Quality Improvement and Health Equity Committee
Quarter 2, 2025 Summary Report

Background

The purpose of this report is to summarize the Blue Shield of California Promise Health Plan (BSCPHP, BSC Promise, or Blue Shield Promise) Quality Improvement and Health Equity Committee (QIHEC) activities, findings, recommendations, and actions that are prepared after each meeting. The QIHEC reports to the Medi-Cal Committee who reports to the Blue Shield of California Board of Directors via consent agenda, and to DHCS upon request. A written summary of the QIHEC activities is made publicly available on the Plan's website at least on a quarterly basis.

Summary of QIHEC Activities

The Blue Shield Promise QIHEC meeting was called to order on Thursday, June 26, 2025, by the Chairperson, Valerie Martinez, Chief Health Equity Officer (CHEO) via telephone conference.

Document Review and Approval (Pre-reads)

The Quality Improvement and Health Equity Transformation Program (QIHETP) program documents were circulated to voting committee members for review and approval via email prior to the meeting. The following documents were approved by voting committee members:

- BSC Promise QIHEC Meeting Minutes Q1 2025
- BSC Promise QIHEC 2025 Work Plan Q2 2025
- HEQ-001: QIHETP Policy and Procedure
- HEQ-002: QIHEC Policy and Procedure
- HEQ-003: Diversity, Equity, and Inclusion (DEI) Training Program Requirements
- HEQ-003: Attachment DEI Training Selection Criteria Guidelines
- HEQ-003: Attachment DEI Training Delegates Grid
- QIHETP Annual Evaluation Report Year (RY) 2025

Health Equity Advancements Resulting in Transformation (HEART) Measure Set

Eduardo Delgado, Health Equity Principal Program Manager, presented quarterly action items and status updates regarding the HEART Measure Set, including the following: 1) Socializing the HEART Dashboard internally, with key stakeholders receiving training and access to the platform. Tracking requested enhancements (members unhoused or receiving doula services) to improve usability and ensure alignment with organizational goals; 2) The Health Equity Office (HEO) prepared its first disparity analysis, complete with statistical reviews, trend analysis, and collaboration from subject matter experts (SME) to establish a foundation for actionable insights; 3) Finalized a quarterly report template, incorporating key metrics from the HEART Dashboard, also featuring a structured format that includes sections for data summaries, analysis, and

recommendations. The template has been distributed to respective teams for input and finalization; and 4) The Comprehensive Disparity Analysis report is complete and ready for review. The report features analysis of 52 metrics including data visualizations, key takeaways, and discussion on next steps.

Eduardo presented a thorough disparity analysis of specific measures including a review of findings, results, and key takeaways for each metric presented. Disparity analysis included disaggregated data by race/ethnicity, age, and/or language for the following measures, reference Table 1 below and Appendix 1.

Table 1. HEART Measure Set Disparity Analysis

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

	Black and Native American persons by 50%.		**significantly less prenatal visit rates**. No significant disparities are present when assessing Age and Language.	**prenatal visit in their first trimester or within 42 days of enrollment**. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Arabic, and Tagalog speaking members.	
4. Postpartum Care	Percentage of deliveries with a postpartum visit between 7 and 84 days post-delivery.	PPC POST REGAL	Los Angeles and San Diego's Unknown, Other, Asian, and Black or African American members are significantly behind other racial/ethnic groups in completing a postpartum care visit. Upon further analysis, **Black/AA members ages 15-24 years have substantially lower completion rates (50.0%) compared to other age groups (25-34 years, 69.6%; 35-44 years, 79.3%).** There are no significant differences across Age and Language.	78.3% of members have completed the postpartum visit within 7 and 84 days post-delivery. Half, 50.0%, Black/AA members ages 15-24 years have not had a postpartum care visit. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Chinese, and Armenian speaking members.	Significant disparities are identified across the Black or African American population including all Black or African American age groups, confirming DHCS' focus as a Bold Goal priority population.
5. Child and Adolescent Well-Care Visits	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL. This is also a Bold Goal metric - Close racial/ethnic disparities in well-child visits and immunizations by 50%.	WCV REGAL	Los Angeles and San Diego counties' **ALL racial/ethnic groups have a significant disparity in completing WCVs**. Members aged 15-21 have a significant disparity in completing well-care visits. Farsi-speaking members have the highest completion rate (58.3%) and Spanish speakers have higher rates (57%) compared to English speakers (43.7%)	Half, 49.8%, of all members ages 3-21, had at least one comprehensive well-care visit. Black or African American and American Indian, Native Hawaiian and White members AND members ages 20-21 and members whose preferred language is Vietnamese and Korean have the lowest rates.	All race/ethnicity groups are flagged as disparate, suggesting potential underutilization or barriers. The significant decline in rates for the 15-21 age group compared to younger age groups. This could indicate reduced engagement with healthcare services during adolescence, possibly due to factors like independence, lack of awareness, or access issues. Spanish speakers have higher rates (57%) compared to English speakers (43.7%), suggesting no disparity and possibly better support, outreach, or access for Spanish-speaking groups.
6. Hemoglobin A1c Control for Patients with Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8% during the measurement year.	HBD REGAL	Los Angeles and San Diego counties' **none of the Racial/Ethnic or Language groups have a significant disparity in completing diabetes control**. Members ages 18-19 (272 total members) do have a significant disparity in diabetes control. Arabic, Cambodian, Tagalog, Vietnamese, and Farsi-speaking members have the highest control rates, well	Just over half, 52.8%, of all members have Hemoglobin A1c control for diabetes. The only population falling below the MPL is members ages 18-19.	Race/ethnicity, language, and county show variations in control rates, but these are not flagged as significant disparities (no red bars), suggesting that these factors may not have a strong independent effect on outcomes after controlling for other variables. **Focus population should include the 272 members ages 18-19 with uncontrolled diabetes.**

			above the Minimum Performance Level (MPL).		
7. Follow-Up After Emergency Department (ED) Visit for Mental Illness	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. This is also a Bold Goal metric - Improve follow up for mental health and substance use disorder by 50%.	FUM REGAL	**Disparities identified across Race/Ethnicity, Age, and Language.** Los Angeles and San Diego counties' race/ethnicity groups are all significantly lower, except for the Middle Eastern/North African population. All age groups are noted as having a disparity. Additionally, all Language populations are significantly lower, except Chinese and Korean-speaking members.	Overall, 35% of all members receive follow-up after mental illness.	These disparities present across Race/Ethnicity, Age, and Language indicate a systemic issue such as coordination of care following an ED visit for mental illness.

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

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

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

enhanced outreach, age-specific programs, and addressing county-level differences are essential to improve screening rates, care engagement, and overall health equity. The Blue Shield

Promise HEO will remain data-transparent and share data results with teams who can impact the rates; take a data-informed approach using the data to drive strategic planning and interventions; and expand the analysis to assess for trends across individual race/ethnicity, age, and language for all metrics within the HEART measure set.

Health Equity Integration Plan Updates

Alexis Duke, Health Equity Business Analyst, presented Health Equity Integration Plan updates across the functional areas including: 1) Quality; 2) Health Education and Cultural and Linguistic Services; 3) Utilization Management; 4) Population Health Management; 5) Medical Services; 6) Community Engagement; 7) Provider Network; and 8) Grievances and Appeals. Across the functional areas there are a total of 36 activities, and 12 of those activities are completed totaling a 33% completion rate as of Quarter 2. This is an improvement as last quarter was 26% completion rate. Examples of activities include staff training, health education classes, listening sessions and incorporating race, ethnicity, gender, language and age into strategic planning for these activities. Figure 1 below, details the health equity integration plan activities spanning across the health plan that align with the Quality Improvement and Health Equity Transformation Program tenets.

Figure 1. Health Equity Integration Plan Activities

Cultivate a culture of equity	*Reimagine the member experience*	*Link Quality and Equity*	*Facilitate the Bridge to Somewhere*	*Optimize integration using real-time data*	*Develop diverse network*	*Demonstrate information in action*	*Expand community presence*	*Center community in our strategy*	*Listen deeply*
• Staff Training- Advancing Health Equity • Expand provider training to include health equity topics • Health Equity Office to train UM leaders in the Diversified Talent Acquisition Toolkit	• Implementing Lucina and Maternity Care Team operations • Add availability of ASL interpretation to health education materials • Translate updated health education referral letter into all threshold languages • Increase availability of health education materials in threshold languages	• Host well-child visits in Los Angeles and San Diego in areas with highest need • Host mobile mammogram events	• Include SDOH assessments in Quality Health Partners visits • Diabetes Management Health Education classes among members diagnosed with Diabetes	• Offer health education classes in multiple languages leveraging member data • Include C-section disparities between Black and White birthing people in the over/under utilization analysis • Stratify overturned appeals by REGAL during measurement period • Outreach calls for identified care gap measures	• Well Child Visits health disparity Performance Improvement Project • Pilot Skilled Nursing Facility preferred placement arrangement from acute setting due to social and health disparities • Obtain data on member and provider ethnic and racial background to evaluate network needs • LGBTQ+ Network enhancements to expand services	• Partner with LA County Doula Hub and community partners supporting doula Hub implementation • Implement staff training on Writing in Plain Language and Readability Assessment • Health Equity Office to review Grievance and Appeals member letters for equity lens and develop process	• Implement health education classes at Community Based Organizations and faith-based sites in San Diego County • Marketing plan integrates health equity focus to identify events and communities in need	• Community Advisory Committee features health equity approaches to inclusion and program planning	• Host listening sessions to inform member and family engagement strategy

Health Equity Integration Plan activities span across the health plan and align with Health Equity Program tenets and regulatory trajectory

The CHEO will present updates to the Health Equity Oversight Committee (HEOC) and a summary report to the Medi-Cal Committee. The HEO tracks activities by using a Health Equity Dashboard. Meetings with the HEO now include quarterly disparity data review, comprehensive reports that pinpoint disparities, and the teams determine action. Each functional area sends monthly progress reports with updates to the Blue Shield Promise HEO. Monthly meetings are held between the HEO and each functional team to review progress and capture health equity narratives. Each leader presents their health equity integration plan and progress to the quarterly Medi-Cal Performance and Operations Driver (POD) meeting Quarterly

Health Equity Spotlight: Member Incentive Program

Lisa Chadwell, Principal Program Manager, Blue Shield Promise Business Development and Program Implementation Department, presented on Blue Shield Promise' new value-added benefits for mothers and babies.

The program is a new initiative designed to support expecting/new parents, and newborns with their mental and physical health through the first year of life with a focus on early engagement, preventive care, and access to essential resources. The program begins by enrolling expectant parents during pregnancy, connecting them to both prenatal and value-add services. A key feature is the Mom and Baby Bag—a newborn supply kit delivered around the time of birth, ideally at the birth location. This touchpoint allows staff to assess additional needs such as housing or food insecurity, Women, Infants and Children (WIC) federal assistance program enrollment, car seat access, or pediatric care setup. Another major component is diaper supply support, where members receive four $100 Amazon vouchers over 12 months, redeemable through a custom catalog. These vouchers are tied to healthcare milestones, such as well-child

visits and postpartum care. Members attest to the milestones they have completed by calling in with provider details, after which they receive an Amazon email to redeem their voucher. The flexibility of Amazon's shipping options ensures that supplies are delivered directly to members, even if they are staying at temporary addresses. Overall, the program aims to build strong early connections with families, promote preventive care, and reduce barriers to essential baby supplies and services.

The program is designed to promote preventive care, reduce barriers to essential baby supplies, and foster early engagement with new parents. QIHEC feedback from attendees was positive, highlighting the program's creativity and alignment with the real needs of families. Future enhancements may include expanding the catalog and exploring additional community partnerships.

Regulatory Updates

The mandatory DEI Medi-Cal training entitled the *2025 Advancing Health Equity: Training to Support Member Interactions* internal training for all staff was released on March 3, 2025. Blue

Shield Promise has reached a 99% completion rate. Blue Shield Promise released the external Provider facing training, 2025 Advancing Health Equity training on the new Blue Shield of California Provider Learning Center platform on April 28, 2025. Blue Shield Promise has reached a 2% completion rate.

In addition, the new Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training as set forth by All Plan Letter 24-017 and Senate Bill 923 was released on April 1, 2025, to internal member-facing staff. The training is entitled *Improving the Healthcare Experience for the Transgender, Gender Diverse, and Intersex Community*. Blue Shield Promise has reached a 54% completion rate.

Blue Shield Promise continues to work through implementing new operational processes across All Plan Letters to ensure compliance with all regulatory guidelines.

I have HEART Advocate Program

The **I HAVE HEART Advocate Program** supports Blue Shield Promise's Quality Improvement and Health Equity Transformation Program efforts by fostering a culture of equity across the organization. Launched in March, the program is now in its second cohort, engaging 62 participants over a six-month period. HEART Advocates participate in monthly meetings, volunteer events, and interactive training strategies that are focused on health equity, cultural humility, and social determinants of health. Activities to date include one-on-one sessions with the CHEO, peer discussions, food bank and Well Child Clinic volunteering, and invitation to attend a QIHEC meeting. The program also offers leadership coffee chats and

safe spaces for reflection on current events. HEART Advocates are encouraged to apply their learnings in their roles and departments, with feedback collected after each session to assess impact. The program aims to develop subject matter experts who champion equity internally, with plans underway to explore external expansion. The current cohort concludes in August, with final outcomes to be shared in the next committee meeting.

Health Equity Performance Dashboard

Valerie Martinez presented on the 2025 Health Equity Performance Dashboard and accomplishments through Quarter 2, 2025 (Figure 1). The HEO will continue to track the goals and objectives for calendar year 2025, which focuses on maintaining NCQA Health Equity Accreditation, ensuring contract compliance is met, continually building and integrating a culture of equity across the organization. Figure 2 details the HEO progress to date.

Figure 2. 2025 Health Equity Performance Dashboard

Goal	Objective	Quarterly Report	Q1	Q2	Q3	Q4
Maintain Health Equity Accreditation	Complete 100% of all Health Equity Accreditation activities as required by 12/31/2025	Rate of standards met	NA - No action needed in Q1	NA - No action needed in Q2		
Ensure contract compliance	100% of health equity related contract deliverables will be compliant by 12/31/2025	Rate of deliverables met	100%	99% (DHS AIR for PHM report)		
	Operationalize 100% of requirements to launch Diversity Equity and Inclusion training program by 12/31/2025	Percent readiness toward complete program launch	56%	60%		
	At least 30% of network providers complete Diversity Equity and Inclusion training by 12/31/2025	Rate of training completion	NA - Training release date 4/25/25	2%		
Build and Integrate a Culture of Equity	90% of finalized Health Equity Integration Plan activities will be completed by 12/31/2025	Rate of integration plans completed	27%	33%		
	Member social drivers of health data collection increases by 5% by 12/31/2025	Rate of social drivers of health collected per member	1.6%	2.1%		
	H.E.A.R.T. advocate program survey yields >90% participant report of value added upon program completion	Satisfaction rate upon program conclusion	NA	NA - No action needed in Q2		

Actions

The committee will continue to present QIHETP Workplan updates, present HEART Measure Set Monitoring Report rates, disparity analysis and identify quarterly Health Equity Spotlight reports. The HEO will track the action items and bring updates forward at the next QIHEC meeting held Thursday, September 18, 2025.

Appendix A. HEART Measure Set: Disparity Analysis

Reference List

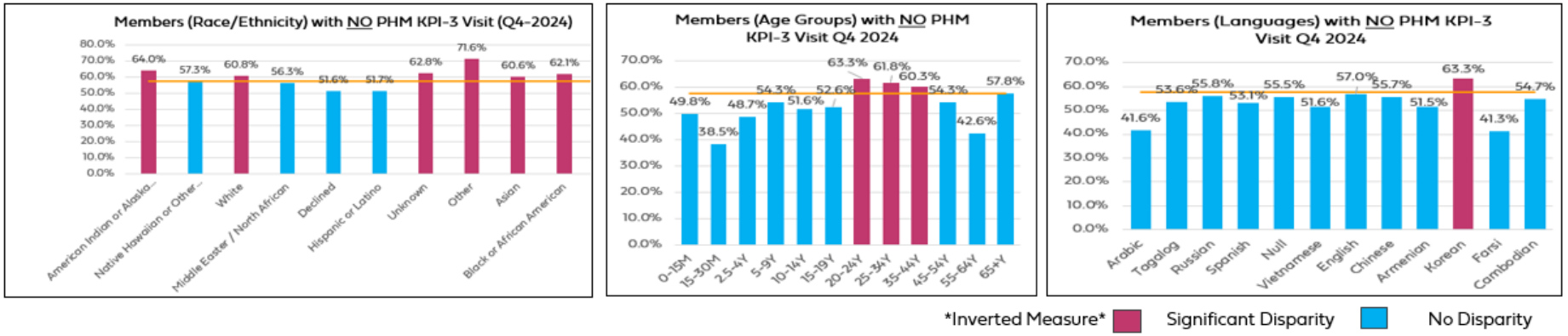
1) Members with no ambulatory or preventive visit within a 12-month period
2) Breast Cancer Screening
3) Prenatal Care
4) Postpartum care
5) Child and Adolescent Well Care Visits
6) Follow-Up After Emergency Department (ED) Visit for Mental Illness
7) Hemoglobin A1c Control for Patients with Diabetes
8) Analysis of the White population

Disparity Analysis of Utilization of Preventive Care Utilization (Equitable Access to Care Domain)

METRIC: Members Not Engaged in Ambulatory Care (PHM KPI-3). Number of members with no ambulatory or preventive visit within a 12-month period.

FINDINGS: The graph below displays that Los Angeles and San Diego's Black /AA, Unknown, Other, American Indian, White, and Asian members are significantly behind other racial/ethnic groups in completing PHM KPI-3. Members ages 20-44 are significantly disparate in completing visits compared to all other age groups. Members whose preferred language is Korean have the lowest rate compared to all other languages. **Almost half of members (42%) are not accessing preventive care, with some REGAL groups having as low as 7 in 10 members with no visit within 12 months.**

RESULTS: Almost half, or 54.8%, of all members have not had a visit within the last 12 months.



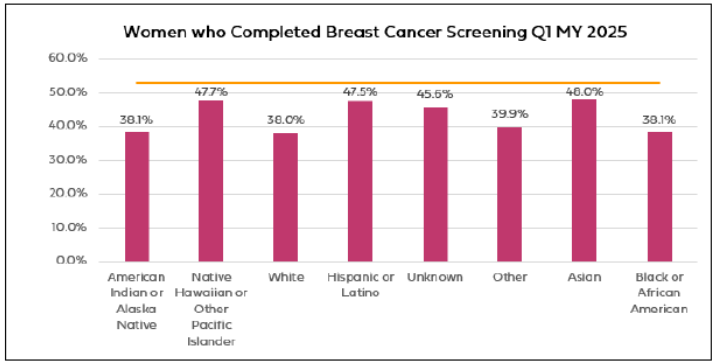
TAKEAWAYS: Across most groups, a significant portion of adults (20-44Y), males, Black, American Indian, White, and Asian, and Korean-speaking populations are not engaged in ambulatory care or preventive care. DHCS refers to these members as "invisible".
Indication: potential for a systemic issue within disparate populations. Discussion: Why aren't most groups accessing care? Need for a utilization study and the impact on cost of healthcare.

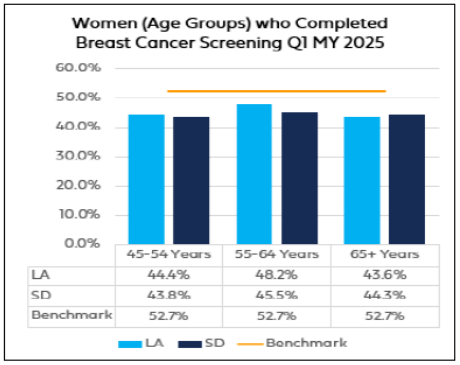
Disparity Analysis of Breast Cancer Screening (High Quality Clinical Care Domain)

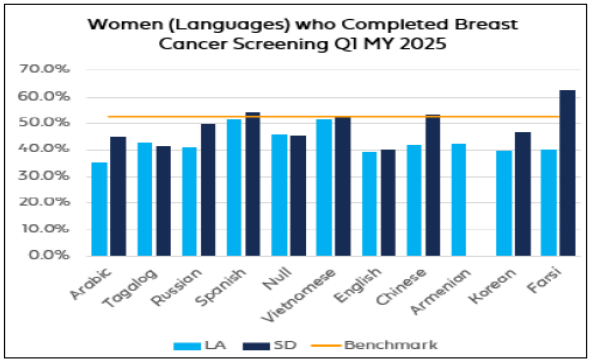
METRIC: Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

FINDINGS: The graph below displays data for Los Angeles and San Diego – Hispanic or Latino, Black /AA, Unknown, Other, American Indian or Alaska Native, White, Native Hawaiian or Other Pacific Islander, and Asian members are significantly behind other racial/ethnic groups in completing a breast cancer screening. Of note, there are no identified disparities between Age and Language. However, women ages 45-54 in both counties show lower BCS visits compared to women ages 55–64.

RESULTS: More than half, or 60.2%, of women had at least one mammogram to screen for breast cancer in the past two years.







Significant Disparity No Disparity

TAKEAWAYS:

- All racial/ethnicity groups have a significant disparity when comparing all groups to one another. All groups are below the benchmark except for members whose preferred language is Farsi, Chinese, and Spanish.
- Promise's Quality team currently designing targeted interventions for Black/AA, Hispanic, and White populations to improve screening rates.

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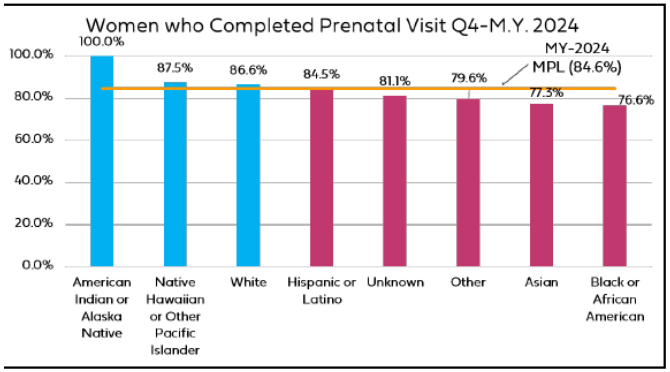
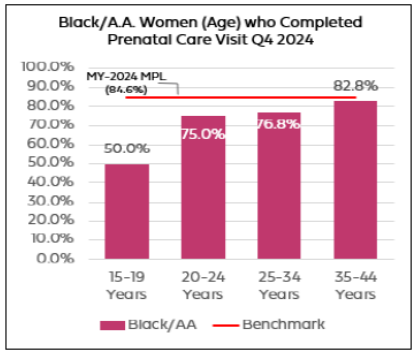
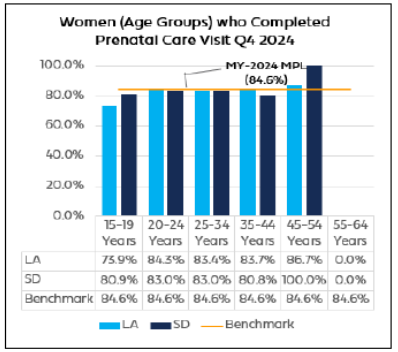
Disparity Analysis of Prenatal Care (Equitable High-Quality Clinical Care Domain)

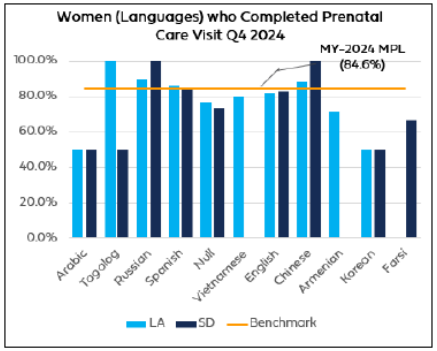
METRIC: Percentage of deliveries with a prenatal visit in the first trimester or within 42 days of enrollment. This is also a Bold Goal metric - Close Maternity care disparity for Black and Native American persons by 50%.

FINDINGS: The graph below displays Los Angeles and San Diego's members completing a prenatal care visit. There are notable differences in completion rates across Age and Race/Ethnicity. Specifically, Hispanic or Latino, Unknown, Other, Asian, and **all Black or African American age ranges 15-44 have significantly less prenatal visit rates**. No significant disparities are present when assessing Age and Language.
RESULTS: 82.9% of all members completed a prenatal visit in the first trimester. Notably, **50.0% of Black/AA members ages 15-19 years have not had a prenatal visit in their first trimester or within 42 days of enrollment**. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Arabic, and Tagalog speaking members.









Significant Disparity No Disparity

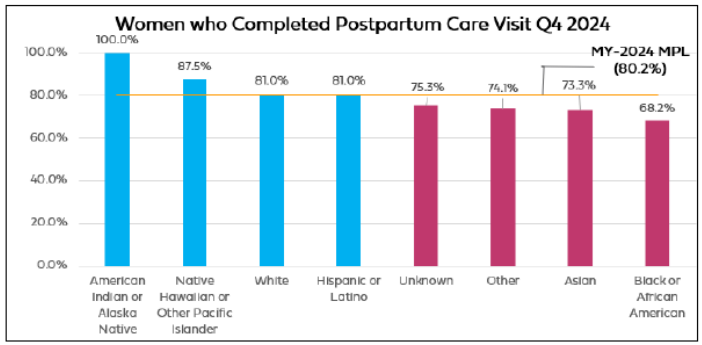
TAKEAWAYS: The consistently low prenatal care completion rate among the 15-19 age group and the Black or African American population is a significant disparity. Early and consistent prenatal care is crucial for both maternal and infant health, making targeted interventions for this age group essential.

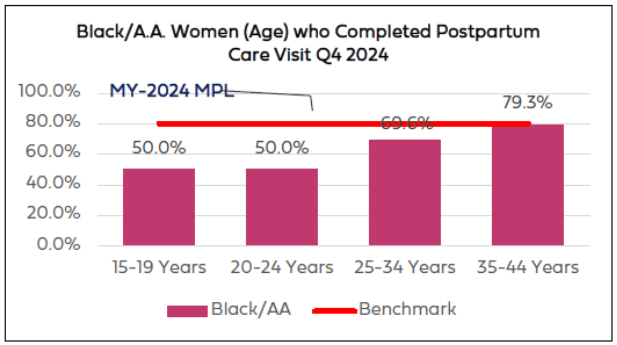
Disparity Analysis of Postpartum Care (Equitable High-Quality Clinical Care Domain)

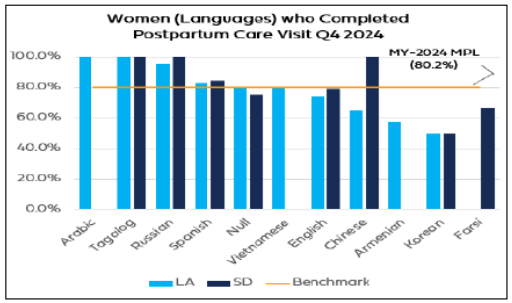
METRIC: Percentage of deliveries with a postpartum visit between 7 and 84 days post-delivery.

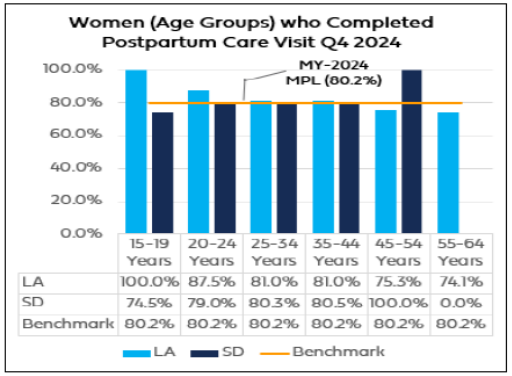
FINDINGS: The graph below displays that Los Angeles and San Diego's Unknown, Other, Asian, and Black or African American members are significantly behind other racial/ethnic groups in completing a postpartum care visit. Upon further analysis, **Black/AA members ages 15-24 years have substantially lower completion rates (50.0%) compared to other age groups (25-34 years, 69.6%; 35-44 years, 79.3%).** There are no significant differences across Age and Language.

RESULTS: 78.3% of members have completed the postpartum visit within 7 and 84 days post-delivery.
Half, 50.0%, Black/AA members ages 15-24 years have not had a postpartum care visit. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Chinese, and Armenian speaking members.









	15-19 Years	20-24 Years	25-34 Years	35-44 Years	45-54 Years	55-64 Years
LA	100.0%	87.5%	81.0%	81.0%	75.3%	74.1%
SD	74.5%	79.0%	80.3%	80.5%	100.0%	0.0%
Benchmark	80.2%	80.2%	80.2%	80.2%	80.2%	80.2%

Significant Disparity No Disparity

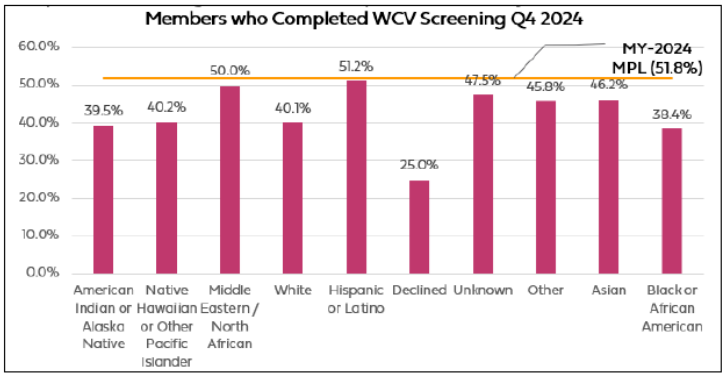
TAKEAWAYS: Significant disparities are identified across the Black or African American population including all Black or African American age groups, confirming DHCS' focus as a Bold Goal priority population.

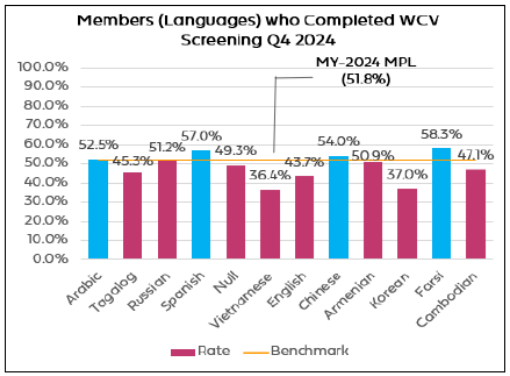
Disparity Analysis of Child and Adolescent Well Care Visit (Equitable High-Quality Clinical Care Domain)

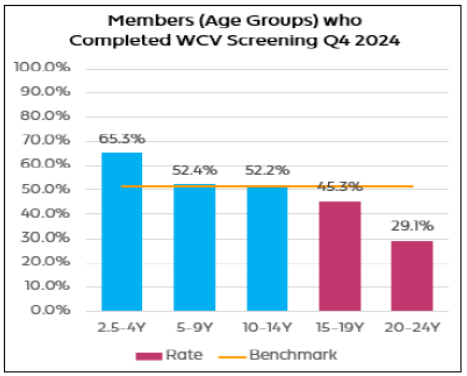
METRIC: Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL. This is also a Bold Goal metric - Close racial/ethnic disparities in well-child visits and immunizations by 50%.

FINDINGS: The graph below displays that Los Angeles and San Diego's **ALL racial/ethnic groups have a significant disparity in completing WCVs**. Members ages 15-21 have a significant disparity in completing well-care visits. Farsi-speaking members have the highest completion rate (58.3%) and Spanish speakers have higher rates (57%) compared to English speakers (43.7%)

RESULTS: Half, 49.8%, of all members ages 3-21 had at least one comprehensive well-care visit. Black or African American and American Indian, Native Hawaiian and White members AND members ages 20-21 and members whose preferred language is Vietnamese and Korean have the lowest rates.







Significant Disparity No Disparity

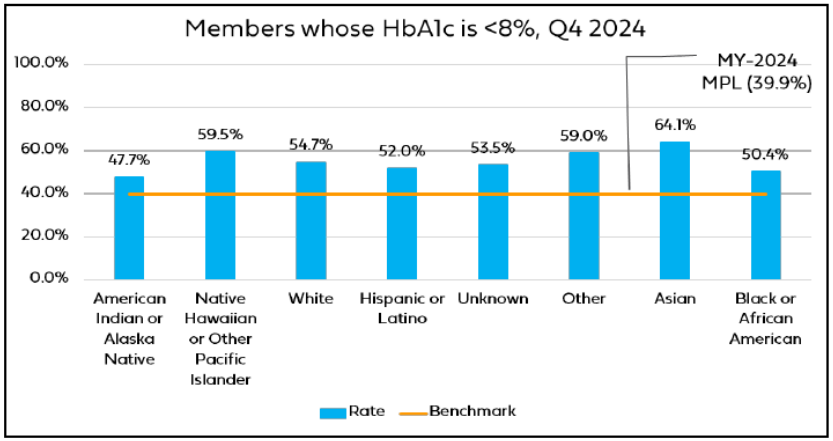
TAKEAWAYS: All race/ethnicity groups are flagged as disparate, suggesting potential underutilization or barriers. The significant decline in rates for the 15-21 age group compared to younger age groups. This could indicate reduced engagement with healthcare services during adolescence, possibly due to factors like independence, lack of awareness, or access issues. Spanish speakers have higher rates (57%) compared to English speakers (43.7%), suggesting no disparity and possibly better support, outreach, or access for Spanish-speaking groups.

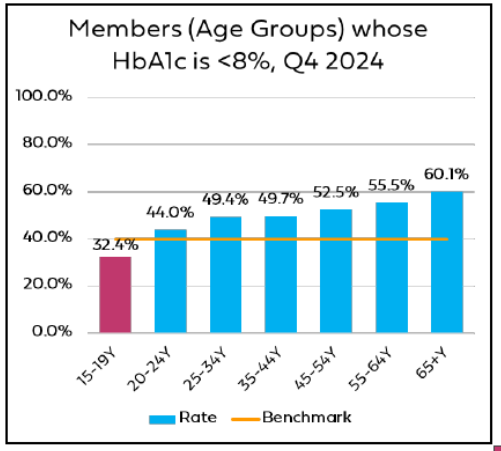
Disparity Analysis of Hemoglobin A1c Control for Patients with Diabetes (Equitable High-Quality Clinical Care Domain)

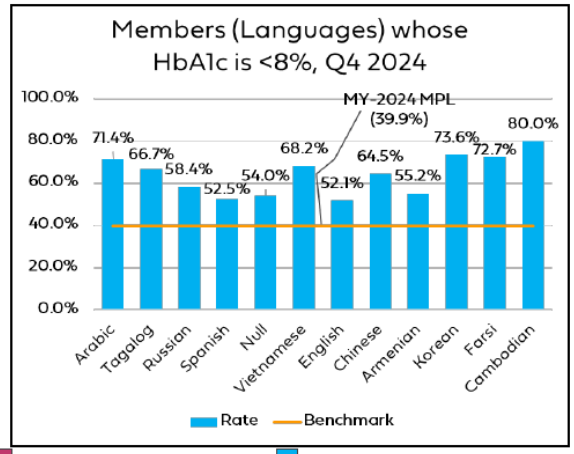
METRIC: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8% during the measurement year.

FINDINGS: The graph below displays that Los Angeles and San Diego's **none of the Racial/Ethnic or Language groups have a significant disparity in completing diabetes control**. Members ages 18-19 (272 total members) do have a significant disparity in diabetes control. Arabic, Cambodian, Tagalog, Vietnamese, and Farsi-speaking members have the highest control rates, well above the Minimum Performance Level (MPL).

RESULTS: Just over half, 52.8%, of all members have Hemoglobin A1c control for diabetes. The only population falling below the MPL is members ages 18-19.







Significant Disparity No Disparity

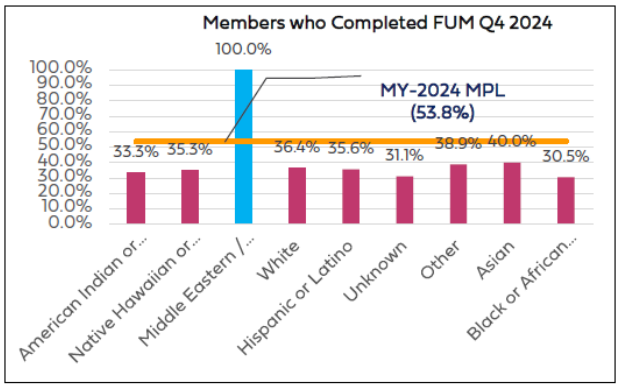
TAKEAWAYS: Race/ethnicity, language, and county show variations in control rates, but these are not flagged as significant disparities (no red bars), suggesting that these factors may not have a strong independent effect on outcomes after controlling for other variables.
Focus population should include the 272 members ages 18-19 with uncontrolled diabetes.

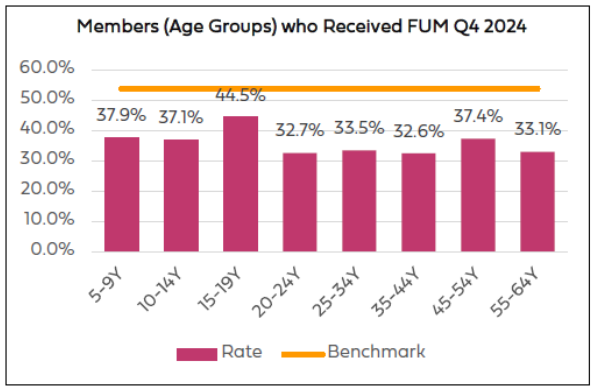
Disparity Analysis of Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM) (Equitable High-Quality Clinical Care Domain)

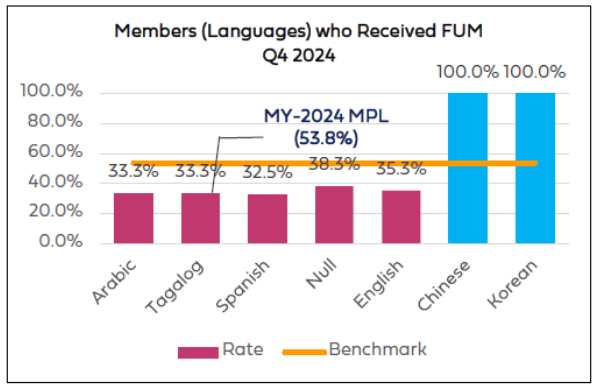
METRIC: The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. This is also a Bold Goal metric - Improve follow up for mental health and substance use disorder by 50%.

FINDINGS: Disparities identified across Race/Ethnicity, Age, and Language. The graph below displays that Los Angeles and San Diego's race/ethnicity groups are all significantly lower, except for the Middle Eastern/North African population. All age groups are noted as having a disparity. Additionally, all Language populations are significantly lower, except Chinese and Korean-speaking members.

RESULTS: Overall, 35% of all members receive follow-up after mental illness.







Significant Disparity No Disparity

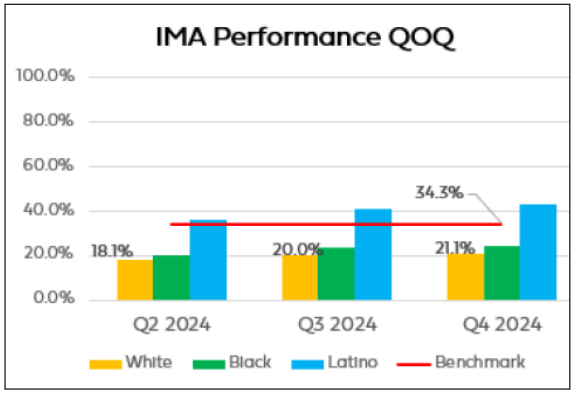
TAKEAWAYS: These disparities present across Race/Ethnicity, Age, and Language indicate a systemic issues such as coordination of care following an ED visit for mental illness.

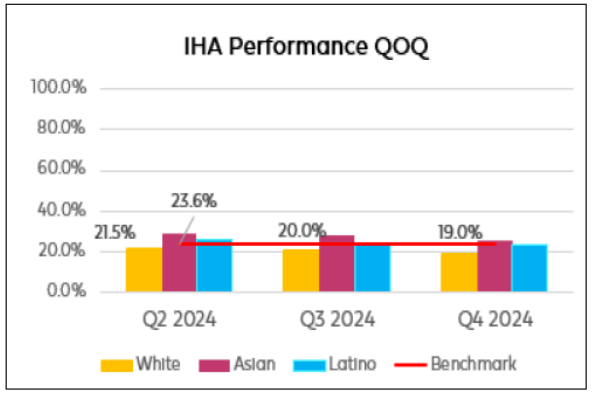
Disparity Analysis of Disparities Among White Members Across Key Health Measures in Los Angeles and San Diego throughout 2024

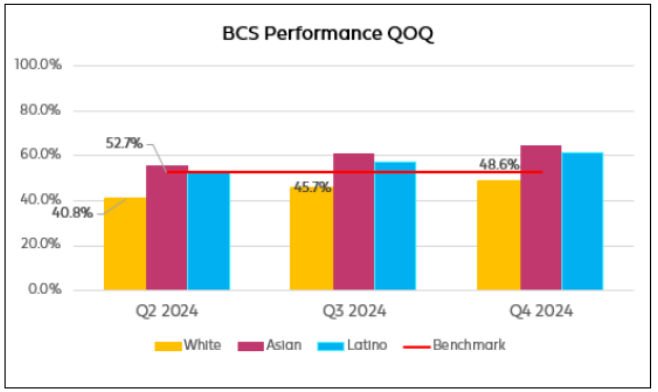
METHODOLOGY: Assessed Quality metrics to identify significant disparities between the White population compared to all other Race and Ethnicities.

FINDINGS: While Health equity efforts often focus on addressing disparities among historically underserved populations, the data below reveals measures where the White population presents with the lowest rates compared to all other Race/Ethnicity groups. Measures with lowest rates include: 1) Immunizations for Adolescents (IMA); 2) Initial Health Assessment (IHA); and 3) Breast cancer Screening (BCS).

RESULTS: IMA: White population performance is consistently the lowest among the groups. This indicates underperformance in access or utilization for White members. **IHA**: The White population shows a steady decline from 21.5% in Q2 to 19.0% in Q4, now below the benchmark and further behind Asian and Latino members. **BCS**: Though improving (from 40.8% in Q2 to 48.6% in Q4), White population still falls behind Asian and Latino groups, with all three quarters showing the lowest performance compared to all other races.







Significant Disparity No Disparity

TAKEAWAYS: The White population is not always the population with the highest rates for utilization, preventive screening, and health outcomes.