Quality Improvement and Health Equity Committee (QIHEC) Quarterly Summary –

February 2026

Introduction

The quarterly reports summarizes the work of Partnership HealthPlan of California (Partnership) to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis.

The Quality Improvement and Health Equity Committee is currently charged with the following:

- Analyze and evaluate the results of Quality Improvement (QI) and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the CAC;
- Recommend actions to address performance deficiencies, including policy recommendations
- Ensuring Appropriate Follow-Up of Identified Performance Deficiencies

QIHEC Meeting Analysis

Partnership has conducted 6 QIHEC meetings with the most recent meeting been on 09/16/25. Located below is the current composition of the QIHEC.

QIHEC Meeting Members

Chair and Co-Chair

Name	Employer/Clinical Site	Role
Robert Moore, MD, MPH, MBA	Partnership Health Plan of CA	Chief Medical Officer
Mohamed Jalloh, PharmD	Partnership Health Plan of CA	Health Equity Officer (Director of Health Equity)

External Invitees:

External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC		X	X	X	X	X
Eugene Durrah Equity Services Manager	Solano County	County						

Ian Kim Chief Medical Officer	Communicare+ Ole	FQHC				X	X	X
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System		X		X		X
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department				X		
Eva Julien Senior Manager, Quality Improvement	Providence	Health System	X		X	X	X	X
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System		X	X	X	X	X
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X	X	X		
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X	X				
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department		X	X		X	X
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X	X				
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X		X	X	X	
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government	X	X	X			X
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X				

**The average attendance of external voting members is at least 5 members per meeting.

Health Disparity Data Analysis

During the November 2024 meeting, QIHEC members reviewed the following information:

- Tribal Health Liaison Introduction
- Disparity Data Update: Grievance and Appeals Grand Analysis
- DEI Training Policy Feedback
- HE Foundations Policy Feedback

During the January 2025 meetings, QIHEC members reviewed the following information:

- HEDIS/MCAS/ QIP Disparity Analysis (Language Stratification)
- Disparity Data Update: Work Plan, Policy, Population Health or QI Intervention discussion
- HE Integration Policy

During the March 2025 meeting, QIHEC members reviewed the following information:

- C&L program Trilogy Doc:
- 2025 MCND9002 C&L Program Description
- C&L/QIHETP Work Plan (2024 and 2025)
- 2024 C&L Evaluation
- Health Equity Initiatives at UC Davis Health
- Health Equity Playbook
- Policy Discussion and Pop Health/QI Intervention Discussion (All)

During the May 2025 meeting, QIHEC members reviewed the following information:

- Grievance and Appeals Grand Analysis
- Humboldt County Public Health: Steps Toward Data Equity
- DEI/Cultural Connection Training Policy (MCEP6004dations Policy Feedback
- Disparity Discussion: Intervention Discussion

During the July 2025 meeting, QIHEC members reviewed the following information:

- MCND9001 PHM Strategy & Prog Description

- Impact Analysis
- Segmentation Report
- Quality Improvement in Health Equity and Transformation Program Description Review (MCEP6001)
- Quality Improvement in Health Equity Policy Review (MCEP6002)
- Disparity Discussions: Community Engagement

During the September 2025 meeting, QIHEC members reviewed the following information:

- Cares Training updates
- Grand Analysis of HEDIS/MCAS/QIP Disparity data analysis (Race/Language Stratification)
- Community feedback: focus groups

There was no January 2026 QIHEC meeting.

QI/HE Activities Summary

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American Native Hawaiian/Pacific Islander White
Goal for Specific Group	Improve Well Care Visit attendance by at least 1.25% across multiple regions or at least 2% in 1 single region in any group ((e.g.) Black/African American, American Indian/Alaska Native, White, Native Hawaiian/Pacific Islander) within 12 months with global goal of improvement by 5% in the next 5 years.
Current Health Plan Actions for Direct Clinical/Service Measure Improvement	
<u>Intervention #1: Provider Recruitment Program and Provider Retention Initiatives</u> Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **Intervention #2: Group Well Child Visits**	

Partnership is conducting a pilot with a clinical site to start group well child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network.

Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs
Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits. QIHEC members have

Intervention #4: Launch the State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County
DHCS assigned Partnership a Health Equity PIP focused on the Well Child Visit Birth-15 Months (W30-6) HEDIS® Measure for the 2023-2026 time period, based on not meeting the Minimum Performance Level (MPL) of 50th percentile for the W30-6 measure in any Reporting Unit. Partnership and DHCS agreed to focus the PIP on African American rates of completion of the W30-6 measure. Partnership selected Solano County as the population of focus for this measure based on several factors. Solano County has the highest member population of any of

This PIP's initial intervention will likely address delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families, continuity of care with their chosen PCP and on Partnership's ability to capture all well-child visits in babies' first 15 months of life. Since the W30-6 HEDIS® measure is an administrative measure by NCQA's definition, Current Procedural Terminology (CPT) codes on claims are the only way for Partnership to count a well-child visit as completed. One barrier to success with the W30-6 HEDIS® measure is that most newborns are not enrolled in Medi-Cal until their second month of life and often later. Often times, Managed Care Plans (MCPs) have a difficult time linking a baby's Medi-Cal ID with data about their early care captured under Mom's Medi-Cal ID. This can also result in babies being auto-assigned to a PCP that they have not been seeing up to that point, causing disruptions in care.

Intervention #5: Launch Participation in DHCS/Institute for Healthcare Improvement (IHI) Collaborative to Improve Pediatric Well-Care Visits
In March of 2024, Partnership engaged in the launch of a one (1)-year, mandated collaborative led by DCHS, intended to improve access, coordination and equity across the communities we serve by initiating a focused effort to improve the completion of pediatric well-care visits, with a specific lens towards equity.
In order to foster learning at the managed-care plan level, the collaborative has required each plan to have an internal project team that meets regularly, as well as attends twice a month collaborative calls led by the Institute for Healthcare Improvement (IHI), and execute the phases of the project.
The front-line project work is conducted in partnership with a primary care organization who have agreed to participate in this program as a pilot partner.

(ADDED Nov 2024) Intervention #6: WCV Enhanced Incentive Pilot: Member gift cards of $100 for completing the visit; a large incentive could be especially impactful for young adults; Same day taxi or Uber rides to provide transportation to children and families when there is not enough time to use Partnership's transportation service; Continuing locum agreements already in place ($10,000/week, 5x 16 visit days = $125/visit);

Offering stipends for providers to work weekend well visit clinics ($600 a half session, 8 visits = $75/visit); Covering overtime for support staff to outreach and case manage members

Intervention #7: Healthy Kids Program: A pilot program was launched targeting children aged 3 to 6 who had not received a well-child visit in over 11 months. The goal was for 50% of engaged members to complete a well-child visit within 120 days. Although the goal was not met, with only 32% completing the visit, engaged members still demonstrated significantly higher completion rates compared to those who were not engaged.

Policy Recommendations (n=0)	**Policy # and Name**	**Recommendation**	**Status and Update**
Quality Improvement/ Population Health Related Interventions Recommendations (n=1)	**Intervention Name**	**Recommendation**	
		Recommendation #1: Improve correct identification of race/ethnicity data using estimation methods. A committee member questioned whether there was any discrepancy in the tribal communities—namely ones that are receiving care in the United Indian Health Services versus other health system.	November Update: CMO and HEO have engaged with DHCS CHEO and staff members regarding the misidentification of AI/AN members.
Community Engagement Intervention Recommendations (n=0)	**Community Event or Idea Name**	**Recommendation**	**Status and Update**

Prenatal Care Visits	
Group(s) of Focus	American Indian/Alaska Native
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years

Current Health Plan Actions for Direct Clinical/Service Measure Improvement

Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event
Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative, and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group.

Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods.

Intervention #2: Contracting Doulas in Partnership Network: Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doula's in the NE/NW regions to ensure that we are able to outreach to our Tribal community members.

Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:
Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. For example, partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, partnership will like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Intervention #4: Contracting Doulas in Partnership Network: Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doula's in the NE/NW regions to ensure that we are able to outreach to our Tribal community members.

Intervention #5: Baby Photoshoot: Partnership is conducting a pilot Baby Photoshoot on-site for our pregnant mothers to celebrate their journey. We want to promote further improved quality of care among our providers until we display our members through a mini photo shoot.

Intervention #6 Growing Together Program: The Growing Together Program includes both prenatal and postpartum components aimed at improving maternal health outcomes. In the Prenatal Program, the intervention focused on conducting outreach to pregnant members to encourage prenatal care and promote TDAP vaccinations. The goal was for 35% of members to receive the TDAP vaccine within 120 days prior to delivery. Although this specific target was not met, with 73% of engaged members receiving the vaccine, those who were successfully reached had significantly higher vaccination rates than those who were not. However, a notable disparity was observed: White members had significantly lower vaccination rates compared to Hispanic members. In the Postpartum Program, the objective was to have 75% of engaged members attend postpartum visits within 60 days of delivery. This goal was achieved, and the difference in attendance between engaged and non-engaged members was statistically significant. Yet again, disparities were evident—White members had lower rates of postpartum visit attendance than Hispanic, Asian, and Native American groups.

Policy Recommendations (n=3)	**Policy # and Name**	**Recommendation**	**Status and Update**
	MCUG3118 Prenatal and Perinatal Care	The committee suggested including a reference to additional race and ethnic groups that incur higher risks during pregnancy, as well as considering incorporating cardiovascular disease risks for populations with higher risks (such as AA, NA, PI).	Approved March 2025
	MPXG5009 Lactation Clinical Practice Guidelines	The committee recommended adding the following text to the policy: “Health plan supports providers in offering culturally congruent care and traditional health services that respects and integrates a patient's cultural beliefs, values, and traditions into their treatment. The care aims to be sensitive to and compatible with the patient's cultural context”	Approved March 2025
	MCNP9006 Doula Service Benefit	The committee recommends text encouraging Doulas attend continuing education that emphasizes culturally competent practices for those who serve tribal communities and offers resources that support this.	Approved March 2025
Quality Improvement/ Population Health Related Interventions Recommendations (n=01)	**Intervention Name**	**Recommendation**	
		<u>Recommendation #1: Include Maternal Mortality Data.</u> A committee member questioned whether we are tracking the maternal mortality data related to the prenatal/postpartum care values. Will be working with the Health Analytics team to update internal dashboards to include such key information.	November 2024 Update: HEO has submitted request for health analytics team to update new dashboard. Health Analytics team is planning to integrate in second phase. November 2025 Update: HEO and QI leaders have developed the new Health Equity Dashboard that

			stratifies MCAS measures by Estimated Race, Language, Homelessness Status, and Sex Assigned at Birth. Population Health Epidemiologist has calculated Maternal Mortality Data Per County
Community Engagement Intervention Recommendations (n=0)	**Community Event or Idea Name**	**Recommendation**	**Status and Update**

CARES (DEI Training)	
Group(s) of Focus	Contracted Practitioners
Goal for Specific Group	Execute contract with DEI training vendor and begin pilot with one clinical site
Current Health Plan Actions for Direct Clinical/Service Measure Improvement	
Intervention #1: DEI Vendor Selection Partnership is finalizing the contracting with a vendor for providing DEI training **Intervention #2: DEI Training Roll Out** Partnership has decided to roll out the training in the following key phases: Phase I: Pilot Site Phase II: All Newly Credentialed and Credentialed Providers	

Policy Recommendations (n=0)	**Policy # and Name**	**Recommendation**	**Status and Update**
Quality Improvement/ Population Health Related Interventions Recommendations (n=1)	**Intervention Name**	**Recommendation**	
		<u>Recommendation #1: Allow QIHEC Members to Review Training and Provide Feedback.</u> A committee member questioned whether they were able to provide feedback on the selected training. The HEO highlighted that they will be able to share the LMS training with the committee members if needed to help refine the training.	November 2024 Update: Partnership has selected training vendor and has selected training site. LMS access is currently being developed and QIHEC members will be eligible to take training in January when available.
Community Engagement Intervention Recommendations (n=0)	**Community Event or Idea Name**	**Recommendation**	**Status and Update**