November 2024

Building an Equitable Health Care System

A Health Equity Roadmap and Recommendations for Collective Impact in California

PBGH California Quality Collaborative

Executive Summary

This issue brief outlines the California Quality Collaborative's (CQC) health equity roadmap, a strategic framework designed to advance equitable health care across California and beyond through primary care efforts. The roadmap builds on CQC's previous efforts and aligns with national and state policies, ensuring that health equity remains central to quality improvement initiatives beyond 2025.

The roadmap focuses on key drivers of equity, including payment model reforms, demographic data collection and partnerships with community-based organizations (CBOs). By aligning public purchasers, payers and providers, CQC seeks to create sustainable change that improves care for all — especially populations that have historically experienced health disparities.

Key Takeaways

- **Equity-Driven Payment Models:** Embed equity metrics into value-based payment models to incentivize providers and payers to reduce disparities.
- **Standardized Data Collection:** Promote harmonized demographic data collection (e.g., race, ethnicity, language, sexual orientation, gender identity, and social needs) to identify and close gaps in care.
- **Community Partnerships:** Strengthen collaboration with CBOs and integrate social drivers of health — such as housing, food and transportation — into care delivery models. Technical Assistance and Provider Support: Equip providers with tools and resources through shared learning collaboratives to build capacity and reduce inequities.
- **Technical Assistance and Provider Support:** Equip providers with tools and resources through shared learning collaboratives to build capacity and reduce inequities.

CQC's roadmap serves as a guide for payers and providers to implement sustainable, equity-focused strategies. Through aligned efforts, the roadmap emphasizes that health equity is essential to achieving the highest quality of health care for all.

Introduction

This issue brief provides an overview of federal and state initiatives advancing health equity. Public purchasers, accreditation and quality improvement organizations and regulators are integrating health equity into their standards, requirements and payment strategies.

CQC has made health equity a core priority across its programs and activities. Building on these efforts, CQC has developed a health equity roadmap to guide future work beyond 2025. This issue brief highlights past and ongoing CQC efforts that inform the roadmap and offers actionable recommendations for aligning payers, providers and public purchasers to embed health equity as an essential component of high-quality care.

Federal Efforts Integrating Health Equity into Quality Improvement

The federal government — the largest public purchaser of health care through the Medicare and Medicaid programs — has increasingly integrated equity into its national quality improvement initiatives.

Elements of health equity have long been part of federal efforts. One foundational effort was the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services, first adopted in 2001 and updated in 2013. These standards guide health care organizations in delivering culturally responsive care and ensuring equitable access for diverse populations. See the full CLAS timeline here.

In recent years, health equity has become an explicit priority in national health care policy. For example, the Centers for Medicare & Medicaid Services (CMS) adopted an updated Framework for Health Equity in 2022, which includes:[1]

1. Expanding the collection, reporting and analysis of standardized data
2. Assessing the causes of disparities within CMS programs and addressing inequities in policies and operations to close gaps
3. Building capacity of health care organizations and the workforce to reduce disparities
4. Advancing language access, health literacy and providing culturally tailored services
5. Increasing all forms of accessibility to health care services and coverage.

Through this framework, CMS publishes annual Medicare quality data stratified by sex, race and ethnicity, highlighting persistent racial and ethnic disparities in health care and hosts an interactive disparities mapping tool. CMS also provides technical assistance resources that support health equity.

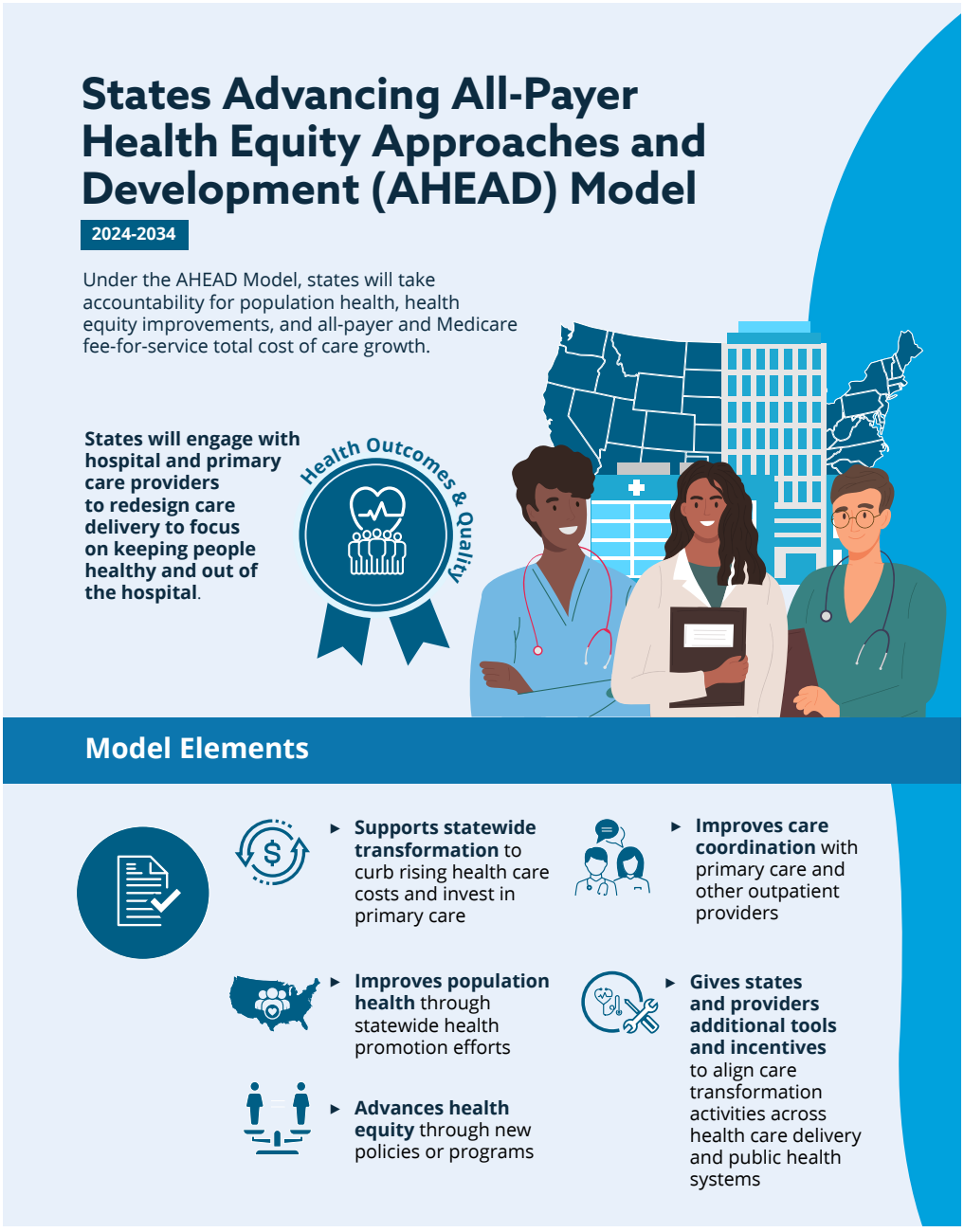
In addition to these efforts:

- Medicare Advantage plans will become eligible for bonus payments starting in 2028 through the Star Ratings system if they meet health equity standards for Medicare-Medicaid dual-eligible and other low-income beneficiaries (payments would begin in Payment Year 2028, based on 2024 and 2025 data).[2]
- Hospitals are required, beginning in Fiscal Year 2023, to report on a new hospital equity measure and screen patients for health-related social needs.[3]

Payment Models Driving Change

Since the enactment of the Affordable Care Act, CMS also has further embedded equity into health care delivery and payment reform programs, including new initiatives from the Center for Medicare & Medicaid Innovation (CMMI).

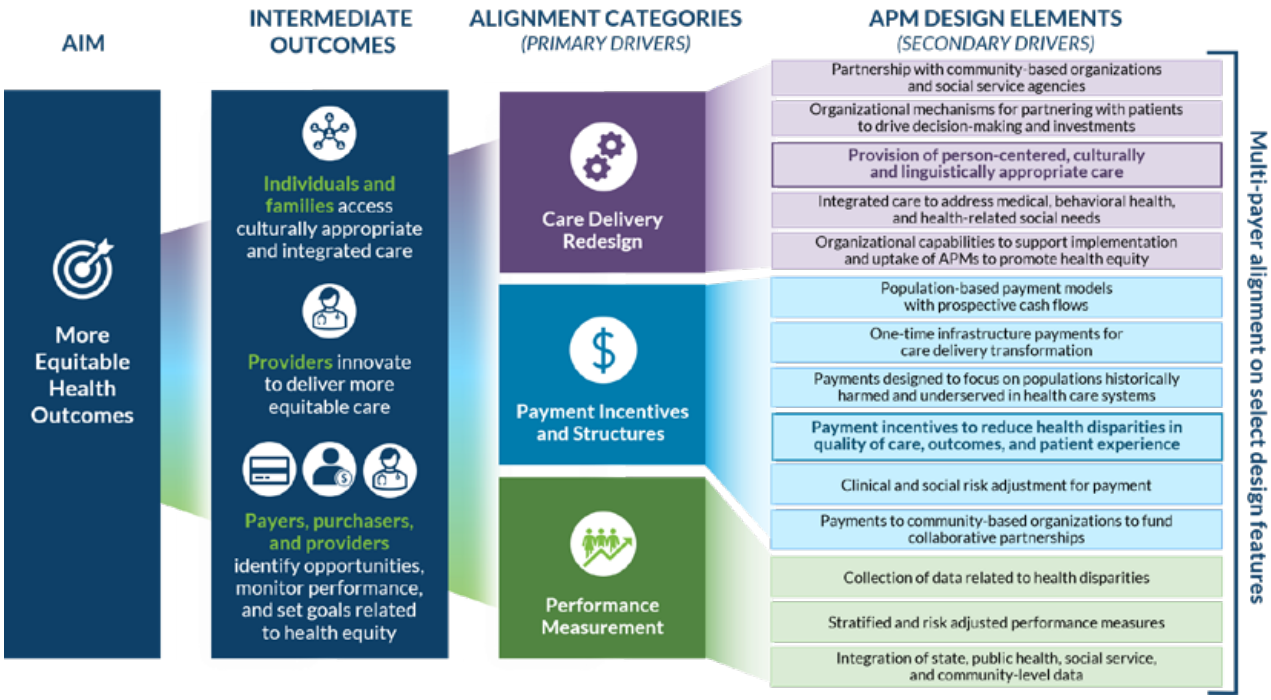
One of the most recent CMMI models is the States Advancing Health Equity Approaches and Developments program, launched in 2024. This all-payer, total cost of care approach to advancing health equity by incentivizing providers to focus on whole-person care and population health outcomes.[4]



Another notable recent CMMI model is the Transforming Maternal Health Model, which reduces disparities in maternal health care and improves health outcomes for women and newborns in underserved communities and rural areas.

CMS is also a key partner in the national Health Care Payment Learning & Action Network (HCPLAN). In 2021, the HCPLAN launched a Health Equity Action Team, which developed a theory of change to integrate equity into value-based payments.[5] The team's recommendations include:[6]

- Collecting data related to health disparities
- Integrating care that addresses medical, behavioral health and health-related social needs
- Forming partnerships with CBOs and social service agencies
- Developing funding streams to support collaborative efforts with CBOs



Advances in Measuring Health Equity

Several national non-governmental organizations have emphasized health equity as a key component of quality measurement and improvement programs.

In 2021, the National Committee for Quality Assurance (NCQA) launched two new accreditation programs:[7]

Health Equity Accreditation: This program requires organizations to demonstrate readiness by collecting data on race, ethnicity, language, gender identity and sexual orientation. It also addresses access to and availability of language services, the cultural responsiveness of practitioner networks and the availability of culturally and linguistically appropriate services programs to reduce health disparities.

Health Equity Accreditation Plus: This program focuses on meeting individual health-related social needs and addressing **community** social risks through comprehensive population health management. It requires the collection, acquisition and analysis of both individual- and community-level data, the formation of cross-sector partnerships and engagement, effective data management and interoperability, a program to mitigate social risks and address social needs and tracking of referrals, outcomes and impact.

The reference in NCQA's Health Equity Accreditation standards to culturally and linguistically appropriate services incorporates the federal Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.[8]

NCQA also leads the development and oversight of Healthcare Effectiveness Data and Information Set (HEDIS) measures, widely used by health plans and providers to measure health care quality performance. Beginning in 2021, select HEDIS measures were required to be stratified by race and ethnicity. As of Measurement Year 2024, thirteen HEDIS measures require stratification by race and ethnicity, with more measures expected to follow, pending alignment with the 2024 Office of Management and Budget's updated standards for collecting and using race and ethnicity data.[9]

Meanwhile, NCQA has shared preliminary HEDIS data stratified by race and ethnicity among some Medicare, Medicaid and commercial health plans, highlighting the persistent and ongoing racial and ethnic disparities in health care.[10]

The Institute for Healthcare Improvement (IHI), a leading national training and learning organization for quality improvement, has developed a framework and guides for advancing health care quality.[11] The framework includes five key components:

- Make health equity a strategic priority
- Develop structure and processes to support health equity work
- Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact
- Decrease institutional racism within the organization
- Develop partnerships with community organizations to improve health and equity

IHI also co-leads the national Rise to Health Coalition, along with the American Medical Association, Council of Medical Specialty Societies, American Nurses Association, American Hospital Association, National Association of Community Health Centers, America's Health Insurance Plans, NCQA, Health Begins, AARP, Race Forward, PolicyLink and Groundwater Institute.[12] These national organizations are working on collaborative approaches to advancing health equity.

The National Business Group on Health[13] and commentators have also recognized the business case for advancing health equity,[14] highlighting four key strategies:

- Improve health care access
- Foster equitable engagement
- Ensure inclusive experience
- Address social determinants of health

In 2022, the National Academies of Sciences, Engineering, and Medicine conducted a workshop exploring how businesses can contribute to improving health equity. The discussions emphasized how economic opportunity, especially in a post-COVID-19 economy with rapidly evolving workforce needs, serves as a crucial social determinant or driver or health.[15]

California Public Purchasers and Regulators Are Integrating Equity into Quality Improvement

California's public purchasers and regulators, following CMS and national quality organizations, have incorporated equity into their quality improvement and payment approaches, are explicitly integrating equity into their quality improvement requirements and activities. For example, Covered California requires its contracted qualified health plans (QHPs) to collect and use member demographic data to stratify quality performance measures and set explicit goals for reducing racial and ethnic disparities as part of its Quality Transformation Initiative (QTI).[16] For Measurement Years 2023-2025, contracted QHPs will be evaluated for quality performance on four core measures:

- Childhood Immunization Status (Combo 10)
- Colorectal Cancer Screening
- Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Control (<8.0%) Controlling High Blood Pressure

QHPs that fail to meet specified measure benchmarks will be required to make payments to a Quality Transformation Fund. For Measurement Year 2023, 0.8% of each QHP's total gross premium per product is at risk for performance on the QTI core measures. The total amount of Quality Transformation Fund payment and other performance standards at risk would increase to 2% of total gross premium per product in Measurement Year 2024, increasing by 1% per year up to 3% in 2025.

Covered California reports that as of Plan Year 2021, all of its QHPs had collected self-reported race and ethnicity data from over 70% of their members, with seven of the 11 plans meeting the contract requirement of collecting such demographic data from at least 80% of members. Covered California is also requiring QHPs to achieve NCQA Health Equity Accreditation.

Beginning with Contract Year 2024, the California Department of Health Care Services (DHCS) is requiring contracted Medi-Cal managed care health plans to collect and use demographic and health-related social needs data about Medi-Cal beneficiaries to reduce racial and ethnic disparities as part of its Comprehensive Quality Strategy.[17] Specifically, Medi-Cal plans are required to develop and implement health equity performance improvement projects to reduce disparities in child/adolescent health, women's health and disease management/behavioral health. The contract authorizes DHCS to require corrective actions and to impose administrative and financial sanctions, such as suspending automatic assignment of enrollees and considering quality and disparity reduction performance in determining future capitation rates. DHCS will also require contracted Medi-Cal plans to achieve NCQA Health Equity Accreditation by 2026 and designate a senior manager as Chief Health Equity Officer.

The California Public Employees' Retirement System (CalPERS), the other major statewide public purchaser, has followed suit with Covered California and DHCS in requiring demographic data collection and stratification, as well as explicit goals for reducing racial and ethnic disparities.[18] CalPERS' Quality Alignment Measure Set will be effective for its contracts with HMOs beginning in 2024, and with its PPOs beginning in 2025. The measures are:

- Childhood Immunizations
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care – Poor Control (HgbA1c >9%)
- Maternity Care (a combined score for Timeliness of Prenatal Care and Postpartum Care)

For CalPERS' contracted HMOs who fail to meet quality benchmarks for these measures, 1% of total gross premium per product is at risk in Plan Year 2024, increasing to 2% of total gross premium per product in Plan Year 2025, and then continuing to increase by 1% per year up to 4% in 2027.

Finally, the California Department of Managed Health Care (DMHC) is implementing its regulatory authority to require all California managed health care plans to report on thirteen health equity and quality measures, stratified by race and ethnicity, beginning with Measurement Year 2023.[19] The measures are:

1. Asthma Medication Ratio (Total Age Range)
2. Breast Cancer Screening
3. Child and Adolescent Well-Care Visits (Total Age Range)
4. Childhood Immunization Status (CIS Combo 10)
5. Colorectal Cancer Screening
6. Controlling High Blood Pressure
7. Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening and Follow-Up on Positive Screen
8. Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8.0%) and Poor HbA1c Control (>9.0%)
9. Immunizations for Adolescents (IMA Combo 2)
10. Plan All-Cause Readmissions (18-64 Years of Age)
11. Prenatal and Postpartum Care – Timeliness of Prenatal Care and Postpartum Care
12. Well-Child Visits in the First 30 Months of Life – First 15 Months and 15 Months to 30 Months
13. CAHPS Health Plan Survey (Medicaid and Commercial) – Getting Needed Care Adult Survey and Getting Needed Care Child Survey

DMHC will develop regulations for administrative penalties for failure to meet the health equity and quality benchmark, currently set at the national Medicaid 50th percentile for all plans, regardless of line of business. DMHC has regulatory authority over managed health care plans that cover 29.7 million lives in California.

These California public purchasers and regulators are aligning their requirements, both to reduce the administrative burden on health plans and to optimize the potential for statewide improvement by aligning efforts to use the same data standards and quality measures. Together, DHCS, Covered California and CalPERS collectively provide health care to more than 18 million Californians, or 46% of the California population.

California Efforts to Address Social Needs and Leverage Community-Based Partnerships

In addition to advancing data standards and quality, California health departments are driving innovative approaches to address social drivers of health. By fostering partnerships between primary care providers, CBOs and community health workers (CHWs), the state aims to connect individuals with essential resources like housing, food and transportation.

DHCS added CHW services as a Medi-Cal benefit on July 1, 2022. As of January 8, 2024, CBOs and local health jurisdictions (LHJs) providing CHW services can now enroll as Medi-Cal providers through the Provider Application and Validation for Enrollment portal.

Changes to Medicaid's 2024 budget neutrality policy have expanded opportunities to finance health-related social needs initiatives through the Medicaid program. Key efforts include:

- **Medi-Cal's In Lieu of Services and Community Supports:** Allows Medi-Cal to fund services such as housing support and nutrition assistance
- **Expansion of Home and Community-Based Services:** Enables Medi-Cal and Medicare beneficiaries to receive services at home or community-based settings

Additionally, DHCS' California Advancing and Innovating Medi-Cal initiative promotes stronger, formalized partnerships between primary care providers and CBOs to deliver community supports and enhanced care management.

The California Department of Public Health Office of Health Equity plays a key leadership role in reducing health and mental health disparities among California's vulnerable communities. A priority of the office is building cross-sector partnerships by collaborating with CBOs and local government agencies.

Recommendations and Proposed Implementation Actions to Advance Health Equity

As part of developing its health equity roadmap, CQC offers the following recommendations and implementation actions for California payers and providers.

Demographic Data Collection

Recommendation	Proposed Action
• Contribute to and leverage supplemental state funding sources to support providers in accelerating the collection and exchange of health information and demographic data.	• Payers can provide application guidance to providers in your network eligible for additional resources, such as DHCS' Equity & Practice Transformation grant and participation in the California Data Exchange Framework. • Payers and providers can incorporate equity into the design of initiatives, programs, learning curricula and resources to build awareness of health equity and health-related social needs. They can also connect to and exchange data through a Qualified Health Information Organization (QHIO) and improve collection and use of demographic and social needs data in alignment with Office of Management and Budget (OMB) standards to identify and decrease disparities.
• Adopt demographic data stratification and reporting standards and requirements harmonized among health plans and provider organizations. • Transition to electronic quality measure submission for entire populations (larger overall denominators can support more stratification of numerators by demographics).	• Payers can require providers in incentive programs to submit demographic data for performance measures and evaluation. • Payers and providers can utilize demographic data in designing quality improvement and disparity reduction activities.
• Increase effectiveness of performance incentive payments to advance equity through alignment, health equity adjustments and reduced burden on providers to collect and report data.	• Payers can integrate national HEDIS measure benchmarks by race and ethnicity into California industry standards, as well as improvement and disparities reduction collaborative goals. • Payers can adapt the California Advanced Primary Care Initiative common payment model and performance incentive design to measure the availability of demographic data, in alignment with purchaser requirements. • Payers can share demographic data and disparity analytics with providers and collaborate with them through collective action to reduce disparities

Social Needs & Partnerships

Recommendation	Proposed Action

• Prepare for incoming requirements to address social drivers of health as a key theme across industry stakeholders and recognize the significant impact of factors like food, housing, transportation, income and education on health outcomes, through:
  • Establishing and implementing common standards
  • Scaling value-based payment models to enhance flexibility and inclusivity based on social risk
  • Redesigning incentive programs
  • Incorporating individual and community input into quality improvement strategies and activities
  • Enhancing data exchange capabilities
  • Providing practice transformation support
	• Payers and providers can incorporate equity into the design of initiatives, programs, learning curricula and resources to build awareness of health equity and health-related social needs. They can also connect to and exchange data through a Qualified Health Information Organization (QHIO) and improve the collection and use of demographic and social needs data in alignment with OMB standards to identify and decrease disparities.
	• Payers and providers can conduct patient focus groups to inform the design of technical assistance programs and quality improvement plans.
	• Payers and providers can develop and implement activities to address high-social needs sub-populations related to postpartum care, children and youth, older adults and behavioral health.
	• Payers and providers can establish partnerships between CQC and organizations with expertise in social needs data collection, exchange and use.

• Set a foundation toward increasing the collection of Social Drivers of Health (SDOH) data through:
  • Exchanging data
  • Incentivizing payment collection
  • Training care teams and sharing best practices
  • Billing and coding
	• Payers can conduct landscape scans to understand needs and current ongoing efforts in improving SDOH in partnership with local community organizations.
	• Payers and providers can disseminate best practices, learning resources and policy recommendations to design payment models and incentive programs to advance health equity.

• Enhance care team capabilities to engage CHWs and CBOs to address social needs.
• Streamline contracting and billing with CBOs through:
  • Standardizing contracting between CBOs and heath plans
  • Reducing administrative burden between CBOs, CHWs and providers (i.e., billing)
  • Aligning payer standards for CHW services
	• Payers can connect providers to CBOs and CHWs through technical assistance initiatives.
	• Payers and providers can disseminate best practices, learning resources and policy recommendations to enable the industry to:
	  • Create sustained partnerships between health plans, CBOs, CHWs and primary care teams
	  • Increase use of appropriate coding and billing for social needs, i.e., Z codes.
	  • Build data collection and exchange capabilities of practices.
	  • Payers can provide standardized training opportunities for CHWs.

• Increase collection of social needs data, integrated into the medical record to support patient care and population health management, through:
  • Harmonizing industry standards
  • Strengthening data exchange capabilities
  • Supporting community information exchanges
  • Increasing use and effectiveness of CBO services
  • Adopting new Medicare codes in 2024 physician fee schedule to promote payment for SDOH screening
	• Payers can create funding sources for providers in advancing health equity and addressing social drivers of health with community partners.
	• Payers and providers can share best practices, learning resources and policy recommendations to increase social needs screening, data collection and exchange and closed-loop community referral systems.

CQC 2024-2027 Aims and Roadmap

Using CQC's aims as a foundation, the organization has developed a roadmap that explicitly highlights health equity-focused activities. To support this effort, CQC convened a Health Equity Advisory Group that guided the roadmap's development through the lens of three primary drivers of health equity:

- Increasing collection and exchange of accurate and complete patient self-reported demographic data (e.g., race, ethnicity and language, sexual orientation and gender identity) for use in care and quality improvement
- Addressing socials needs by supporting care teams and payers in utilizing existing community-based services and organizations
- Equipping payers and delivery systems to build partnerships and engage in meaningful dialogue that impacts health equity and social drivers of health in our communities

2024 – 2027 Aims:

Californians access and engage in **advanced primary care** that is equitable and incorporates collaboration with high-value specialty expertise.

Californians experience reduced morbidity, mortality and inequities in care and health outcomes, with a focus on **cardiovascular disease, diabetes and maternal health**.

2024 – 2027 Drivers of Improvement:

- Spread adoption of and success in **value-based payment models** through multi-payer alignment, care team support and harmonization of measures and reporting.
- Expand the **integration of behavioral health** care into primary care with improved quality and access.
- Increase collection and exchange of accurate and complete patient **self-reported demographic data** (e.g. REaLD, SOGI) for use in care and quality improvement.
- Improve **postpartum care and maternal mental health** through integration with adult and pediatric primary care.
- Address **health-related social needs** through support to care teams and payers to utilize existing community-based services and organizations.
- Equip payers and delivery systems to build partnerships and engage in dialogue to meaningfully impact **health equity** and social drivers of health in our communities.

Guiding Principles for CQC's Roadmap

CQC considered various frameworks by organizations highlighted earlier in this issue brief and has referenced public guiding principles as a foundation for its strategies and initiatives.

In 2022, the leaders of the National Academy of Medicine, IHI and NCQA published a joint commentary in JAMA that declared:

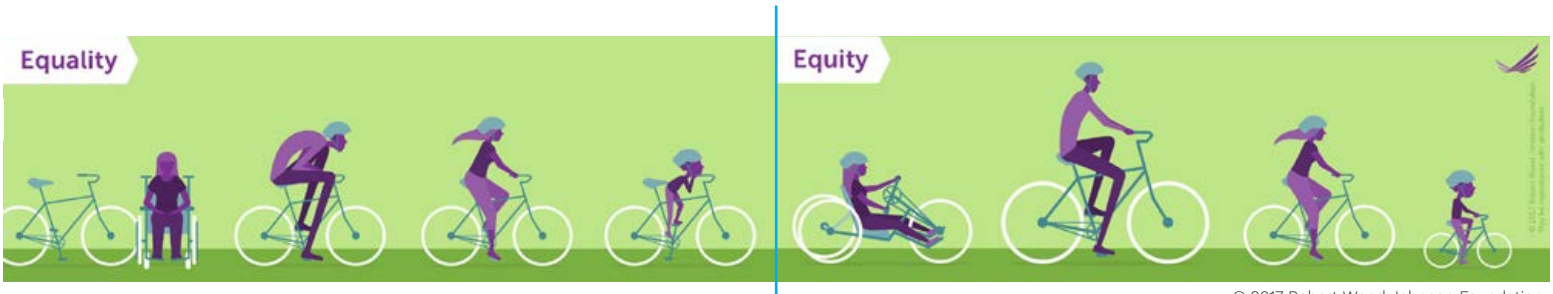
"... there is no equity without quality, and there is no quality without equity....However, improving health care quality does not ensure health equity. When quality improvement efforts do not intentionally address equity, they may actually increase disparities.... As quality improvement efforts are implemented, they must be held accountable for both improving care and reducing disparities."[20]

The California Pan-Ethnic Health Network has detailed how equity can be integrated into health care delivery and payment reform:

- Center equity in quality and payment
- Engage patients, families and caregivers
- Strengthen culturally and linguistically appropriate care
- Improve and integrate physical, behavioral and oral health care
- Hold health plans and systems accountable
- Improve SDOH[21]

Drawing from these national and California frameworks, CQC has adopted the following guiding principles for its work on health equity:

- Achieving improved health care quality is not possible without equity
- Health equity must be a priority for all purchasers and payers
- Purchasers and payers share responsibility for equipping and funding providers to reduce health inequities
- A diverse and well-developed health workforce is essential for advancing health equity
- Engaging health care consumers, patients and health plan members — especially those who have experienced health inequities — is critical to successful interventions
- Advancing health equity requires ongoing, sustained partnerships that extend beyond the health care sector



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Definitions of Health Equity

Given the increased prioritization of health equity, it is important to be explicit and intentional about how it is defined.[22] The following definition of health equity has been adopted for CQC:

> **Health equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to achieve their optimal health, regardless of age, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. Health equity requires additional efforts and investments for those who currently experience worse health and fewer opportunities.**

For CQC, it was also important to distinguish between "health equity" and "health care equity,"[23] with "health care equity" defined as:

> **Health care equity is achieved when all patients and health plan members have equitable access to care, receive equitable care and experience equitable care. Measuring and impacting health care equity is within the control of health care purchasers and providers.**

Additional definitions that CQC has used in improvement collaboratives focused on addressing reductions in disparities include:[24]

> **Health disparities are inequitable, avoidable differences in health outcomes linked to social conditions; both individuals and populations as a whole can experience health disparities; health disparities are associated with historical and current unequal distribution of economic, social, political, and environmental resources, as well as structural racism and other discriminatory conditions.**

> **The social determinants or drivers of health are the conditions in which people are born, grow, learn, work, live, and age; they are a wide set of forces and systems shaping conditions of daily life, including economic, social, political, and environmental policies and systems.**

CQC Improvement Collaboratives

CQC has significant experience integrating equity into its initiatives, programs and activities. For example, equity is a central focus throughout the design and learning curricula of CQC's improvement collaboratives. Participating provider organizations and practices are required to continuously improve their collection of demographic data. This effort was piloted through the CalHIVE Telehealth and Virtual Care collaborative in 2020, where CQC collected data on the availability of race, ethnicity and language (REaL) across provider networks. Provider organizations were asked to stratify access to telehealth services by patients' primary language to demonstrate use of REaL data.

CQC provides technical assistance to support these practices and provider organizations by building capacity and helping them to create the infrastructure needed to collect and analyze data. In addition, CQC:

- **Provides technical assistance** to build awareness of health equity and health-related social needs, connect to and exchange data through a QHIO and improve the collection and use of demographic and social needs data in alignment with OMB standards to identify and decrease disparities.
- **Aligns technical assistance curricula** with ongoing state initiatives, such as the DHCS Equity Practice and Transformation initiative activities and milestones.
- **Conducts patient focus groups** to inform the design of CQC programs and participants' improvement plans.
- **Connects participants to CBOs/CHWs** (i.e., Equity and Quality at Independent Practices in LA County) through curriculum activities, such as monthly learning webinars and in-person events, on topics like building connections to a regular patient feedback loop (e.g., focus groups, surveys)
- **Establishes partnerships** with organizations that have expertise in social needs, demographic data collection, exchange and use, as well as curriculum design tailored to address disparities (e.g., Collaborative Family Healthcare Association, Connecting for Better Health, HealthBegins, PFCCpartners).

Spotlight:

Equity and Quality Improvement at Independent Practices in Los Angeles

Equity and Quality Improvement at Independent Practices in Los Angeles (EQuIP-LA) is an improvement collaborative aimed at promoting health equity for Medi-Cal enrollees of color in Los Angeles County.[25] Supported by the California Health Care Foundation, Health Net and L.A. Care Health Plan, the program involves four provider organizations and 31 small primary care practices serving over 73,000 patients, including 53,000 Medi-Cal enrollees (33,000 Medi-Cal enrollees of color).

EQuIP-LA's core mission aligns with the fundamental principle of health equity: ensuring that all individuals, regardless of race, ethnicity or socioeconomic background, have an equal opportunity to achieve optimal health outcomes. The program focuses on enhancing chronic disease management, preventative screenings and quality improvement processes, while incorporating insights from patient listening sessions and data analysis to tailor its curriculum effectively.

To achieve its health equity goals, EQuIP-LA employs a community-based coaching model to build capacity within practices, allowing them to implement equity-focused interventions. This approach acknowledges that achieving health equity requires addressing systemic issues and social drivers of health. Community-based coaches assist practices in defining equity-focused goals, conducting targeted patient outreach and optimizing care team roles to better serve diverse populations. The program emphasizes the collection and analysis of data stratified by race and ethnicity, a critical step in identifying and addressing health disparities.

Additionally, CQC supported practices in applying for the DHCS Equity and Practice Transformation Payments Program, with five practices successfully joining — further reinforcing the commitment to systemic change.

Through its comprehensive approach, EQuIP-LA not only aims to improve the quality of care for Medi-Cal enrollees of color, but also seeks to empower independent primary care practices with the tools and knowledge necessary for sustainable, equitable health care delivery. By focusing on team-based care, culturally competent practices and addressing social drivers of health, the program fosters an environment where patients feel heard, valued and receive care tailored to their unique needs and circumstances.

This commitment to health equity strives to create a more inclusive health care system that meets the diverse needs of the Los Angeles community, recognizing that different groups may require different resources and approaches to achieve similar health outcomes. The program's strategies, highlighted at the 2023 NCQA Health Innovation Summit, showcase innovative methods for integrating health equity into quality improvement initiatives and contribute to the broader national dialogue on reducing health disparities and achieving equitable health for all.

Spotlight:

CalHIVE Telehealth & Virtual Care

CalHIVE Telehealth & Virtual Care was an improvement collaborative that provided technical assistance to clinicians to leverage telehealth for chronic disease management in patients with diabetes and asthma within the primary care setting.[26]

Launched during the COVID-19 pandemic, the collaborative emphasized that all health care organizations share responsibility for ensuring that the care they provide is equitable to all patients, regardless of race, ethnicity, gender identity, sexuality orientation or any other social or identity dimension. With virtual care, there are known challenges patients and families face around access to broadband and digital devices, digital literacy and comfort with using telehealth for their specific health need.

Golden Valley Health Centers (GVHC), a federally qualified health center operating in the Central Valley and participant of CalHIVE Telehealth & Virtual Care, serves over 130,000 patients annually, a large portion of which are Medi-Cal and under-insured populations. Given the diversity of their patients, GVHC strives to ensure that all patients have access to services to meet their health care needs. To achieve this, GVHC launched telehealth visits during spring 2020 at select clinic sites, with two sites piloting video visits and the remaining sites using phone-only visits.

As part of an internal evaluation in 2021, GVHC quality and data staff looked at the language data available across all modalities of telehealth to assess if patients' spoken language needs during virtual visits affected their experience or the visit's clinical quality. GVHC knew that non-English speaking patients generally used telehealth modalities less than English speaking patients and wanted to understand the data trends as well as root causes. Utilization data for video and phone visits was stratified by patient language spoken, based on information shared by patients during the intake process.

An Investigation into the workflows revealed that there was an easy process to screen and integrate a third-party audio translator, or "language line," for phone visits. This process was more difficult in video visits and often led to poor audio reception, negative feedback from patients and a delay in appointments that impacted staff. Updated workflows, including a new standard workaround for the "language line" instructions, and additional training and education for frontline staff have been generally successful in supporting non-English speaking patients.

California Advanced Primary Care Initiative

Through the California Advanced Primary Care Initiative, CQC and the Integrated Healthcare Association (IHA) have partnered to bring health care payers together to strengthen primary care delivery. The initiative aims to facilitate the delivery of high-performing, value-based care that reduces costs while enhancing quality and equity; through shared standards that were defined, which includes equity as an integral attribute. CQC and IHA are collaborating with payers to design and adopt a unified payment model for primary care providers that offers flexibility, supports team-based care delivery and incentivizes the right care at the right time. The initiative's payment model includes three key elements: direct patient care payment, population health payment and performance-based payment.

Multi-stakeholder Alternative Payment Models have the ability to mitigate detrimental effects on marginalized communities and the providers who serve them by encouraging and supporting systemwide changes in care delivery.[27] To strengthen health equity within the initiative's payment model design and implementation, CQC conducted interviews with subject matter experts in payment models and health equity, gathering recommendations for promoting equity. These recommendations focused on creating accountability for more equitable health outcomes in purchaser and payer contracts and alleviating unintended negative impacts on clinicians serving marginalized populations. The Health Care Payment Learning & Action Network's Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation served as a guiding framework for these efforts.

Maternal Health

As part of its maternal health aim, CQC developed a three-year strategy to enhance primary care's management of postpartum health populations, focusing on reducing maternal mortality and morbidity and improving chronic and behavioral health outcomes during the first year after birth. Recognizing that postpartum health disparities disproportionately affect Black, American Indian/Alaska Native and Pacific Islander communities in California, the strategy prioritizes addressing the health conditions most impacting these populations, such as cardiovascular disease, behavioral health challenges and SDOH factors that worsen inequities in postpartum outcomes.

CQC convened a postpartum sub-workgroup of over 20 experts in DHCS' Birthing Care Pathway project, which covers the journey of a Medi-Cal member from conception through 12 months postpartum, to define recommendations for improving health outcomes for Medi-Cal families. The care model guides medical delivery systems and care teams in piloting postpartum innovations tailored to their unique resources and the specific needs of their pregnant and postpartum patients through pregnancy, delivery and the first year postpartum. With the goal of reducing maternal morbidity, the model outlines essential elements to enhance patient experience, achieve care continuity and improve health outcomes. Additionally, a foundational component of the design was to address the significant racial and ethnic disparities in maternal health outcomes, particularly among Black, American Indian/Alaska Native and Pacific Islander individuals.

Additional CQC maternal health resources:

May 2023

Maternity Deserts an Alarming Trend in the U.S.

May 2022

Supporting Non-Hospital Birthing Options: Employer Strategies to Improve Quality

June 2021

Employer Strategies to Promote High-Value Equitable Maternity Care

Thought Leadership

CQC, a quality improvement program of the Purchaser Business Group on Health, publishes and disseminates guidance and best practices for health care industry stakeholders through issue briefs, webinars and other thought leadership, amplifying industry direction and showcasing success stories in advancing health equity.

December 2023	
Recommendations to Advance Equity Through Payment Models	• Issue Brief • Blog
June 2023	
Advanced Primary Care Key to Reducing Health Inequities	• Blog
February 2023	
A Vicious Circle: Food Insecurity Both a Cause and Effect of Higher Health Care Costs	• Blog
October 2022	
Improving the Collection and Use of Race, Ethnicity and Language Data	• Issue Brief • Blog • Webinar
May 2021	
Opportunities in COVID-19 Vaccine Access and Equity	• Blog

Endnotes

1 CMS Framework for Health Equity 2022–2032, Centers for Medicare & Medicaid Services, 2022

2 Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024 -Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE), Centers for Medicare & Medicaid Services, 89 Fed. Reg. 30448-30848, April 23, 2024

3 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates, Centers for Medicare & Medicaid Services, 87 Fed. Reg. 48780-49499, August 10, 2022

4 States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, Centers for Medicare & Medicaid Services

5 Theory of Change, Health Care Payment Learning & Action Network

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22 CMS Strategic Plan Health Equity, Centers for Medicare & Medicaid Services, updated May, 2024

23 Mai S, Agrawal S, Salhi R. Distinguishing health equity and health care equity: A framework for measurement, N Engl J Med. Catalyst. March 7, 2023

24 Improving the collection and use of race, ethnicity, and language data, California Quality Collaborative, October 2022

25 Equity and Quality at Independent Practices in LA County, California Quality Collaborative

26 CalHIVE Telehealth & Virtual Care, California Quality Collaborative

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About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, is health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. CQC is committed to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

California Quality Collaborative