



Population Needs Assessment

Alameda Alliance for Health 2022

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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 Measurement Year 2020 (Reporting Year 2021) and the DHCS managed care health plan (MCP) specific health disparities data, which were Healthcare Effectiveness Data and Information Set (HEDIS) results from Measurement Year 2020 (Reporting Year 2021).

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 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.

Input from members and community advocates also informed the PNA. Member Advisory Committee members (five Alliance members, two county program representatives, and one clinic representative) participated in focus groups to provide input on priority member health needs, challenges, and potential strategies.

Key Findings

Membership Profile: There were 312,699 total members enrolled in Alameda Alliance Medi-Cal at any time during 2021. Of these members, 36% were ages 19 to 44, 34% under 19, 20% ages 45 to 64, and 10% ages 65 and over. Primary ethnicity was 28% Hispanic (Latino), 23% Other, 16% Black (African American), 10% Chinese, 9% White, 7% Other Asian/Pacific Islander, 4% Vietnamese, 3% Filipino, 1% Unknown, and less than 1% American Indian or Alaskan Native.

There were 5,148 child members with special health care needs (CSHCN) who had California Children's Services eligible medical conditions. Excluding CSHCN, there were 29,179 seniors and persons with disabilities (SPD) members. Over a third (36%) of all members preferred to speak a non-English language. These were the threshold languages Spanish (19%), Chinese (9%), Vietnamese (3%), and Tagalog (1%), along with another 5% that were "other" languages or "unknown".

A total of 18,385 members were identified as likely to be homeless at any time during the year. Nearly all were English speakers. More than half were male. They were mostly adults ages 19 to 64 and Black (African American) or Other ethnicities. The Alameda County homeless count shows the greatest number of homeless residents in North County.

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 seven diagnoses that were common among the membership: Hypertension (13%), Disorders of lipid metabolism (12%), Obesity (10%), Type 2 Diabetes (7%), Anxiety (6%), Asthma (6%), and Depression (6%). The largest ethnicity-age groups as well as the groups with the highest prevalence are listed below. For example, the group with the largest number of members with hypertension was Black (African American) ages 45-64 years. American Indian or Alaskan Native members who were ages 65 and up had the highest proportion of hypertension within that group.

Table 1: Disease Prevalence Overview

Diagnosis	Largest Ethnicity-Age Groups	Highest Prevalence Ethnicity-Age Groups
Hypertension	Black (African American) 45-64 Other 45-64	Am. Indian or Alaskan Native 65+ Filipino 65+
Disorders of lipid metabolism	Chinese 65+ Other 45-64	Filipino 65+ Vietnamese 65+
Obesity	Hispanic (Latino) under 19	Hispanic (Latino) under 19 Am. Indian or Alaskan Native under 19
Type 2 Diabetes	Other 45-64 Black (African American) 45-64	Filipino 65+ Other Asian or Pacific Islander 65+
Anxiety	Other 19-44	White 45-64 Am. Indian or Alaskan Native 45-64
Asthma	Hispanic (Latino) under 19	Am. Indian or Alaskan Native 65+ Am. Indian or Alaskan Native 45-64
Depression	Other 19-44	White 65+ White 45-64

Source: CareAnalyzer, 2021

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. Asian respondents had the lowest rates for getting care quickly. Adults were above benchmark in MY 2019 for questions regarding personal doctor listening carefully and showing respect, but in MY 2020 the rates dropped significantly and were below benchmark. Other below benchmark results were ease of filling out forms for adults and coordination of care for children. 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: The nine HEDIS measures included in the analysis are part of MCAS (Managed Care Accountability Set) for both MY 2020 and MY 2022C. 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 most significantly below the MPL were:

- BCS, Breast Cancer Screening, was low for the plan overall but lowest for White and Black (African American) members.
- CHL, Chlamydia Screening in Women, was significantly lower in Asian members.
- CBP, Controlling Blood High Pressure, was low for the plan overall but lowest for Ages 21-44 and Black (African American) ethnicity.
- CDC-H9, Comprehensive Diabetes Care – Hemoglobin A1C Poor Control, was highest for Ages 21-44 and Black (African American) ethnicity (lower rate is better).

2021 Action Plan Summary

The table below summarizes the action plan updates from the 2021 action plan.

Table 2: 2021 Action Plan Summary

2021 Action Plan Objective	Health Disparity	Progress	Status
1a. 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.	No	Goal not met	Ended in 2021
1b. 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.	Yes	Improved	Ended in 2021
2a. 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.	No	Improved for adults; Worse for children	Ended in 2021
2b. Increase HEDIS Child and Adolescent Well-Care Visits (WCV) measure from 49.3% to 55% for two identified providers by December 31, 2022.	No	Unknown	Changing for 2022
2c. 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.	Yes	No change	Continuing in 2022, updated baseline

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. One is marked as a disparity objective because they were identified in the Health Disparities section of this report.

1. Chronic disease self-management support

a. Blood pressure control

Objective: 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.

b. Diabetes control

Objective: 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.

2. Access and participation in preventive care

a. Well-child visits

Objective: 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.

b. [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 46.09% in Measurement Year 2021 to 53.76% in Measurement Year 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 3: Data Sources

Source	Year	Brief description
Alliance Data		
DHCS monthly eligibility files	2020-2021	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 are loaded into the Alliance source system.
Alliance homeless member indicators	2021	Members are identified as homeless from any of the following sources: homelessness diagnosis codes, homeless shelter place of service code, Homeless Management Information System (HMIS) data, TruCare database assessments, and member home addresses that indicate social services agencies or programs.
CareAnalyzer®	2020-2021	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.
Health Education program participation records	2020-2021	Invoices received from Alameda County Public Health Department and other vendors as well as internal tracking of services provided to members.
County Data		
Alameda County Homeless Count & Survey	2019, 2022	Point-in-time count of homeless residents in Alameda County conducted by volunteers on a given night (late January in 2019, late February in 2022). https://everyonehome.org/main/continuum-of-care/everyone-counts/
CalFresh Data Dashboard	2021	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
Healthy Alameda County	Various	Alameda County Public Health Department source for population data and community health information. http://www.healthyalamedacounty.org/
Member Advisory Committee		
Member Advisory Committee	April-May 2022	Three focus groups with five members, two county program representatives, and one clinic representative to discuss priorities, challenges, and potential strategies.

Source	Year	Brief description
Member Surveys		
Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	2020-2021	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 2020 and August 2021. There were 2,395 responses for adults and 1,406 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 82% and children 90%).
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1H Medicaid Adult and Child	2019-2020	Measurement Year 2020 (Reporting Year 2021) survey in English and Spanish to capture consumer-reported experiences with health care. Members eligible for the survey were continuously enrolled in the plan for at least five of the last six months of the measurement year. Using an NCQ -approved mail and phone survey methodology, there were 210 valid adult surveys and 373 child surveys collected, yielding a response rate of 15.9% for adults and 18.2% for children. There were 29 completed surveys in Spanish for adults and 150 for children.
Quality of Care		
Department of Health Care Services managed care health plan (MCP) specific health disparities data	2020	Measurement Year 2020 (Reporting Year 2021) Alameda Alliance Healthcare Effectiveness Data and Information Set (HEDIS) data stratified by demographics. Report is provided by DHCS.
Cotiviti HEDIS engine	2021-2022	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 March 2022, Alameda County had a population of 1,679,030 persons (Healthy Alameda County, data provided by Claritas). The map below shows the cities within the county.

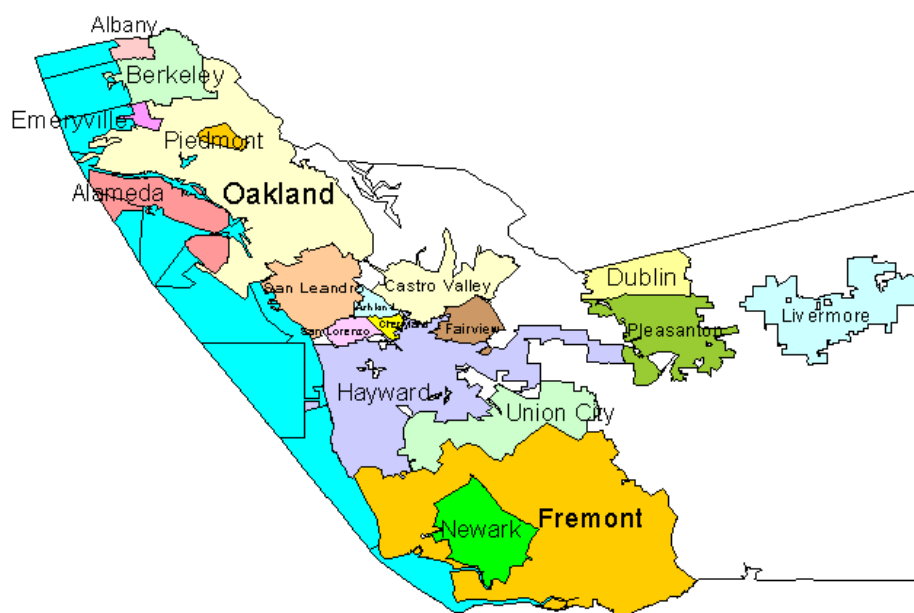


Figure 1: Map of Alameda County

Image source: UC Berkeley Library

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

Table 4: 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 9.3% of county residents live below the federal poverty level (Healthy Alameda County, data from American Community Survey, 2016-2020). In the previous survey from 2015-2019, about 9.9% of county residents lived below the federal poverty level. The map below shows the percentage of residents living in poverty by zip code for 2015-2019 (map not yet available for 2016-2020). The percentage is highest in North and Central Counties.

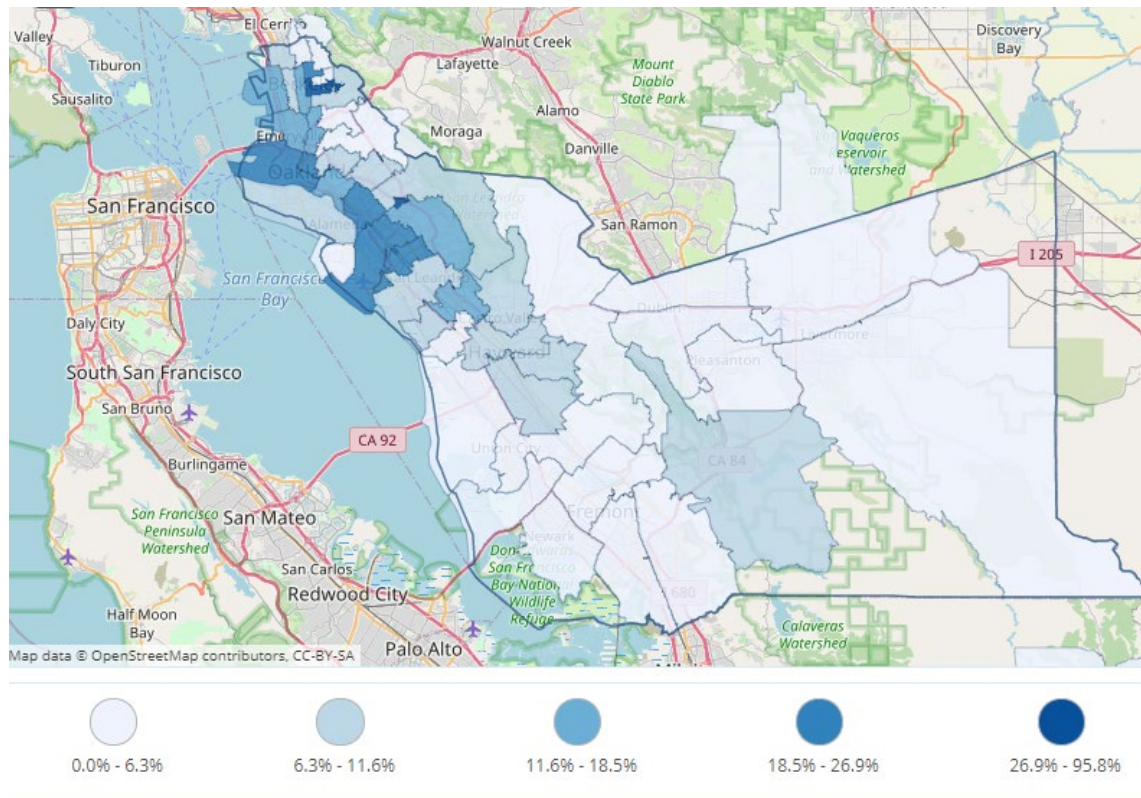


Figure 2: Map of Poverty by Zip Code

Image source: Healthy Alameda County, 2015-2019

According to Feeding America as reported by Healthy Alameda County (2019), 8.4% of county residents were food insecure, a decrease from the previous year's rate of 9.1%.

As of December 2021, 91,973 households received CalFresh, an increase from the 78,156 households in December 2020 (California Department of Social Services). The number of households has been on a slight but steady rise throughout 2021.

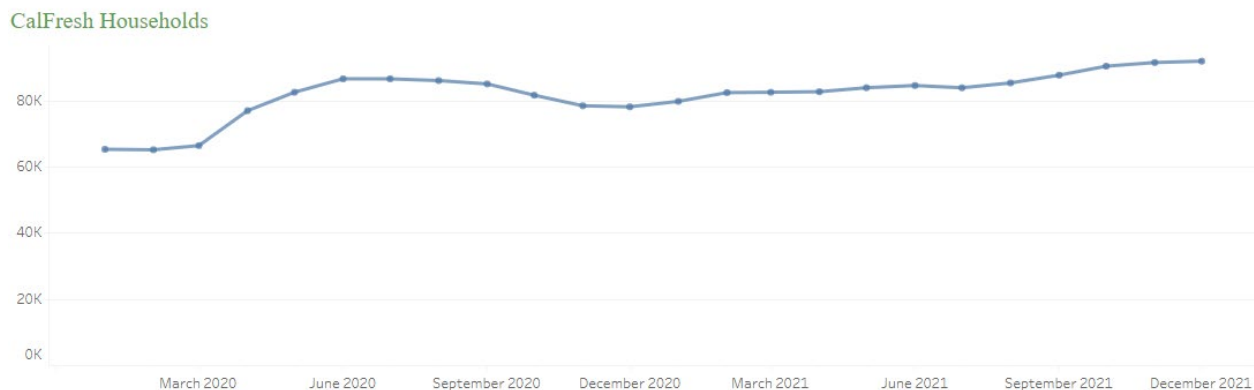


Figure 3: CalFresh Participation

Image source: California Department of Social Services, 2021

Homelessness

In 2022, the EveryOne Counts Homeless Point-In-Time Count reported 9,747 homeless Alameda County residents. Of those, 73% were unsheltered. In 2019, there were 8,022 homeless Alameda County residents and 79% were unsheltered. This map shows the total number of people experiencing homelessness by city in 2019 (map not yet available for 2022).

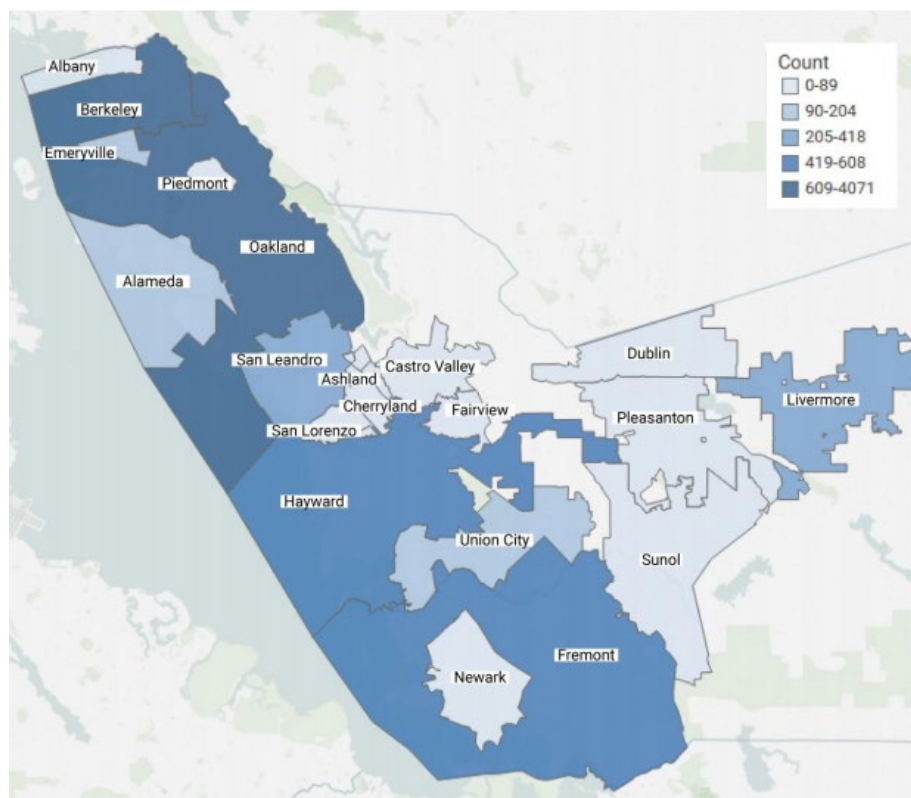


Figure 4: Homelessness by City

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

Total Membership

There were **312,699 total members** enrolled in Alameda Alliance Medi-Cal at any time during 2021 according to DHCS monthly eligibility files. In 2020, there were 293,530 members. From 2020 to 2021 there was a 6.53% increase in membership.

Gender

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

Table 5: Gender

	2021		2020		
GENDER	Count	Percent	Count	Percent	Difference
Female	167,036	53.42%	157,161	53.54%	-0.12%
Male	145,663	46.58%	136,369	46.46%	0.12%

Source: DHCS monthly eligibility files, 2020-2021

Age

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

Table 6: Age

	2021		2020		
AGE BAND	Count	Percent	Count	Percent	Difference
Under 19	106,618	34.10%	103,984	35.43%	-1.33%
19-44	113,539	36.31%	102,463	34.91%	1.40%
45-64	60,995	19.51%	58,277	19.85%	-0.35%
65+	31,547	10.09%	28,806	9.81%	0.27%

Source: DHCS monthly eligibility files, 2020-2021

Region

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

Table 7: County Region

	2021		2020		
COUNTY REGION	Count	Percent	Count	Percent	Difference
North	145,912	46.66%	139,494	47.52%	-0.86%
Central	87,812	28.08%	82,301	28.04%	0.04%
South	46,825	14.97%	43,790	14.92%	0.06%
East	19,701	6.30%	17,819	6.07%	0.23%
Other/Unknown	12,449	3.98%	10,126	3.45%	0.53%

Source: DHCS monthly eligibility files, 2020-2021

Ethnicity

The largest group was Hispanic (Latino) at 28%. A combined Other Asian/Pacific Islander, Chinese, Vietnamese, and Filipino group put Asian and Pacific Islanders as the next largest group at 24%. “Other” ethnicity has been a growing category with 23% of members.

Table 8: Ethnicity

PRIMARY ETHNICITY	2021		2020		Difference
	Count	Percent	Count	Percent	
Hispanic (Latino)	86,146	27.55%	82,206	28.01%	-0.46%
Other	71,301	22.80%	58,142	19.81%	2.99%
Black (African American)	49,761	15.91%	49,917	17.01%	-1.09%
Chinese	30,793	9.85%	29,969	10.21%	-0.36%
White	29,281	9.36%	28,527	9.72%	-0.35%
Other Asian / Pacific Islander*	22,164	7.09%	30,356	10.34%	N/A
Vietnamese	11,661	3.73%	11,614	3.96%	-0.23%
Filipino*	9,033	2.89%	N/A	N/A	N/A
Unknown	1,877	0.60%	2,152	0.73%	-0.13%
American Indian Or Alaskan Native	682	0.22%	647	0.22%	-0.00%

*In 2021, Filipino was listed separately instead of under Other Asian/Pacific Islander.

Source: DHCS monthly eligibility files, 2020-2021

The age distribution varied by ethnic group. Hispanic (Latino) had the highest proportion of children at 44%. Chinese had the highest proportion of ages 65+ at 24%. “Other” ethnicity had the highest proportions of adults 19 to 44 at 29% and 45 to 64 at 24%.

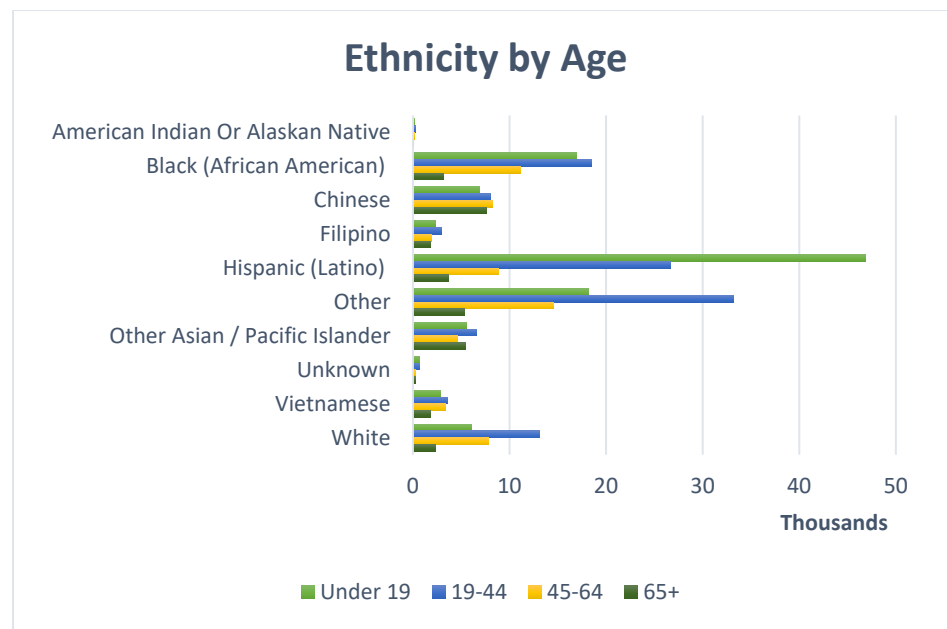


Figure 5: Ethnicity by Age

Source: DHCS monthly eligibility files, 2021

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

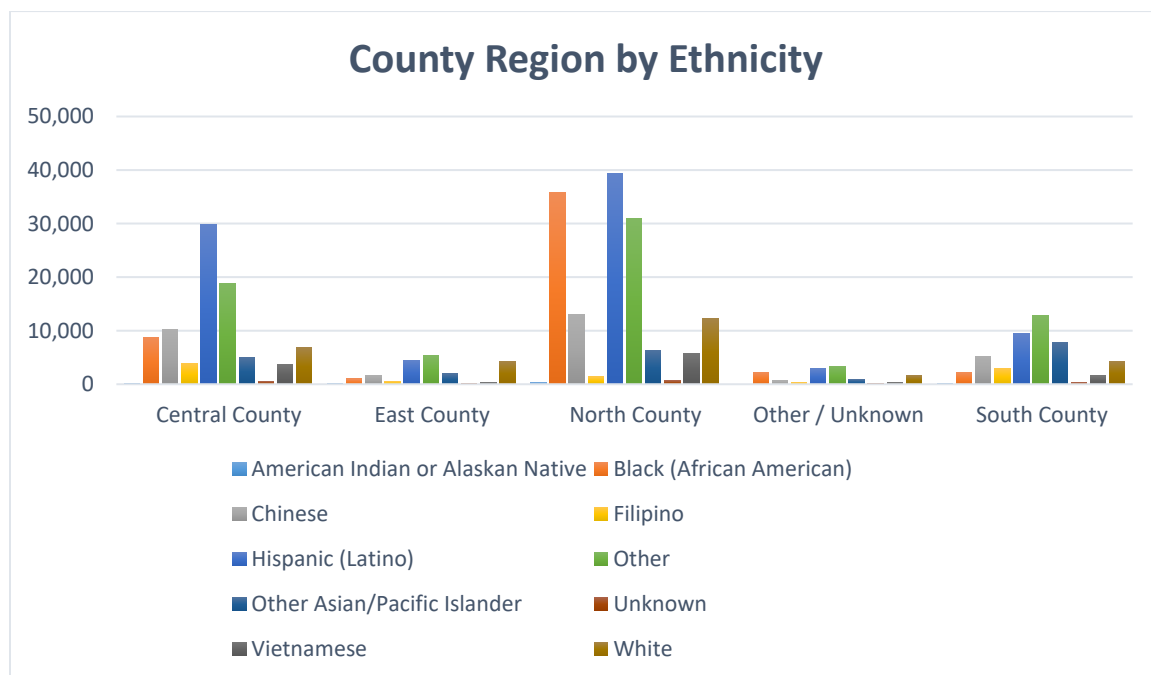


Figure 6: County Region by Ethnicity

Source: DHCS monthly eligibility files, 2021

Language

The majority of members spoke English at 64%. The other threshold languages were Spanish (19%), Chinese (9%), Vietnamese (3%), and Tagalog (1%).

Table 9: Language

LANGUAGE	2021		2020		Difference
	Count	Percent	Count	Percent	
English	199,648	63.85%	185,073	63.05%	0.80%
Spanish	60,596	19.38%	57,109	19.46%	-0.08%
Chinese	27,311	8.73%	26,336	8.97%	-0.24%
Vietnamese	8,886	2.84%	8,883	3.03%	-0.18%
*Unknown	7,390	2.36%	9,599	3.27%	N/A
Other Non-English	6,878	2.20%	6,530	2.22%	-0.03%
*Tagalog	1,990	0.64%	N/A	N/A	N/A

*In 2021, Tagalog was listed separately instead of under Unknown.

Source: DHCS monthly eligibility files, 2020-2021

Age distribution varied by language. English speakers had more people in the 19-44 age range. Spanish speakers were mostly children. Almost half of Tagalog speakers were ages 65+. The age distribution was more even for the other languages.

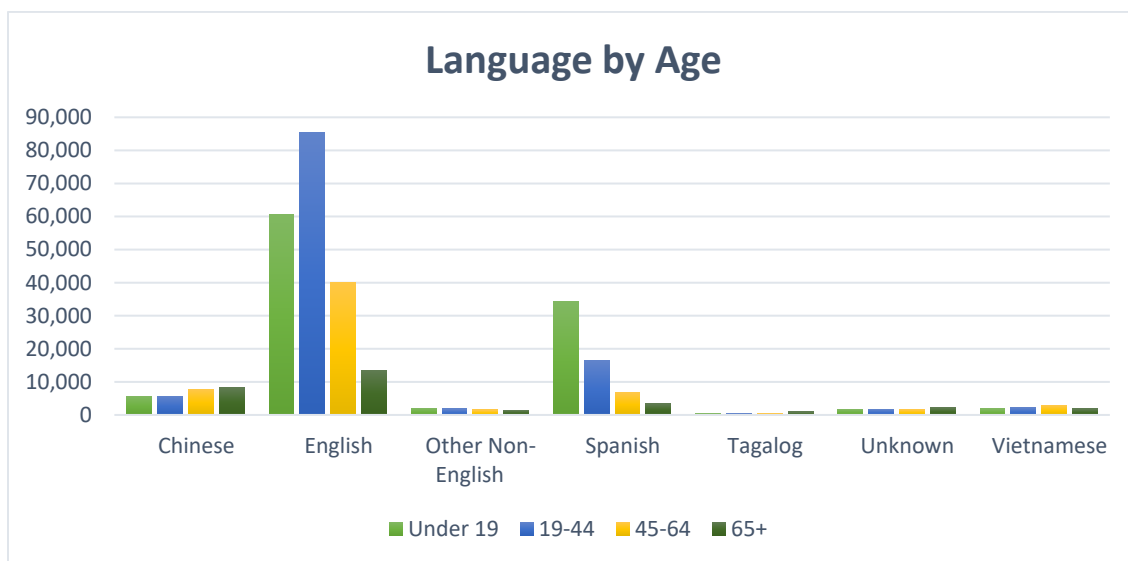


Figure 7: Language by Age

Source: DHCS monthly eligibility files, 2021

Language distribution differed slightly among county regions. Central County and North County had higher proportions of Spanish speakers. East County and Other/Unknown had the highest proportion of English speakers. South County had the highest proportion of Unknown language.

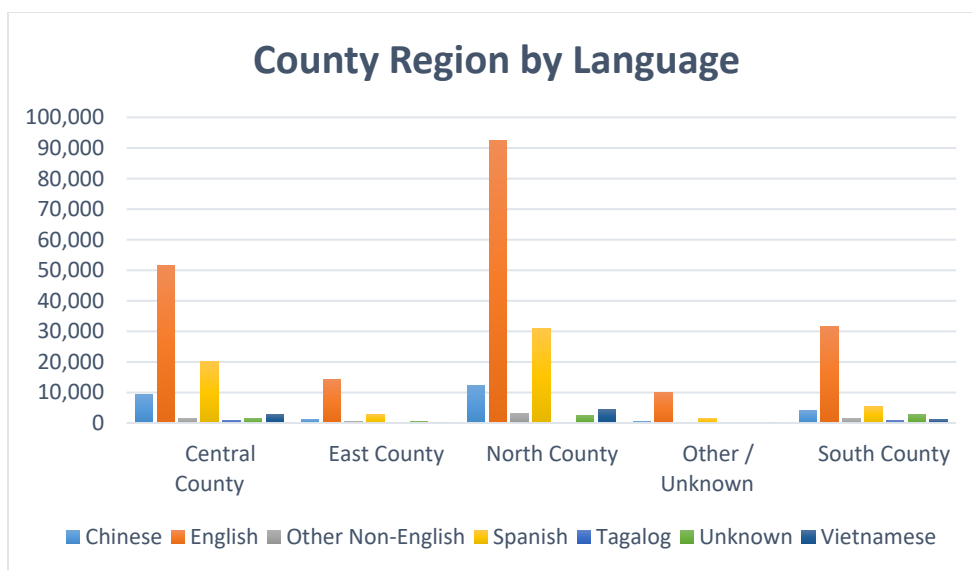


Figure 8: County Region by Language

Source: DHCS monthly eligibility files, 2021

Homelessness

In 2021, a total of **18,385 members experiencing homelessness** were identified, which was 5.88% of the total membership. This was based on indicators such as homelessness diagnosis code, an address that belongs to a social services agency, or others listed under Data Sources.

More than half of the members were male, and most were adults between the ages of 19 and 64. The largest ethnic groups were Black (African American) and Other. Almost all spoke English.

Table 10: Homeless Demographics

HOMELESS DEMOGRAPHICS	Count	Percent
GENDER		
Female	8,048	43.77%
Male	10,337	56.23%
AGE BAND		
Under 19	2,571	13.98%
19-44	8,109	44.11%
45-64	5,617	30.55%
65+	2,088	11.36%
ETHNICITY		
Black (African American)	7,615	41.42%
Other	4,813	26.18%
White	2,455	13.35%
Hispanic (Latino)	1,848	10.05%
Other Asian / Pacific Islander	726	3.95%
Chinese	363	1.97%
Filipino	286	1.56%
Vietnamese	114	0.62%
Unknown	85	0.46%
American Indian Or Alaskan Native	80	0.44%
LANGUAGE		
English	16,940	92.14%
Spanish	552	3.00%
Chinese	347	1.89%
Unknown	253	1.38%
Other Non-English	101	0.55%
Tagalog	100	0.54%
Vietnamese	92	0.50%

Source: Alliance homeless member indicators, 2021

CSHCN Membership

There were **5,148 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 2021. In 2020, there were 8,131 members. This

was a decrease of 36.69% from 2020 to 2021. The data from 2021 more accurately identifies these members.

The largest age band was 12 to 18 years at 38%. About half of CSHCN members lived in North County, and 30% in Central County.

Almost half (45%) of CSHCN members were Hispanic (Latino). More than half (56%) of CSHCN members were English speakers, and a third (34%) were Spanish speakers.

Table 11: CSHCN Demographics

	2021		2020		
CSHCN DEMOGRAPHICS	Count	Percent	Count	Percent	Difference
GENDER					
Female	2,393	46.48%	3,707	45.59%	0.89%
Male	2,755	53.52%	4,424	54.41%	-0.89%
AGE BAND					
Under 12 months	136	2.64%	140	1.72%	0.92%
1-2 years	512	9.95%	586	7.21%	2.74%
3-6	904	17.56%	1,487	18.29%	-0.73%
7-11	1,026	19.93%	2,019	24.83%	-4.90%
12-18	1,961	38.09%	2,909	35.78%	2.32%
19-21	609	11.83%	990	12.18%	-0.35%
COUNTY REGION					
North County	2,456	47.71%	4,060	49.93%	-2.22%
Central County	1,567	30.44%	2,442	30.03%	0.41%
South County	657	12.76%	954	11.73%	1.03%
East County	282	5.48%	432	5.31%	0.16%
Other / Unknown	186	3.61%	243	2.99%	0.62%
HOMELESSNESS					
Homeless	120	2.33%	N/A	N/A	N/A
ETHNICITY					
Hispanic (Latino)	2,311	44.89%	3,640	44.77%	0.12%
Other	867	16.84%	1,569	19.30%	-2.46%
Black (African American)	838	16.28%	1,150	14.14%	2.13%
White	311	6.04%	447	5.50%	0.54%
Chinese	266	5.17%	454	5.58%	-0.42%
Other Asian / Pacific Islander*	266	5.17%	569	7.00%	N/A
Vietnamese	128	2.49%	209	2.57%	-0.08%
Filipino*	108	2.10%	N/A	N/A	N/A
Unknown	33	0.64%	68	0.84%	-0.20%
American Indian Or Alaskan Native	20	0.39%	25	0.31%	0.08%
LANGUAGE					
English	2,877	55.89%	4,563	56.12%	-0.23%

Sources: DHCS monthly eligibility files, 2020-2021
Alliance homeless member indicators, 2021

CSHCN DEMOGRAPHICS	2021		2020		Difference
	Count	Percent	Count	Percent	
Spanish	1,739	33.78%	2,707	33.29%	0.49%
Chinese	222	4.31%	374	4.60%	-0.29%
Other Non-English	113	2.20%	155	1.91%	0.29%
Unknown*	93	1.81%	172	2.12%	N/A
Vietnamese	85	1.65%	160	1.97%	-0.32%
Tagalog*	19	0.37%	N/A	N/A	N/A

*Filipino ethnicity (formerly under Other Asian/Pacific Islander) and Tagalog language (formerly under Unknown) were listed separately for 2021.

Sources: DHCS monthly eligibility files, 2020-2021

Alliance homeless member indicators, 2021

SPD Membership

There were **29,179 seniors and persons with disabilities (SPD) members** enrolled in Alameda Alliance Medi-Cal at any time in 2021. This category excludes CSHCN members. In 2020, there were 28,928 members, an increase of 0.87% from 2020 to 2021.

About half (49%) of the members in this category were ages 65 and over. Only 7% were children. Almost half (45%) of SPD members lived in North County, 23% in Central County, and 21% in South County. The percentage of SPD members identified as homeless was 16%.

Black (African American) was the largest ethnic group at 23%. Combined ethnic groups of Other Asian/Pacific Islander, Chinese, Vietnamese, and Filipino (i.e., Asian American or Pacific Islander) were over a third (35%) of SPD members. The majority (61%) of SPD members were English speakers. The next most common language was Chinese (13%).

Table 12: SPD Demographics

	2021		2020		
SPD DEMOGRAPHICS	Count	Percent	Count	Percent	Difference
GENDER					
Female	15,249	52.26%	15,054	52.04%	0.22%
Male	13,930	47.74%	13,873	47.96%	-0.22%
AGE BAND					
Under 19	2,004	6.87%	1,882	6.51%	0.36%
19-44	5,028	17.23%	5,164	17.85%	-0.62%
45-64	7,755	26.58%	8,283	28.63%	-2.06%
65+	14,392	49.32%	13,598	47.01%	2.32%
COUNTY REGION					
North County	13,183	45.18%	13,318	46.04%	-0.86%
Central County	6,695	22.94%	6,602	22.82%	0.12%
South County	6,017	20.62%	5,937	20.52%	0.10%
East County	2,372	8.13%	2,266	7.83%	0.30%
Other / Unknown	912	3.13%	804	2.78%	0.35%
HOMELESSNESS					
Homeless	4,553	15.60%	N/A	N/A	N/A
ETHNICITY					
Black (African American)	6,685	22.91%	6,930	23.96%	-1.05%
Other	5,494	18.83%	4,883	16.88%	1.95%
Other Asian / Pacific Islander*	4,538	15.55%	5,763	19.92%	N/A
Chinese	3,601	12.34%	3,605	12.46%	-0.12%
Hispanic (Latino)	3,472	11.90%	3,353	11.59%	0.31%
White	2,667	9.14%	2,800	9.68%	-0.54%
Filipino*	1,196	4.10%	N/A	N/A	N/A
Vietnamese	982	3.37%	953	3.29%	0.07%
Unknown	460	1.58%	550	1.90%	-0.32%
American Indian Or Alaskan Native	84	0.29%	90	0.31%	-0.02%
LANGUAGE					
English	17,876	61.26%	17,718	61.25%	0.01%
Chinese	3,698	12.67%	3,646	12.60%	0.07%
Spanish	2,384	8.17%	2,299	7.95%	0.22%
Unknown*	2,283	7.82%	3,073	10.62%	N/A
Other Non-English	1,345	4.61%	1,223	4.23%	0.38%
Vietnamese	988	3.39%	968	3.35%	0.04%
Tagalog*	605	2.07%	N/A	N/A	N/A

*Filipino ethnicity (formerly under Other Asian/Pacific Islander) and Tagalog language (formerly under Unknown) were listed separately for 2021.

Sources: DHCS monthly eligibility files, 2020-2021

Alliance homeless member indicators, 2021

Over 40% of Black (African American) and White SPD members were ages 45-64. Chinese, Other Asian/Pacific Islander, Vietnamese, and Filipino 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.

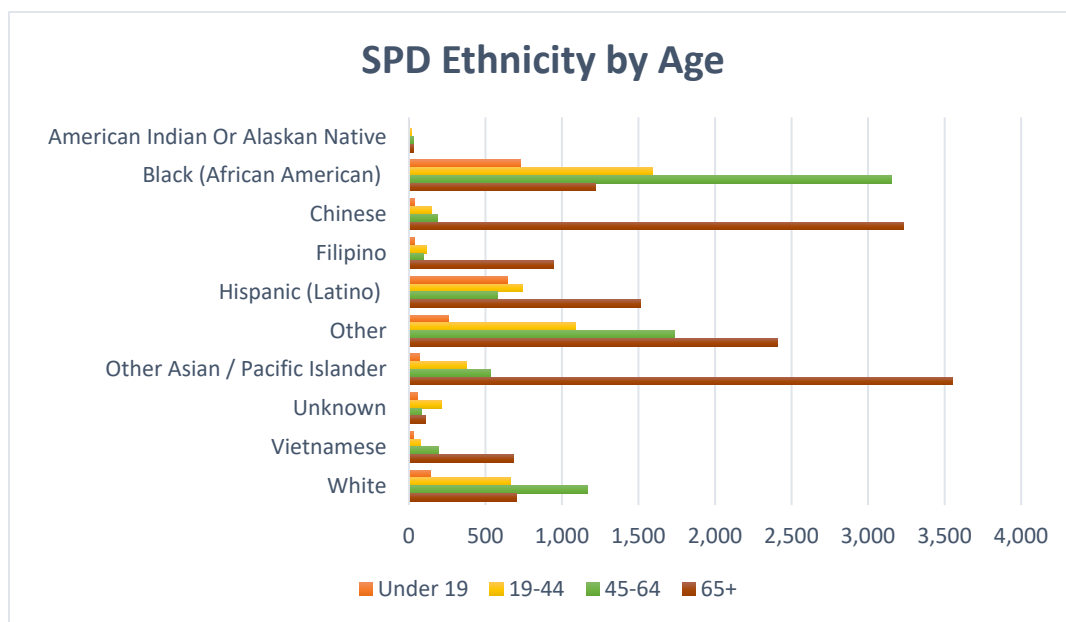


Figure 9: SPD Ethnicity by Age

Source: DHCS monthly eligibility files, 2021

Chinese and Tagalog 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.

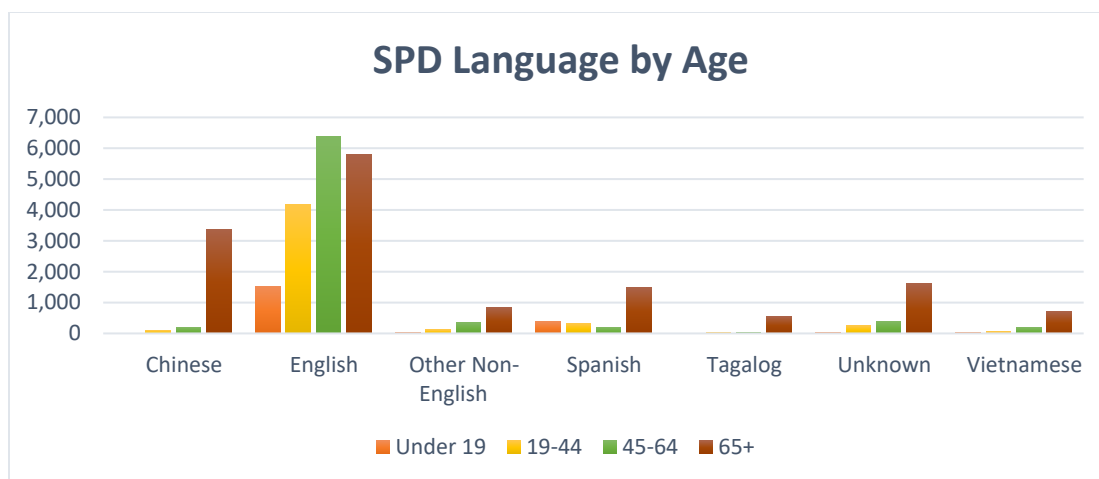


Figure 10: SPD Language by Age

Source: DHCS monthly eligibility files, 2021

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 2021 were included in the database.

Top Diagnoses by Category

Table 13: Top Diagnoses Children

Ophthalmic signs and symptoms was the most common diagnosis as well as the diagnosis with the greatest increase in children. “Signs and symptoms” do not necessarily indicate a specific diagnosis or health condition but do reflect that the related systems were of concern or examined. Obesity was more common in 2021 most likely because of an increase in in-person visits. Also, acute upper respiratory tract infections (URIs) decreased somewhat from the previous year.

CHILDREN (ages 0 to 18, excludes children with special health care needs) 100,075 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Ophthalmic signs and symptoms	18,075	18%	11%	7%
Obesity	13,686	14%	10%	4%
Acute upper respiratory tract infection	10,092	10%	13%	-3%
Refractive errors	9,425	9%	7%	2%
Dermatitis and eczema	8,045	8%	8%	0%
Allergic rhinitis	6,215	6%	6%	0%
Asthma, w/o status asthmaticus	5,990	6%	7%	-1%
Viral syndromes	5,518	6%	8%	-3%
Nutritional disorders, other	5,349	5%	3%	2%
Developmental disorder	5,062	5%	4%	1%
Fever	4,596	5%	5%	-0%
Constipation	4,495	4%	4%	0%
Abdominal pain	4,165	4%	3%	1%
Dermatologic signs and symptoms	4,161	4%	4%	0%
Neurologic signs and symptoms	4,120	4%	3%	1%
Nausea, vomiting	3,890	4%	2%	1%
Gastrointestinal signs and symptoms	3,284	3%	3%	1%
Acne	3,250	3%	2%	1%
Cough	2,972	3%	5%	-2%
Musculoskeletal signs and symptoms	2,820	3%	2%	1%

Source: CareAnalyzer, 2020-2021

Table 14: Top Diagnoses Adults

Many of this year's top diagnoses remained steady from last year. Hypertension, hyperlipidemia, and musculoskeletal signs and symptoms remain the top 3 in adults. Hypertension, hyperlipidemia, and obesity are all related to cardiovascular disease.

ADULTS (ages 19+, excludes children with special health care needs) 178,297 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Hypertension, w/o major complications	28,320	16%	15%	1%
Disorders of lipid metabolism	27,000	15%	13%	2%
Musculoskeletal signs and symptoms	19,128	11%	9%	2%
Abdominal pain	18,383	10%	9%	1%
Neurologic signs and symptoms	17,696	10%	8%	2%
Refractive errors	17,454	10%	7%	2%
Low back pain	16,036	9%	7%	2%
Anxiety, neuroses	13,962	8%	7%	1%
Cardiovascular signs and symptoms	13,005	7%	6%	1%
Obesity	12,966	7%	6%	1%
Gastrointestinal signs and symptoms	12,500	7%	6%	1%
Dermatologic signs and symptoms	11,635	7%	6%	1%
Gastroesophageal reflux	11,336	6%	6%	1%
Major depression	11,278	6%	6%	0%
Nutritional deficiencies	11,267	6%	5%	1%
Musculoskeletal disorders, other	11,196	6%	7%	-1%
Chest pain	10,500	6%	5%	1%
Tobacco use	10,115	6%	6%	0%
Ophthalmic signs and symptoms	9,849	6%	4%	2%
Type 2 diabetes, w/ complication	9,721	5%	5%	1%

Source: CareAnalyzer, 2020-2021

Table 15: Top Diagnoses CSHCN

The observed increases for ophthalmic signs and symptoms and obesity for children ages 0-18 also applied to children with special health care needs. Most diagnoses increased by around 3 percentage points.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (ages 0 to 21) 5,148 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Ophthalmic signs and symptoms	1,037	20%	8%	12%
Obesity	756	15%	7%	8%
Developmental disorder	742	14%	9%	5%
Refractive errors	669	13%	7%	6%
Acute upper respiratory tract infection	580	11%	8%	3%
Neurologic signs and symptoms	526	10%	5%	5%

Source: CareAnalyzer, 2020-2021

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (ages 0 to 21) 5,148 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Asthma, w/o status asthmaticus	497	10%	6%	4%
Dermatitis and eczema	473	9%	6%	4%
Constipation	387	8%	4%	3%
Gastrointestinal signs and symptoms	380	7%	4%	3%
Deafness, hearing loss	375	7%	5%	2%
Dermatologic signs and symptoms	369	7%	4%	3%
Nausea, vomiting	366	7%	3%	4%
Abdominal pain	361	7%	4%	3%
Musculoskeletal disorders, other	356	7%	4%	3%
Allergic rhinitis	348	7%	4%	3%
Viral syndromes	341	7%	6%	0%
Fever	333	6%	4%	2%
Musculoskeletal signs and symptoms	325	6%	4%	3%
Nutritional deficiencies	317	6%	2%	4%

Source: CareAnalyzer, 2020-2021

Table 16: Top Diagnoses SPD

Diagnoses for seniors and persons with disabilities were fairly stable from the previous year, with several increases of 3 or 4 percentage points for cardiovascular and eye-related diagnoses. Like the adult population, hypertension, hyperlipidemia, and musculoskeletal signs and symptoms remain constant and prevalent. Additionally, neurologic signs and symptoms were common, which is expected for this population.

SENIORS AND PERSONS WITH DISABILITIES (excludes children with special health care needs) 29,179 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Hypertension, w/o major complications	12,139	42%	39%	2%
Disorders of lipid metabolism	9,447	32%	29%	4%
Neurologic signs and symptoms	5,791	20%	17%	2%
Musculoskeletal signs and symptoms	5,563	19%	17%	2%
Low back pain	4,461	15%	13%	2%
Cardiovascular signs and symptoms	4,367	15%	12%	3%
Type 2 diabetes, w/ complication	4,195	14%	13%	1%
Nutritional deficiencies	3,810	13%	11%	2%
Gastrointestinal signs and symptoms	3,719	13%	11%	2%
Musculoskeletal disorders, other	3,648	13%	14%	-1%
Abdominal pain	3,640	12%	11%	2%
Respiratory signs and symptoms	3,518	12%	11%	1%
Degenerative joint disease	3,416	12%	11%	1%
Deficiency anemias	3,402	12%	10%	1%
Gastroesophageal reflux	3,389	12%	11%	0%

Source: CareAnalyzer, 2020-2021

SENIORS AND PERSONS WITH DISABILITIES (excludes children with special health care needs) 29,179 total members	2021 Member Count	2021 Percent	2020 Percent	Difference
Refractive errors	3,235	11%	8%	3%
Obesity	3,163	11%	10%	1%
Tobacco use	3,022	10%	10%	0%
Cataract, aphakia	2,980	10%	8%	3%
Chest pain	2,956	10%	9%	1%

Source: CareAnalyzer, 2020-2021

Disease Prevalence Analysis

From the analysis of top diagnoses, seven were selected to focus on for the disease prevalence analysis. We chose to evaluate anxiety and depression because of the ongoing COVID pandemic and increase in utilization of behavioral health care. These were, in order of prevalence: Hypertension (13%), Disorders of lipid metabolism (12%), Obesity (10%), Diabetes (7%), Anxiety (6%), Asthma (6%), and Depression (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. Most members were adults and seniors ages 45 and over. There was a higher prevalence in people with a homeless indicator. There was a slightly higher prevalence in South County. The largest ethnic groups were Other, Black (African American), and Chinese. Other Asian/Pacific Islander and Filipino had the highest prevalence. Most members spoke English, but the highest prevalence was for Tagalog then Unknown language.

Table 17: Hypertension Prevalence

HYPERTENSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	41,924	100.0%	13.4		
ADULT	29,158	69.5%	16.4	3	22.4
CHILD	253	0.6%	0.3	-13.1	-97.8
CSHCN	85	0.2%	1.7	-11.7	-87.3
SPD	12,428	29.6%	42.6	29.2	217.9
Homeless					
No	37,776	90.1%	12.8	-0.6	-4.5
Yes	4,148	9.9%	22.6	9.2	68.7
Gender					
F	24,077	57.4%	14.4	1	7.5
M	17,847	42.6%	12.3	-1.1	-8.2
Age					
Source: CareAnalyzer 2021		0.8%	0.3	-13.1	-97.8

HYPERTENSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
19-44	5,548	13.2%	4.9	-8.5	-63.4
45-64	19,314	46.1%	31.7	18.3	136.6
65+	16,731	39.9%	53	39.6	295.5
Location					
North County	18,112	43.2%	12.4	-1	-7.5
Central County	11,564	27.6%	13.2	-0.2	-1.5
South County	8,718	20.8%	18.6	5.2	38.8
East County	2,608	6.2%	13.2	-0.2	-1.5
Other / Unknown	922	2.2%	7.4	-6	-44.8
Ethnicity					
Other	8,888	21.2%	12.5	-0.9	-6.7
Black (African American)	7,765	18.5%	15.6	2.2	16.4
Chinese	5,913	14.1%	19.2	5.8	43.3
Hispanic (Latino)	5,554	13.2%	6.4	-7	-52.2
Other Asian / Pacific Islander	5,445	13%	24.6	11.2	83.6
White	3,677	8.8%	12.6	-0.8	-6
Filipino	2,197	5.2%	24.3	10.9	81.3
Vietnamese	2,147	5.1%	18.4	5	37.3
Unknown	217	0.5%	11.6	-1.8	-13.4
American Indian Or Alaskan Native	121	0.3%	17.7	4.3	32.1
Language					
English	25,004	59.6%	12.5	-0.9	-6.7
Chinese	6,127	14.6%	22.4	9	67.2
Spanish	4,215	10.1%	7	-6.4	-47.8
Unknown	2,165	5.2%	29.3	15.9	118.7
Vietnamese	2,086	5%	23.5	10.1	75.4
Other Non-English	1,488	3.5%	21.6	8.2	61.2
Tagalog	839	2%	42.2	28.8	214.9

Source: CareAnalyzer, 2021

The largest ethnic groups by age with hypertension were Black (African American) ages 45-64, Other ages 45-64, and Chinese ages 65+. The groups with the highest prevalence were all in the ages 65+ category for American Indian or Alaskan Native, Filipino, and Other Asian/Pacific Islander.

Table 18: Hypertension Ethnicity x Age

HYPERTENSION Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Other API	15	0.3	354	5.3	1,775	38.4	3,301	61.1	5,445	24.6
Filipino	13	0.5	204	7.0	811	43.1	1,169	62.6	2,197	24.3
Chinese	20	0.3	182	2.3	1,927	23.3	3,784	49.9	5,913	19.2
Vietnamese	10	0.4	94	2.6	989	29.4	1,054	56.8	2,147	18.4
Am. Indian	0	0	22	8.8	61	33.5	38	63.3	121	17.7
Black	58	0.3	1,468	7.9	4,517	40.5	1,722	53.9	7,765	15.6
White	9	0.1	492	3.8	2,150	27.5	1,026	44.5	3,677	12.6
Other	22	0.1	1,665	5.0	4,512	31	2,689	50.5	8,888	12.5
Unknown	2	0.3	30	4.5	74	28.6	111	45.7	217	11.6
Hispanic	182	0.4	1,037	3.9	2,498	28.1	1,837	49.5	5,554	6.4
Total	331	0.3	5,548	4.9	19,314	31.7	16,731	39.6	41,924	13.4

Source: CareAnalyzer, 2021

Disorders of lipid metabolism

Disorders of lipid metabolism are interpreted as predominantly hyperlipidemia (high cholesterol). Most members were adults and seniors ages 45 and over. South County had the highest prevalence. The largest ethnic groups were Other and Chinese. Chinese, Other Asian/Pacific Islander, and Vietnamese had the highest prevalence. English and Chinese were the most common languages. The highest prevalence was among Tagalog-speaking members, followed by members who speak Chinese and Vietnamese.

Table 19: Hyperlipidemia Prevalence

HYPERLIPIDEMIA	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	38,235	100.0%	12.2		
ADULT	27,000	70.6%	15.1	2.9	23.8
CHILD	1,666	4.4%	1.7	-10.5	-86.1
CSHCN	122	0.3%	2.4	-9.8	-80.3
SPD	9,447	24.7%	32.4	20.2	165.6
Homeless					
No	35,946	94%	12.2	0	0
Yes	2,289	6%	12.5	0.3	2.5
Gender					
F	21,887	57.2%	13.1	0.9	7.4
M	16,348	42.8%	11.2	-1	-8.2
Age					
Under 19	1,818	4.8%	1.7	-10.5	-86.1
19-44	5,599	14.6%	4.9	-7.3	-59.8
45-64	16,836	44%	27.6	15.4	126.2
65+	13,982	36.6%	44.3	32.1	263.1
Location					
North County	14,903	39%	10.2	-2	-16.4
Central County	11,033	28.9%	12.6	0.4	3.3

Source: CareAnalyzer, 2021

HYPERLIPIDEMIA	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
South County	8,779	23%	18.7	6.5	53.3
East County	2,823	7.4%	14.3	2.1	17.2
Other / Unknown	697	1.8%	5.6	-6.6	-54.1
Ethnicity					
Other	8,078	21.1%	11.3	-0.9	-7.4
Chinese	7,756	20.3%	25.2	13	106.6
Hispanic (Latino)	5,741	15%	6.7	-5.5	-45.1
Other Asian / Pacific Islander	5,168	13.5%	23.3	11.1	91
Black (African American)	3,808	10%	7.7	-4.5	-36.9
White	2,928	7.7%	10	-2.2	-18
Vietnamese	2,638	6.9%	22.6	10.4	85.2
Filipino	1,866	4.9%	20.7	8.5	69.7
Unknown	174	0.5%	9.3	-2.9	-23.8
American Indian Or Alaskan Native	78	0.2%	11.4	-0.8	-6.6
Language					
English	18,940	49.5%	9.5	-2.7	-22.1
Chinese	8,029	21%	29.4	17.2	141
Spanish	4,645	12.1%	7.7	-4.5	-36.9
Vietnamese	2,519	6.6%	28.3	16.1	132
Unknown	1,923	5%	26	13.8	113.1
Other Non-English	1,473	3.9%	21.4	9.2	75.4
Tagalog	706	1.8%	35.5	23.3	191

Source: CareAnalyzer, 2021

The largest ethnic groups by age with hyperlipidemia were Chinese ages 65+, Other ages 45-64, and Chinese ages 45-64. The groups with the highest prevalence were all in the ages 65+ category for Filipino, Vietnamese, and Chinese.

Table 20: Hyperlipidemia Ethnicity x Age

HYPERLIPIDEMIA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Chinese	191	2.8	579	7.2	3,031	36.7	3,955	52.1	7,756	25.2
Other API	101	1.8	565	8.5	1,780	38.5	2,722	50.4	5,168	23.3
Vietnamese	42	1.5	228	6.3	1,397	41.5	971	52.3	2,638	22.6
Filipino	36	1.5	183	6.3	665	35.3	982	52.6	1,866	20.7
Am. Indian	3	1.6	15	6.0	32	17.6	28	46.7	78	11.4
Other	188	1	1,736	5.2	3,883	26.6	2,271	42.6	8,078	11.3
White	36	0.6	499	3.8	1,631	20.9	762	33.1	2,928	10
Unknown	5	0.7	32	4.8	61	23.6	76	31.3	174	9.3
Black	135	0.8	627	3.4	2,132	19.1	914	28.6	3,808	7.7
Hispanic	1,081	2.3	1,135	4.3	2,224	25	1,301	35.1	5,741	6.7
Total	1,818	1.7	5,599	4.9	16,836	27.6	13,982	32.1	38,235	12.2

Source: CareAnalyzer, 2021

Obesity

Children were the largest age group and had the highest prevalence of obesity. Central County had the highest prevalence. The largest ethnic group was Hispanic (Latino), who also had the highest prevalence. English and Spanish were the most common languages. Members who speak Spanish had the highest prevalence of obesity.

Table 21: Obesity Prevalence

OBESITY	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	30,571	100.0%	9.8		
ADULT	12,966	42.4%	7.3	-2.5	-25.5
CHILD	13,686	44.8%	13.7	3.9	39.8
CSHCN	756	2.5%	14.7	4.9	50
SPD	3,163	10.3%	10.8	1	10.2
Homeless					
No	28,989	94.8%	9.8	0	0
Yes	1,582	5.2%	8.6	-1.2	-12.2
Gender					
F	17,257	56.4%	10.3	0.5	5.1
M	13,314	43.6%	9.1	-0.7	-7.1
Age					
Under 19	14,795	48.4%	13.9	4.1	41.8
19-44	7,244	23.7%	6.4	-3.4	-34.7
45-64	6,203	20.3%	10.2	0.4	4.1
65+	2,329	7.6%	7.4	-2.4	-24.5
Location					
North County	14,117	46.2%	9.7	-0.1	-1
Central County	9,548	31.2%	10.9	1.1	11.2
South County	4,805	15.7%	10.3	0.5	5.1
East County	1,415	4.6%	7.2	-2.6	-26.5
Other / Unknown	686	2.2%	5.5	-4.3	-43.9
Ethnicity					
Hispanic (Latino)	12,260	40.1%	14.2	4.4	44.9
Other	5,893	19.3%	8.3	-1.5	-15.3
Black (African American)	5,460	17.9%	11	1.2	12.2
White	2,192	7.2%	7.5	-2.3	-23.5
Other Asian / Pacific Islander	1,767	5.8%	8	-1.8	-18.4
Chinese	1,680	5.5%	5.5	-4.3	-43.9
Filipino	685	2.2%	7.6	-2.2	-22.4
Vietnamese	467	1.5%	4	-5.8	-59.2
Unknown	89	0.3%	4.7	-5.1	-52
American Indian Or Alaskan Native	78	0.3%	11.4	1.6	16.3
Language					
English	18,212	59.6%	9.1	-0.7	-7.1
Spanish	9,081	29.7%	15	5.2	53.1
Chinese	1,576	5.2%	5.8	-4	-40.8
Unknown	645	2.1%	8.7	-1.1	-11.2

Source: Care Analyzer, 2021

OBESITY	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Other Non-English	587	1.9%	8.5	-1.3	-13.3
Vietnamese	337	1.1%	3.8	-6	-61.2
Tagalog	133	0.4%	6.7	-3.1	-31.6

Source: CareAnalyzer, 2021

The largest ethnic group by age with obesity was Hispanic (Latino) under 19. The groups with the highest prevalence were also ages under 19 for Hispanic (Latino) and American Indian or Alaskan Native.

Table 22: Obesity Ethnicity x Age

OBESITY Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Hispanic	8,688	18.5	2,062	7.7	1,138	12.8	372	10	12,260	14.2
Am. Indian	29	15.2	19	7.6	24	13.2	6	10	78	11.4
Black	2,086	12.3	1,417	7.7	1,562	14	395	12.4	5,460	11
Other	1,621	8.9	2,328	7	1,570	10.8	374	7	5,893	8.3
Other API	689	12.5	369	5.6	386	8.3	323	6	1,767	8
Filipino	285	12	144	4.9	148	7.9	108	5.8	685	7.6
White	522	8.6	539	4.1	858	11	273	11.8	2,192	7.5
Chinese	613	8.9	261	3.2	399	4.8	407	5.4	1,680	5.5
Unknown	33	4.6	26	3.9	17	6.6	13	5.3	89	4.7
Total	14,795	13.9	7,244	6.4	6,203	10.2	2,329	7.4	30,571	9.8

Source: CareAnalyzer, 2021

Diabetes

Diabetes was a combined category of diagnosis with or without complications. Most members were adults and seniors ages 45 and over. Prevalence was highest in South County. Members with a homeless indicator had a slightly higher prevalence. The largest ethnic group was Other. Prevalence was highest for Filipino and Other Asian/Pacific Islander ethnicities. About half spoke English, but the highest prevalence was Tagalog, then Unknown language.

Table 23: Diabetes Prevalence

DIABETES	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	22,150	100.0%	7.1		
ADULT	15,707	70.9%	8.8	1.7	23.9
CHILD	52	0.2%	0.1	-7	-98.6
CSHCN	86	0.4%	1.7	-5.4	-76.1
SPD	6,305	28.5%	21.6	14.5	204.2
Homeless					
No	20,410	92.1%	6.9	-0.2	-2.8
Yes	1,740	7.9%	9.5	2.4	33.8
Gender					

Source: CareAnalyzer, 2021

DIABETES	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
F	12,587	56.8%	7.5	0.4	5.6
M	9,563	43.2%	6.6	-0.5	-7
Age					
Under 19	128	0.6%	0.1	-7	-98.6
19-44	2,684	12.1%	2.4	-4.7	-66.2
45-64	10,472	47.3%	17.2	10.1	142.3
65+	8,866	40%	28.1	21	295.8
Location					
North County	9,468	42.7%	6.5	-0.6	-8.5
Central County	6,289	28.4%	7.2	0.1	1.4
South County	4,646	21%	9.9	2.8	39.4
East County	1,310	5.9%	6.6	-0.5	-7
Other / Unknown	437	2%	3.5	-3.6	-50.7
Ethnicity					
Other	4,724	21.3%	6.6	-0.5	-7
Hispanic (Latino)	3,946	17.8%	4.6	-2.5	-35.2
Black (African American)	3,388	15.3%	6.8	-0.3	-4.2
Other Asian / Pacific Islander	3,265	14.7%	14.7	7.6	107
Chinese	2,778	12.5%	9	1.9	26.8
White	1,546	7%	5.3	-1.8	-25.4
Filipino	1,349	6.1%	14.9	7.8	109.9
Vietnamese	1,001	4.5%	8.6	1.5	21.1
Unknown	89	0.4%	4.7	-2.4	-33.8
American Indian Or Alaskan Native	64	0.3%	9.4	2.3	32.4
Language					
English	12,384	55.9%	6.2	-0.9	-12.7
Spanish	3,192	14.4%	5.3	-1.8	-25.4
Chinese	2,899	13.1%	10.6	3.5	49.3
Unknown	1,255	5.7%	17	9.9	139.4
Vietnamese	965	4.4%	10.9	3.8	53.5
Other Non-English	917	4.1%	13.3	6.2	87.3
Tagalog	538	2.4%	27	19.9	280.3

Source: CareAnalyzer, 2021

The largest ethnic groups by age with diabetes were ages 45-64 for Other, Black (African American), and Hispanic (Latino). The groups with the highest prevalence were ages 65+ for Filipino, Other Asian/Pacific Islander, American Indian or Alaskan Native, and Hispanic (Latino).

Table 24: Diabetes Ethnicity x Age

DIABETES Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Filipino	7	0.3	108	3.7	506	26.9	728	39	1,349	14.9
Other API	9	0.2	221	3.3	1,155	25	1,880	34.8	3,265	14.7
Am. Indian	1	0.5	15	6	28	15.4	20	33.3	64	9.4
Chinese	3	0	91	1.1	982	11.9	1,702	22.4	2,778	9
Vietnamese	3	0.1	44	1.2	447	13.3	507	27.3	1,001	8.6
Black	33	0.2	538	2.9	2,002	18	815	25.5	3,388	6.8
Other	8	0	789	2.4	2,459	16.9	1,468	27.5	4,724	6.6
White	2	0	187	1.4	887	11.4	470	20.4	1,546	5.3
Unknown	0	0	6	0.9	29	11.2	54	22.2	89	4.7
Hispanic	62	0.1	685	2.6	1,977	22.2	1,222	33	3,946	4.6
Total	128	0.1	2,684	2.4	10,472	17.2	8,866	28.1	19,087	100.0%

Source: CareAnalyzer, 2021

Anxiety

About two-thirds of members with anxiety were female. Most members were adults ages 19 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. East County had the highest prevalence. Members with homeless indicator had a higher prevalence. The largest ethnic groups were Other and Hispanic (Latino). White and American Indian or Alaskan Native had the highest prevalence. English was the most common language.

Table 25: Anxiety Prevalence

ANXIETY	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	19,534	100.0%	6.2		
ADULT	13,962	71.5%	7.8	1.6	25.8
CHILD	2,511	12.9%	2.5	-3.7	-59.7
CSHCN	247	1.3%	4.8	-1.4	-22.6
SPD	2,814	14.4%	9.6	3.4	54.8
Homeless					
No	17,640	90.3%	6	-0.2	-3.2
Yes	1,894	9.7%	10.3	4.1	66.1
Gender					
F	13,567	69.5%	8.1	1.9	30.6
M	5,967	30.5%	4.1	-2.1	-33.9
Age					
Under 19	2,821	14.4%	2.6	-3.6	-58.1
19-44	9,213	47.2%	8.1	1.9	30.6
45-64	5,713	29.2%	9.4	3.2	51.6
65+	1,787	9.1%	5.7	-0.5	-8.1
Location					
North County	9,027	46.2%	6.2	0	0
Central County	5,168	26.5%	5.9	-0.3	-4.8
South County	3,227	16.5%	6.9	0.7	11.3

Source: CareAnalyzer, 2021

ANXIETY	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
East County	1,479	7.6%	7.5	1.3	21
Other / Unknown	633	3.2%	5.1	-1.1	-17.7
Ethnicity					
Other	5,447	27.9%	7.6	1.4	22.6
Hispanic (Latino)	4,729	24.2%	5.5	-0.7	-11.3
Black (African American)	3,218	16.5%	6.5	0.3	4.8
White	3,057	15.6%	10.4	4.2	67.7
Other Asian / Pacific Islander	1,141	5.8%	5.1	-1.1	-17.7
Chinese	1,105	5.7%	3.6	-2.6	-41.9
Filipino	393	2%	4.4	-1.8	-29
Vietnamese	293	1.5%	2.5	-3.7	-59.7
Unknown	83	0.4%	4.4	-1.8	-29
American Indian Or Alaskan Native	68	0.3%	10	3.8	61.3
Language					
English	14,505	74.3%	7.3	1.1	17.7
Spanish	2,929	15%	4.8	-1.4	-22.6
Chinese	973	5%	3.6	-2.6	-41.9
Unknown	443	2.3%	6	-0.2	-3.2
Other Non-English	388	2%	5.6	-0.6	-9.7
Vietnamese	221	1.1%	2.5	-3.7	-59.7
Tagalog	75	0.4%	3.8	-2.4	-38.7

Source: CareAnalyzer, 2021

The largest ethnic group by age with anxiety was Other ages 19-44. The groups with the highest prevalence were White ages 45-64, American Indian or Alaskan Native ages 45-64, and American Indian or Alaskan Native ages 19-44.

Table 26: Anxiety Ethnicity x Age

ANXIETY Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
White	265	4.4	1,486	11.3	1,054	13.5	252	10.9	3,057	10.4
Am. Indian	8	4.2	30	12	24	13.2	6	10	68	10
Other	282	1.5	3,232	9.7	1,611	11.1	322	6	5,447	7.6
Black	367	2.2	1,455	7.9	1,175	10.5	221	6.9	3,218	6.5
Hispanic	1,587	3.4	1,992	7.5	880	9.9	270	7.3	4,729	5.5
Other API	96	1.7	423	6.4	337	7.3	285	5.3	1,141	5.1
Filipino	49	2.1	155	5.3	122	6.5	67	3.6	393	4.4
Unknown	9	1.3	49	7.4	16	6.2	9	3.7	83	4.4
Chinese	125	1.8	292	3.6	386	4.7	302	4	1,105	3.6
Vietnamese	33	1.2	99	2.7	108	3.2	53	2.9	293	2.5
Total	2,821	2.6	9,213	8.1	5,713	9.4	1,787	5.7	19,534	6.2

Source: CareAnalyzer, 2021

Asthma

Asthma was a combined category of diagnosis with and without status asthmaticus (former term for acute severe asthma). About 40% were children under 19, 30% adults 19 to 44, and 20% adults 45 to 64. The CSHCN and SPD categories had a higher prevalence than the other subpopulations. About 30% each of members were Black (African American) and Hispanic (Latino). Black (African American) and American Indian or Alaskan Native had the highest prevalence. English was the most common language.

Table 27: Asthma Prevalence

ASTHMA	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	17,711	100.0%	5.7		
ADULT	8,709	49.2%	4.9	-0.8	-14
CHILD	5,997	33.9%	6	0.3	5.3
CSHCN	497	2.8%	9.7	4	70.2
SPD	2,508	14.2%	8.6	2.9	50.9
Homeless					
No	16,001	90.3%	5.4	-0.3	-5.3
Yes	1,710	9.7%	9.3	3.6	63.2
Gender					
F	10,297	58.1%	6.2	0.5	8.8
M	7,414	41.9%	5.1	-0.6	-10.5
Age					
Under 19	6,727	38%	6.3	0.6	10.5
19-44	5,466	30.9%	4.8	-0.9	-15.8
45-64	3,814	21.5%	6.3	0.6	10.5
65+	1,704	9.6%	5.4	-0.3	-5.3
Location					
North County	8,945	50.5%	6.1	0.4	7
Central County	4,587	25.9%	5.2	-0.5	-8.8
South County	2,650	15%	5.7	0	0
East County	1,048	5.9%	5.3	-0.4	-7
Other / Unknown	481	2.7%	3.9	-1.8	-31.6
Ethnicity					
Black (African American)	4,853	27.4%	9.8	4.1	71.9
Hispanic (Latino)	4,677	26.4%	5.4	-0.3	-5.3
Other	3,820	21.6%	5.4	-0.3	-5.3
White	1,536	8.7%	5.2	-0.5	-8.8
Other Asian / Pacific Islander	1,096	6.2%	4.9	-0.8	-14
Chinese	755	4.3%	2.5	-3.2	-56.1
Filipino	469	2.6%	5.2	-0.5	-8.8
Vietnamese	380	2.1%	3.3	-2.4	-42.1
Unknown	63	0.4%	3.4	-2.3	-40.4
American Indian Or Alaskan Native	62	0.4%	9.1	3.4	59.6
Language					
English	12,943	73.1%	6.5	0.8	14
Spanish	2,922	16.5%	4.8	-0.9	-15.8

Source: CareAnalyzer, 2021

ASTHMA	N	% of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Chinese	693	3.9%	2.5	-3.2	-56.1
Unknown	405	2.3%	5.5	-0.2	-3.5
Other Non-English	351	2%	5.1	-0.6	-10.5
Vietnamese	276	1.6%	3.1	-2.6	-45.6
Tagalog	121	0.7%	6.1	0.4	7

Source: CareAnalyzer, 2021

The largest ethnic group by age with asthma was Hispanic (Latino) under 19. The groups with the highest prevalence were American Indian or Alaskan Native ages 65+, American Indian or Alaskan Native ages 45-64, and Black (African American) ages under 19.

Table 28: Asthma Ethnicity x Age

ASTHMA Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
Black	1,898	11.2	1,507	8.1	1,178	10.6	270	8.5	4,853	9.8
Am. Indian	12	6.3	18	7.2	23	12.6	9	15	62	9.1
Hispanic	2,909	6.2	1,068	4	491	5.5	209	5.6	4,677	5.4
Other	816	4.5	1,718	5.2	1,002	6.9	284	5.3	3,820	5.4
White	295	4.9	578	4.4	513	6.6	150	6.5	1,536	5.2
Filipino	99	4.2	130	4.5	129	6.9	111	5.9	469	5.2
Other API	289	5.2	232	3.5	217	4.7	358	6.6	1,096	4.9
Chinese	287	4.2	119	1.5	134	1.6	215	2.8	755	4.3
Unknown	17	2.4	29	4.4	7	2.7	10	4.1	63	3.4
Vietnamese	105	3.7	67	1.8	120	3.6	88	4.7	380	3.3
Total	6,727	6.3	5,466	4.8	3,814	6.3	1,704	5.4	17,711	5.7

Source: CareAnalyzer, 2021

Depression

Depression was a combined category of depression and major depression. Over two-thirds of members with depression were female. Most members were adults ages 19 to 64. The SPD category had a higher prevalence than the other subpopulations. Members with homeless indicator had a higher prevalence. The largest ethnic group was Other. White and American Indian or Alaskan Native had the highest prevalence. English was the most common language. Other non-English and English had the highest prevalence.

Table 29: Depression Prevalence

DEPRESSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
Overall Total	17,248	100.0%	5.5		
ADULT	12,318	71.4%	6.9	1.4	25.5
CHILD	1,718	10%	1.7	-3.8	-69.1
CSHCN	163	0.9%	3.2	-2.3	-41.8
SPD	3,049	17.7%	10.4	4.9	89.1
Homeless					

Source: CareAnalyzer, 2021

DEPRESSION	Count	Percent of total	Prevalence (%)	Absolute diff (%)	Relative diff (%)
No	15,328	88.9%	5.2	-0.3	-5.5
Yes	1,920	11.1%	10.4	4.9	89.1
Gender					
F	12,124	70.3%	7.3	1.8	32.7
M	5,124	29.7%	3.5	-2	-36.4
Age					
Under 19	1,895	11%	1.8	-3.7	-67.3
19-44	7,409	43%	6.5	1	18.2
45-64	5,755	33.4%	9.4	3.9	70.9
65+	2,189	12.7%	6.9	1.4	25.5
Location					
North County	8,782	50.9%	6	0.5	9.1
Central County	4,313	25%	4.9	-0.6	-10.9
South County	2,439	14.1%	5.2	-0.3	-5.5
East County	1,153	6.7%	5.9	0.4	7.3
Other / Unknown	561	3.3%	4.5	-1	-18.2
Ethnicity					
Other	4,720	27.4%	6.6	1.1	20
Hispanic (Latino)	3,669	21.3%	4.3	-1.2	-21.8
Black (African American)	3,183	18.5%	6.4	0.9	16.4
White	2,779	16.1%	9.5	4	72.7
Chinese	1,060	6.1%	3.4	-2.1	-38.2
Other Asian / Pacific Islander	1,033	6%	4.7	-0.8	-14.5
Vietnamese	362	2.1%	3.1	-2.4	-43.6
Filipino	307	1.8%	3.4	-2.1	-38.2
Unknown	75	0.4%	4	-1.5	-27.3
American Indian Or Alaskan Native	60	0.3%	8.8	3.3	60
Language					
English	12,739	73.9%	6.4	0.9	16.4
Spanish	2,332	13.5%	3.8	-1.7	-30.9
Chinese	976	5.7%	3.6	-1.9	-34.5
Other Non-English	476	2.8%	6.9	1.4	25.5
Unknown	373	2.2%	5	-0.5	-9.1
Vietnamese	301	1.7%	3.4	-2.1	-38.2
Tagalog	51	0.3%	2.6	-2.9	-52.7

Source: CareAnalyzer, 2021

The largest ethnic group by age with depression was Other ages 19-44. The groups with the highest prevalence were White ages 65+ and White ages 45-64.

Table 30: Depression Ethnicity x Age

DEPRESSION Ethnicity x Age	Under 19		19-44		45-64		65+		Total	
	n	%	n	%	n	%	n	%	n	%
White	186	3.1	1,205	9.2	1,053	13.5	335	14.5	2,779	9.5
Am. Indian	6	3.1	24	9.6	23	12.6	7	11.7	60	8.8
Other	183	1	2,597	7.8	1,583	10.9	357	6.7	4,720	6.6
Black	277	1.6	1,259	6.8	1,359	12.2	288	9	3,183	6.4
Other API	62	1.1	316	4.8	351	7.6	304	5.6	1,033	4.7
Hispanic	991	2.1	1,517	5.7	873	9.8	288	7.8	3,669	4.3
Unknown	10	1.4	37	5.6	17	6.6	11	4.5	75	4
Chinese	103	1.5	226	2.8	274	3.3	457	6	1,060	3.4
Filipino	44	1.9	128	4.4	91	4.8	44	2.4	307	3.4
Vietnamese	33	1.2	100	2.8	131	3.9	98	5.3	362	3.1
Total	1,895	1.8	7,409	6.5	5,755	9.4	2,189	6.9	17,248	5.5

Source: CareAnalyzer, 2021

Access to Care

Access to care was assessed through CAHPS and CG-CAHPS surveys.

CAHPS

Below are the results from the 2021 CAHPS 5.1H survey (Measurement Year 2020). The benchmarks are derived from NCQA's Quality Compass® benchmark and calculated by SPH Analytics. For adults, it is the mean of 164 plan-specific Medicaid adult samples that submitted to NCQA in 2020. The child benchmark includes 175 plans.

The plan rate is shaded in red when significantly below the benchmark at the 95% significance level according to SPH Analytics. The arrows indicate a significantly lower rate compared to the previous year's rate.

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. These rates were consistent between MY 2019 and 2020. Adults were above benchmark in MY 2019 for questions regarding personal doctor listening carefully and showing respect, but in MY 2020 the rates dropped significantly and were below benchmark. Other below benchmark results were ease of filling out forms for adults and coordination of care for children.

Table 31: CAHPS Results

Composite/Attribute/Measure	Adult MY2019	Adult MY2020	Adult Benchmark	Child MY2019	Child MY2020	Child Benchmark
Getting Needed Care	82.6%	79.0%	83.0%	81.0%	82.2%	86.0%
Getting care, tests, or treatment	81.7%	81.7%	85.9%	86.3%	86.5%	91.2%
Getting specialist appointment	83.6%	76.3%	80.1%	75.8%	78.0%	79.8%
Getting Care Quickly	71.7%	72.4%	82.3%	82.0%	78.8%	90.5%
Getting urgent care	78.2%	75.0%	85.0%	82.3%	78.7%	92.6%
Getting routine care	65.2%	69.7%	79.8%	81.7%	78.9%	89.0%
How Well Doctors Communicate	95.7%	83.5%↓	93.2%	92.7%	93.2%	95.3%
Personal doctor explained things	95.3%	81.5%↓	93.3%	90.5%	92.1%	95.6%
Personal doctor listened carefully	97.2%	84.3%↓	93.4%	95.0%	95.5%	96.4%
Personal doctor showed respect	97.2%	86.9%↓	94.7%	97.5%	97.2%	97.2%
Personal doctor spent enough time	93.3%	81.5%↓	91.3%	87.9%	88.1%	91.9%
Customer Service	88.8%	84.1%	89.3%	84.0%	90.2%	88.8%
Provided information or help	82.7%	77.3%	84.2%	77.4%	85.3%	83.8%
Treated with courtesy and respect	94.9%	90.9%	94.4%	90.6%	95.0%	93.8%
Coordination of Care	80.3%	83.0%	85.1%	84.2%	73.8%	86.1%
Ease of Filling out Forms	91.9%	91.3%	95.8%	95.9%	95.8%	96.5%

Source: CAHPS 5.1H, SPH Analytics, 2020-2021 (MY 2019-2020)

Rates by ethnicity and race are as follows. Asian adults had the lowest rates for getting needed care, getting care quickly, and ease of filling out forms. For children, those identified as not Hispanic had a lower rate than Hispanic ethnicity for getting care quickly.

Table 32: CAHPS Results by Ethnicity and Race

ADULT	Ethnicity		Race ¹			
Composite, Attribute, or Measure	Hispanic	Not Hispanic	White	Black	Asian	Other
Getting Needed Care	81.0%	80.8%	91.0%^	83.2%	72.2%	76.6%
Getting Care Quickly	84.8%	68.8%	96.3%^	66.4%	59.7%	85.6%
How Well Doctors Communicate	80.0%	87.8%	93.5%	83.3%	81.5%	88.6%
Customer Service	94.4%	81.5%	82.1%	92.9%	80.0%	90.9%
Coordination of Care	78.9%	87.5%	84.6%	80.0%	81.8%	86.7%
Ease of Filling Out Forms	89.7%	92.2%	92.2%	97.1%	88.9%	100%^*
CHILD	Ethnicity		Race			
Composite, Attribute, or Measure	Hispanic	Not Hispanic	White	Black	Asian	Other
Getting Needed Care	86.9%	77.4%	70.8%	72.6%	82.6%	75.8%
Getting Care Quickly	90.4%+	71.1%	82.6%	78.8%	68.1%	80.7%
How Well Doctors Communicate	93.9%	93.1%	91.6%	94.8%	93.3%	90.4%
Customer Service	91.2%	89.9%	85.3%	89.3%	90.0%	95.7%
Coordination of Care	72.7%	75.0%	57.1%	81.8%	66.7%	72.2%
Ease of Filling Out Forms	97.3%	94.9%	97.5%	94.5%	93.4%	94.1%

1. Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native are not listed due to small sample sizes.

^Rate is significantly higher than “Asian” race.

*Rate is significantly higher than “White” race.

+Rate is significantly higher than “Not Hispanic” ethnicity.

Source: CAHPS 5.1H, SPH Analytics, 2020-2021 (MY 2019-2020)

CG-CAHPS

Below are the results from the language services questions on the CG-CAHPS. The survey was administered in four languages (English, Spanish, Chinese, and Vietnamese), but the responses are summarized by preferred language. The survey will be translated to Tagalog for 2022.

Interpreter use was highest among Chinese and Spanish speakers for both adults and children.

Table 33: CG-CAHPS Interpreter Needed

CG-CAHPS: Interpreter needed?	2021 Adult responses	2021 Adult % yes	2020 Adult % yes	2021 Children responses	2021 Children % yes	2020 Children % yes
Total	8,185	36%	30%	4,931	32%	28%
English	4,014	5%	6%	2,250	4%	5%
Spanish	1,046	63%	61%	1,895	55%	53%

Source: CG-CAHPS Member Satisfaction Survey, 2020-2021

CG-CAHPS: Interpreter needed?	2021 Adult responses	2021 Adult % yes	2020 Adult % yes	2021 Children responses	2021 Children % yes	2020 Children % yes
Chinese	1,871	82%	71%	446	75%	63%
Vietnamese	770	41%	42%	137	31%	30%
Tagalog	40	28%	/	5	0%	/
Other languages	444	41%	44%	198	26%	32%

Source: CG-CAHPS Member Satisfaction Survey, 2020-2021

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.

Adults had a lower favorable response rate than children and a higher use of family and friends. Tagalog, English, and Other language speakers had the lowest favorable response rates for adults. The overall favorable rate was the same in 2020 and 2021. The rate decreased the most from 2020 for English, Vietnamese, and Other languages.

For children, Other languages, English, and Vietnamese had the lowest favorable response rates. The rates decreased from 2020 for Other languages and Vietnamese. These groups also have smaller numbers of members.

Table 34: CG-CAHPS Ability to Communicate

ADULT: Able to communicate with doctor and clinic staff in preferred language?	2021 Total responses	2021 Favorable	2021 Family and Friends	2021 No	2020 Favorable	Favorable Difference
Total	2,395	84%	13%	2%	84%	0%
English	186	52%	43%	5%	59%	-7%
Spanish	475	88%	9%	3%	88%	0%
Chinese	1,289	91%	8%	1%	92%	-1%
Vietnamese	275	87%	11%	2%	93%	-6%
Tagalog	11	45%	55%	0%	N/A	N/A
Other languages	170	55%	38%	6%	60%	-5%
CHILD	2021 Total responses	2021 Favorable	2021 Family and Friends	2021 No	2020 Favorable	Favorable % Change
Total	1,406	93%	4%	3%	91%	2%
English	79	76%	8%	16%	76%	0%
Spanish	915	94%	4%	2%	93%	1%
Chinese	329	98%	2%	1%	96%	2%
Vietnamese	40	80%	10%	10%	91%	-11%
Tagalog	0	N/A	N/A	N/A	N/A	N/A
Other languages	43	72%	19%	9%	85%	-13%

Source: CG-CAHPS Member Satisfaction Survey, 2020-2021

Health Disparities

Health disparities were identified through the plan specific HEDIS data from DHCS. The nine measures included in the analysis are part of MCAS (Managed Care Accountability Set) for both MY 2020 and MY 2022 to align the most recently available data with current priorities for DHCS.

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 2021 (Measurement Year 2020) that represented at least 5% of the sample for the measure.

The table below lists subgroup rates that were significantly lower at the 95% or 99% (**bold**) significance level using one-sided binomial testing.

Table 35: HEDIS Disparities Reporting Year 2021 (MY 2020)

Measure	Subgroup	% of sample	MPL (%)	Rate (%)	Absolute diff (%) ¹	Relative diff (%) ²
BCS Breast Cancer Screening	Overall	100%	58.82	56.21	2.61	4.44
	Ages 50-64	87%		56.81	2.01	3.42
	Ages 65-74	13%		52.17	6.65	11.31
	English	54%		50.04	8.78	14.93
	White	10%		46.23	12.59	21.40
	Black or African American	16%		46.85	11.97	20.35
	Other Ethnicity	17%		56.05	2.77	4.71
CHL Chlamydia Screening in Women	White	7%	58.44	53.99	4.45	7.61
	Asian	13%		49.34	9.1	15.57
CBP Controlling High Blood Pressure	Overall	100%	61.8	51.34	10.46	16.93
	Ages 21-44	14%		41.07	20.73	33.54
	Ages 45-64	66%		52.96	8.84	14.30
	Ages 65+	20%		52.38	9.42	15.24
	Female	58%		51.68	10.12	16.38
	Male	42%		50.87	10.93	17.69
	English	58%		47.5	14.3	23.14
	Other Language	7%		39.29	22.51	36.42
	Asian	36%		48.65	13.15	21.28
	Black or African American	17%		39.44	22.36	36.18
	Other Ethnicity	18%		48	13.8	22.33
CDC-H9 Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Poor Control >9%	Overall	100%	37.47 (lower rate is better)	41.46	-3.99	-10.65
	Ages 21-44	21%		55.95	-18.48	-49.32
	English	60%		43.93	-6.46	-17.24
	Black or African American	18%		52.86	-15.39	-41.07
	Other Ethnicity	22%		46.59	-9.12	-24.34

1. Absolute difference = MPL - Rate

2. *Relative difference = Absolute difference/MPL x 100*

Source: DHCS health disparities data, 2021 (MY 2020)

Significant disparities were identified in four of the nine HEDIS measures analyzed.

- BCS (Breast Cancer Screening) was low for the plan but especially low for White and Black (African American) members.
- CHL (Chlamydia Screening in Women) was significantly lower in Asian members.
- CBP (Controlling Blood High Pressure) was low for the plan overall. It was lowest for ages 21-44 and for Black (African American) ethnicity. Ages 45-64 and Asian were not as low but made up a higher proportion of the sample. Other Language also had a low rate, but the significance level was not as low.
- CDC-H9 (Comprehensive Diabetes Care – Hemoglobin A1C Poor Control) was highest for ages 21-44 and Black (African American) ethnicity (lower rate is better).

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

The Alliance Quality Improvement Department reviewed the data and identified potential priority areas. This was followed by focus groups with the Alliance Member Advisory Committee (see Stakeholder Engagement section for more details on focus group methods). As a result of the data, focus groups, and staff input on current population health strategies, the following areas and program gaps were selected to address in the 2022 action plan.

Note: Data source references are links that can be used to navigate to the corresponding tables in the key findings.

1. Chronic disease self-management support

a. Blood pressure control

Data sources

References: Table 14: Top Diagnoses Adults; Table 16: Top Diagnoses SPD; Table 18: Hypertension Ethnicity x Age; Table 35: HEDIS Disparities Reporting Year 2021 (MY 2020)

Controlling high blood pressure (CBP) was below the MPL overall in MY 2020 by 10 percentage points. It was lowest for Black (African American) ethnicity and ages 21-44, which each made up about 15% of the sample. Asian ethnicity and ages 45-64 were also below the MPL. These groups made up a third and two-thirds of the sample, respectively.

Hypertension was the top diagnosis for adults (16%) and seniors and persons with disabilities (43%). The largest ethnic groups by age with hypertension were Black (African American) ages 45-64 and Other ages 45-64. The groups with the highest prevalence were all in the ages 65+ category for American Indian or Alaskan Native, Filipino, and Other Asian/Pacific Islander.

Current activities: The Alliance is working with Community Health Center Network (CHCN) to expand their Self Measured Blood Pressure (SMBP) program. In this program, health center care teams support patients with uncontrolled blood pressure in using an SMBP device and monitoring the data collected remotely to tailor treatment plans. In 2020, the Alliance assisted with providing SMBP devices to two CHCN clinics.

Program gaps: The expansion of the SMBP program at CHCN aims to address gaps in patient self-efficacy and education and challenges with blood pressure measurement at office visits. Access to devices that allow for remote patient monitoring is a gap. The program is currently intended for any Alliance CHCN member with uncontrolled blood pressure, but it should be evaluated whether certain demographic groups experience a greater benefit from this intervention. Linkages to resources to assist with stressors and healthy lifestyle are also needed.

b. Diabetes control

Data sources

References: Table 24: Diabetes Ethnicity x Age; Table 35: HEDIS Disparities Reporting Year 2021 (MY 2020)

Diabetes control (CDC-H9) was above the MPL (where lower is better) overall in MY 2020 by four percentage points. It was highest for ages 21-44 and Black (African American) ethnicity, which each made up about 20% of the sample.

Disease prevalence data showed that the largest ethnic groups by age with diabetes were ages 45-64 for Other, Black (African American), and Hispanic (Latino). The groups with the highest prevalence were ages 65+ for Filipino, Other Asian/Pacific Islander, American Indian or Alaskan Native, and Hispanic (Latino).

Current activities: Health Education provides materials on diabetes self-management and shares information with members and providers about community and hospital programs. The Alliance diabetes disease management program is being enhanced to provide health coaching and referrals to complex case management, pharmacy, health navigation, and health education programs. Quality Improvement and Health Education have begun partnering with Eastmont Wellness on member incentives for their diabetes class series and are exploring other quality improvement opportunities.

Program gaps: The current activities mostly reach members who directly request diabetes materials or programs from the Alliance or are referred by providers or Case Management staff. There are many more members with diabetes who are not engaging with Alliance supports. Health Education diabetes program participation was on the rise in 2021 with more telehealth one-on-one support with dietitians through the diabetes community programs, but key staff providing that service retired in 2022. There is a demand for more individualized support with healthy eating and blood sugar monitoring in informal settings. Classes and programs in the community can help provide support but are also challenging for members to schedule and attend.

2. Access and participation in preventive care

Getting routine care quickly for both adults and children was recognized as an underlying theme that could be integrated into the following preventive care objectives instead of being included as its own general objective.

a. Well-child visits

Data sources

References: Table 31: CAHPS Results

Plans were not held to an MPL for Well-Child Visits (W30 and WCV) in MY 2020, but it continues to be a priority for the Quality Improvement department so that children receive

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services. Based on preliminary MY 2021 HEDIS results, the Alliance chose to focus on W30. The related CAHPS measure, getting routine care quickly for children, continues to be below benchmark.

Current activities: The Alliance is growing a partnership with First 5 Alameda County to conduct outreach calls to 5,000 children ages 0 to 5 this fiscal year (July 2022 to June 2023) to encourage well-child visits and help members connect to support services. Alliance also supports texting well-child visit reminders to children and adolescents who are part of the delegate Children First Medical Group (CFMG). Lastly, Quality Improvement provides member incentives to patients of La Clinica for well-child visits.

Program gaps: Although there are multiple outreach efforts to children in progress, another target group for outreach are members who have not utilized health care services. Although the CAHPS survey indicates potential timely access issues for children, these are not currently captured in other Alliance survey data. Community partners like First 5, providers, and members may need more education around the timely access standard and filing of grievances to help the Alliance track any issues.

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

Data sources

References: Table 31: CAHPS Results; Table 35: HEDIS Disparities Reporting Year 2021 (MY 2020)

In the HEDIS disparities data, breast cancer screening rates were low overall by nearly three percentage points and lowest for White and Black (African American) ethnicities. White ethnicity was 10% of the sample while Black (African American) was 16% of the sample.

Although breast cancer screening is just one aspect of getting routine care, adults continued to be below benchmark for getting care routine care quickly in 2019 and 2020.

Current activities: The Alliance has a partnership with LifeLong Medical Care to improve breast cancer screening rates among their members through texting outreach and member incentives. They have a high volume of Black (African American) patients. Quality Improvement is working to establish a partnership with a medical imaging company that can provide mobile mammograms.

Program gaps: To get a mammogram, most members have to make an appointment at a radiology site outside of their usual clinic. Mammogram appointment availability, particularly in Oakland, is a potential access issue that needs more investigation. Both providers and members may not be aware of the timely access standard of 15 business days and that filing a grievance helps the Alliance track issues. The Alliance currently relies on PCPs and does not directly educate or outreach to members about breast cancer screening.

4. Action Plan

2021 PNA Action Plan Review and Update

1. Culturally and linguistically appropriate asthma self-management support

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

<p>Objective 1a.) 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.</p> <p>Data source: Health Education program participation records</p>	<p>Progress Measure: In 2021, there were 76 Black (African American) and 91 Hispanic (Latino) participants, a total of 167 members and decrease of 20% from 2019.</p> <p>Data source: Health Education program participation records</p> <p>Progress Toward Objective: This objective was not met. While participation declined from 2019 to 2021, there was an increase of 40% in participation (119 to 167 members) from 2020 to 2021.</p> <p>As noted in the 2020 PNA Action Plan Review and Update, participation declined after 2019 due to the pandemic, which affected program delivery and staffing, and discontinued Emergency Department (ED) data from the local children's hospital. The children's hospital changed reporting processes, then were unable to focus on rebuilding the weekly ED report due to COVID-19 priorities. Participation is anticipated to increase with reduced COVID-19 restrictions and new CalAIM funding for asthma remediation. This objective has ended, but the Alliance will continue to fund and promote Asthma Start services.</p>
Strategies	
<p>Strategy 1.) Continue funding Asthma Start outreach and in-home case management services for Hispanic (Latino) and Black (African American) families.</p>	<p>Progress Discussion: The Alliance funded Asthma Start program outreach and services in 2021. Asthma Start conducted outreach to 155 Black (African American) and 186 Hispanic (Latino) members. Half of those who were outreached to enrolled in the program. Being able to get in contact with the members to do the outreach continued to be a challenge. On January 1, 2022, a new billing system was implemented for Asthma Start and asthma remediation as a Community Supports service offered through CalAIM.</p>

<p>Strategy 2.) Create provider promotion materials with Asthma Start to encourage referrals.</p>	<p>Progress Discussion: In Q4 2021, the Alliance published a provider communication promoting Asthma Start services. The communication explained which supplies the program provides to participants for free, which was a question that had been raised during an African American asthma advisory group meeting. The Alliance also began conversations with three delegates offering to present to their providers about asthma remediation and Asthma Start services and provide information to post on their websites.</p>
<p>Strategy 3.) Launch regular mailing to families of children with asthma to encourage participation in the Asthma Start program.</p>	<p>Progress Discussion: The Alliance continues to mail members who have an ED visit at four network hospitals and is working with the local children's hospital to receive similar reports. The planned letter campaign to children with asthma who are not reached through these post-ED mailings was delayed due to other organizational priorities for communications and is now targeted to begin this summer.</p>

1b. [HEALTH DISPARITY] Asthma in the Black (African American) adult population

<p>Objective 1b.) 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.</p> <p>Data source: Cotiviti HEDIS engine</p>	<p>Progress Measure: As of April 2022, the Measurement Year (MY) 2021 AMR rate was 57.29% (279/487) for Black (African American) adults ages 19 to 64. The point-in-time AMR rate as of April 2022 was 70% (119/170).</p> <p>Data source: Cotiviti HEDIS engine</p> <p>Progress Toward Objective: The current MY 2021 rate is about 8 percentage points above the MY 2020 baseline and 5 percentage points below the MY 2020 MPL goal. The point-in-time rate is above the MY 2020 MPL goal.</p> <p>While strategies 1 and 2 were slower to launch than expected or put on hold, Pharmacy and Health Education continued to conduct member phone consult outreach in strategy 3. This project was the focus of an African American asthma advisory group meeting. Because AMR will not be part of the Medical Managed Care Accountability Set (MCAS) for 2022 and the strategies are underway or concluded, this objective will be discontinued.</p>
<p>Strategies</p>	

<p>Strategy 1.) Conduct targeted mailing with member incentive to view an educational video and/or visit their doctor for an asthma checkup.</p>	<p>Progress Discussion: Quality Improvement and Health Education developed an educational PowerPoint and recorded a video. Recording and editing took longer than expected, and the project was put on hold after the recording was finished because the lead staff member left the department. The next steps for the project are to post the video online and incorporate the materials into the Disease Management adult asthma program.</p>
<p>Strategy 2.) Support a large delegate clinic system in holding asthma workshops for members out of compliance with AMR.</p>	<p>Progress Discussion: The partner delegate clinic system has not resumed holding asthma workshops due to COVID-19.</p>
<p>Strategy 3.) Collaborate with pharmacy to provide member phone consults and provider outreach that support AMR compliance for ages 21 to 44.</p>	<p>Progress Discussion: Health Education's collaboration with Pharmacy and Case Management has continued, with three rounds of member outreach calls completed between February 2021 to March 2022. A total of 18 members successfully completed the call out of 62 attempted members. It was time-consuming and difficult to reach the members, but once contacted most were willing to participate. In the first two rounds of outreach in 2021, 10 of 11 members had improved AMR scores at least two months later and 9 of 11 did not have an ED visit. The project team is interested in continuing this type of collaboration. Provider outreach regarding AMR was put on hold due to other care gap priorities.</p>
<p>Strategy 4.) Integrate African American Advisory Group recommendations into member and provider outreach.</p>	<p>Progress Discussion: There were three African American asthma advisory group meetings in total, the last one taking place in July 2021. At this meeting, Case Management and Pharmacy presented on the member outreach calls and asked for feedback on continuing the effort with Health Education.</p>

2. Access and participation in preventive care

2a. Getting routine care appointments quickly

<p>Objective 2a.) 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.</p> <p>Data source: CAHPS</p>	<p>Progress Measure: The CAHPS rate for getting a checkup or routine care appointment as soon as needed for MY 2020 was 69.7% for adults and 78.9% for children.</p> <p>Data source: 2021 CAHPS 5.1H (MY 2020)</p> <p>Progress Toward Objective: The CAHPS rate for adults increased from MY 2019 to MY 2020 by 5 percentage points and decreased for children by 4 percentage points.</p> <p>Although providers were challenged in 2020 with limited in-person visits and staffing shortages, the rate for adults improved from 2019 to 2020. This could be due to fewer people seeking care and increased access for some with telehealth options. In behavioral health data, telehealth appears to have led to fewer cancellations. The rate for children decreased, possibly because telehealth was less suitable for this population. This goal will be discontinued in 2022 to integrate Access strategies into other PNA objectives. The strategies listed here will continue as part of regular department activities.</p>
<p>Strategies</p>	
<p>Strategy 1.) Share timely access survey results and access-related grievances with delegate and directly contracted providers and discuss opportunities for improvement.</p>	<p>Progress Discussion: CAHPS survey results and access-related grievances are shared at regularly scheduled joint operations meetings with delegates. Through the Provider Appointment Availability Survey (PAAS), nonresponsive and noncompliant providers receive corrective action plans about timely access standards. Access-related potential quality issues are another way that the plan identifies issues and educates providers with grievances.</p> <p>In joint operations meetings, providers continued to share how they are working to adjust to COVID-19 and the new normal. There is opportunity to work with the Provider Services department to better understand what is going on in individual provider offices.</p>
<p>Strategy 2.) Conduct ongoing member and provider education regarding timely access standards and survey results.</p>	<p>Progress Discussion: An article about the member satisfaction survey and timely access standards was submitted for the Fall/Winter 2021 newsletter, but the publish date was delayed to May 2022. Provider notices about the PAAS survey, CAHPS surveys, and</p>

	timely access standards were distributed in Q3 and Q4 2021 via the provider packet. In Q1 2022, the provider packet included a piece specifically about routine appointment availability and timely access standards in response to CAHPS survey results. Timely access notifications will continue to be sent quarterly to providers.
Strategy 3.) Hold member satisfaction workgroup meetings to consider member feedback and implement improvement strategies.	Progress Discussion: After receiving the CAHPS results, an Alliance cross-functional workgroup met to consider improvement opportunities and plan strategies. The results and workgroup discussion were presented at the February 2022 Access & Availability Subcommittee meeting. The next steps are to continue the workgroup to discuss and develop improvement strategies with internal stakeholders.

2b. Well-child visits

Objective 2b.) 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	Progress Measure: Unknown Data source: Cotiviti HEDIS engine
	Progress Toward Objective: The two providers in this project retired, so the objective could not be measured. A new provider was identified for the birthday card and gaps in care initiative. In 2022, the Quality Improvement department decided to focus on the two W30 measures instead of WCV based on preliminary MY 2021 HEDIS results. This objective will be discontinued and replaced with a new objective around W30.
Strategies	
Strategy 1.) Encourage providers to review the gaps in care report and use it for patient outreach to schedule a well-child visit.	Progress Discussion: Gaps in care reports continue to be sent to providers. In coordination with strategy 3, the plan is to hold review meetings after the birthday cards are sent.
Strategy 2.) Provide member incentives upon completion of well-child visit.	Progress Discussion: Member incentives are provided as part of the birthday card initiative in strategy 3.
Strategy 3.) Send birthday cards to members inviting them to complete a well-child visit during their birthday	Progress Discussion: The plan is to send birthday cards to 616 members ages 3 to 17 with a birthday between April and December. The card will remind them to complete a well visit and receive a \$25 gift

month and receive a member incentive.	card. The cards were mailed out in May for children with a birthday in April and May. The project had been delayed because of the high volume of Communications and Outreach projects.
Strategy 4.) Continue provider incentive for WCV through Pay for Performance program.	Progress Discussion: In 2021, the Pay for Performance (P4P) program included 7 well child measures, including WCV. Throughout 2021 the Alliance continued to review progress and educate delegates and providers on the P4P measures. This program continues as part of ongoing Quality Improvement department work.

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

Objective 2c.) 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	Progress Measure: As of April 2022, the MY 2021 rate for Black (African American) women breast cancer screening was 46.09% (1,121/2,432). The point-in-time BCS rate as of April 2022 is 36.51% (1,043/2,857). Data source: Cotiviti HEDIS engine
	Progress Toward Objective: The BCS rate for Black (African American) women did not change from MY 2020 to MY 2021, as of April 2022. No interventions were tested during 2021 due to COVID-19 and lack of clinic staffing to engage in quality improvement projects. A partnership with LifeLong Medical Care launched in January 2022. This objective will continue in 2022 with a revision to the baseline from Measurement Year 2020 to 2021.
Strategies	
Strategy 1.) Educate members on why and where to get a breast cancer screening and provide member incentive upon completion of screening.	Progress Discussion: In January 2022, the Alliance launched a member incentive program with LifeLong Medical Care, which has multiple clinics in Oakland and Berkeley and provide care for many Black (African American) women. They are using text messaging to inform members about the incentive, why it is important to screen, and instruct them on how to schedule a mammogram. The process to get a mammogram can be challenging to follow and takes time. After the member says yes, their provider needs to sign off on the referral. Then the member needs to call a radiology site to get an appointment and complete the screening. Finally, LifeLong verifies the mammogram was completed via electronic health record review and sends their findings monthly to the Alliance along with up-to-date mailing

	addresses to send the gift card. As of June 2022, 13 gift cards have been mailed to Black (African American) members. This strategy will continue.
Strategy 2.) Ensure gaps in care reports are pulled timely by providers' staff and that they understand how to utilize the reports.	Progress Discussion: Discussions with several delegate clinics within the Community Health Center Network have shown they understand how to utilize the gap in care reports. Gap in care postcards for BCS were created, but clinics have not been interested in using them so far. Quality Improvement plans to evaluate Alameda Health Systems and directly contracted providers next. This strategy will not be included in 2022 but continues as part of ongoing Quality Improvement department work.
Strategy 3.) Discuss with providers at delegate clinic how to streamline the standing order process and address barriers for members such as transportation.	Progress Discussion: The Alliance is attempting to establish a relationship and consistent discussion schedule with a delegate clinic. This strategy will be modified in 2022 to focus on mobile mammograms.

2022 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. One objective has been marked as a health disparity objective.

1. Chronic disease self-management support

1a. Blood pressure control

<p>Objective: <i>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.</i></p> <p>Data Source: <i>Cotiviti HEDIS engine</i></p>
Strategies
1.) Support CHCN delegate with Self Measured Blood Pressure (SMBP) devices and offer quality improvement and health education resources.
2.) Evaluate program effectiveness by demographic subgroups.
3.) Explore SMBP remote patient monitoring device coverage.

1b. Diabetes control

<p>Objective: <i>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.</i></p> <p>Data Source: <i>Health Education program participation records</i></p>
Strategies
1.) Improve timely identification, outreach, and Alliance case and disease management program supports for members with poor control or care gaps.
2.) Expand reach of health coaching and improve awareness of and access to community diabetes self-management programs.
3.) Support Eastmont Wellness with incentive for members who complete a diabetes class series and with additional interventions for patients with poor diabetes control.

2. Access and participation in preventive care

2a. Well-child visits

<p>Objective: <i>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.</i></p> <p>Data Source: <i>Cotiviti HEDIS engine</i></p>
Strategies
1.) Continue funding current outreach initiatives for First 5, Children First Medical Group (CFMG), and La Clinica.
2.) Conduct outreach to non-utilizers and new members.
3.) Educate community partners, providers, and members about timely access standards for routine care appointments and track issues.

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

<p>Objective: <i>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.</i></p> <p>Data Source: <i>Cotiviti HEDIS engine</i></p>
Strategies
1.) Continue LifeLong clinic texting campaign with member incentive for breast cancer screening completion.
2.) Launch mobile mammogram and encourage appointments in coordination with other gaps in care.
3.) Create Alliance outreach and education materials for breast cancer screening.
4.) Investigate mammogram appointment availability and educate members and providers about timely access standards.

5. Stakeholder Engagement

Member Advisory Committee

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

Three focus groups were conducted in April-May 2022 with Member Advisory Committee (MAC) members to discuss the key findings and identify gaps and potential strategies. The first focus group had two Alliance members; the second had three Alliance members; and the third had three representatives from a Federally Qualified Health Center clinic, Alameda County Public Health Asthma Start Program, and Alameda County Child Health and Disability Prevention Program.

Of the five Alliance members, all were female. They were Black (African American), Hispanic (Latino), Asian, and White ethnicities. Four were seniors or persons with disabilities. They ranged from ages 29 to 72.

Health Education invited all 11 MAC members to participate in a small group discussion. The eight MAC members that agreed were sent data about the membership and summaries of potential quality and access priority areas. In the group, facilitators reviewed the packet and answered questions. Then, each MAC member was asked to identify the top priority areas the Alliance should address. Based on the responses, the group then discussed challenges for members and potential strategies for two chosen priority areas.

Contracted health care providers

PNA findings are shared with contracted health care providers, practitioners, and allied health care personnel through a quarterly provider packet communication that lists the PNA objectives and points providers to the Alliance website to view the summary and full report. In addition, the findings and action plan are presented to the Health Care Quality Committee in the fall, which includes leadership from delegates.

For providers and clinics that are stakeholders in one or more PNA objectives, the Quality Improvement department will share the relevant data and work to collaboratively address member needs.