Females whose preferred language was Chinese (100%); Vietnamese (66.7%); Spanish (47.5%); and Arabic (40.0%); and Males whose preferred language was (Farsi (100%); Non-English (50.0%); Spanish (45.1%); and Vietnamese (40.0%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

MY 2022 Health Equity Measure Performance – San Diego

R/E group did not meet 50th Percentile and/or lowest performance

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Immunizations for Adolescents - Combination 2 Immunizations	411	1209	34.00%	35.04%	Ethnicity	Hispanic/Latino	233	578	40.31%	59	138	42. 75%
						Not Hispanic/Latino	68	289	23.53%	24	118	20.34%
						Unknown-Ethnicity	-	-	-	27	86	31.40%
						Asked-No Answer	0	0	0.00%	-	-	-
					Race	American Indian & Alaska Native	0	1	0.00%	0	1	0.00%
						Asian	17	49	34.69%	0	0	0.00%
						Black	11	72	15.28%	5	13	38.46%
						Native Hawaiian/ Other Pacific Islander	3	15	20.00%	14	35	40.00%
						Other	0	0	0.00%	289	719	40.19%
						Two or More Races	0	0	0.00%	0	0	0.00%
						White	38	152	25.00%	34	152	22.37%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown –Race				-	-	-

Figure 14 Immunizations for Adolescents by Race and Ethnicity

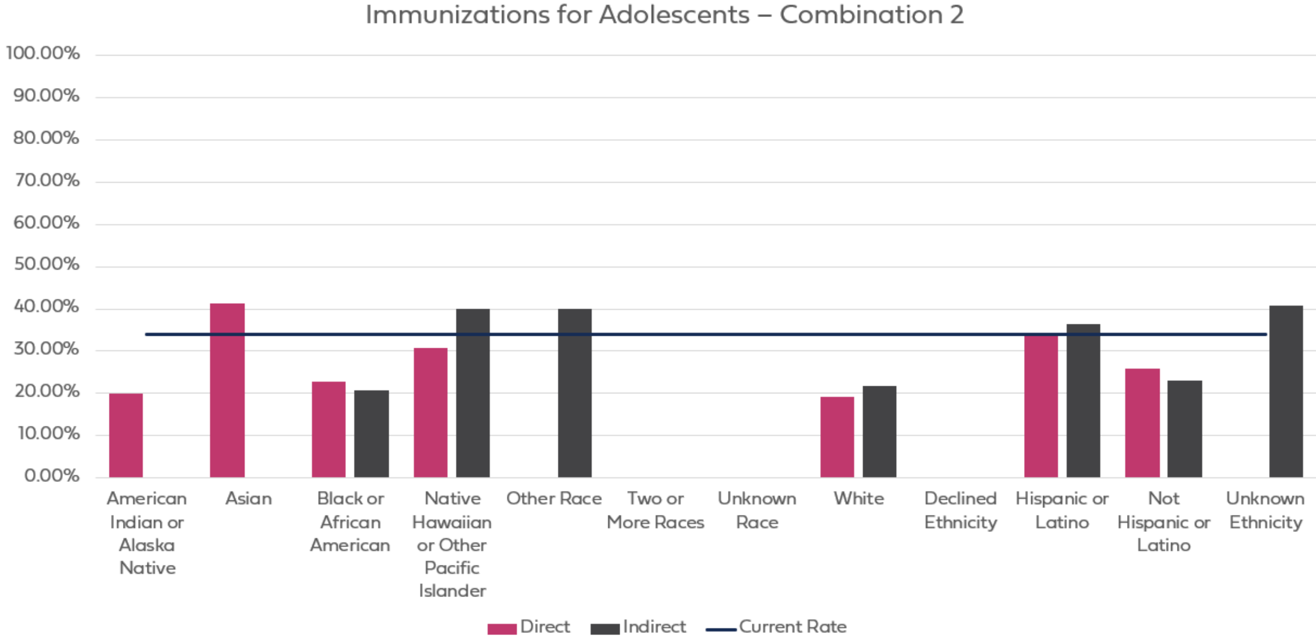


Figure 15 Immunizations for Adolescents by Race and Ethnicity

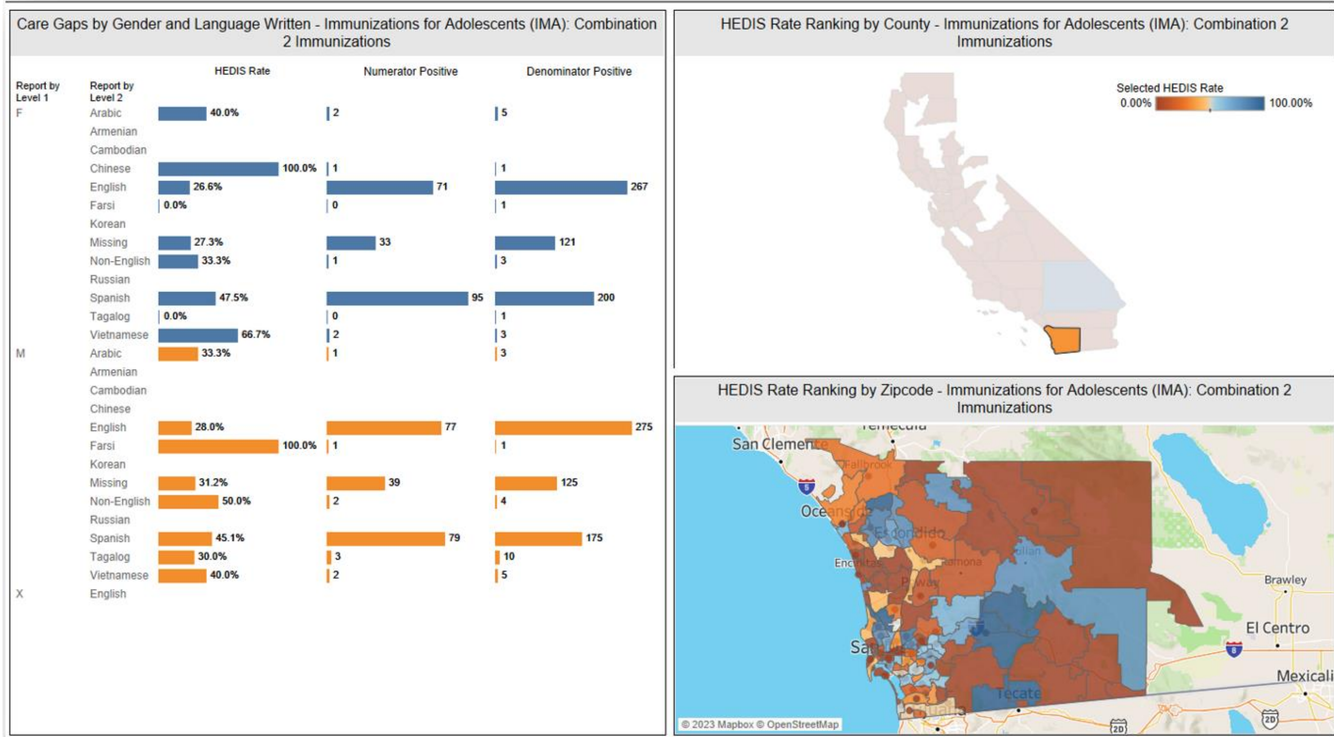


Figure 16 Immunizations for Adolescents by Gender, Language, County and Zip Code

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7 day

Follow-Up after emergency department visit for Alcohol and Other Drug Abuse or Dependence 7 Day (FUA-7 day) measure assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit within 7 days of the ED visit (8 days total).

The overall FUA-7 day rate for MY 2022 was 34.00%, exceeding the 50th percentile MPL of 20.54%. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest FUA-7 day compliance rate included: American Indian & Alaska Native (33.3%); White (24.35%) and Not Hispanic/Latino (22.44%). Adversely, **the racial and ethnic groups with the lowest FUA-7 day compliance rates included: Black (14.74%); Two or More Races (0.00%); Other (0.00%); and Native Hawaiian/Other Pacific Islander (0.00%).** Males ages 12-18 have the highest compliance rate (36.4%). **Males ages 50-64 and 65 and older have the lowest FUA -7 day compliance rates (17.6% and 0.0%, respectively).** Adversely, **Females ages 65 and older have the highest compliance rate (33.3%). Females ages 12-18 have the lowest FUA -7 day compliance rates (11.1%).**

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Missing (24.5%). Adversely, the **languages with the lowest**

FUA 7-day compliance rates included: Arabic (0.0%); Korean (0.0%); Tagalog (0.0%); and Vietnamese (0.0%). Of note, several groups did meet the MPL including: Not Hispanic/Latino (22.44%); American Indian & Alaska Native (33.3%); Asian (23.53%; White (24.35%); Females 50-64 (28.7%) Females 65 and older (33.3%); Males 12-18 (36.4%); and Males 19-49 (21.3%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

MY 2022 Health Equity Measure Performance – San Diego

R/E group did not meet 50th Percentile and/or lowest performance

Measure	MY 2022 3/30/2023 Num	MY 2022 3/30/2023 Denom	MY 2022 3/30/2023 Current Rate	MY2022 50th Percentile	Race/Ethnicity		Direct Num	Direct Denom	Direct Rate	Indirect Num	Indirect Denom	Indirect Rate
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 day	245	1193	20.54%	13.39%	Ethnicity	Hispanic/Latino	30	168	17.86%	12	69	17.39%
						Not Hispanic/Latino	103	459	22.44%	25	115	21.74%
						Unknown-Ethnicity	-	-	-	70	363	19.28%
						Asked-No Answer	0	0	0.00%	-	-	-
					Race	American Indian & Alaska Native	2	6	33.33%	0	1	0.00%
						Asian	4	17	23.53%	0	0	0.00%
						Black	14	95	14.74%	4	29	13.79%
						Native Hawaiian/ Other Pacific Islander	0	2	0.00%	2	15	13.33%
						Other	0	1	0.00%	66	343	19.53%
						Two or More Races	0	0	0.00%	0	1	0.00%
						White	84	345	24.35%	63	319	19.75%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown –Race	-	-	-	-	-	-

Figure 17 Follow-Up after Emergency Department Visit for AOD 7 day by Race and Ethnicity

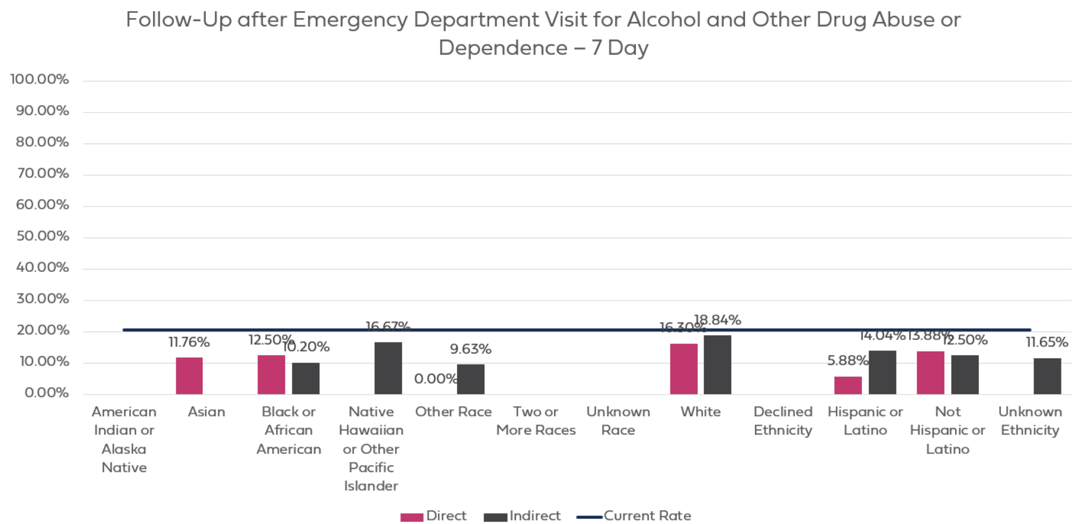


Figure 18 Follow-Up after Emergency Department Visit for AOD 7 day by Race and Ethnicity

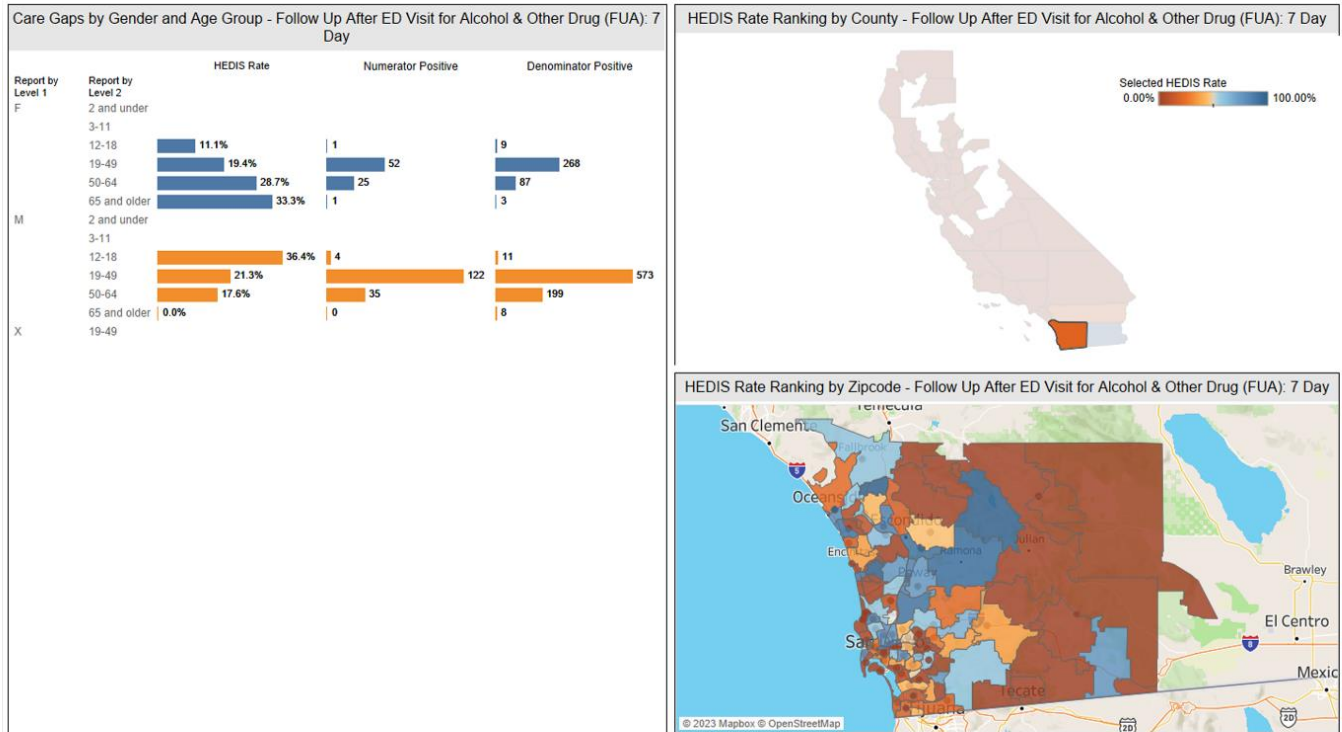


Figure 19 Follow-Up after Emergency Department Visit for AOD 7 day by Gender, Age, County and Zip Code

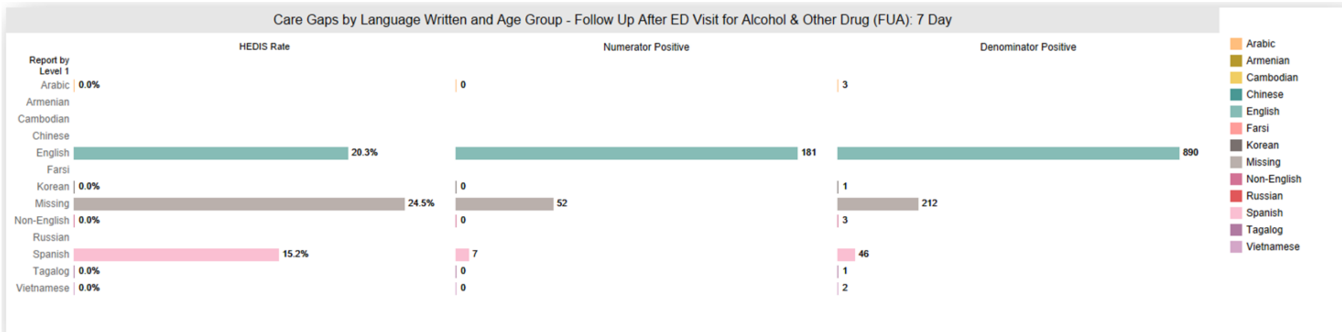


Figure 20 Follow-Up after Emergency Department Visit for AOD 7 day by Language

Follow-Up after emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30 day

Follow-Up after emergency department visit for Alcohol and Other Drug Abuse or Dependence 30 Day (FUA-30 day) measure assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit within 7 days of the ED visit (8 days total).

The overall FUA-30 day rate for MY 2022 was 33.45%, exceeding the 50th percentile MPL of 21.24%. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest FUA-30 day compliance rate included: White (42.90%); Asian (41.18%); and Not Hispanic/Latino (39.43%). Adversely, **the racial and ethnic groups with the lowest FUA-30**

day compliance rates were: Two or More Races (0.00%); Other (0.00%); and Native Hawaiian/Other Pacific Islander (0.00%). Males ages 12-18 have the highest compliance rate (36.4%). **Males ages 65 and older have the lowest FUA -30 day compliance rates (12.5%).** Adversely, **Females ages 50-64 have the highest compliance rate (43.7%). Females ages 12-18 have the lowest FUA -30 day compliance rates (22.2%).**

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Missing (36.8%). Adversely, the **languages with the lowest FUA 30-day compliance rates included: Arabic (0.0%); Korean (0.0%); Tagalog (0.0%); and Vietnamese (0.0%).** Of note, several groups did meet the MPL including: Not Hispanic/Latino (39.43%); Hispanic/Latino (29.17%); American Indian & Alaska Native (33.3%); Asian (41.8%); Black (28.42%); White (42.9%); Females 12-18 (22.2%); Females 19-49 (33.6%); Females 50-64 (43.7%); Females 65 and older (33.3%); Males 12-18 (36.4%); Males 19-49 (31.8%); Males 50-64 (35.2%); English (33.7%); Missing (36.8%); and Non-English (33.3%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

MY 2022 Health Equity Measure Performance – San Diego

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	399	1193	33.45%	21.24%	Ethnicity	Hispanic/Latino	49	168	29.17	14	69	20.29%
					Ethnicity	Not Hispanic/Latino	181	459	39.43%	39	115	33.91%
					Ethnicity	Unknown-Ethnicity	-	-	-	110	363	30.30%
					Ethnicity	Asked-No Answer	0	0	0.00%	-	-	-
					Race	American Indian & Alaska Native	2	6	33.33%	0	1	0.00%
					Race	Asian	7	17	41.18%	0	0	0.00%
					Race	Black	27	95	28.42%	7	29	24.14%
					Race	Native Hawaiian/ Other Pacific Islander	0	2	0.00%	5	15	33.33%
					Race	Other	0	1	0.00%	99	343	28.86%
					Race	Two or More Races	0	0	0.00%	0	1	0.00%
					Race	White	148	345	42.90%	98	319	30.72%
					Race	Asked - No Answer	0	0	0.00%	-	-	-
					Race	Unknown – Race	-	-	-	-	-	-

Figure 21 Follow-Up after Emergency Department Visit for AOD 30 day by Race and Ethnicity

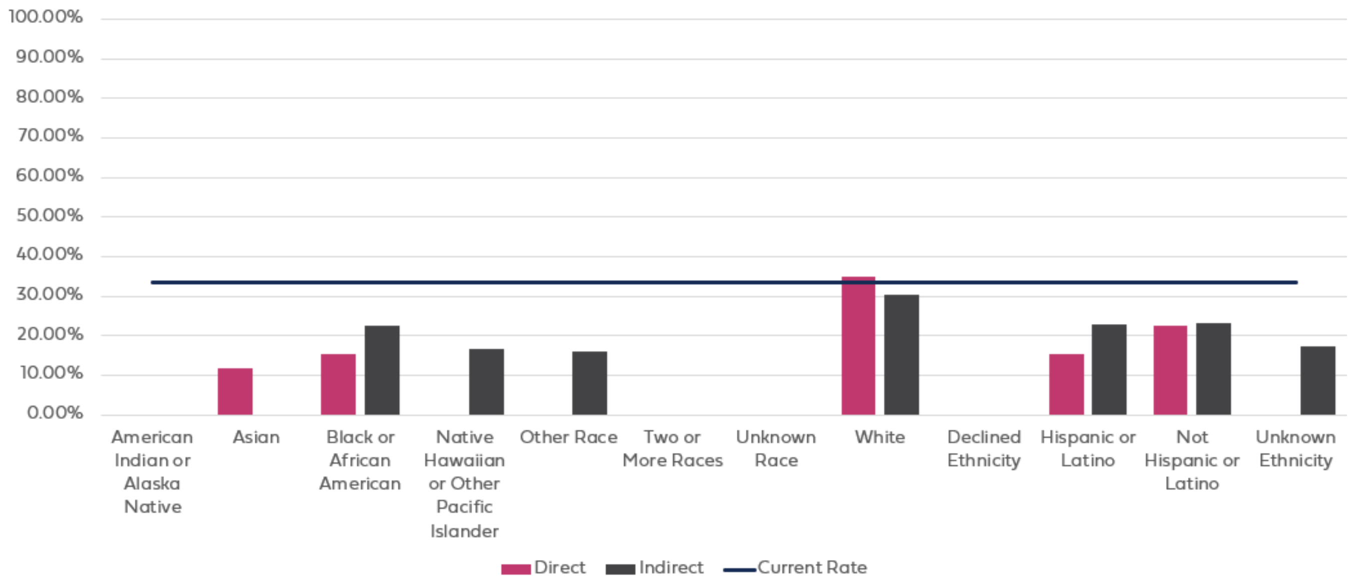


Figure 22 Follow-Up after Emergency Department Visit for AOD 30 day by Race and Ethnicity

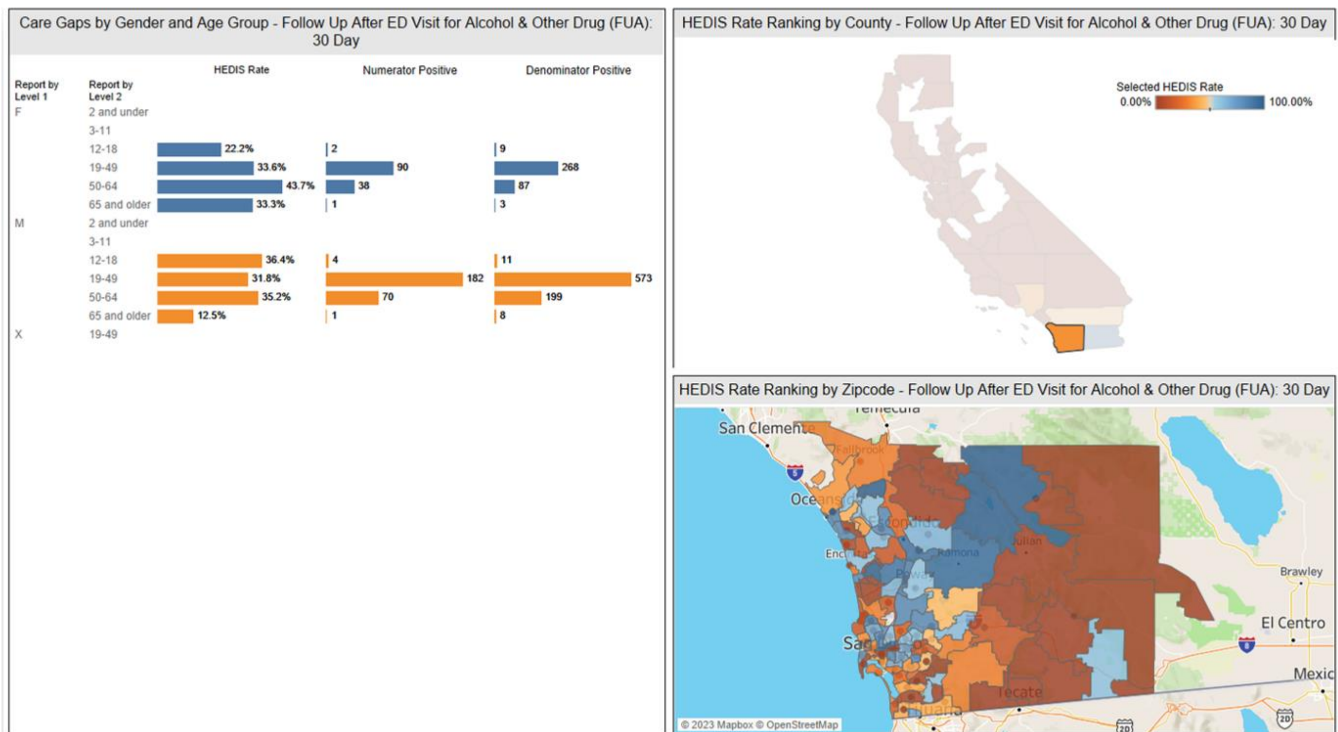


Figure 23 Follow-Up after Emergency Department Visit for AOD 30 day by Gender, Age, County, and Zip Code

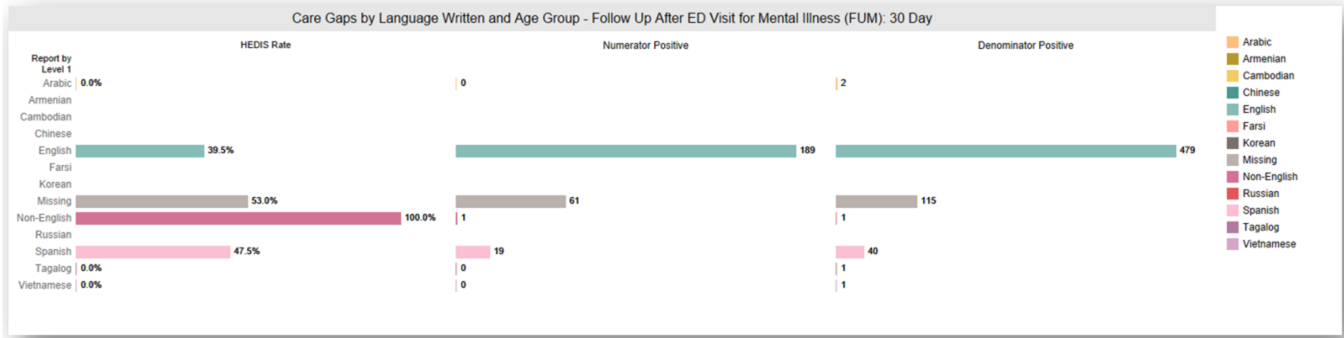


Figure 24 Follow-Up after Emergency Department Visit for AOD 30 day by Language

Follow-Up after Emergency Department Visit for Mental Illness - 7 day

Follow-Up after emergency department visit for Mental Illness 7 Day (FUM-7 day) measure assesses the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 7 days of the ED visit (8 days total).

The overall FUM-7 day rate for MY 2022 was 29.28%, exceeding the 50th percentile MPL of 40.38%. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest FUM-7 day compliance rate included: American Indian & Alaska Native (50.0%); Hispanic/Latino (31.07%); and White (29.35%). Adversely, **the racial and ethnic groups with the lowest FUM-7 day compliance rates included: Native Hawaiian/Other Pacific Islander (0.00%) and Asian (25%).** Males ages 3-11 have the highest compliance rate (33.3%). **Males 12-18 have the lowest FUM -7 day compliance rates (9.1%).** Adversely, **Females ages 65 and older have the highest compliance rate (100%). Females ages 3-11 have the lowest FUM -7 day compliance rates (0%).** Of note, none of the male age bands met the MPL.

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Non-English (100%). Adversely, the **languages with the lowest FUM 7-day compliance rates included: Arabic (0.0%); Tagalog (0.0%); and Vietnamese (0.0%).** Of note, several groups did meet the MPL including: American Indian & Alaska Native (50.0%); Females 50-64 (43.7%), Non English (100%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Follow-Up after Emergency Department Visit for Mental Illness - 7 day	195	666	29.28%	40.38%	Ethnicity	Hispanic/Latino	43	116	31.07%	9	46	19.57%
						Not Hispanic/Latino	75	264	28.41%	19	54	35.19%
						Unknown-Ethnicity	-	-	-	48	192	25.00%
						Asked-No Answer	0	0	0.00%	-	-	-
					Race	American Indian & Alaska Native	1	2	50.00%	0	0	0.00%
						Asian	3	12	25.00%	0	0	0.00%
						Black	18	69	26.09%	5	27	18.52%
						Native Hawaiian/ Other Pacific Islander	0	2	0.00%	2	7	28.57%
						Other	0	0	0.00%	59	196	30.10%
						Two or More Races	0	0	0.00%	1	2	50.00%
						White	54	184	29.35%	50	168	29.76%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown – Race	-	-	-	1	3	33.33%

Figure 25 Follow-Up After Emergency Department Visit for Mental Illness - 7 Day by Race and Ethnicity

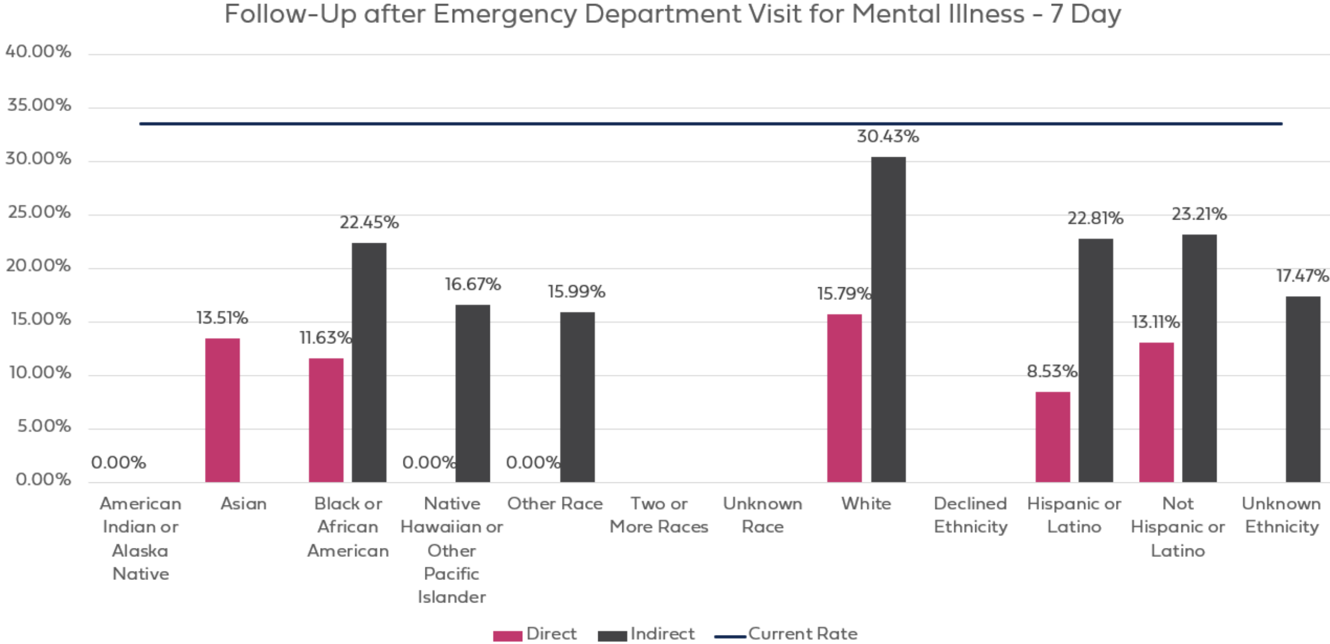


Figure 26 Follow-Up After Emergency Department Visit for Mental Illness - 7 Day by Race and Ethnicity

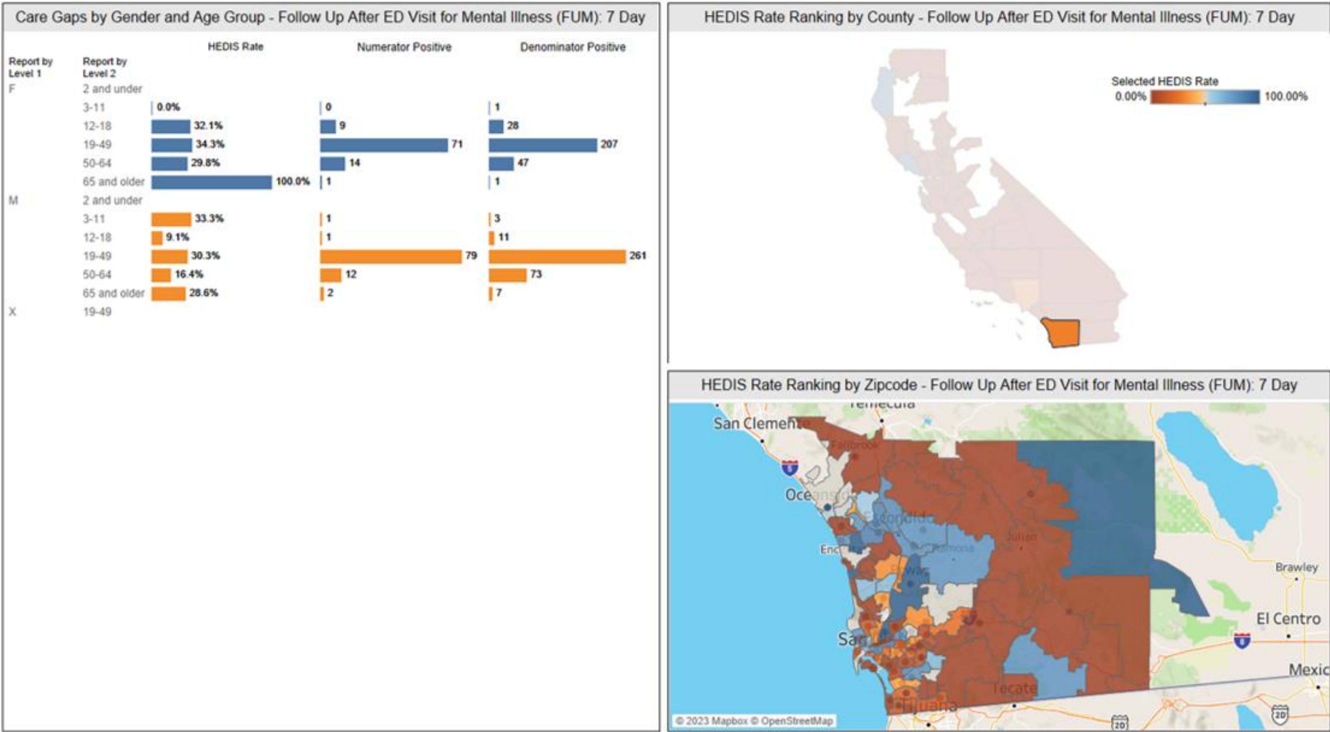


Figure 27 Follow-Up After Emergency Department Visit for Mental Illness - 7 Day by Gender, Age, County, and Zip Code

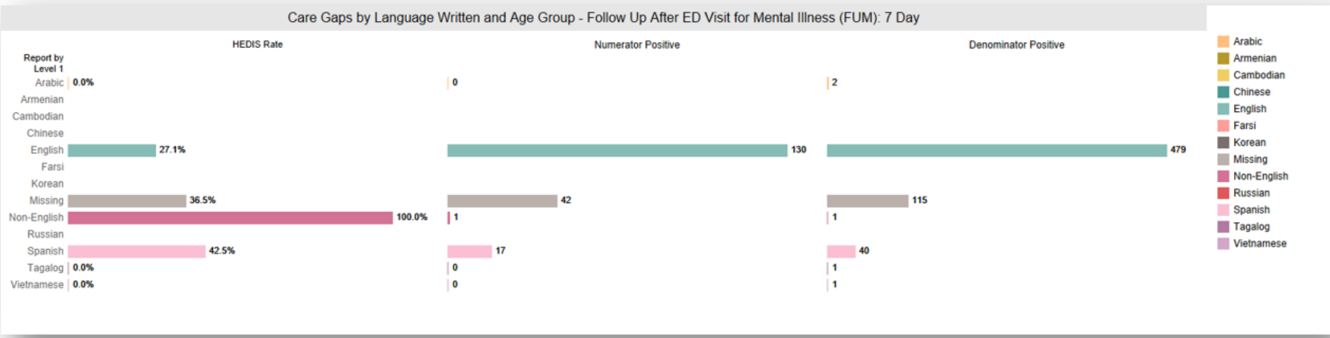


Figure 28 Follow-Up After Emergency Department Visit for Mental Illness - 7 Day by Language

Follow-Up after Emergency Department Visit for Mental Illness - 30 day

Follow-Up after emergency department visit for Mental Illness 30 Day (FUM-30 day) measure assesses the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 30 days of the ED visit (31 days total).

The overall FUM-30 day rate for MY 2022 was 33.45%, exceeding the 50th percentile MPL of 54.51%. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest FUM-30 day compliance rate included: Not Hispanic/Latino (51.72%). American Indian & Alaska Native (50.0%); White (41.85%) and Asian (41.67%). Adversely, **the racial and ethnic groups with the lowest FUM-30 day compliance rates were: Black (34.78%) and Native Hawaiian/Other Pacific Islander (0.00%).** Of note, none of the Race or Ethnicity

categories met the MPL. Males ages 65 and older have the highest compliance rate (36.4%). **Males ages 3-11 have the lowest FUM -30 day compliance rates (66.7%).** Adversely, **Females ages 65 and older have the highest compliance rate (100%). Females ages 3-11 have the lowest FUM - 30 day compliance rates (0.0%).**

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Non-English (100%). Adversely, the **languages with the lowest FUM 30 -day compliance rates included: Arabic (0.0%); Tagalog (0.0%); and Vietnamese (0.0%).** Of note, several groups did meet the MPL including: Females 65 and older (100%); Males 3-11 (66.7%); Males 65 and older (57.1%); and Non-English (100%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

MY 2022 Health Equity Measure Performance – San Diego

R/E group did not meet 50th Percentile and/or lowest performance

Measure	MY 2022 3/30/2023 Num	MY 2022 3/30/2023 Denom	MY 2022 3/30/2023 Current Rate	MY2022 50th Percentile	Race/Ethnicity		Direct Num	Direct Denom	Direct Rate	Indirect Num	Indirect Denom	Indirect Rate
Follow-Up after Emergency Department Visit for Mental Illness - 30 day	399	1193	33.45%	54.51%	Ethnicity	Hispanic/Latino	60	116	51.72%	14	46	30.43%
						Not Hispanic/Latino	104	264	39.39%	27	54	50.00%
						Unknown-Ethnicity	-	-	-	74	192	38.54%
						Asked-No Answer	0	0	0.00%	-	-	-
					Race	American Indian & Alaska Native	1	2	50.00%	0	0	0.00%
						Asian	5	12	41.67%	0	0	0.00%
						Black	24	69	34.78%	9	27	33.33%
						Native Hawaiian/ Other Pacific Islander	0	2	0.00%	2	7	28.57%
						Other	0	0	0.00%	59	196	30.10%
						Two or More Races	0	0	0.00%	1	2	50.00%
						White	77	184	41.85%	71	168	42.26%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown – Race	-	-	-	3	3	100.00%

Figure 29 Follow-Up After Emergency Department Visit for Mental Illness - 30 Day by Race and Ethnicity

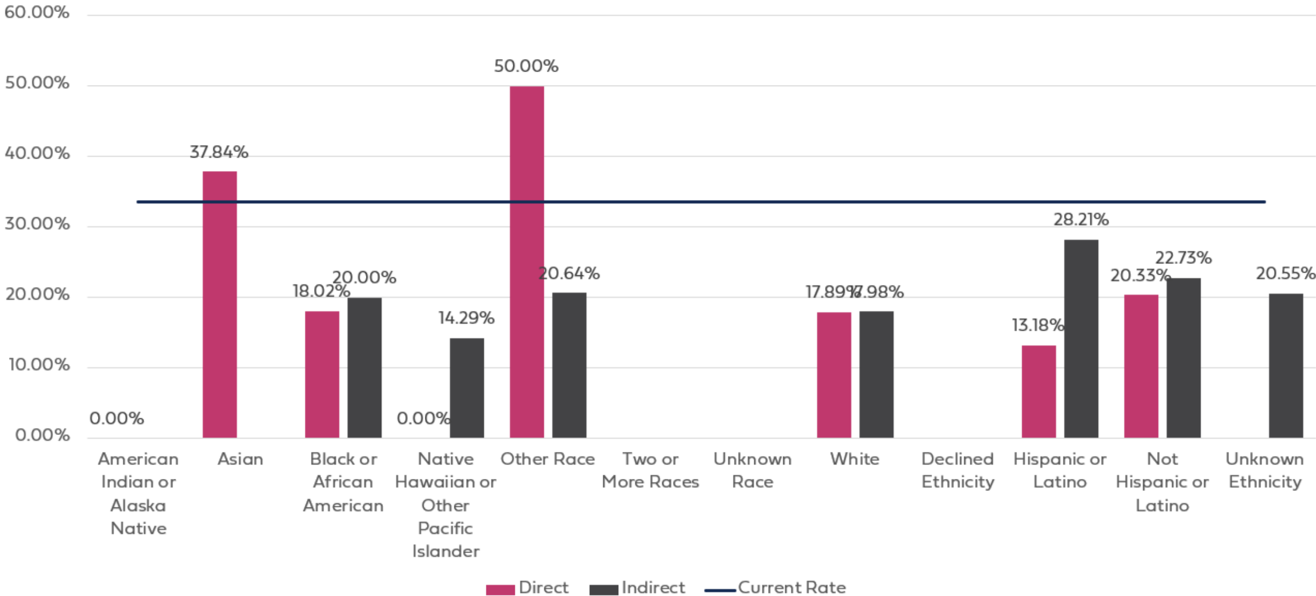


Figure 30 Follow-Up After Emergency Department Visit for Mental Illness - 30 Day by Race and Ethnicity

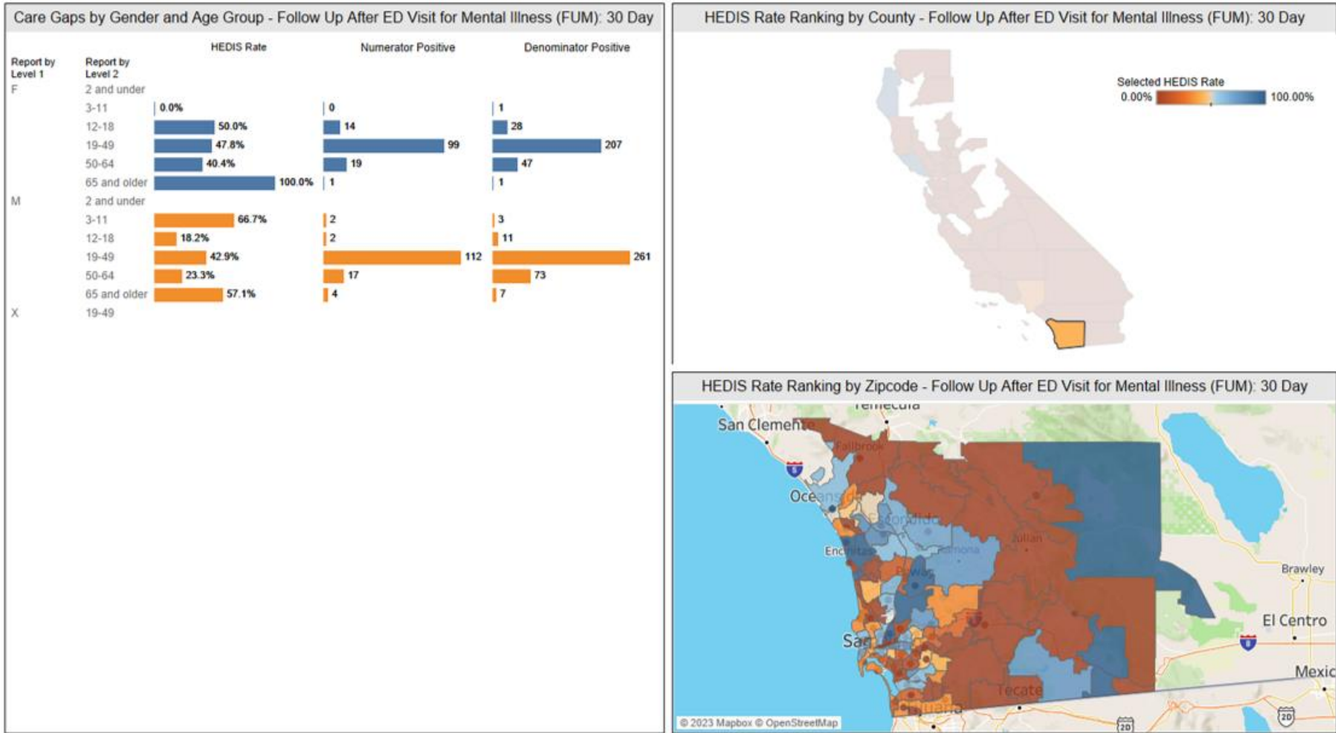


Figure 31 Follow-Up After Emergency Department Visit for Mental Illness - 30 Day by Age, Gender, County, and Zip Code

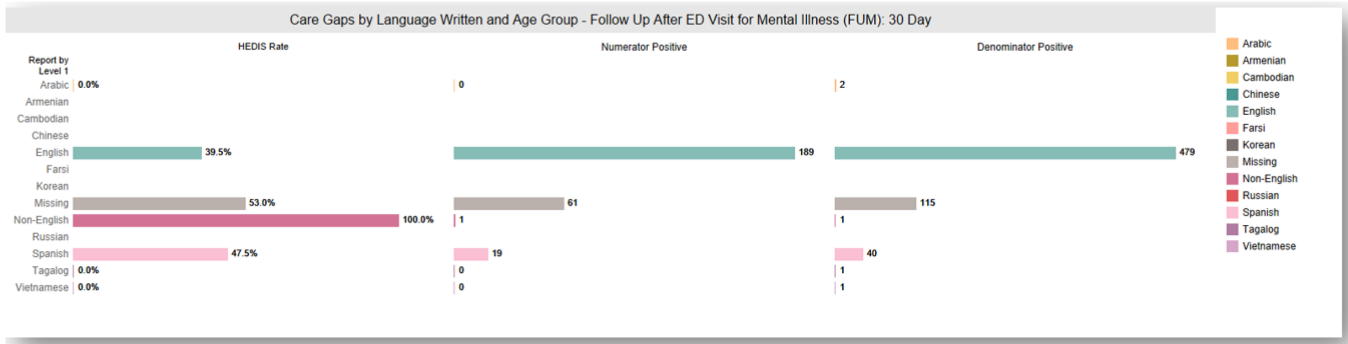


Figure 32 Follow-Up After Emergency Department Visit for Mental Illness - 30 Day by Language

Depression Screening and Follow-Up for Adolescents and Adults (Screening)

Depression Screening and Follow-Up for Adolescents and Adults (DSF Screening) assesses the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument.

The overall DSF Screening rate for MY 2022 was 0.48%. A benchmark was not established for MY 2022. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic group with the highest DSF Screening compliance rate was: Other (1.41%). All other categories for Race and Ethnicity were reported at less than 1.0%. Males ages 12-18; Males 19-49; and Males 50-64 have the highest compliance rates at 0.3%. **Males ages 65 and older have the lowest** DSF Screening **compliance rates (0.0%). Females ages 12-19 and Females ages 19-49 have the highest compliance rate (0.7%). Females ages 65 and older have the lowest DSF Screening compliance rates (0.0%).**

Compliance rates by language reveal variation among 13 different categories. The top language with the highest compliance rate was Arabic (1.0%). Adversely, the **languages with the lowest DSF Screening compliance rates are: Armenian (0.0%); Cambodian (0.0%); Chinese (0.0%); Farsi (0.0%); Korean (0.0%); Non-English (0.0%); Russian (0.0%); and Tagalog (0.0%).**

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Depression Screening and Follow-Up for Adolescents and Adults (Screening)*	275	57,465	0.48%	No Benchmark	Ethnicity	Hispanic/Latino	61	13432	0.45%	33	6902	0.48%
						Not Hispanic/Latino	67	14939	0.46%	33	8958	0.37%
						Unknown-Ethnicity	-	-	-	80	13209	0.61%
						Asked-No Answer	0	25	0.00%	-	-	-
					Race	American Indian & Alaska Native	0	163	0.00%	1	27	3.70%
						Asian	7	2629	0.27%	0	0	0.00%
						Black	8	2637	0.30%	1	1291	0.08%
						Native Hawaiian/ Other Pacific Islander	1	468	0.21%	7	2616	0.27%
						Other	1	71	1.41%	121	24783	0.49%
						Two or More Races	0	33	0.00%	0	49	0.00%
						White	55	9224	0.60%	73	13469	0.54%
						Asked - No Answer	0	5	0.00%	-	-	-
						Unknown – Race	-	-	-	0	0	0.00%

Figure 33 Depression Screening and Follow-Up for Adolescents and Adults (Screening) by Race and Ethnicity

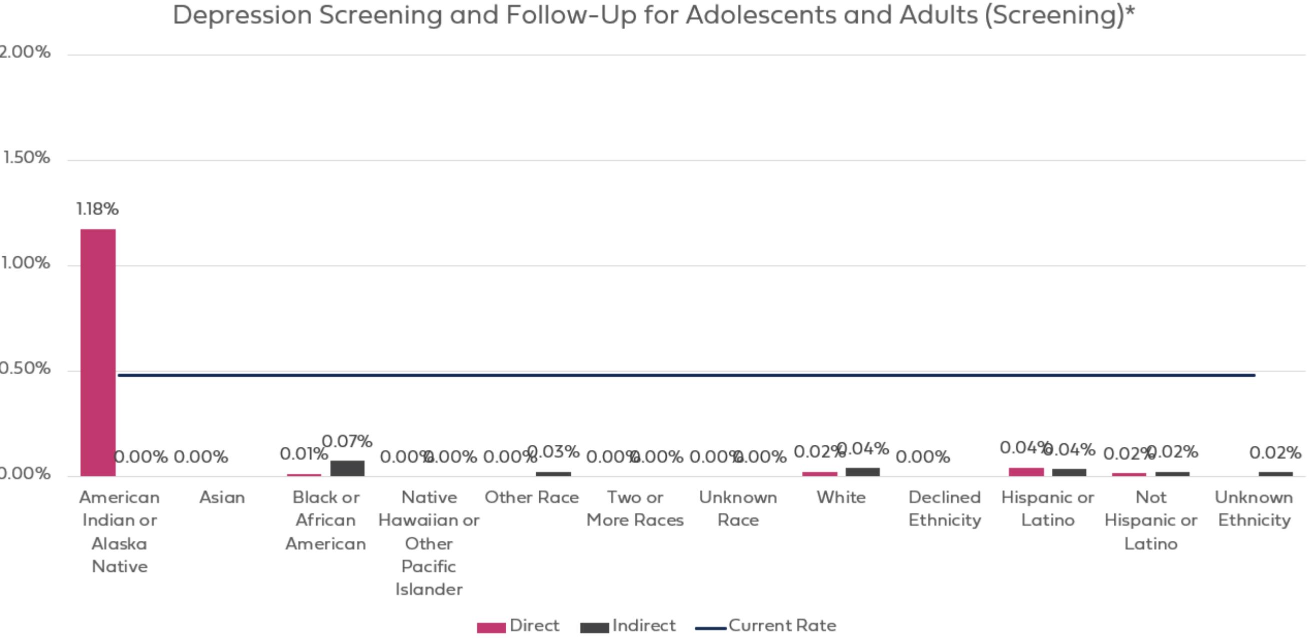


Figure 34 Depression Screening and Follow-Up for Adolescents and Adults (Screening) by Race and Ethnicity

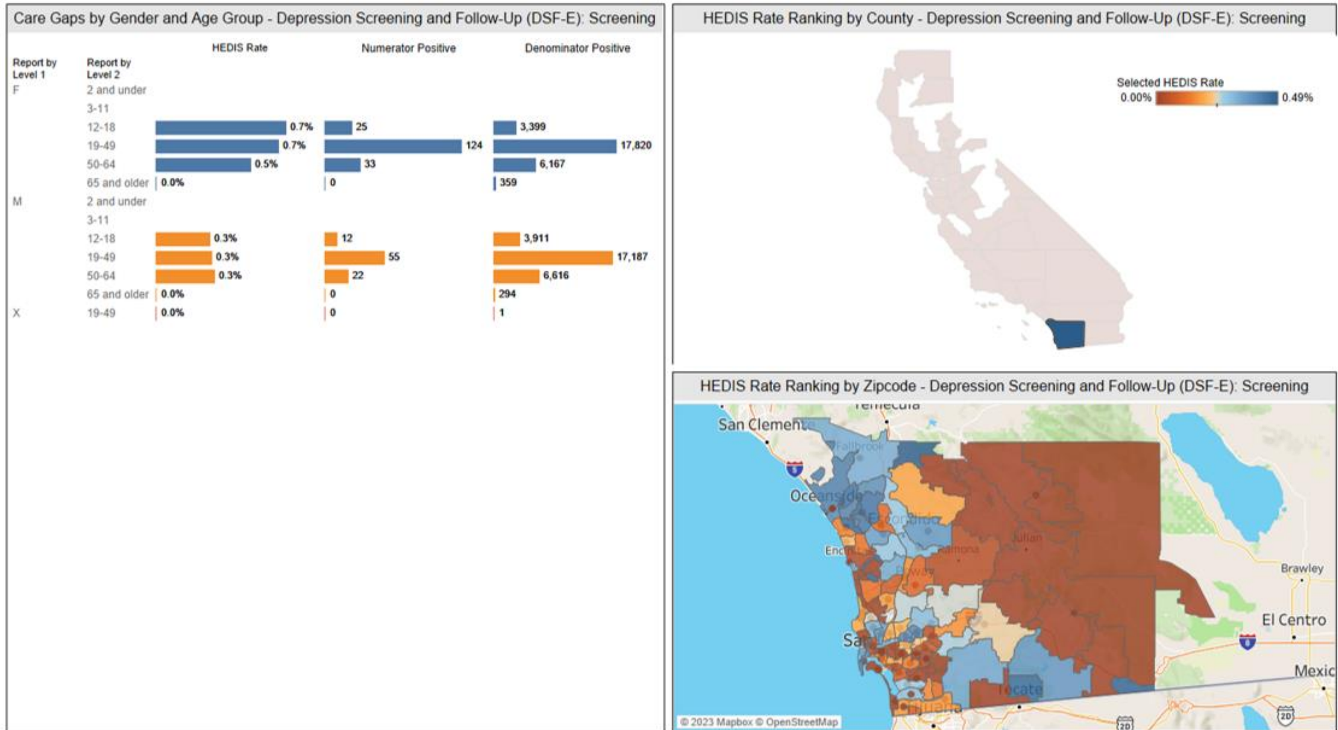


Figure 35 Depression Screening and Follow-Up for Adolescents and Adults (Screening) by Gender, Age, County, and Zip Code

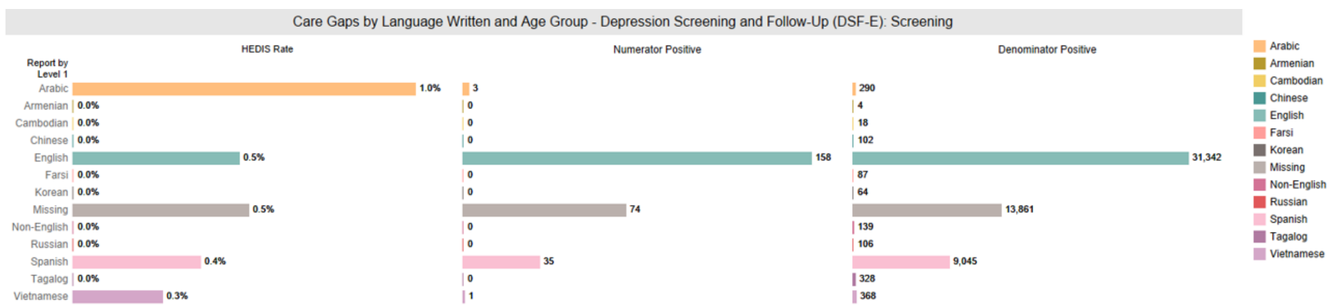


Figure 36 Depression Screening and Follow-Up for Adolescents and Adults (Screening) by Language

Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up)

Depression Screening and Follow-Up for Adolescents and Adults (DSF Follow-Up) assesses the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument.

The overall DSF Screening rate for MY 2022 was 83.33%. A benchmark was not established for MY 2022. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest DSF Follow-Up compliance rate included: Asian (100%); Black (100%); Native Hawaiian/Other Pacific Islander (100%); and Other (100%).

Males ages 12-18 have the highest compliance rates at 100%. **Males ages 19-49 have the lowest DSF Follow-Up compliance rates (76.0%).** Females ages 19-49 have the highest compliance

rate (87.8%). Females ages 12-18 and Females ages 51-64 and older reported the same DSF Follow-Up compliance rate of 81.8%.

Compliance rates by language reveal variation among 13 different categories. The top language with the highest compliance rate was Arabic (100%). Adversely, the **languages with the lowest** DSF Follow-Up **compliance rate was: Spanish (72.7%)**.

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up)*	85	102	83.33%	No Benchmark	Ethnicity	Hispanic/Latino	19	24	79.17%	9	12	75.00%
						Not Hispanic/Latino	24	28	85.71%	8	9	88.89%
						Unknown-Ethnicity	0	0	0.00%	-	-	-
						Asked-No Answer	25	29	86.21%	-	-	-
					Race	American Indian & Alaska Native	0	0	0.00%	0	0	0.00%
						Asian	4	4	100.00%	0	0	0.00%
						Black	4	4	100.00%	1	1	100.00%
						Native Hawaiian/ Other Pacific Islander	1	1	100.00%	0	0	0.00%
						Other	1	1	100.00%	33	42	78.57%
						Two or More Races	0	0	0.00%	0	0	0.00%
						White	17	21	80.95%	24	28	85.71%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown – Race	-	-	-	0	0	0.00%

Figure 37 Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up) by Race and Ethnicity

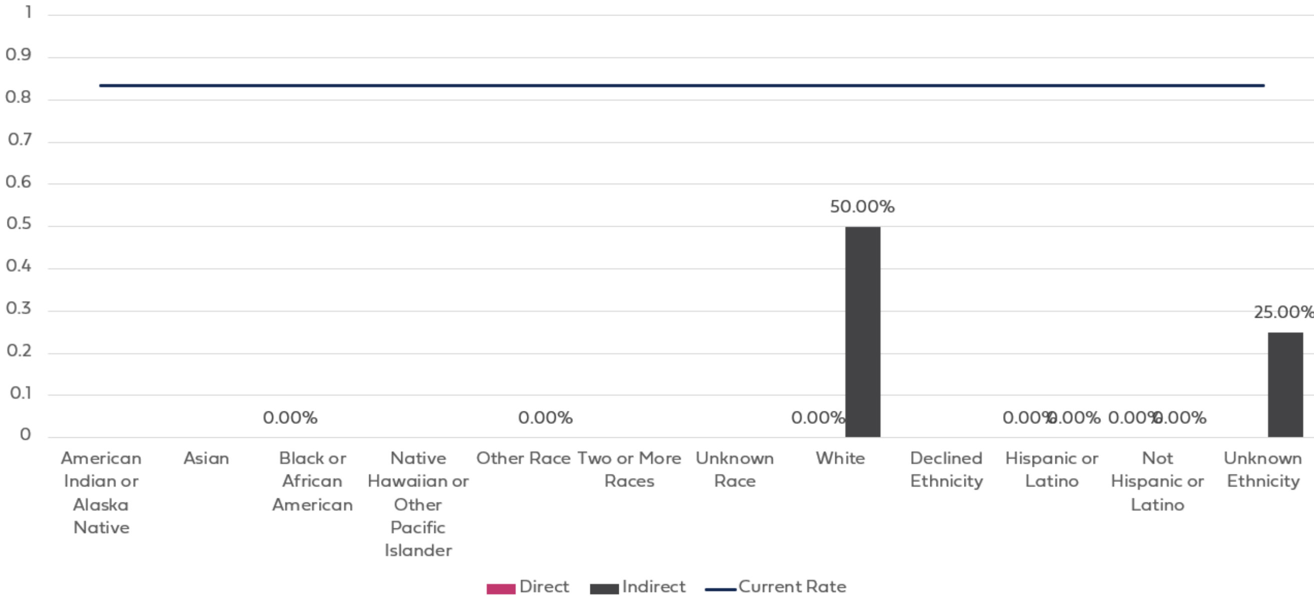


Figure 38 Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up) by Race and Ethnicity

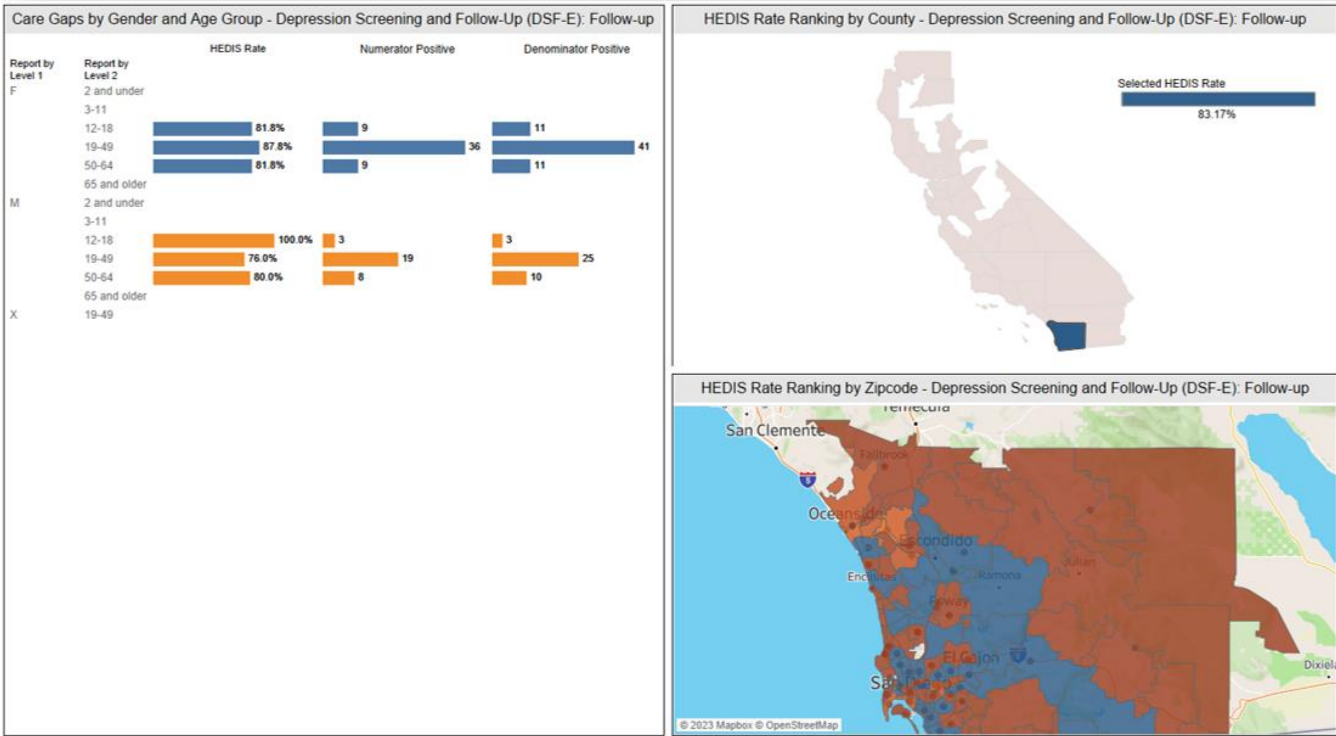


Figure 39 Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up) by Gender, Age, County, and Zip Code

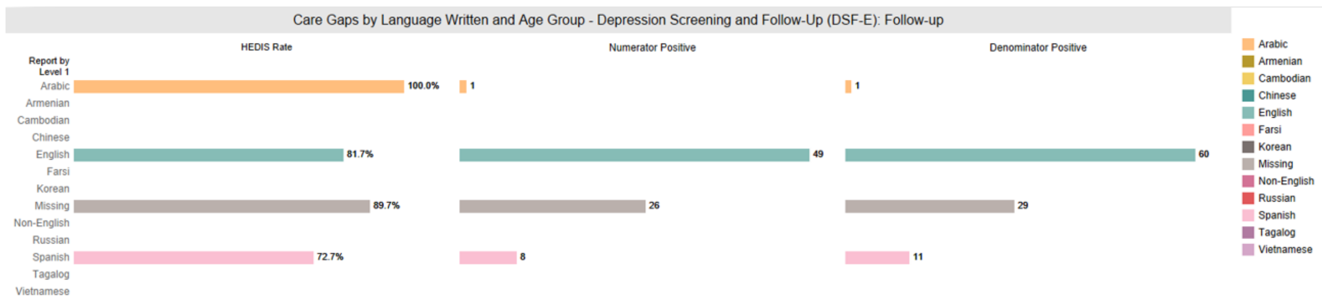


Figure 40 Depression Screening and Follow-Up for Adolescents and Adults (Follow-Up) by Language

Prenatal and Postpartum Care – Postpartum Care

The Prenatal and Postpartum Care (PPC – Postpartum) measure assesses the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

The overall PPC – Postpartum rate for MY 2022 was 81.57%, exceeding the 50th percentile MPL of 77.37%. The following graphs depict stratified outcomes reported by Race, Ethnicity, and Language.

The top racial and ethnic groups with the highest PPC – Postpartum compliance rate were: Other (100%); Asked-No Answer (100%); and Native Hawaiian/Other Pacific Islander (100%). Adversely, **the racial and ethnic groups with the lowest PPC – Postpartum compliance rates included: White (77.78%) and Asian (76.92%).** Age was not stratified at the time of this report. The HEO recommends stratification by age to assess rates for postpartum visit completion between age bands.

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Vietnamese (100%). Adversely, the **languages with the lowest PPC – Postpartum compliance rates included: Russian and Tagalog (50.0%).** Of note, several groups did meet the MPL including: Hispanic/Latino (78.15%); Not Hispanic/Latino (80.79%); Asked-No Answer (100%); Black (88.89%); Native Hawaiian/Other Pacific Islander (100%); Other (100%); White (77.78%); Arabic (80%); English (81.4%); Missing (85.0%); Non-English (87.5%); Spanish (80.1%); and Vietnamese (100%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Prenatal and Postpartum Care - Postpartum care	823	1009	81.57%	77.37%	Ethnicity	Hispanic/Latino	211	270	78.15%	122	143	85.31%
						Not Hispanic/Latino	122	151	80.79%	58	72	80.56%
						Unknown-Ethnicity	-	-	-	309	372	83.06%
						Asked-No Answer	1	1	100%	-	-	-
					Race	American Indian & Alaska Native	0	1	0.00%	1	1	100.00%
						Asian	10	13	76.92%	0	0	0.00%
						Black	32	36	88.89%	12	15	80.00%
						Native Hawaiian/ Other Pacific Islander	5	5	100.00%	27	30	90.00%
						Other	3	3	100.00%	504	613	82.22%
						Two or More Races	0	0	0.00%	1	1	100.00%
						White	77	99	77.78%	147	185	79.46%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown – Race	-	-	-	4	7	57.14%

Figure 41 Prenatal and Postpartum Care - Postpartum Care by Race and Ethnicity

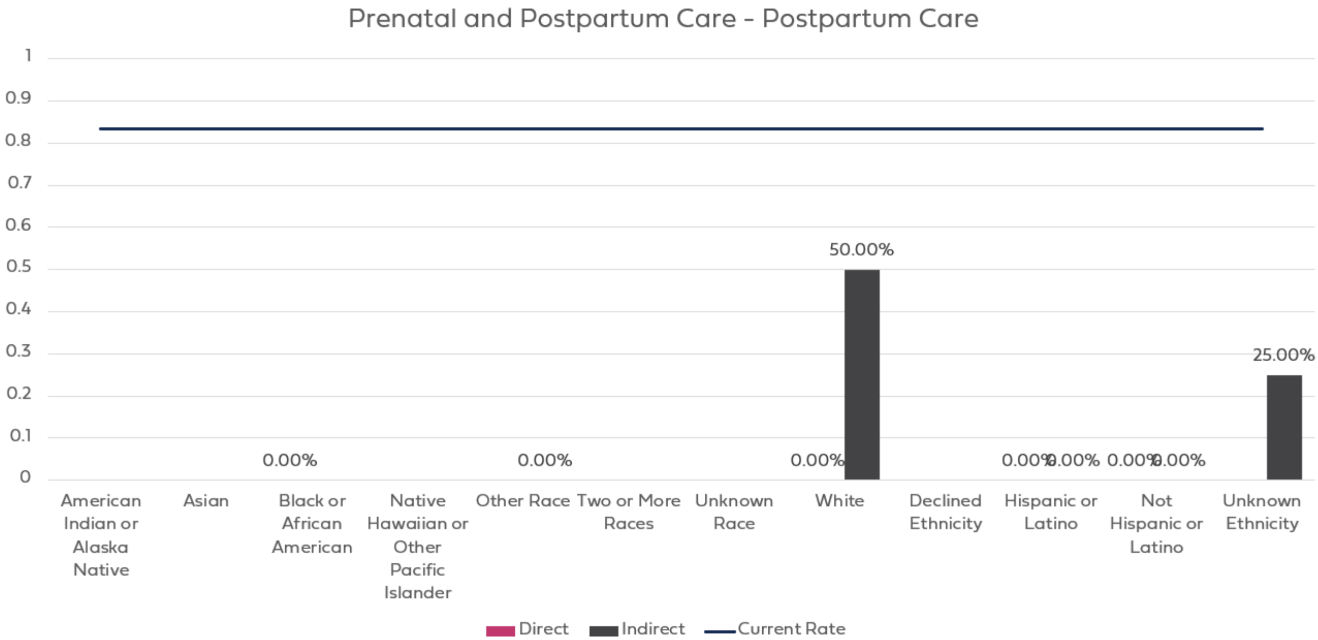


Figure 42 Prenatal and Postpartum Care - Postpartum Care by Race and Ethnicity

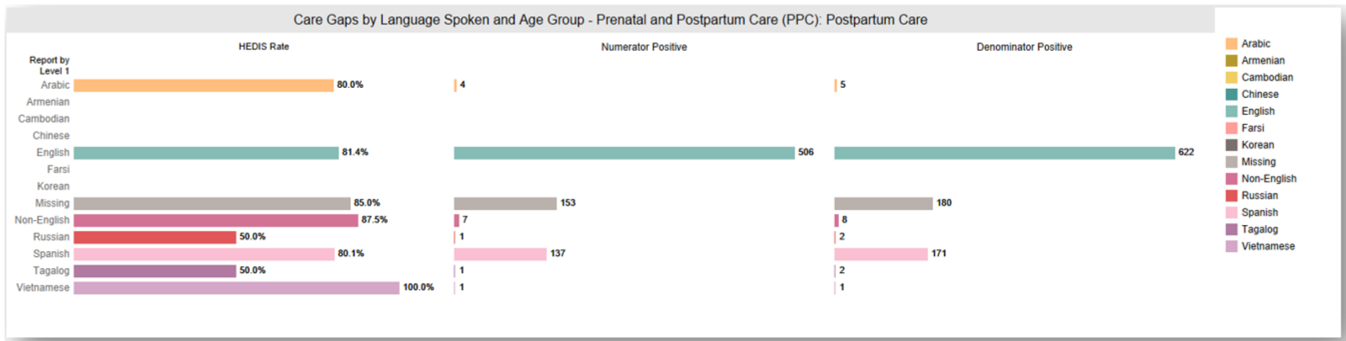


Figure 43 Prenatal and Postpartum Care - Postpartum Care by Language

Prenatal and Postpartum Care – Timeliness of Prenatal Care

The Prenatal and Postpartum Care (PPC Timelines of Prenatal Care) measure assesses the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

The overall PPC – Postpartum rate for MY 2022 was 81.76%, below the 50th percentile MPL of 85.40%. The following graphs depict stratified outcomes reported by Race, Ethnicity, and Language.

The top racial and ethnic groups with the highest PPC Timelines of Prenatal Care compliance rate were: Asked-No Answer (100%); American Indian & Alaska Native (100%); and Native Hawaiian/Other Pacific Islander (100%). Adversely, **the racial and ethnic groups with the lowest** PPC Timelines of Prenatal Care **compliance rates included: White (76.77%) and Other (33.3%). Age was not stratified at the time of this report. The HEO recommends stratification by age to assess rates for timeliness of prenatal care between age bands.**

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate included: Non-English (100%); Russian (100%); and Vietnamese (100%). Adversely, the **languages with the lowest PPC Timelines of Prenatal Care compliance rates were Arabic (60.0%) and Tagalog (50.0%).** Of note, several groups did meet the MPL including: Asked-No Answer (100%); American Indian & Alaska Native (100%); Native Hawaiian/Other Pacific Islander (100%); Non-English (100%); Russian (100%); and Vietnamese (100%)

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023 Num	MY 2022 3/30/2023 Denom	MY 2022 3/30/2023 Current Rate	MY2022 50th Percentile	Race/Ethnicity		Direct Num	Direct Denom	Direct Rate	Indirect Num	Indirect Denom	Indirect Rate
Prenatal and Postpartum Care - Timeliness of prenatal care	825	1009	81.76%	85.40%	Ethnicity	Hispanic/Latino	221	270	81.85%	122	143	85.31%
						Not Hispanic/Latino	119	151	78.81%	60	72	83.33%
						Unknown-Ethnicity	-	-	-	291	372	78.23%
						Asked-No Answer	1	1	100.00%	-	-	-
					Race	American Indian & Alaska Native	1	1	100.00%	1	1	100.00%
						Asian	10	13	76.92%	0	0	0.00%
						Black	29	36	80.56%	11	15	73.33%
						Native Hawaiian/ Other Pacific Islander	5	5	100.00%	24	30	80.00%
						Other	1	3	33.33%	514	613	83.85%
						Two or More Races	0	0	0.00%	1	1	100.00%
						White	76	99	76.77%	137	185	74.05%
						Asked - No Answer	0	0	0.00%	-	-	-
						Unknown – Race	-	-	-	4	7	57.14%

Figure 44 Prenatal and Postpartum Care - Timeliness of Prenatal Care by Race and Ethnicity

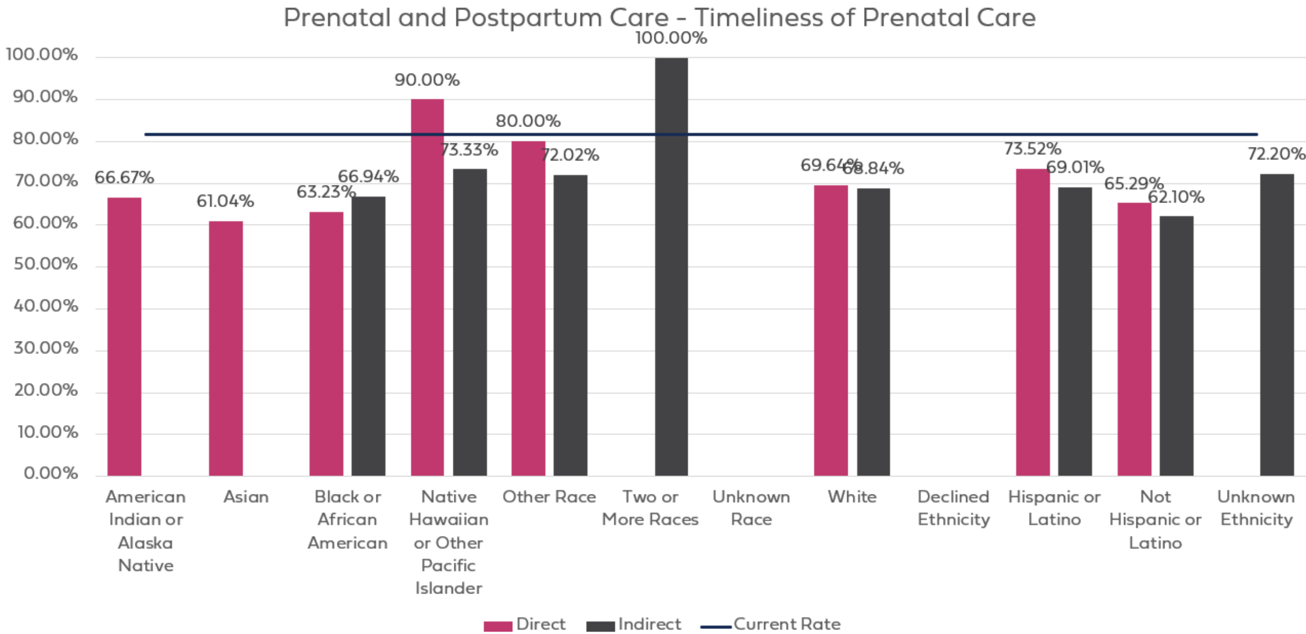


Figure 45 Prenatal and Postpartum Care - Timeliness of Prenatal Care by Race and Ethnicity

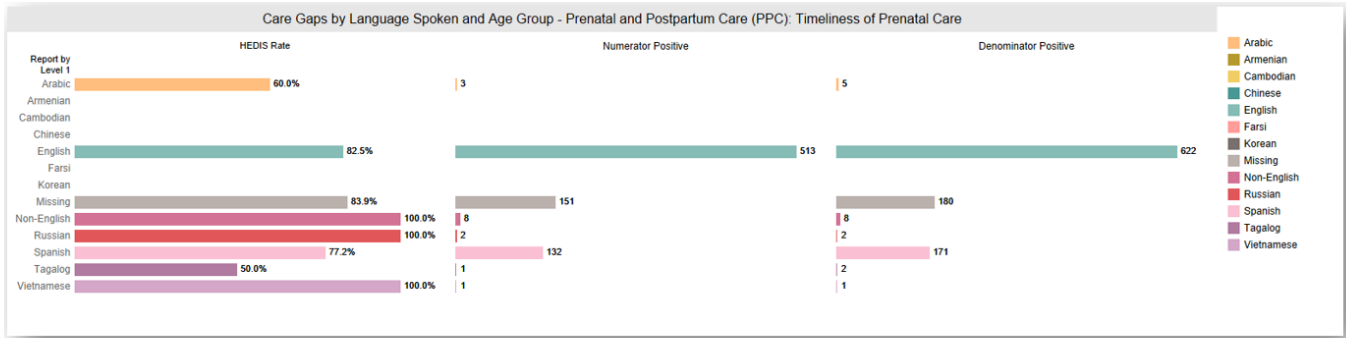


Figure 46 Prenatal and Postpartum Care - Timeliness of Prenatal Care by Language

Hemoglobin A1c Control for Patients with Diabetes - <8%

Hemoglobin A1c Control for Patients with Diabetes <8% (CDC HbA1c Control) assesses the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c control <8.0%.

The overall CDC HbA1c Poor Control rate for MY 2022 was 52.55%, below the 50th percentile MPL of 50.12%. The following graphs depict stratified outcomes reported by REGAL.

The top racial and ethnic groups with the highest CDC HbA1c Control compliance rates included: Two or More Races (33.3%). Adversely, **the racial and ethnic groups with the** lowest CDC HbA1c **Poor Control compliance rates included: Black (1.16%); Other (0.0%); and White (2.31%).** Males ages 65 and older have the highest compliance rate (50.8%). **Males ages 12-18 have the lowest CDC HbA1c Poor Control compliance rates (0.0%).** Similarly, Females ages 65 and older have the highest compliance rate (67.5%). **Females ages 19-49 have the lowest CDC HbA1c Poor Control compliance rates (44.6%).**

Compliance rates by language reveal variation among 11 different categories. The top language with the highest compliance rate was Arabic (83.3%). Adversely, the **languages with the lowest CDC HbA1c Poor Control compliance rates included: Russian (40.0%); Missing (47.4%); and English (47.4%).** Of note, none of the REGAL categories met the MPL.

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Hemoglobin A1c Control for Patients with Diabetes – <8%	2950	5500	52.55%	50.12%	Ethnicity	Hispanic/Latino	39	1274	3.06%	14	653	2.14%
						Not Hispanic/Latino	42	1340	3.13%	19	559	3.40%
						Unknown-Ethnicity	-	-	-	31	1172	2.65%
						Asked-No Answer	-	-	-	-	-	-
					Race	American Indian & Alaska Native	2	25	8.00%	0	1	0.00%
						Asian	21	315	6.67%	-	-	-
						Black	4	345	1.16%	0	87	0.00%
						Native Hawaiian/ Other Pacific Islander	4	72	5.56%	6	204	2.94%
						Other	0	8	0.00%	57	2371	2.40%
						Two or More Races	1	3	33.33%	0	2	0.00%
						White	19	824	2.31%	31	724	4.28%
						Asked - No Answer	-	-	-	-	-	-
						Unknown – Race	-	-	-	0	17	0.00%

Figure 47 Hemoglobin A1c Control for Patients with Diabetes <8% by Race and Ethnicity

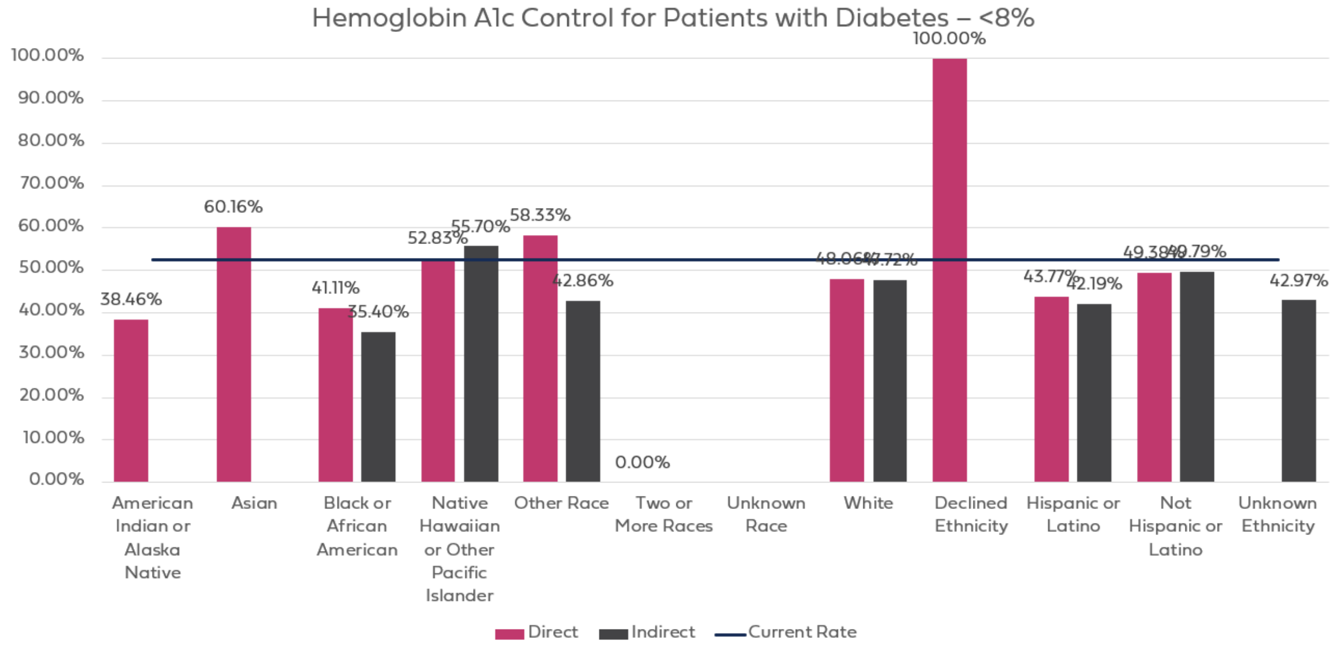


Figure 48 Hemoglobin A1c Control for Patients with Diabetes <8% by Race and Ethnicity

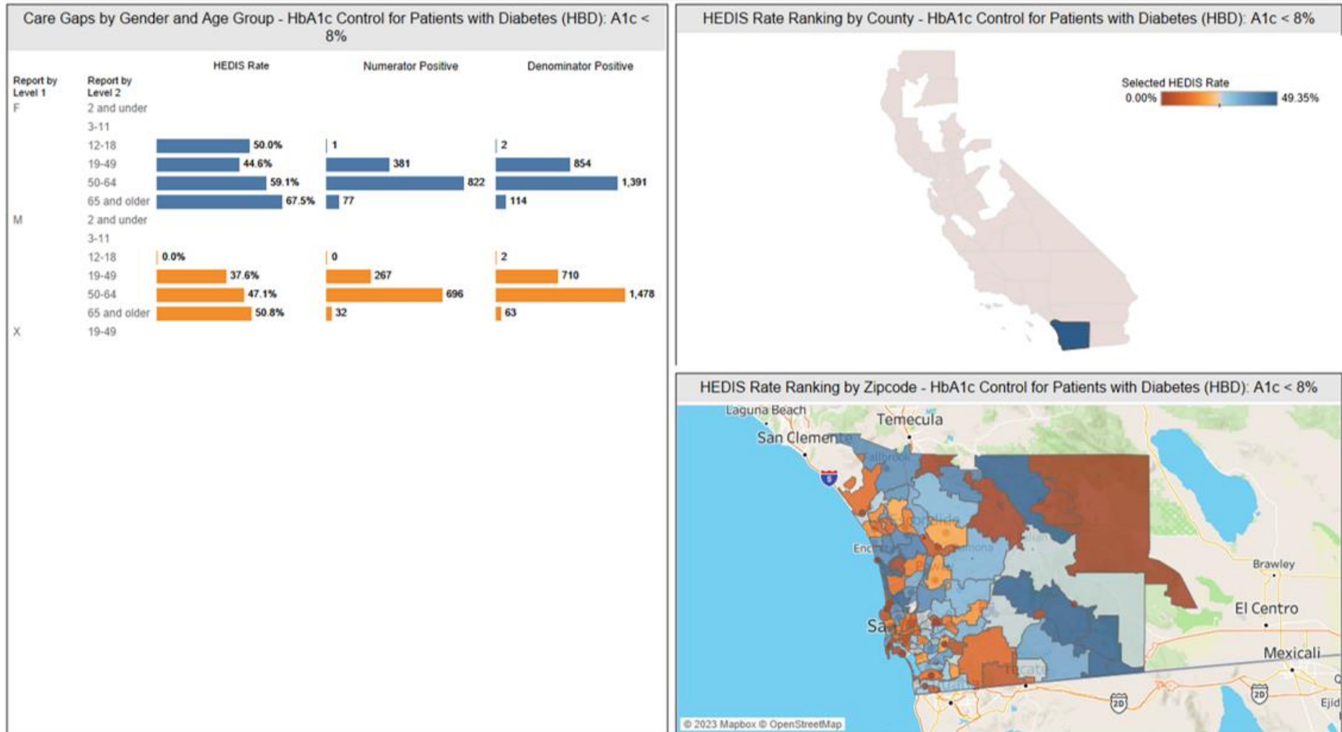


Figure 49 Hemoglobin A1c Control for Patients with Diabetes <8% by Gender, Age, County, and Zip Code

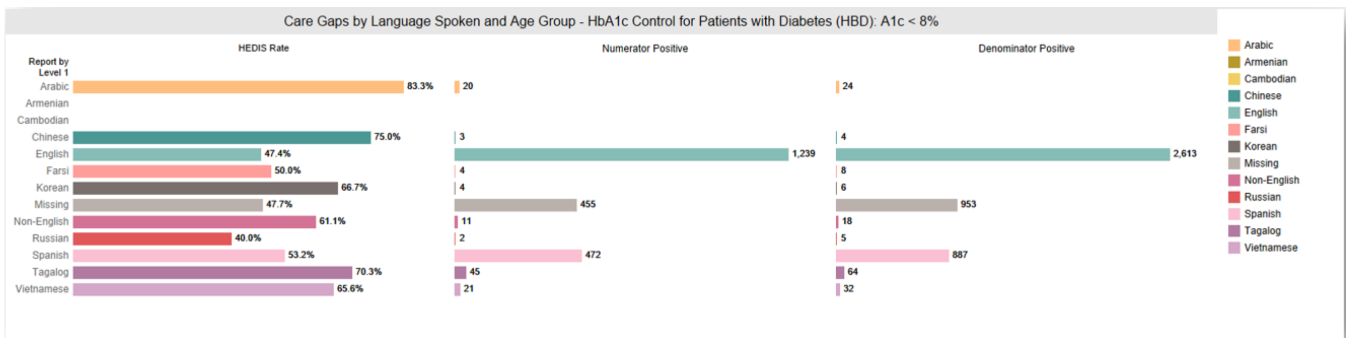


Figure 50 Hemoglobin A1c Control for Patients with Diabetes <8% by Language

Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9)

Hemoglobin A1c Control for Patients with Diabetes HbA1c Poor Control >9 (CDC HbA1c Poor Control) assesses the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control >9.0%. Note that this is an inverted measure and lower rates are favorable.

The overall CDC HbA1c Poor Control rate for MY 2022 was 41.52%, below the 50th percentile MPL of 39.90%. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest CDC HbA1c Control compliance rates included: Two or More Races (66.7%). Adversely, **the racial and ethnic groups with the lowest CDC HbA1c Poor Control compliance rates included: Black (98.26%); Other (100%); and White (96.97%)**. Of note, **none of the Race or Ethnicity categories met the MPL**. Males ages 65 and older have the highest

compliance rate (36.5%). **Males ages 12-18** (only 18-year-olds are eligible) **have the lowest** CDC HbA1c Poor Control **compliance rates (100%).** Similarly, Females ages 65 and older have the highest compliance rate (24.6%). **Females ages 12-18 (only 18-year-olds are eligible) have the** lowest CDC HbA1c Poor Control compliance **rates (50.0%).**

Compliance rates by language reveal variation among 11 different categories. The top language with the highest compliance rate was Arabic and Korean (16.7%, respectively). Adversely, the **languages with the lowest CDC HbA1c Poor Control compliance rates included: Russian (60.0%); Farsi (50.0%); and Korean (45.8%). Of note, none of the REGAL categories met the MPL.**

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9) [lower is better]	2071	4988	41.52%	39.90%	Ethnicity	Hispanic/Latino	1226	1274	96.23%	633	653	96.94%
						Not Hispanic/Latino	1289	1340	96.19%	538	559	96.24%
						Unknown-Ethnicity	-	-	-	1134	1172	96.76%
						Asked-No Answer	-	-	-	-	-	-
					Race	American Indian & Alaska Native	23	25	92.00%	1	1	100.00%
						Asian	293	315	93.02%			
						Black	339	345	98.26%	87	87	100.00%
						Native Hawaiian/ Other Pacific Islander	67	72	93.06%	197	204	96.57%
						Other	8	8	100.00%	2296	2371	96.84%
						Two or More Races	2	3	66.67%	2	2	100.00%
						White	799	824	96.97%	689	724	95.17%
						Asked - No Answer	-	-	-	-	-	-
						Unknown – Race	-	-	-	17	17	100.00%

Figure 51 Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control by Race and Ethnicity

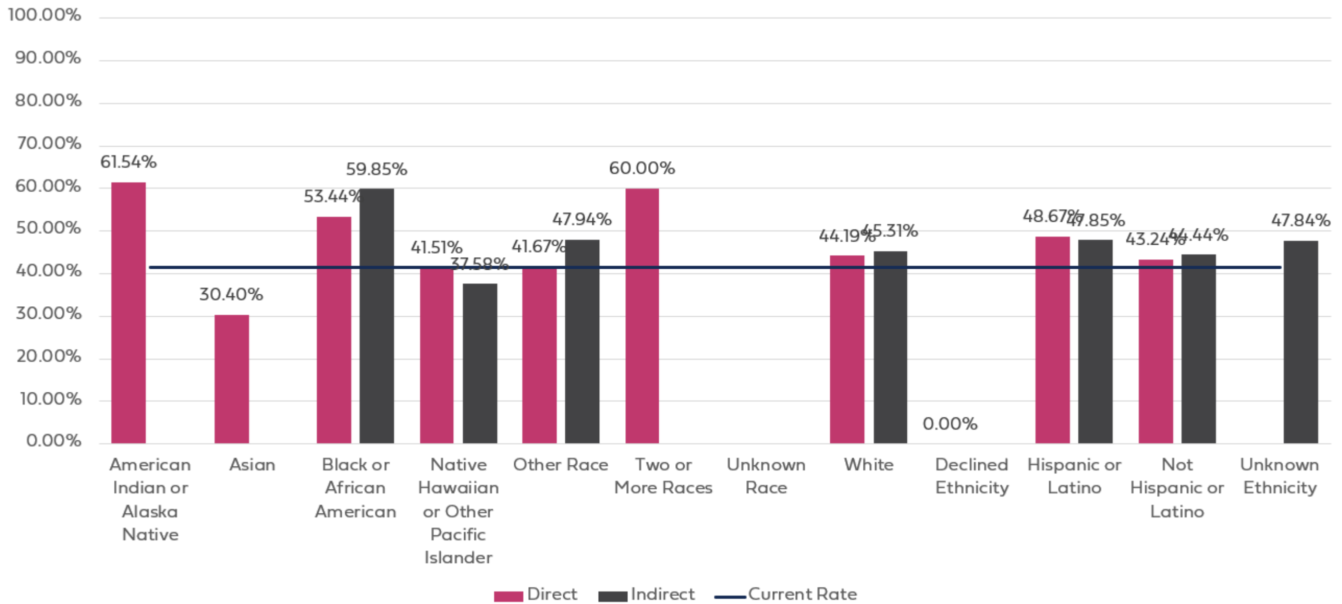


Figure 52 Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control by Race and Ethnicity

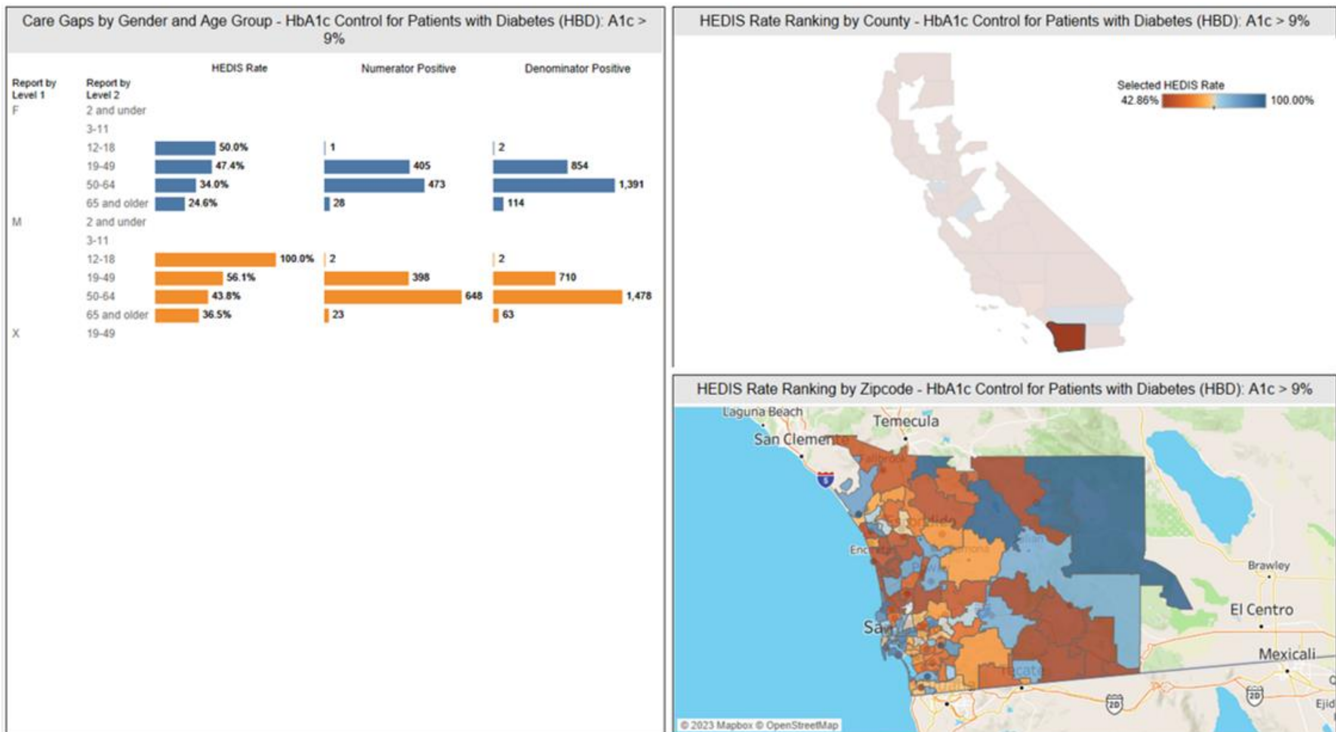


Figure 53 Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control by Gender, Age, County, and Zip Code

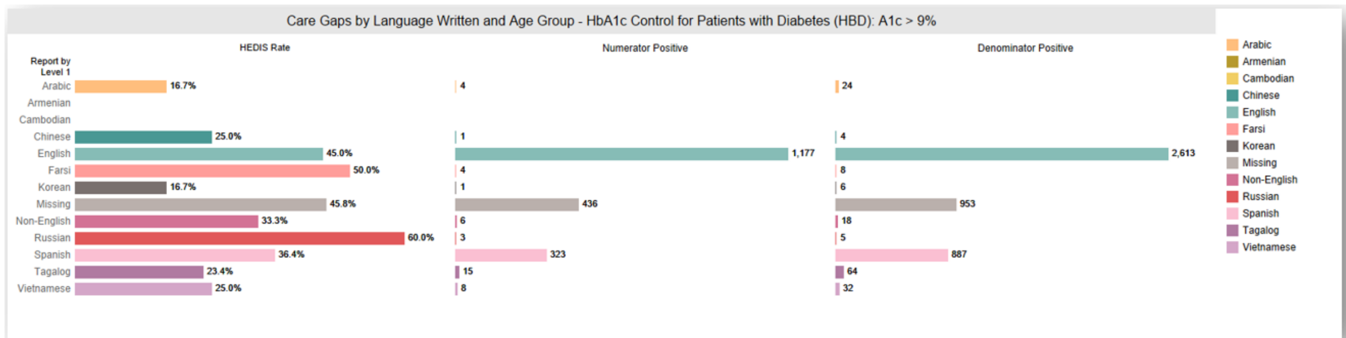


Figure 54 Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control by Language

Controlling Blood Pressure

Controlling Blood Pressure (CBP) assesses the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

The overall CBP rate for MY 2022 was 62.40%, below the 50th percentile MPL of 59.85%. The following graphs depict stratified outcomes reported by Gender, Age, and Language. Stratified data by race and ethnicity does not reflect medical record abstraction and therefore, is not included in this assessment. When looking at Gender, Females (65.6%) had higher reports of controlled blood pressure compared to Males (58.1%). Of note, both fell below the MPL. Females ages 50-64 had the highest compliance rates at 67.3%. Similarly, Males ages 65 and older had the highest compliance rates at 63.0%. **The lowest rates were observed in Females ages 19-49 (61.4%) and Males ages 12-18 (40.0%).**

Compliance rates by language reveal variation among 12 different categories. The top language with the highest compliance rate was Cambodian (100%). Adversely, the **languages with the lowest CBP compliance rates included: Russian and Tagalog (55.6%, respectively); and Missing (57.8%).** Of note, several groups did meet the MPL including: Females (65.6%); Cambodian (100%); Korean (87.5%); Arabic (69.7%); Chinese (76.9%); English (61.1%); Farsi (75.0%); Non-English (65.3%); Spanish (69.2%); Vietnamese (76.4%); Males 19-49 (61.4%); Males 50-64 (67.3%); Males 65 and older (63.5%); Females 19-49 (61.4%); Females 50-64 (67.3%); and Females 65 and Older (63.5%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Controlling Blood Pressure	4075	6530	62.40%	59.85%	Ethnicity	Hispanic/Latino	48	1037	4.63%	32	569	5.62%
						Not Hispanic/Latino	96	1774	5.41%	38	709	5.36%
						Unknown-Ethnicity	-	-	-	47	1349	3.48%
						Asked-No Answer	-	-	-	-	-	-
					Race	American Indian & Alaska Native	2	22	9.09%	0	2	0.00%
						Asian	27	387	6.98%			
						Black	11	415	2.65%	1	87	1.15%
						Native Hawaiian/ Other Pacific Islander	6	69	8.70%	12	208	5.77%
						Other	0	6	0.00%	97	2011	4.82%
						Two or More Races	0	2	0.00%	0	2	0.00%
						White	67	1194	5.61%	38	1017	3.74%
						Asked - No Answer	-	-	-	-	-	-
						Unknown – Race	-	-	-	0	0	0.00%

Figure 55 Controlling Blood Pressure by Race and Ethnicity

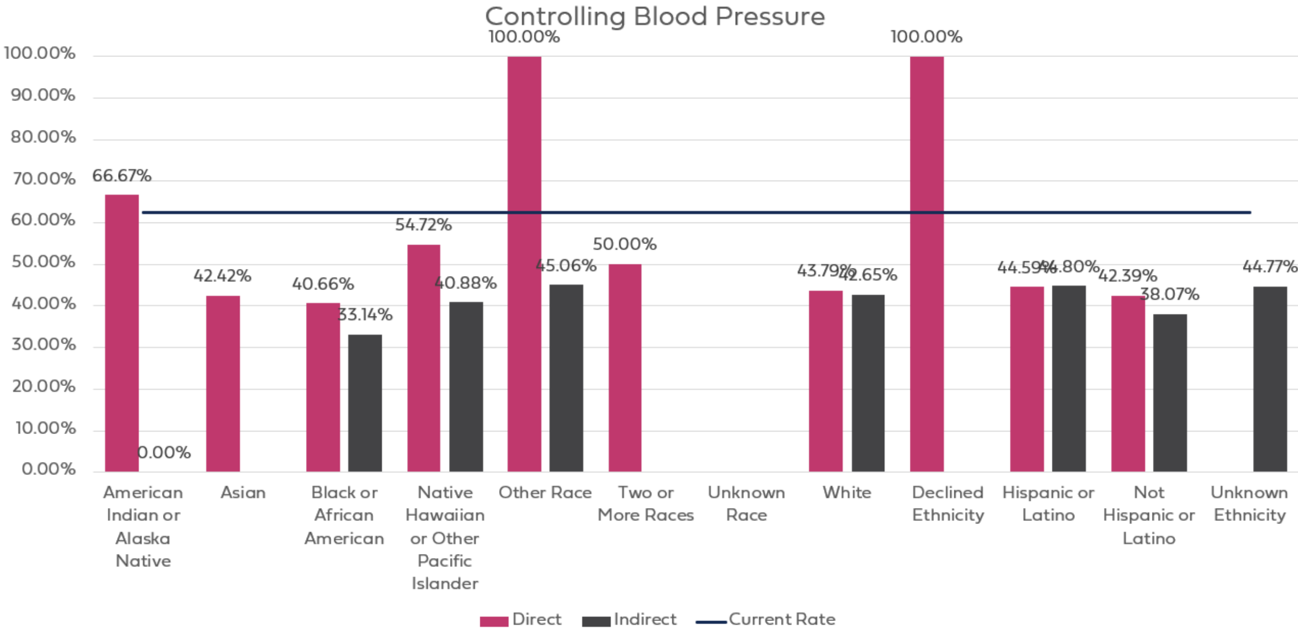


Figure 56 Controlling Blood Pressure by Race and Ethnicity

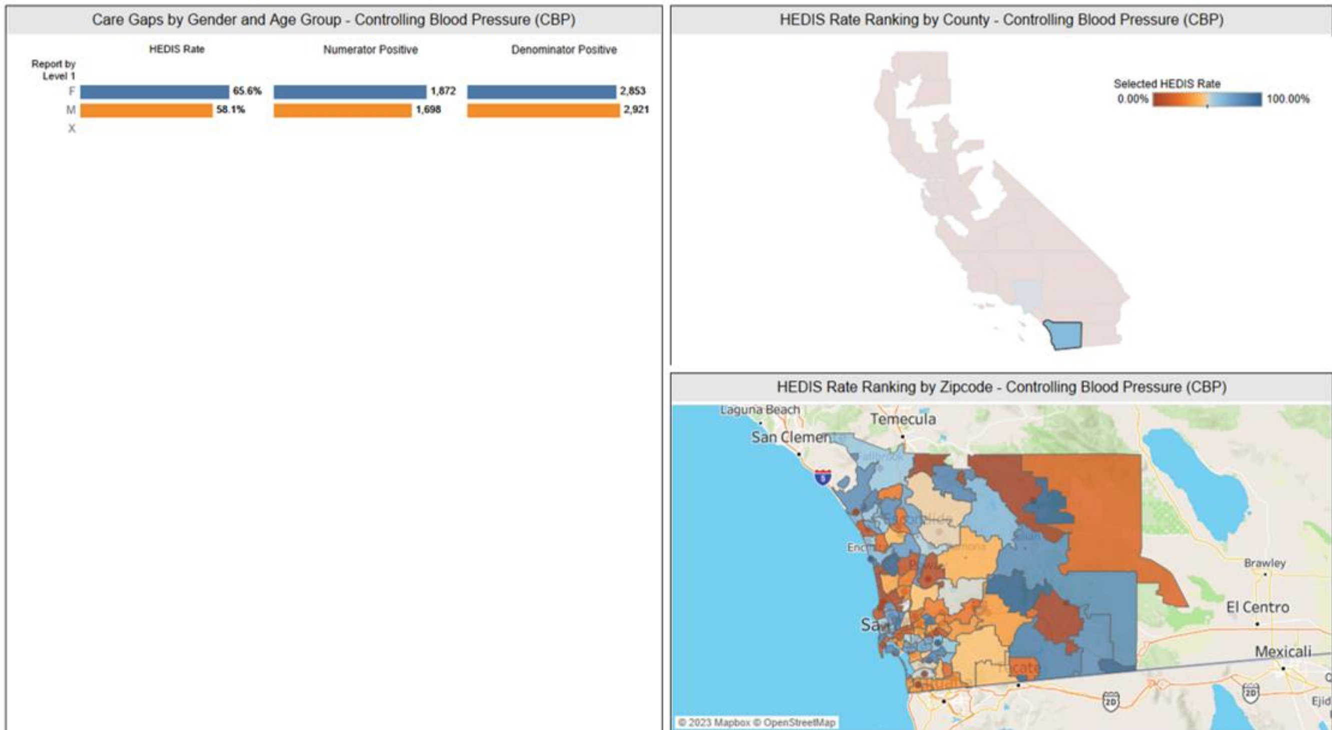


Figure 57 Controlling Blood Pressure by Gender, County, and Zip Code

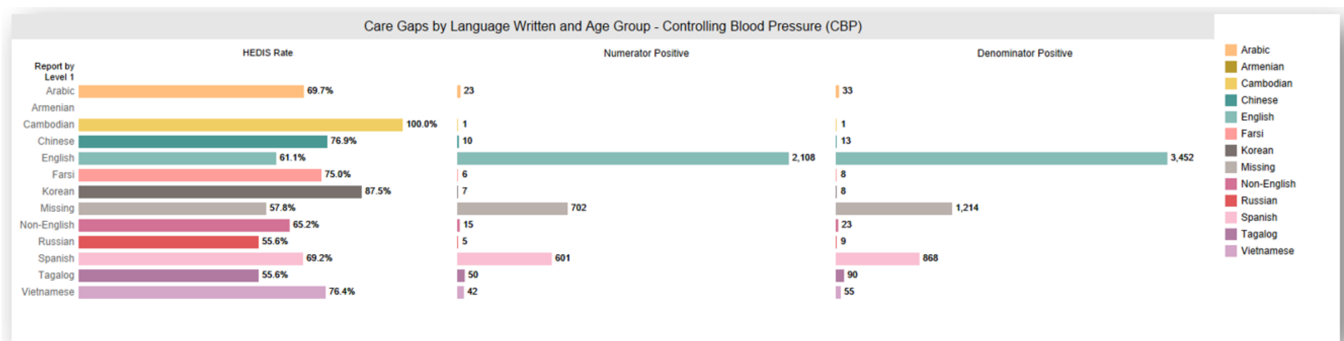


Figure 58 Controlling Blood Pressure by Language

Childhood Immunization Status – Combination 10 Immunizations

Childhood Immunization Status – Combination 10 (CIS) assesses the percentage of children (who turn 2 years of age during the measurement period) who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

The overall CIS rate for MY 2022 was 42.97%, below the 50th percentile MPL of 34.79%. The following graphs depict stratified outcomes reported by Gender and Language. Stratified data by race and ethnicity does not reflect medical record abstraction and therefore, is not included in this

assessment. The age criteria for CIS includes children who turn 2 during the measurement period and therefore, data was not stratified by Age. When looking at Gender, Males (43.5%) had slightly higher reports of CIS compliance compared to Females (42.8%). Of note, both did meet the MPL.

Compliance rates by language reveal variation among 8 different categories. The top language with the highest compliance rate was Chinese (100%). Adversely, the **languages with the lowest CIS compliance rates included: Vietnamese (33.3%) and English (37.7%).**

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Childhood Immunization Status - Combination 10 Immunizations	550	1280	42.97%	34.79%	Ethnicity	Hispanic/Latino	15	373	4.02%	20	357	5.60%
						Not Hispanic/Latino	5	189	2.65%	6	206	2.91%
						Unknown-Ethnicity	-	-	-	9	460	1.96%
						Asked-No Answer	-	-	-	-	-	-
					Race	American Indian & Alaska Native	0	1	0.00%	-	-	-
						Asian	1	30	3.33%			
						Black	1	35	2.86%	0	56	0.00%
						Native Hawaiian/ Other Pacific Islander	0	3	0.00%	1	51	1.96%
						Other	-	-	-	36	911	3.95%
						Two or More Races	0	1	0.00%	0	5	0.00%
						White	3	118	2.54%	10	357	2.80%
						Asked - No Answer	-	-	-	-	-	-
						Unknown – Race	-	-	-	3	17	17.65%

Figure 59 Childhood Immunization Status - Combination 10 by Race and Ethnicity

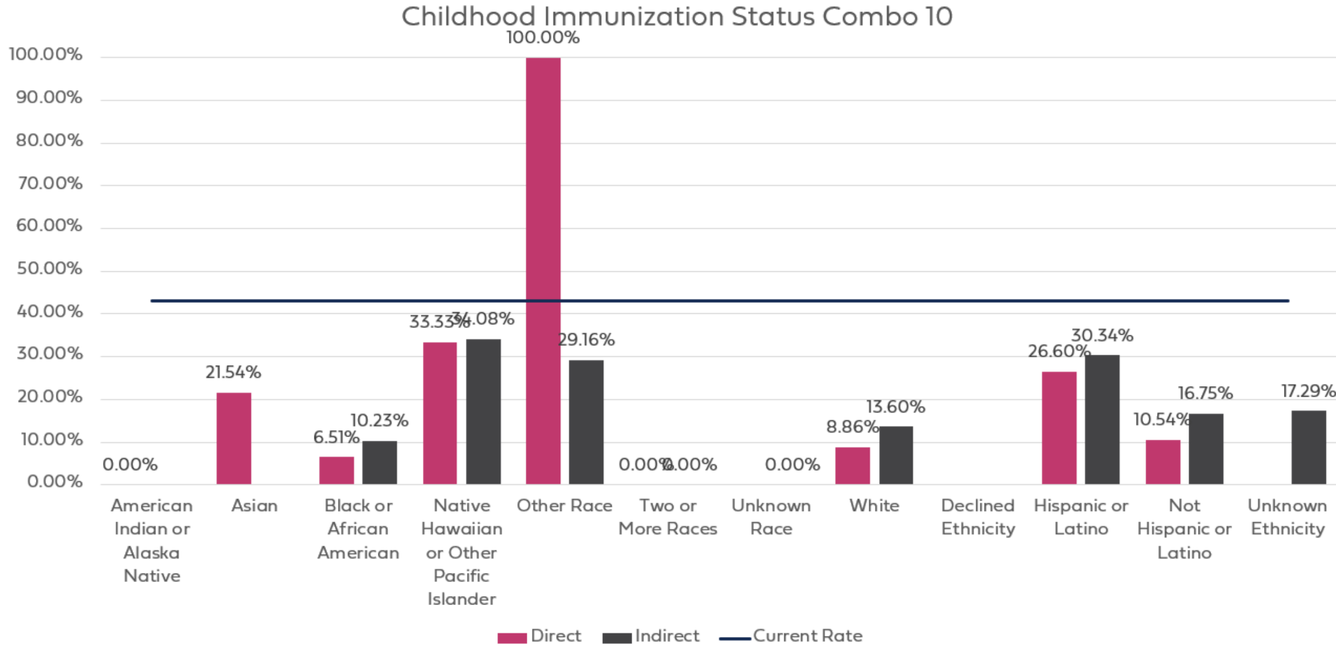


Figure 60 Childhood Immunization Status - Combination 10 by Race and Ethnicity

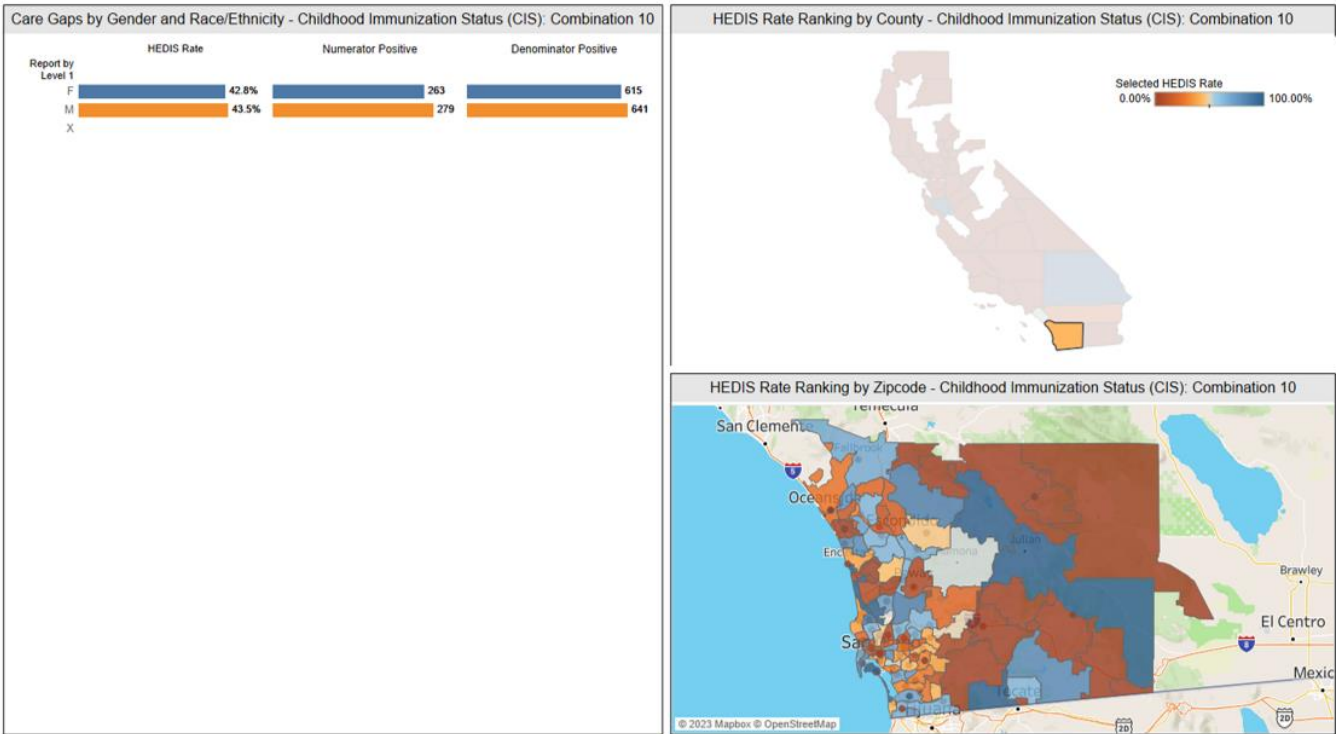


Figure 61 Childhood Immunization Status - Combination 10 by Age, County, and Zip Code

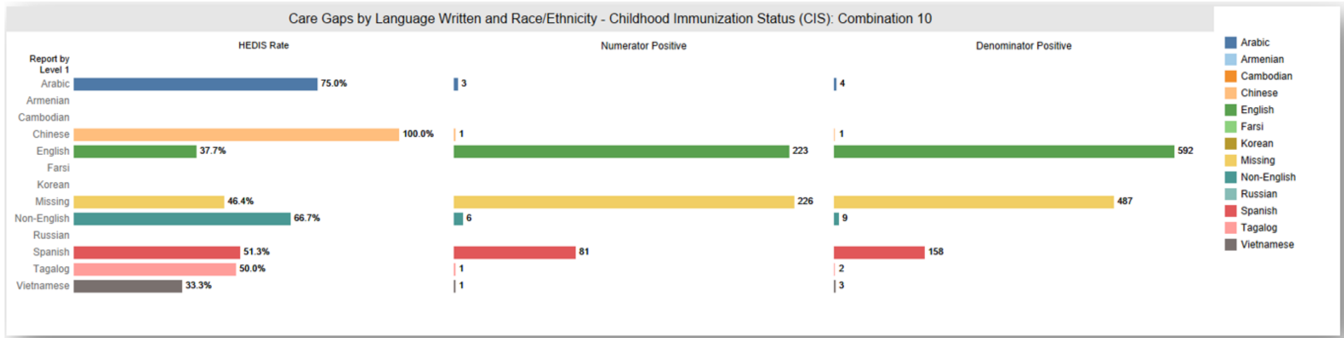


Figure 62 Childhood Immunization Status - Combination 10 by Language

Colorectal Cancer Screening

Colorectal Cancer Screening (COL) assesses the percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.

The overall COL rate for MY 2022 was 33.57%. An MPL benchmark was not established at the time of this report. The following graphs depict stratified outcomes reported by REGAL. The top racial and ethnic groups with the highest COL compliance rates included: Two or More Races (71.43%). Adversely, **the racial and ethnic groups with the lowest** COL **compliance rates included: Asked – No Answer (0.0%); American Indian & Alaska Native (18.68%); Black (19.80%).** Females ages 45-75 had higher compliance rates (36.4%) compared to Males (28.8%). Similarly, Females ages 50-75 had higher compliance rates (39.2%) compared to Males (31.3%).

Compliance rates by language reveal variation among 12 different categories. The top languages with the highest compliance rates for ages 50-75 were Farsi (48.3%); Vietnamese (47.1%); and Arabic (46.8%). The top languages with the highest compliance rates for ages 45-75 were Vietnamese (45.3%); Tagalog (44.1%); and Arabic (44.0%).

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups.

Measure	MY 2022 3/30/2023			MY2022 50th Percentile	Race/Ethnicity		Direct			Indirect		
	Num	Denom	Current Rate				Num	Denom	Rate	Num	Denom	Rate
Colorectal Cancer Screening	5617	16730	33.57%	No benchmark	Ethnicity	Hispanic/Latino	730	2760	26.45%	311	1608	19.34%
						Not Hispanic/Latino	1370	5648	24.26%	586	2877	20.37%
						Unknown-Ethnicity	-	-	-	991	3869	25.61%
						Asked-No Answer	0	3	0.00%	-	-	-
					Race	American Indian & Alaska Native	17	91	18.68%	2	5	40.00%
						Asian	293	1048	27.96%	-	-	-
						Black	200	1010	19.80%	45	268	16.79%
						Native Hawaiian/ Other Pacific Islander	40	187	21.39%	172	711	24.19%
						Other	3	12	25.00%	1257	5211	24.12%
						Two or More Races	5	7	71.43%	3	7	42.86%
						White	1101	4389	25.09%	839	3787	22.15%
						Asked - No Answer	-	-	-	-	-	-
						Unknown – Race	-	-	-	11	32	34.38%

Figure 63 Colorectal Cancer Screening by Race and Ethnicity

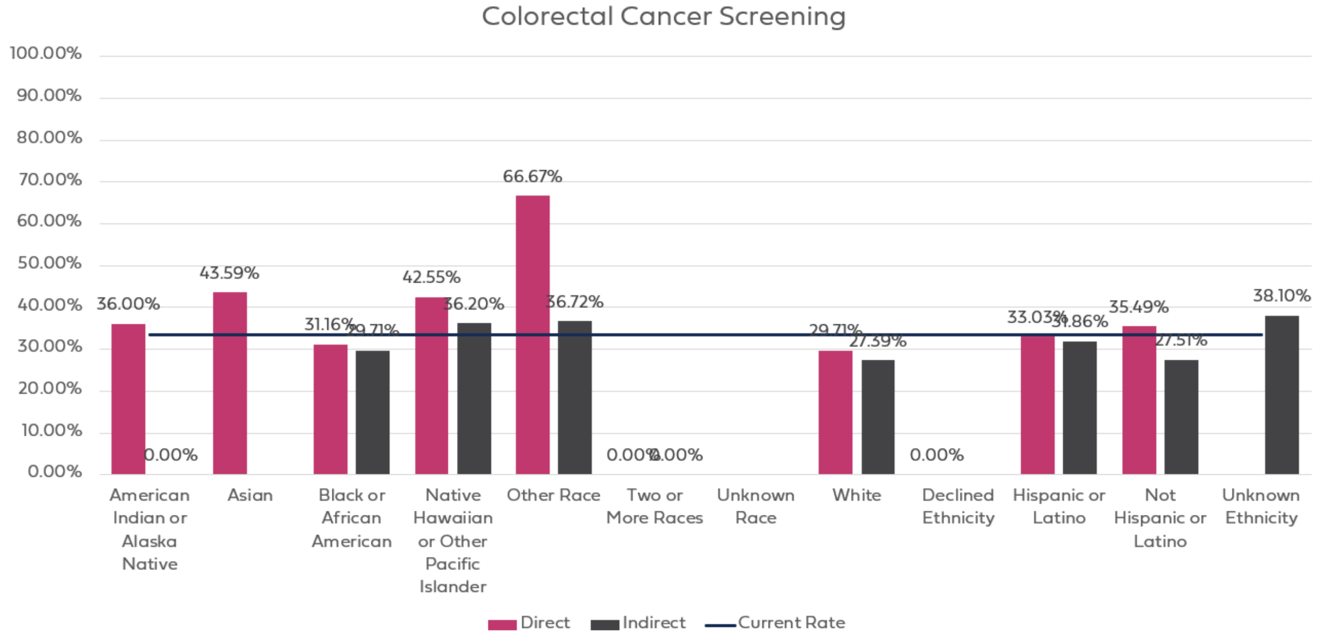


Figure 64 Colorectal Cancer Screening by Race and Ethnicity

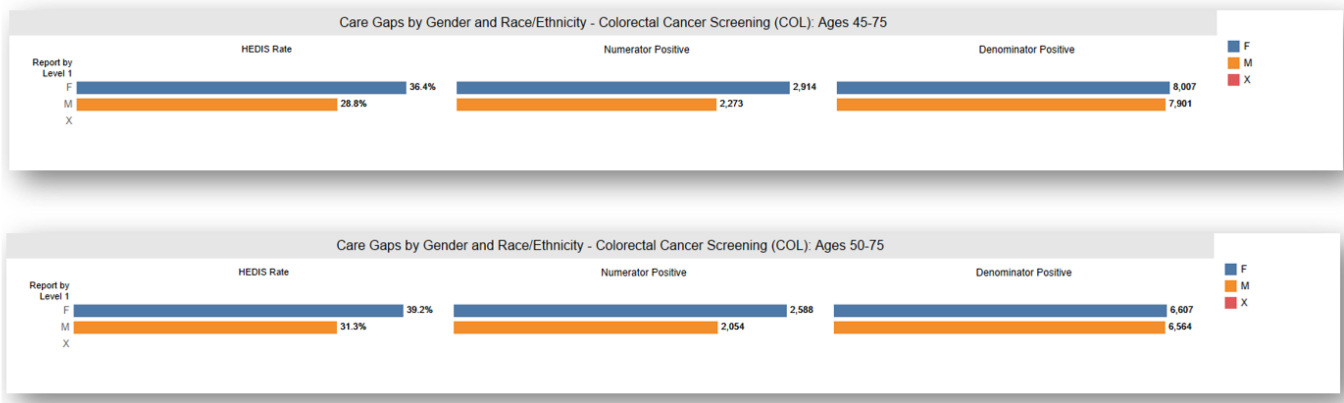


Figure 65 Colorectal Cancer Screening by Gender and Age

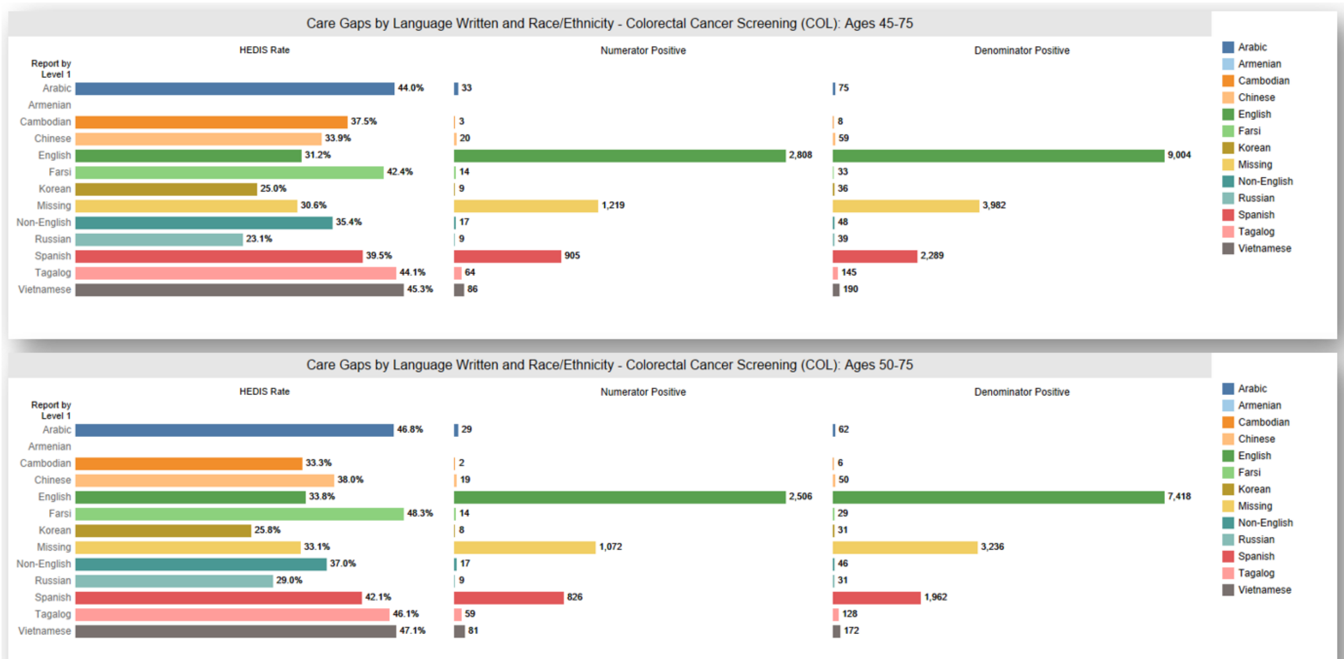


Figure 66 Colorectal Cancer Screening by Age and Language

C. Disparity Analysis

A total of 15 measures are included in this Assessment. The following categories were reported below the comparison group with the reported highest rates and may be indicative of a disparity or difference in care gaps between populations. Statistical analyses are recommended to confirm statistically significant differences between groups.

The following categories were reported below the comparison group with the reported highest rates and may be indicative of a disparity or difference in care gaps between populations. Statistical analyses are recommended to confirm statistically significant differences between groups.

Race

The White demographic reports the lowest rates for the most (9 of 15) HEDIS® measures when comparing to the highest performing Races, followed by Black or African American, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaskan Native with 5 or more disparities identified per group.

Common disparities for these groups include immunizations for children and adolescents, prenatal and postpartum care, Behavioral Health management, and diabetes management.

Language

The Tagalog demographic reports the lowest rates for the most (8 of 15) HEDIS® measures when comparing to the highest performing Languages, followed by Arabic, English, Vietnamese, and Russian with 4 or more disparities identified per group.

Common disparities for these groups include immunizations for children and adolescents, Behavioral Health management, and controlling blood pressure.

Age

The 12-19 age demographic reports the lowest rates for the most (3 of 15) HEDIS® measures when comparing to the other age bands.

Common disparities for this group includes: Child and Adolescents Well Care Visits for ages 19 and up; follow-Up after emergency department visit for Mental Illness; and Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control.

Gender

Females report the lowest rates for Child and Adolescents Well Care Visits (ages 19+) and follow-Up after Emergency Department Visit when compared to Males.

The Health Equity Office recommends statistical analyses to confirm statistically significant differences between groups. Statistical analysis is necessary to identify significant disparities, especially since the total number of eligible members per category ranged significantly, with some denominators having 1+ eligible members.

Race	Percent of Total Membership	Measure(s) with >10% variation from highest rate
White	16.66%	• Immunizations for Adolescents • Follow-Up after emergency department visit for Mental Illness 7 Day • Mental Illness 7 Day • Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up • Prenatal and Postpartum Care – Postpartum • Prenatal and Postpartum Care – Timeliness • Hemoglobin A1c Control for Patients with Diabetes <8% • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
Black of African American	9.06%	• Immunizations for Adolescents • Follow-Up after Emergency Department Visit for AOD 7 day • Follow-Up after Emergency Department Visit for AOD 30 day • Follow-Up after emergency department visit for Mental Illness 7 Day • Follow-Up after emergency department visit for Mental Illness 30 Day • Depression Screening and Follow-Up for Adolescents and Adults – Screening • Hemoglobin A1c Control for Patients with Diabetes <8% • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
Asian	4.19%	• Follow-Up after emergency department visit for Mental Illness 7 Day • Depression Screening and Follow-Up for Adolescents and Adults – Screening • Prenatal and Postpartum Care – Postpartum • Prenatal and Postpartum Care – Timeliness • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
Native Hawaiian and Other Pacific Islander	3.17%	• Immunizations for Adolescents • Follow-Up after emergency department visit for Mental Illness 7 Day • Follow-Up after emergency department visit for Mental Illness 30 Day • Hemoglobin A1c Control for Patients with Diabetes <8%

		• Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
American Indian or Alaskan Native	0.12%	• Child and Adolescents Well Care Visits • Immunizations for Adolescents • Depression Screening and Follow-Up for Adolescents and Adults – Screening • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
Some Other Race	66.72%	• Prenatal and Postpartum Care – Timeliness • Hemoglobin A1c Control for Patients with Diabetes <8% • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Colorectal Cancer Screening
Two or More Races	0.07%	• Child and Adolescents Well Care Visits • Depression Screening and Follow-Up for Adolescents and Adults – Screening
Race Detail Unknown	0.01%	None identified
Asked – No Answer	NA	NA

Ethnicity	Percent of Total Membership	Measure(s)
Hispanic or Latino	33.63%	None identified
Not Hispanic or Latino	26.26%	• Immunizations for Adolescents • Follow-Up after emergency department visit for Mental Illness 30 Day
Unknown	40.11%	None identified
Asked – No Answer	NA	NA

Age	Percent of Total Membership	Measure(s)
0-1	3.2%	
2-11	25.6%	• Follow-Up after emergency department visit for Mental Illness 7 Day • Follow-Up after emergency department visit for Mental Illness 30 Day

12-19	22.3%	• Child and Adolescents Well Care Visits (ages 19+) • Follow-Up after emergency department visit for Mental Illness 7 Day • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control
20-44	33.0%	• Follow-Up after Emergency Department Visit for AOD 7 day
45-64	15.5%	• Follow-Up after emergency department visit for Mental Illness 7 Day
65+	0.4%	• Follow-Up after Emergency Department Visit for AOD 30 day • Depression Screening and Follow-Up for Adolescents and Adults - Screening

Gender	Percent of Total Membership	Measure(s)
Female	223,833 (54.1%)	• Child and Adolescents Well Care Visits (ages 19+) • Follow-Up after Emergency Department Visit for AOD 7 day • Follow-Up after Emergency Department Visit for AOD 30 day
Male	189,907 (45.9%)	• Child and Adolescents Well Care Visits (ages 19+)

Language	Percent of Total Membership	Measure(s)
Tagalog	755 (0.1%)	• Child and Adolescents Well Care Visits • Immunizations for Adolescents • Follow-Up after Emergency Department Visit for AOD 7 day • Follow-Up after Emergency Department Visit for AOD 30 day • Follow-Up after emergency department visit for Mental Illness 7 Day • Depression Screening and Follow-Up for Adolescents and Adults – Screening • Prenatal and Postpartum Care – Postpartum • Controlling Blood Pressure
Arabic	962 (0.2%)	• Immunizations for Adolescents • Follow-Up after Emergency Department Visit for AOD 7 day • Follow-Up after Emergency Department Visit for AOD 30 day • Follow-Up after emergency department visit for Mental Illness 7 Day • Follow-Up after emergency department visit for Mental Illness 30 Day

		• Prenatal and Postpartum Care - Postpartum
English	213,967 (51.7%)	• Child and Adolescents Well Care Visits • Immunizations for Adolescents • Follow-Up after emergency department visit for Mental Illness 30 Day • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Controlling Blood Pressure • Childhood Immunization Status – Combination 10
Vietnamese	1,943 (0.4%)	• Follow-Up after Emergency Department Visit for AOD 7 day • Follow-Up after Emergency Department Visit for AOD 30 day • Follow-Up after emergency department visit for Mental Illness 7 Day • Childhood Immunization Status – Combination 10
Russian	1,057 (0.2%)	• Depression Screening and Follow-Up for Adolescents and Adults – Screening • Prenatal and Postpartum Care – Postpartum • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control • Controlling Blood Pressure
Non-English	1,318 (0.3%)	• Child and Adolescents Well Care Visits • Immunizations for Adolescents • Depression Screening and Follow-Up for Adolescents and Adults - Screening
Korean	627 (0.1%)	• Child and Adolescents Well Care Visits • Follow-Up after Emergency Department Visit for AOD 7 day • Depression Screening and Follow-Up for Adolescents and Adults - Screening
Farsi	137 (0.3%)	• Child and Adolescents Well Care Visits • Depression Screening and Follow-Up for Adolescents and Adults – Screening • Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control
Cambodian	NA	• Child and Adolescents Well Care Visits • Depression Screening and Follow-Up for Adolescents and Adults - Screening
Armenian	1,047 (0.2%)	• Depression Screening and Follow-Up for Adolescents and Adults - Screening
Chinese	2,383 (0.7%)	• Depression Screening and Follow-Up for Adolescents and Adults - Screening
None Selected	46,793 (11.3%)	None identified
Spanish	142,240 (34.3%)	None identified
Hmong	11 (0.0%)	None identified

D. Analysis of DHCS' Bold Goals

The following analysis provides a benchmark comparison to the Bold Goals established by DHCS and a set of recommendations to achieve the Bold Goals.

Close racial/ethnic disparities in well-child visits by 50%.

Based on this assessment, disparities or difference between populations were identified for Black or African American and American Indian or Alaskan Native populations. The health plan's overall rate of Child and Adolescent Well Care Visits was 44.66%. The rates for Black and African American and American Indian or Alaskan Native were reported below that rate. The HEO recommends statistical analysis to confirm statistically significant differences between these populations.

The MY 2022 rates are as follows:

Measure	Black or African American	American Indian or Alaskan Native
Well-Child Visits	36.71% (total rate: 44.66%; n=1,196)	26.92% (total rate: 44.66%; n=52)

The HEO recommends BSCPHP establish a goal for MY 2023 to decrease these rates by 50%.

Close maternity care disparity for Black and Native American persons by 50%.

Maternity care rates for Black or African American and American Indian or Alaskan Native populations are as follows:

Measure	Black or African American	American Indian or Alaskan Native
Prenatal and Postpartum Care – postpartum visit	88.9% (total rate: 81.57%; n=36)	0.00% (total rate: 81.57%; n=1)
Prenatal and Postpartum Care – timeliness of prenatal care	80.56% (total rate: 81.76%; n=36)	100% (total rate: 81.76%; n=1)

These rates are not indicative of a disparity when comparing rates to the overall performance rates. The MPL was not met. As such, the HEO recommends BSCPHP establish a goal for MY 2023 to decrease these rates by 50%.

Improve maternal and adolescent depression screening by 50%.

Maternal depression screening was not included in this analysis. This measure has been added to the HEART Measure set for continuous monitoring. Once rates are established, the HEO recommends BSCPHP establish a goal for MY 2023 to decrease these rates by 50%.

The rate of adolescent depression screening was 81.8%. A benchmark MPL was not established for this measure at the time of this report. The HEO recommends BSCPHP establish a goal for MY 2023 to increase depression screening rates by 50%.

Improve follow up for mental health and substance use disorder by 50%.

Follow-up for mental health and substance use disorder rates are as follows:

Measure	MY 2022 Rate	Minimum Performance Level
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7 day	20.54%	13.39%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30 day	33.45%	21.24%
Follow-Up after Emergency Department Visit for Mental Illness – 7 day	29.28%	40.38%
Follow-Up after Emergency Department Visit for Mental Illness 30 day	33.45%	54.51%

The MPL for the Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measures was met.

The MPL for Follow-Up after Emergency Department Visit for Mental Illness was not met. HEO recommends BSCPHP establish a goal for MY 2023 to increase these rates by 50%.

Ensure all health plans exceed the 50th percentile for all children's preventive care measures.

This Assessment does not contain a comprehensive assessment of all children's preventive care measures. The HEO recommends the Quality department provide a report of MY 2022 results for all children's preventive care measures to confirm which measures exceed the 50th percentile and which will require quality improvement.

Conclusion

This analysis of HEDIS® results serves as a baseline disparity analysis. Results will be used to inform quality improvement efforts and health equity initiatives to close gaps in care specific to disparate groups. The Health Equity Office and Quality department will collaborate to review this stratified data set via the Health Equity Advancements Resulting in Transformation (HEART) Measure Set. Additional HEDIS® measures will be added to the HEART Measure Set to ensure the DHCS MCAS measures are continuously monitored to identify disparities or differences between populations. These results will be presented to Blue Sheild Promise's Quality Improvement and Health Equity Committee (QIHEC). Additionally, quarterly monitoring reports of stratified HEDIS® measures will be presented to the QIHEC for continued monitoring and oversight of disparities. Actions will be taken as advised by the QIHEC. Actions may include presenting results to the Provider Advisory Committee and Member Advisory Committee to gather feedback and recommendations. Subsequent detailed analysis of final HEDIS® rates will be performed in 2024 and presented to the QIHEC.

XXII. References

1. https://www.census.gov/library/stories/state-by-state/california-population-change-between-census-decade.html
2. Health Disparities by Race and Ethnicity in California, 2021: Pattern of Inequity (chcf.org)
3. Key Data on Health and Health Care by Race and Ethnicity | KFF
4. Department of Healthcare Services Managed Care Accountability Set Measurement Year 2022-2023 MY2022-RY2023 MCAS
5. Department of Managed Health Care APL 22-028 – Health Equity and Quality Measure Set and Reporting Process

blue california | Promise Health Plan

Health Equity Recommendations Report

Assessing Provider Network Capacity to meet the Ethnic, Cultural, and Linguistic Needs of Members

Date: November 1, 2023

Prepared By: Brigitte Lamberson, Health Equity Principal Program Manager and Valerie Martinez, Promise Chief Health Equity Officer

Executive Summary

Introduction

Blue Shield of California Promise Health Plan (BSCPHP, or BSP) Health Equity Office (HEO) conducted an assessment to establish recommendations for meeting compliance for the California Department of Health Care Services (DHCS) Medi-Cal Contract operational readiness requirements regarding BSP's ability to meet the ethnic, cultural, and linguistic needs of members. BSP's HEO is comprised of the Chief Health Equity Officer, Health Equity Principal Program Manager, Chief Executive Officer, Chief Medical Officer, Senior Director of Quality, and Director of Quality. The HEO was included in readiness preparation and identified an opportunity to offer the identified responsible parties a report of best practices and recommendations considering these requirements are related to health equity.

Summary

Multiple regulators require Medi-Cal Managed Care Plans to implement the following related to meeting member's ethnic, cultural, and linguistic needs.

1) Per DHCS, Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.
2) Per DHCS, Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population.
3) Per the Department of Managed Healthcare (DMHC), the Plan must survey the linguistic needs of the Plan's enrollees.
4) Per National Committee for Quality Assurance (NCQA), the Plan must prepare a report describing practitioner demographics and assessments of identified needs.

BSP submitted plans to DHCS outlining how contract requirements and narrative included in the DHCS Request for Proposal Bid submission will be satisfied. BSP will need to speak to

these requirements as part of DMHC medical surveys and submit documents as part of the NCQA Health Equity Accreditation survey process.

BSP staff are currently working to establish activities needed to meet these requirements into 2024. BSP's Health Equity Office prepared a set of recommendations that incorporate equity into these activities. Recommendations were analyzed to determine which meets minimum requirements, and which allow us to differentiate and lead the market in this work. Teams and individuals responsible for these requirements should refer to this report when planning initiatives and operations to meet the ethnic, cultural, and linguistic needs of members.

Requirements

The HEO reviewed the following requirements set forth by the DHCS, the Department of Managed Care (DMHC) and National Committee for Quality Assurance (NCQA) to assess BSP's requirement to meet the ethnic, cultural, and linguistic needs of members:

Department of Healthcare Services

1) Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.[1]
2) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area.[2]
3) **The** Plan **must** display Cultural and Linguistic training completion in the provider directory.[3]

Department of Managed Care

1) The Plan demonstrates that it has surveyed the linguistic needs of the Plan's enrollees.[4]
2) The Plan has identified its threshold language(s).[5]
3) The Plan has established and implemented an LA training program for all staff who have routine contact with LEP enrollees.[6]

National Committee for Quality Assurance

1) The organization annually assesses the cultural, ethnic, racial and linguistics needs of its members; and adjusts the availability of practitioners within its network, if necessary[7]

---

[1] DHCS Medi-Cal Contract, Exhibit A Attachment III Section 5.2.3.E
[2] DHCS Medi-Cal Contract, Exhibit A Attachment III Section 5.2.11.4
[3] DHCS All Plan Letter (APL) 22-026:
[4] LA-002 - Key Element 2: 2. CA Health and Safety Code section 1367.04(b); 28 CCR 1300.67.04(c)(1)(B)
[5] LA-002 - Key Element 3: CA Health and Safety Code section 1367.04(b)(1)(A); 28 CCR 1300.67.04(b)(5)
[6] LA-004 - Key Element 1: 1. 28 CCR 1300.67.04(c)(3)

2) The organization analyzes practitioner network cultural responsiveness [8]. The organization uses information about the demographic profile of the individuals it serves and the practitioner network to identify potential unmet needs and assesses the network's ability to deliver culturally appropriate care. The Plan must prepare a report describing practitioner demographics and assessments of identified needs. The organization may assess practitioners':
   - Attitude about working with people from different cultures.
   - Awareness of health beliefs and health-related behaviors among people from prevalent cultures in the service area.
   - Ability to determine language or cultural barriers interfering with communication.
   - Skills in assessing patient understanding.
   - Participation in CME cultural humility training.

Methodologies

The HEO reviewed submissions, existing reports, NCQA Health Plan Accreditation Standards, DHCS and DMHC regulatory requirements, and interviewed key stakeholders to assess how the above requirements will be satisfied.

The Health Equity Office met with the Medi-Cal Growth Office, Provider Relations and Contracting, Health Education and Cultural and Linguistics, and Community Engagement departments to assess how teams plan to meet these health plan operational readiness requirements.

Assessment

Requirements

The following table outlines the eight identified requirements related to provider network capacity and recruiting and retaining a diverse provider network.

[7] NCQA Health Plan Standards and Guidelines for Health Plan Accreditation 2022. Network Management (NET) 1: Availability of Practitioners, Element A – Cultural Needs and Preferences, Factors 1 and 2.

[8] NCQA Health Plan Standards and Guidelines for Health Equity Accreditation. Health Equity (HE) 4: Element B -, Factors 1 and 2

Requirement (Detailed deliverable)	Source (Requirement)	Accountable Owner (Party responsible for operations and oversight to ensure activities are completed; escalates issues as identified)	Artifact (Document used to demonstrate compliance) *gap identified	Status (Does not meet requirements; partially meets requirements; meets requirements; exceeds requirements)
1) Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.	DHCS Contract	Operational gap	Annual Network Adequacy Report*	Minimally meets requirements
2) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area.	DHCS Contract	Operational gap	Annual Network Adequacy Report*	Partially meets requirements
3) The Plan must display Cultural and Linguistic training completion in the provider directory.	DHCS All Plan Letter (APL) 22-026	Operational gap	Quarterly data Cultural and Linguistics Annual Evaluation*	Partially meets requirements Recommend CLAS report
4) The Plan demonstrates that it has surveyed the linguistic needs of the Plan's enrollees.	DMHC Language Assistance Technical Assistance Guide	Linda Fleischman	Cultural and Linguistics Annual Evaluation*	Meets DHCS, but does not meet DMHC. Need CLAS report
5) The Plan has identified its threshold language(s).	DMHC Language Assistance Technical Assistance Guide	Linda Fleischman	Cultural and Linguistics Annual Evaluation*	Meets requirements. Recommend CLAS report
6) The Plan has established and implemented an LA training program for all staff who have routine contact with LEP enrollees	DMHC Language Assistance Technical Assistance Guide	Linda Fleischman	Training records; quarterly data Cultural and Linguistics Annual	Partially meets requirements – need CLAS report

			Evaluation*	
7) The organization annually: assesses the cultural, ethnic, racial and linguistics needs of its members; and adjusts the availability of practitioners within its network, if necessary.	NCQA Health Plan Accreditation	Linda Fleischman (with support from Melinda Kjer	Annual Network Adequacy Report	Meets requirements
8) The organization analyzes practitioner network cultural responsiveness. The organization uses information about the demographic profile of the individuals it serves and the practitioner network to identify potential unmet needs and assesses the network's ability to deliver culturally appropriate care. The Plan must prepare a report describing practitioner demographics and assessments of identified needs.	NCQA Health Plan Accreditation	Linda Fleischman with support from Melinda Kjer	Annual Network Adequacy Report	Meets requirements

BSP’s Commitment

The following content contains BSPs commitment to meet these requirements.

Deliverable #1: Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

BSP submitted the following response to DHCS as part of readiness review.

“Annually, a Geographic Access Mapping report is produced for the purpose of analyzing provider network adequacy of members’ distance to providers that speak their preferred language. For any distance gaps, Blue Shield of California Promise Health Plan (Blue Shield Promise) identifies alternative methods for members to access providers that speak their preferred language. Alternative methods include informing members that they have access to No Cost transportation for appointments as well as the ability to schedule tele health visits with a provider that speaks their preferred language. There is the opportunity to meet with a provider that meets the distance requirements and use an onsite interpreter who speaks the member’s preferred language. Data is captured by language and zip code for our services areas, Los Angeles, and San Diego counties as part of our Blue Shield Promise Health Plan Managed Care Accessibility Analysis.

We will further assess member distribution by race and ethnicity and compare the data to our provider network as part of our analysis. This will help us determine identifiable gaps within our provider network and work to build a diverse network.

Additionally, contracted Provider offices are routinely monitored for cultural and linguistic services program compliance through the California Department of Health Care Services (DHCS) required Facility Site Review (FSR) and Medical Record Review (MRR) audit. As part of the FSR/MRR audit review, a Blue Shield Promise trained Nurse Auditor assesses the office site to ensure they provide required language assistance services including bilingual staff and interpreter services at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

The Provider office must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. It is the provider/designee responsibility to assess interpreter skills and capabilities of their staff providing interpreter services using at least one or more of the following: Assessment of interpreter skills may include written or oral assessment of bilingual skills; Documentation of the number of years of employment as an interpreter or translator; Documentation of successful completion of a specified type of interpreter training programs, i.e., medical, legal, court, or semi-technical; or other reasonable alternative documentation of interpreter capability.

While Blue Shield Promise does not track individual bilingual assessments for each Provider Office, we educate and encourage Provider Offices to follow the Affordable Care Act Section 1557 and keep a record of all bilingual providers and staff on site who are deemed

capable and competent as interpreters based on the most appropriate bilingual assessment. This information informs our Provider Directory data collection as we accurately maintain Provider Office and Office staff languages spoken for the members we serve.

Blue Shield Promise has identified an opportunity to develop a process moving forward to capture provider race/ethnicity and capacity to provide culturally sensitive services to a diverse membership.

While Blue Shield Promise currently captures Provider language during the Credentialing process and continue to increase the number of provider's languages we add to the provider directory, we are strengthening the process to identify and contract with ethnically diverse providers through several activities including but not limited to: 1) Collecting race, ethnicity, and language data at Credentialing and Recredentialing touch points by adding race, ethnicity, and language needs within the initial and recredentialing outreach letter and/or digital fields to our potential and existing Providers; 2) Enhance the current Provider Access and Availability Survey (PAAS) and include a supplemental questionnaire to capture Provider race, ethnicity, and language data; and 3) Conduct outreach to a sample size Provider Network to update their personalized profile.

Implementing these activities will improve our data collection process at various points of contact with our Provider Network. Adding race, ethnicity, and language information as a required field early in the credentialing process will give us a better understanding of our diverse network. Considerations will be made to seek this information during the Provider contracting process well before the credentialing process. Furthermore, monthly analysis and monitoring of the Provider Network race, ethnicity and language measure set will keep Provider information and status up to date and determine membership needs are met.

Going forward, all impacted functional area leaders will work with our Chief Health Equity Officer, state and local medical associations and other stakeholders to continue to strengthen relationships with ethnically diverse providers."

Deliverable #2: Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area.

BSP submitted the following response to DHCS as part of readiness review.

"Blue Shield Promise completes the Annual Network Certification Process Timely Access Compliance Report and submits the report to the DHCS to demonstrate compliance with network adequacy standards set forth in All Plan Letter (APL) 21-006. This report is a comprehensive evaluation of Blue Shield Promise' Provider Network and reviews network adequacy for time/distance standards, provider-to-member ratios, appointment wait-times for certain types of services, and provider directory data including gender, language, cultural competency, and routinely updates the Provider Directory.

As part of the Annual Network Certification Process Timely Access Compliance Report, Blue Shield Promise evaluates our Provider Network against network adequacy standards using the network directory data to determine a need for cultural and linguistically competent Providers for recruitment.

Blue Shield Promise recruits Provider specialty by conducting research on credible websites such as healthgrades.com, and targeted outreach to area Providers. Provider quality scores are considered when deciding whether to contract with a new Provider. Once a specialty is identified, a blanket letter is sent out to Providers in the area and begins the letter of offer and acceptance (LOA) process. Language information is not available or captured at this contact point.

Blue Shield Promise identified an opportunity to review and enhance our current blanket letter sent out to Providers as part of our recruitment efforts. We recognize there is a need to survey Providers for their race, ethnicity, and language information at the time of recruitment. This information will help us be more equitable in our selection and recruitment. We will develop and include a Provider race, ethnicity, and language survey/data form as part of the LOA process to collect the data. Further development of database fields to current database and storage will be considered.

Furthermore, to socialize the need for a diverse Provider network and workforce. Blue Shield Promise will advertise diversity, disseminate and educate Providers on the University of California, Berkeley's A toolkit for recruiting and hiring a more diverse workforce to current Provider Network, Subdelegates, Delegates.

Socializing this information are the initial steps for changing racist and systemic structures that exist in our healthcare system. Blue Shield Promise will also explore health care professional pipeline considerations in an effort to recruit new Medical School graduates into the network and inform career ladder/mentorship programs in the workforce.

Blue Shield Promise works diligently to retain contracted providers and maintain access and availability to our members. Onboarding our contracted network is the initial start in building a strong and long-term relationship with our providers. Our onboarding process consists of training providers on Blue Shield Promises processes and procedures, Provider Manual, resources and introduction to the provider's assigned Provider Services Liaison. Training includes and is not limited to Diversity, Equity, and Inclusion training (sensitivity, diversity, communication skills, and cultural competency training).

Thereafter, Blue Shield Promise continues to improve our ongoing relationship with providers by scheduling regular meetings with providers, taking parting in community events that allow us to enhance our understanding of the community and the needs of both the members and providers.

The Provider Relations department also offers ongoing Provider Education and Trainings to keep providers aware and updated on resources, policies and procedures, managed care and regulatory requirements around cultural competency, cultural diversity, and equity and

inclusion. We meet with our Delegated groups to communicate an annual copy of the Blue Shield Promise Annual Language Accessibility Analysis. The report is promoted, reviewed, and discussed during the annual Joint Operation Meeting.

Blue Shield Promise has developed quality programs to incentivize providers to deliver high quality, and culturally and linguistically competent services to our members. We also have our Provider Outreach department who work with our providers to help them grow and maintain their membership.

Overall, Blue Shield Promise strives to retain culturally and linguistically competent providers to ensure members have access to a provider who speaks their preferred language."

Industry Best Practices

Based on review of industry practices, other Managed Care Plans are committing to the following:

1) Develop Policies and Procedures for identifying contractual relationships with diverse providers.
2) Recruit bi-lingual clinicians to build a diverse Provider network that meets Member language needs and reflects their racial and ethnic diversity.
3) Ask providers to share race/ethnicity data upon credentialing.
4) Establish Network Management plan goals and oversight metrics to ensure Provider Network is representative of the Members they serve.
5) Assess, recruit, provide workforce support, identify Provider race/ethnic background, and then support our Members in finding Providers that meet their cultural preferences. For example, collect self-reported Provider race/ethnicity data and upload into systems.
6) The Provider Directory includes Provider language capabilities from which Members can search for a Provider that meets their needs.
7) The ethnicity results will be included in annual Population Needs Assessment and documented in each provider's record to help better match members who request providers by ethnicity.
8) Encourage providers to identify their willingness to meet the needs of underserved members. For example, we conduct an annual survey asking providers if they will agree to be designated as culturally competent to serve the LGBTQ+ community and provide gender-affirming care. That information is readily available to Care Managers and Member Services call center staff to help LGBTQ+ members find affirming care.
9) Geographic analysis highlights linguistic needs and priorities for PCP and specialist sites in Medi-Cal counties.
10) Semi-annual analysis of Provider network to identify C&L gaps and recruit and contract additional Providers accordingly.

11) All Providers are trained in cultural sensitivity in the delivery of services. As part of training, assess for Providers' cultural needs through provider satisfaction surveys and use this data to customize our DEI and CLAS training.
12) Use the PNA to understand these opportunities.
13) The Health Education Department offers learning opportunities to support Providers, including cultural humility and implicit bias training and a Maternal Health Equity Curriculum series.
14) In partnership with Physicians for a Healthy California, launched a cultural education series teaching Providers to overcome health disparities driven by language barriers, misunderstanding culturally-based practices, unconscious bias, and low health literacy.
15) Developed "Partnering with Patients"- cultural competency materials for Providers that include a language identification poster, diabetes and culture guide for physicians, and enhanced patient communication handouts.
16) Partner with Industry Collaborative Effort (ICE) to develop a complete set of Provider materials, available on website.

Recommendations

As part of readiness preparation and this assessment of requirements and current operations, the HEO has developed a set of recommendations to meet the two DHCS contract requirements.

Deliverable #1: Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

BSP's HEO recommends the following process for meeting the intent of this requirement.

1) Design a strategy to assess members' cultural needs and a plan to monitor to ensure the provider network meets those needs.
    a. Ask providers to share race/ethnicity data upon credentialing.
    b. Establish Network Management plan goals and oversight metrics to ensure Provider Network is representative of the Members they serve.
    c. Ensure the Provider Directory includes Provider language capabilities from which Members can search for a Provider that meets their needs.
    d. Create a system to search provider demographic data to help better match members who request providers by specific demographic characteristics.
    e. Develop a process to capture providers' cultural competency. Considering the provider landscape does not allow for a 1:1 match of all races and ethnicities, focus on building cultural competency and capacity to serve multi-cultural and/or vulnerable populations. Survey comfort, competency, and/or training records to serve multi-cultural and/or vulnerable populations.
    f. Build capacity among provider network to meet members' cultural needs. Establish a process to ensure all providers to complete cultural competency training upon contracting and routinely thereafter. Prepare a strategic plan

to offer additional training in topics related to health equity, cultural humility, implicit bias, gender affirming care.

2) Identify an accountable owner who will oversee these activities and present updates to various forums. HEO recommends designating a leader from the Network department.
    a. Present results at various forums such as Medi-Cal Business Review, POD meeting, Quality Improvement and Health Equity Committee.
    b. Document discussion and action taken in the narrative report, capturing reporting updates and recommendations at subsequent meetings.
3) Identify teams who will generate necessary data.
    c. Establish report parameters.
    d. Establish deadlines to obtain data, allowing time to prepare narrative report.
4) Identify accountable owner who will prepare an annual Network Adequacy report and Annual Culturally and Linguistically Appropriate Services (CLAS) Report. A semi-annual report is recommended to meet other Managed Care Plan monitoring frequency.
    e. A similar report is generated for NCQA Health Plan Accreditation and should be used for this deliverable, adding the following considerations to ensure the DHCS intent is met.
    f. Prepare a narrative report containing a comprehensive assessment of the results, analysis, and recommendations of the aforementioned activities.
5) The following operations should be considered when preparing the report.
    g. Collect data on ethnic, racial, and linguistic needs of members from U.S. Census, local County data, and membership data (via the DHCS 834 file, data collected at multiple points of contact, imputed data, self-reported data, member surveys, member complaints).
    h. Conduct research or review literature to understand members' cultural needs and preferences based on the characteristics of the organization's members. This may include, but is not limited to, an assessment of member demographic data such as geography, zip code, age, gender, preferred language, race, ethnicity, sexual orientation and/or gender identity, education level, and/or income).
    i. Correlate data with members' preferences based on member feedback or complaint data. Use member feedback to supplement conclusions about members' cultural needs.
    j. Assess the cultural, ethnic, racial, and linguistic characteristics of network practitioners to evaluate whether network practitioners meet members' needs. Compare provider demographic composition to member composition, assessing opportunities to better align the provider network with BSP membership.
    k. Assess provider cultural competency, monitoring completion of cultural and linguistic training.
    l. Highlights linguistic needs of members and priorities to ensure network adequacy for PCP and specialist sites.
    m. Assess Provider Directory data assessing accurate maintenance Provider Office and Office staff languages spoken for members served.

n. Take action to adjust the practitioner network if it does not meet members' cultural, ethnic, racial, and linguistic needs.

6) Develop Policies and Procedures for identifying contractual relationships with diverse providers and to document process for monitoring and reporting results.

Deliverable #2: Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area.

BSP's HEO recommends the following process for meeting the intent of this requirement.

1) Identify an accountable owner who will oversee these activities and present updates to various forums. HEO recommends designating a leader from the Network department.
2) Collaborate with the BSP Chief Health Equity Officer, state and local medical associations and other stakeholders to help identify and continue to strengthen relationships with ethnically diverse providers.
3) Prepare a strategy to recruit, credential, and contract with practitioners who speak a language that reflects members' linguistic needs.
4) Develop Policies and Procedures for recruiting and retaining a diverse network of providers and to document process for monitoring and reporting results.
5) Capture Provider race, ethnicity, and language information at the time of recruitment.
6) Develop and include a Provider race, ethnicity, and language survey/data form as part of the LOA process to collect the data.
7) Recruit, credential, and contract with practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population.
8) Require practitioners to complete cultural competency training courses based on the racial/ethnic composition of the member population.
9) Explore possibilities to develop database fields to current database and storage.
10) Advertise diversity, disseminate and educate Providers on the University of California, Berkeley's A toolkit for recruiting and hiring a more diverse workforce, and other evidence-based publications to current Provider Network, Subdelegates, Delegates.
11) Explore considerations to launch a health care professional pipeline considerations to recruit new Medical School graduates into the network and inform career ladder/mentorship programs in the workforce.
12) Establish routine meetings schedule with providers and identify community events that allow us to enhance our understanding of the community and the needs of both the members and providers.
13) Identify accountable owner who will prepare an annual Network Adequacy Report.
    a) A similar report is generated for NCQA Health Plan Accreditation and should be used for this deliverable, adding the following considerations to ensure the DHCS intent is met.
    b) Prepare a narrative report containing a comprehensive assessment of the results, analysis, and recommendations of the aforementioned activities.

Recommendations for Other Related Deliverables

The HEO recommends the Cultural and Linguistics department or designated accountable owners assess overlap in requirements for DMHC and NCQA, leveraging existing operations, reports, and documents to support meeting the two DHCS requirements related to provider network and member's cultural needs.

1) Confirm that Cultural and Linguistic training completion is displayed in the provider directory.
2) The Plan demonstrates that it has surveyed the linguistic needs of the Plan's enrollees.
3) The Plan has identified its threshold language(s).
4) The Plan has established and implemented an LA training program for all staff who have routine contact with LEP enrollees.
5) The organization annually: assesses the cultural, ethnic, racial and linguistics needs of its members; and adjusts the availability of practitioners within its network, if necessary.
6) The organization analyzes practitioner network cultural responsiveness. The organization uses information about the demographic profile of the individuals it serves and the practitioner network to identify potential unmet needs and assesses the network's ability to deliver culturally appropriate care. The Plan must prepare a report describing practitioner demographics and assessments of identified needs.

Considerations

1) These requirements require collaboration and a deep understanding of the various relations across multiple regulators.
2) This report contains recommendations that can be applied to other lines of business.
3) Impacted areas include Cultural and Linguistics, Network, teams responsible for generating provider data, and the NCQA accreditation team.
4) Ownership gaps have been identified as a critical need to prepare operations and documents needed to demonstrate compliance.
5) NCQA reports will help partially meet these requirements. Those reports should be leveraged and augmented to include analysis of activities implemented to ensure the provider network meets the cultural needs of members and BSP is recruiting and retaining a diverse provider network.

Conclusion

This report contains an assessment and recommendations to ensure the provider network meets the cultural needs of members and BSP is recruiting and retaining a diverse provider network. The report does not contain an assessment of related Network Adequacy requirements. The HEO recommends accountable owners assess requirements for all lines of business and prepare recommendations that can be integrated across the health plan, not just specific to BSP. The HEO recommends all involved parties form a collaborative workgroup to review related work and prepare a strategic plan to meet DHCS requirements.

The HEO also recommends the workgroup prepare an action plan that considers these recommendations as these will help meet and exceed Regulator expectations. The strategic plan should be presented to the BSP Quality improvement and Health Equity Committee.

Appendix

Definitions

Covered Services means those health care services, set forth in Welfare and Institutions Code (W&I) sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq.*, 17 CCR section 6800 *et seq.*, the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the DHCS Medi-Cal Contract, and All Plan Letters (APL) that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS (DHCS Medi-Cal Contract, 2023).

Culture The shared values, ideals, and beliefs of a group of people (NCQA, 2021 HP Standards and Guidelines, Appendix 5 Glossary).

Cultural Competence The ability of practitioners and systems to respect and respond to diverse member values, beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services (NCQA, 2021 HP Standards and Guidelines, Appendix 5 Glossary).

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement (DHCS Medi-Cal Contract, 2023).

Ethnic means a large group(s) of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background (Merriam-Webster Dictionary, 2023).

Ethnicity A shared culture and way of life, especially reflected in language, religion, and material culture products and distinguishing from OMB's use of the term to mean only Hispanic ethnicity (NCQA, 2021 HP Standards and Guidelines, Appendix 5 Glossary. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," IOM, 2003).

Health Equity means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations (DHCS Medi-Cal Contract, 2023).

Linguistic is of or relating to language or linguistics (Merriam-Webster Dictionary, 2023).

Organizational Cultural Competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with Medi-Cal members from diverse cultural and linguistic backgrounds.

Practitioner A licensed or certified professional who provides medical care or behavioral healthcare services (NCQA, 2021 HP Standards and Guidelines, Appendix 5 Glossary).

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement (DHCS Medi-Cal Contract, 2023).

Promise Health Plan

Health Equity Assessment: Equity and the Redetermination Process

Responsible Health Equity Office Staff

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

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

Contents

I. Introduction and Background 3
II. Key Findings 4
III. Redetermination Process 5
Review of Process 5
Results 5
Conclusion 8
IV. References 9

I. Introduction and Background

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

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

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

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

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

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

II. Key Findings

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

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

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

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

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

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

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

III. Redetermination Process

Review of Process

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

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

Results

Ethnicity

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

Race

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

Language

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

Age

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

Conclusion

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

IV. References

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

HEART Measure Set

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

21	Perinatal Immunization Status - Tdap	Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or Deliveries where members had any of the following: • Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. •	PERINATAL IZ Tdap	NCQA	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Inovalon	Not Started	Quarterly	TBD	TBD
22	Pre term birth	Pre term birth before 37 weeks of pregnancy of babies born during the measurement period	PRETERM BIRTH	New Measure	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Claims	Not Started	Quarterly	TBD	TBD
23	Low birth weight	Birthweight of babies born during the measurement period (<1,00 grams; 1,500-2,499 grams; >2,500 grams)	LBW	New Measure	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Claims	Not Started	Quarterly	TBD	TBD
24	Breast feeding rates	Rate of breastfeeding at least 6 months following birth from all deliveries occuring during the measurement period	BRFDNG	New Measure	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Claims	Not Started	Quarterly	TBD	TBD
25	Maternal Morbidity	Rate of Maternal morbidity by REGAL during the measurement period	MAT MORB	DHCS	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Tableau	Not Started	Quarterly	TBD	TBD
26	C-section rates by REGAL	C-section rates by REGAL during the measurement period	CSCTN	DMHC, DHCS	Equitable High Quality Clinical Care	Maternal Health	Katie Abbott Nicole Evans	Tableau	Validation Complete	Quarterly	TBD	TBD
27	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
28	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
29	Colorectal Cancer Screening by REGAL	Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified	COL REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
30	Hemoglobin A1c Control for Patients with Diabetes by REGAL	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year	HBD REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
31	Controlling High Blood Pressure by REGAL	Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL	CBP REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
32	Child and Adolescent Well Care Visits by REGAL	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL	WCV REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
33	Childhood Immunization Status by REGAL	Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA);	CIS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
34	Immunizations for Adolescents by REGAL	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and	IMA REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
35	Prenatal and Postpartum Care: Postpartum Care by (REGAL)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL	PPC POST REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
36	Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL)	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL	PPC TIME REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
37	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their firs 15 months of life stratified by REGAL	W30 REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
38	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
39	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
40	Asthma Medication Ratio by REGAL	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL	AMR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
41	Potentially Preventable 30-day Post-Discharge Readmission by (REGAL)	Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL	PPR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Not Started	Quarterly	TBD	TBD
42	Care Management for High-Risk Members after Discharge	The total number of transitions for high-risk members during the Intake Period within a 12-month period.	PHM KPI 5	DMHC, DHCS CalAIM, NCQA	Equitable Social Interventions	Population Health Management	Ayesha Sharma	Claims Care Connect Risk Stratification ECM	Validation Complete	Quarterly	TBD	TBD

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

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

Equitable Structures of Care			
	Measure Description	**Measure Definition**	**Measure Acronym**
1	Complex Care Management (CCM) Enrollment Among all Eligible Members	The number of members eligible for CCM for 1 or more days within a 90-day period.	PHM KPI 4 Rate A
2	CCM Enrollment Among all Eligible Members Who Were Not Already Enrolled During the Previous Measurement Period	The number of members eligible for CCM for 1 or more days within a 90-day period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.	PHM KPI 4 Rate B
3	Enrollment Growth by REGAL	Enrollment growth stratified by REGAL during the measurement period	ENR REGAL
4	Bilingual calls managed by Call Center	Call center number of internal bilingual calls by member's preferred language during the measurement period	CALL CTR BLNGL
5	Multi-lingual staff	Total number of multi-lingual staff during the measurement period	MUL STAFF
6	PCP Staff Training	Compliance rate for all FSRs completed assessing FSR section "Site personnel receive training on member rights" performed during measurement period	PCP TRNG
7	Cultural Competency Training	Cultural competency training – internal completion rate by member-facing staff	CULT COMP TRNG
8	Health Education Materials	Health Education materials available in all threshold languages during the measurement period; and Percent of health ed materials	HEALTH ED
9	Member-facing staff representative of membership	Rate of bilingual member-facing health plan staff by language is representative of membership during the measurement period	BLNGL STF
10	Provider Network by Threshold Language	Percent of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area – i.e. X% speak threshold languages (per geographic area)	PROV NTWK LANG
Overall Well-Being			
	Measure Description	**Measure Definition**	**Measure Acronym**
11	Depression Screening and Follow up for Adolescents and Adults by REGAL	Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period	DSF REGAL
12	Perinatal Depression Screening	Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period	PND
13	Postpartum Depression Screening and follow-up	Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. during the measurement period	PDS
14	Positive maternal mental health screening	Positive maternal mental health screening results by REGAL during the measurement period	MMH POS
Equitable Access to Care			
	Measure Description	**Measure Definition**	**Measure Acronym**
15	Members Utilizing Emergency Department Care More than Primary Care	The total number of members who had more emergency department (ED) visits than primary care visits within a 12-month period.	PHM KPI 1
16	Members Engaged in Primary Care	The number of members who had at least one primary care visit within a 12-month period.	PHM KPI 2
17	Members Not Engaged in Ambulatory Care	The number of members with no ambulatory or preventive visit within a 12-month period.	PHM KPI 3
18	Disnerollment by REGAL	Voluntary disenrollment by REGAL during the measurement period	DISENR REGAL

19	Redetermination Rate by REGAL	Redetermination rate of members reinstated by REGAL during the measurement period	REDET REGAL
20	CRC Reach by REGAL	Number of Blue Shield members served Community Resource Centers during the measurement period	CRC REGAL
21	Interpreter service utilization	Number of Language line interpreter service requests by language during the measurement period	INT SVC UTIL
22	Translated documents	Number of translated documents by language or alternative format during the measurement period	TRNSLTD DOCS
23	Physical Accessibility	Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period	PARS
24	IHA Completion	IHA completion rate stratified by REGAL during the measurement period	IHA
25	DPP Enrollment by REGAL	DPP enrollment by REGAL during the measurement period	DPP REGAL
26	Getting Needed Care	Getting Needed Care by REGAL during the measurement period	GNC REGAL
27	Getting Care Quickly by (REGAL)	Getting Care Quickly by REGAL during the measurement period	GCQ REGAL
Equitable Social Interventions			
Measure Description		**Measure Definition**	**Measure Acronym**
28	Care Management for High-Risk Members after Discharge	The total number of transitions for high-risk members during the Intake Period within a 12-month period.	PHM KPI 5
29	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH
30	Populations of Focus	Percent of members stratified into each populations of focus	POF
31	Community Support utilization	Community support utilization by category	CS UTIL
Equitable High-Quality Clinical Care			
Measure Description		**Measure Definition**	**Measure Acronym**
32	Overturned appeals stratified by race and ethnicity	Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period	APP-RE
33	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL
34	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL
35	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL
36	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life stratified by REGAL	W30 REGAL
37	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL
38	Colorectal Cancer Screening by REGAL	Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified by REGAL	COL REGAL
39	Hemoglobin A1c Control for Patients with Diabetes by REGAL	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year	HBD REGAL

40	Controlling High Blood Pressure by REGAL	Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL	CBP REGAL
41	Asthma Medication Ratio by REGAL	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL	AMR REGAL
42	Child and Adolescent Well Care Visits by REGAL	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL	WCV REGAL
43	Childhood Immunization Status by REGAL	Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday during the measurement period stratifed by REGAL	CIS REGAL
44	Immunizations for Adolescents by REGAL	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates during the measurement period stratified by REGAL	IMA REGAL
45	Potentially Preventable 30-day Post-Discharge Readmission by (REGAL)	Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL	PPR REGAL
46	Prenatal and Postpartum Care: Postpartum Care by (REGAL)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL	PPC POST REGAL
47	Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL)	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL	PPC TIME REGAL
48	EPSDT Preventive Utilization Gap	Percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period stratified by REGAL	EPSDT UTIL GAP
49	C-section rates by REGAL	C-section rates by REGAL during the measurement period	CSCTN
50	Maternal Morbidity	Rate of Maternal morbidity by REGAL during the measurement period	MAT MORB
51	Perinatal Immunization Status - Flu	Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date; or Deliveries where members had an influenza virus vaccine adverse reaction any time during or before the Measurement Period.	PERINATAL IZ FLU
52	Perinatal Immunization Status - Tdap	Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or Deliveries where members had any of the following: • Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. • Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis) any time during or before the Measurement Period.	PERINATAL IZ Tdap

53	NICU Admits	Rate of newborns of babies born during the measurement period to prenatal care patients aditted to the Neonatal Intensive Care Unit upon birth	NICU ADMITS
54	Pre term birth	Pre term birth before 37 weeks of pregnancy of babies born during the measurement period	PRETERM BIRTH
55	Low birth weight	Birthweight of babies born during the measurement period (<1,00 grams; 1,500-2,499 grams; >2,500 grams)	LBW
56	Breast feeding rates	Rate of breastfeeding at least 6 months following birth from all deliveries occuring during the measurement period	BRFDNG
57	Pregnancy Mortality Surveillance System (PMSS)	Pregnancy Mortality Surveillance System (PMSS) definition: A pregnancy-related death as a death while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy.	PMSS REGAL
Equitable Experiences of Care			
Measure Description		**Measure Definition**	**Measure Acronym**
58	Grievances stratified by race and ethnicity	Grievance category stratified by race and ethnicity for all grievances received during the measurement period	GRV-RE
59	Discrimination-related grievances	Percentage of Discrimination grievances based on all grievances received during the measurement period	DISC GRV
60	C&L grievances	Percent of C&L grievances (discrimination-related, interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period	C&L GRV

HEART Measure Set																
No.	**Measure Description**	**Measure Definition**	**Measure Acronym**	**Measure Steward**	**Health Equity Framework Domain**	**Responsible Functional Area**	**Responsible Owner(s)**	**Subject Matter Expert (SME)**	**Responsible Person for Data Report Pull/Submission to**	**Report Source**	**Reporting Frequency**	**Baseline**	**Target**	**Data Link**	**Notes**
1	ED Utilization	Members who had more ED visits than primary care visits within a 12-month period by REGAL during the measurement period	ED UTIL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan	Natalie Johnstone	Paige Brogan		Quarterly	TBD	TBD		REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5
2	PCP Utilization	Members who had a primary care visit within a 12-month period by REGAL during the measurement period	PCP UTIL	DMHC, DHCS CalAIM, EPSDT, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan	Natalie Johnstone	Paige Brogan		Quarterly	TBD	TBD		REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5
3	Preventive Care Access	Percentage of members with no ambulatory or preventive visit within a 12-month period	PREV UTIL	DMHC, DHCS CalAIM, NCQA	Equitable Access to Care	Cal AIM	Paige Brogan	Natalie Johnstone	Paige Brogan		Quarterly	TBD	TBD		REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5
4	Transitions and Care Manager Interaction	Transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge. by REGAL during the measurement period	TOC	DMHC, DHCS CalAIM, NCQA	Equitable Social Interventions	Cal AIM	Paige Brogan	Natalie Johnstone	Paige Brogan		Quarterly	TBD	TBD		REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5
5	CCM Enrollment	Members eligible for CCM who are successfully enrolled in the CCM program by REGAL during the measurement period	CCM ENR	DMHC, DHCS CalAIM, NCQA	Equitable Structures of Care	Cal AIM	Paige Brogan	Natalie Johnstone	Paige Brogan		Quarterly	TBD	TBD		
6	EPSDT PCP Utilization	Members ages 0-20 who had a primary care visit within a 12-month period by REGAL during the measurement period	EPSDT UTIL	DMHC, DHCS CalAIM, EPSDT	Equitable High-Quality Clinical Care	Clinical Access Programs	Jesse Brennan-Cooke	Sherri Callahan	Brigitte Lamberson	CMS-416	Quarterly	TBD	TBD		
7	Cultural competency-related grievances	Percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period	CULT COMP GRV	NCQA	Equitable Experiences of Care	Appeals and Grievances	Lorraine Greywitt	Allan Shin	Allan Shin	834 file + Grievance universe file	Quarterly	TBD	TBD		A&G do not track this measure; no code to distinguish this. HECL team confirm they track similar metric. Need to confirm this is duplicative to Linda Fleischman's measure.
8	Maternal Mental Health Screening Referral	Rate of members with positive maternal mental health screening referred to behavioral health services during the measurement period	MMH REF	DMHC, DHCS	Equitable Social Interventions	Behavioral Health	David Bond	David Bond	Gi Villavicencio	Gi Villavicencio	Manual Report	TBD	TBD		Suggestion to pend until reporting is resolved; BH confirmed limited referral data, members can call BH number on member card without a referral. Can only track Code and Screening encounters (90-
9	Plan All-Cause Readmissions by (REGAL)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis	PCR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Alyson Spencer Christine Nguyen Paige Brogan Ayesha Sharma	Christine Nguyen	Brigitte Lamberson	Christine Nguyen (Inovalon Vendor)	TBD	TBD		

Appendix 4: Quality Improvement Health Equity Transformation Program Action Plan

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

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

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

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

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

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

Customer Care Conversation Guide

Using Sexual Orientation and Gender Identity (SOGI) Inclusive Language Over the Telephone

Purpose

Effective March 28, 2024, fields reporting sexual orientation and gender identity will be made available in Shield Advisor. Staff interacting with members are encouraged to use members' preferred pronouns to enhance engagement with members.

This conversation guide is to help you create a safe space, welcoming environment, and speak respectfully to our members using their preferred pronouns. This sensitivity extends to members who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA+).

Please note that a more robust training on Diversity, Equity, Inclusion and Cultural Sensitivity will be provided in addition to this initial training.

Regulatory Requirements

- National Committee for Quality Assurance (NCQA) Health Equity (HE) 2, requires that Blue Shield of California gather individuals' race/ethnicity, language, gender, identity, and sexual orientation data that helps provide culturally and linguistically appropriate services (CLAS).
- Assembly Bill (AB) 133 requires all "specified entities" to "exchange health information or provide access to health information to and from" other specified entities in real-time, as defined in the bill.

General Guidelines

As health care professionals we strive to establish solid, trusting relationships with our members to promote healthy behaviors. As with other minority groups, when working with LGBTQIA+ members, it is important to build rapport to counteract the exclusion, discrimination, and stigma that many have experienced previously in health care[i].

Communication Strategies and Scripts - Summary of Best Practices (Review with Team)	
Best Practice	**Example**
When addressing new/existing members, avoid pronouns or gender terms like "sir" or "ma'am."	How may I help you today?
When talking to coworkers about new/existing members, also avoid pronouns and gender terms. Or use gender-neutral words such as "they." Never refer to someone as "it."	"The member is waiting on hold on the line." "They are calling because [insert reason]."
If you are unsure about a member's preferred name or pronouns, ask politely and privately.	"What name and pronouns would you like us to use?" "I would like to be respectful—how would you like to be addressed?"
Ask respectfully about names if they do not match in your records.	"Could your record be under another name?"

Avoid asking for a person's "real" name. Patients may feel offended because these terms assume that their preferred names are not real.	"What is the name on your insurance?"
Ask only for information that is required.	Ask yourself: • What do I know? • What do I need to know? • How can I ask in a sensitive way?
Avoid saying "Thank you, dear/honey/sir/ma'am."	Instead say, "Thank you."
Did you make a mistake? Apologize.	"I apologize for using the wrong pronoun. I did not mean to disrespect you."
Avoid These Terms! **Stop! Avoid these terms! Some terms are considered offensive or outdated.** **Avoid using these:**	**Go! Use these instead! Some acceptable terms are:**
Transgendered	Transgender or trans
He-she, she-male, it	He, she, they (or ask)
Transvestite, transsexual, tranny*	Transgender, or however that person describes themselves
*Although often considered derogatory, some transgender people use these terms in a positive way to describe themselves or others. Reference: Centers for Disease Control and Prevention (CDC). Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings.	

Sample Case Scenario (Review with Team)	
When Rey calls to make a change to their assigned Primary Care Provider, the call center staff person assumes she is talking to a young man. So, she asks Rey, "How may I help you, sir?" Even though these greetings are often considered a polite way to speak with a patient, how a person sounds or looks may not align with how they identify. We know that Rey identifies as non-binary, meaning that they neither identify as a man or a woman.	What could the call center staff person say instead? Simply use a positive tone and say, "How may I help you?" Gendered words and phrases like sir, ma'am, young man, and young lady are commonly used. However, they are not necessary to maintain politeness or communicate your message.

Tips for Using Inclusive Language (Review with Team)

1. Using a warm tone can help a member feel supported and heard while discussing potentially sensitive issues with us.
2. Avoid assumptions about the gender identity, sexual orientation, and health behaviors of our members.
3. Avoid gendered language like sir, ma'am, young man, or young lady. As discussed during Rey's scenario
4. Use a member's chosen name and pronouns at all times. This includes when we're speaking with a member or about them – for example, when coordinating a member call with a colleague as we saw in the scenario.
5. If we make a mistake, we can offer a sincere and brief apology. Over-apologizing or dwelling on the mistake can make a patient feel uncomfortable.

Frequently Asked Questions (Read Prior/After – ask for clarification if you have questions)

1. **What is a pronoun?**

   A pronoun is a word that refers to either the people talking ("I" or "you") or someone or something that is being talked about (like "she", "it", "them", and "this"). Gender pronouns (he/she/they/ze etc.) specifically refer to the person you are referring to.

   Pronouns are part of someone's gender expression, and people can have multiple sets of pronouns for themselves (such as using both he/him/his and they/them/theirs). Pronouns are not "preferred" but instead are required for respectful communication. Not only transgender or nonbinary communities use pronouns, as it is something we all use from a young age.

2. **How do I ask someone what pronouns they use?**

If a term that a member uses is unclear or requires clarification, ask the member what pronoun they use in an open and respectful manner.

Try asking: “What pronouns do you use?” or “Can you remind me what pronouns you use?” It can feel awkward at first, but it is not half as awkward as making a hurtful assumption.

It is important to remember that by consistently asking people for their pronouns, you can help create a more normalized and safe way for others to share their pronouns, which they may not have been able to do before.

If someone does not share their pronouns, use their name as a placeholder.

3. What if I make a mistake?

Sometimes mistakes happen, and simple apologies can go a long way. If a slip occurs, it is fine to say something like, “I apologize for using the wrong pronoun/name. I did not mean to disrespect you,” and move on.

4. Why is it important to respect people’s pronouns?

You can’t always know what someone’s pronouns are over the telephone. Asking and correctly using someone’s pronouns is one of the most basic ways to show your respect for their gender identity.

When someone is referred to with the wrong pronoun, it can make them feel disrespected, invalidated, dismissed, alienated, or dysphoric (often all the above). All major professional American psychological and psychiatric associations recognize that inclusive language usage for LGBTQIA+ youth and adults drastically decreases experiences of depression, social anxiety, suicidal ideation, and other negative mental health factors.

It is a privilege to not have to worry about which pronoun someone is going to use for you based on how they perceive your gender. If you have this privilege, yet fail to respect someone else’s gender identity, it can be considered disrespectful and hurtful, but also oppressive.

Purposefully misgendering (using the wrong pronouns, ignoring someone’s pronouns in use, or using incorrect gendered language for someone) is offensive and disrespectful to anyone, but especially to trans and gender non-confirming individuals.

5. What are some commonly used pronouns?

She/her/hers and he/him/his are a few commonly used pronouns. Some people call these “feminine” and “masculine” pronouns, but many people avoid these labels because not everyone who uses he/him/his feels “masculine” and not everyone who uses she/her/hers feels “feminine”.

There are many other pronouns in use, some of them more gender neutral. See the table below for examples of pronouns you may hear people use.

Examples of gendered pronouns, gender-neutral pronouns and neo-pronouns				
	Subject	Object	Possessive	Pronunciation
Female Pronouns	she	her	hers	shee, her, herz
Male Pronouns	he	him	his	hee, him, hiz
Gender-Neutral Pronouns	they	them	theirs	tha, them, therz
	ze*	zim*	zirs*	zee, zim, zeer
	sie/zie*	hir*	hirs*	zee, heer, heers

* Not currently in Shield Advisor. These are denoted as they/them/theirs in our system currently.

Some people also use more than one set of pronouns. This can be denoted as "they/she" or "they/them/theirs and she/her/hers". When someone uses multiple sets of pronouns, it could mean that they are okay with either one being used, or that they accept both, but have a preference towards the one that is listed first.

If you have any questions, respectfully ask the person. A person of any gender can use multiple sets of pronouns.

6. **I feel uncomfortable asking people about their sexual orientation or gender identity. What if I offend someone?**

   Most people recognize the usefulness of asking demographic information, including SOGI. While some individuals will refuse to answer questions, they consider too personal, research has shown that survey respondents are twice as likely to refuse to answer questions about income as about sexual orientation.

   Don't make a big deal about asking SOGI measures. If someone asks you why you're asking the question, you can let them know that you're required by law to ask about SOGI, that discrimination based on a person's sexual orientation or gender identity is against the law in California and that the information will not affect eligibility for programs.

Glossary of Terms **(Read Prior/After – ask for clarification if you have questions)**

Agender or non-binary: transgender or gender nonconforming person who identifies as neither male nor female or can be seen as a statement of not having a gender identity.

Cisgender: Cisgender people are those whose gender identity and assigned sex at birth correspond (i.e., a person who is not transgender).

Gender identity: A person's internal sense of being a man/male, woman/female, both, neither, or another gender.

Gender expression/role: The way a person acts, dresses, speaks, and behaves (i.e., feminine, masculine, androgynous). Gender expression does not necessarily correspond to listed sex at birth or gender identity.

Gender nonconforming: Describes a gender expression that differs from a given society's norms for males and females. A gender nonconforming person is not necessarily transgender.

Genderqueer: A relatively new term, used by some individuals who do not identify as either male or female; or identify as both. Other terms include gender variant, gender expansive, gender fluid, and non-binary.

Gender expansive: People who do not identify with traditional gender roles—masculine and feminine. People who describe themselves as gender expansive can identify in many different ways, such as a third gender, no gender, more than one gender, or a "fluid" gender.

Latinx: Used as a gender-neutral or non-binary alternative to Latino or Latina.

Transgender: Transgender people are those whose gender identity and assigned sex at birth do not correspond. Transgender is also used as an umbrella term to include gender identities outside of male and female. Transgender is sometimes abbreviated as trans. Some of the terms used to describe populations within the transgender community are:

Transgender/trans man; female-to-male (FTM): People whose assigned sex at birth is female and whose gender identity is male may use these terms to describe themselves. Some will simply use the term man.

Transgender/trans woman; male-to-female (MTF): People whose assigned sex at birth is male and whose gender identity is female may use these terms to describe themselves. Some will simply use the term woman.

Transsexual: The term transsexual is sometimes used in medical literature to describe those who have transitioned through medical interventions. Some transgender people prefer to describe themselves as transsexual; however, many consider the term to be outdated or derogatory. We advise that providers avoid this term, unless a patient explicitly requests to be referred to as transsexual.

Transition process: For transgender people, this refers to the process of coming to recognize, accept, and express one's gender identity. Most often, this refers to the period when a person makes social, legal, and/or medical changes, such as changing their clothing, name, or sex/gender

designation on legal documents or using medical interventions such as hormone therapy or surgeries.

Sexual orientation: Sexual orientation is distinct from gender identity. A helpful concept to remember is that gender identity and sexual orientation are not the same. A person's sense of their gender is not related to who they are attracted to. It is important to remember that whenever possible, it is best to ask, we cannot make assumptions.

Sexual orientation is how a person describes their emotional, romantic, and sexual attraction to others.

- Straight (not lesbian or gay) describes women who are attracted to men and men who are attracted to women.
- Lesbian describes a woman who is attracted to other women.
- Gay describes a person who is attracted to people of their own gender. Most commonly this term is used when referring to men who are attracted to men but may be used interchangeably with lesbian for women who are attracted to other women.
- Bisexual describes a person who is attracted to more than one gender. This can include men, women, and people of other gender identities.
- Pansexual describes a person who is emotionally and physically attracted to people of all gender identities, or whose attractions are not related to other people's gender.
- Asexual describes a person who experiences little or no sexual attraction to others. Asexual people may still engage in sexual activity.
- Transgender people can be any sexual orientation (gay, lesbian, bisexual, heterosexual/straight, no label at all, or some other self-described label).
- Queer is an umbrella term to describe people who think of their sexual orientation or gender identity as outside of societal norms.

Resources

1. Assembly Bill (AB) 133. Health. Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB133
2. Centers for Disease Control and Prevention. Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings. Retrieved from https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/affirmative-care.html#communicationstrategies
3. Department of Managed Healthcare (DMHC). SOGI Data Collection. Retrieved from https://www.dmhc.ca.gov/Portals/0/Docs/20220324_SOGI_DataCollection.pdf
4. Human Rights Campaign Foundation. Resources. Retrieved from https://welcomingschools.org/resources/definitions-gender-sexual-orientation
5. Lane County Oregon. Train the Trainer Manual. How to Ask. Measuring Health Equity – Demographic Data Collection in Lane County & Human Services. Retrieved from https://cdnsm5-hosted.civiclive.com/UserFiles/Servers/Server_3585797/File/Government/HHS/LaneCare/CRW%20-%20Families/How%20to%20Ask-%20Train%20the%20Trainer%202019.03.13.pdf
6. Massachusetts Transgender Political Coalition. Pronouns Guide. Retrieved from https://www.masstpc.org/pronouns/#:~:text=Ze%20%2F%20Zim%20%2F%20Zir%20%2F%20Zirs%20%2F,is%20zirs.%20%2F%20Ze%20is%20looking%20at%20zirself
7. National Committee for Quality Assurance (NCQA) Health Equity Accreditation. Health Equity (HE) Standard 2.
8. National LGBTQIA+ Health Education Training Center (2018). Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios. Retrieved from learning-to-address-implicit-bias-towards-lgbtq-patients-case-scenarios.pdf
9. National LGBTQIA+ Health Education Training Center. SO/GI Data Collection Demonstration Videos retrieved from https://www.lgbtqiahealtheducation.org/courses/so-gi-data-collection-training/
10. Pride Training. Pronouns 101. Retrieved from https://www.pridetraining.org.au/pages/pronoun-page
11. Public Health Awakened (2017). Scripts and Resources to Protect Transgender Rights. Retrieved from https://publichealthawakened.org/scripts-and-resources-to-protect-transgender-rights/
12. The Trevor Project. Resource Center. Retrieved from https://www.thetrevorproject.org/resources/
13. Transgender Training Institute. TTI's Guide to Pronouns. Retrieved from https://www.transgendertraininginstitute.com/resources/pronouns/
14. University of California Davis. LGBTQIA Resource Center. Retrieved from https://lgbtqia.ucdavis.edu/educated/glossary#:~:text=LGBTQIA%2B%3A%20Abbreviation%2 0for%20Lesbian,the%20community%20as%20a%20whole.
15. University of Wisconsin. Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) Resource Center.

[i] National LGBT Health Education Center, 2018