2022 Population Needs Assessment

HCQC
September 16, 2022

ALAMEDA Alliance FOR HEALTH

What is the Population Needs Assessment?

- Part of the Alliance Population Health Strategy
- The Population Needs Assessment (PNA) Goal:
  - Identify and understand Medi-Cal member health needs and health disparities
  - Evaluate health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns
  - Implement targeted strategies
- DHCS required report – next report due in 2025

What are the required components?

- Key Findings
  - Member profile
  - Health status
  - Health disparities
  - Gaps in health education, quality improvement, and cultural & linguistic services
- Action plan
- Stakeholder engagement

Data

Required Data

- Member Satisfaction Survey (CAHPS), MY2020
- Health disparities based on HEDIS, MY2020
- Stakeholder input (Member Advisory Committee)

Additional Data Used

- County data on social determinants of health (ex. housing, CalFresh)
- Member demographic data (age, sex, race/ethnicity, location), 2021
- Member health status (CareAnalyzer), 2021
- CG-CAHPS: post-visit member survey, 2021

Member subgroups

- Children with special health care needs (CSHCN)
- Seniors and persons with disabilities (SPD)
- Members with limited English proficiency (LEP)
- Members with diverse cultural and ethnic backgrounds

Member Profile

312,699 Alliance Medi-Cal members

enrolled at any time during 2021

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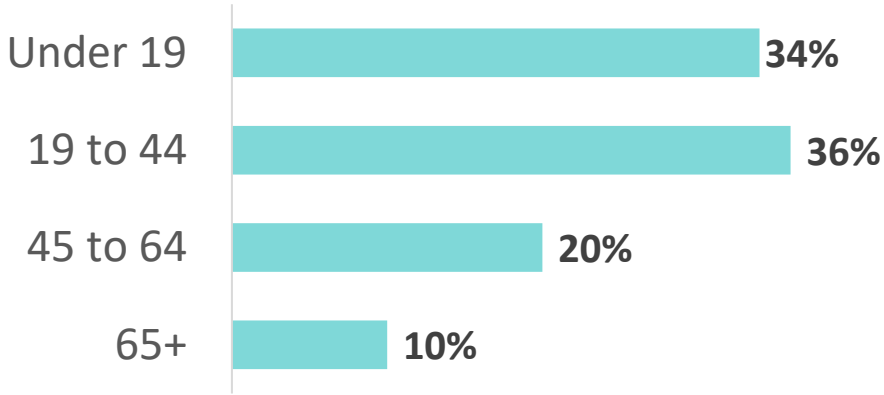
Member Gender and Age

Gender*

53%
Female

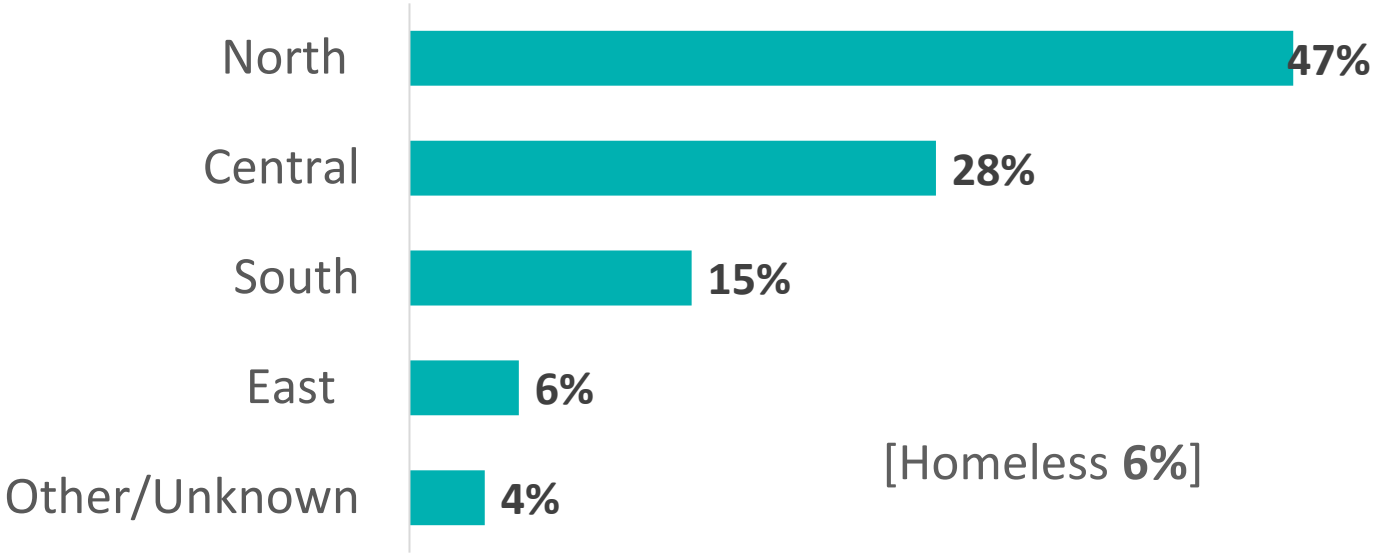
47%
Male

Age



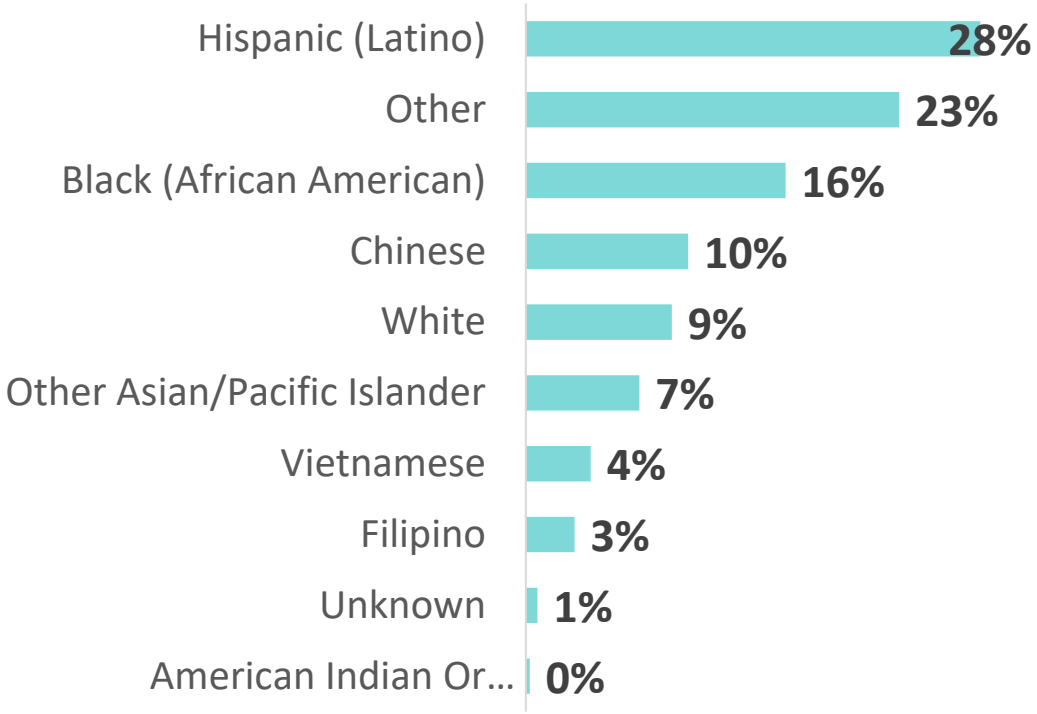
* Medi-Cal does not yet track non-binary gender identification.

Member County Region



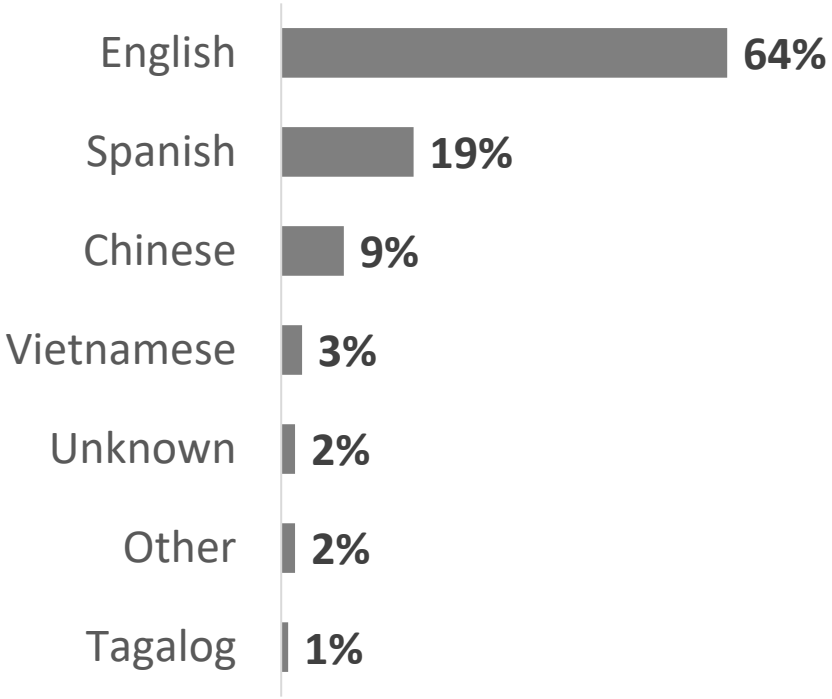
County Region	Cities included
North County	Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont
Central County	Castro Valley, Hayward, San Leandro, San Lorenzo (Note: Ashland, Cherryland, and Fairview are unincorporated areas and not in member addresses.)
East County	Dublin, Livermore, Pleasanton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

Member Ethnicity



- For Under 19, the largest ethnic group was Hispanic (Latino)
- For 19 – 44 years, the largest ethnic groups were Other and Hispanic (Latino)
- For 45 – 64 years, the largest ethnic groups were Other and Black (African American)
- For 65+ years, the largest ethnic group was Chinese

Member Language



- Among non-English speakers:
  - For Under 19 and 19-44 years, the largest language group was Spanish
  - For 65+ years, the largest language group was Chinese

Member Health Status

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Health Issues by Subgroup

Rank	Child 100,075 members	CSHCN 5,148 members	Adult 178,297 members	SPD 29,179 members
1st	Eye symptoms 18%	Eye symptoms 20%	Hypertension 16%	Hypertension 42%
2nd	Obesity 14%	Obesity 15%	Hyperlipidemia 15%	Hyperlipidemia 32%
3rd	Colds and flu 10%	Developmental disorder 14%	Muscle, bone, or joint symptoms 11%	Neurologic symptoms 20%
4th	Vision problems 9%	Vision problems 13%	Abdominal pain 10%	Muscle, bone, or joint symptoms 19%
5th	Eczema & skin rashes 8%	Colds and flu 11%	Neurologic symptoms 10%	Low back pain 15%
6th	Allergies 6%	Neurologic symptoms 10%	Vision problems 10%	Cardiovascular symptoms 13%
7th	Asthma 6%	Asthma 10%	Low back pain 9%	Type 2 Diabetes 13%
8th	Virus 6%	Eczema & skin rashes 9%	Anxiety 8%	Nutrition deficiencies 13%

Member Health Issues by Age and Ethnicity

Health Issue	Groups with the most people	Groups with highest prevalence
Hypertension	Black 45-64 Other 45-64	Am. Indian 65+ Filipino 65+
Hyperlipidemia	Chinese 65+	Filipino 65+ Vietnamese 65+ Chinese 65+
Obesity	Hispanic under 19	Hispanic under 19 Am. Indian under 19
Diabetes	Other 45-64 Black 45-64	Filipino 65+ Other Asian/PI 65+
Anxiety	Other 19-44	White 45-64 Am. Indian 45-64
Asthma	Hispanic under 19	Am. Indian 65+ Am. Indian 45-64
Depression	Other 19-44	White 65+ White 45-64

HEDIS Disparities MY2020

Subgroup rates listed were significantly lower at the 95% or 99%* significance level.

Breast Cancer Screening (BCS)	% of sample	MPL (%)	MY 2020 Rate (%)
BCS – Overall*	100%	**58.82**	56.21
BCS – Ages 50-64*	87%		56.81
BCS – Ages 65-74*	13%		52.17
BCS – English *	54%		50.04
BCS – Black or African American*	16%		46.85
BCS – White*	10%		46.23
BCS – Other Ethnicity*	17%		56.05

Chlamydia Screening in Women (CHL)	% of sample	MPL (%)	MY 2020 Rate (%)
CHL – Asian*	13%	**58.44**	49.34
CHL – White	7%		53.99

HEDIS Disparities MY2020

Controlling High Blood Pressure (CBP)	% of sample	2020 MPL (%)	MY 2020 Rate (%)
CBP – Overall*	100%	**61.8**	51.34
CBP – Ages 21-44*	14%		41.07
CBP – Ages 45-64*	66%		52.96
CBP – Ages 65+	20%		52.38
CBP – Female*	58%		51.68
CBP – Male*	42%		50.87
CBP – English*	58%		47.5
CBP – Other Lang.	7%		39.29
CBP – Asian*	36%		48.65
CBP – Black or African American*	17%		39.44
CBP – Other Ethnicity	18%		48

Comprehensive Diabetes Care – Hemoglobin A1C (HbA1c) Poor Control > 9% (CDC-H9)	% of sample	2020 MPL (%)	MY 2020 Rate (%)
CDC-H9 – Overall	100%	**37.47** ***lower is better***	41.46
CDC-H9 – Ages 21-44*	21%		55.95
CDC-H9 – English	60%		43.93
CDC-H9 – Black or African American*	18%		52.86
CD-H9 – Other Ethnicity	22%		46.59

Member Satisfaction

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CAHPS MY2020
(Member Satisfaction Survey)

Rates listed were significantly lower (red) at the 95% significance level.

Composite/Attribute/Measure	Adult Rate	Adult Benchmark	Child Rate	Child Benchmark
Getting care quickly (composite)	**72.4%**	**82.3%**	**78.8%**	**90.5%**
Getting urgent care quickly	75.0%	85.0%	78.7%	92.6%
Getting routine care quickly	69.7%	79.8%	78.9%	89.0%
Coordination of Care	83.0%	85.1%	73.8%	86.1%
Ease of Filling out Forms	91.3%	95.8%	95.8%	96.5%

CAHPS MY2020
(Member Satisfaction Survey)

Rates listed were significantly lower (red) at the 95% significance level.

Composite/Attribute/Measure	Adult Rate	Adult Benchmark
How Well Doctors Communicate (composite)	**83.5%**	**93.2%**
Personal doctor explained things	81.5%	93.3%
Personal doctor listened carefully	84.3%	93.4%
Personal doctor showed respect	86.9%	94.7%
Personal doctor spent enough time	81.5%	91.3%

Action Plan

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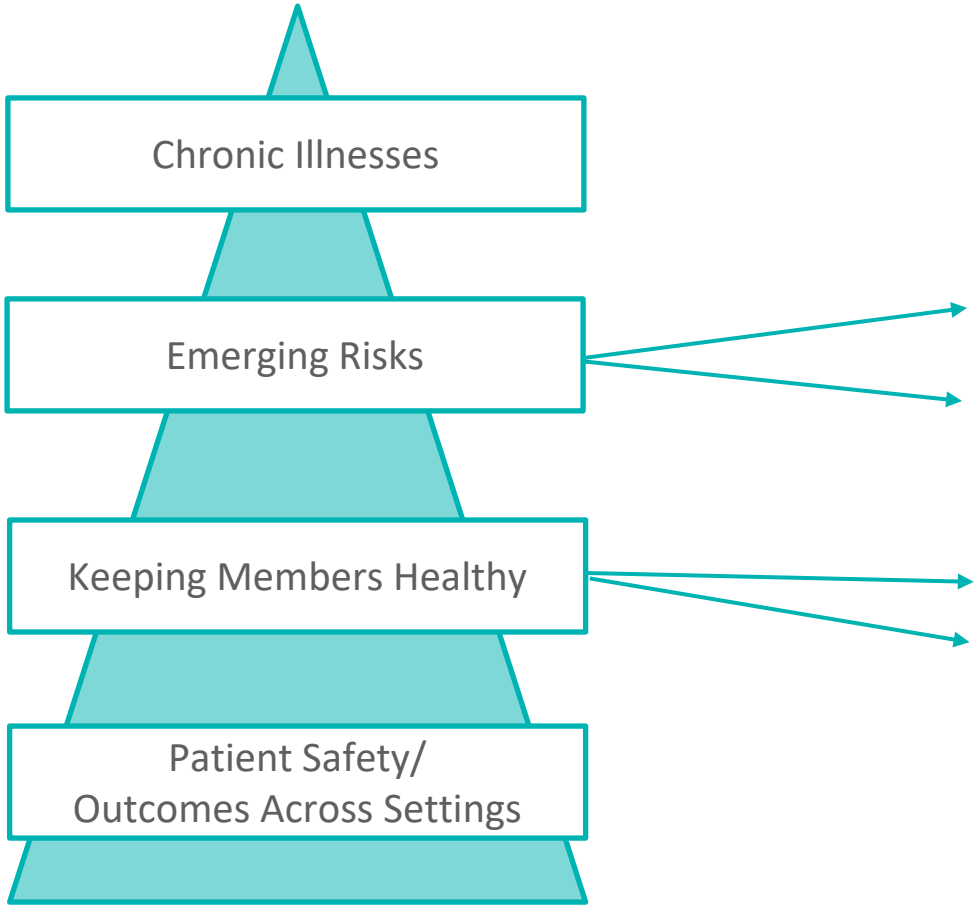
2021 Action Plan Update

2021 Objective	Measure	Progress	Status
1a. Asthma in the Hispanic (Latino) and Black (African American) child populations	Asthma Start participation	Goal not met	Ended in 2021
1b. Asthma in the Black (African American) adult population	HEDIS AMR	Improved	Ended in 2021
2a. Getting routine care appointments quickly	CAHPS	Improved for adults; Worse for children	Ended in 2021
2b. Well-child visits	HEDIS WCV	Unknown	Changing for 2022
2c. Breast cancer screening in Black (African American) women	HEDIS BCS	No change	Continuing in 2022, updated baseline

2022 Action Plan
Population Health Pyramid



PNA
2022 Action Plan

Blood pressure control

Diabetes control

Well-child visits

Breast cancer screening

Focus Area 1: Chronic disease self-management support

Blood pressure control

Diabetes control

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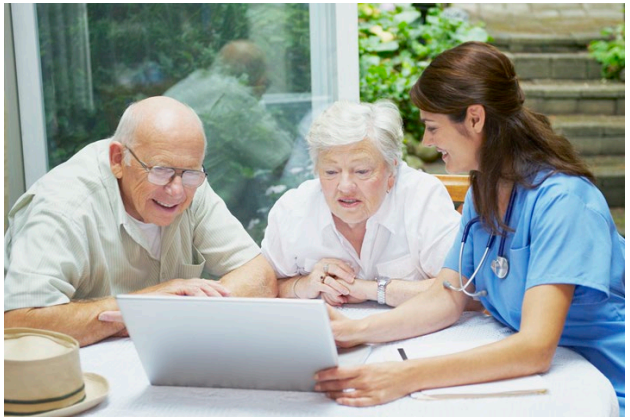
Chronic disease management

Findings:

- HEDIS **CBP (Controlling High Blood Pressure)** rates were low overall and for most subgroups for MY2020.
  - MY2021 update - at MPL
- HEDIS **CDC-H9 (Diabetes Control – HbA1c Poor Control)** rate was higher than the MPL in MY2020 (where lower is better) overall.
  - MY2021 update - better than MPL
- For both CBP and CDC-H9, people ages 21-44 and Black (African American) members had the lowest rates for control for MY2020.
- **Hypertension** is the top diagnosis for adults and SPDs.

Blood Pressure Control



Objective 1a: *Increase HEDIS Controlling Blood Pressure (CBP) measure for members 18 to 85 years of age with a diagnosis of hypertension who are assigned to Community Health Center Network (CHCN) delegate from 60.22% in Measurement Year 2021 to 65.00% in Measurement Year 2023.*

Strategies	Support CHCN delegate with Self Measured Blood Pressure (SMBP) devices and offer quality improvement and health education resources.
	Evaluate program effectiveness by demographic subgroups.
	Explore SMBP remote patient monitoring device coverage.

Diabetes Control

Objective 1b: *Increase the number of members 19 years of age and older with diabetes who engage with Alliance health education and disease management programs regarding diabetes self-management by 20% from 224 members in 2021 to 269 members in 2023.*

Strategies	Improve timely identification, outreach, and Alliance case and disease management program supports for members with poor control or care gaps.
	Expand reach of health coaching and improve awareness of and access to community diabetes self-management programs.
	Support Eastmont Wellness with incentive for members who complete a diabetes class series and with additional interventions for patients with poor diabetes control.

Focus Area 2: Access and Participation in Preventive Care

Well-child visits

Breast cancer screening

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Preventive Care

Findings:

- Children and adults were significantly lower than the CAHPS benchmark for **getting routine care quickly**.
- Well-child visits were not measured for HEDIS in 2020. Results for MY 2021 indicated **W30 (Well-child visits in the first 30 months of life)** as a priority.
- HEDIS **BCS (Breast Cancer Screening)** rates were low overall and lowest for White and Black (African American) members for MY2020.
  - MY2021 update – overall rate below MPL

Well-child Visits

Objective 2a: *Increase HEDIS Well-Child Visits (W30) in the First 30 Months of Life from 44.08% in Measurement Year 2021 for 0-15 months to 54.92% in Measurement Year 2022 and 63.73% for 15-30 months in Measurement Year 2021 to 71.43% in Measurement Year 2022.*

Strategies	Continue funding current outreach initiatives for First 5, Children First Medical Group (CFMG), and La Clinica.
	Conduct outreach to non-utilizers and new members.
	Educate community partners, providers, and members about timely access standards for routine care appointments and track issues.

Breast Cancer Screening in Black Women

[HEALTH DISPARITY] Objective 2b: *Improve HEDIS Breast Cancer Screening (BCS) measure among Black (African American) women ages 52 to 74 from 46.09% in Measurement Year 2021 to 53.76% in Measurement Year 2022.*

Strategies	Continue LifeLong clinic texting campaign with member incentive for breast cancer screening completion.
	Launch mobile mammogram and encourage appointments in coordination with other gaps in care.
	Create Alliance outreach and education materials for breast cancer screening.
	Investigate mammogram appointment availability and educate members and providers about timely access standards.

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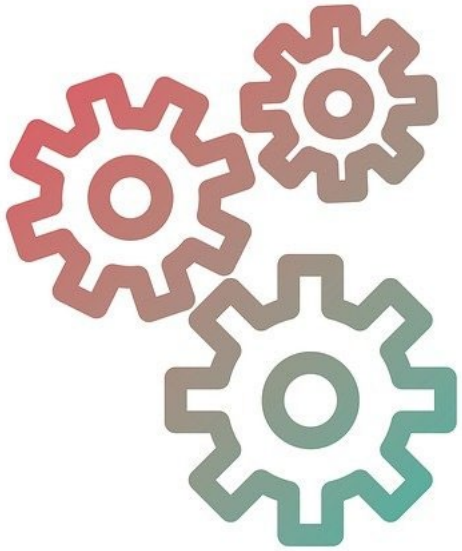
Alinea Mobile Mammography

Questions

- Which objectives offer collaboration opportunities?



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Thank You

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