Population Needs Assessment

Alameda Alliance for Health

2021

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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).

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 addresses the special needs of seniors and persons with disabilities, children with special health care needs, members with limited English proficiency, and members from diverse cultural and ethnic backgrounds. The PNA identifies program gaps from the data and presents an action plan with health education, cultural and linguistic, and quality improvement activities to address the gaps.

Data Sources
Required data sources included in this report were the Consumer Assessment of Health Care Providers and Systems (CAHPS) results from 2020 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 2019 (Reporting Year 2020).

Membership profile data includes 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 2020 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. Reports on interpreter utilization and members per primary care provider by language were also reviewed.

Input from members and community advocates also informed the PNA. Member Advisory Committee members (seven Alliance members, one clinic representative, and one community advocate) participated in focus groups or mailed in a survey to provide input on priority member health needs and potential strategies.

Key Findings

Membership Profile: There were 293,530 total members enrolled in Alameda Alliance Medi-Cal at any time during 2020. Of these members, 35% were under age 19, 35% ages 19 to 44, 20% ages 45 to 64, and 10% ages 65 and over. Primary ethnicity was 28% Hispanic (Latino), 20% Other, 17% Black (African American), 10% Other Asian/Pacific Islander, 10% Chinese, 10% White, 4% Vietnamese, 1% Unknown, and less than 1% American Indian or Alaskan Native.

There were 8,131 child members with special health care needs (CSHCN) who had California Children's Services eligible medical conditions. Excluding CSHCN, there were 28,927 seniors and persons with disabilities (SPD) members. Over a third (37%) of all members preferred to speak a non-English language. The threshold languages were Spanish (19%), Chinese (9%), and Vietnamese (3%), along with another 5% that were "other" languages or "unknown". Tagalog, the newest threshold language, will be included in next year's analysis.

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 was used to identify top diagnoses and disease prevalence by subpopulations children, adults, CSHCN, and SPD.

For a more in-depth analysis on disease prevalence, the PNA focused on five chronic diseases that were common among the membership: Hypertension (13%), Disorders of lipid metabolism (11%), Obesity (8%), 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).

Table 1: Chronic Disease Overview

Chronic Disease	Age groups	Ethnic groups
Hypertension	Ages 45 to 64, **Ages 65+**	Black (African American), Other, **Other Asian/Pacific Islander**
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 (Latino)**, Black (African American), Other
Diabetes	Ages 45 to 64, **Ages 65+**	**Other Asian/Pacific Islander**, Other
Asthma	**Under 19**, Ages 19 to 44, Ages 45 to 64	Hispanic (Latino), **Black (African American)**

Source: CareAnalyzer, 2020

Access to Care: For both children and adults, the CAHPS survey showed low rates for getting routine care appointments quickly. Children also had a low rate for getting urgent care quickly. The CG-CAHPS survey indicated a lower rate among adults than children for using qualified interpreters (or doctor's office speaks your language). Adults instead had a higher rate of using family or friends as interpreters.

Quality of Care Disparities: Disparities were identified from the HEDIS data as any subgroup with a rate below the minimum performance level (MPL, defined by DHCS as the 50th percentile) that represented at least 5% of the sample for the measure. Of these disparities, the rates that were significantly below the MPL were:

- Asthma Medication Ratio (AMR) for ages 19 to 50, ages 51 to 64, females, English speakers, and Black or African American members
- Breast Cancer Screening (BCS) for English speakers, Black or African American, and White members
- Chlamydia screening (CHL) for Asian 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. Two are marked as disparity objectives because they were identified in the Health Disparities section of this report.

1. **Culturally and linguistically appropriate asthma self-management support**

    a. **Asthma in Hispanic (Latino) and Black (African American) children**
    Objective: Increase annual participation of Hispanic (Latino) 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.

    b. **[HEALTH DISPARITY] Asthma in Black (African American) adults**
    Objective: Increase HEDIS Asthma Medication Ratio (AMR) measure from 49.17% in Measurement Year 2020 to the Measurement Year 2020 MPL of 62.43% for Black (African American) adults ages 19 to 64 by December 31, 2022.

2. **Access and participation in preventive care**

    a. **Getting routine care appointments quickly**
    Objective: Improve CAHPS rate for getting checkup or routine care appointment as soon as needed to pre-COVID 2019 rates from 65.2% to 70.3% for adults and 82.0% to 85.6% for children by December 31, 2022.

    b. **Well-child visits**
    Objective: Increase HEDIS Child and Adolescent Well-Care Visits (WCV) measure from 49.3% to 55% for two identified providers by December 31, 2022.

    c. [HEALTH DISPARITY] Breast cancer screening in Black (African American) women
    Objective: Improve HEDIS Breast Cancer Screening (BCS) measure among Black (African American) women ages 52 to 74 from 46.76% in Measurement Year 2020 to 53.76% by December 31, 2022.

2. Data Sources

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 2: Data Sources

Source	Year	Brief description
Alliance Data		
CareAnalyzer®	2020	Analytics program that uses the Johns Hopkins ACG® system to measure morbidity in a population. It combines the following data sources: medical claims and encounters, pharmacy encounters, membership enrollment, provider, electronic health record extracts from two large delegates, lab results, and CAIR (immunization registry). Database is updated monthly.
DHCS monthly eligibility files	2020	Member enrollment and demographics from Medi-Cal applications through the County Social Services office, Health Care Options, or Ombudsman's office. DHCS sends daily and monthly 834 files that is loaded into the Alliance source system.
Interpreter services reports	2020	Monthly invoices and reports from Alliance interpreter vendors that detail services provided to Alliance members.
Provider repository	2020	Database with provider information collected during onboarding of providers and updated quarterly through provider communications. It includes languages that Alliance providers can speak to provide services to members.
Asthma Start program participation records	2020	Invoices received from Alameda County Public Health Department for asthma case management services provided to Alliance child members.
County Data		
Alameda County Homeless Count & Survey	2019	Point-In-Time Count of homeless residents in Alameda County conducted by volunteers on a given night in late January. https://everyonehome.org/main/continuum-of-care/everyone-counts/
CalFresh Data Dashboard	2020	California Department of Social Services dashboard of CalFresh data collected from County Social Services offices. https://www.cdss.ca.gov/inforesources/data-portal/research-and-data/calfresh-data-dashboard
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/

Source	Year	Brief description
Kids Data	2015-2017	Lucile Packard Foundation source for data on children collected from public sources, including the California Healthy Kids Survey that is administered by school districts to students in grades 5, 7, 9, and 11. https://www.kidsdata.org/
LGBTQ Community Needs Assessment	2017	San Francisco Bay Area Needs Assessment survey of over 1,400 LGBTQ community members commissioned by Horizons Foundation. The survey was available online and on paper in both English and Spanish. https://www.horizonsfoundation.org/wp-content/uploads/2019/03/SF-Bay-Area-LGBTQ-Needs-Assessment-Report-2018-.pdf
Member Advisory Committee		
Member Advisory Committee	April 2021	Three focus groups and two mailed responses with seven members, one clinic representative, and one community advocate to discuss gaps in services and potential strategies.
Member Surveys		
Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	2020	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 September 2019 and August 2020. There were 2,032 responses for adults and 1,555 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 88% and children 89%).
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Medicaid Adult and Child	2020	Survey in English and Spanish to capture consumer-reported experiences with health care. Using an NCQA approved mail and phone survey methodology, there were 193 valid adult surveys and 338 child surveys collected, yielding a response rate of 14.7% for adults and 16.5% for children. There were 25 completed surveys in Spanish for adults and 118 for children.
Quality of Care		
Department of Health Care Services managed care health plan (MCP) specific health disparities data	2019	Measurement Year 2019 (Reporting Year 2020) Alameda Alliance Healthcare Effectiveness Data and Information Set (HEDIS) data stratified by demographics. Report is provided by DHCS.
Cotiviti HEDIS engine	2020-2021	NCQA-certified HEDIS reporting software that incorporates medical claims and encounters, pharmacy encounters, and lab results data from providers and vendors.

3. Key Data Assessment Findings

Membership/Group Profile

Alameda County

Population and geography

As of January 2021, Alameda County had a population of 1,682,115 persons (Healthy Alameda County, data provided by Claritas). The map below shows the cities within the county.

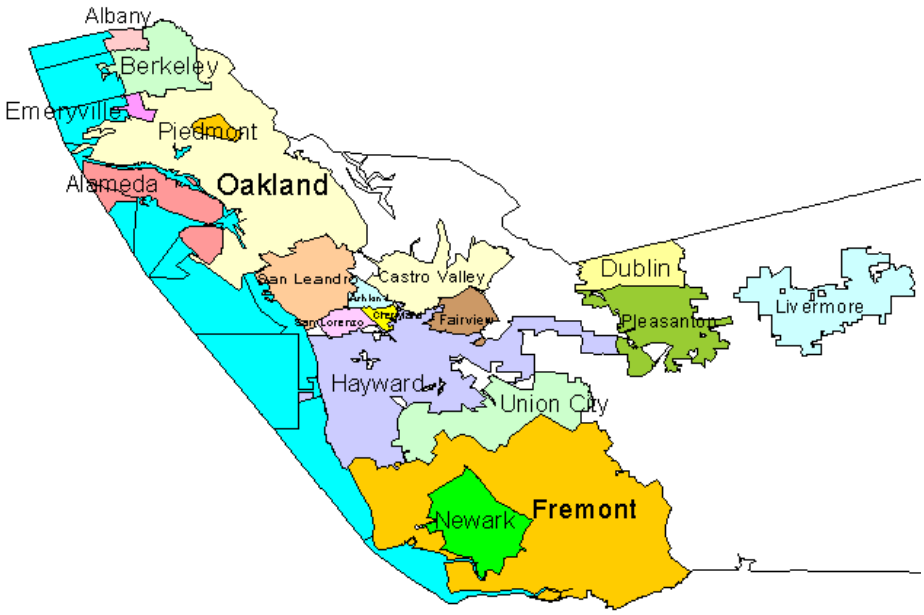

Figure 1: Map of Alameda County

Image source: UC Berkeley Library

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

Table 3: 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 9.9% of county residents live below the federal poverty level (Healthy Alameda County, data from American Community Survey, 2015-2019). 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.

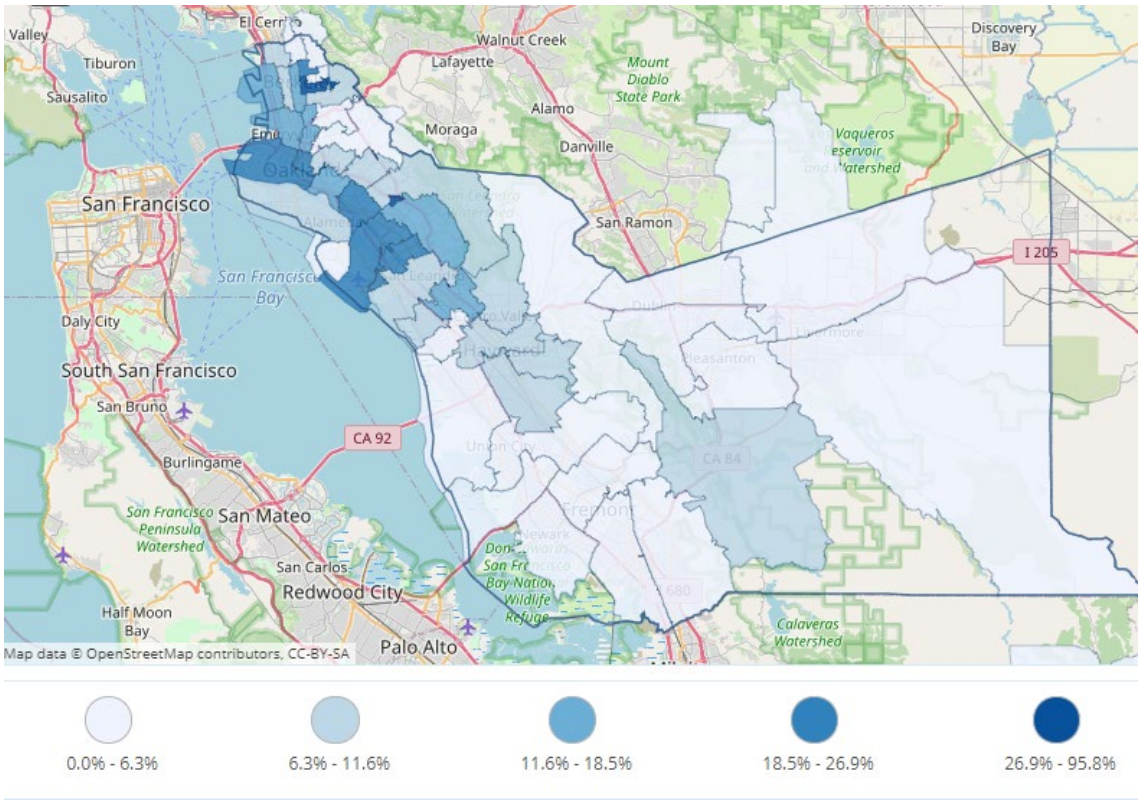

Figure 2: Map of Poverty by Zip Code

Image source: Healthy Alameda County, 2015-2019

According to Feeding America as reported by Healthy Alameda County (2018), 9.1% of county residents were food insecure.

As of December 2020, 78,156 households received CalFresh (California Department of Social Services). There was an increase of about 10,500 households between March and April when the COVID-19 pandemic began.

Figure 3: CalFresh Participation

Image source: California Department of Social Services, 2020

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.

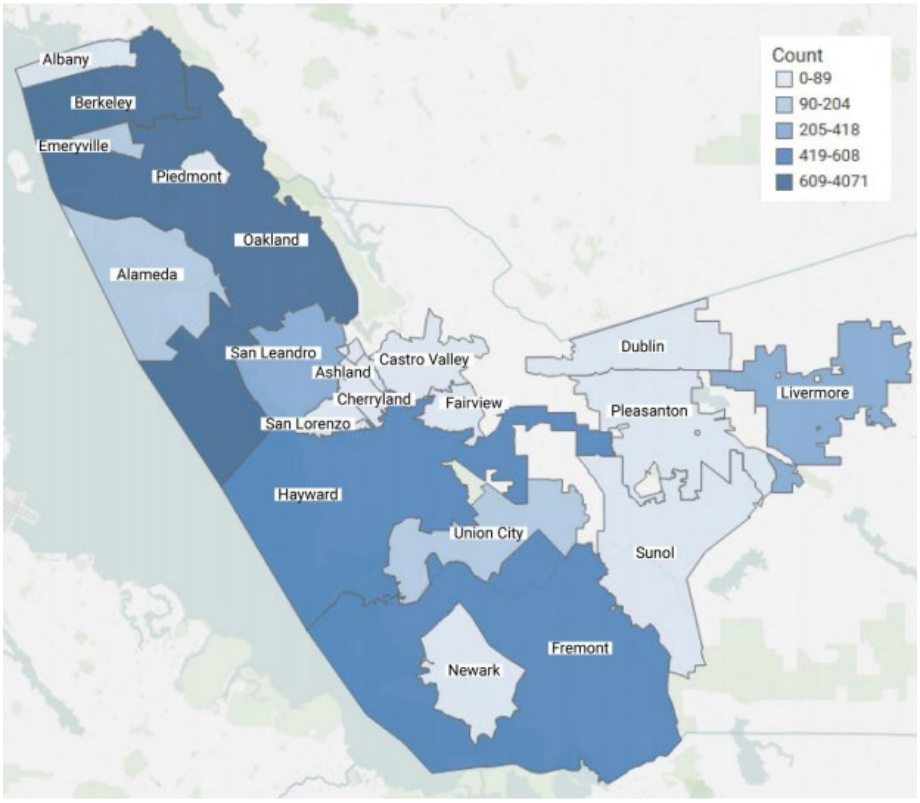

Figure 4: Homelessness by City

Image source: Homeless Point-In-Time Count, 2019

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 (2015-2017) for Alameda County obtained through Kids Data.

Table 4: Youth Sexual Orientation and Transgender

Sexual Orientation	Female			Male		
Grade Level	**Gay / Lesbian / Bisexual**	**Straight**	**Not Sure**	**Gay / Lesbian / Bisexual**	**Straight**	**Not Sure**
7th Grade	5.6%	81.3%	13.1%	2.0%	86.2%	11.8%
9th Grade	10.6%	82.9%	6.5%	3.5%	92.1%	4.3%
11th Grade	9.9%	85.2%	4.8%	4.3%	92.4%	3.3%
Non-Traditional	31.5%	65.1%	3.4%	4.6%	91.6%	3.8%

Transgender	Female		Male	
Grade Level	**Yes**	**No**	**Yes**	**No**
7th Grade	0.7%	99.3%	0.9%	99.1%
9th Grade	0.8%	99.2%	1.7%	98.3%
11th Grade	1.2%	98.8%	1.8%	98.2%
Non-Traditional	1.6%	98.4%	1.2%	98.8%

Source: Kids Data, 2015-2017

Total Membership

There were **293,530 total members** enrolled in Alameda Alliance Medi-Cal at any time during 2020 according to DHCS monthly eligibility files.

Gender

Females made up a slight majority of the membership at 54%.

Table 5: Gender

GENDER	Count	Percent
Female	157,161	53.54%
Male	136,369	46.46%

Source: DHCS monthly eligibility files, 2020

Age

The largest age bands were children under 19 and younger adults ages 19 to 44 at 35% each.

Table 6: Age

AGE BAND	Count	Percent
Under 19	103,984	35.43%
19-44	102,463	34.91%
45-64	58,277	19.85%
65+	28,806	9.81%

Source: DHCS monthly eligibility files, 2020

Region

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

Table 7: County Region

COUNTY REGION	Count	Percent
North	139,494	47.52%
Central	82,301	28.04%
South	43,790	14.92%
East	17,819	6.07%
Other/Unknown	10,126	3.45%

Source: DHCS monthly eligibility files, 2020

Ethnicity

The largest group was Hispanic (Latino) at 28%. A combined Other Asian/Pacific Islander, Chinese, and Vietnamese group put Asian and Pacific Islanders as the next largest group at 25%. “Other” ethnicity was 20% of members.

Table 8: Ethnicity

PRIMARY ETHNICITY	Count	Percent
Hispanic (Latino)	82,206	28.01%
Other	58,142	19.81%
Black (African American)	49,917	17.01%
Other Asian / Pacific Islander	30,356	10.34%
Chinese	29,969	10.21%
White	28,527	9.72%
Vietnamese	11,614	3.96%
Unknown	2,152	0.73%
American Indian Or Alaskan Native	647	0.22%

Source: DHCS monthly eligibility files, 2020

The age distribution varied by ethnic group. Hispanic (Latino) had the highest proportion of children at 56%. Chinese and Other Asian/Pacific Islander had higher proportions of 65+ than other ethnic groups at almost 25%.

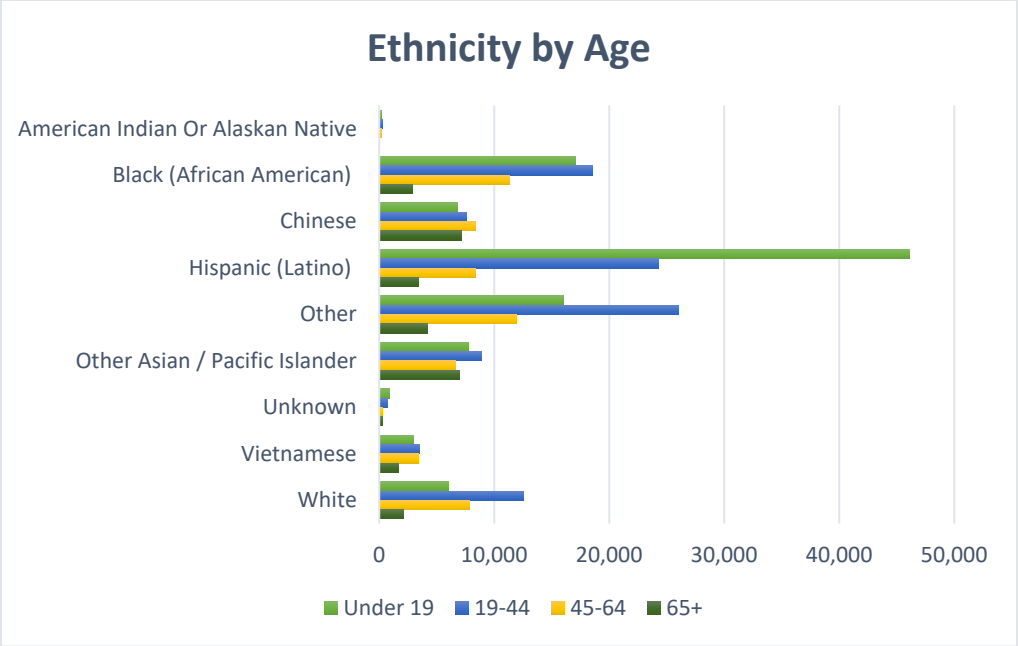

Figure 5: Ethnicity by Age

Source: DHCS monthly eligibility files, 2020

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

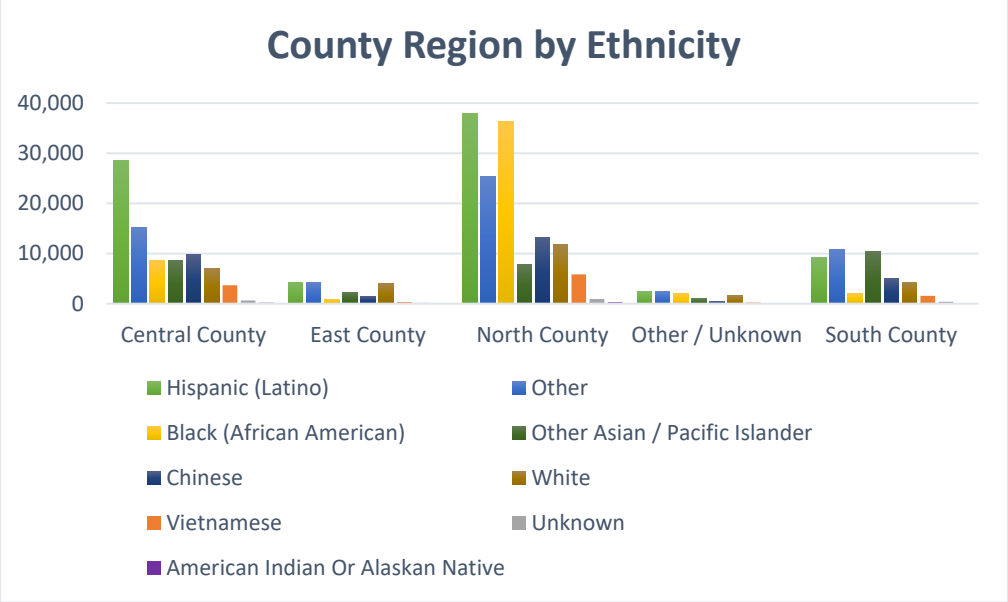

Figure 6: County Region by Ethnicity

Source: DHCS monthly eligibility files, 2020

Language

The majority of members spoke English at 63%. The other threshold languages were Spanish (19%), Chinese (9%), and Vietnamese (3%). Tagalog, the newest threshold language, will be added next year. It is currently included in the "Unknown" category.

Table 9: Language

PRIMARY LANGUAGE	Count	Percent
English	185,073	63.05%
Spanish	57,109	19.46%
Chinese	26,336	8.97%
Unknown	9,599	3.27%
Vietnamese	8,883	3.03%
Other Non-English	6,530	2.22%

Source: DHCS monthly eligibility files, 2020

Each language had a different age distribution. English speakers had more people in the 19-44 age range. Spanish speakers were mostly children. The age distribution was more even for the other languages.

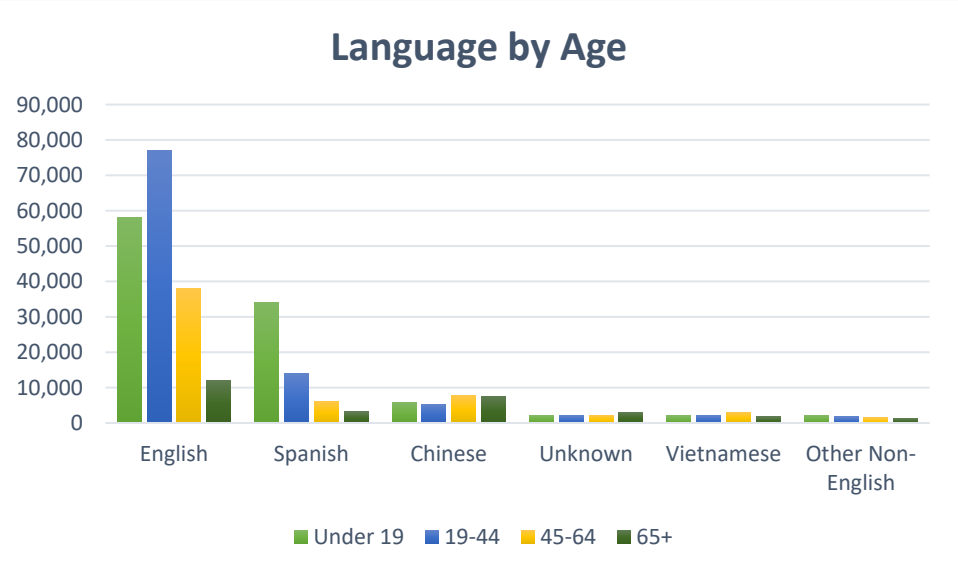

Figure 7: Language by Age

Source: DHCS monthly eligibility files, 2020

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

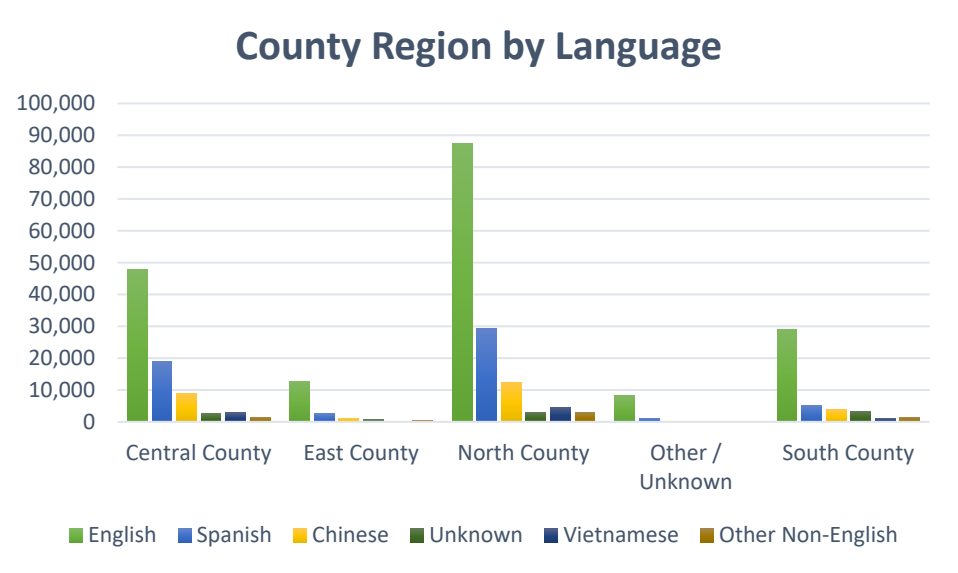

Figure 8: County Region by Language

Source: DHCS monthly eligibility files, 2020

CSHCN Membership

There were **8,131 children with special health care needs (CSHCN) members**, defined in this report as children with California Children's Services eligible medical conditions enrolled in Alameda Alliance Medi-Cal at any time during 2020.

The largest age band was 12 to 18 years at 36%. Half of CSHCN members lived in North County, and 30% in Central County.

Almost half (45%) of CSHCN members were Hispanic (Latino), and 19% were Other. More than half (56%) of CSHCN members were English speakers, and a third (33%) were Spanish speakers.

Table 10: CSHCN Demographics

CSHCN DEMOGRAPHICS	Count	Percent
GENDER		
Female	3,707	45.59%
Male	4,424	54.41%
AGE BAND		
Under 12 months	140	1.72%
1-2 years	586	7.21%
3-6	1,487	18.29%
7-11	2,019	24.83%
12-18	2,909	35.78%
19-21	990	12.18%
COUNTY REGION		
North County	4,060	49.93%

CSHCN DEMOGRAPHICS	Count	Percent
Central County	2,442	30.03%
South County	954	11.73%
East County	432	5.31%
Other / Unknown	243	2.99%
ETHNICITY		
Hispanic (Latino)	3,640	44.77%
Other	1,569	19.30%
Black (African American)	1,150	14.14%
Other Asian / Pacific Islander	569	7.00%
Chinese	454	5.58%
White	447	5.50%
Vietnamese	209	2.57%
Unknown	68	0.84%
American Indian Or Alaskan Native	25	0.31%
LANGUAGE		
English	4,563	56.12%
Spanish	2,707	33.29%
Chinese	374	4.60%
Unknown	172	2.12%
Vietnamese	160	1.97%
Other Non-English	155	1.91%

Source: DHCS monthly eligibility files, 2020

SPD Membership

There were **28,927 seniors and persons with disabilities (SPD) members** enrolled in Alameda Alliance Medi-Cal at any time in 2020. This category excludes CSHCN members.

Less than half (47%) of the members in this category were ages 65 and over. Almost half (46%) of SPD members lived in North County, 23% in Central County, and 21% in South County.

Over a third (36%) of SPD members were Asian American or Pacific Islander (combined category of Other Asian/Pacific Islander, Chinese, and Vietnamese). Black (African American) was the highest single category at 24%. The majority (61%) of SPD members were English speakers. The next most common languages were Chinese (13%) and Unknown (11%).

Table 11: SPD Demographics

SPD DEMOGRAPHICS	Count	Percent
GENDER		
Female	15,054	52.04%
Male	13,873	47.96%
AGE BAND		
Under 19	1,882	6.51%
19-44	5,164	17.85%
45-64	8,283	28.63%
65+	13,598	47.01%
COUNTY REGION		
North County	13,318	46.04%
Central County	6,602	22.82%
South County	5,937	20.52%
East County	2,266	7.83%
Other / Unknown	804	2.78%
ETHNICITY		
Black (African American)	6,930	23.96%
Other Asian / Pacific Islander	5,763	19.92%
Other	4,883	16.88%
Chinese	3,605	12.46%
Hispanic (Latino)	3,353	11.59%
White	2,800	9.68%
Vietnamese	953	3.29%
Unknown	550	1.90%
American Indian Or Alaskan Native	90	0.31%
LANGUAGE		
English	17,718	61.25%
Chinese	3,646	12.60%
Unknown	3,073	10.62%
Spanish	2,299	7.95%
Other Non-English	1,223	4.23%
Vietnamese	968	3.35%

Source: DHCS monthly eligibility files, 2020

East and South Counties had higher proportions of seniors in the SPD category, while Central and North Counties had higher proportions of adults.

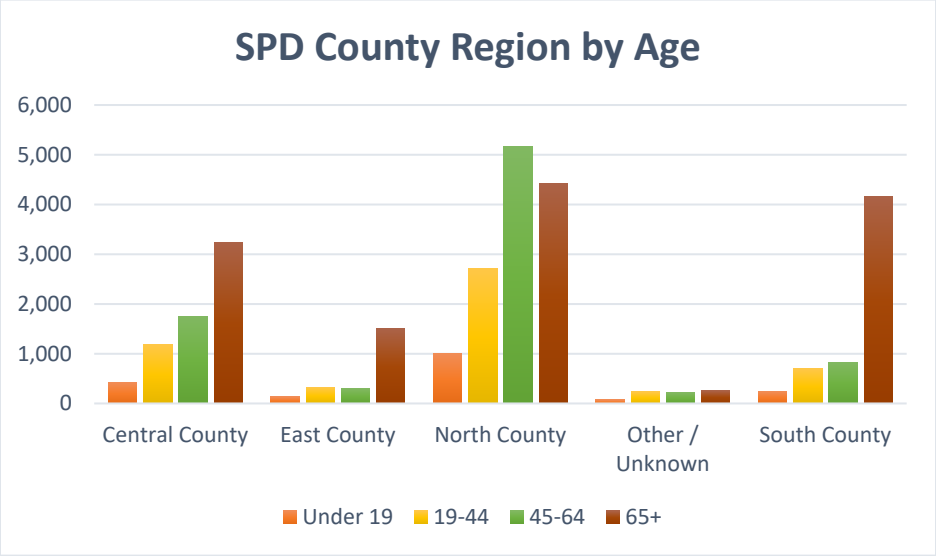

Figure 9: SPD County Region by Age

Source: DHCS monthly eligibility files, 2020

Half of the Black (African American) and White SPD members were ages 45-64. Chinese, Other Asian/Pacific Islander, and Vietnamese were all predominantly 65+. Hispanic (Latino) had the highest proportion of children among the ethnic groups, followed by Unknown and Black (African American). Unknown ethnicity had the highest proportion of 19-44.

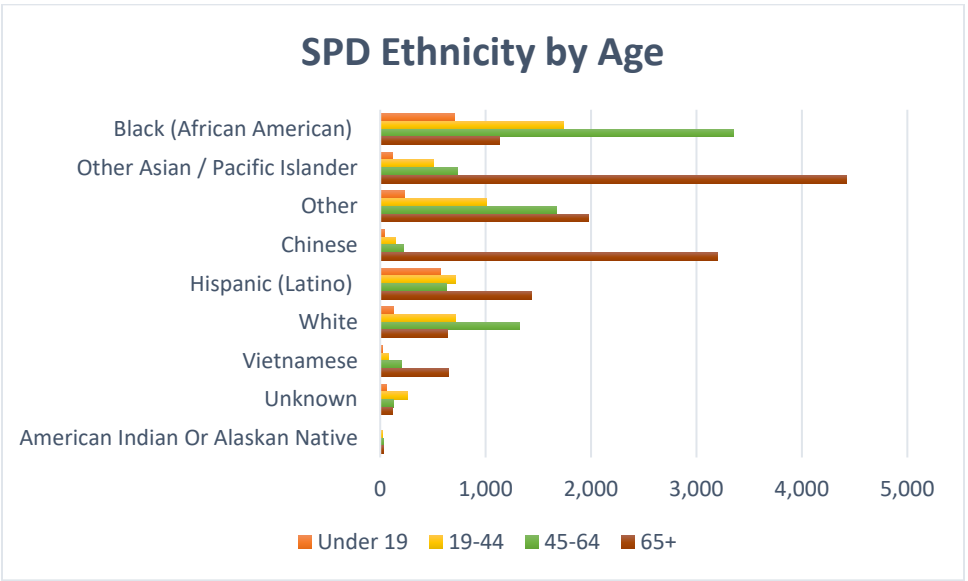

Figure 10: SPD Ethnicity by Age

Source: DHCS monthly eligibility files, 2020

Chinese had the highest proportion of seniors among the language groups. English had a higher proportion of adults than seniors. Spanish had a higher proportion of children than other language groups, followed by English.

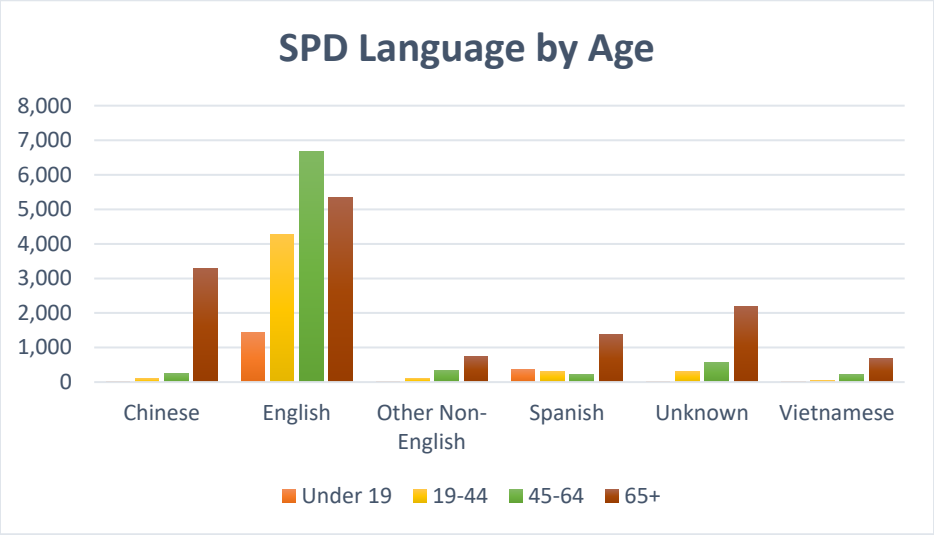

Figure 11: SPD Language by Age

Source: DHCS monthly eligibility files, 2020

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 2020 were included in the database.

Top Diagnoses by Category

Table 12: Top Diagnoses Children

CHILDREN (ages 0 to 18, excludes children with special health care needs) 94,961 total members	**Member Count**	**Percent**
Acute upper respiratory tract infection	11,951	13%
Ophthalmic signs and symptoms	10,350	11%
Obesity	9,040	10%
Viral syndromes	7,723	8%
Dermatitis and eczema	7,517	8%
Refractive errors	6,674	7%
Asthma, w/o status asthmaticus	6,496	7%
Allergic rhinitis	5,720	6%
Fever	4,730	5%
Cough	4,545	5%
Otitis media	4,337	5%
Developmental disorder	3,984	4%
Dermatologic signs and symptoms	3,925	4%
Constipation	3,852	4%
Abdominal pain	3,241	3%
Nutritional disorders, other	2,986	3%
Neurologic signs and symptoms	2,840	3%
Conjunctivitis, keratitis	2,525	3%
Gastrointestinal signs and symptoms	2,409	3%
Acne	2,361	2%

Source: CareAnalyzer, 2020

Table 13: Top Diagnoses Adults

ADULTS (ages 19+, excludes children with special health care needs) 161,511 total members	**Member Count**	**Percent**
Hypertension, w/o major complications	24,159	15%
Disorders of lipid metabolism	21,358	13%
Musculoskeletal signs and symptoms	14,541	9%
Abdominal pain	14,421	9%
Neurologic signs and symptoms	13,525	8%
Refractive errors	12,031	7%
Low back pain	11,712	7%
Anxiety, neuroses	11,551	7%

Musculoskeletal disorders, other	11,423	7%
Obesity	10,410	6%
Major depression	9,753	6%
Gastrointestinal signs and symptoms	9,702	6%
Acute upper respiratory tract infection	9,701	6%
Cardiovascular signs and symptoms	9,432	6%
Gastroesophageal reflux	9,327	6%
Dermatologic signs and symptoms	9,188	6%
Tobacco use	8,887	6%
Chest pain	8,264	5%
Nutritional deficiencies	8,025	5%
Viral syndromes	7,900	5%

Source: CareAnalyzer, 2020

Table 14: Top Diagnoses CSHCN

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (ages 0 to 21) 8,131 total members	**Member Count**	**Percent**
Developmental disorder	729	9%
Acute upper respiratory tract infection	684	8%
Ophthalmic signs and symptoms	651	8%
Refractive errors	560	7%
Obesity	535	7%
Viral syndromes	498	6%
Asthma, w/o status asthmaticus	483	6%
Dermatitis and eczema	449	6%
Neurologic signs and symptoms	434	5%
Deafness, hearing loss	395	5%
Fever	363	4%
Constipation	355	4%
Otitis media	346	4%
Gastrointestinal signs and symptoms	339	4%
Musculoskeletal disorders, other	339	4%
Abdominal pain	318	4%
Dermatologic signs and symptoms	317	4%
Allergic rhinitis	310	4%
Cough	303	4%
Musculoskeletal signs and symptoms	290	4%

Source: CareAnalyzer, 2020

Table 15: Top Diagnoses SPD

SENIORS AND PERSONS WITH DISABILITIES (excludes children with special health care needs) 28,927 total members	Member Count	Percent
Hypertension, w/o major complications	11,397	39%
Disorders of lipid metabolism	8,284	29%
Neurologic signs and symptoms	5,037	17%
Musculoskeletal signs and symptoms	4,903	17%
Musculoskeletal disorders, other	4,012	14%
Type 2 diabetes, w/ complication	3,744	13%
Low back pain	3,725	13%
Cardiovascular signs and symptoms	3,552	12%
Gastroesophageal reflux	3,269	11%
Gastrointestinal signs and symptoms	3,226	11%
Respiratory signs and symptoms	3,116	11%
Degenerative joint disease	3,113	11%
Nutritional deficiencies	3,057	11%
Abdominal pain	3,052	11%
Deficiency anemias	2,979	10%
Tobacco use	2,928	10%
Major depression	2,913	10%
Obesity	2,799	10%
Anxiety, neuroses	2,798	10%
Chest pain	2,627	9%

Source: CareAnalyzer, 2020

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 (13%), Disorders of lipid metabolism (11%), Obesity (8%), Diabetes (7%), and Asthma (6%).

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 slightly higher prevalence in South County. The largest ethnic groups were Black (African American), Other, and Other Asian/Pacific Islander. Other Asian/Pacific Islander also had the highest prevalence, followed by Chinese and Vietnamese. Most members spoke English. The highest prevalence was for Unknown language, then Chinese and Vietnamese.

Table 16: Hypertension Prevalence

HYPERTENSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	36,931	100.0%	12.6		
CSHCN	83	0.2%	1	-11.6	-92.1
SPD	11,690	31.7%	40.4	27.8	220.6
Gender					
F	21,232	57.5%	13.5	0.9	7.1
M	15,699	42.5%	11.5	-1.1	-8.7
Age					
Under 19	263	0.7%	0.3	-12.3	-97.6
19-44	4,821	13.1%	4.7	-7.9	-62.7
45-64	17,921	48.5%	30.8	18.2	144.4
65+	13,926	37.7%	48.3	35.7	283.3
Location					
North County	16,618	45%	11.9	-0.7	-5.6
Central County	10,067	27.3%	12.2	-0.4	-3.2
South County	7,331	19.9%	16.7	4.1	32.5
East County	2,235	6.1%	12.5	-0.1	-0.8
Other / Unknown	680	1.8%	6.7	-5.9	-46.8
Ethnicity					
Black (African American)	7,417	20.1%	14.9	2.3	18.3
Other	6,896	18.7%	11.9	-0.7	-5.6
Other Asian / Pacific Islander	6,891	18.7%	22.7	10.1	80.2
Chinese	5,293	14.3%	17.7	5.1	40.5
Hispanic (Latino)	4,845	13.1%	5.9	-6.7	-53.2
White	3,322	9%	11.6	-1	-7.9
Vietnamese	1,938	5.2%	16.7	4.1	32.5
Unknown	222	0.6%	10.3	-2.3	-18.3
American Indian Or Alaskan Native	107	0.3%	16.5	3.9	31
Language					
English	22,120	59.9%	12	-0.6	-4.8
Chinese	5,440	14.7%	20.7	8.1	64.3
Spanish	3,571	9.7%	6.3	-6.3	-50
Unknown	2,722	7.4%	28.4	15.8	125.4
Vietnamese	1,839	5%	20.7	8.1	64.3
Other Non-English	1,239	3.4%	19	6.4	50.8

Source: CareAnalyzer, 2020

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 17: Hypertension Ethnicity x Age

HYPERTENSION Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Black	45	17.1%	1,443	29.9%	4,472	25.0%	1,457	10.5%	**7,417**	**20.1%**
Other	19	7.2%	1,236	25.6%	3,554	19.8%	2,087	15.0%	**6,896**	**18.7%**
Other API	18	6.8%	497	10.3%	2,544	14.2%	3,832	27.5%	**6,891**	**18.7%**
Chinese	22	8.4%	152	3.2%	1,897	10.6%	3,222	23.1%	**5,293**	**14.3%**
Hispanic	146	55.5%	911	18.9%	2,231	12.4%	1,557	11.2%	**4,845**	**13.1%**
White	6	2.3%	431	8.9%	2,095	11.7%	790	5.7%	**3,322**	**9.0%**
Vietnamese	6	2.3%	93	1.9%	992	5.5%	847	6.1%	**1,938**	**5.2%**
Unknown	1	0.4%	34	0.7%	85	0.5%	102	0.7%	**222**	**0.6%**
Am. Indian	0	0.0%	24	0.5%	51	0.3%	32	0.2%	**107**	**0.3%**
Total	**263**	**100.0%**	**4,821**	**100.0%**	**17,921**	**100.0%**	**13,926**	**100.0%**	**36,931**	**100.0%**

Source: CareAnalyzer, 2020

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 18: Hypertension Language x Age

HYPERTENSION Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	100	38.0%	4,027	83.5%	12,172	67.9%	5,821	41.8%	**22,120**	**59.9%**
Chinese	18	6.8%	105	2.2%	1,832	10.2%	3,485	25.0%	**5,440**	**14.7%**
Spanish	124	47.1%	433	9.0%	1,574	8.8%	1,440	10.3%	**3,571**	**9.7%**
Unknown	7	2.7%	143	3.0%	918	5.1%	1,654	11.9%	**2,722**	**7.4%**
Vietnamese	5	1.9%	59	1.2%	894	5.0%	881	6.3%	**1,839**	**5.0%**
Other	9	3.4%	54	1.1%	531	3.0%	645	4.6%	**1,239**	**3.4%**
Total	**263**	**100.0%**	**4,821**	**100.0%**	**17,921**	**100.0%**	**13,926**	**100.0%**	**36,931**	**100.0%**

Source: CareAnalyzer, 2020

Disorders of lipid metabolism

Disorders of lipid metabolism are interpreted as predominantly hyperlipidemia (high cholesterol). 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. English was the most common, but the highest prevalence was among Chinese, Vietnamese, and Unknown languages.

Table 19: Hyperlipidemia Prevalence

HYPERLIPIDEMIA	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	30,920	100.0%	10.5		
CSHCN	100	0.3%	1.2	-9.3	-88.6
SPD	8,284	26.8%	28.6	18.1	172.4
Gender					
F	17,693	57.2%	11.3	0.8	7.6
M	13,227	42.8%	9.7	-0.8	-7.6
Age					
Under 19	1,307	4.2%	1.3	-9.2	-87.6
19-44	4,233	13.7%	4.1	-6.4	-61
45-64	14,368	46.5%	24.7	14.2	135.2
65+	11,012	35.6%	38.2	27.7	263.8
Location					
North County	11,911	38.5%	8.5	-2	-19
Central County	8,874	28.7%	10.8	0.3	2.9
South County	7,243	23.4%	16.5	6	57.1
East County	2,444	7.9%	13.7	3.2	30.5
Other / Unknown	448	1.4%	4.4	-6.1	-58.1
Ethnicity					
Chinese	6,492	21%	21.7	11.2	106.7
Other Asian / Pacific Islander	6,110	19.8%	20.1	9.6	91.4
Other	5,838	18.9%	10	-0.5	-4.8
Hispanic (Latino)	4,367	14.1%	5.3	-5.2	-49.5
Black (African American)	3,037	9.8%	6.1	-4.4	-41.9
White	2,503	8.1%	8.8	-1.7	-16.2
Vietnamese	2,335	7.6%	20.1	9.6	91.4
Unknown	163	0.5%	7.6	-2.9	-27.6
American Indian Or Alaskan Native	75	0.2%	11.6	1.1	10.5
Language					
English	15,154	49%	8.2	-2.3	-21.9
Chinese	6,664	21.6%	25.3	14.8	141
Spanish	3,451	11.2%	6	-4.5	-42.9
Unknown	2,291	7.4%	23.9	13.4	127.6
Vietnamese	2,169	7%	24.4	13.9	132.4
Other Non-English	1,191	3.9%	18.2	7.7	73.3

Source: CareAnalyzer, 2020

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

Table 20: Hyperlipidemia Ethnicity x Age

HYPERLIPIDEMIA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Chinese	143	10.9%	424	10.0%	2,708	18.8%	3,217	29.2%	**6,492**	**21.0%**
Other API	100	7.7%	616	14.6%	2,298	16.0%	3,096	28.1%	**6,110**	**19.8%**
Other	127	9.7%	1,190	28.1%	2,899	20.2%	1,622	14.7%	**5,838**	**18.9%**
Hispanic	750	57.4%	843	19.9%	1,747	12.2%	1,027	9.3%	**4,367**	**14.1%**
Black	106	8.1%	466	11.0%	1,835	12.8%	630	5.7%	**3,037**	**9.8%**
White	39	3.0%	430	10.2%	1,478	10.3%	556	5.0%	**2,503**	**8.1%**
Vietnamese	34	2.6%	217	5.1%	1,312	9.1%	772	7.0%	**2,335**	**7.6%**
Unknown	7	0.5%	29	0.7%	62	0.4%	65	0.6%	**163**	**0.5%**
Am. Indian	1	0.1%	18	0.4%	29	0.2%	27	0.2%	**75**	**0.2%**
Total	**1,307**	**100.0%**	**4,233**	**100.0%**	**14,368**	**100.0%**	**11,012**	**100.0%**	**30,920**	**100.0%**

Source: CareAnalyzer, 2020

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

Table 21: Hyperlipidemia Language x Age

HYPERLIPIDEMIA Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	428	32.7%	2,905	68.6%	7,836	54.5%	3,985	36.2%	**15,154**	**49.0%**
Chinese	131	10.0%	360	8.5%	2,675	18.6%	3,498	31.8%	**6,664**	**21.6%**
Spanish	657	50.3%	496	11.7%	1,342	9.3%	956	8.7%	**3,451**	**11.2%**
Unknown	40	3.1%	194	4.6%	797	5.5%	1,260	11.4%	**2,291**	**7.4%**
Vietnamese	24	1.8%	166	3.9%	1,190	8.3%	789	7.2%	**2,169**	**7.0%**
Other	27	2.1%	112	2.6%	528	3.7%	524	4.8%	**1,191**	**3.9%**
Total	**1,307**	**100.0%**	**4,233**	**100.0%**	**14,368**	**100.0%**	**11,012**	**100.0%**	**30,920**	**100.0%**

Source: CareAnalyzer, 2020

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 children. Most members lived in North and Central Counties. The largest ethnic group was Hispanic (Latino), who also had the highest prevalence. About 60% spoke English and 30% spoke Spanish. Spanish had the highest prevalence.

Table 22: Obesity Prevalence

OBESITY	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	22,784	100.0%	7.8		
CSHCN	535	2.3%	6.6	-1.2	-15.4
SPD	2,799	12.3%	9.7	1.9	24.4
Gender					
F	13,333	58.5%	8.5	0.7	9
M	9,451	41.5%	6.9	-0.9	-11.5
Age					
Under 19	9,835	43.2%	9.5	1.7	21.8
19-44	5,946	26.1%	5.8	-2	-25.6
45-64	5,211	22.9%	8.9	1.1	14.1
65+	1,792	7.9%	6.2	-1.6	-20.5
Location					
North County	10,695	46.9%	7.7	-0.1	-1.3
Central County	7,081	31.1%	8.6	0.8	10.3
South County	3,404	14.9%	7.8	0	0
East County	1,160	5.1%	6.5	-1.3	-16.7
Other / Unknown	444	1.9%	4.4	-3.4	-43.6
Ethnicity					
Hispanic (Latino)	8,887	39%	10.8	3	38.5
Black (African American)	4,308	18.9%	8.6	0.8	10.3
Other	3,992	17.5%	6.9	-0.9	-11.5
Other Asian / Pacific Islander	1,916	8.4%	6.3	-1.5	-19.2
White	1,747	7.7%	6.1	-1.7	-21.8
Chinese	1,416	6.2%	4.7	-3.1	-39.7
Vietnamese	390	1.7%	3.4	-4.4	-56.4
Unknown	75	0.3%	3.5	-4.3	-55.1
American Indian Or Alaskan Native	53	0.2%	8.2	0.4	5.1
Language					
English	13,426	58.9%	7.3	-0.5	-6.4
Spanish	6,584	28.9%	11.5	3.7	47.4
Chinese	1,344	5.9%	5.1	-2.7	-34.6
Unknown	662	2.9%	6.9	-0.9	-11.5
Other	463	2%	7.1	-0.7	-9
Vietnamese	305	1.3%	3.4	-4.4	-56.4

Source: CareAnalyzer, 2020

About 60% of children with obesity were Hispanic (Latino). For adults 19 to 44, the largest ethnic groups were Hispanic (Latino), Other, and Black (African American). For adults 45 to 64, the largest were Black (African American) and Other.

Table 23: Obesity Ethnicity x Age

OBESITY Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	6,073	61.7%	1,676	28.2%	877	16.8%	261	14.6%	**8,887**	**39.0%**
Black	1,268	12.9%	1,346	22.6%	1,409	27.0%	285	15.9%	**4,308**	**18.9%**
Other	956	9.7%	1,592	26.8%	1,174	22.5%	270	15.1%	**3,992**	**17.5%**
Other API	649	6.6%	434	7.3%	464	8.9%	369	20.6%	**1,916**	**8.4%**
White	316	3.2%	527	8.9%	710	13.6%	194	10.8%	**1,747**	**7.7%**
Chinese	387	3.9%	256	4.3%	424	8.1%	349	19.5%	**1,416**	**6.2%**
Vietnamese	148	1.5%	78	1.3%	118	2.3%	46	2.6%	**390**	**1.7%**
Unknown	20	0.2%	20	0.3%	21	0.4%	14	0.8%	**75**	**0.3%**
Am. Indian	18	0.2%	17	0.3%	14	0.3%	4	0.2%	**53**	**0.2%**
Total	**9,835**	**100.0%**	**5,946**	**100.0%**	**5,211**	**100.0%**	**1,792**	**100.0%**	**22,784**	**100.0%**

Source: CareAnalyzer, 2020

About half of the children with obesity spoke Spanish. About three-quarters of adults 45 to 64 and half of adults 65+ spoke English.

Table 24: Obesity Language x Age

OBESITY Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	4,196	42.7%	4,583	77.1%	3,771	72.4%	876	48.9%	**13,426**	**58.9%**
Spanish	4,856	49.4%	890	15.0%	609	11.7%	229	12.8%	**6,584**	**28.9%**
Chinese	337	3.4%	220	3.7%	413	7.9%	374	20.9%	**1,344**	**5.9%**
Unknown	179	1.8%	120	2.0%	186	3.6%	177	9.9%	**662**	**2.9%**
Other	160	1.6%	87	1.5%	129	2.5%	87	4.9%	**463**	**2.0%**
Vietnamese	107	1.1%	46	0.8%	103	2.0%	49	2.7%	**305**	**1.3%**
Total	**9,835**	**100.0%**	**5,946**	**100.0%**	**5,211**	**100.0%**	**1,792**	**100.0%**	**22,784**	**100.0%**

Source: CareAnalyzer, 2020

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 25: Diabetes Prevalence

DIABETES	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	19,087	100.0%	6.5		
CSHCN	69	0.4%	0.8	-5.7	-87.7
SPD	5,771	30.2%	20	13.5	207.7
Gender					
F	10,899	57.1%	6.9	0.4	6.2
M	8,188	42.9%	6	-0.5	-7.7
Age					
Under 19	94	0.5%	0.1	-6.4	-98.5
19-44	2,271	11.9%	2.2	-4.3	-66.2
45-64	9,451	49.5%	16.2	9.7	149.2
65+	7,271	38.1%	25.2	18.7	287.7
Location					
North County	8,389	44%	6	-0.5	-7.7
Central County	5,330	27.9%	6.5	0	0
South County	3,973	20.8%	9.1	2.6	40
East County	1,058	5.5%	5.9	-0.6	-9.2
Other / Unknown	337	1.8%	3.3	-3.2	-49.2
Ethnicity					
Other Asian / Pacific Islander	4,147	21.7%	13.7	7.2	110.8
Other	3,671	19.2%	6.3	-0.2	-3.1
Hispanic (Latino)	3,361	17.6%	4.1	-2.4	-36.9
Black (African American)	3,079	16.1%	6.2	-0.3	-4.6
Chinese	2,409	12.6%	8	1.5	23.1
White	1,368	7.2%	4.8	-1.7	-26.2
Vietnamese	885	4.6%	7.6	1.1	16.9
Unknown	105	0.6%	4.9	-1.6	-24.6
American Indian Or Alaskan Native	62	0.3%	9.6	3.1	47.7
Language					
English	10,708	56.1%	5.8	-0.7	-10.8
Spanish	2,623	13.7%	4.6	-1.9	-29.2
Chinese	2,499	13.1%	9.5	3	46.2
Unknown	1,680	8.8%	17.5	11	169.2
Vietnamese	829	4.3%	9.3	2.8	43.1
Other Non-English	748	3.9%	11.5	5	76.9

Source: CareAnalyzer, 2020

For adults ages 45 to 64 with diabetes, Other, Black (African American), Hispanic (Latino), 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 26: Diabetes Ethnicity x Age

DIABETES Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Other API	8	8.5%	266	11.7%	1,631	17.3%	2,242	30.8%	**4,147**	**21.7%**
Other	4	4.3%	619	27.3%	1,944	20.6%	1,104	15.2%	**3,671**	**19.2%**
Hispanic	52	55.3%	588	25.9%	1,707	18.1%	1,014	13.9%	**3,361**	**17.6%**
Black	23	24.5%	492	21.7%	1,875	19.8%	689	9.5%	**3,079**	**16.1%**
Chinese	4	4.3%	94	4.1%	926	9.8%	1,385	19.0%	**2,409**	**12.6%**
White	2	2.1%	158	7.0%	875	9.3%	333	4.6%	**1,368**	**7.2%**
Vietnamese	1	1.1%	33	1.5%	420	4.4%	431	5.9%	**885**	**4.6%**
Unknown	0	0.0%	11	0.5%	40	0.4%	54	0.7%	**105**	**0.6%**
Am. Indian	0	0.0%	10	0.4%	33	0.3%	19	0.3%	**62**	**0.3%**
Total	**94**	**100.0%**	**2,271**	**100.0%**	**9,451**	**100.0%**	**7,271**	**100.0%**	**19,087**	**100.0%**

Source: CareAnalyzer, 2020

More than half of adults ages 45 to 64 with diabetes spoke English. For seniors ages 65+, English was about 40% of the group, followed by Chinese around 20%.

Table 27: 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%**

Source: CareAnalyzer, 2020

Asthma

Asthma was a combined category of diagnosis with and without status asthmaticus (former term for acute severe asthma). More than half of the members with asthma were female. About 40% were children under 19, 30% adults 19 to 44, and 20% adults 45 to 64. The SPD category had a higher prevalence than the other subpopulations, even though ages 65+ did not. About half lived in North County. About 30% each of members were Hispanic (Latino) and Black (African American). Black (African American) had the highest prevalence. English was the most common language.

Table 28: Asthma Prevalence

ASTHMA	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	17,370	100.0%	5.9		
CSHCN	485	2.8%	6	0.1	1.7
SPD	2,579	14.8%	8.9	3	50.8
Gender					
F	10,103	58.2%	6.4	0.5	8.5
M	7,267	41.8%	5.3	-0.6	-10.2
Age					
Under 19	7,239	41.7%	7	1.1	18.6
19-44	4,976	28.6%	4.9	-1	-16.9
45-64	3,696	21.3%	6.3	0.4	6.8
65+	1,459	8.4%	5.1	-0.8	-13.6
Location					
North County	8,945	51.5%	6.4	0.5	8.5
Central County	4,471	25.7%	5.4	-0.5	-8.5
South County	2,517	14.5%	5.7	-0.2	-3.4
East County	970	5.6%	5.4	-0.5	-8.5
Other / Unknown	467	2.7%	4.6	-1.3	-22
Ethnicity					
Hispanic (Latino)	4,866	28%	5.9	0	0
Black (African American)	4,815	27.7%	9.6	3.7	62.7
Other	3,320	19.1%	5.7	-0.2	-3.4
Other Asian / Pacific Islander	1,549	8.9%	5.1	-0.8	-13.6
White	1,494	8.6%	5.2	-0.7	-11.9
Chinese	806	4.6%	2.7	-3.2	-54.2
Vietnamese	391	2.3%	3.4	-2.5	-42.4
Unknown	70	0.4%	3.3	-2.6	-44.1
American Indian Or Alaskan Native	59	0.3%	9.1	3.2	54.2
Language					
English	12,301	70.8%	6.6	0.7	11.9
Spanish	3,105	17.9%	5.4	-0.5	-8.5
Chinese	743	4.3%	2.8	-3.1	-52.5
Unknown	563	3.2%	5.9	0	0
Other	366	2.1%	5.6	-0.3	-5.1
Vietnamese	292	1.7%	3.3	-2.6	-44.1

Source: CareAnalyzer, 2020

For children under 19 with asthma, the largest ethnic group was Hispanic (Latino), followed by Black (African American). For adults 19 to 64, Black (African American) and Other were the largest groups.

Table 29: Asthma Ethnicity x Age

ASTHMA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	3,209	44.3%	1,019	20.5%	456	12.3%	182	12.5%	**4,866**	**28.0%**
Black	1,866	25.8%	1,543	31.0%	1,176	31.8%	230	15.8%	**4,815**	**27.7%**
Other	851	11.8%	1,373	27.6%	860	23.3%	236	16.2%	**3,320**	**19.1%**
Other API	456	6.3%	308	6.2%	381	10.3%	404	27.7%	**1,549**	**8.9%**
White	319	4.4%	536	10.8%	529	14.3%	110	7.5%	**1,494**	**8.6%**
Chinese	368	5.1%	102	2.0%	134	3.6%	202	13.8%	**806**	**4.6%**
Vietnamese	131	1.8%	63	1.3%	124	3.4%	73	5.0%	**391**	**2.3%**
Unknown	24	0.3%	19	0.4%	14	0.4%	13	0.9%	**70**	**0.4%**
Am. Indian	15	0.2%	13	0.3%	22	0.6%	9	0.6%	**59**	**0.3%**
Total	**7,239**	**100.0%**	**4,976**	**100.0%**	**3,696**	**100.0%**	**1,459**	**100.0%**	**17,370**	**100.0%**

Source: CareAnalyzer, 2020

For children under 19 with asthma, more than half spoke English. The next most common language was Spanish at about a third. Most adults 19 to 64 spoke English.

Table 30: Asthma Language x Age

ASTHMA Language x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
English	4,254	58.8%	4,350	87.4%	2,975	80.5%	722	49.5%	**12,301**	**70.8%**
Spanish	2,304	31.8%	402	8.1%	246	6.7%	153	10.5%	**3,105**	**17.9%**
Chinese	342	4.7%	66	1.3%	118	3.2%	217	14.9%	**743**	**4.3%**
Unknown	146	2.0%	66	1.3%	143	3.9%	208	14.3%	**563**	**3.2%**
Other	119	1.6%	56	1.1%	109	2.9%	82	5.6%	**366**	**2.1%**
Vietnamese	74	1.0%	36	0.7%	105	2.8%	77	5.3%	**292**	**1.7%**
Total	**7,239**	**100.0%**	**4,976**	**100.0%**	**3,696**	**100.0%**	**1,459**	**100.0%**	**17,370**	**100.0%**

Source: CareAnalyzer, 2020

Access to Care

Access to care was assessed through CAHPS, CG-CAHPS, interpreter services, and provider language access data.

CAHPS

Below are the results from the 2020 CAHPS survey. The benchmarks are derived from NCQA's Quality Compass® benchmark and calculated by SPH Analytics. For adults, it is the mean of 165 plan-specific Medicaid adult samples that submitted to NCQA in 2019. The child benchmark includes 112 plans.

The plan rate is shaded in red when significantly below the benchmark at the 95% significance level according to SPH Analytics and shaded in green when significantly above the benchmark. Adults and children were below benchmark for getting care quickly overall and getting routine care. Children also had a low rate for getting urgent care. Adults were above benchmark for questions regarding personal doctor listening carefully and showing respect.

Table 31: CAHPS Results

Composite/Attribute/Measure	Adult Rate	Adult Benchmark	Child Rate	Child Benchmark
Getting Needed Care	**82.6%**	**82.5%**	**81.0%**	**84.5%**
Getting care, tests, or treatment	81.7%	84.8%	86.3%	89.6%
Getting specialist appointment	83.6%	80.3%	75.8%	79.7%
Getting Care Quickly	**71.7%**	**82.0%**	**82.0%**	**89.4%**
Getting urgent care	78.2%	85.1%	82.3%	91.2%
Getting routine care	65.2%	79.3%	81.7%	87.7%
How Well Doctors Communicate	**95.7%**	**92.0%**	**92.7%**	**94.0%**
Personal doctor explained things	95.3%	92.2%	90.5%	94.5%
Personal doctor listened carefully	97.2%	92.3%	95.0%	95.3%
Personal doctor showed respect	97.2%	93.6%	97.5%	96.3%
Personal doctor spent enough time	93.3%	89.9%	87.9%	89.7%
Customer Service	**88.8%**	**88.8%**	**84.0%**	**88.4%**
Provided information or help	82.7%	93.3%	77.4%	83.2%
Treated with courtesy and respect	94.9%	94.3%	90.6%	93.6%
Coordination of Care	**80.3%**	**83.6%**	**84.2%**	**83.8%**
Ease of Filling out Forms	**91.9%**	**94.4%**	**95.9%**	**95.0%**

Source: CAHPS 5.0H, SPH Analytics, 2020

Rates by ethnicity and race are as follows. “Other” race had significantly lower rates for both adults and children when it came to getting care quickly. “Not Hispanic” ethnicity had a lower rate in children for the ease of filling out forms. “Other” race in children was lower compared to Black/African Americans for the ease of filling out forms.

Table 32: CAHPS Results by Ethnicity and Race

ADULT	Ethnicity		Race		
Composite, Attribute, or Measure	**Hispanic**	**Not Hispanic**	**White**	**Black**	**Other**
Getting Needed Care	78.6%	84.5%	81.5%	90.2%	81.6%
Getting Care Quickly	80.1%	67.9%	**86.1%^**	79.3%	59.5%
How Well Doctors Communicate	96.4%	95.0%	98.9%	95.5%	93.9%
Customer Service	88.6%	87.9%	89.8%	100%	94%
Coordination of Care	83.3%	76.7%	93.3%	86.7%	73.1%
Ease of Filling Out Forms	91.8%	92.6%	95.7%	94.3%	88.8%
CHILD	**Ethnicity**		**Race**		
Composite, Attribute, or Measure	**Hispanic**	**Not Hispanic**	**White**	**Black**	**Other**
Getting Needed Care	85.0%	76.2%	87.3%	84.2%	77.4%
Getting Care Quickly	85.2%	78.1%	**89.4%^**	**92.5%^**	75.9%
How Well Doctors Communicate	95.2%	89.7%	95.7%	91.4%	91.0%
Customer Service	90.0%	77.5%	95.9%	87.5%	75.0%
Coordination of Care	85.1%	84.0%	80.0%	81.8%	82.9%
Ease of Filling Out Forms	**98.1%***	93.3%	96.8%	**100%^**	93.6%

*Rate is significantly higher than "Not Hispanic" ethnicity.
^Rate is significantly higher than "Other" race.

Source: CAHPS 5.0H, SPH Analytics, 2020

CG-CAHPS

Below are the results from the language services questions on the CG-CAHPS. Interpreter use was highest among Chinese and Spanish speakers.

A favorable response for being able to communicate with doctor and clinic staff in preferred language was either that the health plan provided an interpreter, or the doctor or clinic spoke their language or provided an interpreter. English and Other language speakers had the lowest rate of favorable responses. Children had a higher favorable response rate than adults.

Table 33: CG-CAHPS Language Questions

CG-CAHPS: Interpreter needed?	Adult responses	Adult % yes	Children responses	Children % yes
Total	7,746	30%	6,242	28%
English	4,088	6%	3,099	5%
Spanish	875	61%	2,237	53%
Chinese	1,152	71%	396	63%
Vietnamese	692	42%	155	30%
Other languages	939	44%	355	32%

ADULT: Able to communicate with doctor and clinic staff in preferred language?	Total responses	Favorable %	Family and Friends %	No %
Total	2,032	84%	13%	3%
English	222	59%	32%	9%
Spanish	447	88%	8%	4%
Chinese	727	92%	5%	2%
Vietnamese	261	93%	5%	2%
Other languages	174	60%	36%	4%
CHILD: Able to communicate with doctor and clinic staff in preferred language?	**Total responses**	**Favorable %**	**Family and Friends %**	**No %**
Total	1,555	91%	5%	3%
English	131	76%	11%	12%
Spanish	1,047	93%	5%	2%
Chinese	225	96%	3%	1%
Vietnamese	46	91%	4%	4%
Other languages	106	85%	7%	8%

Source: CG-CAHPS Member Satisfaction Survey, 2020

Interpreter utilization

Below are the top languages for interpreter services for 2020. The data includes the Alliance commercial line of business, which is 2% of total membership. The top languages were Chinese, Vietnamese, and Spanish. Tagalog was 0.7% of total interpreter services.

Table 34: Interpreter Utilization

INTERPRETER SERVICES	Services	Percent
Cantonese	23,243	49.4%
Vietnamese	6,386	13.6%
Spanish	5,265	11.2%
Mandarin	2,100	4.5%
Khmer	1,628	3.5%
Arabic	1,284	2.7%
Korean	756	1.6%
Punjabi	621	1.3%
Mongolian	533	1.1%
Farsi	521	1.1%
Tigrinya	442	0.9%
American Sign Language	402	0.9%
Hindi	376	0.8%
Dari	351	0.7%
Tagalog	341	0.7%
Total services	**47,018**	**100%**

Source: Alliance interpreter services reports, 2020

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 2020. Vietnamese was the highest at 505 members per provider in Q4 2020. Arabic was the most unstable due to small numbers of providers and members. The member to provider ratios were within expected ranges.

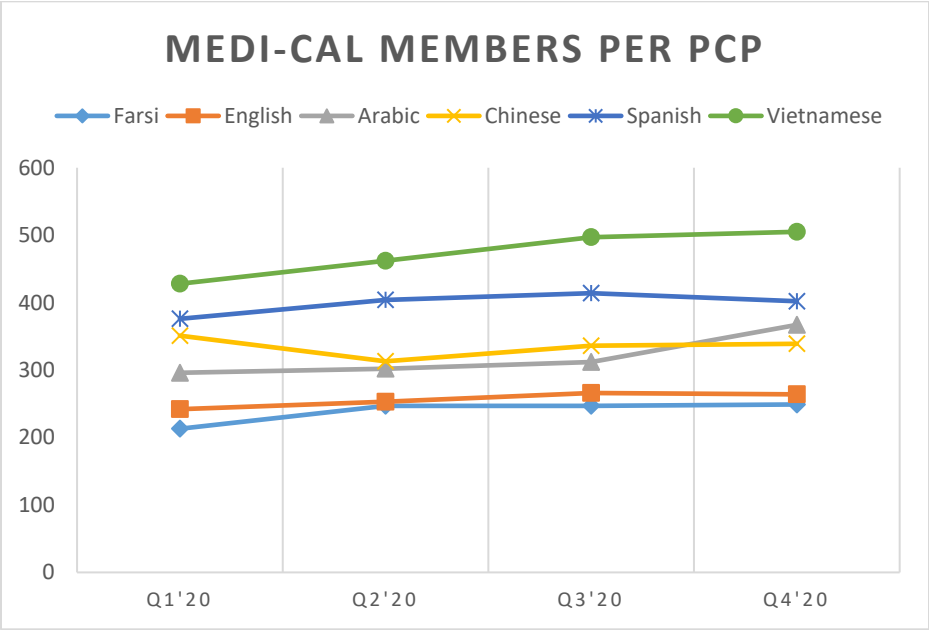

Figure 12: Provider Access by Language

Source: Alliance provider repository, 2020

Health Disparities

Health disparities were identified through the plan-specific HEDIS data from DHCS, which included 13 measures this year. Disparities were defined as any subgroup with a rate below the minimum performance level (MPL, defined by DHCS as the 50th percentile) for HEDIS Reporting Year 2020 (Measurement Year 2019) that represented at least 5% of the sample for the measure. This analysis was applied to the five measures that had an MPL.

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 Reporting Year 2020

Measure	Subgroup	% of sample	MPL (%)	Rate (%)	Absolute diff (%)	Relative diff (%)
AMR Asthma Medication Ratio	Total	100%	63.6	59.93*	3.67	5.77
	19-50 years	29%		52.52*	11.08	17.42
	51-64 years	19%		49.27*	14.33	22.53
	Female	53%		58.2*	5.4	8.49
	Male	47%		61.87	1.73	2.72
	English	71%		58.68*	4.92	7.74
	White	9%		63.44	0.16	0.25
	Asian	17%		61.31	2.29	3.60
	Black (African American)	30%		52.42*	11.18	17.58
	Other	14%		61.9	1.7	2.67
BCS Breast Cancer Screening	65 - 74 years	13%	58.73	57.04	1.69	2.88
	English	54%		55.45*	3.28	5.58
	White	11%		49.87*	8.86	15.09
	Black (African American)	16%		52.85*	5.88	10.01
CHL Chlamydia screening in women	Spanish	27%	58.33	58.28	0.05	0.09
	White	6%		54.5	3.83	6.57
	Asian	15%		55.06	3.27	5.61
	Other	19%		56.89	1.44	2.47

Notes: Absolute difference = MPL - Rate
Relative difference = Absolute difference/MPL x 100
Source: DHCS health disparities data, 2020

Disparities were identified in three of the five measures analyzed.

- AMR, Asthma Medication Ratio, was significantly lower than the MPL for the plan overall, but lowest for ages 19-50 years, ages 51-64 years, and Black (African American) ethnicity.

- BCS, Breast Cancer Screening, was lowest for White and Black (African American) ethnicities.

- CHL, Chlamydia screening in women, was significantly lower in Asians. The rate was lowest in White ethnicity, but this did not reach significance.

Member Advisory Committee Input

Focus groups and mailed responses with Member Advisory Committee (MAC) members were also used to identify member needs. There were three focus groups and two mailed responses. The first focus group had two members; the second had a representative from a Federally Qualified Health Center clinic and one representative from the Alameda County Public Health Asthma Start Program; and the third had three members. The mailed responses were from two members.

Of the seven members, six were female and one was male. They were Hispanic (Latino), Black (African American), Asian, and Other ethnicities. Five were seniors or persons with disabilities. One was a parent of a child with special health care needs. They ranged from ages 28 to 71.

Health Education invited all MAC members to participate in a small group discussion. Those that agreed were sent data in an infographic format showing the membership makeup, top health and access issues, and largest gaps for subgroups to quality benchmarks. The meeting packet also summarized 2020 action plan activities. In the group, facilitators reviewed the packet and answered questions. Then, each MAC member was asked to identify their top needs the Alliance should address and potential strategies. Other MAC members added ideas for potential strategies to the stated need.

The needs discussed have been grouped under themes, as shown in the table below.

Table 36: Member Advisory Committee Input

Theme	Needs
Member and provider awareness and use of member benefits	Provide more information and outreach to members and providers about: • Which providers members can see. • What health education programs are available. • Which medicines are covered, such as over-the-counter drugs. • How to use health care services. • Why not to use family and friends as interpreters and how to access qualified interpreters. • When to go to checkups (especially with the pandemic) and why it is important. • What is covered for people with disabilities.
Quality of member benefits	Provide or incentivize quality services with: • Better vision and dental coverage. • Merit system for providers with good member satisfaction scores.
Wait time	Improve members reporting that they were able to get care quickly. Areas with long wait include: • Getting a PCP referral to visit a specialist. • Getting school physicals. • Prior authorizations for medicines.

Theme	Needs
Disease management support and prevention	Provide more support in managing and preventing health conditions for members who: • Have high blood pressure or prediabetes and could prevent heart disease or diabetes. • Are not taking medicines correctly. • Have autoimmune diseases. • Have mental health issues and/or physical disabilities. • Are expecting parents and could start learning about healthy habits to prevent childhood obesity.
Provider communication	Improve communication between member and provider when: • There are barriers to interpreter use and it is easier to use family and friends. • Providers do not have their video on during video appointments.

Source: MAC focus groups and mailed survey, 2021

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 to address in the 2021 action plan.

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 asthma self-management support**

    a. **Asthma in Hispanic (Latino) and Black (African American) children**

    Data sources

    References: Table 12: Top Diagnoses Children; Table 14: Top Diagnoses CSHCN; Table 28: Asthma Prevalence; Table 29: Asthma Ethnicity x Age; Table 35: HEDIS Disparities

    Asthma without status asthmaticus was the 7th most common diagnosis for both children (7%) and for children with special health care needs (6%). Among members with asthma, the largest age group was children under 19 years (42%). Slightly under half (44%) of the children with asthma were Hispanic (Latino) and about a quarter (26%) were Black (African American). Most families of children with asthma spoke English (59%), followed by Spanish (32%). Black (African American) members, including both adults and children, were 18% less than the MPL [relative difference] for the Asthma Medication Ratio (AMR) measure.

    Current activities: Health Education refers children with asthma into the local public health department's pediatric in-home case management program, Asthma Start, through three main methods: 1) hospital emergency department (ED) reports, 2) population health report, and 3) health education program member requests. Weekly ED reports from hospitals 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, a monthly population health report is run on inpatient visits and medication use for children with asthma to make referrals to Asthma Start for members who are at high risk. Lastly, members can mail or call the Alliance to request program information about asthma management.

    This year, the Alliance and Asthma Start program have started a new contract that enhances reimbursement for outreach to culturally diverse populations and supports asthma mitigation supplies. This will support more referrals through the population health report and additional member and provider outreach.

    Program gaps: The Asthma Start program is still working to outreach to and engage both members and providers. Health Education found in the 2019 Asthma Start program evaluation that Black (African American) families were harder to reach after being referred. The Asthma Start program manager agreed that this was in line with the staff's experience. This analysis is still pending for 2020, but with the shift to telephonic and virtual support

during the pandemic, it appears that participation from Hispanic (Latino) families dropped much more than for Black (African American) families.

b. Asthma in Black (African American) adults

Data sources

References: Figure 6: County Region by Ethnicity; Table 28: Asthma Prevalence; Table 29: Asthma Ethnicity x Age; Table 35: HEDIS Disparities

Although asthma was most common in children, HEDIS disparities data for AMR (Asthma Medication Ratio) pointed to gaps in asthma control for ages 51 to 64 (23% less than MPL [relative difference]), ages 19 to 50 (17%), and Black or African American (18%) members. These three groups each comprised about 20 to 30% of the HEDIS sample.

Chronic disease prevalence data showed that Black (African American) ethnicity was the largest group for the 19 to 44 (31%) and 45 to 64 (32%) age groups. They also had the highest prevalence of asthma at 63% greater than the overall prevalence. North County had the highest proportion (52%) and prevalence of asthma (9% greater), and most of the Black (African American) population lived in North County.

Current activities: Multiple Alliance departments, led by Pharmacy, are participating in the Asthma Affinity Group project to reach members and providers in the 2020 PNA action plan target group of Black (African American) adults ages 21 to 44 who are below the MPL for AMR. Health Education continues to send information about community programs for adults with asthma such as Better Breather Clubs and an asthma community class upon member request. Health Education and Quality Improvement also started an African American Advisory Group with a MAC member, Asthma Start parent, and staff to provide input into culturally appropriate interventions.

Program gaps: The outreach through the Asthma Affinity Group project has been limited so far to a small pilot for members. Provider outreach on AMR is needed to identify their patients with persistent asthma and review their medications. The HEDIS data included in the PNA this year has expanded the age range from 21 to 44 to all adults under age 65.

2. Access and participation in preventive care

a. Getting routine care appointments quickly

Data sources

References: Table 31: CAHPS Results; Table 32: CAHPS Results by Ethnicity and Race; Table 36: Member Advisory Committee Input

In the CAHPS survey, both adults (65%) and children (82%) had rates significantly below the Quality Compass benchmarks of 79% and 88%, respectively, for being able to get a checkup or routine care appointment as soon as needed. According to the vendor's analysis, the rates for getting care quickly overall were significantly higher for White race (86%) than

Other (60%) for adults and for White (89%) and Black (93%) races compared to Other (76%) for children. “Other” is any race other than White or Black/African American.

One Member Advisory Committee member and a clinic advocate both identified the issue of getting care quickly as one of the most important needs. The member spoke specifically about the wait to see a specialist if they need to see their PCP first. The clinic advocate was concerned about members feeling that they are not getting into care quickly. She talked about the limited in-person visits during the pandemic and the longer waits during back-to-school season because of school physicals. The other community advocate added that keeping telehealth options could be beneficial for some people in getting care quickly.

Current activities: The Access team uses CAHPS, grievances, the Provider Appointment Availability Survey (PAAS), and secret shopper/confirmatory surveys to monitor, track, and trend timeliness to care. Providers who are not responsive or noncompliant in the PAAS are issued corrective action plans. If a provider is noncompliant with the secret shopper/confirmatory survey, they are sent a timely access educational letter and tracked for two consecutive quarters. Providers are issued a corrective action plan if they continue to be noncompliant. Access has convened a member satisfaction workgroup with multiple Alliance departments to implement improvement strategies using the PDSA methodology. Getting care quickly is one of the top priorities for this workgroup.

Program gaps: During COVID-19, it was difficult to accurately monitor timeliness to care given the shift in provider care from in person to telehealth visits. It was also a challenging time to engage providers and staff in access to care improvement strategies as resources were dedicated to meeting the public health crisis. Timely access to specialists continues to be a challenge, although it is unclear how much of this issue in the past year was related to COVID-19.

b. Well-child visits

Data sources

References: Table 36: Member Advisory Committee Input

The HEDIS disparities data in the PNA this year did not include well-child visits, but it was identified as a disparity last year, and the Quality Improvement team continues to prioritize and track this area.

As with last year, MAC members also talked about encouraging preventive care visits. One parent of an Alliance member said that because many children were not able to see the doctor during the pandemic, the Alliance should do an outreach campaign via text messages, postcards, e-mails, and/or calls to bring patients back in for checkups. Another MAC member wrote about checkups in general, asking whether someone can call members to let them know about the visit and its importance.

Current activities: The Alliance educates both delegates and directly contracted providers about the Pay for Performance program, which includes well-child visits. The Alliance regularly shares performance rates on well-child visits with its delegates at quarterly joint

operations and committee meetings. Quality and Analytics also sends monthly gaps in care reports to directly contracted providers. Quality started to implement birthday cards with member incentives for well-child visits through two providers in the first half of 2021. In addition to provider partnerships, Quality has partnered with First 5 Alameda County to conduct outreach calls to families with children up to age 6 to encourage well-child visits.

Program gaps: COVID-19 presented significant challenges to preventive care services, including well-child visits. Additionally, the HEDIS measure for well-child visits has recently changed, making it challenging for both the plan and providers to keep up with the measures and billing codes. The measure is currently WCV, expanding the age range to 3 to 21.

c. Breast cancer screening in Black (African American) women

Data sources

References: Table 35: HEDIS Disparities

In the HEDIS disparities data, breast cancer screening rates were lowest for White (15% less than MPL [relative difference]) and Black (African American) ethnicities (10% less). White members comprised 11% and Black (African American) 16% of the sample.

Current activities: The Alliance has a partnership with a delegate clinic's radiology department to help increase breast cancer screening rates and explore the use of standing, batch mammogram orders. The delegate has large clinics in North County, which is where most Black (African American) members live. The Alliance also distributes gaps in care reports to providers. Quality developed and was approved for an equity Performance Improvement Project for breast cancer screening in Black (African American) women ages 52 to 74.

Program gaps: The standing order process needs to be streamlined and expanded within the partner clinic. Providers have reported that they do not always see the gaps in care report and that transportation is a barrier for breast cancer screening. Furthermore, the Alliance has not recently done member outreach around breast cancer screening. Though the rates for White and Black (African American) women were both low, Black (African American) was chosen as the focus of the quality improvement project because of their larger numbers.

4. Action Plan

2020 PNA Action Plan Review and Update

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 1a.) 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	**Progress Measure:** In 2020, 171 Asian and Pacific Islander members received blood pressure cuffs (150) or attended diabetes self-management programs (21). **Data source:** Asian Health Services final project report; Health Education program participation records
	Progress Toward Objective: This objective was met mostly through a clinic collaboration around hypertension. Some in-person and group disease self-management programs were suspended due to COVID-19. However, some members benefitted from more flexible (virtual and/or one-on-one) options for diabetes self-management programs during the pandemic. The self-management tools will be published in 2021. This objective will not continue in 2021, but the strategies will continue as part of the Alliance disease management program.
Strategies	
Strategy 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.	**Progress Discussion:** The Alliance provided 150 blood pressure cuffs between June and December 2020 to a clinic that mainly serves Asian and Pacific Islander patients. At PCP appointments, medical assistants screened Alliance patients with hypertension to see whether they had a blood pressure cuff and knew how to use one. Member education was done through video and face-to-face instruction. The partnership with this clinic ended in 2020, but the strategy to promote member access and participation in diabetes self-management programs will continue as part of the Alliance disease management program.
Strategy 2.) Publish and distribute self-management tools in threshold and most prevalent Asian or Pacific Islander non-threshold languages.	**Progress Discussion:** Heart Health and Diabetes care book drafts were submitted for design by June 2020. Field-testing for the books was completed in February 2021. The Alliance anticipates that the book will be ready to distribute by July 2021. Health Education will send the books to members and translate into other languages on request. This strategy will be part of the Alliance disease management program.

Strategy 3.) Integrate disease self-management referrals into Alliance Case Management programs.	**Progress Discussion:** In February 2021, Health Education presented on diabetes self-management program referrals to Case Management staff and to Community-Based Care Management Entities in the Health Homes program. This strategy will be part of the Alliance disease management program.

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

Objective 1b.) Connect 100 Hispanic (Latino) members with healthy weight resources by June 30, 2022. **Data source:** Health Education program participation records	**Progress Measure:** Health Education programs (clinic-based health education, parenting class) served 9 Hispanic (Latino) children or parents in 2020. **Data source:** Health Education program participation records
	Progress Toward Objective: The programs mentioned are from Strategy 4. The care book and referral listings that were part of Strategies 2 and 3 are under development but have not been completed because of competing priorities for materials approvals and projects. Strategy 1 was completed, and Health Education plans to reconnect with clinics to promote healthy weight resources and discuss what other services the Alliance may offer to reach more members. Health Education will continue to work on this area but will not include it as a PNA objective for 2021.
Strategies	
Strategy 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.	**Progress Discussion:** Health Education hosted an Alliance Child Weight Virtual Forum on March 4, 2021. There were six community organizations or clinics represented, and one individual. A recording of the forum was emailed to other clinic partners who were not able to attend. Health Education had follow-up conversations with three of the attendees and plan to reach out to the clinics to let them know what the Alliance might be able to offer and ask what they would be interested in partnering on. This strategy will be revised to focus on outreach to providers.
Strategy 2.) Compile and distribute to clinics food and physical activity referral information, including opportunities for children with special needs.	**Progress Discussion:** Health Education updated an internal referral database in July 2020, which includes several food and physical activity referrals. State approval is pending to publish the updates with a member-facing class and program listing template. In January 2021, minor updates to a provider-facing health education resource guide were published, adding a program referral for nutrition counseling. A link to the guide was emailed via Health Education newsletter to clinic contacts in March 2021. Health

	Education has begun to explore the feasibility of creating an online program listing on the Alliance website as well as using an external referral database website. This strategy will continue.
Strategy 3.) Complete and distribute child healthy living care book in Spanish and English to Hispanic (Latino) members and providers.	**Progress Discussion:** The "Live Healthy with 5-2-1-0!" care book draft was submitted for design in July 2020. Field-testing for the book was completed in February 2021. The Alliance anticipates that the book will be ready to distribute by July 2021. Health Education will promote the book with providers once it is available. This strategy will be part of the outreach to providers.
Strategy 4.) Provide financial support for clinic and school-based nutrition or healthy weight programs.	**Progress Discussion:** Health Education continues to fund one clinic's health education services in clinic and school-based health center work. In 2020, funds were used entirely for clinic-based visits since their school-based work shifted during the pandemic to screenings. They served eight Hispanic children. In 2021, the school-based health center adapted a nutrition curriculum to a virtual format and delivered it to middle school students. Health Education will continue to support this clinic and seek to collaborate with another school-based clinic. In response to feedback from providers that parenting skills were needed to help children develop healthy habits, Health Education began to offer positive parenting classes in July 2020 through a community partner. They hold classes in Spanish and offer interpreters as well. In 2020, Health Education paid for one Hispanic member to attend. This strategy will continue.

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

Objective 1c.) Increase annual participation of Hispanic (Latino) 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	**Progress Measure:** There were 62 Black (African American) and 57 Hispanic (Latino) participants in 2020, a total of 119 members and decrease of 42% from 2019. **Data source:** Asthma Start program participation records
	Progress Toward Objective: Participation declined in 2020 due to two major factors: 1) COVID-19 delayed in-home case management services while the program reorganized to offer virtual home visits, and 2) a relationship change with the local Children's Hospital drastically reduced referrals from recent emergency department (ED) visits. Health Education

	has reworked the referral strategy and increased support for Asthma Start outreach. This objective will continue as is.
Strategies	
Strategy 1.) Collaborate with Asthma Start to increase culturally sensitive member outreach and availability of asthma mitigation supplies.	**Progress Discussion:** As of April 2020, the Alliance has a new service agreement with Asthma Start that will increase reimbursement for outreach to culturally diverse populations and support asthma mitigation supplies. Asthma Start will also begin offering enhanced asthma mitigation supplies and home modifications through grant funding from the DHCS Asthma Mitigation Project. This collaboration will continue.
Strategy 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.	**Progress Discussion:** The Alliance now receives daily ED visit feeds from six new hospitals allowing for timelier referral of pediatric members who had asthma-related visits to Asthma Start. Previously there had been two hospitals. To further augment referrals, Health Education has updated claims, encounter, and pharmacy-based referrals to Asthma Start. This strategy is complete.
Strategy 3.) Educate pediatric providers regarding Asthma Start services and the referral process.	**Progress Discussion:** This strategy was postponed due to COVID-19 and will be implemented Q4 2021.

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

Objective 1d.) 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	**Progress Measure:** As of May 5, 2021, the point-in-time AMR rate for 2021 was 51.40% for Black (African American) adults ages 21 to 44. **Data source:** Cotiviti HEDIS engine
	Progress Toward Objective: The most current rate is over 10 percentage points below the Measurement Year 2019 MPL. The asthma workshop strategy was postponed due to COVID-19, and there is an effort underway to create an asthma education PowerPoint and video. Pharmacy and other Alliance departments participated in an Asthma Affinity Group project to pilot member phone consults and provider outreach. Health Education and Quality Improvement launched the African American Advisory Group. This objective will be modified to extend the age range and timeline to 2022.
Strategies	

Strategy 1.) Partner with providers to hold asthma workshops for targeted members out of compliance with AMR.	**Progress Discussion:** The asthma workshop strategy was postponed because of COVID-19. The Quality Improvement team is developing an educational PowerPoint and video that will be posted on the Alliance website and used as a component of a quality improvement project. In January 2021, the Asthma Affinity Group drafted a provider letter that informs the provider about members who are out of compliance for AMR and includes resources. The workshop and provider outreach strategies will continue.
Strategy 2.) Collaborate with pharmacy to provide member phone consults that support AMR compliance.	**Progress Discussion:** The Asthma Affinity Group completed a pilot program in February 2021, reaching 6 out of 12 targeted members. They reviewed each member's ED visits and then called the members to provide care navigation, education, and support. The project team is now planning how to reach more members. This strategy will continue.
Strategy 3.) Integrate best practices for culturally sensitive asthma care for Black (African American) adults into asthma workshops and consults.	**Progress Discussion:** Health Education and Quality Improvement started an African American Advisory Group in November 2020. The group discussed barriers and facilitators to asthma management for African Americans and provided input on the draft asthma educational video. The results of the Asthma Affinity Group pilot program will be presented to the group at the next meeting. This strategy will continue.

2. Access and participation in routine care appointments

2a. Getting routine care appointments quickly

Objective 2a.) 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	**Progress Measure:** The CAHPS rate for getting a checkup or routine care as soon as needed decreased from 70.3% to 65.2% for adults and from 83.5% to 81.7% for children. **Data source:** 2020 CAHPS
	Progress Toward Objective: The CAHPS rates for both adults and children decreased, which may be due to the pandemic and a provider shift to telehealth. This objective will be modified to reflect pre-COVID rates for getting care quickly and extend the timeline to 2022.
Strategies	

Strategy 1.) Outreach to providers identified by Grievance & Appeals staff as having the highest number of access-related grievances per quarter.	**Progress Discussion:** The Alliance meets regularly with delegate leadership during joint operations meetings to discuss access grievances. In addition, specialists who did not meet the timely access requirements in the Provider Appointment Availability Survey (PAAS) were given corrective action plans. This strategy will continue and include monitoring beyond grievances.
Strategy 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.	**Progress Discussion:** Timely access standards were shared with members through the 2020 Fall/Winter member newsletter and on the plan website. Providers receive information on the standards in provider quarterly packets. Secret shopper/confirmatory surveys conducted by the Alliance were also used to assess provider compliance with timely access standards. Non-compliant providers are sent a timely access educational letter, and provider compliance is tracked for two consecutive quarters. This strategy will continue.

2b. Well-child visits

Objective 2b.) 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.)	**Progress Measure:** For ages 3 to 6, there was a 22.17 percentage point decrease for Black (African American) and 19.78 percentage point decrease for White members from Measurement Year 2019 to 2020. **Data source:** Cotiviti HEDIS engine
	Progress Toward Objective: The W34 measure changed to WCV, so the progress measure was calculated differently than the original objective. The main barrier for well-child visits in 2020 was the pandemic and fears about going to the doctor's office. Providers were also not as available to participate in quality improvement projects during this time, but the Alliance did partner with nine providers to encourage well-child visits. This objective will be modified to align with the current Performance Improvement Project around WCV that targets two identified providers without the focus on specific ethnicities.
Strategies	

Strategy 1.) Partner with clinics with low compliance rates that serve Black (African American) and White children on appointment availability, reminders, and member incentives.	**Progress Discussion:** Quality partnered with nine PCPs to offer member incentives at the completion of a well-child visit. The member incentive strategy will continue with two providers.
Strategy 2.) Update gaps in care member letters to be more member-friendly.	**Progress Discussion:** Quality created a birthday card that offers a member incentive to complete their well-child visit during their birthday month. Two providers are using these cards during January to June 2021. Quality is also creating general reminder postcards for members that will include color-coded dots indicating gaps in care to the provider. This project is currently pending State approval. These strategies, particularly the birthday card project, will continue with the two providers.
Strategy 3.) Educate providers about gaps in care report and disparities in well-child visit participation.	**Progress Discussion:** The Alliance educates providers about the Pay for Performance (P4P) program, which includes well-child visits, through the program guide. In the beginning of 2021, the Alliance reviewed the P4P program with delegates in meetings. Provider Services representatives reviewed the P4P program with their assigned directly contracted providers. The Alliance regularly shares performance rates on well-child visits with its delegates at quarterly joint operations and committee meetings and sends gaps in care reports to directly contracted providers. This strategy will continue.

3. Information and coordination of member benefits

Objective 3.) 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	**Progress Measure:** This CAHPS question has been discontinued for 2020. **Data source:** CAHPS
	Progress Toward Objective: This CAHPS question was discontinued. The Alliance will consider this objective completed and look at other metrics related to member benefits in the future, such as those included in the DHCS CAHPS survey. Barriers for implementing these strategies included competing priorities for staff time and materials development. The Alliance provided resources virtually or over the phone and increased staff participation in Alameda

	County's Special Needs Committee. This objective will not continue in 2021.
Strategies	
Strategy 1.) Discuss CAHPS results regarding providing needed information with Alliance departments to identify and implement strategies to improve scores.	**Progress Discussion:** The member satisfaction workgroup comprised of diverse departments at the Alliance discussed the CAHPS results in the fall of 2020. This group will reconvene in the second half of 2021 to continue strategizing. Health Education will share feedback from the Member Advisory Committee focus groups.
Strategy 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.).	**Progress Discussion:** The Alliance completed a major update of the public website and member portal to increase member access to key information. These resources were promoted to members in the 2020 Fall/Winter member newsletter. After the shelter in place orders, the Communications & Outreach team conducted new member orientations over the phone. The calls increased member participation in new member orientations and explained how to access plan benefits. In addition, Health Education has included member benefit information in two new materials. A resource guide for SPDs was completed in April 2020. It is posted on the Alliance website and has been shared with Case Management staff to distribute to members. The second, pending translation and distribution, is a brochure titled "Where Do I Go for Health Care?" that introduces new members to resources such as the advice nurse line and benefits they can access by calling Member Services or online.
Strategy 3.) Engage community groups serving children with special health care needs regarding member benefits, their experiences, and education on how to access.	**Progress Discussion:** The Alliance's Health Care Services department, Communications & Outreach department, and behavioral health delegate now participate in Alameda County's Special Needs Committee as a way to share information on member benefits to providers and community agencies that serve children with special needs.

2021 PNA Action Plan Table

Based on the assessment of the key findings and gap analysis, Alliance Quality Improvement will implement the following strategies to address identified program gaps over the next year and beyond. The two objectives identified through the Health Disparities section of this report have been marked as health disparity objectives.

1. Culturally and linguistically appropriate asthma self-management support

1a. Asthma in Hispanic (Latino) and Black (African American) children

Objective: *Increase annual participation of Hispanic (Latino) 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:** *Asthma Start program participation records*
Strategies
1.) Continue funding Asthma Start outreach and in-home case management services for Hispanic (Latino) and Black (African American) families.
2.) Create provider promotion materials with Asthma Start to encourage referrals.
3.) Launch regular mailing to families of children with asthma to encourage participation in the Asthma Start program.

1b. [HEALTH DISPARITY] Asthma in Black (African American) adults

Objective: *Increase HEDIS Asthma Medication Ratio (AMR) measure from 49.17% in Measurement Year 2020 to the Measurement Year 2020 MPL of 62.43% for Black (African American) adults ages 19 to 64 by December 31, 2022.* **Data Source:** *Cotiviti HEDIS engine*
Strategies
1.) Conduct targeted mailing with member incentive to view an educational video and/or visit their doctor for an asthma checkup.
2.) Support a large delegate clinic system in holding asthma workshops for members out of compliance with AMR.
3.) Collaborate with pharmacy to provide member phone consults and provider outreach that support AMR compliance for ages 21 to 44.
4.) Integrate African American Advisory Group recommendations into member and provider outreach.

2. Access and participation in preventive care

2a. Getting routine care appointments quickly

Objective: *Improve CAHPS rate for getting checkup or routine care appointment as soon as needed to pre-COVID 2019 rates from 65.2% to 70.3% for adults and 82.0% to 85.6% for children by December 31, 2022.* **Data Source:** *CAHPS*
Strategies
1.) Share timely access survey results and access-related grievances with delegate and directly contracted providers and discuss opportunities for improvement.
2.) Conduct ongoing member and provider education regarding timely access standards and survey results.
3.) Hold member satisfaction workgroup meetings to consider member feedback and implement improvement strategies.

2b. Well-child visits

Objective: *Increase HEDIS Child and Adolescent Well-Care Visits (WCV) measure from 49.3% to 55% for two identified providers by December 31, 2022.* **Data Source:** *Cotiviti HEDIS engine*
Strategies
1.) Encourage providers to review the gaps in care report and use it for patient outreach to schedule a well-child visit.
2.) Provide member incentives upon completion of well-child visit.
3.) Send birthday cards to members inviting them to complete a well-child visit during their birthday month and receive a member incentive.
4.) Continue provider incentive for WCV through Pay for Performance program.

2c. [HEALTH DISPARITY] Breast cancer screening in Black (African American) women

Objective: *Improve HEDIS Breast Cancer Screening (BCS) measure among Black (African American) women ages 52 to 74 from 46.76% in Measurement Year 2020 to 53.76% by December 31, 2022.* **Data Source:** *Cotiviti HEDIS engine*
Strategies
1.) Educate members on why and where to get a breast cancer screening and provide member incentive upon completion of screening.
2.) Ensure gaps in care reports are pulled timely by providers' staff and that they understand how to utilize the reports.
3.) Discuss with providers at delegate clinic how to streamline the standing order process and address barriers for members such as transportation.

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 action plan review (Completed March 18, 2021)**
   Health Education presented a review of the 2020 action plan and progress toward objectives and strategies at a quarterly meeting of the MAC, to be further discussed in small groups the following month.

2) **Focus groups and interviews (Completed April 20-29, 2021)**
   MAC feedback was solicited through small focus groups and surveys to accommodate availability (see section "Member Advisory Committee Input" for more details on the participants). The key findings were presented to MAC members. They were asked to identify the highest priority member needs related to the data. MAC members were then asked to consider what the plan could do to address these needs.

3) **Share results (Planned for September-November 2021)**
   PNA results with gap analysis and action plan will be shared with:

   a. The Alliance MAC at a quarterly meeting.
   b. Alliance providers via presentations at the Health Care Quality Committee meeting and provider communications distributed through quarterly provider packet and posted on the Alliance website.
   c. Alliance staff via presentations at all staff and internal subcommittee meetings for use in planning and guiding culturally and linguistically relevant programs and member communication.