ALAMEDA
Alliance
FOR HEALTH

Population Needs Assessment

Alameda Alliance for Health

2020

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1. Population Needs Assessment Overview

Purpose
The goal of the Population Needs Assessment (PNA) is to improve health outcomes and ensure that Alameda Alliance for Health (Alliance) is meeting the needs of all its Medi-Cal members. The PNA is an annual requirement from the Department of Health Care Services (DHCS) that replaces the previous requirement to conduct a Group Needs Assessment (GNA) every five years.

The PNA identifies member health needs and health disparities from data about the membership, health status and disease prevalence, access to care, and quality of care. It must address the special needs of seniors and persons with disabilities, children with special health care needs, members with limited English proficiency, and other members from diverse cultural and ethnic backgrounds. From the data findings, the PNA identifies program gaps and presents an action plan with health education, cultural & linguistic, and quality improvement activities to address them.

Data Sources
The Alliance Quality Improvement Department conducted the PNA from December 2019 to June 2020. Required data sources were the Consumer Assessment of Health Care Providers and Systems (CAHPS) results from 2019 and the DHCS managed care health plan (MCP) specific health disparities data, which were Heathcare Effectiveness Data and Information Set (HEDIS) results from Measurement Year 2018 (Reporting Year 2019).

Membership profile data came from the Alliance DHCS monthly eligibility files and publicly available Alameda County data sources. Health status and disease prevalence was reported from CareAnalyzer®, an analytics program used by the Alliance to measure morbidity. Access to care data included the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey implemented by third party vendor SPH Analytics in 2019 for both children and adults as well as another member survey called CG-CAHPS (Clinician and Group-CAHPS) that the Alliance fields quarterly by mail to capture additional information such as language access. Access was also analyzed with grievances, interpreter utilization, and members per primary care provider by language.

Input from members and community advocates also informed the PNA. Member Advisory Committee members (six Alliance members, one clinic representative, and one community advocate) participated in focus groups or interviews and provided input on priority member health needs and potential strategies.

Key Findings

Membership Profile: There were 303,554 total members enrolled in Alameda Alliance Medi-Cal at any time during 2019. Of these members, 37% were under age 19, 34% ages 19 to 44, 20% ages 45 to 64, and 9% ages 65 and over. Primary ethnicity was 29% Hispanic (Latinx), 18% Black (African American), 16% Other, 11% Other Asian/Pacific Islander, 10% Chinese, 10% White, 4% Vietnamese, 1% Unknown, and less than 1% American Indian or Alaskan Native.

There were 8,509 children with special health care needs receiving services from California Children's Services (CCS). Excluding CCS, there were 30,309 Senior and Persons with Disabilities (SPD) members. Over a third (37%) of all members preferred to speak a non-English language. These

were the threshold languages, Spanish (19%), Chinese (9%), and Vietnamese (3%), along with another 5% that were other languages or unknown.

Although Alliance membership-specific data on the homeless and LGBTQ populations is not available, the 2019 homeless count in Alameda County reported 8,022 homeless residents. The LGBTQ population in the San Francisco-Oakland-Hayward metropolitan area was reported by the Gallup Daily 2012-2014 tracking poll to be the highest among U.S. metropolitan areas at 6.2% of the adult population.

Health Status and Disease Prevalence: The CareAnalyzer® database used to identify top diagnoses and disease prevalence did not include members delegated to Kaiser. A total of 269,798 members were part of this analysis. By subpopulation, the top three diagnoses were: Children (Acute upper respiratory tract infection, Obesity, Ophthalmic signs and symptoms); Adults (Hypertension, Disorders of lipid metabolism, Abdominal pain); CCS (Acute upper respiratory tract infection, Refractive errors, Obesity); SPD (Hypertension, Disorders of lipid metabolism, Neurologic signs and symptoms).

For a more in-depth analysis on disease prevalence, the PNA focused on five chronic diseases that were common among the membership: Hypertension (14%), Disorders of lipid metabolism (11%), Obesity (11%), Diabetes (7%), and Asthma (6%). The largest age groups and ethnic groups are listed below. The bolded groups have the highest prevalence among age groups or ethnic groups (e.g., a greater proportion of members ages 65+ had hypertension compared to other age groups).

Chronic Disease	Age groups	Ethnic groups
Hypertension	Ages 45 to 64, **Ages 65+**	Black (African American), **Other Asian/Pacific Islander**, Chinese
Disorders of lipid metabolism	Ages 45 to 64, **Ages 65+**	**Chinese**, Other Asian/Pacific Islander
Obesity	Under 19, Ages 19 to 44, **Ages 45 to 64**	**Hispanic (Latinx)**, Black (African American)
Diabetes	Ages 45 to 64, **Ages 65+**	**Other Asian/Pacific Islander**, Hispanic (Latinx), Black (African American)
Asthma	**Under 19**, Ages 19 to 44	**Black (African American)**, Hispanic (Latinx)

Access to Care: For both children and adults, the CAHPS survey and access-related grievances indicated issues for wait time for routine care appointments and getting needed care easily or as soon as needed. CAHPS and CG-CAHPS indicated additional issues for adults: being able to understand your personal doctor, your personal doctor seeming informed about care received from other health care providers, getting information about how the health plan works from written materials or the Internet, getting needed help from customer service, and using qualified interpreters (or doctor's office speaks your language) instead of using family or friends.

Quality of Care Disparities: Disparities were defined from the HEDIS data as any subgroup with a rate below the minimum performance level (MPL, defined by DHCS as the 25th percentile) that represented at least 5% of the sample size for each measure. Of these disparities, the rates that were significantly below the MPL were: Asthma Medication Ratio (AMR) for Ages 21 to 44; Children and Adolescents' Access to Primary Care Practitioners (CAP) 12 to 19 years for Males; and CAP ages

25 months to 6 years, 7 to 11 years, and 12 to 19 years for Black (African American) and White members.

Program gaps and objectives

From the data and member and community advocate input on program gaps and strategies, the following program gaps and related action plan objectives were identified:

1. **Gap: Culturally and linguistically appropriate disease self-management education**

    a. **Hypertension, Hyperlipidemia, and Diabetes in the Asian and Pacific Islander adult and senior populations**
    Objective: Reach 100 Asian and Pacific Islander members with hypertension, hyperlipidemia, and/or diabetes through materials, classes, and/or other supports by June 30, 2022.

    b. **Obesity in the Hispanic (Latinx) child population**
    Objective: Connect 100 Hispanic (Latinx) members with healthy weight resources by June 30, 2022.

    c. **Asthma in the Hispanic (Latinx) and Black (African American) child populations**
    Objective: Increase annual participation of Hispanic (Latinx) and Black (African American) children ages 0 to 18 in Asthma Start in-home case management program by 25% from 209 (2019) to 261 members by December 31, 2021.

    d. **Asthma in the Black (African American) adult population**
    Objective: Achieve HEDIS Asthma Medication Ratio (AMR) measure of at least Measurement Year 2019 MPL of 63.60% for Black (African American) adults ages 21 to 44 by December 31, 2021.

2. **Gap: Access and participation in routine care appointments**

    a. **Getting routine care appointments quickly**
    Objective: Improve CAHPS rate for getting checkup or routine care appointment as soon as needed from 70.3% to 72% for adults and from 83.5% to 85.6% for children by December 31, 2021.

    b. **Well-child visits**
    Objective: Improve HEDIS Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) measure from 68.63% for Black (African American) and 68.42% for White members to the Measurement Year 2019 MPL of 72.87% by December 31, 2021.

    Note: Because Children and Adolescents' Access to Primary Care Practitioners (CAP) measures have been discontinued for Measurement Year 2019, CAP-256 (25 months to 6 years) is used as the baseline and W34 as the goal.

3. **Gap: Information and coordination of member benefits**
    Objective: Improve CAHPS rate for providing needed information (from written materials and Internet) from 52.6% to 62% for adults by December 31, 2021.

2. Data Sources

Methodology
The process of conducting the PNA went from December 2019 to June 2020. Alliance Health Care Services staff started by discussing the requirements and process. The Member Advisory Committee (MAC) was presented an overview of the PNA in December 2019 and asked to provide any input on data sources and process.

From January to April 2020, Health Education worked with Quality and Analytics staff to identify, obtain, and analyze the data to include in the PNA. Health Education staff asked for input on program gaps from MAC volunteers in April through focus groups and interviews.

Health Education held two meetings in early May with the entire Quality department– the first to identify gaps from the data, and the second to identify strategies and objectives for the action plan. The Quality team worked to refine the objectives and strategies over the next couple of weeks.

The draft was completed in early June and reviewed by the Quality Improvement Medical Director, Senior Director, and managers. It was then presented to Health Care Services leadership, including the Chief Medical Officer, for review before submission to Compliance and DHCS.

Data Sources
The table below lists the final data sources included in the PNA and brief description of each, with more details included in the key data assessment findings where the data are presented.

Table 1: Data Sources

Source	Year	Brief description
Alliance data		
CareAnalyzer®	2019	Analytics program that uses the Johns Hopkins ACG® system to measure morbidity.
Grievances	2019	Standard and exempt access grievances filed by members against the plan, providers, delegates, and vendors.
Interpreter service reports	2019	Services provided by interpreter vendors to Alliance members.
DHCS monthly eligibility files	2019	Member enrollment and demographics from DHCS.
Provider repository	2019	Database with provider information, including languages that Alliance providers can speak to provide services to members.
County data		
Alameda County Homeless Count & Survey	2019	Point-In-Time Count of homeless residents in Alameda County. https://everyonehome.org/main/continuum-of-care/everyone-counts/
CalFresh Data Dashboard	2019	California Department of Social Services dashboard of CalFresh data. https://www.cdss.ca.gov/inforesources/data-portal/research-and-data/calfresh-data-dashboard

Source	Year	Brief description
Gallup Daily	2012-2014	Daily poll conducted by Gallup of approximately 1,000 U.S. adults aged 18 and older every day using phone numbers, in English and Spanish. https://news.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx
Healthy Alameda County	Various	Alameda County Public Health Department source for population data and community health information. http://www.healthyalamedacounty.org/
Kids Data	2013-2015	Lucile Packard Foundation source for data on children. https://www.kidsdata.org/
LGBTQ Community Needs Assessment	2017	San Francisco Bay Area Needs Assessment survey of the LGBTQ community commissioned by Horizons Foundation. https://www.horizonsfoundation.org/wp-content/uploads/2019/03/SF-Bay-Area-LGBTQ-Needs-Assessment-Report-2018-.pdf
Focus groups and Interviews		
Member Advisory Committee	April 2020	Two focus groups and two interviews with six members, one clinic representative, and one community advocate to discuss gaps in services and potential strategies.
Member Surveys		
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Medicaid Adult and Child	2019	Survey in English and Spanish to capture consumer-reported experiences with health care. Using a four Wave Mail with Phone survey methodology, there were 277 valid adult surveys and 426 child surveys collected, yielding a response rate of 21.3% for each group. There were 32 completed surveys in Spanish for adults and 202 for children.
Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	Q4 2018-Q4 2019	Survey in English, Spanish, Chinese, and Vietnamese to capture consumer-reported experiences with health care. Four quarterly mailed surveys fielded by Alameda Alliance with PCP visit dates occurring between April 2018 and August 2019. There were 2,098 responses for adults and 1,763 responses for children on the questions about being able to communicate with doctor and clinic staff in preferred language for those who answered that they needed an interpreter (Question response rate for adults 87% and children 84%).
Quality of Care		
Department of Health Care Services managed care health plan (MCP) specific health disparities data	2018	Measurement Year 2018 (Reporting Year 2019) Alameda Alliance Healthcare Effectiveness Data and Information Set (HEDIS) data stratified by demographics.

3. Key Data Assessment Findings

Membership/Group Profile

Alameda County

Population and geography

As of January 2020, Alameda County had a population of 1,682,509 persons (Healthy Alameda County, data provided by Claritas). The map below shows the cities within the county.
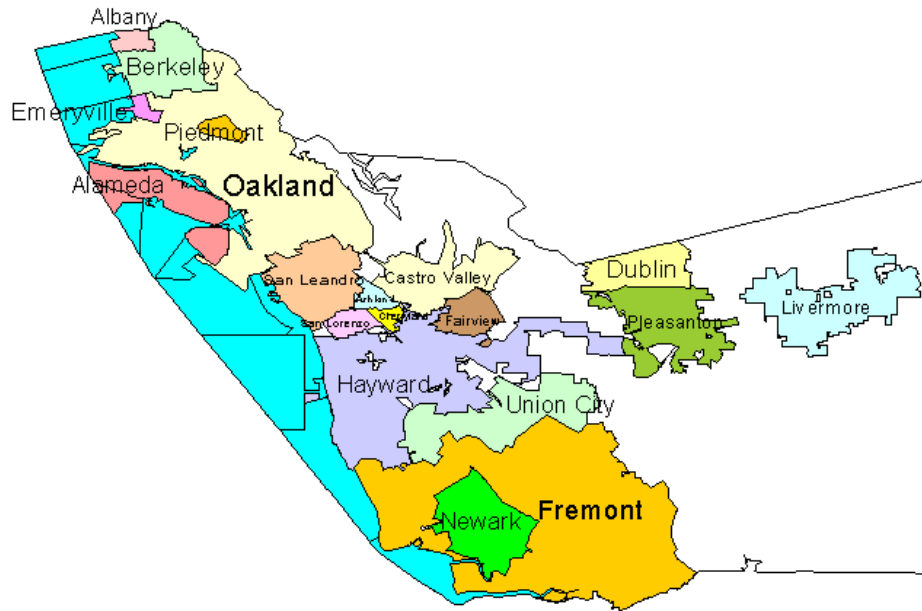
Figure 1: Map of Alameda County

Image source: UC Berkeley Library

Four unofficial regions of the county are defined for this report to summarize our membership by location:

Table 2: County Regions

County Region	Cities included
North County	Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont
Central County	Castro Valley, Hayward, San Leandro, San Lorenzo (Note: Ashland, Cherryland, and Fairview are unincorporated areas and not in member addresses.)
East County	Dublin, Livermore, Pleasanton
South County	Fremont, Newark, Union City

Poverty

About 10.6% of county residents live below the federal poverty level (Healthy Alameda County, data from American Community Survey, 2014-2018). The level of poverty varies by county region and is highest in North and Central Counties. The map below shows the percentage of residents living in poverty by zip code.

| 0.0% - 6.4% | 6.4% - 10.6% | 10.6% - 15.9% | 15.9% - 28.7% | 28.7% - 90.9% |
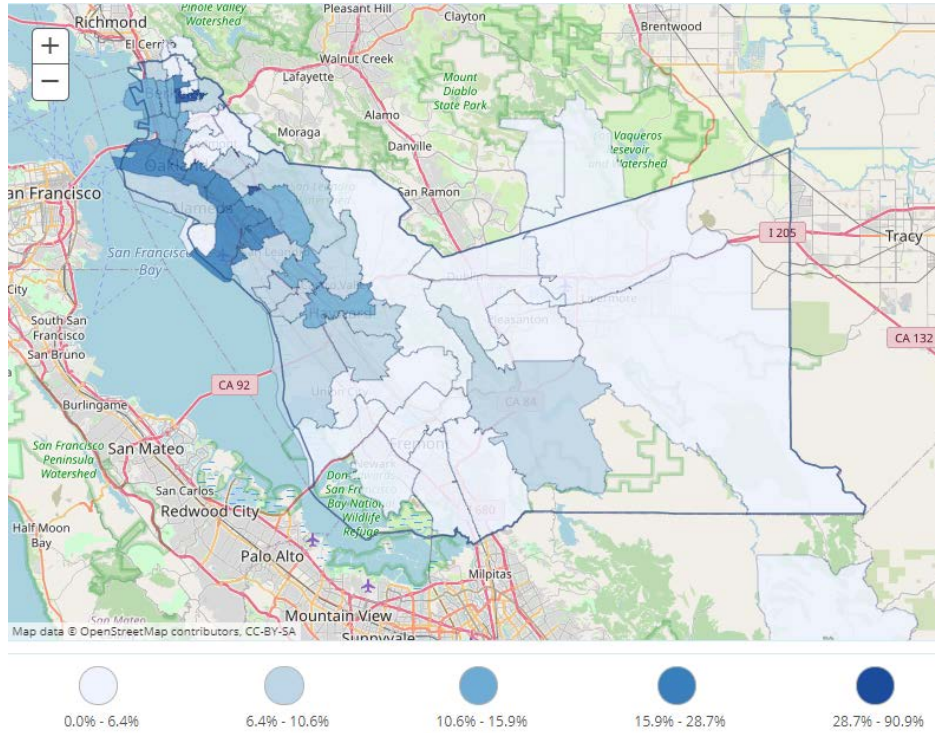
Figure 2: Map of Poverty by Zip Code

Image source: Healthy Alameda County

According to Feeding America (2017), 12.2% of county residents were food insecure. As of December 2019, 65,129 persons received CalFresh (California Department of Social Services).
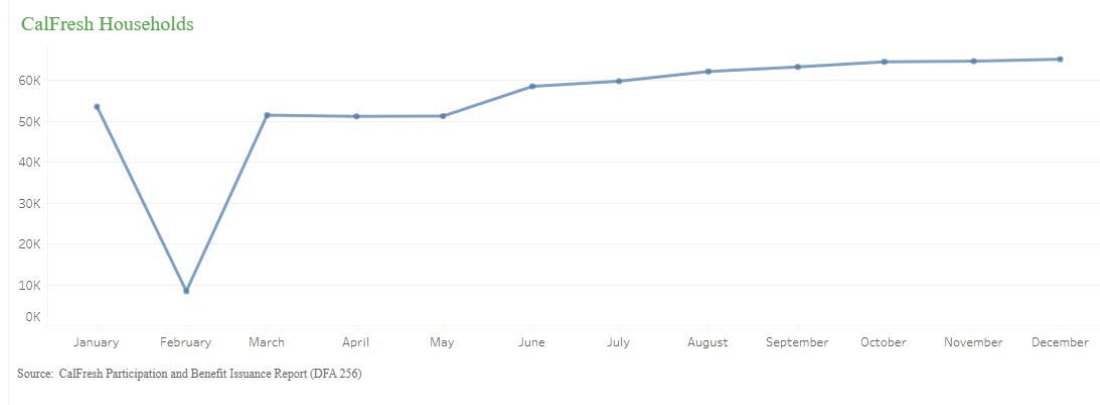

Figure 3: CalFresh Participation

Image source: California Department of Social Services

Homelessness

The 2019 EveryOne Counts Homeless Point-In-Time Count reported 8,022 homeless Alameda County residents. Of those, 79% were unsheltered. This map shows the total number of people experiencing homelessness by city.
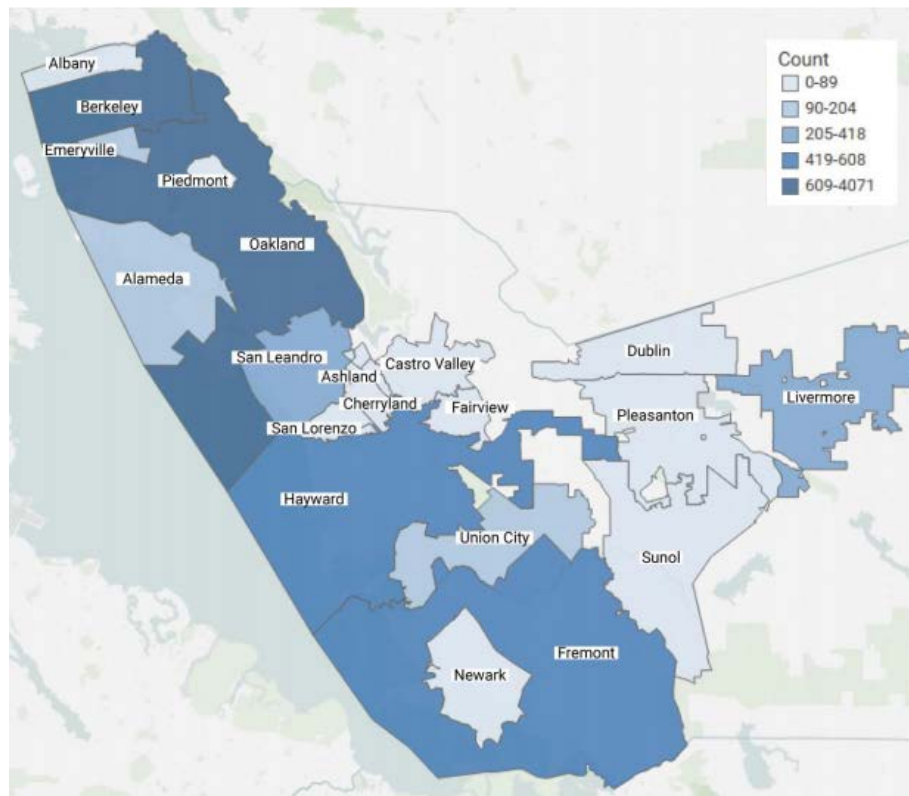
Figure 4: Homelessness by City

Image source: Homeless Point-In-Time Count

LGBTQ data

According to the Gallup Daily 2012-2014 tracking poll, the San Francisco metropolitan area (including San Francisco, Oakland, and Hayward areas) had the highest percentage of the adult population who identify as lesbian, gay, bisexual, or transgender (LGBT) of any of the top 50 U.S. metropolitan areas at 6.2%.

In 2017, the Horizons Foundation conducted a community needs assessment with over 1,400 LGBTQ community members. About a third of the respondents lived in San Francisco County, followed by about a quarter who lived in Alameda County. About 17% of respondents were transgender, genderqueer, or non-binary.

Children were surveyed about sexual orientation and gender in 7th, 9th, 11th grades, and in non-traditional programs. These are the results from the California Healthy Kids Survey (2013-2015) for Alameda County obtained through Kids Data.

Table 3: Youth Sexual Orientation and Transgender

Sexual Orientation	Female			Male		
Grade Level	Straight	Gay / Lesbian / Bisexual	Not Sure	Straight	Gay / Lesbian / Bisexual	Not Sure
7th Grade	84.4%	3.6%	12.0%	86.4%	1.7%	11.9%
9th Grade	87.1%	6.7%	6.3%	93.5%	2.7%	3.8%
11th Grade	88.1%	7.6%	4.2%	94.7%	3.2%	2.1%
Non-Traditional	78.3%	15.6%	6.1%	76.1%	13.1%	10.8%

Transgender	Female		Male	
Grade Level	Yes	No	Yes	No
7th Grade	0.7%	99.3%	0.9%	99.1%
9th Grade	0.9%	99.1%	2.0%	98.0%
11th Grade	0.6%	99.4%	4.0%	96.0%
Non-Traditional	0.7%	99.3%	9.4%	90.6%

Total Membership

There were **303,554 total members** enrolled in Alameda Alliance Medi-Cal at any time during 2019.

Gender
Females made up a slight majority of the membership at 53%.

Table 4: Gender

GENDER	Count	Percent
Female	162,378	53.49%
Male	141,176	46.51%

Age
The largest age bands were children under 19 at 37% and younger adults ages 19 to 44 at 34%.

Table 5: Age

AGE BAND	Count	Percent
Under 19	110,854	36.52%
19-44	103,539	34.11%
45-64	60,528	19.94%
65+	28,633	9.43%

Region
Almost half of the membership lived in North County, and over a quarter lived in Central County.

Table 6: County Region

COUNTY REGION	Count	Percent
North	143,079	47.13%
Central	84,403	27.80%
South	45,631	15.03%
East	17,642	5.81%
Other/Unknown	12,799	4.22%

Ethnicity

The largest group was Hispanic (Latinx) at 29%. A combined Other Asian/Pacific Islander, Chinese, and Vietnamese group put Asian and Pacific Islanders as the next largest group at 26%.

Table 7: Ethnicity

PRIMARY ETHNICITY	Count	Percent
Hispanic (Latinx)	86,925	28.64%
Black (African American)	55,191	18.18%
Other	49,175	16.20%
Other Asian / Pacific Islander	33,454	11.02%
Chinese	31,749	10.46%
White	31,550	10.39%
Vietnamese	12,449	4.10%
Unknown	2,287	0.75%
American Indian Or Alaskan Native	774	0.25%

The age distribution varied by ethnic group. Chinese and Other Asian/Pacific Islander had higher proportions of seniors than other ethnic groups. Hispanic (Latinx) had the highest proportion of children.
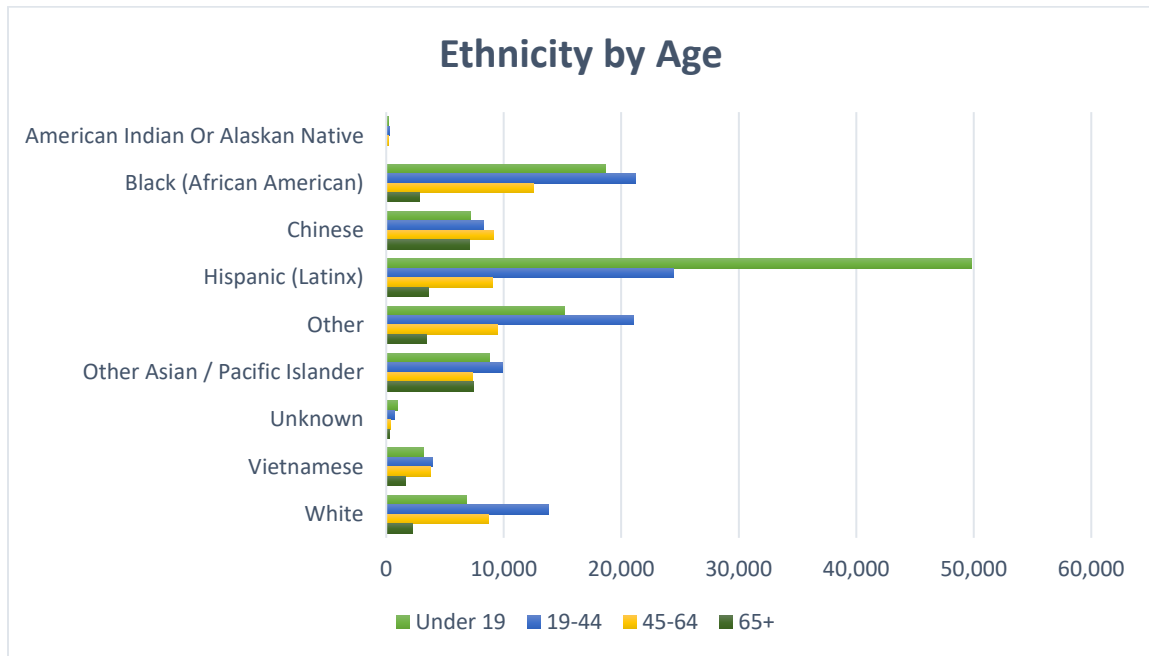
Figure 5: Ethnicity by Age

The makeup of ethnicities varied by county region. The largest ethnic groups by region were Hispanic (Latinx) for Central County; Hispanic (Latinx) and White for East County; Hispanic (Latinx) and Black (African American) for North County; and Other Asian/Pacific Islander, Hispanic (Latinx), and Other for South County.
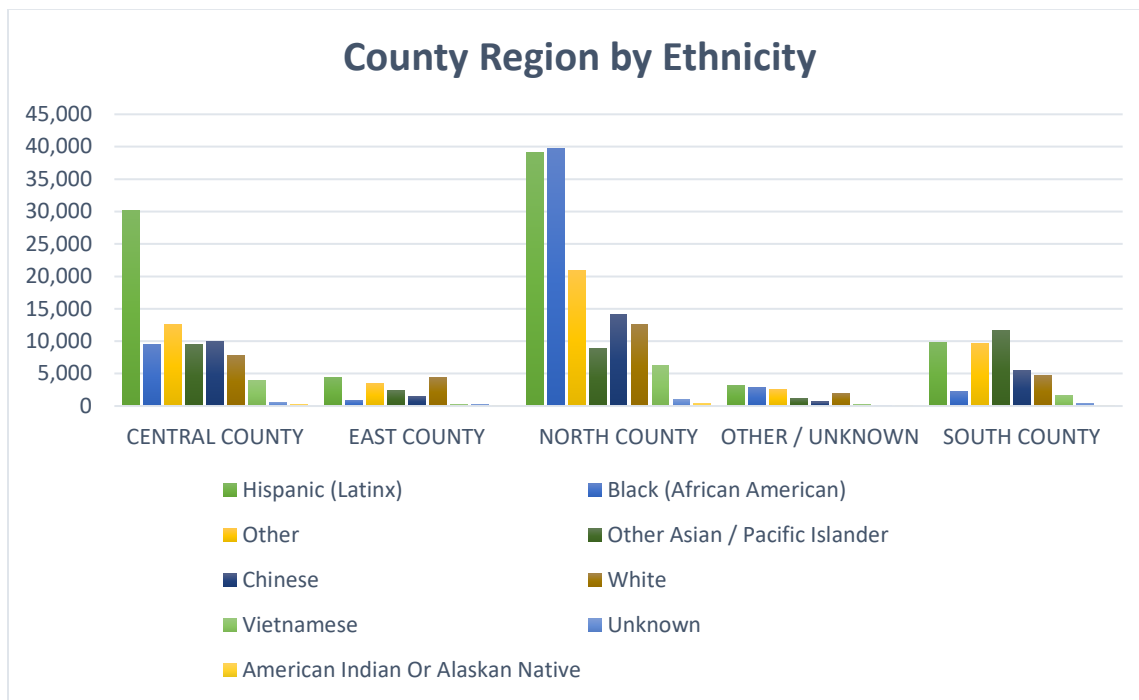
Figure 6: County Region by Ethnicity

Language

The majority of members spoke English at 63%. The other threshold languages were Spanish (19%), Chinese (9%), and Vietnamese (3%).

Table 8: Language

PRIMARY LANGUAGE	Count	Percent
English	191,360	63.04%
Spanish	58,493	19.27%
Chinese	27,340	9.01%
Unknown	10,331	3.40%
Vietnamese	9,211	3.03%
Other Non-English	6,819	2.25%

Each language had a different age distribution. Chinese speakers had more people in the older age groups. English speakers were mostly adults below the age of 65, then children, with much fewer seniors. Spanish speakers were mostly children.
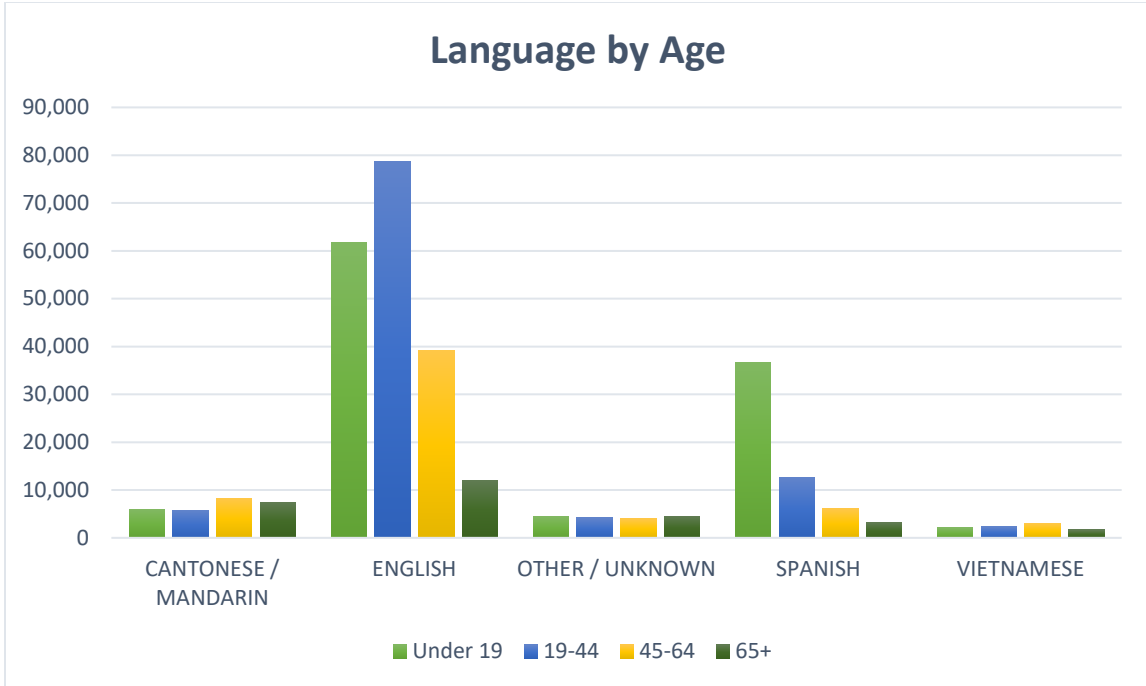
Language by Age

Figure 7: Language by Age

Language distribution had slight differences among county regions. East County had the highest proportion of English speakers. South County had the highest proportion of unknown language speakers and the lowest of Spanish speakers.

County Region by Language
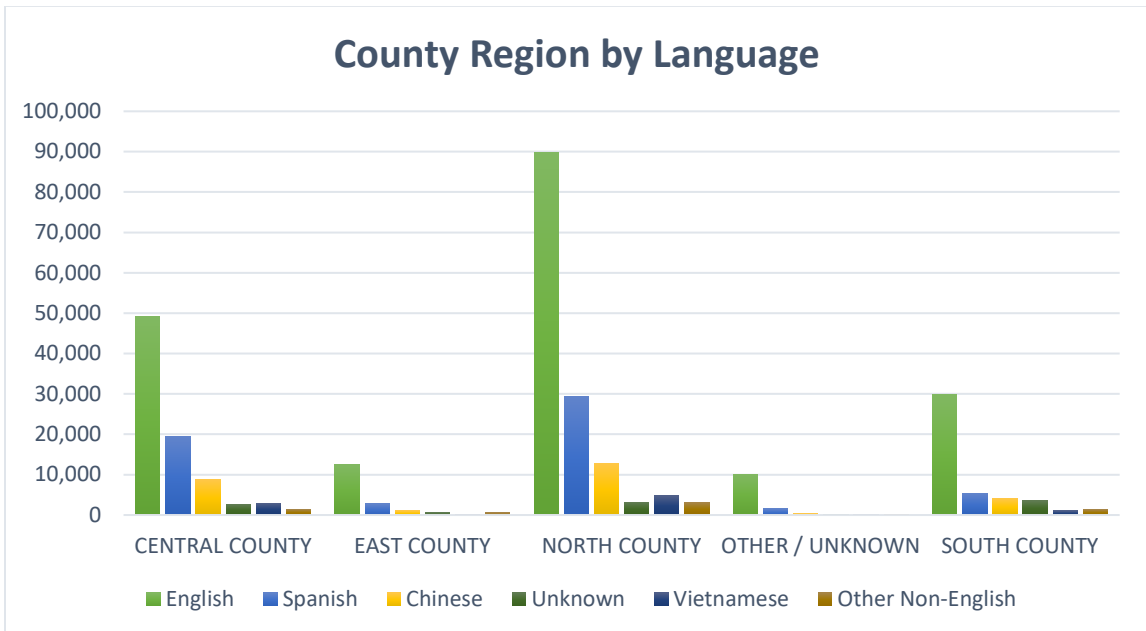
Figure 8: County Region by Language

CCS Membership

There were **8,509 CCS (California Children's Services) members** enrolled in Alameda Alliance Medi-Cal at any time during 2019.

The largest age band was 12 to 18 years at 35%.

Table 9: CCS by Age

CCS BY AGE BAND	Count	Percent
Up to 12 mos	79	0.98%
1-2	601	7.46%
3-6	1,545	19.17%
7-11	2,050	25.44%
12-18	2,782	34.52%
19-21	1,002	12.43%

About half (49%) of CCS members lived in North County, and 30% in Central County. The age distribution for CCS was similar across county regions.
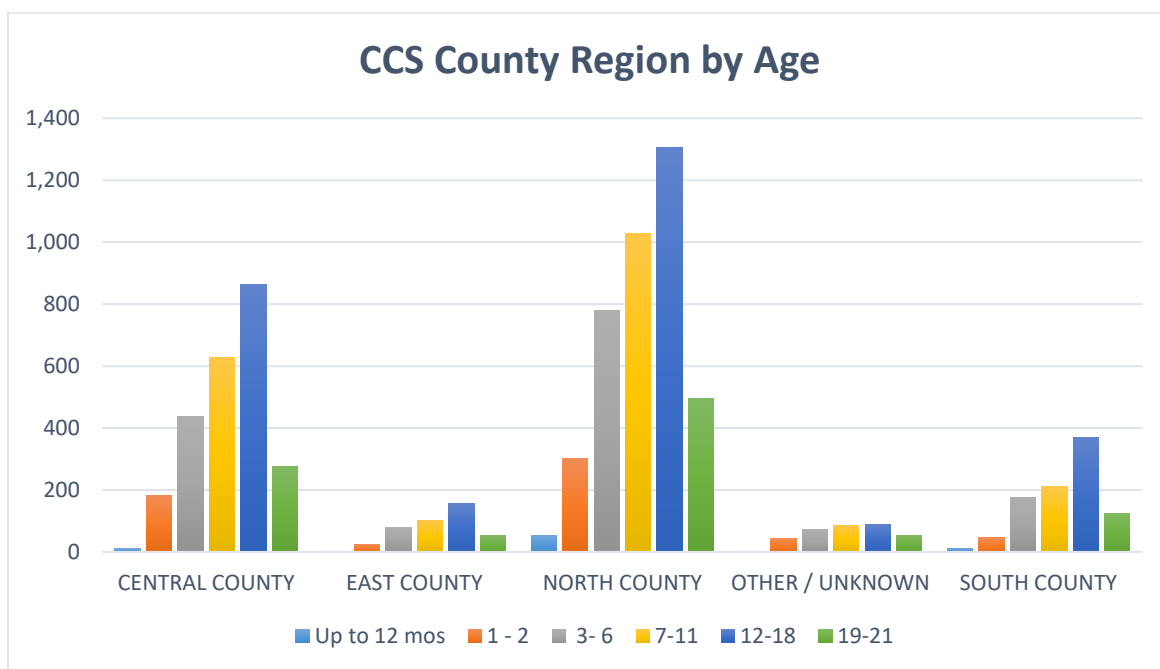
Figure 9: CCS County Region by Age

Almost half (46%) of CCS members were Hispanic (Latinx), and 20% were Black (African American). The age distribution remained constant across ethnic groups.

CCS Ethnicity by Age
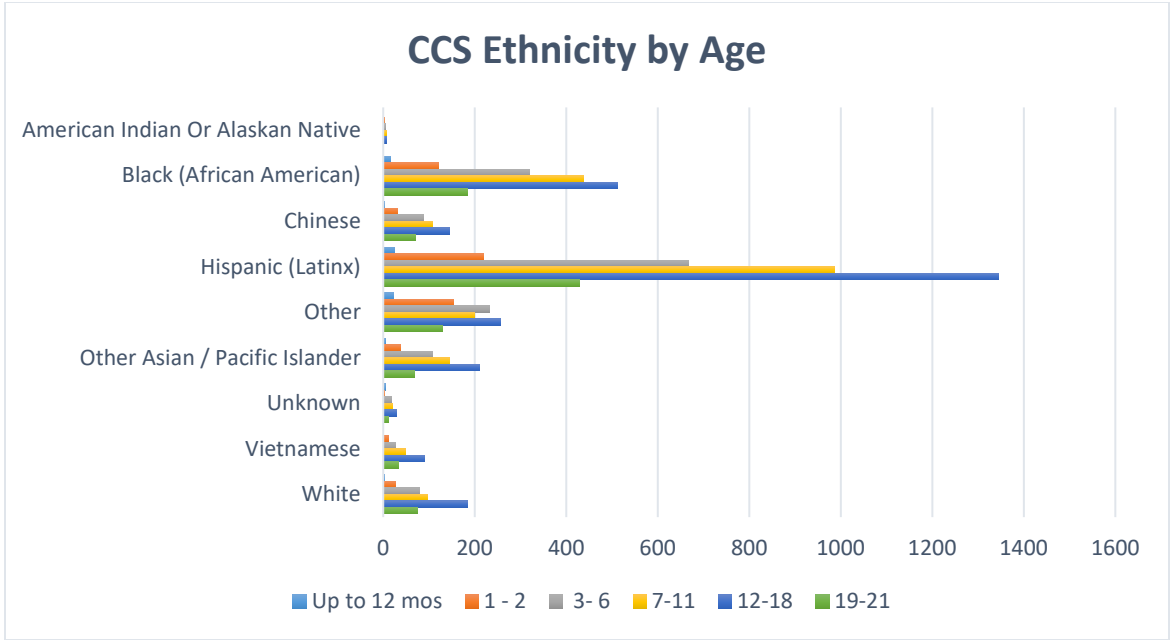
Figure 10: CCS Ethnicity by Age

More than half (56%) of CCS members were English speakers, and a third (33%) were Spanish speakers. There was a similar age distribution across language groups.
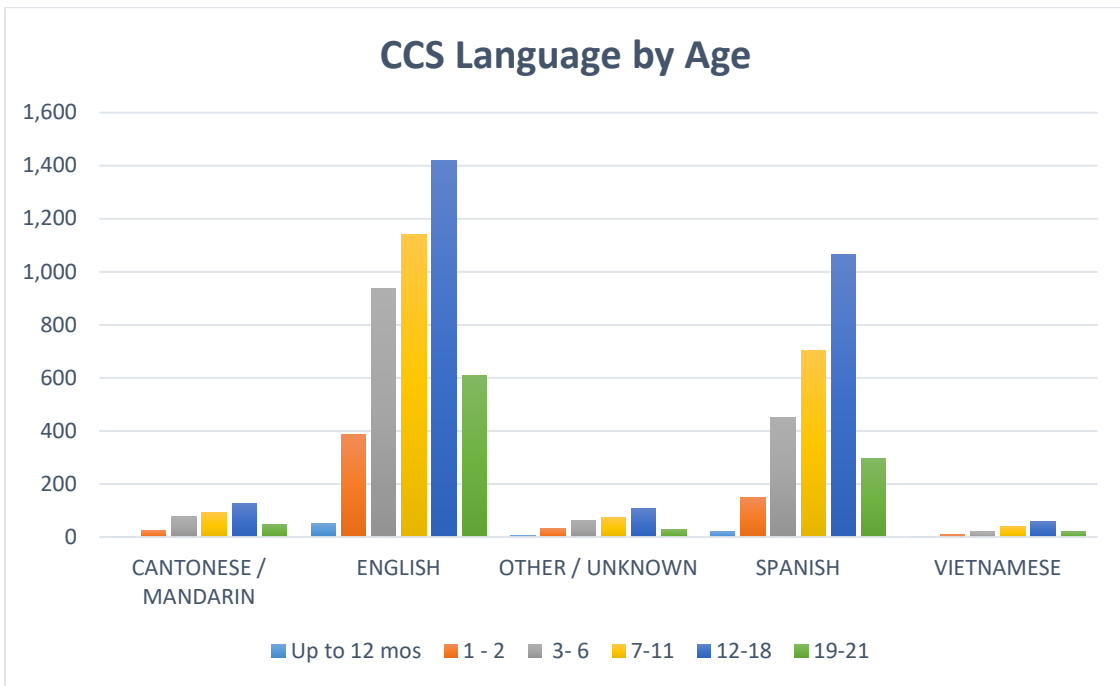
CCS Language by Age

Figure 11: CCS Language by Age

SPD Membership

There were **30,309 SPD (Seniors and Persons with Disabilities) members** enrolled in Alameda Alliance Medi-Cal at any time in 2019. This category excludes the members enrolled in California Children's Services.

Less than half (44%) of the members in this category were ages 65 and over.

Table 10: SPD by Age

SPD BY AGE BAND	Count	Percent
Under 19	2,185	7.21%
19-44	5,645	18.62%
45-64	9,004	29.71%
65+	13,475	44.46%

Almost half (46%) of SPD members lived in North County, 23% in Central County, and 20% in South County. East and South Counties had higher proportions of seniors in the SPD category, while Central and North Counties had higher proportions of adults.
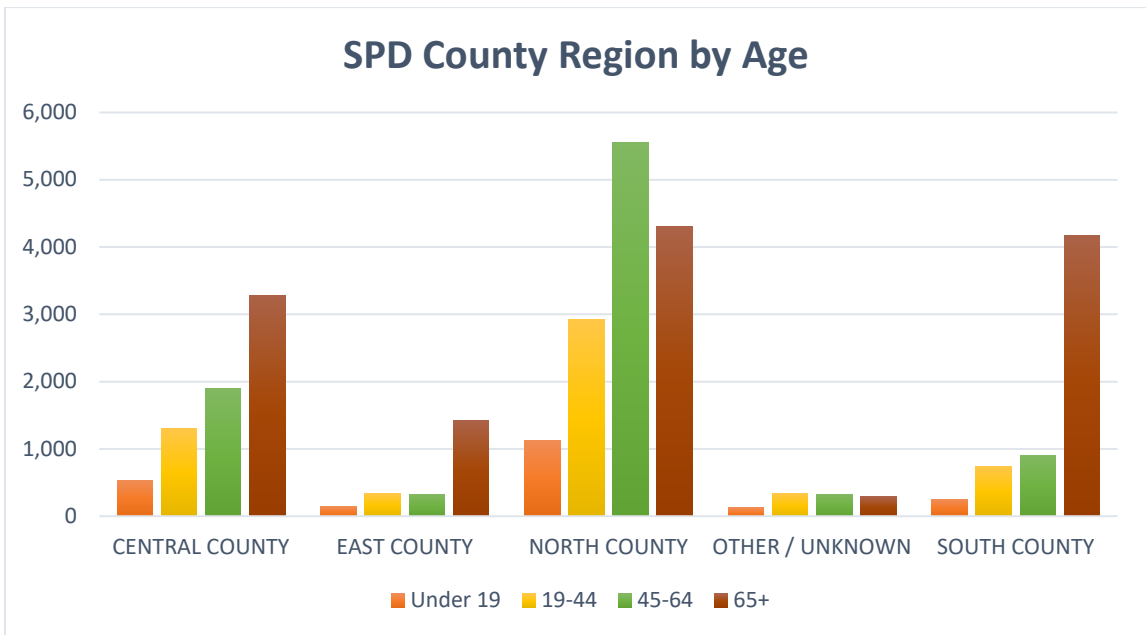
Figure 12: SPD County Region by Age

Over a third (36%) of SPD members were Asian or Pacific Islander (combined category of Other Asian/Pacific Islander, Chinese, and Vietnamese). Black (African American) was the highest single category at 25%. The age distribution varied by ethnicity. The majority of Black (African American) and White SPD members were adults. Chinese, Other Asian/Pacific Islander, and Vietnamese were all predominantly seniors. Hispanic (Latinx) was evenly divided between seniors and adults. They had the highest proportion of children among the ethnic groups, followed by Black (African American).
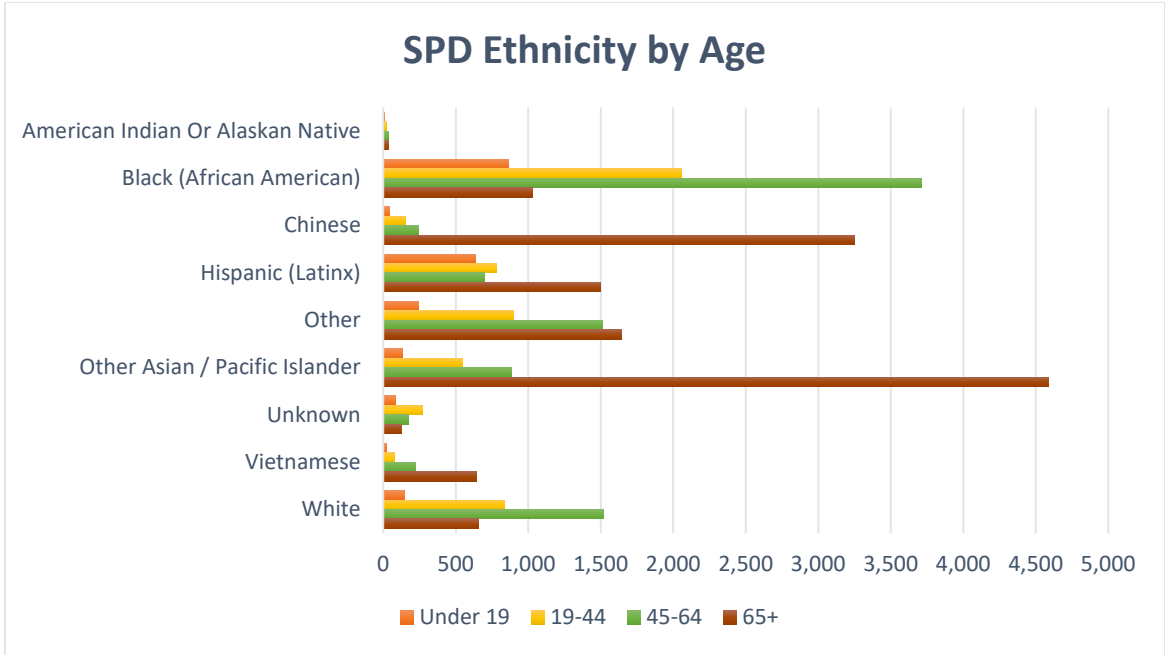
Figure 13: SPD Ethnicity by Age

The majority (61%) of SPD members were English speakers. The next most common languages were Other (15%) and Chinese (12%). Seniors were the majority in most language groups, and Chinese had the highest proportion of seniors among the language groups. English speakers had a higher proportion of adults than seniors. Spanish speakers had a higher proportion of children than other language groups, followed by English speakers.
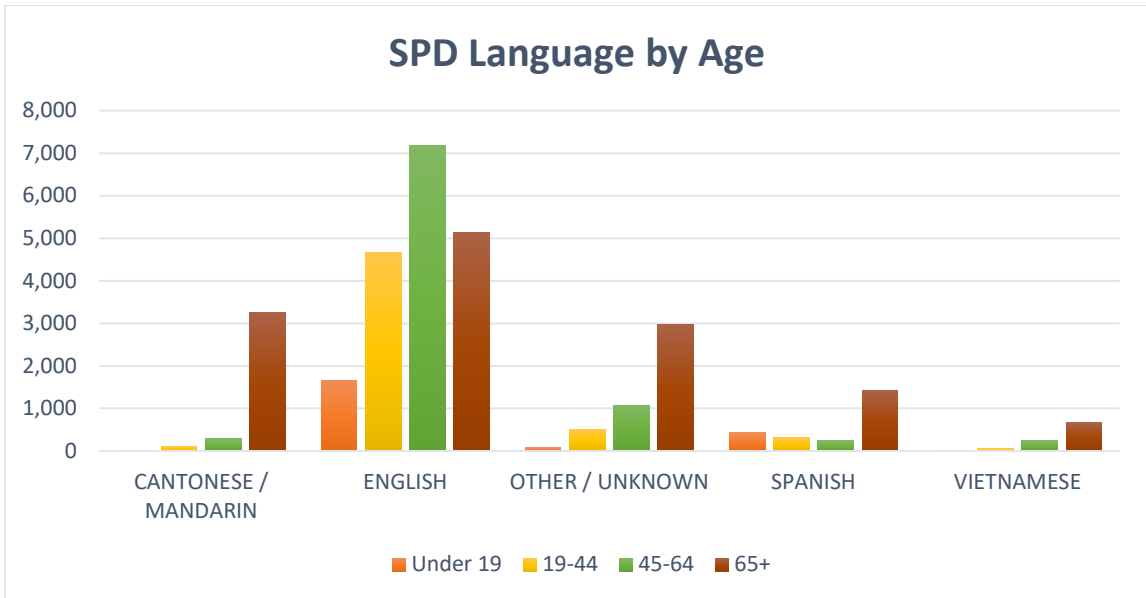
Figure 14: SPD Language by Age

Health Status and Disease Prevalence

The CareAnalyzer® database was used to identify top diagnoses and disease prevalence among Alliance members. Members enrolled at any time during 2019 were included in the database except for those delegated to Kaiser. Therefore, there were a total of **269,798 members.**

Top diagnoses by category

Table 11: Top Diagnoses Children

CHILDREN (ages 0 to 18, excludes California Children's Services) 87,433 total members	Member Count	Percent
Acute upper respiratory tract infection	16,826	19%
Obesity	10,579	12%
Ophthalmic signs and symptoms	10,274	12%
Disorders of teeth	9,449	11%
Viral syndromes	9,245	11%
Refractive errors	9,134	10%
Dermatitis and eczema	8,246	9%
Asthma, w/o status asthmaticus	6,913	8%
Allergic rhinitis	6,612	8%
Cough	6,433	7%
Otitis media	6,415	7%
Fever	5,186	6%
Developmental disorder	4,311	5%
Dermatologic signs and symptoms	4,145	5%
Abdominal pain	4,053	5%
Constipation	3,703	4%
Conjunctivitis, keratitis	3,698	4%
Gingivitis	3,510	4%
Nausea, vomiting	3,355	4%
Gastroenteritis	3,346	4%

Table 12: Top Diagnoses Adults

ADULTS (ages 19+, excludes California Children's Services) 147,073 total members	Member Count	Percent
Hypertension, w/o major complications	24,698	17%
Disorders of lipid metabolism	20,330	14%
Abdominal pain	14,990	10%
Musculoskeletal signs and symptoms	14,968	10%
Neurologic signs and symptoms	13,381	9%
Obesity	13,258	9%
Refractive errors	12,388	8%
Low back pain	12,380	8%

Musculoskeletal disorders, other	12,118	8%
Acute upper respiratory tract infection	10,861	7%
Tobacco use	10,517	7%
Cardiovascular signs and symptoms	9,956	7%
Anxiety, neuroses	9,942	7%
Gastrointestinal signs and symptoms	9,715	7%
Dermatologic signs and symptoms	9,249	6%
Major depression	8,996	6%
Chest pain	8,579	6%
Urinary symptoms	7,951	5%
Gastroesophageal reflux	7,740	5%
Type 2 diabetes, w/ complication	7,599	5%

Table 13: Top Diagnoses CCS

CALIFORNIA CHILDREN'S SERVICES (ages 0 to 21) 6,870 total members	Member Count	Percent
Acute upper respiratory tract infection	1,538	22%
Refractive errors	1,060	15%
Obesity	1,008	15%
Developmental disorder	921	13%
Viral syndromes	903	13%
Asthma, w/o status asthmaticus	875	13%
Ophthalmic signs and symptoms	829	12%
Disorders of teeth	821	12%
Dermatitis and eczema	730	11%
Otitis media	711	10%
Allergic rhinitis	688	10%
Cough	603	9%
Neurologic signs and symptoms	550	8%
Fever	548	8%
Abdominal pain	508	7%
Deafness, hearing loss	498	7%
Constipation	469	7%
Dermatologic signs and symptoms	469	7%
Musculoskeletal disorders, other	468	7%
Gastrointestinal signs and symptoms	420	6%

Table 14: Top Diagnoses SPD

SENIORS AND PERSONS WITH DISABILITIES (excludes California Children's Services) 28,422 total members	Member Count	Percent
Hypertension, w/o major complications	12,104	43%
Disorders of lipid metabolism	8,208	29%
Neurologic signs and symptoms	5,813	20%

Musculoskeletal signs and symptoms	5,647	20%
Musculoskeletal disorders, other	4,648	16%
Low back pain	4,304	15%
Cardiovascular signs and symptoms	3,993	14%
Type 2 diabetes, w/ complication	3,816	13%
Obesity	3,717	13%
Tobacco use	3,563	13%
Abdominal pain	3,509	12%
Degenerative joint disease	3,451	12%
Respiratory signs and symptoms	3,442	12%
Gastrointestinal signs and symptoms	3,382	12%
Gastroesophageal reflux	3,341	12%
Chest pain	3,234	11%
Major depression	3,149	11%
Deficiency anemias	3,102	11%
Cataract, aphakia	3,082	11%
Refractive errors	3,024	11%

Chronic disease prevalence

From the analysis of top diagnoses, five chronic diseases were selected to focus on for the disease prevalence analysis. These were, in order of prevalence: hypertension, disorders of lipid metabolism, obesity, diabetes, and asthma.

Demographic prevalence differences were calculated compared to the overall prevalence:

- Absolute difference (% points) = Subgroup prevalence – Overall prevalence
- Relative difference (%) = Absolute difference / Overall prevalence x 100

Hypertension

Hypertension was a combined category of diagnosis with and without complications. Over half of the members with hypertension were female. Most members were adults and seniors ages 45 and over. Most lived in North or Central Counties, but there was a higher prevalence in South County. The largest ethnic groups were Black (African American) and Other Asian/Pacific Islander. Other Asian/Pacific Islander also had the highest prevalence, followed by Chinese. Most members spoke English. The highest prevalence was for Unknown language.

Table 15: Hypertension Prevalence

HYPERTENSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	38,043	100.0%	14.1		
CSHCN	84	0.2%	1.2	-12.9	-91.3
SPD	12,374	32.5%	43.5	29.4	208.8
Gender					
F	21,691	57.0%	15.1	1.0	7.4
M	16,352	43.0%	12.9	-1.2	-8.4

HYPERTENSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Age					
Under 19	338	0.9%	0.4	-13.7	-97.5
19-44	4,800	12.6%	5.2	-8.9	-63.1
45-64	18,789	49.4%	34.0	19.9	141.2
65+	14,116	37.1%	52.5	38.4	272.0
Location					
North County	17,321	45.5%	13.2	-0.9	-6.3
Central County	10,206	26.8%	14.1	0.0	-0.2
South County	7,396	19.4%	18.8	4.7	33.2
East County	2,159	5.7%	14.1	0.0	0.1
Other / Unknown	961	2.5%	8.3	-5.8	-40.8
Ethnicity					
Hispanic (Latinx)	5,231	13.8%	6.8	-7.3	-51.6
Black (African American)	8,017	21.1%	16.3	2.2	15.5
White	3,626	9.5%	13.5	-0.6	-4.5
Other	5,390	14.2%	12.4	-1.7	-11.8
Chinese	5,756	15.1%	19.6	5.5	39.3
Other Asian / Pacific Islander	7,599	20.0%	25.4	11.3	80.1
Vietnamese	2,065	5.4%	17.6	3.5	25.1
Unknown	248	0.7%	12.3	-1.8	-12.8
American Indian or Alaskan Native	111	0.3%	16.2	2.1	14.8
Language					
English	22,128	58.2%	13.4	-0.7	-5.3
Spanish	3,812	10.0%	7.1	-7.0	-49.4
Chinese	5,828	15.3%	22.6	8.5	60.3
Unknown	3,026	8.0%	31.2	17.1	121.5
Vietnamese	1,936	5.1%	21.8	7.7	54.7
Other Non-English	1,313	3.5%	20.6	6.5	46.2

For adults ages 45 to 64 with hypertension, Black (African American) was the largest ethnic group. For ages 65+, Other Asian/Pacific Islander and Chinese were the largest groups.

Table 16: Hypertension Ethnicity x Age

HYPERTENSION Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	195	57.7%	868	18.1%	2,481	13.2%	1,687	12.0%	5,231	13.8%
Black	56	16.6%	1,649	34.4%	4,949	26.3%	1,363	9.7%	8,017	21.1%
White	11	3.3%	513	10.7%	2,264	12.0%	838	5.9%	3,626	9.5%
Other	28	8.3%	891	18.6%	2,822	15.0%	1,649	11.7%	5,390	14.2%
Chinese	17	5.0%	173	3.6%	2,174	11.6%	3,392	24.0%	5,756	15.1%
Other API	25	7.4%	549	11.4%	2,898	15.4%	4,127	29.2%	7,599	20.0%
Vietnamese	6	1.8%	107	2.2%	1,051	5.6%	901	6.4%	2,065	5.4%
Unknown	-	0.0%	29	0.6%	95	0.5%	124	0.9%	248	0.7%
Am. Indian	-	0.0%	21	0.4%	55	0.3%	35	0.2%	111	0.3%
Total	**338**	**100%**	**4,800**	**100%**	**18,789**	**100%**	**14,116**	**100%**	**38,043**	**100%**

English was the most common language for ages 45 to 64 and 65+ with hypertension, but Chinese was also a large portion of the 65+ group.

Table 17: Hypertension Language x Age

| HYPERTENSION | Under 19 | | 19-44 | | 45-64 | | 65+ | | Total | |
Language x Age	n	%	n	%	n	%	n	%	n	%
English	45	42.9%	4,012	83.6%	12,465	66.3%	5,506	39.0%	22,128	58.2%
Spanish	63	48.2%	392	8.2%	1,704	9.1%	1,553	11.0%	3,812	10.0%
Chinese	17	5.0%	120	2.5%	2,078	11.1%	3,613	25.6%	5,828	15.3%
Unknown	4	1.2%	147	3.1%	1,038	5.5%	1,837	13.0%	3,026	8.0%
Vietnamese	4	1.2%	62	1.3%	936	5.0%	934	6.6%	1,936	5.1%
Other	5	1.5%	67	1.4%	568	3.0%	673	4.8%	1,313	3.5%
Total	**38**	**100%**	**4,800**	**100%**	**18,789**	**100%**	**14,116**	**100%**	**38,043**	**100%**

Disorders of lipid metabolism

Disorders of lipid metabolism are interpreted as predominantly hyperlipidemia. Over half of the members with hyperlipidemia were female. Most members were adults and seniors ages 45 and over. There were high numbers of members in North, Central, and South Counties, but South and East Counties had the highest prevalence. The largest ethnic groups were Chinese and Other Asian/Pacific Islander. These groups also had the highest prevalence, along with Vietnamese. For language, English was the most common but the highest prevalence was among Chinese, Vietnamese, and Unknown languages.

Table 18: Hyperlipidemia Prevalence

HYPERLIPIDEMIA	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	29,656	100.0%	11.0		
CSHCN	116	0.4%	1.7	-9.3	-84.6
SPD	8,208	27.7%	28.9	17.9	162.7
Gender					
F	16,788	56.6%	11.7	0.7	6.7
M	12,868	43.4%	10.2	-0.8	-7.5
Age					
Under 19	1,115	3.8%	1.2	-9.8	-89.4
19-44	3,862	13.0%	4.2	-6.8	-62.0
45-64	14,221	48.0%	25.7	14.8	134.2
65+	10,458	35.3%	38.9	27.9	253.6
Location					
North County	11,594	39.1%	8.8	-2.1	-19.5
Central County	8,431	28.4%	11.6	0.6	5.7
South County	6,787	22.9%	17.2	6.2	56.8
East County	2,271	7.7%	14.8	3.9	35.0
Other / Unknown	573	1.9%	5.0	-6.0	-54.7
Ethnicity					
Hispanic (Latinx)	4,228	14.3%	5.5	-5.5	-49.8
Black (African American)	2,819	9.5%	5.7	-5.3	-47.9
White	2,444	8.2%	9.1	-1.9	-17.5

HYPERLIPIDEMIA	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Other	4,220	14.2%	9.7	-1.3	-11.4
Chinese	6,969	23.5%	23.8	12.8	116.3
Other Asian / Pacific Islander	6,263	21.1%	20.9	9.9	90.4
Vietnamese	2,451	8.3%	20.9	9.9	90.5
Unknown	182	0.6%	9.0	-2.0	-18.0
American Indian or Alaskan Native	80	0.3%	11.7	0.7	6.1
Language					
English	13,783	46.5%	8.3	-2.7	-24.3
Spanish	3,240	10.9%	6.1	-4.9	-44.8
Chinese	6,943	23.4%	26.9	15.9	145.1
Unknown	2,294	7.7%	23.7	12.7	115.4
Vietnamese	2,202	7.4%	24.8	13.8	125.7
Other Non-English	1,194	4.0%	18.7	7.8	70.5

For both adults 45 to 64 and seniors 65+ with hyperlipidemia, Chinese was the largest ethnic group, followed by Other Asian/Pacific Islander.

Table 19: Hyperlipidemia Ethnicity x Age

HYPERLIPIDEMIA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	680	61.0%	762	19.7%	1,809	12.7%	977	9.3%	4,228	14.3%
Black	77	6.9%	467	12.1%	1,762	12.4%	513	4.9%	2,819	9.5%
White	24	2.2%	411	10.6%	1,480	10.4%	529	5.1%	2,444	8.2%
Other	84	7.5%	781	20.2%	2,106	14.8%	1,249	11.9%	4,220	14.2%
Chinese	132	11.8%	532	13.8%	3,065	21.6%	3,240	31.0%	6,969	23.5%
Other API	87	7.8%	596	15.4%	2,485	17.5%	3,095	29.6%	6,263	21.1%
Vietnamese	26	2.3%	267	6.9%	1,413	9.9%	745	7.1%	2,451	8.3%
Unknown	-	0.0%	29	0.8%	62	0.4%	91	0.9%	182	0.6%
Am. Indian	5	0.4%	17	0.4%	39	0.3%	19	0.2%	80	0.3%
Total	**1,115**	**100%**	**3,862**	**100%**	**14,221**	**100%**	**10,458**	**100%**	**29,656**	**100%**

About half of the adults 45 to 64 with hyperlipidemia spoke English and 20% spoke Chinese. About a third of seniors 65+ spoke English and a third spoke Chinese.

Table 20: Hyperlipidemia Language x Age

HYPERLIPIDEMIA Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	315	28.3%	2,543	65.8%	7,388	52.0%	3,537	33.8%	13,783	46.5%
Spanish	600	53.8%	427	11.1%	1,312	9.2%	901	8.6%	3,240	10.9%
Chinese	128	11.5%	433	11.2%	2,929	20.6%	3,453	33.0%	6,943	23.4%
Unknown	30	2.7%	173	4.5%	801	5.6%	1,290	12.3%	2,294	7.7%
Vietnamese	21	1.9%	183	4.7%	1,235	8.7%	763	7.3%	2,202	7.4%
Other	21	1.9%	103	2.7%	556	3.9%	514	4.9%	1,194	4.0%
Total	**1,115**	**100%**	**3,862**	**100%**	**14,221**	**100%**	**10,458**	**100%**	**29,656**	**100%**

Obesity

Over half of the members with obesity were female. The largest age group was children under 19, followed by adults 19 to 44 and 45 to 64. Prevalence was slightly higher among ages 45 to 64 and children under 19. Most members lived in North and Central Counties. The largest ethnic group was Hispanic (Latinx). They also had the highest prevalence, followed by American Indian or Alaskan Native. More than half spoke English and about a third spoke Spanish. Spanish had the highest prevalence.

Table 21: Obesity Prevalence

OBESITY	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	28,562	100.0%	10.6		
CSHCN	1,008	3.5%	14.7	4.1	38.6
SPD	3,717	13.0%	13.1	2.5	23.5
Gender					
F	16,875	59.1%	11.8	1.2	11.3
M	11,687	40.9%	9.2	-1.4	-12.8
Age					
Under 19	11,846	41.5%	12.4	1.8	17.4
19-44	7,458	26.1%	8.1	-2.5	-23.7
45-64	7,032	24.6%	12.7	2.1	20.3
65+	2,226	7.8%	8.3	-2.3	-21.9
Location					
North County	13,804	48.3%	10.5	-0.1	-0.5
Central County	8,134	28.5%	11.2	0.6	5.9
South County	4,673	16.4%	11.9	1.3	12.1
East County	1,240	4.3%	8.1	-2.5	-23.4
Other / Unknown	711	2.5%	6.2	-4.4	-41.7
Ethnicity					
Hispanic (Latinx)	11,983	42.0%	15.6	5.0	47.7
Black (African American)	5,363	18.8%	10.9	0.3	2.9
White	2,375	8.3%	8.8	-1.8	-16.7
Other	3,896	13.6%	9.0	-1.6	-15.1
Chinese	1,743	6.1%	5.9	-4.6	-43.8
Other Asian / Pacific Islander	2,568	9.0%	8.6	-2.0	-19.0
Vietnamese	428	1.5%	3.7	-6.9	-65.5
Unknown	109	0.4%	5.4	-5.2	-49.0
American Indian or Alaskan Native	97	0.3%	14.1	3.6	33.6
Language					
English	16,007	56.0%	9.7	-0.9	-8.7
Spanish	9,138	32.0%	17.1	6.5	61.6
Chinese	1,610	5.6%	6.2	-4.3	-41.0
Unknown	882	3.1%	9.1	-1.5	-14.0
Vietnamese	318	1.1%	3.6	-7.0	-66.2
Other Non-English	607	2.1%	9.5	-1.1	-10.0

Almost two-thirds of children with obesity were Hispanic (Latinx). For adults 19 to 44, the largest ethnic groups were Hispanic (Latinx), Black (African American), and Other. For adults 45 to 64, the largest were Black (African American) and Hispanic (Latinx).

Table 22: Obesity Ethnicity x Age

OBESITY Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	7,747	65.4%	2,333	31.3%	1,462	20.8%	441	19.8%	11,983	42.0%
Black	1,531	12.9%	1,705	22.9%	1,810	25.7%	317	14.2%	5,363	18.8%
White	354	3.0%	691	9.3%	1,116	15.9%	214	9.6%	2,375	8.3%
Other	889	7.5%	1,538	20.6%	1,172	16.7%	297	13.3%	3,896	13.6%
Chinese	423	3.6%	364	4.9%	584	8.3%	372	16.7%	1,743	6.1%
Other API	683	5.8%	656	8.8%	723	10.3%	506	22.7%	2,568	9.0%
Vietnamese	169	1.4%	96	1.3%	107	1.5%	56	2.5%	428	1.5%
Unknown	27	0.2%	38	0.5%	26	0.4%	18	0.8%	109	0.4%
Am. Indian	23	0.2%	37	0.5%	32	0.5%	5	0.2%	97	0.3%
Total	**11,846**	**100%**	**7,458**	**8.1%**	**7,032**	**100%**	**2,226**	**100%**	**28,562**	**100%**

About half of children with obesity spoke Spanish. For adults 19 to 64, three-quarters spoke English.

Table 23: Obesity Language x Age

OBESITY Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	4,502	38.0%	5,531	74.2%	4,922	70.0%	1,052	47.3%	16,007	56.0%
Spanish	6,475	54.7%	1,245	16.7%	1,021	14.5%	397	17.8%	9,138	32.0%
Chinese	372	3.1%	294	3.9%	554	7.9%	390	17.5%	1,610	5.6%
Unknown	196	1.7%	192	2.6%	255	3.6%	239	10.7%	882	3.1%
Vietnamese	119	1.0%	53	0.7%	94	1.3%	52	2.3%	318	1.1%
Other	182	1.5%	143	1.9%	186	2.6%	96	4.3%	607	2.1%
Total	**11,846**	**100%**	**7,458**	**100%**	**7,032**	**100%**	**2,226**	**100%**	**28,562**	**100%**

Diabetes

Diabetes was a combined category of diagnosis with or without complications. Over half of the members with diabetes were female. Most members were adults and seniors ages 45 and over. The largest county region was North County, but prevalence was highest in South County. The largest ethnic group and highest prevalence was Other Asian/Pacific Islander. About half spoke English, but the highest prevalence was Unknown language.

Table 24: Diabetes Prevalence

DIABETES	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	18,433	100.0%	6.8		
CSHCN	55	0.3%	0.8	-6.0	-88.3
SPD	5,858	31.8%	20.6	13.8	201.7
Gender					
F	10,521	57.1%	7.3	0.5	7.6
M	7,912	42.9%	6.2	-0.6	-8.5
Age					
Under 19	67	0.4%	0.1	-6.8	-99.0
19-44	1,990	10.8%	2.2	-4.7	-68.5
45-64	9,255	50.2%	16.8	9.9	145.2
65+	7,121	38.6%	26.5	19.6	287.3
Location					
North County	8,204	44.5%	6.3	-0.6	-8.4
Central County	5,027	27.3%	6.9	0.1	1.4
South County	3,784	20.5%	9.6	2.8	40.7
East County	977	5.3%	6.4	-0.4	-6.5
Other / Unknown	441	2.4%	3.8	-3.0	-43.9
Ethnicity					
Hispanic (Latinx)	3,430	18.6%	4.5	-2.4	-34.5
Black (African American)	3,054	16.6%	6.2	-0.6	-9.2
White	1,377	7.5%	5.1	-1.7	-25.2
Other	2,659	14.4%	6.1	-0.7	-10.2
Chinese	2,542	13.8%	8.7	1.8	26.9
Other Asian / Pacific Islander	4,282	23.2%	14.3	7.5	109.4
Vietnamese	900	4.9%	7.7	0.9	12.5
Unknown	129	0.7%	6.4	-0.4	-6.4
American Indian or Alaskan Native	60	0.3%	8.7	1.9	28.0
Language					
English	9,881	53.6%	6.0	-0.9	-12.7
Spanish	2,638	14.3%	4.9	-1.9	-27.7
Chinese	2,609	14.2%	10.1	3.3	48.1
Unknown	1,688	9.2%	17.4	10.6	155.1
Vietnamese	837	4.5%	9.4	2.6	38.0
Other Non-English	780	4.2%	12.2	5.4	79.2

For adults ages 45 to 64 with diabetes, Black (African American), Hispanic (Latinx) and Other Asian/Pacific Islander were about 20% each. For seniors 65+, the largest ethnic group was Other Asian/Pacific Islander, followed by Chinese.

Table 25: Diabetes Ethnicity x Age

DIABETES Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	36	53.7%	540	27.1%	1,781	19.2%	1,073	15.1%	3,430	18.6%
Black	20	29.9%	485	24.4%	1,929	20.8%	620	8.7%	3,054	16.6%
White	-	0.0%	155	7.8%	876	9.5%	346	4.9%	1,377	7.5%
Other	1	1.5%	387	19.4%	1,425	15.4%	846	11.9%	2,659	14.4%
Chinese	2	3.0%	82	4.1%	1,015	11.0%	1,443	20.3%	2,542	13.8%
Other API	8	11.9%	278	14.0%	1,716	18.5%	2,280	32.0%	4,282	23.2%
Vietnamese	-	0.0%	37	1.9%	444	4.8%	419	5.9%	900	4.9%
Unknown	-	0.0%	17	0.9%	39	0.4%	73	1.0%	129	0.7%
Am. Indian	-	0.0%	9	0.5%	30	0.3%	21	0.3%	60	0.3%
Total	**67**	**100%**	**1,990**	**100%**	**9,255**	**100%**	**7,121**	**100%**	**18,433**	**100%**

More than half (60%) of adults ages 45 to 64 with diabetes spoke English. For seniors ages 65+, English was about 40% of the group, followed by Chinese at 22%.

Table 26: Diabetes Language x Age

DIABETES Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	33	49.3%	1,510	75.9%	5,607	60.6%	2,731	38.4%	9,881	53.6%
Spanish	31	46.3%	265	13.3%	1,342	14.5%	1,000	14.0%	2,638	14.3%
Chinese	1	1.5%	69	3.5%	969	10.5%	1,570	22.0%	2,609	14.2%
Unknown	1	1.5%	76	3.8%	599	6.5%	1,012	14.2%	1,688	9.2%
Vietnamese	-	0.0%	26	1.3%	386	4.2%	425	6.0%	837	4.5%
Other	1	1.5%	44	2.2%	352	3.8%	383	5.4%	780	4.2%
Total	**67**	**100%**	**1,990**	**100%**	**9,255**	**100%**	**7,121**	**100%**	**18,433**	**100%**

Asthma

Asthma was a combined category of diagnosis with and without status asthmaticus (previous term for acute severe asthma). More than half of the members with asthma were female. About half were children under 19. Although only 5% of the total members, California Children's Services (CSHCN) had double the prevalence of children (excluding CSHCN). About half lived in North County. The prevalence was similar across county regions. About 30% each of members were Hispanic (Latinx) and Black (African American). Black (African American) had the highest prevalence. English was the most common language.

Table 27: Asthma Prevalence

ASTHMA	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	16,447	100.0%	6.1		
CSHCN	876	5.3%	12.8	6.7	109.2
SPD	2,459	15.0%	8.7	2.6	41.9
Gender					
F	9,114	55.4%	6.4	0.3	4.4
M	7,333	44.6%	5.8	-0.3	-5.0
Age					
Under 19	8,026	48.8%	8.4	2.3	38.1
19-44	3,949	24.0%	4.3	-1.8	-29.8
45-64	3,241	19.7%	5.9	-0.2	-3.7
65+	1,231	7.5%	4.6	-1.5	-25.0
Location					
North County	8,760	53.3%	6.7	0.6	9.6
Central County	4,051	24.6%	5.6	-0.5	-8.4
South County	2,210	13.4%	5.6	-0.5	-7.9
East County	894	5.4%	5.8	-0.3	-4.2
Other / Unknown	532	3.2%	4.6	-1.5	-24.2
Ethnicity					
Hispanic (Latinx)	4,846	29.5%	6.3	0.2	3.7
Black (African American)	4,928	30.0%	10.0	3.9	64.2
White	1,401	8.5%	5.2	-0.9	-14.7
Other	2,342	14.2%	5.4	-0.7	-11.3
Chinese	777	4.7%	2.7	-3.4	-56.5
Other Asian / Pacific Islander	1,623	9.9%	5.4	-0.7	-11.0
Vietnamese	412	2.5%	3.5	-2.6	-42.3
Unknown	68	0.4%	3.4	-2.7	-44.7
American Indian or Alaskan Native	50	0.3%	7.3	1.2	19.6
Language					
English	11,285	68.6%	6.8	0.7	11.7
Spanish	3,164	19.2%	5.9	-0.2	-2.9
Chinese	713	4.3%	2.8	-3.3	-54.6
Unknown	589	3.6%	6.1	0.0	-0.3
Vietnamese	310	1.9%	3.5	-2.6	-42.7
Other Non-English	386	2.3%	6.1	0.0	-0.6

For children under 19 with asthma, the largest ethnic group was Hispanic (Latinx) at 44%, followed by Black (African American) at 28%.

Table 28: Asthma Ethnicity x Age

ASTHMA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	3,495	43.5%	794	20.1%	406	12.5%	151	12.3%	4,846	29.5%
Black	2,234	27.8%	1,400	35.5%	1,121	34.6%	173	14.1%	4,928	30.0%
White	317	3.9%	483	12.2%	512	15.8%	89	7.2%	1,401	8.5%
Other	869	10.8%	775	19.6%	526	16.2%	172	14.0%	2,342	14.2%
Chinese	377	4.7%	86	2.2%	139	4.3%	175	14.2%	777	4.7%
Other API	545	6.8%	320	8.1%	380	11.7%	378	30.7%	1,623	9.9%
Vietnamese	145	1.8%	61	1.5%	127	3.9%	79	6.4%	412	2.5%
Unknown	31	0.4%	16	0.4%	10	0.3%	11	0.9%	68	0.4%
Am. Indian	13	0.2%	14	0.4%	20	0.6%	3	0.2%	50	0.3%
Total	**8,026**	**100%**	**3,949**	**100%**	**3,241**	**100%**	**1,231**	**100%**	**16,447**	**100%**

For children under 19 with asthma, more than half spoke English (59%). The next most common language was Spanish at about a third (32%).

Table 29: Asthma Language x Age

ASTHMA Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	4,730	58.9%	3,457	87.5%	2,528	78.0%	570	46.3%	11,285	68.6%
Spanish	2,534	31.6%	283	7.2%	211	6.5%	136	11.0%	3,164	19.2%
Chinese	339	4.2%	57	1.4%	134	4.1%	183	14.9%	713	4.3%
Unknown	169	2.1%	78	2.0%	149	4.6%	193	15.7%	589	3.6%
Vietnamese	87	1.1%	27	0.7%	111	3.4%	85	6.9%	310	1.9%
Other	167	2.1%	47	1.2%	108	3.3%	64	5.2%	386	2.3%
Total	**8,026**	**100%**	**3,949**	**100%**	**3,241**	**100%**	**1,231**	**100%**	**16,447**	**100%**

Access to Care

Access to care issues were identified through CAHPS, CG-CAHPS, grievances, interpreter services, and provider language access data.

Data results

CAHPS

Below are the results from the 2019 CAHPS survey. The adult benchmark is derived from NCQA's Quality Compass® benchmark and calculated by SPH Analytics. It is the mean of 152 plan-specific Medicaid adult samples that submitted to NCQA in 2018. The child benchmark is the 2018 Quality Compass® Public Report, which is the mean summary rate from the Medicaid child plans who submitted to NCQA in 2018 (approximately 155 plan specific samples).

The benchmark is shaded in red for the composite or measure where the plan rate was significantly below the benchmark at the 95% significance level according to SPH Analytics.

Table 30: CAHPS results

Composite/Attribute/Measure	Adult Rate	Adult Benchmark	Child Rate	Child Benchmark
Getting Needed Care	**76.0%**	**82.6%**	**83.5%**	**87.5%**
Ease of getting necessary care	83.6%	84.8%	85.0%	89.5%
Getting appointments with specialists as soon as needed	68.3%	80.6%	81.9%	80.8%
Getting Care Quickly	**74.5%**	**82.2%**	**85.4%**	**89.3%**
Got care as soon as needed when care was needed right away	78.7%	84.7%	87.4%	90.9%
Got check-up/routine care appointment as soon as needed	70.3%	80.0%	83.5%	88.3%
How Well Doctors Communicate	**88.4%**	**91.6%**	**93.7%**	**93.9%**
Personal doctor explained things in an understandable way	87.2%	91.8%	94.5%	94.4%
Personal doctor listened carefully to you	88.4%	91.9%	94.5%	95.4%
Personal doctor showed respect for what you had to say	91.2%	93.1%	96.9%	96.3%
Personal doctor spent enough time with you	86.9%	89.6%	89.0%	89.3%
Customer Service	**80.7%**	**88.3%**	**86.1%**	**88.8%**
Customer service provided information or help	70.5%	82.6%	80.3%	83.8%
Customer service treated member with courtesy and respect	90.9%	94.0%	91.8%	93.9%
Shared Decision Making	**78.7%**	**79.6%**	**78.4%**	**78.4%**
Doctor/health provider talked about reasons you might want to take a medicine	97.3%	91.9%	85.3%	91.2%
Doctor/health provider talked about reasons you might not want to take a medicine	65.8%	68.5%	62.2%	64.9%
Doctor/health provider asked you what you thought was best when starting or stopping a prescription medicine	73.0%	78.1%	87.7%	78.8%
Health Promotion and Education	**72.5%**	**73.4%**	**73.2%**	**72.7%**
Coordination of Care	**70.4%**	**83.4%**	**86.0%**	**83.2%**
Providing Needed Information	**52.6%**	**68.4%**	**N/A**	**N/A**
Ease of Filling out Forms	**93.2%**	**94.4%**	**94.1%**	**94.7%**

Rates by ethnicity and race are as follows. Hispanic/Latino ethnicity tended to have higher rates than Non-Hispanic/Latino on most measures.

Table 31: CAHPS results by Ethnicity and Race

ADULT	Ethnicity			Race			
Composite, Attribute, or Measure	**Hispanic**	**Not Hispanic**	**Range**	**White**	**Black**	**Other**	**Range**
Getting Needed Care	87.8%	74.2%	13.6%	85.4%	70.8%	73.0%	12.4%
Getting Care Quickly	80.0%	72.3%	7.7%	74.9%	84.4%	65.6%	9.3%
How Well Doctors Communicate	96.2%	86.3%	9.8%	87.6%	85.9%	88.2%	0.6%
Customer Service	96.9%	75.4%	21.4%	86.0%	91.7%	76.7%	9.3%
Shared Decision Making	80.0%	80.5%	0.5%	83.9%	72.1%	80.6%	3.2%
Health Promotion and Education	64.3%	75.7%	11.4%	75.5%	75.0%	72.2%	3.3%
Coordination of Care	97.7%	63.5%	28.2%	74.1%	61.5%	71.8%	2.3%
Providing Needed Information	100.0%	51.5%	48.5%	46.7%	40.0%	60.9%	14.2%
Ease of Filling Out Forms	94.6%	93.4%	1.3%	93.7%	91.3%	93.5%	0.1%

CHILD	Ethnicity			Race			
Composite, Attribute, or Measure	**Hispanic**	**Not Hispanic**	**Range**	**White**	**Black**	**Other**	**Range**
Getting Needed Care	89.1%	78.5%	10.6%	82.6%	89.2%	79.8%	9.4%
Getting Care Quickly	84.6%	86.5%	1.9%	89.6%	98.7%	79.8%	18.9%
How Well Doctors Communicate	92.0%	95.6%	3.5%	91.8%	94.8%	91.9%	3.0%
Customer Service	87.0%	83.7%	3.3%	84.4%	88.6%	83.6%	5.1%
Shared Decision Making	80.9%	74.1%	6.8%	82.6%	84.2%	74.2%	10.1%
Health Promotion and Education	74.5%	72.7%	1.7%	67.1%	80.5%	73.9%	13.3%
Coordination of Care	88.2%	83.8%	4.5%	84.0%	82.4%	86.3%	3.9%
Ease of Filling Out Forms	91.6%	97.0%	5.4%	90.7%	96.6%	94.1%	5.8%

CG-CAHPS

Below are the results from the language services questions on the CG-CAHPS. A favorable response was either that the health plan provided an interpreter, or the doctor or clinic spoke their language or provided an interpreter. While interpreter use was highest among Spanish, Chinese, and Vietnamese-speakers, English and Unknown language speakers had the lowest rate of favorable responses. Children had a higher favorable response rate than adults.

Table 32: CG-CAHPS language questions

CG-CAHPS: Interpreter needed	Adult responses	Adult % yes	Children responses	Children % yes
Total	8,766	27.6%	7,392	28.3%
English	4,665	5.4%	3,422	4.2%
Spanish	1,124	55.2%	2,891	50.2%

CG-CAHPS: Interpreter needed	Adult responses	Adult % yes	Children responses	Children % yes
Chinese	1,586	66.1%	551	65.3%
Vietnamese	647	42.8%	139	33.1%
Unknown	744	29.8%	389	23.9%

ADULT: Able to communicate with doctor and clinic staff in preferred language?	Total responses	Favorable %	Family and Friends %	No %
Total	2,098	80.8%	15.6%	3.6%
English	236	61.9%	30.1%	8.1%
Spanish	464	84.3%	12.5%	3.2%
Chinese	945	86.0%	11.4%	2.5%
Vietnamese	252	91.3%	6.7%	2.0%
Unknown	201	57.2%	36.8%	6.0%

CHILD: Able to communicate with doctor and clinic staff in preferred language?	Total responses	Favorable %	Family and Friends %	No %
Total	1,763	91.7%	5.8%	2.5%
English	128	79.7%	12.5%	7.8%
Spanish	1,164	93.0%	5.5%	1.5%
Chinese	346	95.4%	1.7%	2.9%
Vietnamese	42	100.0%	0.0%	0.0%
Unknown	83	73.5%	19.3%	7.2%

Grievances related to access & availability

The table below shows the categories of access and availability grievances from 2019. The Alliance defines grievances as any written or oral expression of dissatisfaction regarding the plan and/or providers, including quality of care concerns or services provided. The data below includes both standard grievances that are to be resolved within 30 days and exempt grievances which are resolved by the end of the next business day by the Alliance Member Services Department.

Table 33: Access Grievances

Grievance Type	Total	Percent
Excessive long wait/appointment schedule time	1,064	43%
Lack of Telephone accessibility	588	24%
Lack of PCP availability	306	13%
Lack of Specialist availability	222	9%
Lack of Language availability	193	8%

Grievance Type	Total	Percent
Lack of Physical availability	73	3%
Total	**2,446**	**100%**

Interpreter utilization

Below are the utilization numbers for telephonic and in-person interpreters for 2019. The data includes the Alliance commercial line of business, which consists of 2% of Alliance members.

The top languages for interpreter services were the Alliance threshold languages. Spanish was more frequently used for telephonic while Cantonese was more frequently used for in-person. This may reflect the language capacity of Alliance Member Services for telephonic service and language capacity of providers for appointments. Although not captured by DHCS monthly eligibility files language data, Punjabi also appeared to be a language commonly spoken by members.

Table 34: Interpreter utilization

TELEPHONIC INTERPRETERS	Total	Percent
Spanish	3,298	26.3%
Cantonese	2,211	17.6%
Vietnamese	1,401	11.2%
Mandarin	1,204	9.6%
Farsi/Dari	697	5.6%
Punjabi	649	5.2%
Arabic	528	4.2%
Tagalog	279	2.2%
Hindi*	255	2.0%
Mam	184	1.5%

*secondary vendor did not include detail for Hindi

IN-PERSON INTERPRETERS	Total	Percent
Cantonese	7,309	33.6%
Vietnamese	2,884	13.3%
Spanish	2,671	12.3%
Mandarin	1,641	7.6%
Arabic	1,418	6.5%
Cambodian	893	4.1%
ASL (American Sign Language)	743	3.4%
Korean	462	2.1%
Mongolian*	441	2.0%
Tigrinya*	439	2.0%

*secondary vendor did not include detail for Mongolian and Tigrinya

Provider language access

This graph shows the number of Medi-Cal members per PCP by language (member's preferred language and provider's ability to provide services in that language) in 2019. Vietnamese was

the highest at 453 members per provider. Arabic was the most unstable due to small numbers of providers and members. The member to provider ratios were within expected ranges.
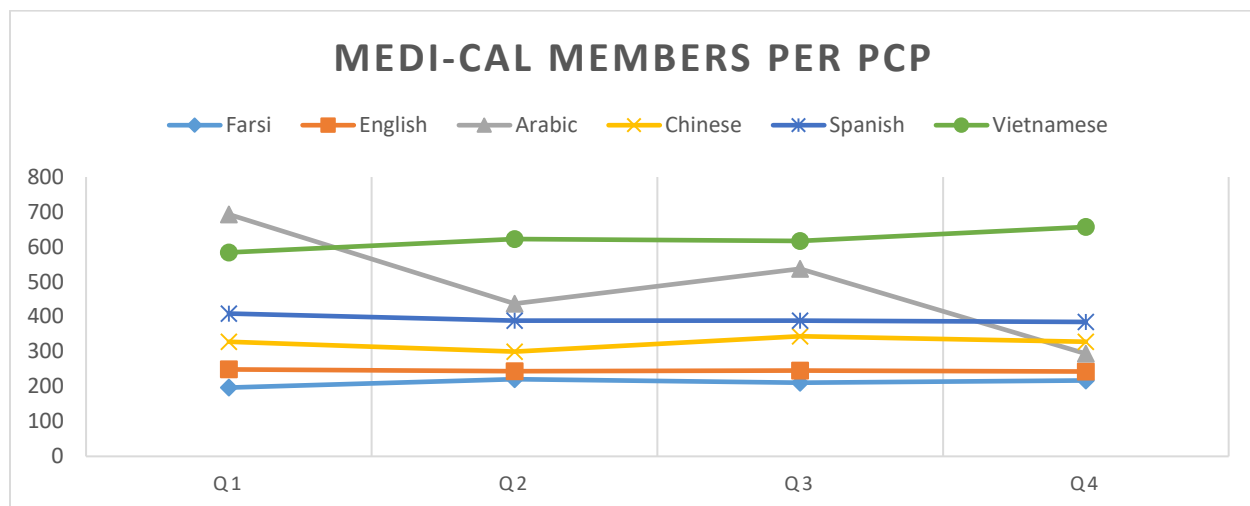
Figure 15: Provider language access

Issue summary

Wait time for routine care appointments
In the CAHPS survey, **70.3% of adults** and **83.5% of children** were able to get a checkup or routine care appointment as soon as needed. Both rates were significantly below the Quality Compass benchmarks of 80.0% and 88.3%, respectively. "Other" race had a lower rate for both adults and children. Excessive wait or appointment schedule time was the most common type of access grievance (43%, or 1,064 out of 2,446 grievances).

Getting needed care
In the CAHPS survey, **68.3% of adults** were able to get an appointment with a specialist as soon as needed, which was significantly below the benchmark of 80.6%. "Black or African American" and "Other" races had a lower rate of getting necessary care for adults. **85.0% of children** found it easy to get necessary care, which was significantly below the benchmark of 89.5%. Lack of specialist availability accounted for 9% of access grievances.

Understanding providers for adults
In the CAHPS survey, **87.2% of adults** answered that their personal doctor explained things in a way that was easy to understand. This was significantly below the benchmark of 91.8%.

Coordination of care for adults
In the CAHPS survey, **70.4% of adults** answered that their personal doctor seemed informed and up-to-date about care received from other doctors or health providers. This was significantly below the benchmark of 83.4%.

Information from the health plan for adults
In the CAHPS survey, **52.6% of adults** were able to get information about how the health plan works from written materials or the Internet, which was significantly below the benchmark of 68.4%. Similarly, **70.5% of adults** got the information or help they needed from the health plan's customer service, significantly below the benchmark of 82.6%. "White" and "Black or African American" races had lower rates for the first measure, and "Other" race had lower rate for the second measure.

Use of family or friends as interpreters for adults
The CG-CAHPS survey asks members who needed an interpreter if they were able to communicate with their doctor and clinic staff in their preferred language. The favorable response rate, either doctor's office or health plan provided an interpreter or spoke my language, was 80.8%. There were **15.6% of adults** who responded that they used a family or friend as an interpreter, and 3.6% who responded that they were not able to communicate. English and Unknown language had higher unfavorable response rates. In comparison, the child survey had a 91.7% favorable response rate.

Health Disparities

Health disparities were identified through the plan-specific HEDIS data from DHCS. Disparities were defined as any subgroup with a rate below the minimum performance level (MPL, defined by DHCS as the 25th percentile) for HEDIS Reporting Year 2019 (Measurement Year 2018) that represented at least 5% of the sample size.

The MPL is highlighted in red where the subgroup rates were significantly lower at the 95% or 99% (*) significance level using one-sided binomial testing.

Table 35: HEDIS disparities RY 2019

Measure	Subgroup	% of sample	MPL (%)	Rate (%)	Absolute diff (%)	Relative diff (%)
AMR	Ages 21-44	21%	56.85	53.68	3.17	5.58
AMR	Ages 45-64	25%	56.85	55.63	1.22	2.15
AMR	Black (African American)	30%	56.85	55.76	1.09	1.92
CAP-1219	Male	51%	85.81	85.25	0.56	0.65
CAP-1219	Black (African American)	17%	85.81*	82.15	3.66	4.27
CAP-1219	White	6%	85.81*	82.73	3.08	3.59
CAP-1224	Black (African American)	16%	93.64	93.33	0.31	0.33
CAP-256	Black (African American)	17%	84.39*	81.79	2.6	3.08
CAP-256	White	6%	84.39*	74.48	9.91	11.74
CAP-711	Black (African American)	18%	87.73*	81.79	5.94	6.77
CAP-711	White	6%	87.73*	79.57	8.16	9.30
CCS	Ages 24-29	21%	54.26	51.19	3.07	5.66
CDC-BP	White	8%	56.2	53.13	3.07	5.46
CDC-E	Ages 21-44	17%	50.85	49.3	1.55	3.05
CDC-E	Other ethnicity	14%	50.85	50	0.85	1.67
CDC-E	White	8%	50.85	50	0.85	1.67
CDC-HT	Black (African American)	20%	84.93	82.72	2.21	2.60
CDC-HT	White	8%	84.93	84.38	0.55	0.65
PPC-PRE	Ages 18-20	6%	76.89	72.73	4.16	5.41

Notes: Absolute difference = MPL - Rate
Relative difference = Absolute difference/MPL x 100

Asthma Medication Ratio (AMR, MPL=56.85%)
- Adults, both in subgroups **ages 21-44** (53.68%) and **ages 45-64** (55.63%) had lower rates than all pediatric age subgroups. Adults were 21% of the sample size. Ages 21-44 was significantly lower than the MPL.
- There was also a disparity for **Black or African Americans** (55.76%), who were 30% of the sample size.

Children and Adolescents' Access to Primary Care Practitioners (CAP-1219, MPL=85.81%; CAP-1224, MPL=93.64%, CAP-256, MPL=84.39%; CAP-711, MPL=87.73%)

- All CAP disparities except for CAP-1224 were significantly below the MPL.
- **Black or African American** members were below the MPL for all four CAP measures. The measure that they were most below the MPL for was 7 to 11 years (81.79%). They made up 16-18% of each sample size.
- **White** members were below the MPL for three CAP measures; the exception was 12 to 24 months. The rates were particularly low for 25 months to 6 years (74.48%) and 7 to 11 years at (79.57%). They made up 5-6% of each sample size.
- There was a lower rate for **male** members ages 12 to 19 (85.25%).

Cervical Cancer Screening (CCS, MPL=54.26%)

- **Ages 24-29** (51.19%) were below the MPL and made up 21% of the sample size.

Comprehensive Diabetes Care (CDC-BP, MPL=56.2%; CDC-E, MPL=50.85%; CDC-HT, MPL=84.93%)

- **White** members were below the MPL for Blood Pressure Control (53.13%), Eye Exam Performed (50%), and HbA1c Testing (84.38%). They made up about 8% of the sample size.
- For Eye Exam Performed, **ages 21-44** (49.30%) and **other ethnicity** (50%) were also below the MPL. They made up 17% and 13% of the sample size, respectively.
- For HbA1c Testing, **Black or African American** (82.72%) members were also below the MPL and made up about 20% of the sample size.

Timeliness of Prenatal Care (PPC-PRE, MPL=76.89%)

- **Ages 18-20** (72.73%) were below the MPL and made up 6% of the sample size.

Member Advisory Committee Input

Focus groups and interviews with Member Advisory Committee (MAC) members were also used to identify member needs. There were two focus groups and two interviews. The first focus group had four members, and the second had a representative from a Federally Qualified Health Center clinic and one representative from the Alameda County Public Health Child Health and Disability Prevention Program.

The six members were all female. They were White, Hispanic (Latinx), Black (African American), and Asian ethnicities. Of the six, three were seniors or persons with disabilities. Three were parents of Alliance child members, of which one was a parent of a child with special health care needs. They ranged from ages 29 to 71.

Health Education invited all MAC members to participate in a small group discussion. Those that agreed were sent preliminary data in an infographic format showing the membership makeup, top health and access issues, and largest gaps for subgroups to quality benchmarks. In the group or interview, facilitators answered questions about the data and then asked members to brainstorm needs that related to quality improvement program areas. Then, each MAC member was asked to identify their top need the Alliance should address and potential strategies. Other MAC members added ideas for potential strategies to the stated need. For each person who mentioned a topic was a top priority, an asterisk was placed (*). One quote from each participant is also included.

Feedback have been tagged as targeting subpopulations: Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPD), Limited English Proficiency (LEP), and members with diverse cultural and ethnic backgrounds (DIV).

Access to care input

- *Dental care**:* Two members in a focus group agreed that finding dental care for both children and adults was difficult, and would like there to be a good referral list as well as member surveys about ability to see a dentist.
    - *"Dentist is hard to find with Medi-Cal for adults, really I been having a hard time finding dentist for my children as well, because a lot of them keep saying that they are full and all of this. So it is man, it is pretty much a headache."*
- *Coordination of care at school for children with special needs*:* One member said it was most important to address the issue that children with special needs have medical equipment and feeding accommodations at school. This takes communication between the provider and school, and the Alliance could provide more leadership on systemic change and quality monitoring. (CSHCN)
    - *"En mi experiencia, hay una línea bien fina que separa el sistema educativo y el sistema médico. Pero en el caso de los niños especiales, lamentablemente porque las necesidades médicas que tienen, van a cargarlo al sistema educativo. El sistema educativo muchas veces nos dice no, ese equipo no ... pero ¿dónde queda ese derecho de niño? ... En ambos sistemas hay un líder. Sentarse a conversar, ver por qué, eh, son necesidades médicas y siempre hay esa línea...*

¿por qué no hay un, como le llamamos, una inclusión, una interacción? En vez de decir no, es que tu eres médico y tu educación y aquí se parte, no, o tal vez modifica las leyes, no, una ley también podría ser bueno, nos pueden ayudar".

   o *[Translation]* "In my experience, there is a very fine line that separates the educational system and the medical system. Because in the case of special children, unfortunately the educational system is charged with taking on their medical needs. The educational system often tells us no, not this equipment… but where are the child's rights? …In both systems there is a leader. Sit down to talk, to see why there are medical needs, but there is always that line… Why is there not inclusion, an interaction? Instead of saying no [not my responsibility], that you are the doctor and you are education and here we split. Or, maybe modify the laws, a law could also be good, that would help us."

- *Medicine approvals*:* One member said that the medicine review and denials process was most important because a denial could be costly to the member. The Alliance could review their process and connect members with alternatives and pharmaceutical programs.
   o *"When a patient is prescribed with certain medicines and to be told by the Alliance that it is not covered, is devastating to a patient okay, it's really, really bad. Everybody, it affects everybody…people have had to go out of pocket which cuts into their food cost, it cuts into their transportation cost…which really makes an impact in their household."*

- *Durable medical equipment for children with special needs:* One member said that it is difficult for children with special needs to access quality equipment. (CSHCN)

- *Enough time at appointments:* One member said she had a concern about the doctor not having enough time at appointments to finish and be thorough.
   o *"When I go in to see my doctor and I know there is a time limit, and she always goes over but she is not finished, so is she supposed to quit at a certain time and just not do a thorough checkup with me or what?"*

- *Transportation access:* One member said that members complain about transportation service taking longer than expected and having miscommunications. This is a concern for elderly or frail people who need to wait. (SPD)

Language needs input

- *Health education in member's language*:* One member requested more classes taught and materials to be sent in the member's language. (LEP)
   o *"…those you need to do every day like a habit, you can prevent your blood pressure getting too high… but not a lot of people know that or… they don't want to do it, so I think if you have a class, let people come join and let the doctor teach them how important is those if you do it every day you can prevent… like high blood pressure, diabetes… pregnancy… Send it out and also the language, some people, they're scared, they don't understand. If you have Chinese, you have Chinese classes, Vietnamese, then Vietnamese classes… so they understand 100%, then easy for them to get in."*

- *Education about family and friends:* Advocates thought that the Alliance could educate members on why the medical field discourages the use of family and friends as interpreters. (LEP)
- *Interpreter access:* One member said that she heard from members that it is hard to get an appointment with an interpreter and they might have to wait for the interpreter at the appointment. Another member said that there might not be an interpreter available when a member wants to make a complaint. (LEP)

Cultural and linguistic competency input

- *Culturally relevant materials:* One advocate talked about how materials, for example, nutrition or breastfeeding, could incorporate culturally relevant foods or practices. (DIV)

Health education input

- *Education about health conditions**:* One member and one advocate said that providing health education so members understand their health conditions and how they can manage it was most important. The advocate talked about a barrier of some patients being more interested in discussing a concern like medicines instead of their conditions. They suggested mailing out materials to members with a condition or providing flyers and booklets. One member also wanted more classes.
  - *"In the clinic side we've had challenges in general, with people on drugs or opioids it's been difficult for providers to even address chronic diseases, patients are pretty adamant in discussing their medications only, that has been something we've been talking about, how do we even get to talk about their chronic diseases or preventative care or nutrition when the individual is largely wanting to talk about their opioid or refill? …The priority as I see it… that people have a really good understanding about managing their chronic diseases and participating in that."*
- *Provider communication:* One member said that the way doctors communicate could cause worry, and it would be better to have more information.
  - *"Sometimes they'll say we don't know why your "X" is elevated, they should give us more information so we are not going home thinking, do we have cancer or we are dying... and so I'm sitting here thinking something is wrong and I feel they shouldn't say that until they have more evidence of what you have, because a lot of patients sometimes worry themselves to death."*
- *Understanding member rights:* One member talked about the need for members to understand how to make a complaint. One advocate mentioned that members should also understand their health care rights and benefits, like transportation, health education, and interpreters. (LEP)

Quality improvement efforts input

- *Education about preventive medicine*:* The advocates discussed the opportunities to provide more messaging and promotion of well-child visits, prenatal appointments, and

dental care for children. There might also be a way to partner with schools to provide services and education.

- o *"Since you did have a high number of members under 19… ways to educate and promote about the importance to getting their annual checkup. I don't know if it would be a mailing or something inserted if you're already doing mailings or a postcard to remind them around their birthday… or text messages... The other one was on the early preventive prenatal appointments, so in that first trimester… ways that people could find out if they are pregnant, they get in for prenatal appointment right away... The third was the oral health area… having the pediatric providers do fluoride varnish at well-child visits … and referral to a dentist to have the child get to the dentist at age 1..."*

- *Monitor quality of services for children with special needs:* One member requested a systematic way of monitoring the services for children with special needs instead of taking it one complaint at a time. There also are no quality HEDIS measures for this population. (CSHCN)
- *Routine visit reminders for adults:* One member said that her provider at Kaiser does not seem to reach out about routine appointments or provide reminders.
- *Targeted education for groups:* One member suggested providing brief information to groups that had quality of care differences about why they need a certain service. (DIV)

Other input

- *Food and recreation:* One advocate talked about food deserts and lack of recreation facilities for members particularly in certain zip codes.

Gap Analysis for Health Education, Cultural and Linguistic, and/or Quality Improvement Activities

The Alliance Quality Improvement Department reviewed the data and identified the following program gaps. The associated program areas and subpopulations (children with special needs, seniors and persons with disabilities, members with limited English proficiency, and members from diverse cultural and ethnic backgrounds) are included with each gap.

Note: Data source references are links that you can use to navigate to the corresponding sections in the key findings.

1. **Culturally and linguistically appropriate disease self-management education**

   a. **Hypertension, Hyperlipidemia, and Diabetes in the Asian and Pacific Islander adult and senior populations**
   Program areas: Health education, Language needs, Cultural and linguistic competency
   Subpopulations: Seniors and Persons with Disabilities, Limited English Proficiency, Diverse Cultural and Ethnic Backgrounds

   Data sources
   References: Figure 6: County Region by Ethnicity; Table 15: Hypertension Prevalence; Table 17: Hypertension Language x Age; Table 18: Hyperlipidemia Prevalence; Table 24: Diabetes Prevalence; Table 34: Interpreter utilization; Language needs input

   These three related diseases were most common in adults and seniors ages 45 and over. They were highly prevalent in the Other Asian/Pacific Islander ethnic group, with 80% greater prevalence of hypertension, 90% of hyperlipidemia, and 109% of diabetes than the total population. "Unknown" language had 122% greater prevalence of hypertension, 115% of hyperlipidemia, and 155% of diabetes. Although "Unknown" language is difficult to interpret, interpreter utilization data suggest that some of these members speak Asian languages that are not captured by Medi-Cal language data. Punjabi, Mongolian, Hindi were in the top non-threshold languages for interpreters. The prevalence was highest in South County (33% greater for hypertension, 57% for hyperlipidemia, and 40% for diabetes), which had a larger population of Other Asian/Pacific Islander members.

   Chinese and Vietnamese ethnicities also had greater prevalence of these diseases. The Chinese ethnic group had the highest prevalence for hyperlipidemia (116% greater). Chinese-speaking members made up a large proportion of seniors with these diseases (26% hypertension, 33% hyperlipidemia, 22% diabetes). One of the MAC members also gave feedback about lack of programs provided in the member's language, offering Chinese and Vietnamese as examples.

   Current activities: Health Education pays for members to attend diabetes and hypertension classes and diabetes support groups with the Alameda County Public Health Chronic Disease Program. For diabetes, members are also referred to hospital diabetes self-management programs and a private practice with a dietitian who speaks Chinese. Chinese and

Vietnamese are threshold languages, so there are translated health education handouts on all three conditions available.

Program gaps: For existing programs, not all Case Management staff know how to refer members to appropriate programs and resources. Health Education does not currently have outreach or programs targeted to Other Asian/Pacific Islander populations. The data show that diabetes may be a good focus for the Other Asian/Pacific Islander population. There are no Alliance programs in Vietnamese or programs besides diabetes in Chinese. Chinese seniors and heart health could be an area for health education as well.

b. **Obesity in the Hispanic (Latinx) child population**
   Program areas: Health education, Language needs, Cultural and linguistic competency
   Subpopulations: Children with special health care needs, Diverse Cultural and Ethnic
   Backgrounds

Data sources
References: Table 11: Top Diagnoses Children; Table 13: Top Diagnoses CCS; Table 21: Obesity Prevalence; Table 22: Obesity Ethnicity x Age; Table 23: Obesity Language x Age; Health education input; Other input

After acute upper respiratory tract infections, obesity was the most common diagnosis (12%) for the child population (excluding California Children's Services). For California Children's Services, it was the third most common diagnosis, but slightly more prevalent (15%).

Chronic disease prevalence data show that 65% of children under 19 with obesity were Hispanic and 55% spoke Spanish. For the 19 to 44 age group, 31% were Hispanic and 17% spoke Spanish. One MAC advocate raised the lack of access for members to free or low-cost healthy food and physical activity opportunities.

Current activities: Health Education supports a school-based clinic in doing nutrition education. Assessments were recently completed from providers and members about needs around child healthy weight. Some clinics offer their own programs and/or dietitians, and UCSF Benioff Children's Hospital Oakland has a class available by provider referral about healthy living and access to a consult with a dietitian. They also have a referral system that they use to connect families with food and physical activity opportunities in the Oakland area, which the Alliance is partnering to adopt in Alliance Case Management and one Oakland clinic. Health Education also currently participates in a countywide coalition of partners who work on food access. Lastly, Health Education is updating child healthy living materials.

Program gaps: There is a need to expand access for children both with and without special health care needs to resources and programs through the Alliance, their providers, and school-based clinics. Referral information for nutrition and physical activity opportunities is lacking outside UCSF Benioff Children's Hospital Oakland. There is also a lack of access to a multi-disciplinary weight management program for children with obesity, which used to be available through UCSF Benioff Children's Hospital Oakland.

c. **Asthma in the Hispanic (Latinx) and Black (African American) child populations**

Program areas: Health education, Cultural and linguistic competency
Subpopulations: Children with special health care needs, Diverse Cultural and Ethnic
Backgrounds

Data sources
References: Table 11: Top Diagnoses Children; Table 13: Top Diagnoses CCS; Table 27:
Asthma Prevalence; Table 28: Asthma Ethnicity x Age; Table 35: HEDIS disparities

Asthma without status asthmaticus was the 8th most common diagnosis for children
(excluding California Children's Services) and the 3rd most common chronic disease (after
obesity and dermatitis and eczema), with 8% of children having an asthma diagnosis. For
California Children's Services, asthma was the 6th most common diagnosis and 2nd most
common chronic disease (after obesity), with 13% of the children with special health care
needs having an asthma diagnosis.

Among members with asthma, the largest subgroup was children under 19 years (48.8%).
Slightly under half (43.5%) of the children with asthma were Hispanic (Latinx) and over a
quarter (27.8%) were Black (African American). Most families of children with asthma spoke
English (58.9%), followed by Spanish (31.6%). Black (African American) members, including
both adults and children, were 2% less than the MPL [relative difference] for the Asthma
Medication Ratio (AMR) measure.

Current activities: Health Education has a robust referral system for children with asthma
into our local public health department's pediatric in-home case management program,
Asthma Start. Weekly emergency department (ED) reports from UCSF Benioff Children's
Hospital Oakland are used to send an educational mailing to the families whose child had an
ED visit due to asthma and refer the family for outreach by Asthma Start. In addition,
monthly reports are run on inpatient visits and medication use for children with asthma to
make referrals to Asthma Start for members who are at high risk. In 2019, there were 123
Hispanic (Latinx) and 86 Black (African American) members who participated in Asthma
Start.

Program gaps: Although the referral program for pediatric members with asthma is robust,
the Alliance is challenged by the number of members that cannot be reached. Additional
Asthma Start staff time is needed to successfully connect with hard-to-reach families.

d. **Asthma in the Black (African American) adult population**
    Program areas: Health education, Cultural and linguistic competency, Quality
    Improvement
    Subpopulations: Diverse Cultural and Ethnic Backgrounds

Data sources
References: Figure 6: County Region by Ethnicity; Table 27: Asthma Prevalence; Table 28:
Asthma Ethnicity x Age; Table 35: HEDIS disparities

Although asthma was most common in children, HEDIS disparities data pointed to gaps in
asthma control for ages 21 to 44 (6% less than MPL [relative difference]), ages 45 to 64 (2%),
and Black or African American (2%) members. These three groups each comprised 20 to 30%

of the HEDIS sample for AMR (Asthma Medication Ratio). Ages 21 to 44 was significantly below the MPL.

Chronic disease prevalence data also show that Black (African American) ethnicity was the largest group for the 19 to 44 (36%) and 45 to 64 (35%) age groups. They also had the highest prevalence of asthma at 64% greater than the overall prevalence. North County had the highest proportion (53%) and prevalence of asthma (10% greater), and most of the Black (African American) population lived in North County.

Current activities: Asthma programs in Health Education mainly focus on children. Adults are referred to community programs like Better Breather Clubs and an asthma community class. The Quality Improvement team recently partnered with Alameda Health Systems in Oakland to offer a pilot asthma workshop for adults.

Program gaps: There is a need to expand our reach to members with asthma to include adults, particularly Black (African American) adults. More opportunities to connect with members through workshops and one-on-one support could improve the appropriate use of medications. There is also a gap in availability of support groups. Better Breather Clubs support groups are only available in Central and South Counties, with no locations in North County. Alliance efforts so far have not emphasized cultural competency of providers or education strategies.

2. **Access and participation in routine care appointments**

   a. **Getting routine care appointments quickly**
   Program areas: Access to Care
   Subpopulations: All

   Data sources
   References: Table 30: CAHPS results; Table 33: Access Grievances

   Excessive wait or appointment schedule time was the most common type of access grievance (43%). This was also reflected in the CAHPS survey, where both adults (70%) and children (83%) had rates significantly below the Quality Compass benchmarks of 80% and 88%, respectively, for being able to get a checkup or routine care appointment as soon as needed.

   Current activities: There are ongoing efforts in Access to remind providers about the timely access survey and issue corrective action plans for noncompliant providers.

   Program gaps: There is a need for education for providers and members about the timely access standards and methods used to monitor them. The Alliance needs to identify providers of concern from access grievances and work with them to address appointment availability. Access is a barrier to being able to achieve quality of care improvements for routine care appointments.

b. Well-child visits
Program areas: Quality Improvement, Health Education
Subpopulations: None

Data sources
References: Table 35: HEDIS disparities; Quality improvement efforts input

In the HEDIS disparities, Black (African American) and White subgroups fell under the MPL for Children and Adolescents' Access to Primary Care Practitioners (CAP) measures. The largest gaps were for CAP-711 (7 to 11 years), where Black or African American was 7% less than MPL [relative difference] and White was 9% less, as well as CAP-256 (25 months to 6 years), where White was 12% less and Black or African American was 3% less. For CAP-1219 (12 to 19 years), Black or African American and White were both 4% less. For these measures, Black or African American made up about 18% of the sample while White made up 6%.

MAC members also talked about the lack of reminders for routine care appointments and ways to promote or educate about preventive services for children.

Current activities: Quality and Analytics sends gaps in care letters to members informing them about health care services they should get. They send monthly gaps in care reports to providers, a process that started in April 2020. CAP has been phased out for AWC (Adolescent Well-Care Visits, ages 12 to 21) in HEDIS Measurement Year 2019, and only W15 (Well-child visits, first 15 months of life) and W34 (Well-child visits, ages 3 to 6) remain for the younger age groups. Quality Improvement will be starting a performance improvement project for W34 in June, which covers some of the same ages as CAP-256, and have also planned a project with Tri-City Health Center for AWC. Health Education is developing educational material about preventive care visits.

Program gaps: The gaps in care letters are not very member-friendly, and some providers may not understand how to use the gaps in care report. The quality improvement projects were planned before the PNA findings and could incorporate some of the demographic considerations.

3. **Information and coordination of member benefits**
   Program areas: Access to Care, Health education, Language access
   Subpopulations: All, Limited English Proficiency, Children with special health care needs

   Data sources
   References: Table 30: CAHPS results; Table 32: CG-CAHPS language questions; Access to care input; Language needs input; Health education input

   In the CAHPS survey, 53% of adults were able to get information about how the health plan works from written materials or the Internet, which was significantly below the benchmark of 68%. Similarly, 71% of adults got the information or help they needed from the health plan's customer service, significantly below the benchmark of 83%.

In another member survey the Alliance conducts, CG-CAHPS, 16% of adults responded that they used a family or friend as an interpreter, and 4% responded that they were not able to communicate in their preferred language with their provider.

MAC members also spoke to issues of members and providers needing to better understand and obtain benefits such as interpreter services, transportation, dental, care coordination, and health education. One MAC advocate talked about how there should be more education on why family and friends are not recommended as interpreters. She also mentioned the need for someone like a navigator at her clinic for members to understand transportation and other benefits. Other members also talked about issues with transportation coordination and getting interpreters (wait time, access to make complaints). Although the Alliance does not oversee the dental benefit, members still see dental care as related to their Medi-Cal and spoke to the difficulties with getting dental care. One member talked about her challenges coordinating medical needs with schools for a child with special health care needs.

Current activities: The Alliance currently shares information about benefits with the Evidence of Coverage (EOC) or Member Handbook online and through the mail. Communications & Outreach provides new member orientations about accessing health plan benefits and started doing them over the phone in March 2020. Health Education has a health care checklist handout and a newly created resource guide for Seniors and Persons with Disabilities with information about transportation and interpreters. The Alliance also distributes information on the availability of language services in the member newsletter, which has included articles on the downside of using family and friends. Health Education is also working on a brochure about getting health care and assistance with benefits through Member Services to add to new member packets.

Program gaps: Other Alliance departments that provide written or online information to members should know about these CAHPS results and be part of addressing them. Because the EOC is long and may be hard for members to find things, members may need simpler explanations readily available on the website for both members and providers to refer to. Health Education has not explored the care coordination gap for children with special health care needs and could work on this with Case Management.

4. Action Plan

Based on the assessment of the key findings and gap analysis, Alliance Quality Improvement will implement the following targeted strategies to address identified program gaps over the next year and beyond.

1. Culturally and linguistically appropriate disease self-management education

1a. Hypertension, Hyperlipidemia, and Diabetes in the Asian and Pacific Islander adult and senior populations

Objective: *Reach 100 Asian and Pacific Islander members with hypertension, hyperlipidemia, and/or diabetes through materials, classes, and/or other supports by June 30, 2022.* **Data Source:** *Health Education program participation records*
Strategies
1.) Work with community partners to promote disease management classes or other supports (in-person, phone, or web) for Asian and Pacific Islander members with hypertension, hyperlipidemia, and/or diabetes.
2.) Publish and distribute self-management tools in threshold and most prevalent Asian or Pacific Islander non-threshold languages.
3.) Integrate disease self-management referrals into Alliance Case Management programs.

1b. Obesity in the Hispanic (Latinx) child population

Objective: *Connect 100 Hispanic (Latinx) members with healthy weight resources by June 30, 2022.* **Data Source:** *Health education program records*
Strategies
1.) Present community assessment of current best practices and gaps regarding childhood obesity to clinic and community partners, get feedback as to plan role in addressing childhood obesity, and promote Alliance healthy weight resources.
2.) Compile and distribute to clinics food and physical activity referral information, including opportunities for children with special needs.
3.) Complete and distribute child healthy living care book in Spanish and English to Hispanic (Latinx) members and providers.
4.) Provide financial support for clinic and school-based nutrition or healthy weight programs.

1c. Asthma in the Hispanic (Latinx) and Black (African American) child populations

Objective: *Increase annual participation of Hispanic (Latinx) and Black (African American) children ages 0 to 18 in Asthma Start in-home case management program by 25% from 209 (2019) to 261 members by December 31, 2021.* **Data Source:** *Health Education program participation records*
Strategies
1.) Collaborate with Asthma Start to increase culturally sensitive member outreach and availability of asthma mitigation supplies.
2.) Increase the number of hospitals who share regular data regarding ED visits with the Alliance. Screen ED data for pediatric members who visited the ED due to asthma and refer to Asthma Start.
3.) Educate pediatric providers regarding Asthma Start services and the referral process.

1d. Asthma in the Black (African American) adult population

Objective: *Achieve HEDIS Asthma Medication Ratio (AMR) measure of at least Measurement Year 2019 MPL of 63.60% for Black (African American) adults ages 21 to 44 by December 31, 2021.* **Data Source:** *HEDIS*
Strategies
1.) Partner with providers to hold asthma workshops for targeted members out of compliance with AMR.
2.) Collaborate with pharmacy to provide member phone consults that support AMR compliance.
3.) Integrate best practices for culturally sensitive asthma care for Black (African American) adults into asthma workshops and consults.

2. Access and participation in routine care appointments

2a. Getting routine care appointments quickly

Objective: *Improve CAHPS rate for getting checkup or routine care appointment as soon as needed from 70.3% to 72% for adults and from 83.5% to 85.6% for children by December 31, 2021.* **Data Source:** *CAHPS*
Strategies
1.) Outreach to providers identified by Grievance & Appeals staff as having the highest number of access-related grievances per quarter.
2.) Increase the level of education to members and providers regarding the timely access standards for appointment availability and surveys in collaboration with Grievance & Appeals, Communications & Outreach, and Provider Services.

2b. Well-child visits

Objective: *Improve HEDIS Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) measures from 68.63% for Black (African American) and 68.42% for White members to the Measurement Year 2019 MPL of 72.87% by December 31, 2021.* **Data Source:** *HEDIS (Note: Because CAP measures have been discontinued, CAP-256 is used as the baseline and W34 as the goal.)*
Strategies
1.) Partner with clinics with low compliance rates that serve Black (African American) and White children on appointment availability, reminders, and member incentives.
2.) Update gaps in care member letters to be more member-friendly.
3.) Educate providers about gaps in care report and disparities in well-child visit participation.

3. Information and coordination of member benefits

Objective: *Improve CAHPS rate for providing needed information (through written materials and the Internet) from 52.6% to 62% for adults by December 31, 2021.*   **Data Source:** *CAHPS*
Strategies
1.) Discuss CAHPS results regarding providing needed information with Alliance departments to identify and implement strategies to improve scores.
2.) Provide members and providers with easier to read information on member benefits, such as interpreter services, transportation, and care coordination benefits. Collaborate with Communications & Outreach and Provider Services to ensure the information is appropriately disseminated to members and providers (e.g., website, mailings, etc.).
3.) Engage community groups serving children with special health care needs regarding member benefits, their experiences, and education on how to access.

5. Stakeholder Engagement

The stakeholder engagement process has three steps.

Note: The Community Advisory Committee (CAC) is called the Member Advisory Committee (MAC) at Alameda Alliance for Health.

1) **PNA introduction and plan (Completed December 19, 2019)**
   In this first step, Health Education presented the plan for the PNA at a quarterly meeting of the MAC. Included in the presentation was the PNA purpose, data to be included, special groups to address, and plan for stakeholder involvement. Input was solicited from our MAC members for each area.

2) **Focus groups and interviews (Completed April 20-29, 2020)**
   Given COVID-19, there was not an in-person MAC meeting in March. Therefore MAC feedback was solicited through a series of small focus groups and interviews to accommodate availability and language needs (see section "Member Advisory Committee Input" for more details on the participants). Preliminary assessment data was presented to MAC members. They were asked for input into member needs related to the PNA program areas of focus. MAC members were then asked to consider what the plan could do to address the highest priority needs for members.

3) **Share results (Planned for September-November, 2020)**
   PNA results with gap analysis and action plan will be shared with:

   a. The Alliance MAC, with updates on status of action plan objectives at the quarterly MAC meetings.
   b. Alliance providers via presentations at the Health Care Quality Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance provider webpages.
   c. Alliance staff via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.