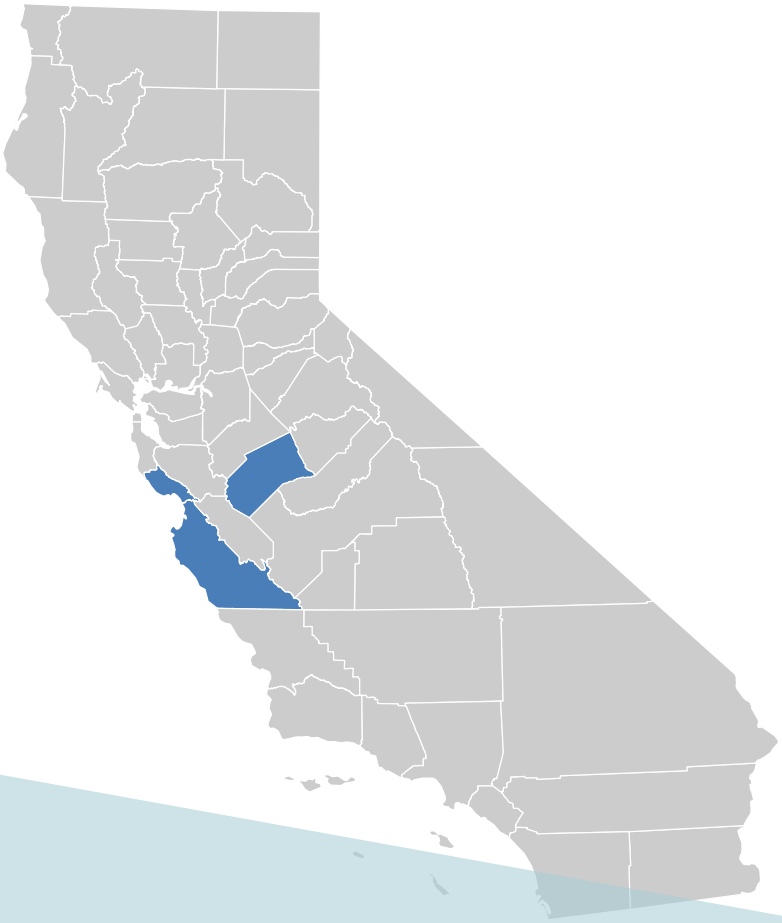
Medi-Cal

Health Education and Cultural and Linguistic Population Needs Assessment (PNA) 2021

Santa Cruz, Monterey, & Merced Counties Reporting Areas

August 12, 2021

By Quality Improvement and Population Health Department



This Report Meets the Population Needs Assessment Requirements of the Department of Health Care Services Medi-Cal Managed Care Contract

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1. Population Needs Assessment Overview

Central California Alliance for Health (the Alliance) is a regional non-profit managed health care plan established in 1996 in Santa Cruz County. Monterey (1999) and Merced (2009) counties have since been added to comprise the tri-county service area. The Alliance's primary line of business is that of Medi-Cal (99% of members) and provides IHSS services in the county of Monterey to the remaining <1% of members.[1] Using California's County Organized Health System (COHS) model, the Alliance served 333,388 Medi-Cal members in Merced, Monterey and Santa Cruz counties as of December 2020 (125,246 in Merced, 145,539 in Monterey and 62,603 in Santa Cruz, see Table 1 below).

The Health Education and Cultural and Linguistic Population Needs Assessment (PNA) focuses on health disparities, gaps in services, and health status and behaviors of Alliance Medi-Cal members in our tri-county reporting areas. The PNA also emphasizes findings related to the unique needs of Seniors and Persons with Disabilities (SPD), members with children with special health care needs, members with Limited English Proficiency, and members from diverse cultural and ethnic backgrounds. Multiple internal and external data sources were used. Findings from the PNA highlight areas of success, as well as areas of opportunities for improvement in the health plan.

To achieve this purpose, the Alliance established the following goals:

- Evaluating member health risks (*health status and disease prevalence*)
- Identifying member health needs (*access to care*)
- Identify health disparities (*social determinates of health*)
- Prioritizing and evaluating health education and Cultural & Linguistic (C&L) services, and Quality Improvement (QI) programs and resources (*unmet needs and gaps*)

The Quality Improvement and Population Health Director, Quality and Health Programs Manager, Quality and Population Health Manager, and Quality and Health Programs Supervisor provided oversight of the PNA. Development of the PNA included input from internal Continuous Quality Improvement Work Groups (CQIWs) made up of the following departments, to name a few: Member Services (MS), Quality Improvement and Population Health (QI/PH), Community Care Coordination (CCC), Utilization Management and Complex Case Management (UM/CCM), Regional Operations (RO), Strategic Development (SD), Provider Services and Information Technology Services (ITS). Additionally, the following committees were consulted and informed on the implementation and the progress of the PNA: Member Services Advisory Group (MSAG), Continuous Quality Improvement Committee (CQIC), Continuous Quality Improvement Workgroup-Interdisciplinary (CQIW-I), and Whole Child Model Family Advisory Committee (WCMFAC).

The 2020 PNA report is being referenced as a comparison throughout this 2021 PNA report as appropriate. This report was reviewed and approved by the Alliance Chief Medical Officer.

Membership Profile

The Alliance serves most Medi-Cal members in the health plan's tri-county area, including the Seniors and Persons with Disabilities (SPD) and the Whole Child Model (WCM), which include children with special health care needs populations. The largest percentage of the plan's Medi-Cal membership is made up of adults ages 18-64 (51%), followed by children and teens ages 0-17 (48%), and seniors ages 65 and older

[1] This report excludes any data using IHSS members unless otherwise noted.

(1%), see Table 1 below. This is a shift from what was reported in the 2020 PNA report, children were the largest population for the plan at 51%. Females make up a higher percentage than males (53% vs. 47%). Members with disabilities make up almost 5% of the Alliance's Medi-Cal membership. Children with special health care needs who are eligible for the Whole Child Model Program (WCM) make up 4% of the plan's child and teen Medi-Cal membership (Appendix A).

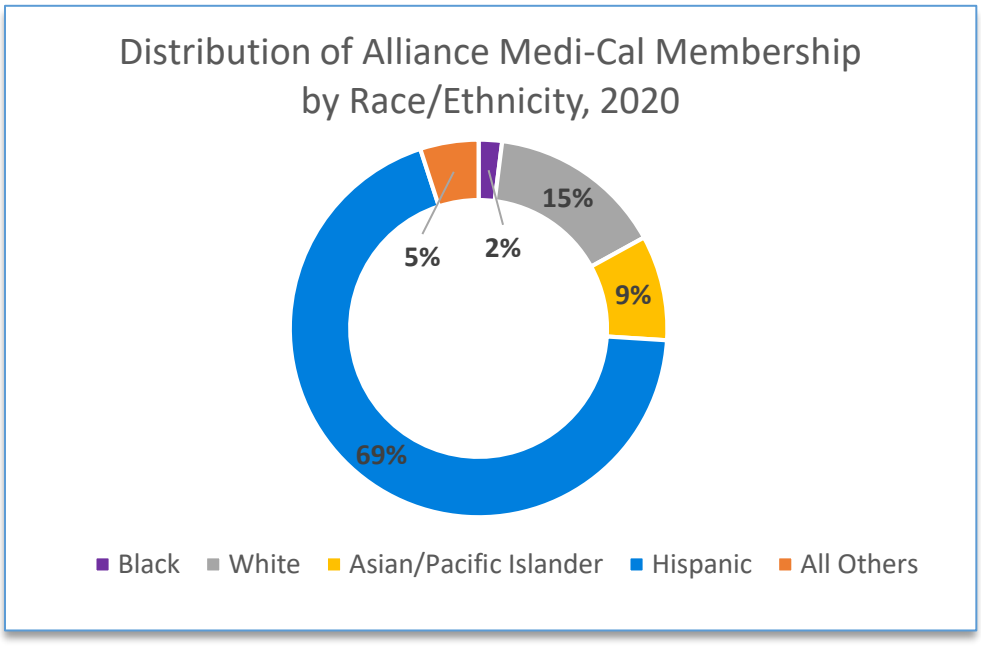
Table 1. Alliance Membership Distribution by County and Age Group, 2020

Age Group	Merced (N/%)		Monterey (N/%)		Santa Cruz (N/%)		Combined (N/%)	
0-1	5,840	5%	7,669	5%	2,388	4%	15,897	5%
2-17	53,937	43%	67,275	46%	22,032	35%	143,244	43%
18-44	47,791	38%	50,139	34%	25,324	40%	123,254	37%
45-64	16,360	13%	18,305	13%	11,881	19%	46,546	14%
65+	1,318	1%	2,151	2%	978	2%	4,447	1%
Totals	125,246		145,539		62,603		333,388	

Source: Alliance Membership Data, 2020

A large majority of Medi-Cal members self-identify as Hispanic (69%), followed by White (15%), Asian/Pacific Islander (9%), all others (5%), and Black (2%), see Figure 1 below. There was no significant change in percentages of ethnic populations served compared to the 2020 PNA. Even though the Hispanic population still represents the highest ethnic population served in 2020, the percentage of Medi-Cal members who prefer Spanish (44%) remains slightly lower than the percentage of members who prefer English (55%).

Figure 1. Proportions of Membership by Race and Ethnicity, 2020



Source Alliance Membership Data, 2020

Data Sources and Methods

The 2021 PNA data was collected from numerous reliable primary and secondary data sources described in Table 2 in the following section. The review of the global Medi-Cal population outlined above is based on data from California Department of Healthcare Services (DHCS) enrollment files and includes all Medi-Cal members only excluding those with other health coverage. Internal sources included queries of claims and encounter data, the most recent Healthcare Effectiveness Data and Information Set (HEDIS) results for HEDIS 2021 (Measurement Year 2020), provider satisfaction survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for member experience, member surveys/interviews, and member advisory workgroups. Additional external data sources were accessed from 2020 DHCS Health Disparities Data and CAHPS; the California Health Interview Survey (CHIS); the Centers for Disease Control and Prevention (CDC); the California Department of Public Health (CDPH); and the US Department of Disease Prevention and Health Promotion, Healthy People 2030 (HP2030). Other stakeholder engagement data included the Alliance Member Services Advisory Group, Whole Child Model Family Advisory Committee, and Alliance Your Health Matters community engagement initiatives.

In addition, to further assist in identifying Medi-Cal members' perceptions, preferences, and behaviors as it relates to health education and cultural and linguistic services, the Alliance conducted member and provider surveys. The Alliance recognizes that provider focus in 2020 was dedicated to managing the health and safety of patients and staff at the height of the COVID-19 pandemic. Members were also focus in keeping themselves and family members safe. Results are discussed through the lens of the unique impacts to the health care system in 2020.

- The Alliance annual PNA member outreach survey included a total of 350 members surveyed by phone during April-May in 2021. The Alliance used a standardized survey that consisted of 12 questions that were delivered to members from all categories: Limited English Proficiency (LEP), deaf and hard of hearing, child, adult, seniors and persons with disabilities, and members who have a chronic health condition(s). The survey was made available in English, Spanish, Hmong, and other languages. A total of 47 surveys were completed for an overall response rate of 13%. Participants from the PNA outreach member survey expressed a wide variety of access to care experiences, health education and cultural and linguistic needs.
- The Alliance annual Provider Satisfaction Survey assesses contracted providers' overall satisfaction with core health plan operations. Annual results are used to inform future initiatives and educational opportunities for the provider network, and in conjunction with other health plan data, provide insight into where the Alliance can focus improvement efforts. A total of 185 providers responded to the survey (the 2020 survey was conducted between September and December).
- The Alliance Member Insight Study was launched in early January 2020 but put on hold due to the pandemic, at this time a total of 25 interviews were completed. It was re-launched in January-March 2021, with a total of 53 completed interviews (the data shared in the PNA report will focus on the Jan-Mar 2021 interviews). The purpose of this study was to obtain information and feedback from Alliance members through an interview process. As part of this process, the Alliance seeks to gain insights from our Medi-Cal members on current satisfaction with the plan, opportunities for improvement and future demand. The focus was connecting with English speaking families and English and Spanish-speaking seniors in our tri-county service area.

Health Status and Disease Prevalence

Chronic conditions among children and adults continue to be a serious concern at the Alliance. In addition to heart disease, asthma and diabetes, obesity is most prevalent within members over the age of 21 and among members residing in Merced County (33%) when compared to Santa Cruz (19%) and Monterey County (25%).[i]

Food insecurity continues to be an area of focus for the Alliance. Of those surveyed through the Member Insight Study in 2021, 36% of members expressed concerns about food insecurity, likely further exacerbating some of the chronic conditions and poor perceived health status of Alliance members. Followed by 26% of members sharing that nutrition education is a resource they would need in order to stay healthy. According to the Food Research & Action Center (FRAC)[ii], food insecurity is a marker for household struggles with hunger. The results include harm to children, working-age adults, people with disabilities, and seniors. Adults and children living in a food insecure household have a multitude of problems including poorer health outcomes, learning issues and lower productivity. In 2018, the Alliance Care Management Department included two food insecurity questions designed to identify food insecure households as part of their program assessments questions. Since the inception of these two questions, results have indicated that 28% of members responded, “often true” and “sometimes true”, that they lived in a food insecure household. A total of 8,674 members have been screened for food insecurity in the Alliance tri-county servicing area, a 20% increase when compared to the 2020 PNA report. In addition, in 2020, the COVID-19 pandemic amplified the urgency to respond to food insecurity across the Alliance’s service area. The Medi-Cal Capacity Grant Program (MCGP) provided grants to health care and community-based organizations to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey and Santa Cruz counties. Grantees were able to provide fresh and healthy food to members through the Partners for Healthy Food Access (Awarded $400,000) and COVID-19 Response Fund (Awarded $1,004,608) grant programs. Access to food was also a common resource that members identified during the COVID-19 member outreach campaign efforts. Under the complex conditions brought by the COVID-19 pandemic, member outreach was critical in 2020 to inform, foster dialogue, and provide support to our at-risk members. It also ensured that no one was left behind during these times.

Emergency Department and Inpatient Utilization

Appropriate use of the Emergency Department (ED) is critical to maintain care access and continue timely and effective use of the primary care medical home. The rate of ED visits and hospital inpatient admissions have increased significantly since the 2020 PNA. As it relates to Diabetes and Heart Disease, both diseases continue to be among the top 10 inpatient diagnoses for Alliance members, which is noteworthy given that the overall inpatient utilization rate for Alliance members has decreased, from 83 admissions per thousand members per year (PKPY) in 2019, to 75 PKPY in 2020 (HEDIS MY2019, MY2020) ED and inpatient rates are highest for Infants under one year of age and persons aged 85 years and older and for Black members (Table 4). Three of the top ten diagnoses for ED visits are considered Preventable/Avoidable (Table 3).

Alliance preventive care rates compare favorably to national averages; however, there are disparities between ethnic groups for some HEDIS measures. Whites have lower rates than Hispanics and Blacks for Prenatal Care. Blacks have lower rates than Hispanics and Whites for several measures, including Asthma Medication Ratio, Well Infant Care 15 months, Well Child Care at 3-6 years, and Diabetes A1c Screening. Additional disparities occur between counties for some measures. For example, Blacks residing in Merced County have much lower rates of Immunizations for Adolescents, Childhood Immunizations (Combo 10) and Cervical Cancer Screening than those residing in the Santa Cruz/Monterey region.

Health Education, Cultural and Linguistic, and Quality and Improvement Needs

Health literacy continues to be an identified need for the Alliance. Providing care to an increasingly diverse member population that is challenged with a triad of cultural, linguistic, and health literacy barriers remains a priority of focus of the Alliance. Low health literacy, cultural barriers, and Limited English Proficiency have been coined the "triple threat" to effective health communication by the Joint Commission[iii]. Improvements in health practice that address low health literacy are needed to reduce disparities in health status. Health literacy is about equity not just information. Health literacy is about communicating health messages in ways that give everyone—individuals, families, and communities–the same chance to stay alive and live as well as possible. It's about equitable access to care and equitable treatment once you get in. People with low health literacy and Limited English Proficiency are said to be twice as likely as individuals without these barriers to report poor health status. Cultural beliefs may also impact communication between members and providers and affect a members' ability to follow a provider's instructions.

Both the 2021 PNA member outreach survey (13%) and the 2021 Member Insight Study (13%) had similar findings that indicated health literacy being a challenge that most members shared. Members also shared that phone (50%) followed by mail (44%) is their preferred way to receive information from the Alliance. In addition, the 2021 PNA member outreach survey indicated the top topics for which members are mostly interested in receiving information or help from the Alliance include:

- Nurse Advice Line (34%)
- How to handle a chronic condition (17%)
- Choosing a Doctor (17%)
- More information on transportation benefits (33%)

The 2021 PNA report was written to meet the requirements of the Department of Health Care Services (DHCS) All Plan Letter 19-011 and was completed within the context of the ongoing COVID-19 pandemic and public demonstrations. It is important to acknowledge this context because the pandemic has amplified social inequalities for communities of color and most importantly, we know that social determinants of health influence and significantly impact an individual or community's level of vulnerability in a public health crisis, including inequity in access to health care and health information. Ensuring that Alliance members have the information they need has become vital during these critical times and developing them in a way that is culturally appropriate is always a best practice to improve program engagement and outcomes with members. The 2021 PNA report may include information on how the ongoing crisis is currently impacting how the local community thinks about health, access to primary care, and maintaining well-being and connection within a community, and it may also include information that reflects historical information only.

Action Plan

Since the completion of the 2021 PNA report, the Alliance has developed several interventions to address the identified gaps. Findings from the 2021 PNA report highlight areas of success, as well as areas of opportunities for improvement in the health plan. Based on the findings outlined in the 2021 PNA report, the following are key recommendations for the 2021-2023 planned actions for the Alliance tri-county servicing areas.

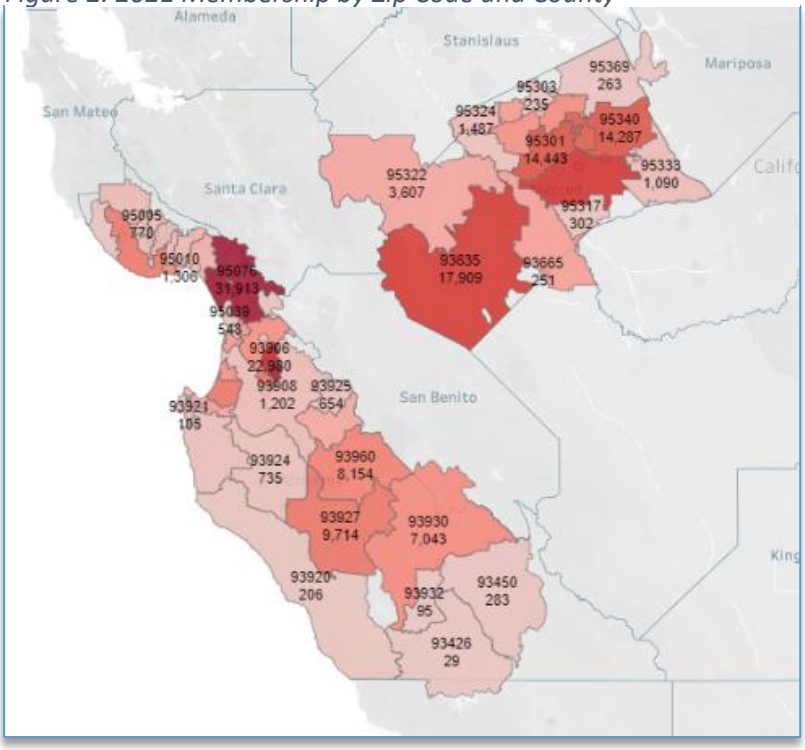
1. ***Access to Care***: By December 31, 2022, increase the percentage of members who report in CAHPS they were 'usually' or 'always' able to get care quickly by 2%, from 81.7% (adult) and 86.6% (child) to 83.7% (adult) and 88.6% (child) in all three service counties.

2. ***Cultural and Linguistic***: By December 31, 2022, increase staff/provider utilization of telephonic interpreting calls by 4% from 28,825 to 29,978 and provider utilization of on-site face-to-face interpreting during medical visits from 1,127 to 1,172 in all three service counties for Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members.
3. ***Health Disparities:*** By June 30, 2023, increase the percentage of members who attend their well-child visits (W30) in the first 30 months by 5% from 62.39% to 67.39% and their childhood immunization rate (CIS-10) for 2 years old from 21.65% to 26.65% in Merced County.
4. ***Health Education/Quality Improvement***: By December 31, 2021, at least 50% of Healthier Living Program participants will have reported "Good/Very Good/Excellent" in their ability to manage their chronic health condition(s).

2. Introduction

Central California Alliance for Health (the Alliance) is a regional non-profit managed care plan using the California's County Organized Health System (COHS) model. The Alliance was established in 1996 in Santa Cruz County, followed by Monterey and Merced Counties, the Alliance serves a tri-county service area. The Alliance provider network consists of contracted providers to promote prevention, early detection and effective treatment, and seeks to improve access to quality health care for Alliance members. The Alliance has pursued this mission through incorporation of the Patient Centered Medical Home, which links members to primary care physicians who deliver timely services and preventive care and arrange appropriate referrals to specialty care. The Alliance served 333,388 Medi-Cal members in Merced, Monterey and Santa Cruz counties as of December 2020 (125,246 in Merced, 145,539 in Monterey and 62,603 in Santa Cruz), see Figure 2, Source: Alliance Enrollment Files for 2021. Since the 2020 PNA report, annual enrollment data show membership slightly decreased by 1.4% or 4,860 members. This includes members with at least one month of eligibility during the calendar year who may not have been continuously enrolled, and would explain the overall decrease from 2019 to 2020. However, member month data show membership actually increased between 2019 and 2020 amid the COVID-19 pandemic. For example, in December 2019, the Alliance served 335,287 members compared to 365,230 members in December 2020. It is expected membership will continue to increase relative to pre-pandemic rates.

Figure 2. 2021 Membership by Zip Code and County



3. Data Sources and Methods

2021 PNA Data was collected from primary and secondary reliable sources. Aside from the global Medi-Cal population outlined above, all analysis is based on data for Medi-Cal members only and excludes those with other health coverage including Medi-Care unless otherwise noted. This methodology is consistent with the 2020 PNA report. Numerous internal and external sources were utilized to support the information provided in this report. The sources and methods used are described below, see Table 2 for data sources used for this 2021 PNA report.

Table 2. *Data Sources Used For the PNA*

Population Needs Assessment Data Sources		
Source Name	**Source Description**	**Internal/External**
CAVE Business Intelligence tool	Ranking of medical conditions by age group, child (0-20 years) and adult (21+). This data was pulled using claims from these dates of service: 10/1/2019-9/30/2020. Note, members with Medi-Care or other Health coverage were not excluded from this analysis.	Internal
Claims, Enrollment and Encounter data	Medical claims for all Alliance members enrolled was used for medical condition tables that reflects dates of service for members enrolled during this time (1/1/2020-12/31/2020). Only finalized claims (paid or denied) are used from the Alliance data warehouse. Authorization data was used for the prior three years (2018-2020). DHCS enrollment files were used to support data and calculated rates reported for 2020 and 2021.	Internal
Grievance and Appeals Data	In 2020 Alliance Grievances were assessed to review if there were any trends related to unmet needs and gaps in care.	Internal
Membership Data	Membership as of December 31, 2020. Enrollment data were stratified by county of enrollment, age, race and ethnicity, spoken language, disability status, Whole Child Model (WCM) program enrollment and zip code of residence. Data were retrieved April 16, 2021. Data is described in detail in the Membership Profile section. (Appendix A)	Internal
Healthcare Effectiveness Data and Information Set (HEDIS) data	Inovalon, an NCQA-certified vendor supported the Alliance in the Medical Record Review for measurement year 2020. The Alliance reported out on 13 Hybrid (chart review) measures and 26 administrative measures. Monterey and Santa Cruz counties are reported as a unit and Merced County separately. The Alliance passed 2021 Medical Review audit successfully. (Appendix B)	Internal
PNA Member Outreach Survey	In 2021, the Alliance administered a telephonic survey to members using standardized questions. A total of 47 surveys were completed. Bilingual English/Spanish/Hmong/other languages surveys were conducted to a random sample of 350 members who met the sample criteria. To generate interest and increase the likelihood of response, the first 100 members to complete the survey won one $25 gift card. Of the 350 members on the list to call, a total of 47 were completed, for a response rate of 13.4%. See Section G for the analysis of the member survey results.	Internal
Medi-Cal Capacity Grant Program (MCGP)	In 2020, the MCGP provided immediate relief during the coronavirus pandemic by establishing the COVID-19 Response Fund. The COVID-19 Response Fund was created to meet the	Internal

	urgent challenges facing Alliance members during the pandemic. In addition to the $600,000 awarded to local food banks, $400,000 was awarded to local entities to meet members' evolving needs, including funding for diapers and formula, meal delivery for high-risk members, and personal protective equipment and sanitizing supplies for providers of food and homeless services.	
Your Health Matters Outreach Program	Purpose is to provide education and resources to Alliance members during community events that are sponsored in the Alliance tri-county areas. Due to COVID-19 in 2020, Alliance staff conducted telephonic surveys to assist member in navigating the health care system and access care. In 2020, the outreach program completed 22 outreach campaigns in-person and drive through, impacting the Alliance tri-county service areas. A total of 2,486 members were reached out and 90 member surveys were completed. As for telephonic outreach, a total of 5 outreach efforts were conducted with a total of 1,584 members reached.	Internal
Member Outreach Campaigns	In 2020, the Alliance launched a series of member outreach campaigns to connect, educate, and support members who were impacted by all of the emergent issues (i.e. COVID-19, wildfires, air quality, water shut-offs, and PSPS events). A total of 131,113 members were outreached. Outreach interventions range from live calls, mailing, and robocalls.	Internal
Member Insight Study	In 2021, the Alliance engaged in obtaining information and feedback from Alliance Medi-Cal members through semi-structured interviews. Interviews were designed to gain insights from Alliance members on: satisfaction with the plan, opportunities for improvement, and future demand. Two target groups were interviewed: Families (with children 0-21) and Seniors (65+). A total of 53 interviews were completed in the Alliance tri-county service areas.	Internal
Provider Satisfaction Survey	The Alliance conducts an annual Provider Satisfaction Survey in order to assess contracted providers' overall satisfaction with core health plan operations. Annual results are used to inform future initiatives and educational opportunities for the provider network, and in conjunction with other health plan data, provide insight into where the Alliance can focus improvement efforts. In 2021, a total of 185 provider surveys were completed.	Internal
California Health Interview Survey (CHIS)	Is a random-dial telephone survey conducted on a continuous basis and covers a wide range of health topics. CHIS reports provide a detailed picture of the health care needs of California's large and diverse population overall and at the county level. Data was compiled that reflects 2015-2019 for the Medi-Cal members in each respective county unless otherwise noted. https://healthpolicy.ucla.edu/Pages/home.aspx	External
Centers for Disease Control and Prevention (CDC)	Provides data on obesity for children and adults in the US.	External
Required Consumer Assessment of Healthcare	SPH Analytics, a NCQA-certified vendor conducted the survey of the Alliance members in 2020. The look back period is six months and the measurement period for the survey was between	External

Providers and Systems (CAHPS) Data	January 2019 and December 2019. The survey was administered in English and Spanish in Merced, Monterey and Santa Cruz Counties. SPH Analytics used a two-wave mail methodology with a phone follow up to non-respondents.	
DHCS Required Health Disparities Data & DHCS CAHPS	2020 Health Disparities data and CAHPS specific to the Alliance received from DHCS.	External
California Department of Public Health (CDPH)	Provides a variety of health-related data including the chronic disease prevalence, the leading causes of death by county, and County Health Status Profiles (2020).	External
Office of Minority Health, U.S. Department of Health and Human Services (OMHRC)	The OMHRC is a source for minority health literature, research, and referrals for consumers, community organizations and health professionals. The most recent Census Bureau projections data were used (2015).	External
Robert Wood Johnson Foundation	County Health Rankings and Roadmaps (2021).	External
US Department of Disease Prevention and Health Promotion - Healthy People 2030 (HP2030)	Provides evidence-based data and 2010-2030 (11-year) national objectives for improving the health of all Americans. Benchmarks used as reference points.	External
Health Resources and Services Administration (HRSA)	The Health Professional Shortage Area (HPSA) Find tool displays data on the geographic, population, and facility HPSA designations throughout the U.S.	External

Health Plan Data

Claims and encounter data were used to report on inpatient, emergency department, and behavioral health utilization, and Whole Child Model (formerly known as California Children's Services) program participation. HEDIS data were used to report on preventive care rates. Member demographic information was self-reported on the Medi-Cal application and transferred via electronic download from the Department of Healthcare Services (DHCS) Medi-Cal Managed Care Division (MMCD) to the Health Solutions Plus (HSP) system. Aside from the global Medi-Cal population, all analysis is based on data for Medi-Cal members only with at least one month of eligibility during calendar year 2020. This equates to 125,246 in Merced, 145,539 in Monterey and 62,603 in Santa Cruz. Comparisons to the 2020 PNA were made, where applicable.

4. Key Findings

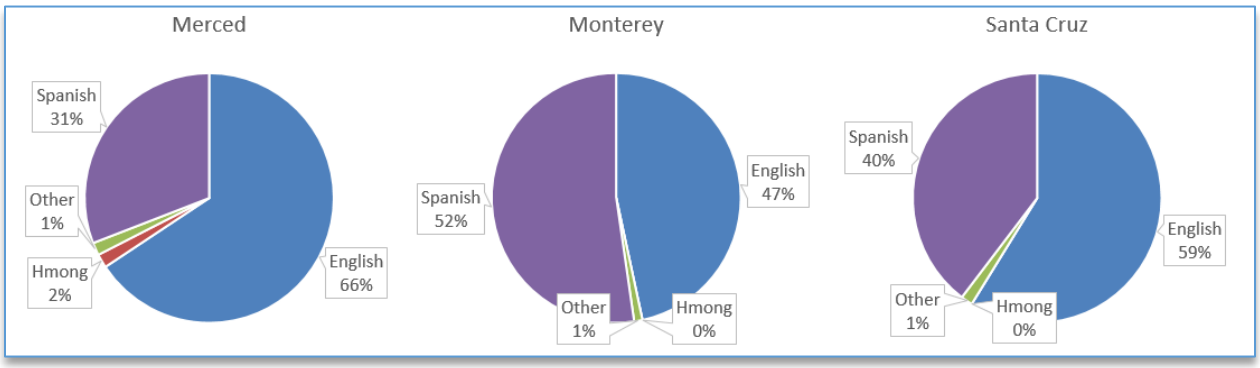
A. Membership Demographic Profile

Since the 2020 PNA report, the proportion of Medi-Cal members under age 18 has decreased across all three counties: 48% to 43% in Merced, 41% to 34% in Santa Cruz, and 52% to 47% in Monterey. Meanwhile, the proportion of members aged 18 to 64 increased: 51% to 56% in Merced, 58% to 63% in Santa Cruz, and 46% to 51% in Monterey. The decrease in pediatric membership may be attributed to the recent expansion of full scope Medi-Cal to young adults under the age of 26, regardless of immigration status. During this same time period, it is also possible more adults gained coverage relative to children

due to increasing unemployment rates. According to the Current Population Survey, unemployment rates in all three counties increased from December 2019 compared to December 2020: 8.5% to 11.0% in Merced, 5.2% to 8.1% in Santa Cruz, and 7.0% to 10.3% in Monterey. The percent of members 65 and older slightly increased to 2020 findings at 2% in all counties. Overall proportion of gender identification is unchanged since 2020 at 53% Female, 47% Male, source is Alliance Membership data.

Most Medi-Cal members in Merced, Monterey and Santa Cruz counties identify as Hispanic (69%), followed by White (15%), Asian/Pacific Islander (9%) all others (5%) and Black (2%). Overall, the number of members who prefer English as their spoken language has remained at 55%, while the percentage of those who'd prefer Spanish has slightly increased from 43% to 44%, see Figure 3 for county-specific findings. For details about SPD, WCM and Non-SPD populations by spoken language, see Appendices D's tables.

Figure 3. Alliance Membership Spoken Language by County, 2020



Source: Alliance Membership Data, 2020

Seniors and Persons with Disabilities (SPDs) account for almost 5% of the Alliance membership in Merced, Monterey and Santa Cruz counties and males make up the marginal majority (51%).[iv] Most of the SPD population is between the ages of 18 and 64 (63%), followed by ages 65 or older (19%). Hispanics represent 42% of SPDs, followed by Whites (24%) and Asian/Pacific Islanders (23%). This stratification is noteworthy, given that the percentage of SPDs from each of these ethnic groups differs from their overall membership.

Through the WCM program, children up to age 21 can get the health care and services they need. There are currently 6,523 Medi-Cal members who are receiving services through WCM, in the Merced County (2,634), Monterey County (2,994) and Santa Cruz County (895). Approximately three-quarters (73%) of WCM members are Hispanic, 13% are Asian/Pacific Islander, 9% are White, and 2% are Black. Currently 13% of WCM members are age 1 or under, followed by 73% ages 2 to 17 and 14% ages 18 to 21.

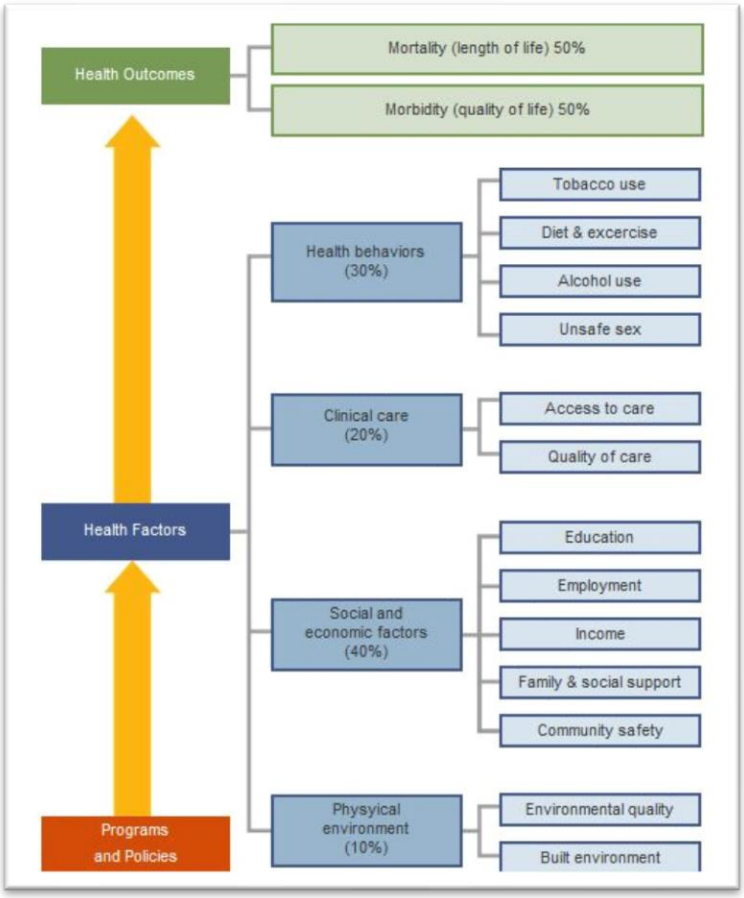
B. Health Status and Disease Prevalence

Overview and Methodology

Beginning with an overview of the health measures collected from the Robert Wood Johnson Foundation (RWJF) county reports and followed by other internal and external data sources, current health issues facing our communities and specifically upon our members will be explored. Regarding residents' assessment of their health (a measure of quality of life), the 2021 County Health Rankings data indicate

that 28% of Merced residents rate their health as fair or poor, compared to 24% in Monterey and 16% in Santa Cruz.[v] On average, 18% of Californians rate their health as fair or poor, indicating that Monterey and Merced are outliers among California Counties. More alarming is the average number of mental health days reported as unhealthy in the past 30 days, of which there were 5.0 in Merced compared to 4.3 in Santa Cruz and 4.4 in Monterey. With the statewide average at 3.7, all counties within the Alliance Service Area are at or worse than the statewide average of mentally unhealthy days.

Figure 4. County Rankings Model for Population Health



The RWJF report assesses length of life through rates of premature death as defined as years of potential life lost before the age of 75 (Years of potential life lost before age 75 per 100,000 population (age-adjusted to 2020). For this measure, Santa Cruz and Monterey are among the better performers in California (which has a rate of 5,300 years lost), with rates of 4,700 and 5,100 years lost in these counties respectively (years 2016-18 combined), while Merced's rate is significantly higher at 6,600 years lost for the same time period. In terms of overall health rankings, Santa Cruz County ranks 9th (1st quartile) as determined by how long people live and how healthy people feel, while Monterey is in the second quartile (20th) and Merced is in the third quartile (38th), indicating significant differences in actual and perceived health between counties in the Alliance Service Area.

Health factors as measured by the RWJF include health behaviors, clinical care (defined as access to care, quality of care), social and economic factors, and the physical environment, and in this regard Santa Cruz again ranks in the top quartile, while Monterey is in the second and Merced in the third. The County Rankings Population Health model (Figure 4) supports these observations and helps the Alliance align data here; more will be described under Key Findings and Action Plan.

C. Food Insecurity Findings

Many Alliance members experience food insecurity challenges, and it is directly tied to low-income status and economic instability. People with limited income often have to choose between paying for rent, food or medication. The impact of food insecurity on health outcomes and quality of life is significant:

- Higher risk of chronic disease such as diabetes, obesity and hypertension.
- Impaired concentration and school performance in children, which is linked to higher levels of behavioral and emotional problems from preschool through adolescence.
- Physical and mental problems in pregnant women, as well as birth complications.
- Slowed healing, increased health complications, lengthened hospital stays and increased admission to hospitals and long-term care facilities.

The impact is also costly. In 2014, national health-related expenses attributable to food insecurity were estimated at $160 billion, nearly equal to the direct medical costs from annual diabetes care. Food insecurity is a complex but preventable condition in need of innovative, multi-sector solutions among health care providers, community-based organizations, government agencies and the private sector. Adults and children living in a food insecure household have a multitude of problems including poorer health outcomes, learning issues and lower productivity. Food insecurity continues to be an area of focus for the Alliance.

The 2021 PNA member outreach survey also revealed that a number of Alliance members who were surveyed were experiencing food insecurity in their households. The Alliance has made it a priority to support prevention and wellness by prompting member engagement and partnering with community partners to address the Social Determinants of Health (SDoH). The Alliance continues to engage and develop unique initiatives to address food insecurity among members living in the Alliance tri-county servicing areas:

- In 2018, the Alliance formed a food insecurity workgroup, focused on identifying and addressing members' needs. The workgroup led the integration of food insecurity screening in Care Management assessments, utilizing the Hunger Vital Sign, which is a 2-question food insecurity screening tool based on the US Household food Security Scale. Members who are identified as experiencing food insecurity are offered connection to local, free food resources. As of the end of 2020, 8,674 members have been screened and 2,431 (28%) of members responded, “often true” and “sometimes true”, that they lived in a food insecure household. This is a 20% increase when compared to the 2020 PNA report.
- Of those surveyed through the Member Insight Study in 2021, 36% of members expressed concerns about food insecurity, likely further exacerbating some of the chronic conditions and poor perceived health status of Alliance members. Followed by 26% of members sharing that nutrition education is a resource they would need in order to stay healthy.
- In addition, in 2020, the COVID-19 pandemic amplified the urgency to respond to food insecurity across the Alliance’s service area. The Medi-Cal Capacity Grant Program (MCGP) provides grants to health care and community-based organizations to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey and Santa

Cruz counties. Grantees were able to provide fresh and healthy food to members through the Partners for Healthy Food Access (Awarded $400,000) and COVID-19 Response Fund (Awarded $1,004,608) grant programs. Examples of projects include:

a. Food prescription program with mobile market for locally gardened fresh fruits and vegetables.
b. Youth-focused sustainable produce program with referral to farm stand and nutrition/ cooking education.
c. Accessible, nutritious food distribution sites and nutrition/cooking classes for individuals, families and In-Home Support Services workers.

- The Alliance launched a post-discharge meal delivery pilot program in October 2018. This program provides home-delivered meals to complex patient's post-hospital discharge, with the goal of reducing hospital readmissions and emergency department utilization. Pilot participants receive fourteen medically tailored meals per week for twelve weeks post-discharge and are referred for case management support to ensure linkage to ongoing support. A total of $650K has been allocated to the meal delivery service with two vendors serving the three counties in the Alliance's service area. As of this writing, the pilot has served 494 members with over 70,200 home-delivered meals.
- Access to food was also a common resource that members identified during the member outreach campaign efforts. Under the complex conditions brought by the COVID-19 pandemic, member outreach was critical in 2020 to inform, foster dialogue, and provide support to our at-risk members. It also ensured that no one was left behind during these times.

Addressing food insecurity ties into the Alliance's vision of "healthy people, healthy communities." The Alliance has a long history of expanding support and resources to members and continues to look for innovative and effective ways to invest in member health and wellness.

Health Issues and Health Care Utilization

According to California Health Interview Survey (CHIS) the most prevalent chronic health conditions for (2015-19 combined) in the Medi-Cal populations in Merced, Monterey and Santa Cruz counties (all indicated respectively) include asthma (18%, 14% and 13%), cardiovascular disease (4%, 7% and 7%), diabetes (18%, 13% and 11%), and needed help for emotional/mental health problems or use of alcohol/drug (2019 only) (22%, 12% and 48%). It is also critical to note that CHIS data found that members that were overweight or obese remains highest in Merced and Monterey County (56%, 48% and 34%) and is overall prevalent in the region.

While Obesity is not an acute health condition, it is critical to acknowledge and monitor because of its significant relationship to its role in the severity of asthma, diabetes, cancer and cardiovascular conditions and others. As a health plan, obesity impacts many other health conditions with significant outcomes, it is associated with cognitive decline, school absenteeism, and long-term negative economic consequences. This is considered a "lifestyle" condition, but the literature confirms that a person who is an otherwise healthy person overweight or obese is at increased risk for these conditions.[vi,vii] Our membership, especially those who identify as Black or Hispanic, experiencing obesity present a unique opportunity to prevent and mitigate severe outcomes and premature mortality. Recognizing the need to support our membership experiencing obesity, the Alliance implemented a Diabetes Prevention Program in 2017.

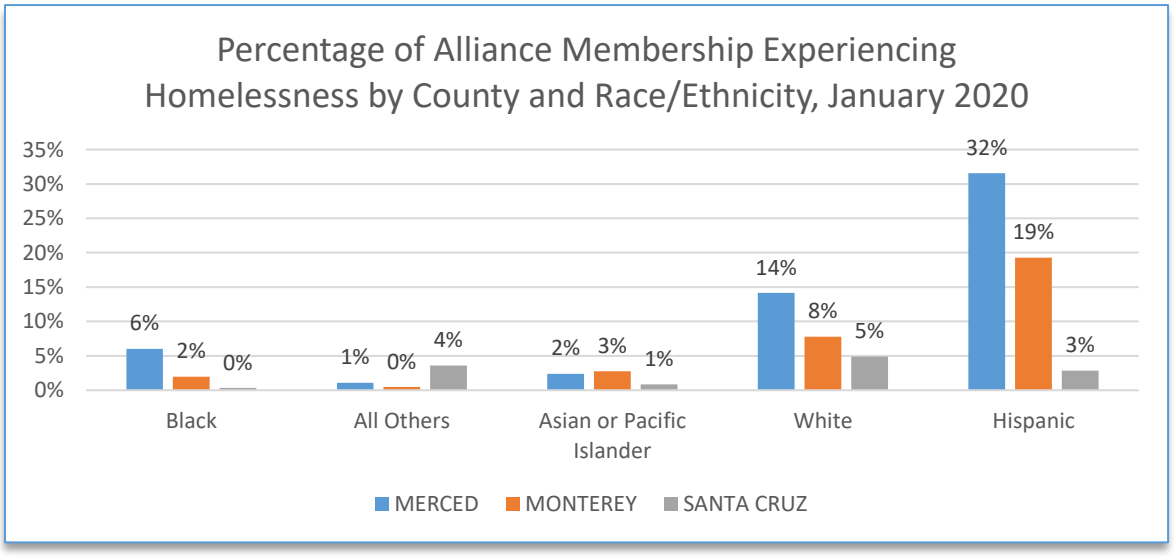
Homelessness continues to be one of the most challenging issues facing California and is likely to worsen with the COVID-19 pandemic. According to the U.S. Interagency Council on Homelessness, more than a quarter of the U.S. homeless population were in California in 2019. Homelessness has also emerged as a priority issue for the Alliance. Enrollment data for December 2020 reveal 25,478 members experienced homelessness, defined as an

> "Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution (Housing and Urban Development)".

This translates to almost 8% of the Alliance's membership, and remained almost unchanged compared to December 2019, during which 24,512 members reported experiencing homelessness. For details about homeless populations by race/ethnicity, age, and spoken language see Appendix C tables.

Merced County accounts for more than half of the Alliance's homeless membership (55%), followed by Monterey (32%), and Santa Cruz (13%) counties. Overall, Hispanic members are experiencing higher rates of homelessness (54%), followed by White (27%), Black (8%), Asian/Pacific Islander (6%), and all other members (5%). See Figure 5 below for county specific percentages by race/ethnicity. The largest percentage of the plan's homeless membership is between the ages of 18 and 44 (50%), followed by pediatric members ages 2-17 (27%). Males make up a higher percentage than females (54% vs 46%).

Figure 5. Homelessness by Race and Ethnicity

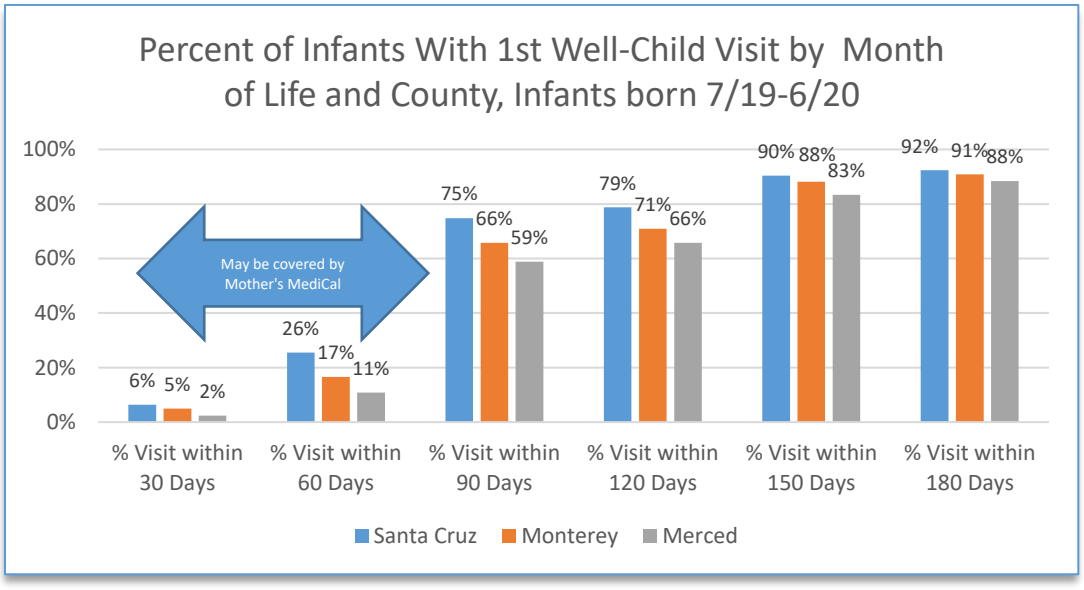


The Alliance recognizes the direct link between housing and health, and how the pandemic has increased the urgency to respond to homelessness. In 2020, the Alliance provided housing support to community partners across Santa Cruz and Merced counties through its Medi-Cal Capacity Grant Program to help

meet members' evolving needs. In Santa Cruz, the Alliance awarded the non-profit *Housing Matters* two separate grants. Through a $2.5M Capital Implementation Grant, the Alliance supported the construction of a permanent supportive housing complex on the Housing Matters' Santa Cruz campus. The Alliance also supported the Recuperative Care Center at Housing Matters through $1.5M in grant funding from its Recuperative Care Pilot Program. The pilot program funds housing for members who are currently experiencing homelessness and recovering from an acute illness or injury. During the same time, the Alliance helped fund the construction of the County of Merced's Navigation Center through its Capital Implementation Grant. The center provides a variety of services to individuals experiencing homelessness in Merced, including low-barrier, emergency shelter.

Timely access to care remains a challenge for some infants. Figure 6 below describes timely access to care for infants by county. Infants born to Alliance members are covered under their mother's plan for their month of birth and the following month, up to 62 days depending upon month of birth. In California, there is no mechanism to automatically enroll the infant into Medi-Cal, therefore we see a frequent gap in coverage at a critical period in the infant's development. Santa Cruz County's United Way has a program that meets mother's in the hospital after delivery and helps them complete the infant's Medi-Cal application. This intervention is reflected in Figure 6 (below) with 26% of kids born in Santa Cruz having their first well check in their second month of life. Santa Cruz continues to lead the way up to six months of age. Finally, another important detail is that the 12% of infants in Merced without well childcare at 6 months of age, 3% points behind Monterey and 4% points lower than Santa Cruz County. This access to care is critical for infants for evaluation and as needed to provide early intervention services to improve physical, verbal, emotional and behavioral outcomes for children.

Figure 6. Percent of Infants with Timely Initiation of Well Child Care by County



Source: Claims data

Another view of the Alliance's membership's health issue(s) is provided to us through a review of claims data and the most frequently coded conditions for children (0-20 years) and adults (21 years+), Table 3 below. The top medical conditions were consistent across the counties, with the top condition for children as Upper Respiratory infections and for adults, other arthropathy disorders and low back pain as

well as Diabetes and Hypertension were noted in the top five conditions. It is noted that some of the conditions lacked specificity and require additional review and information to understand the underlying health issues.

Table 3. *All Claims Data, Most Common Health Conditions, Children and Adults, 2020*

	Members 0-20 years of age		Members 21+ years of age	
County	Episode	Members	Episode	Members
MERCED	Upper respiratory infections	12657	Other arthropathy disorders	7697
	General presenting symptoms	8384	Low back pain	7221
	Otitis media	4621	Diabetes w/no complications	6464
	Other arthropathy disorders	3651	Hypertension	5791
	Abdominal pain	3137	Disorders of lipid metabolism	4902
MONTEREY	Upper respiratory infections	14968	Diabetes w/no complications	7931
	General presenting symptoms	11859	Other arthropathy disorders	7106
	Otitis media	4971	Low back pain	6746
	Other arthropathy disorders	3659	Hypertension	6029
	Dermatitis and eczema	3048	Disorders of lipid metabolism	5851
SANTA CRUZ	Upper respiratory infections	4759	Other arthropathy disorders	4165
	General presenting symptoms	3425	Diabetes w/no complications	3709
	Otitis media	1457	Low back pain	3614
	Other arthropathy disorders	1335	General presenting symptoms	3207
	Dermatitis and eczema	1244	Hypertension	3080

Source: CAVE BI Tool

The rate of Emergency Department (ED) utilization among members in this region was 264 PKPY in Merced, 237 PKPY in Monterey and 239 in Santa Cruz (Alliance Claims Data, 2020). The higher rate in Merced County holds true across most demographics and in the number of visits determined avoidable (11% Merced County, 10% in Monterey, and 10% in Santa Cruz,) based on an algorithm developed by New York University. The impact from COVID-19 pandemic is visible here with decreased ED utilization across all three counties and is also impacting our avoidable ED rates. Finally, referring to the Table 4 below we can examine all three counties for differences between infants and our oldest members respectively by racial/ethnic groups. It is important to note that some of these rates—including children less than one year and adults over 65—are impacted by the small number of members in those categories.

Table 4. *Emergency Department Visit Rates by Race and Age per 1,000 Members, 2020*

Age Groups	All Others	Asian or Pacific Islander	Black	Hispanic	White
Ages 00-01	614.8	604.4	957.8	721.1	576.6
Ages 02-17	276.7	151.6	391.5	292.3	303.3
Ages 18-44	578.6	375.5	1058.0	711.0	757.6
Ages 45-64	712.0	509.2	1313.9	795.3	933.8
Ages 65+	555.8	444.4	1175.4	692.3	860.6

The most common ED diagnoses reported for all members during 2020 are shown in Table 5. Like the diagnosis list from claims data in Table 3, the primary diagnosis or conditions listed here are less specific and fail to fully illustrate the health conditions of the member. Unfortunately, this table also displays the use of the ED for common mild acute illnesses that can be addressed by their Primary Care Provider. From this list, there is still an opportunity to create a culture where the PCP is the first point of contact for all health issues.

Table 5. *Top Ten Most Common Primary Emergency Department Visit Diagnoses, 2020*

Primary Diagnosis	Count
ABDOMINAL AND PELVIC PAIN	7689
Unknown	7127
ACUTE UPPER RESPIRATORY INFECTIONS OF MULTIPLE AND UNSPECIFIED SITES	5797
CONTACT WITH AND (SUSPECTED) EXPOSURE TO COMMUNICABLE DISEASES	5352
PAIN IN THROAT AND CHEST	5185
ENCOUNTER FOR MEDICAL OBSERVATION FOR SUSPECTED DISEASES AND CONDITIONS RULED OUT	5020
DORSALGIA	3196
ACUTE PHARYNGITIS	2641
COUGH	2552
OTHER JOINT DISORDER, NOT ELSEWHERE CLASSIFIED	2547

Table 6. *Inpatient Admission Rates by Race and Age per 1,000 Members, 2020*

	All Others	Asian or Pacific Islander	Black	Hispanic	White
Ages 00-01	38.25	17.78	44.55	35.08	34.33
Ages 02-17	13.00	0.00	13.79	11.20	11.43
Ages 18-44	84.71	78.84	111.61	103.71	81.23
Ages 45-64	130.87	111.77	212.16	121.82	164.39
Ages 65+	142.93	149.39	227.50	171.82	200.09

As listed above, diabetes and cardiovascular disease from CHIS data are also among the top inpatient diagnoses for Alliance members, as shown in Table 6. Of note, the Whole Child Model population is included in the inpatient admissions, which may include pre-term infants and chronic pediatric illnesses. In this table, we see mostly maternal child health admissions along with heart disease and diabetes. Finally, this data only reveals the leading diagnosis, not illuminating the complete health status of the member represented by the data. Table 7 below reports the most common reasons for inpatient admissions for all members, 2020. Majority of diagnoses are related to pregnancy and delivery. Despite this we see Diabetes Mellitus and Hypertensive Heart and Chronic Kidney Disease which links to HEDIS measures and all claims data with these conditions as well.

Table 7. *Most Common Primary Diagnoses for Inpatient Admissions, All Members, 2020*

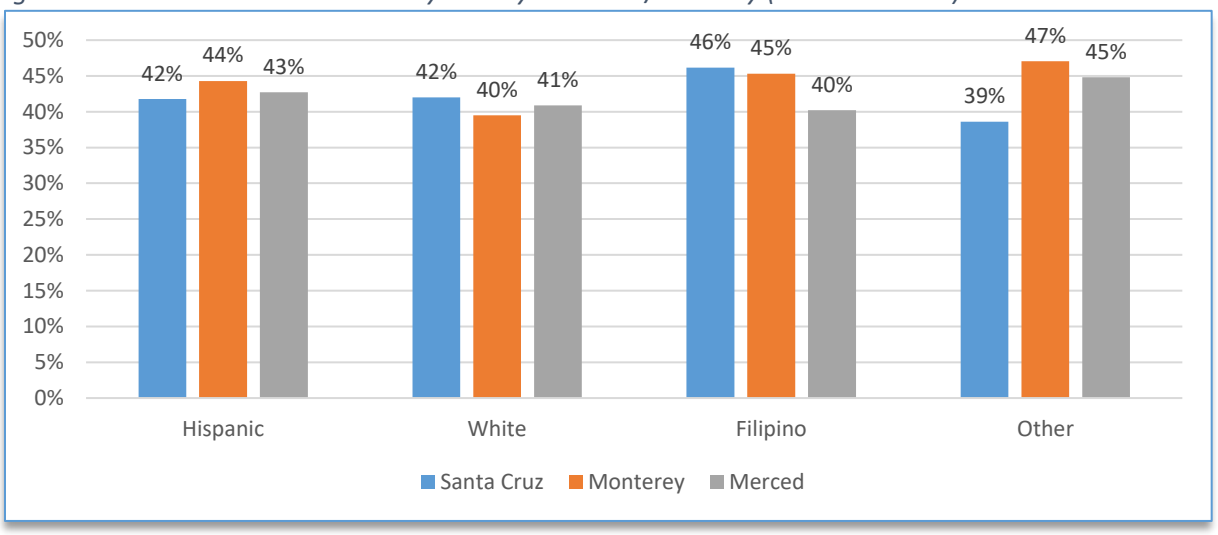
Diagnosis and Count of Admissions	
UNKNOWN	2699
LIVEBORN INFANTS ACCORDING TO PLACE OF BIRTH AND TYPE OF DELIVERY	2391
SEPSIS	1849
OTHER MATERNAL DISEASES CLASSIFIABLE ELSEWHERE BUT COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	634
LATE PREGNANCY	632
DIABETES MELLITUS	423
PREMATURE RUPTURE OF MEMBRANES	394
CHOLELITHIASIS	303
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	281
CELLULITIS	280

HEDIS Findings

HEDIS 2021 reported rates for Measurement Year (MY) 2020 were reasonable condition given the extensive impact on primary care services by the COVID-19 pandemic. Despite the pandemic the Alliance's Santa Cruz-Monterey Region still experienced high performance in key measures childhood and adolescent immunizations, postpartum care and asthma medication ratio. Measures that challenged the Alliance included, Controlling High Blood Pressure, Diabetes measure for HbA1c Control, Childhood Immunizations (Merced), Breast Cancer Screening, and Chlamydia Screening in Women. Full HEDIS MY2020 results are in Appendix B, select findings will be highlighted in this section, note that when a racial/ethnic group denominator count falls below 11, it will not be displayed. The one measure where the entire region was experiencing challenges is Well Child Visits in the First 15 Months of Life-6 visits (W30-6+). Analysis to this point highlights the challenge of securing data from the well child visits that occur under the mother's medical plan ID, followed by frequent gap of coverage for the child moving to their own coverage and PCP. Finally, the lack of access to strong pediatric medical homes impacts the initiation and frequency of visits, members often failing to stay on the recommended Bright Futures schedule and consequently this measure.[viii]

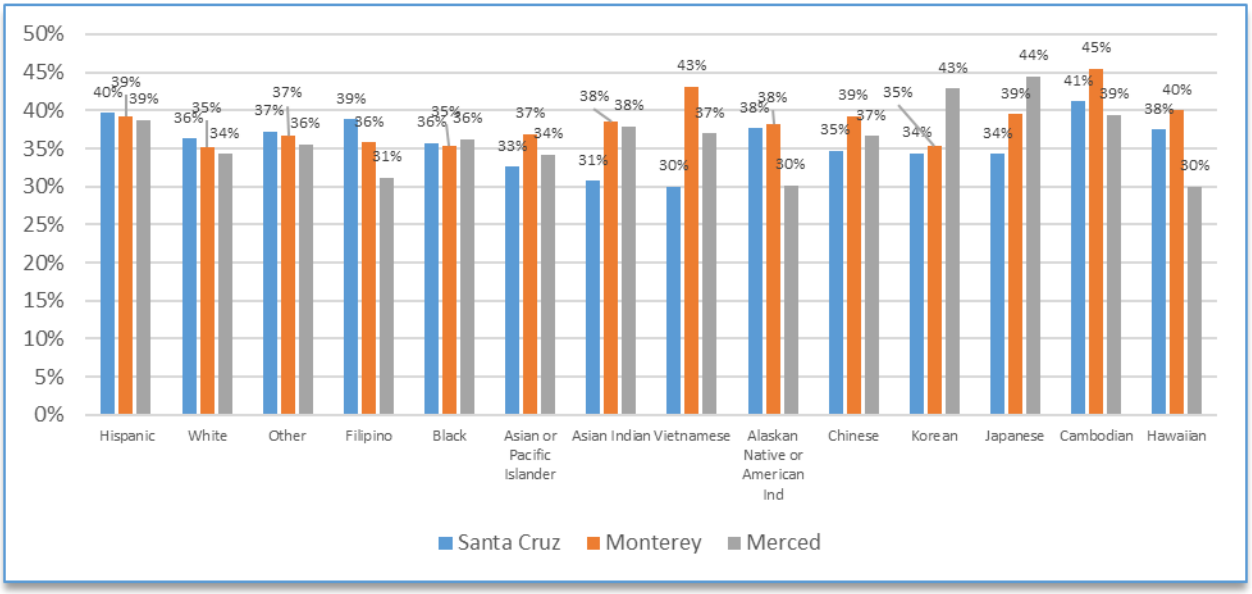
Regarding the Asthma Medication Ratio (AMR) measure, we found that the counties were similar in performance, but when stratified by race we see that our members grouped into "Other Race" members, closely followed by White members have the lowest rate of medication compliance (Figure 7). Improvements have been made across all counties in the past five years. As reviewed before, asthma is a prevalent health issue across the network and for members with persistent asthma, consistent use of controller medications makes a critical difference between maintaining good health or needing ED visits. AMR measure relies upon the provider to correctly diagnose an asthmatic state requiring controller medications and educating the member about how to use the array of medications that they may receive (ideally with an asthma action plan). The AMR measure relies upon the member and provider to engage with each other and work to understand and implement the asthma action plan, filling and using medication as directed. The Alliance has worked hard to build a feedback loop to the providers for this measure, it is one of the earliest reports on the Provider Portal. Ensuring that the provider can monitor which members with asthma are filling their prescriptions is one of the best indicators we can give the Providers that a member may not be in good control, including asthma related ED visits and IP stays.

Figure 7. Asthma Medication Ratio by County and Race/Ethnicity (HEDIS MY2020)



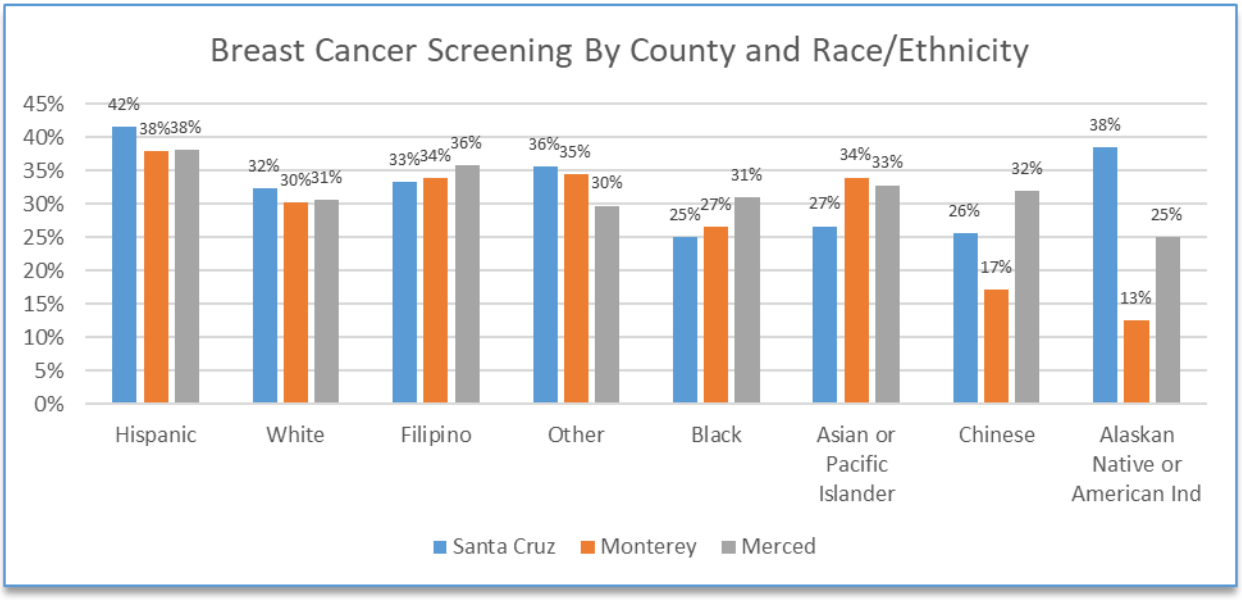
Unlike AMR where all counties reported similar rates, Cervical Cancer Screening (CCS) remain lower in Merced County, Figure 8. This measure is gender and aged based and pulls in a significant denominator (54,029). This is a challenging measure because the screening requires a pelvic exam, which not all providers nor members are comfortable with, leading to increased access issues. Because of the large denominator, members of Alaskan Native/Native American descent are illustrated for this measure that they currently have lower rates of testing, as opposed to Hispanics members and Vietnamese. This finding should prompt further investigation into this small population of Alaskan Native/Native American members to identify other clinical areas that may need support. Given California's resources, women should not be going without screening and services, but we do fail to provide adequate services for our existing members.[ix]

Figure 8. Cervical Cancer Screening by County and Race/Ethnicity (HEDIS MY2020)



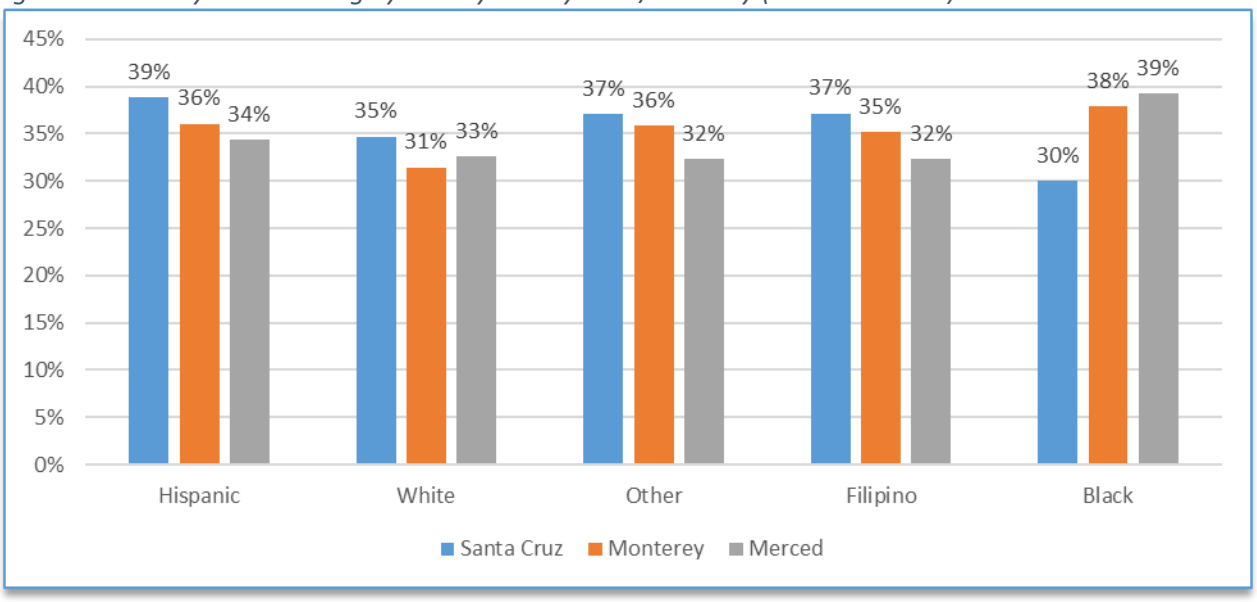
The rates follow the same pattern with the Breast Cancer Screening (BCS) measure in Figure 9. These results of preventive screening for women are concerning, especially in Merced County, see CHL, CCS.

Figure 9. Breast Cancer Screening by County and Race/Ethnicity (HEDIS MY2020)



Again, with the Chlamydia Screening measure (CHL) we see a drop off in screening rates for Black (30%) and White (31%) members , and highest screening rates here is demonstrated by our Hispanic members (39%) in Santa Cruz and Merced counties. It is not immediately clear how such a significant disparity can occur in sexual health services (CCS, CHL) in the covered communities.

Figure 10. Chlamydia Screening by County and by Race/Ethnicity (HEDIS MY2020)

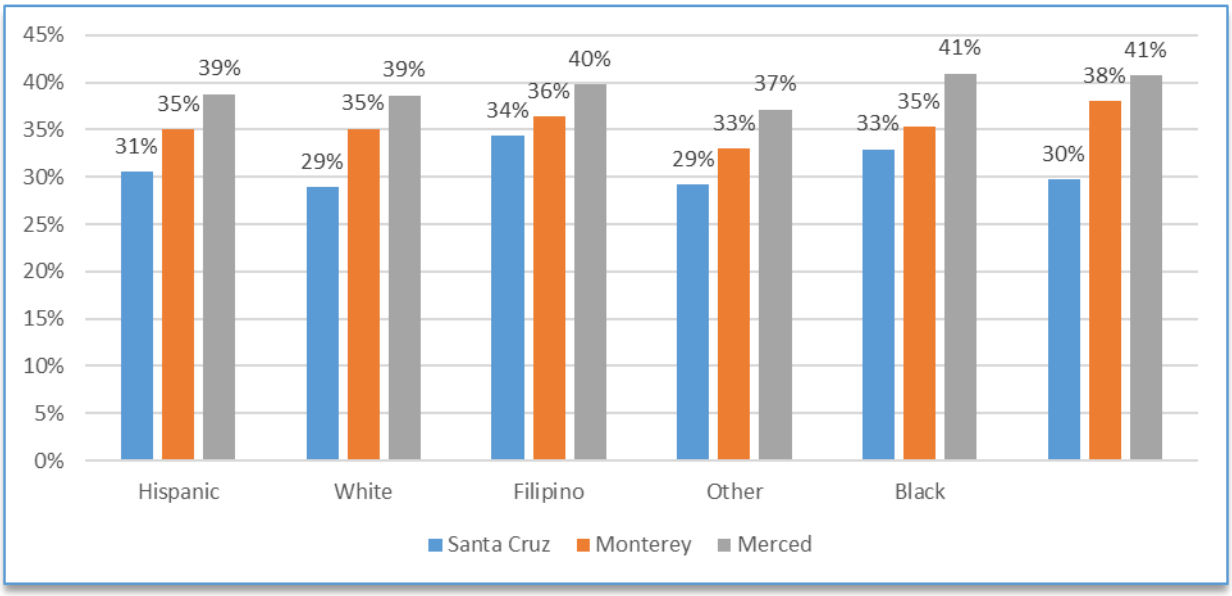


As this report has indicated asthma, cardiovascular disease and diabetes are common physical chronic health conditions. While there is a HEDIS measure that looks at hypertension (CBP), the sample size was insufficient for stratification (see Appendix B). HEDIS has a suite of measures that report out on diabetes-related issues. Comprehensive Diabetes Care (CDC) In the Comprehensive Diabetes Control measure the

differences begin to emerge is with the proportion of members who are in poor control (or missing a test value), Figure 12 below. To interpret this measure, the lower percentage is the better rate. Merced county members with diabetes are faring significantly worse than their coastal counterparts in Santa Cruz and Monterey Counties. This measure is a strong indicator of the need to support high quality of care for all members with Diabetes in the Merced Area. This measure may also indicate a lack of access to data as well, the measure will place anyone without a test value into the "poor control" category. The Alliance again has worked on communication with Providers to ensure that they are aware of members with diabetes and their current screening information is on hand. The Alliance furthermore allows providers to submit data with point-of-care testing results for A1c values to ensure a comprehensive data set is created for each member.

Finally, this measure was included due to the high prevalence of diabetes in our membership. Like asthma, without careful partnership and management of the condition by the member and provider, members experience sequalae of their condition requiring ED visits and IP stays.

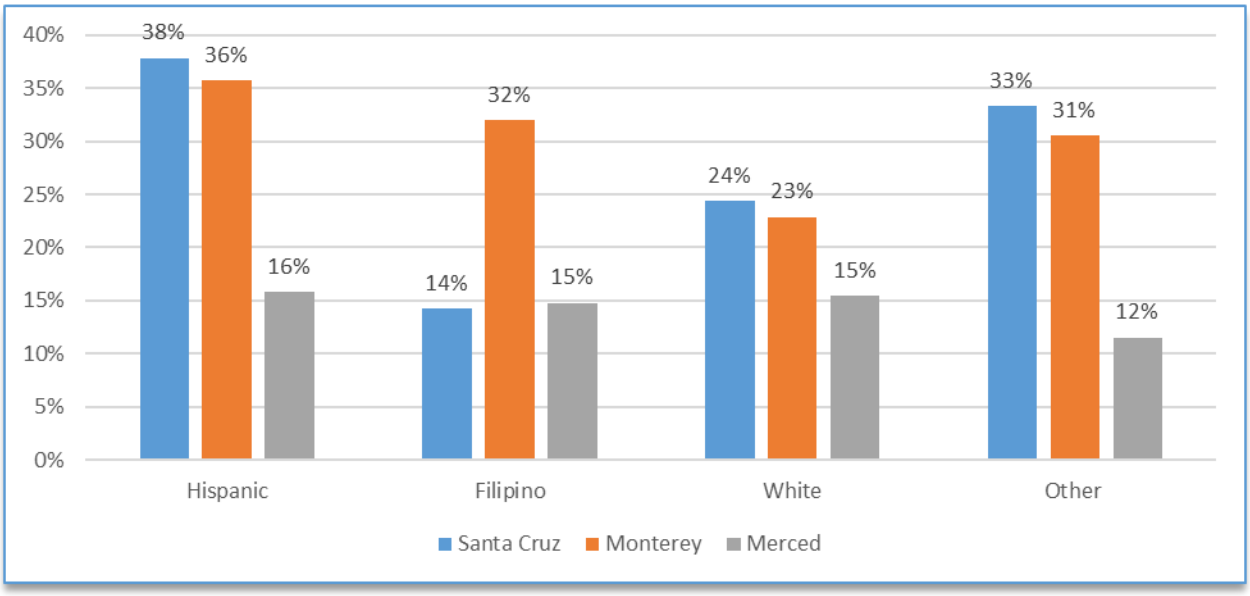
Figure 11. Comprehensive Diabetes Care HbA1c: Poor Control >9 (Reverse Measure) By County and Race/Ethnicity (HEDIS MY2020)



The final HEDIS measure in this section is that of Children Immunization Status, Combination 10 (All ACIP Recommended Vaccines) for Two Year Old's (CIS). The Alliance initiated work in the area of pediatric immunizations in 2015, primarily in Merced due to rates that were below the 25th percentile. Working in all counties, the Alliance has supported annual provider trainings, member outreach and incentive campaigns, networking and communication through local coalitions. These efforts are appreciated, providers do engage, but the current state of health care delivery is fragile, and most clinics are not able to track, remind, and recall each child's immunization status. Therefore, missed opportunities frequently occur when the child is present in the clinic yet not given the vaccines that they are behind on. Another area of opportunity is Healthy Futures (RIDE) Immunization Registry use. This regional registry is not utilized consistently and has had challenges with supporting our Providers. The transition to incorporate RIDE with CAIR2 (California State Immunization Registry) also adds to the challenges of tracking immunization status of children. To assist local medical providers, the Alliance has supported Public Health from the sidelines due to the critical priority of access to care and protecting our members from

disease. Figure 12, indicates the disparities between the counties and by Race and Ethnicity. With the exception of Filipino, Santa Cruz and Monterey rates by Race/Ethnicity track close together. Overall, the childhood immunization rates struggle in Merced County despite the interventions mentioned above.

Figure 12. Childhood Immunization Status by County and Race/Ethnicity, MY2020



We have highlighted a handful of measures where there are significant findings and they relate to the other themes emerging from our data.

Oral Health

Oral health is an integral, but often overlooked component of overall health. Poor oral health has adverse effects on both general health and quality of life. The causes of poor oral health are many (cost, access, language barriers, etc.), and contribute to large disparities among low-income children and adults and communities of color. Oral health provider shortages further compound these disparities. The American Dental Association recommends a minimum of one annual visit, and most data examine this frequency. According to California Health Interview Survey (CHIS), pooled data from 2018 to 2019 (Table 8), shows the reason for the last dental visit comparing Medi-Cal covered adults to non-Medi-Cal. We see higher rates of Medi-Cal members accessing dental care for a specific program compared to the non-Medi-Cal population. It is also important to note that while Medi-Cal Program includes dental services as a benefit for children and adults, it has lower reimbursement rates and lower provider participation compared to private dental insurance.

Table 8. *Reason for Last Dental Visit (Adult) by County and Medi-Cal Coverage Status, 2018-2019*

Reason for last dental visit - Adults	Merced	Santa Cruz	Monterey
Routine Checkup or Cleaning (Covered by Medi-Cal)	49.6%	51.6%	62.3%
Routine Checkup or Cleaning (Not covered by Medi-Cal)	55.3%	73.0%	74.4%
Specific Problem (Covered by Medi-Cal)	32.3%	40.9%	22.5%
Specific Problem (Not covered by Medi-Cal)	27.0%	17.9%	16.7%
Both (Covered by Medi-Cal)	18.0%	7.6%	15.2%
Both (Not covered by Medi-Cal)	17.7%	9.1%	8.9%

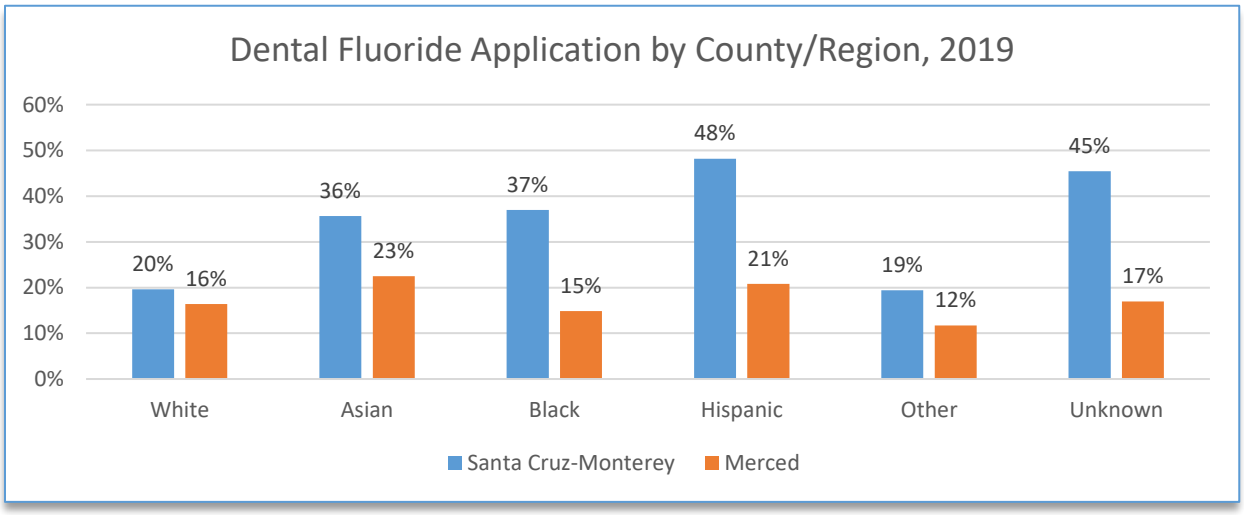
Source: CHIS 2018-19 Combined

Accordingly, increasing the proportion of children, adolescents, and adults who use the oral health system is one of the Leading Health Indicators (LHIs), a small subset of high-priority Healthy People 2030 objectives. Still, oral health access to care, particularly for children in Merced County, remains challenged with poor outcomes.

Dental caries is the most common childhood chronic disease that is largely preventable. The American Academy of Pediatrics states fluoride is effective for the prevention of caries and recommends fluoride varnish application in the primary care setting every three to six months for children under age five. Although only a small number of applications occur in the primary care setting, the provision of dental fluoride varnish is low, with Merced County lagging behind Santa-Cruz and Monterey counties. Overall, slightly over a third of (36%) of eligible child members received dental fluoride from a non-dental provider, indicating an opportunity to work with providers to ensure child members can access this service.

Using the Preventive Services Rate Sheet from DHCS, Figure 13 compares the *Dental Fluoride Varnish* measure by county/region and race/ethnicity, and represents the percentage of children six months to five years of age who had one or more dental fluoride varnish applications by a provider in 2019. Hispanic members in Santa Cruz-Monterey counties had the highest rates of dental fluoride application (48%) followed by unknown (45%), Black (37%), Asian (36%), and White members (20%). In comparison, Asian members in Merced County had slightly higher rates of application (23%) compared to Hispanic members (21%), followed by Unknown (17%), White (16%), and Black Members (15%). The Alliance has included a measure for the application of dental fluoride in its Care Based Incentive (CBI) Program to normalize application by providers since Medi-Cal members can be at higher risk for dental caries.

Figure 13. Dental Fluoride Application by County/Region and Race/Ethnicity, 2019

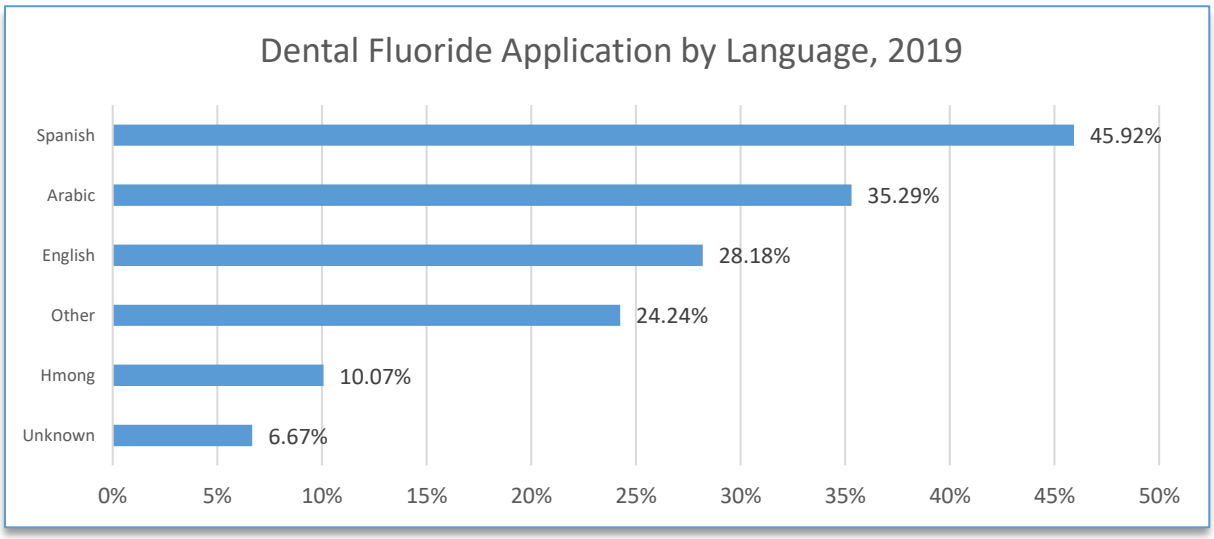


Source: RY2020 CA Preventive Services Rate Sheet

When comparing the rates of dental fluoride varnish application by language, we see application is highest for Spanish speaking members in both the Santa-Cruz-Monterey and Merced county/regions combined (45.92%) followed by Arabic (35.92%), English (28.12%), Other (24.42%), Hmong (10.07%), and

Unknown (6.67%) speaking members (see Figure 17 below.) The favorable rate for Spanish-speaking members may be partially due to the racial/ethnic and language demographics of our membership.

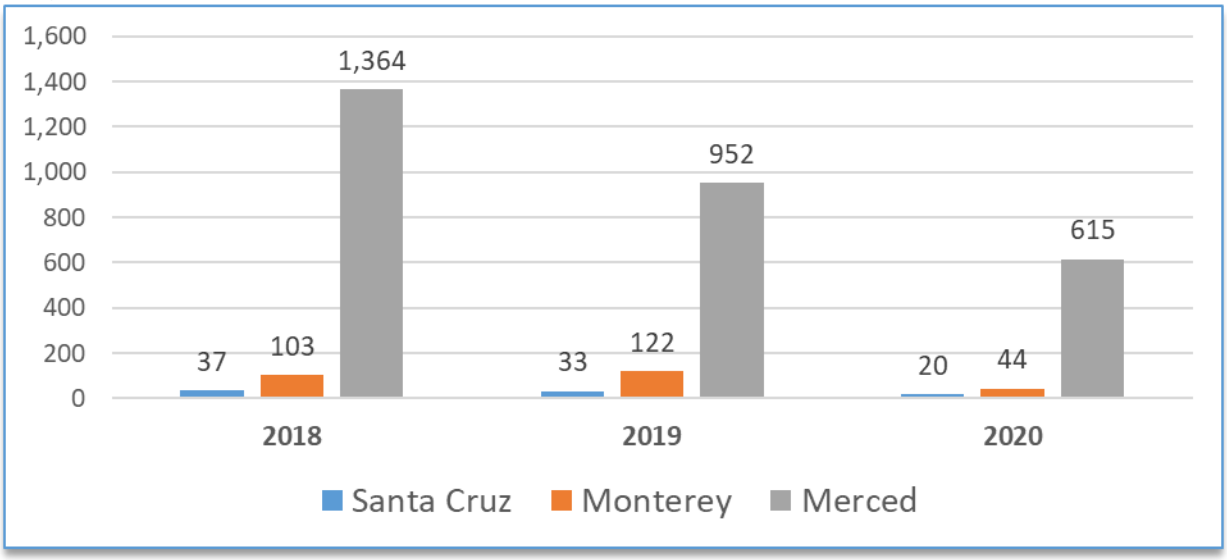
Figure 14. Dental Fluoride Application by Language, 2019



Source: RY2020 CA Preventive Services Rate Sheet

Severe dental caries can lead to treatment under general anesthesia. This can be costly, traumatic, and might not be locally available. Figure 18 displays Merced, Monterey, and Santa Cruz counties and the number of members under 21 years of age with one or more service of general anesthesia for dental services from 2018 to 2020. Here we see profound oral health disparities pertaining to the use of general anesthesia for children in Merced County compared to both Santa Cruz and Monterey counties.

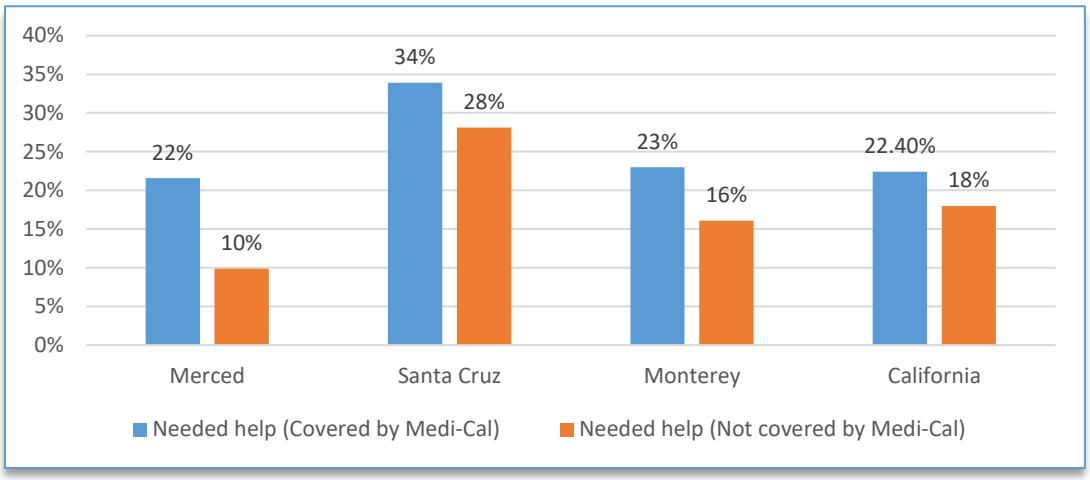
Figure 15. Members with One or More Service of General Anesthia for Dental Care, 2018-2020 (Claims Data)



Mental Health and Substance Abuse

Our Membership, as Medicaid members living at or below poverty level typically experience distress, discrimination and other challenges in their daily lives. Figure 16 displays Merced, Monterey and Santa Cruz Counties and the rates of adult's report seeking care for Mental Health issues by county comparing the Medi-Cal population to those community members not covered by Medi-Cal.

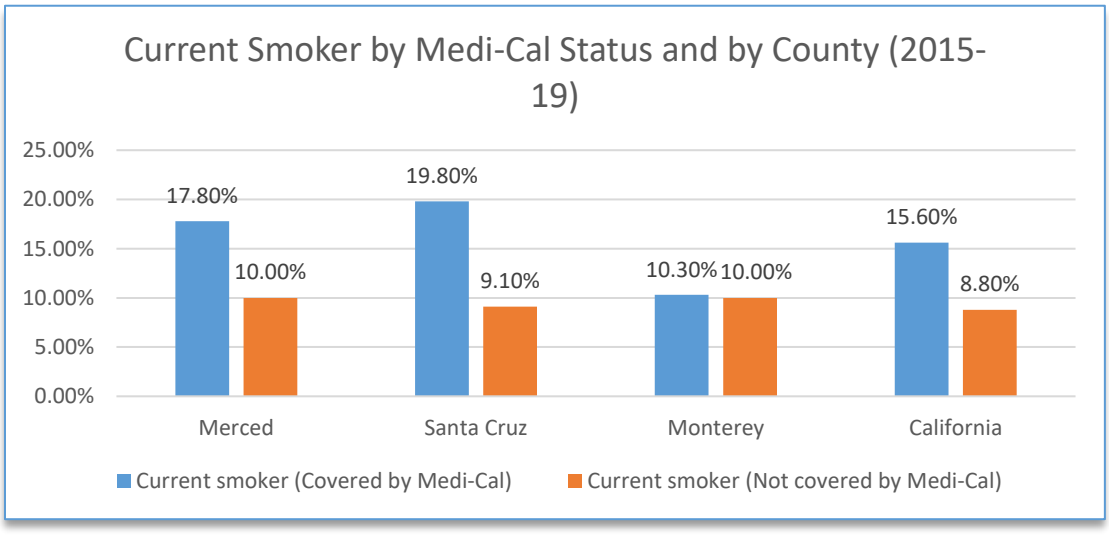
Figure 16. Needed Help for Emotional/Mental Health Problems Compared by Medi-Cal Coverage and County, 2015-19



Source: CHIS Data

According to the Centers for Disease and Control, tobacco remains the number one cause of preventable death and disability in California and the country. The adverse effects on tobacco on both oral and overall health are well established. Figure 17 displays the rates of current smoker status in Merced, Monterey, and Santa Cruz counties by comparing the Medi-Cal population to those community members not covered by Medi-Cal.

Figure 17. Current Smoker Status by County and Medi-Cal Status, 2015-19

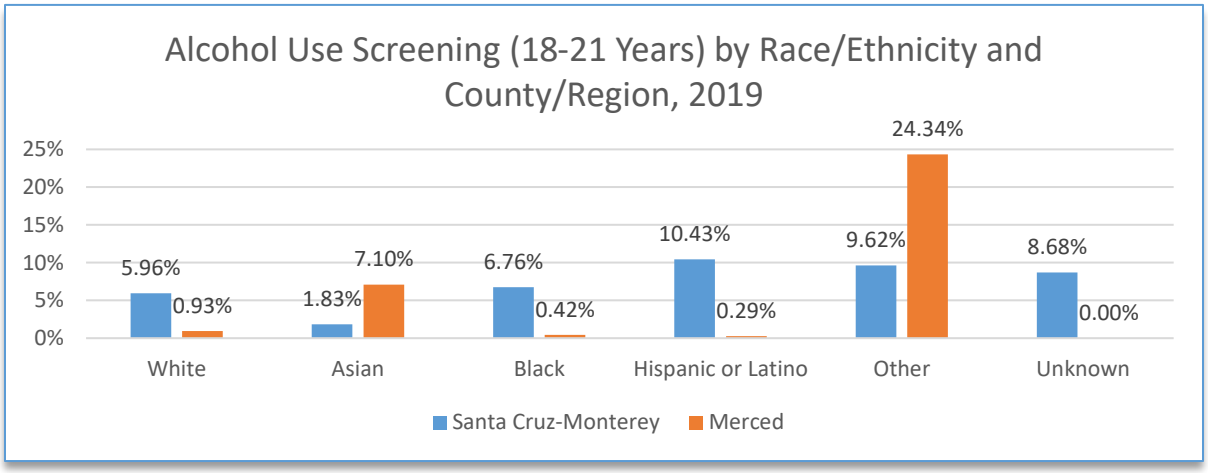


Source: CHIS Data

For youth, alcohol and tobacco use are a significant health concern linked to a wide range of academic, social, and health problems. The American Academy of Pediatrics recommends youth aged 11 years and older should be screened for alcohol and other drugs (AOD) use at each annual preventive health visit. Similarly, the U.S. Preventive Services Task Force recommends providers include education or brief counseling during visits to prevent initiation of tobacco use among school-aged children and adolescents.

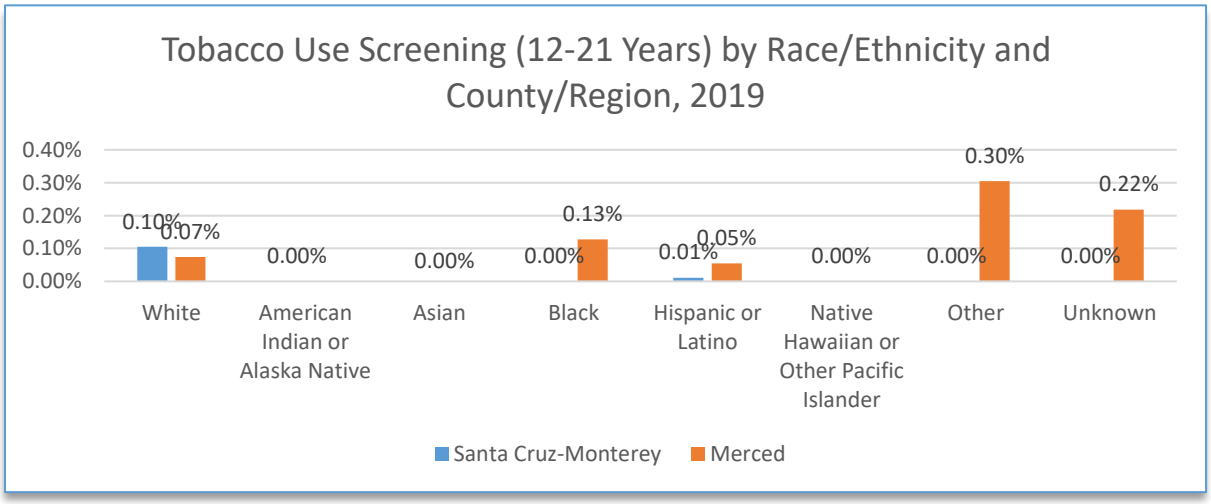
Using the Preventive Services Rate Sheet from DHCS, Figures 18 and 19 below show the *Alcohol Use Screening (AUS)* and *Tobacco Use Screening (TUS)* indicator rates by race/ethnicity for Santa Cruz/Monterey and Merced counties. The *AUS* indicator represents the percentage of members ages 18 to 21 years who had one or more screenings for alcohol use, while the *TUS* indicator represents the percentage of members ages 12 to 21 who had one or more screenings for tobacco use in 2019. Overall, rates for both measures were low: 10% (Santa Cruz/Monterey) and 2% (Merced) for alcohol use screening, and less than 1% for tobacco use screening in both counties/regions. Because both indicators are HSAG-calculated, rates for alcohol and tobacco use screening may be incomplete.

Figure 18. Alcohol Use Screening, 2019



**Included groups with denominator >30 per HSAG*

Figure 19. Tobacco Use Screening, 2019



**Included groups with denominator >30 per HSAG*

Providers play an important role in the supporting tobacco users and their efforts to quit. Included in the DHCS required Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Medicaid Survey are three questions related to medical assistance with smoking and tobacco use cessation among adults 18 years of age and older:

Table 9. *CAHPS Summary Rates for Adults, Smoking and Tobacco Use Cessation, 2020*

Measure	2020	2019	2019 US Benchmark	2019 US %tile Rank
Advising Smokers and Tobacco Users to Quit	71.9%	77.8%	76.7%	Below 25th
Discussing Cessation Medications	49.2%	54.5%	52.9%	25th – 50th
Discussing Cessation Strategies	40.6%	51.0%	46.4%	Below 25th

As Table 9 shows, in 2020, 72% of surveyed Alliance adult members who use tobacco reported being advised by their provider to quit, 49% reported that they discussed the use of cessation medications with their provider, and 41% reported discussing cessation strategies other than medications. While almost three in four tobacco users reported being advised to quit by their provider, less than half of tobacco users reported receiving information on medications and other strategies that can help them quit. Insight from these data suggest limited number of discussions among members and providers. Comprehensive cessation interventions that motivate and help users to quit tobacco use can be very effective. Supporting providers to have these discussions may help to reduce the burden of tobacco use among members.

D. Access to Care

The Department of Health Care Services (DHCS) designates counties as rural, small, medium, or large based on population density. Merced and Monterey Counties are designated as small, with 51-200 people per square mile, while Santa Cruz is designated as medium, with 201-600 people per square mile. Each County has one or more Health Professional Shortage Areas (HPSA) as determined by the Health Resources and Services Administration based on geographic area, population characteristics, and/or available facilities (e.g. Federally Qualified Health Centers). HPSA designation indicates a shortage of primary care, mental health, or dental health providers, which may impact timely access to care. Table 10 shows current HPSA designations within the Alliance Service Area, with the most HPSA designations existing in Merced and Monterey Counties. For the Alliance Service Area, data indicate that the greater the geographic density, the less HPSA designations (Santa Cruz). Both Merced and Monterey are challenged with a shortage of primary care and mental health providers in multiple cities.

Table 10. *Health Professional Shortage Areas (Source: HRSA)*

County, City	Dental Health	Mental Health	Primary Care
Merced County, CA	2	1	5
Atwater			1
Ballico	1		
Ballico/Delhi/Livingston			1

Firebaugh/Mendota	1		
Le Grand/Planada			1
Los Banos			1
Merced Central			1
Merced County		1	
Monterey County, CA	5	5	4
Big Sur		1	1
Bradley/San Ardo	1		
Carmel Valley	1		
King City	1		
King City/San Ardo	1	1	
Marina		1	
Prunedale	1		1
Prunedale/Salinas		1	
Salinas	1		1
Soledad		1	1
Santa Cruz County, CA	1	1	1
Freedom/Watsonville			1
Santa Cruz		1	

Provider to member ratio by geographic area represents another data point for assessment of the adequacy of the delivery system in each County. The Alliance is required to ensure a ratio of no more than 2,000:1, members to Primary Care Provider (PCP) ratio, and a member to total Physician ratio of no less than 1,200:1 (mental health providers are excluded from this ratio). In theory, the lower the ratio, the fewer members per provider and therefore better access to health care services, see Table 11.

Table 11. *Primary Care Provider Ratio to Member by Overall County Ratio*

County (Urbanicity Designation)	Overall County (RWJ*)
Merced (Small)	2,220:1
Monterey (Small)	1,590:1
Santa Cruz (Medium)	990:1
California	1,250:1

Source: RWJ County Rankings, 2021

Table 12. *Primary Care Provider Ratio to Member by Statewide DHCS Average Ratio*

County (Urbanicity Designation)	Ratio Type	Alliance Ratio	DHCS Average Ratio*
Merced (Small)	Member to PCP	1:5,505	1:691
	Member to Physician	1:298	1:215
Monterey (Small)	Member to PCP	1:774	1:691
	Member to Physician	1:198	1:215
Santa Cruz (Medium)	Member to PCP	1:266	1:529
	Member to Physician	1:62	1:164

Source: CHCF, 2019

Not surprisingly, Santa Cruz (with the higher population density and lowest number of HPSA designations) has the healthiest member to provider ratios. Monterey and Merced ratios are lower than statewide averages, indicating fewer providers per member.

Table 12 shows Alliance specific ratios by statewide DHCS average ratios, as of August 2019. The Alliance ratios are well above those statewide ratios reported by CHCF, and with the exception of Merced and Monterey County ratios, were higher than the minimum recommended. Not surprisingly, Santa Cruz (with the greatest population density and lowest number of HPSA designations) has the healthiest member to provider ratios. Monterey County ratios are on par with DHCS statewide averages for small counties (with the Monterey PCP ratio being slightly over the statewide average), while Merced ratios are lower than DHCS statewide averages, indicating fewer providers per member than like counties designated as small based on population density.

Mental health provider to member ratios aren't reported to the same degree as medical providers, but a 2018 report published by the Health force Center at UCSF shows that for most mental health provider types (Psychiatrist, Psychologist, Therapist, Counselor, Social Worker), the majority of the Alliance Service Area falls in the lower half of all ratios statewide. Merced County is in the bottom quartile for all provider ratio types except Counselors, while Monterey is in the second or third quartile depending on provider type, and Santa Cruz has the strongest penetration, falling in the top quartile for Psychiatry, Therapist, Counselor, and Social Worker to member ratio.[x] Given that estimates indicate that nearly 17% of Californians are in need of mental health treatment, the ratios in Merced and Monterey are particularly concerning (Meeting the Demand for Health.).[xi] The gap between utilization in Santa Cruz County versus Merced and Monterey is significant, utilization has improved in part due to telemedicine services becoming available.

In December 2013, the Board approved a contract with Beacon Health Strategies/College Health Independent Physicians Association (Beacon) for delivery of the Alliance Behavioral Health benefit. This benefit provides for mental health and substance use disorder services which are delivered through a bifurcated system of shared responsibilities between the MCPs and CMHPs. The Alliance provides outpatient services for mental health disorders that result in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Covered services include individual and group mental health evaluation and treatment (psychotherapy); psychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; outpatient laboratory, drugs, supplies, and supplements; and psychiatric consultation for all members, mild to moderate mental health conditions are differentiated from specialty mental health conditions by determining the severity of functional impairment in children. Anxiety disorders, depression, attention deficit disorder, and other mental health conditions resulting in mild functional impairment are covered through the Alliance benefit. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are available to those under 21, which allows for approval of services in additional situations. More serious conditions including psychosis, eating disorders and conditions resulting in significant functional impairment, are covered through the specialty mental health benefit managed by the County's specialty mental health plan.

Part of the evaluation of the Alliance Behavioral Health program consists of the review of how well we are serving our members as determined by a review of member utilization of services and member satisfaction with performance.

Member Utilization

Member utilization is monitored through overall utilization rate, screening and kept appointments. Utilization rate, is the percentage of members who had at least one mental health visit per year, referred to as the penetration or utilization rate. In 2020, 8.42%% of Alliance members had at least one mental health visit per year.

Benchmarks from the seven other health plans that Beacon serves are also of interest. The average utilization in 2018 for Beacon Plans was 4.0% (range 1.7% to 7.5%). It is of note that Beacon plan averages for their seven contracted Plans are higher than statewide averages reported by DHCS in the MCMC dashboard.

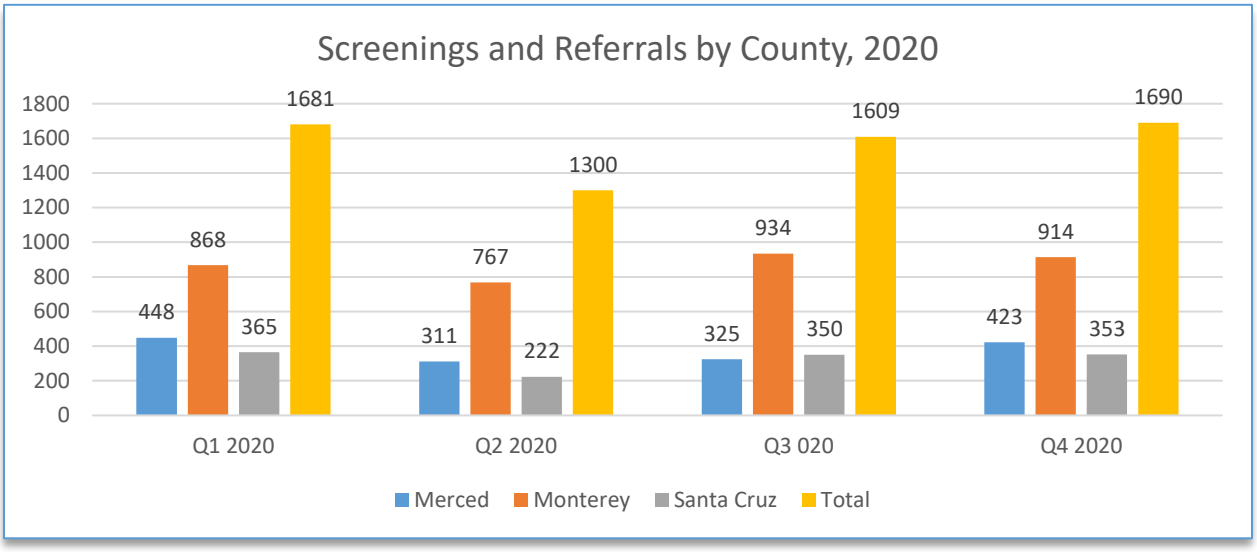
Staff also consider benchmarks derived from the 2015 National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) which indicated that 13.9% of the US adult population was estimated to have had mild-moderate mental illness and would have a need for services each year. A long-term goal for the Alliance and for the Medi-Cal program would be to target the utilization of services at the level applicable to the general US population.

Looking at utilization by county, age, and ethnic group however reveals disparities which merit attention and action. Overall utilization for all ages in 2020 was 13.80% in Santa Cruz, 7.28% in Monterey and 7.01% in Merced. Utilization trends from 2019-2020 stayed the same, with little to no increase in utilization from members.

Overall utilization rates by ethnicity statewide reveal that Hispanic and Black members have the lowest utilization rates and Whites, the highest. Comparing Alliance percentages to the Medi-Cal Managed Care rates, overall Alliance rates are higher for all ethnicities and follow the same relative utilization by ethnic group. Also, language capability continues to be a gap with only a small number of fluent Spanish speaking counselors and MDs available, and as suggested by statewide data indicating that Hispanic members seek visits less often. A lack of bilingual and bicultural providers throughout the region is likely a contributing factor.

The Alliance monitors the number of members who are screened for services, and the percent of those who make and keep appointments following screening as demonstrated by claims data. In 2020, Beacon completed 6,280 screenings and referrals, see Figure 20 below.

Figure 20. Behavioral Health Screenings and Referrals by County, 2020



Of these, 55% were in Monterey County, 24% in Merced County, and 19% in Santa Cruz County. Seventy-five percent of screenings were members self-referring or from providers, 20% were from County programs and 2% were identified by Beacon as being appropriate for county services.

Member Satisfaction

The Alliance relies on both member survey data and grievance system data to assess member satisfaction.

Behavioral Health

Beacon conducts and reports an annual Member Satisfaction Survey. The goal for each survey question is a positive response from 85% of respondents. Access satisfaction metrics include receiving timely care and personal doctor's knowledge of counseling or treatment. In survey year 2020 (measurement year 2019), 88.2% of responding members reported a positive response to the ease of getting care in the last 12 months, an increase of 8.7% from the previous year, 79.5%). 62.5% of members report obtaining an appointment within 10 days (a decrease of 9.7% from the previous year, 72.2%) and 76.0% reported getting needed care within 48 hours (an increase of 14.2% from the previous year, 61.8%). Member satisfaction with care was assessed by asking about feeling that their personal doctor knew about their care. 51.0% of members reported that they felt their personal physician know about their behavioral health care (an 8.9% decrease from the previous year, 59.9%). Overall member survey results in 2020 indicated opportunities for improvement, with performance in some key metrics below the 85% positive response goal. Because of this, Beacon continues to have an open Corrective Action Plan with the purpose of improving improve member satisfaction.

Key interventions implemented and/or currently in progress by Beacon to address the member satisfaction issues include:

- Provider education regarding access and availability standards.
- Sharing results with providers along with tools targeted towards barriers identified through the survey.

- Active recruitment of providers based on specialty, cultural/linguistic and geographic needs, and expansion of telehealth.
- Provider availability surveys and timely update of information available to patients.
- Ensuring members are aware of Beacon's availability to assist in obtaining appointments when member is unable to secure and appointment.
- Continue to explore various means of capturing appointment accessibility data such as through complaints, claims, appointment request and survey.

Monitoring of member grievances reveals that grievances have remained below Beacon's one grievance per 1,000 members from Q4 2019 throughout 2020 All member grievances were resolved within the required 30-day timeframe throughout this time period.

Overall utilization is adequate when compared to the Medi-Cal benchmarks. Gains can be made in overall utilization, including adults and children under 5 years of age in Monterey and Merced, and in utilization by members who identify as Hispanic and Black. In addition, continued improvement in percent of members keeping appointments will be sought.

Although the network is deemed adequate, and there has been improvement since the initial implementation of the benefit, gaps remain. Access to counseling in Santa Cruz is above average based on utilization rates, but additional counselors are needed in Monterey and Merced Counties as indicated by utilization rates below State average. Further evidence of inadequate access is demonstrated by decreases in member satisfaction with access over the last several years. MD access in all counties is challenged in large part by psychiatric availability regionally, statewide and nationally. The Alliance and Beacon continue to work to increase the number of contracted providers in all three counties. Furthermore, in early 2020, the Alliance implemented a Community Care Coordination department, responsible for overseeing the behavioral health program as well as collaborating with clinical and social service agencies, improving member navigation across the health care system in the Alliance's service area.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Alliance conducted the DHCS required Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Medicaid Survey 5.0 in 2020 to assess members' health care experiences. The CAHPS Medicaid Survey is a product of the Agency for Healthcare Research and Quality's CAHPS program, which is a public-private initiative to develop and maintain standardized surveys of patients' experiences with ambulatory and facility-level care. Each CAHPS survey assesses healthcare quality by asking consumers and patients to report on their experiences with health care services in different settings. There are standardized instruments for adults and children.

SPH Analytics, a NCQA-certified vendor was selected to conduct the survey. The look back period is six months and the measurement period for the survey was between January and December 2019. The survey was administered in English and Spanish between March and June 2020. It used a two-wave mail methodology with a phone follow up to non-respondents. The survey response information is summarized in Table 13. The response rate for the 2020 survey was lower in comparison to the response rate for the 2019 survey (adult: 24.9% and child: 32%). The decline in response rates is reflective of a nationwide trend, possibly due to COVID-19. Consequently, there is potential for response bias as members were asked to reflect on their health care experiences over the past year while simultaneously living through a pandemic.

Table 13. *DHCS Required CAHPS Medi-Cal Member Survey Response, 2020*

	Adult	Child
Sample Size	1,350	1,650
Number of Ineligible Surveys	42	21
Number of Completed Surveys	236	312
Response Rate	18.0%	19.2%

The CAHPS Health Plan Survey 5.0 produces several measures of patient experience and includes composite, rating, and single-item measures. Within the CAHPS Health Plan Medicaid Survey, there are four composite measures: (1) *Getting Needed Care,* (2) *Getting Care Quickly,* (3) *How Well Doctors Communicate,* and (4) *Health Plan Customer Service.* Composite measures combine two or more survey related questions and use a never/sometimes/usually/always response scale. The survey also includes four overall rating measures: (1) *Rating of Health Care*, (2) *Rating of Personal Doctor*, (3) *Rating of Specialist*, and (4) *Rating of Health Plan*. These measures use an 11-point scale ranging from zero to ten.

Member experience is presented by Summary Rates, which are defined by NCQA and represent the percentage of respondents who chose the most positive question responses. Summary Rates include the following response option(s): "Yes;" "Always" or "Usually" and "8 – 10". Percentile rankings are presented in relation to NCQA's 2019 Medicaid Adult and Child Quality Compass benchmarks.

The Quality Compass benchmarks help evaluate plan performance by comparing plans within the state and nation. The benchmarks represent the mean summary rate from all Medicaid samples that submitted data to NCQA in 2019 and reflect Measurement Year 2018 data. At the time of reporting, 2020 benchmarks were not available. Therefore, caution is recommended when making comparisons to 2019 benchmark data.

The 2019 national benchmark comparison for the adult sample included 165 plans and 57,645 respondents, while the child sample included 112 plans and 46,860 respondents. The 2019 State benchmark comparison for the adult sample included approximately 16 plans and 304 respondents, while the child sample included approximately 12 plans and 519 responses.

The 2020 summary rate for adult comparison with the 2019 summary rate and with the 2019 Quality Compass benchmarks is presented in Table 14.

Table 14. *CAHPS Summary Rates for Adults, 2020*

Composite/Measure/Attribute	2020	2019	2019 CA Benchmark	2019 CA %tile Rank	2019 US Benchmark
Getting Needed Care	83.0%	78.3%	77.6%	Above 75th	82.5%
Getting Care Quickly	80.3%	76.3%	75.3%	Above 75th	82.0%
How Well Doctors Communicate	90.8%	88.2%	89.7%	50th – 75th	92.0%
Health Plan Customer Service	89.0%	86.7%	87.0%	Above 75th	88.8%

Rating of Health Care	69.7%	71.1%	72.0%	25th – 50th	75.4%
Rating of Personal Doctor	78.7%	84.2%	78.9%	50th - 75th	82.1%
Rating of Specialist	82.2%	82.4%	80.5%	50th – 75th	82.3%
Rating of Health Plan	75.6%	72.5%	73.8%	50th – 75th	77.6%

In comparison to the 2019 summary rate, the following five composites showed an increase in rate for 2020: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service,* and *Rating of Health Plan*. The following three composites/ratings showed a decrease in rate for 2020 in comparison to the 2019 rate: *Rating of Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist*. For all composites and ratings, 2020 summary rates were not statistically significantly lower/higher than 2019 summary rates.

The 2020 summary rate for child and comparison with the 2019 summary rate and with the 2019 Quality Compass benchmarks is presented in Table 15.

Table 15. *CAHPS Summary Rates for Children, 2020*

Composite/Measure/Attribute	Summary Rate and Percentile Ranking				
	2020	2019	2019 CA Benchmark	2019 CA %tile Rank	2019 US Benchmark
Getting Needed Care	80.4%	76.9%	79.8%	50th - 75th	84.5%
Getting Care Quickly	86.8%	80.9%	83.2%	Above 90th	89.4%
How Well Doctors Communicate	92.6%	90.5%	91.7%	50th - 75th	94.0%
Health Plan Customer Service	91.2%	87.6%	88.5%	Above 75th	88.4%
Rating of Health Care	82.0%	87.4%	85.1%	25th – 50th	87.5%
Rating of Personal Doctor	88.8%	92.1%	88.6%	At 50th	90.1%
Rating of Specialist*	83.1%	87.6%	N/A	N/A	87.5%
Rating of Health Plan	86.5%	88.7%	86.6%	50th – 75th	86.5%

**CA Benchmark for Rating of Specialist is not available since NCQA does not calculate state-level benchmarks for measures that have less than five health plans with reportable results*

In comparison to the 2019 summary rate, the following four composites showed an increase in rate for 2020: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Health Plan Customer Service.* In comparison to the 2019 summary rate, the following four ratings showed a decrease in rate for 2020: *Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, and Rating of*

Health Plan. For all composites and ratings, 2020 summary rates were not statistically significantly lower/higher than 2019 summary rates.

When comparing rates by county, Santa Cruz County had the least number of members that participated in both the adult and child surveys. For adult, responses in Santa Cruz County performed better on all composites/ratings than the other two counties (Table 16). *How Well Doctors Communicate* was the highest performing composite for both Monterey and Merced while *Health Plan Customer Service* was the highest performing composite for Santa Cruz County. *Rating of Health Care* was the lowest performing composite for providers in all three counties.

Table 16. *CAHPS Summary Rates for Adult by County, 2020*

Composite/Measure/Attribute	Monterey (N = 96)	Merced (N = 84)	Santa Cruz (N = 56)
Getting Needed Care	80.9%	82.8%	86.8%
Getting Care Quickly	77.3%	79.6%	86.9%
How Well Doctors Communicate	89.2%	89.9%	95.0%
Health Plan Customer Service	87.5%	85.5%	97.4%
Rating of Health Care	67.2%	68.4%	75.7%
Rating of Personal Doctor	76.6%	72.4%	90.5%[1]
Rating of Specialist	81.6%	75.8%	94.7%
Rating of Health Plan	75.6%	73.8%	78.4%

[1] *Rate is significantly higher compared to both Monterey and Merced Counties*

In comparison, providers in Santa Cruz County performed better on half of all composites for the child survey than the other two counties (Table 17). For child, responses in Monterey, Merced, and Santa Cruz had the highest performance on the composites *How Well Doctors Communicate*, *Getting Care Quickly*, and *Rating of Personal Doctor*, respectively. For Merced, the rate for *Getting Care Quickly* was significantly higher compared to Monterey County. For Santa Cruz, *Rating of Personal Doctor* was significantly higher compared to both Monterey and Merced Counties. Lowest performing composites by county also varied for child. Providers in Monterey, Merced and Santa Cruz had the lowest performance on the composites *Getting Needed Care*, *Rating of Health Care*, and *Rating of Specialist*, respectively.

Table 17. *CAHPS Summary Rates for Child by County, 2020*

Composite/Measure/Attribute	Monterey (N = 165)	Merced (N = 101)	Santa Cruz (N = 46)
Getting Needed Care	77.7%	80.7%	90.1%
Getting Care Quickly	83.2%	93.0%[1]	87.5%
How Well Doctors Communicate	91.7%	92.2%	96.7%

Health Plan Customer Service	92.7%	90.4%	87.5%
Rating of Health Care	83.5%	77.8%	87.0%
Rating of Personal Doctor	88.9%	83.6%	100.00%[2]
Rating of Specialist	85.7%	81.8%	77.8%
Rating of Health Plan	88.1%	83.8%	86.7%

[1] *Rate is significantly higher compared to both Monterey County*

[2] *Rate is significantly higher compared to both Monterey and Merced Counties*

F. Health Disparities and Inequities

Children and Adolescents

Evaluation for disparities in health measures for children and adolescent was completed using the DHCS measurement year 2019 Preventives Service Report rate sheets. These rate sheets contain data specific to the Alliance for three measures that assess the utilization of preventive services by pediatric members: *Well-Child Visits in the First 15 Months*, *Well-Child Visits for Age 15 to 30 Months*, and *Child and Adolescent Well-Care Visits*. Results were reviewed as the data was initially reported, Santa Cruz and Monterey counties combined, and Merced County reported separately.

Results revealed variation in rates of well child visits by county/region and spoken language, with overall lower rates in Merced County compared to Santa Cruz/Monterey counties. Infants attended far fewer visits compared to children and adolescents in the entire region. Results also parallel the growing body of evidence showing racial/ethnic disparities in access to well child visits with Black infants experiencing the lowest rate of visits, while Hispanic and Spanish-speaking child members had some of the highest rates of visits. In light of the impact of COVID-19 on visits in 2020, the Alliance initiated a Performance Improvement Project (PIP) in 2020 to increase access to preventive services and rates for children and adolescents in Merced County.

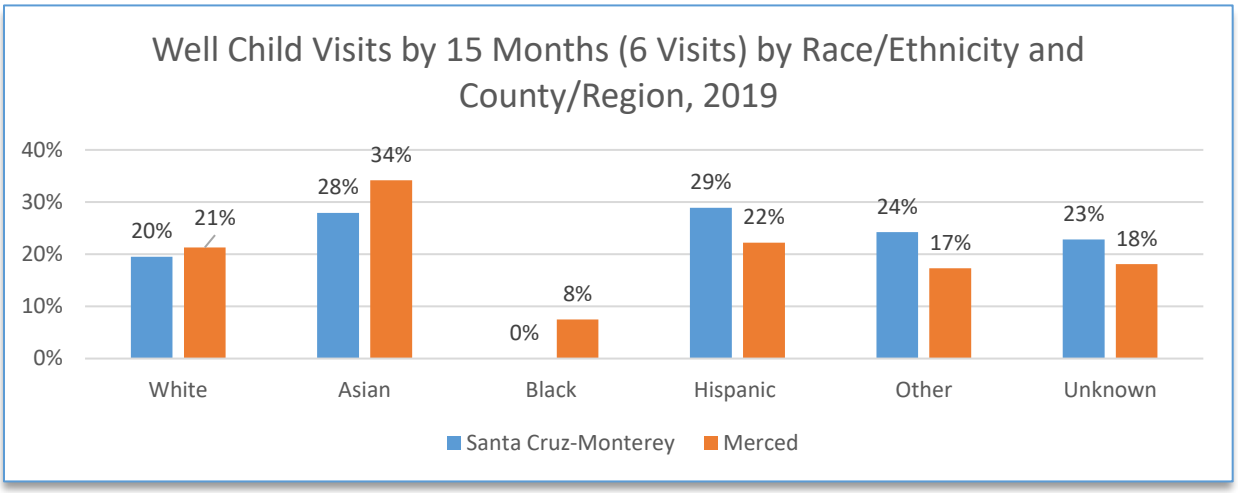
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)

The *W30-6* measure represents the percentage of children who turned 15 months in the measurement year and received six or more well-child visits with a provider. Well-child visits are particularly important during the early months of a child's life to assess growth and development and address problems early. Despite the benefits of visits, rates were low for infants in 2019. Only a quarter of the eligible Alliance pediatric membership (25%) received six or more visits prior to their 15th month in 2019, and Santa Cruz/Monterey had the most favorable rate (27%) compared to Merced County (22%).

Figure 21 below displays the percentage of visits stratified by race/ethnicity and county/region. As shown, Asian infants in Merced County had the highest rates of visits overall (34%), while both Asian and Hispanic infants had the highest rates (28% vs. 29%) in the Santa Cruz/Monterey region. These results are promising for improving the health of Asian and Hispanic infants, as research suggests minority infants are less likely to receive well-childcare compared to White infants. Still, Black infants in Merced and Santa

Cruz/Monterey had the lowest rate of visits. The unfavorable rate for Black infants is partially due to the racial/ethnic demographics within both regions.

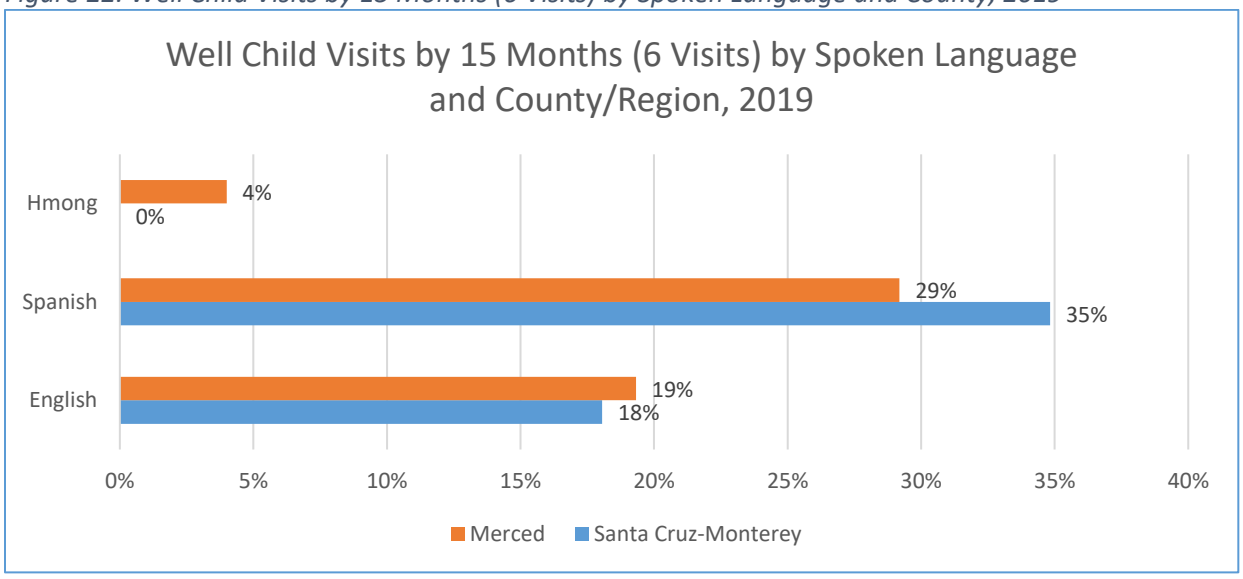
Figure 20. Well Child Visits by 15 Months by Race/Ethnicity and County/Region, 2019



**Racial/ethnic groups included if denominator was >10 members*

Because English-speaking children (ages 0 to 17) make-up less than half of the entire Alliance pediatric membership (47%), visits in the first 15 months were also stratified by spoken language. As shown in Figure 22 below, infants in the Spanish speaking group had the highest compliance rates in both Santa Cruz-Monterey (35%) and Merced (29%) counties followed by infants in the English spoken language groups (18% vs 19%). In Merced County, infants in the Hmong speaking group had the lowest rate of compliance (4%). Hmong was not reported as a spoken language for infant members in Santa Cruz/Monterey.

Figure 22. Well Child Visits by 15 Months (6 Visits) by Spoken Language and County, 2019



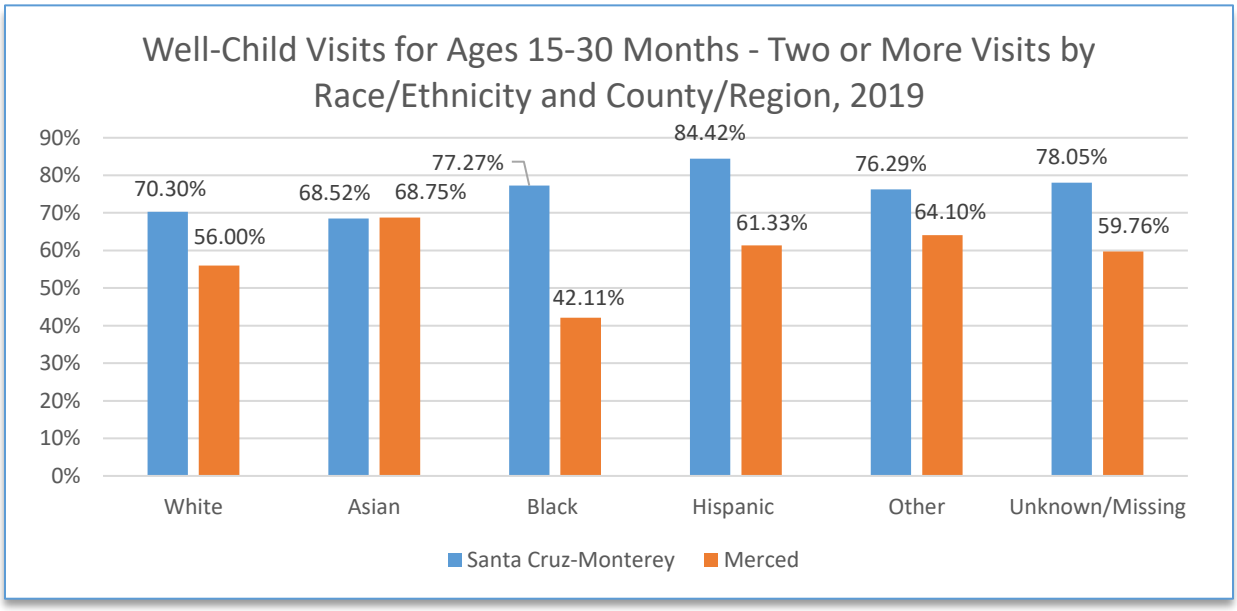
Spoken language groups included if denominator was >10 members

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months— Two or More Well-Child Visits (W30-2)

In response to a gap in oversight of visits for children younger than three years of age, the introduction of the *W30-2* measure captures the previously missed age range. This indicator measures the percentage of children who turned 30 months old during the measurement year and received a two or more well-child visits with a PCP.

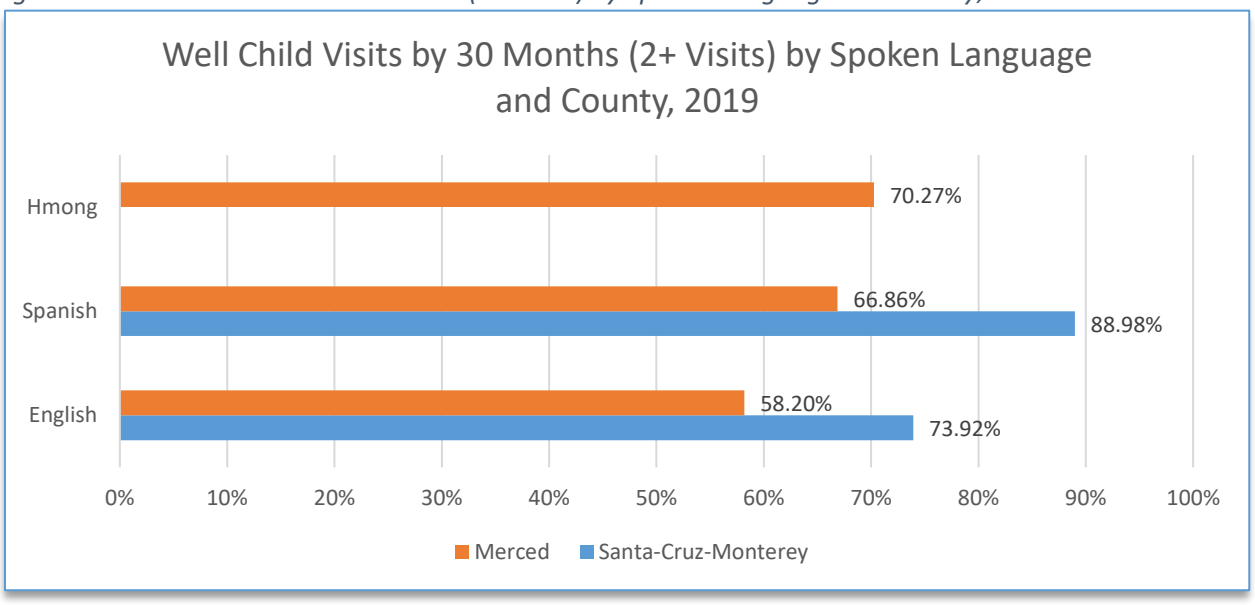
To better understand the number of visits received for children in the eligible Alliance population, Figure 23 displays the percentage of W30-2 visits stratified by race/ethnicity and county/region. Overall, 74.31% percent of child members received two or more visits between their 15 and 30-month birthdays. Children in Santa Cruz/Monterey had higher compliance (82%) compared to children in Merced (61%). When examining rates by ethnicity, Hispanic children in Santa Cruz/Monterey had the highest rate of visits (84%), while Asian children (69%) had the highest rate of visits in Merced County. Yet, Black children in Merced County experienced considerably lower rates (42.11%) compared to their counter parts.

Figure 23. Well Child Visits for Ages 15-30 Months (2+ Visits) by Race/Ethnicity and County/Region, 2019



As shown in Figure 24 below, compliance rates for W30-2 visits were also highest for Spanish speaking child members in Santa/Cruz Monterey (89%), followed by English speaking child members (74%). Across all spoken language groups, child members in Merced County had lower compliance rates compared to Santa Cruz/Monterey. Compliance rates were highest for Hmong speaking child members in Merced County followed by child members in the Spanish (67%) and English speaking (58%) groups. The favorable rate for Hmong speaking child members is most likely due to Merced County's large Hmong speaking population.

Figure 24. Well Child Visits – 30 Months (2+ Visits) by Spoken Language and County, 2019



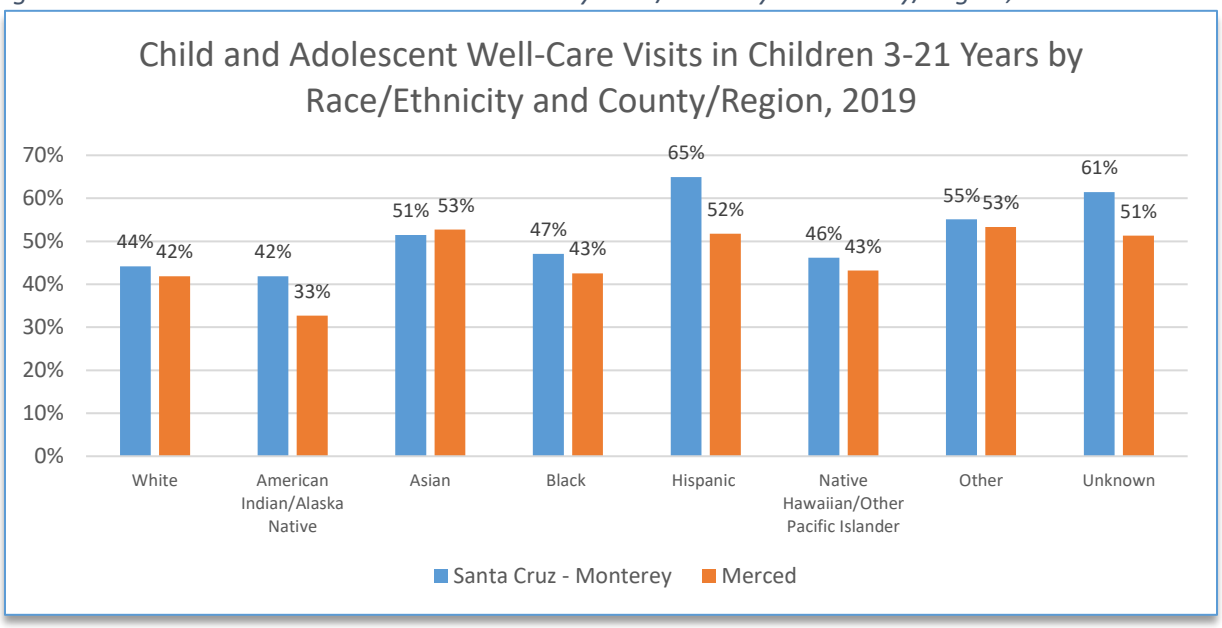
**Spoken language groups included if denominator was >10 members*

Child and Adolescent Well-Care Visits – Total

The *Child and Adolescent Well-Care Visits – Total (WCV)* measure represents the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or OBGYN practitioner during the measurement year. Overall, 58% of eligible child and adolescent Alliance members ages 3-21 had at least one well child visit in 2019, with Santa Cruz/Monterey reporting an overall higher rate of compliance (62%) compared to Merced County (58%).

Figure 25 below displays the percentage of *WCV* visits stratified by race/ethnicity and county/region. As shown, Hispanic children and adolescents in Santa Cruz/Monterey had the highest rates of visits overall (65%), followed by "Unknown" (61%), "Other" (55%), Asian (51%), Black (47%), Native Hawaiian/Other Pacific Islander (46%), White (44%), and American Indian (42%). When comparing Santa Cruz/Monterey to Merced, Asian and "Other" children and adolescents both had the highest compliance rates (53%). Hispanic children and adolescent members had a close compliance rate at 52%, followed by "Unknown" (51%), and Native Hawaiian/Hawaiian/Another Pacific Islander and Black (53%). White and American Indian/Alaska Native children and adolescents in Merced County had the lowest rates of compliance overall, at 42% and 33%, respectively. Although White children and adolescents in Merced County had a more favorable *WCV* rate compared to American Indian/Alaska Native children and adolescents, they represent a large proportion of members in the denominator and a priority population for preventive care in Merced County.

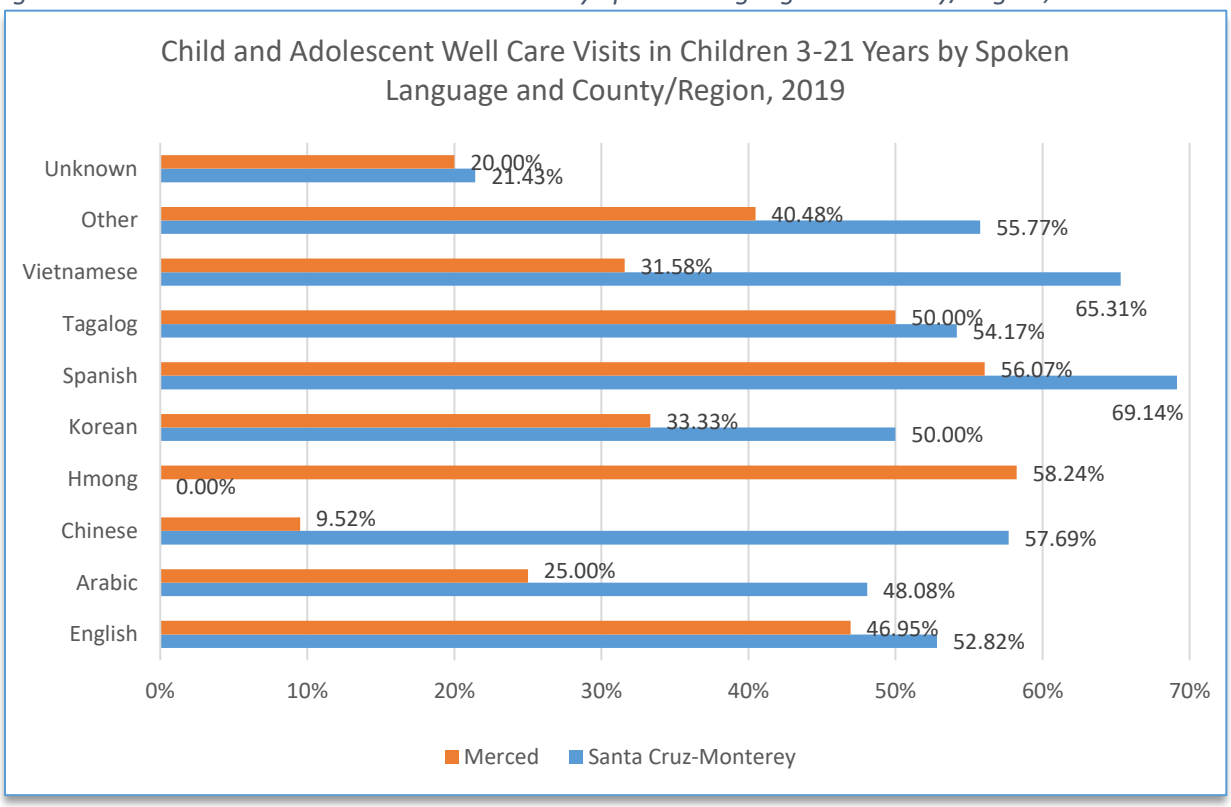
Figure 25. Child and Adolescent Well-Care Visits by Race/Ethnicity and County/Region, 2019



**Racial/ethnic groups included if denominator was >10 members*

As shown in Figure 26, members in Santa Cruz/Monterey whose spoken language was flagged as Spanish had the highest overall rate of WCV compliance (69%). Among groups in Santa Cruz/Monterey whose primary spoken language was assessed, Vietnamese speaking members had the second highest rate of compliance (65%), followed by Chinese (58%) and Tagalog speaking members (54%). However, these spoken language groups represent a small proportion of the denominator compared to English speaking members whose rate of compliance closely followed at 53%. In Merced, Hmong speaking members had the highest rate of compliance (58%) relative to Spanish (56%) and English-speaking members (47%). Meanwhile, Vietnamese (32%), Arabic (25%), and Chinese speaking (10%) groups had the lowest rates of compliance in Merced. However, these groups also represent a small proportion of the eligible member population in Merced.

Figure 26. Child and Adolescent Well-Care Visits by Spoken Language and County/Region, 2019



G. Health Education, Cultural and Linguistic, and Quality and Improvement Needs

Improving cultural and linguistic competence in health care will contribute in the reduction of disparities in health outcomes among different groups. Health disparities may be associated to race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, gender, and geographic location all contribute to an individual's ability to achieve good health[xii]. The National Institute of Medicine reviewed the research on the causes of disparities in health care in their report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care[xiii]. The report concludes, "Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled." They find that minorities are less likely than whites to receive medically necessary services across a range of health conditions and common procedures. The following are examples compiled by the Office of Minority Health, U.S. Department of Health and Human Services[xiv]:

Blacks:

- The death rate for Blacks is generally higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

Asian Americans:

- Asian Americans contend with numerous factors which may threaten their health. Some negative factors are infrequent medical visits, language and cultural barriers, and lack of health insurance.
- Asian Americans are most at risk for the following health conditions: cancer, heart disease, stroke, unintentional injuries (accidents), and diabetes.

Hispanics:

- Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance.
- The Centers for Disease Control and Prevention has cited some of the leading causes of illness and death among Hispanics, which include heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Hispanics also have higher rates of obesity than non-Hispanic whites.

The Alliance has done a comparison of Healthy People 2030 goals and targets. The following presents eight Healthy People 2030 (HP2030) objectives which closely match select 2020 Alliance Merced, Santa Cruz, and Monterey counties HEDIS measures and the results obtained in survey. Each HP2030 objective is identified and the target percentage rate given along with the source of information including Alliance 2020 HEDIS measure, see results in Table 18. Alliance Merced, Santa Cruz, and Monterey counties measures exceeded HP2030 targets in four of the eight areas reviewed (*). Areas below the HP2030 targets remain the same as previous PNA report and include adolescent health, cervical cancer screening, reduction of an A1c value greater than 9 percent, and timely postpartum care.

Table 18. *Select HEDIS 2020 Rates Compared to Healthy People 2030 Objectives*

Healthy People 2030 Objective	HP2030 Target	Santa Cruz and Monterey Results	Merced County Results
Adolescent Health -AH-01 Increase the proportion of adolescents who have had a wellness checkup in the past 12 months.	82.6%	63.26%	55.23%
Cancer -C-09 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.	84.3%	73.72%	62.77%
Diabetes -7 Increase the proportion of persons with diagnosed diabetes whose blood pressure is under control. (HEDIS 2019)	57.0%	76.28% *	67.40%*
Diabetes – 5 Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent	16.2%	36.50%	37.23%
Mother, Infant, and Child Health - MICH-08 Increase the proportion of pregnant women who receive early and adequate prenatal care.	80.5%	91.73%*	90.27%*
Mother, Infant, and Child Health – 19 Increase the proportion of women giving birth who attend a postpartum care visit with a health care worker	90.8%	88.56%	79.56%
Nutrition and Weight Status -NWS-05 Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to physical activity	32.6%	85.60%*	68.81%*

Healthy People 2030 Objective	HP2030 Target	Santa Cruz and Monterey Results	Merced County Results
Nutrition and Weight Status -6.3 Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet	15.2%	87.20%*	72.68%*

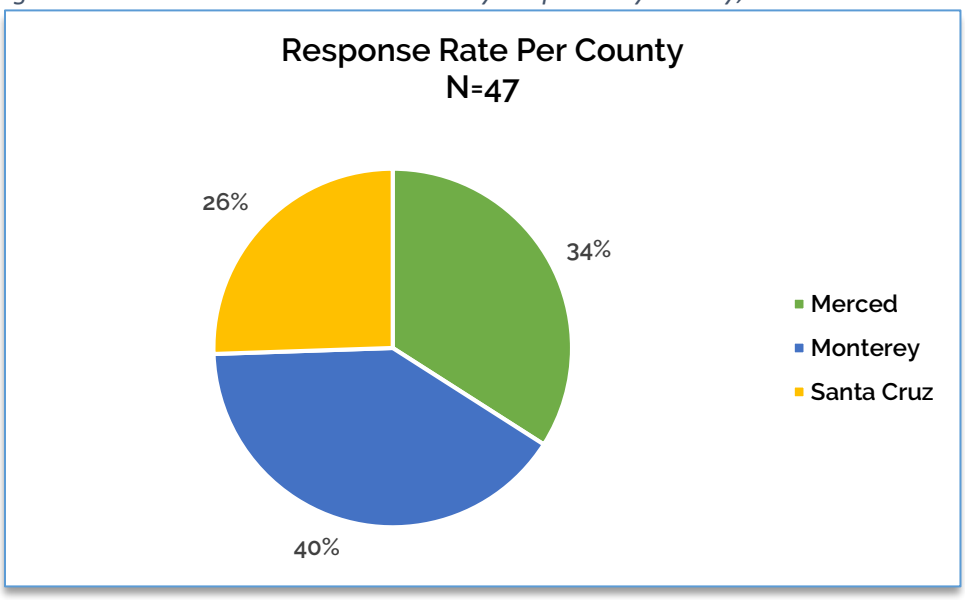
Low health literacy, cultural barriers, and limited English Proficiency have been coined the "triple threat" to effective health communication by The Joint Commission[xv]. Providing care to an increasingly diverse member population that is challenged with a triad of cultural, linguistic, and health literacy barriers has been a priority of focus of the Alliance in eliminating health disparities. As a health plan, the Alliance can facilitate the interconnections between member culture, language, and health literacy in order to improve health outcomes for culturally diverse members.

To further assist in identifying Medi-Cal members' perceptions, preferences, and behaviors as it relates to health education and cultural and linguistic services, the Alliance conducted a PNA member outreach survey in 2021. A total of 350 members were outreached by phone to complete the survey during April-May 2021. The Alliance used a standardized survey that consisted of 12 questions (members from all categories: Limited English Proficiency (LEP), deaf and hard of hearing, child, adult, seniors and persons with disabilities, and members with chronic health conditions). Survey was made available in English, Spanish, Hmong, and other languages. A total of 47 surveys were completed for an overall response rate of 13%. The response rate for the PNA Member Outreach Survey was substantially lower than usual for Alliance member surveys (compared to the 25% response rate from the previous year). We found that this can be attributed to when the outreach calls were done. During the timeframe of April-May 2021, members were coping with the several COVID-19 member outreach efforts and many members declined the survey. Therefore, in order to ensure higher response rate, a total of 18 Target® gift cards in the amount of $25 were given among participants who completed the survey. Table 19 represents the response rates by type of respondent and language of survey and Figure 27 survey response rate broken down by county.

Table 19. *PNA Member Outreach Survey Completed by Member Language and Age, 2021*

Language Spoken		Member's Age		Survey Type	
Language	**Members**	**Age**	**Total**	**Type**	**Total**
English	16	Under 18	19	Adult	28
Spanish	31	18-24	5	Child	19
Hmong	0	25-34	1		
Other	0	35-44	5		
		45-54	8		
		55-64	4		
		65+	5		

Figure 217. PNA Member Outreach Survey Response by County, 2021



Overall, all participants responded being 95.74% satisfied with the help they receive from the Alliance in coordinating theirs or their child's care in the last 12 months. This is a slight decreased in comparison to the rate for the 2020 survey (98%). About 90% of participants shared that their health beliefs do not go against their PCPs advice. In addition, the top topics for which respondents are mostly interested in receiving information or help from the Alliance include:

- Nurse Advice Line (34%) (2020 – 29%)
- How to handle a chronic condition (17%)
- Choosing a Doctor (17%)
- More information on transportation benefits (33%)

Participants from the PNA outreach member survey also expressed a wide variety of cultural and linguistic experiences and health education needs. The culturally bound beliefs, values, and preferences a person holds influence how a person interprets healthcare messages. The PNA outreach member surveyed showed that majority (83%) of participants indicated that the materials they received from the Alliance provide information that is easy to understand and in their preferred language (84%). This decreased from the previous survey conducted in 2020 (87%).

In regard to oral health, 52.17% of respondents have not seen a dentist in the last 6 months, and 21.73% have not seen a dentist for more than two years. Members expressed the lack of coverage for dental services and the need for coverage to expand. This question is new to the PNA survey and was brought to our attention by one of our members during the Member Services Advisory Group meeting when we were presenting the 2020 key findings. According to Healthy People 2030, Social Determinants of Health (SDoH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. For the purpose of addressing SDoH conditions, the PNA outreach member data analysis and member feedback are broken down into the following SDoH conditions: neighborhood and physical environment, education, food, and health care system. A summary of the key findings and/or themes from the PNA member

outreach survey individual member responses are outlined in Table 20 below. Overall, the data results showed similar key findings and/or themes when reviewed by each county. There is a wide range of gaps related to access to care, availability of providers, and use of technology needed for health education. Language is the common denominator used to identify many of these gaps. In general, Spanish speakers want more help on how to access and use medical care and Alliance services.

Table 20. *2021 PNA member outreach survey key findings by SDoH Conditions.*

SDoH Conditions	Key Findings/Themes
Neighborhood and Physical Environment	1. Safety: • Not enough safe places in the community to play and/or walk 2. Transportation: • Not enough transportation to medical appointments. COVID-19 impact access to care • Difficulty setting up accessing the transportation benefit • Long distance to access care
Education	Health Literacy • Not enough bi-cultural doctors who explain and give information • Information from the Alliance needs to be more clear, concise, easier to understand in the right language • Members expresses that the complex terms were challenging to understand • Members expressed not being literate and are unable to read information sent by the Alliance (i.e. 2nd – 3rd grade reading level)
Health Care System	1. Access to Care: • Need assistance with making appointments to specialists and PCPs • Lack of health care providers nearby (i.e. specialists, mental health care providers) • Not enough appointments to be seen (wait time for next appointment is far out) 2. Quality of Care: • Members expressed that some doctors do not give member enough time to explain their health concerns/discomforts • Members expressed seeing multiple providers and lack of communication between providers

In addition, the 2021 PNA Member Outreach Survey, to augment our knowledge of existing culturally and linguistically services, health education, and health plan needs from Medi-Cal members' perspectives, the following member surveys were analyzed (total count is shown for the number of surveys completed for each survey initiative):

- Member Insight Study……N=53
- Your Health Matters Outreach Program Survey……N=90

- Alliance Provider Satisfaction Survey……N=185
- COVID-19 Member Outreach Campaign…… N=688

Key findings from the surveys and responses to questions include:

Perceived health needs and expectations – Based on the 2021 PNA member outreach survey data, the CAHPS data, and the 2021 Member Insight Study access to care appears to be an issue for Alliance members.

The PNA member outreach survey identified issues related to access including:

- "Not enough appointment times at doctors' offices and clinics" (19.15%)
- "Not enough clinics and doctors nearby" (21.28%) both frequently mentioned when members were asked what they thought were important health concerns and issues
- "Who to call at night when sick" (30.43%) was also frequently mentioned when asked what information would be helpful to them on how to use the Alliance benefits.

The CAHPS data also echoes these access issues. Two measures, "Getting needed care" and "Getting care quickly" both showed improvement scores of 83.0% and 80.3% for adults when compared to the previous PNA report. For children the scores significantly increased when compared to the previous PNA report (76.9% and 80.9%), 80.4% and 86.8% respectively.

Additionally, results from the 2021 Member Insight Survey showed that 49% of Alliance members rely that the Alliance does a good job providing information and resources. A few respondents shared that they would like a doctor who speaks their language (7%) or that they would like support connecting to a specialist (20%). Most members said it was easy to keep up with regular check-ups and immunizations for their child(ren). However, about 23% cited challenges scheduling appointments due to COVID-19. Challenges include:

- No appointments available until a later date
- Not enough staff at the doctor's office or clinic to answer the phone
- Doctor's offices/clinics need to prioritize other patients

The Alliance conducts an annual Provider Satisfaction Survey in order to assess contracted providers' overall satisfaction with core health plan operations. Annual results are used to assess provider's awareness of Alliance resources, inform future initiatives and educational opportunities for the provider network, and in conjunction with other health plan data, provide insight into where the Alliance can focus improvement efforts. In 2020, a total of 1,028 eligible providers were surveyed, with a provider response rate of 18% and group response rate of 45%. When providers were asked if they refer their patients to the Alliance Nurse Advice Line, a resource for members to obtain needed care, about 68% indicated "No". When asked why, 35% said they were not aware of the services. There is an opportunity to further explore alternative methods for promoting awareness of the Alliance NAL amongst members and network providers.

Additionally, this theme also came up during the 2021 Member Insight Survey, where lack of providers and limited choice of PCPs was also a finding reported by the members during the interviews.

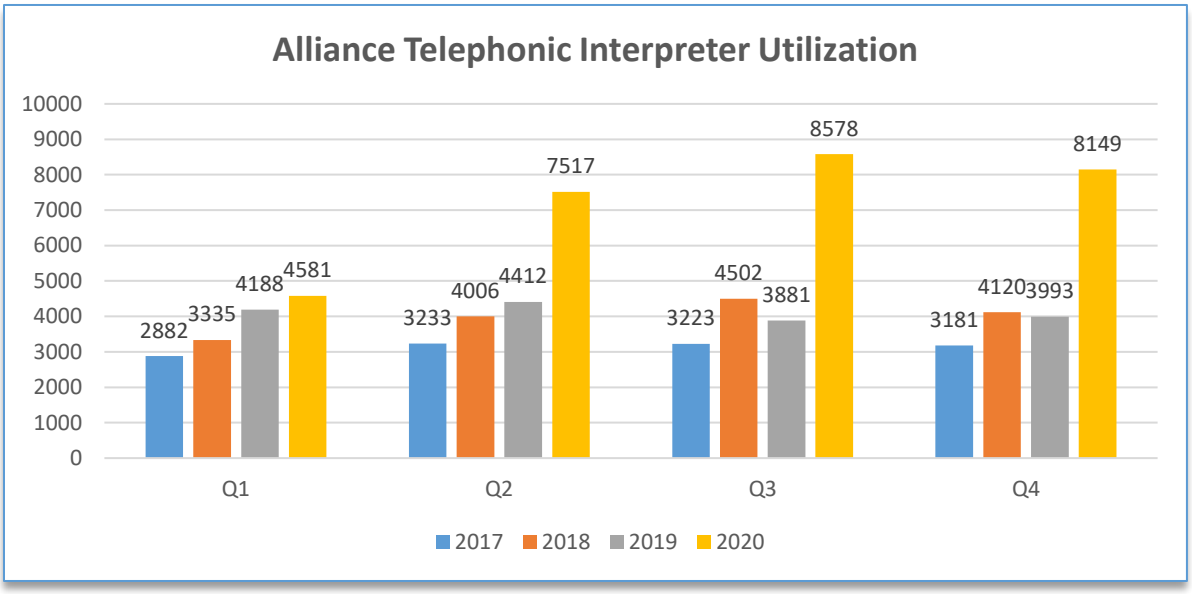
- 38% cited challenges making appointments because of COVID-19 such as the clinic/doctor not having enough available appointments, appointments were cancelled or postponed, priority was given to younger kids (<1), or the clinic doesn't answer the phone sometimes.
- 10% described general challenge making appointments saying it takes a while to connect with someone by the phone or they don't know how to connect to a specialist.
- 43% said it was easy to make an appointment
- 10% said they had challenges with access to personal transportation
- Most members from Merced County did not identify challenges finding a doctor or clinic. However, a few members from Merced noted there are limited specialists available and shared that they must travel long distances to see a specialist.

Reported language needs –The Alliance is committed to help bridge cultural and linguistic differences and ensure that all members have access to health care providers and services in their language of choice. The overall utilization of telephonic interpreting services has significantly increased among network providers, Alliance staff, and contracted Alliance vendors using the Alliance Language Assistance Service Program. A total of 28,825 telephonic interpreting services calls were reported for the measuring year of 2020 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 74.97% increase when compared to the 2020 PNA report (16,474) respectively. This increase can be contributed to the shift in the way members were accessing their medical care. In 2020, members were redirected to begin their health care journey via telehealth and telephonic options. Figure 28 illustrates utilization volume.

When members were asked how well their language needs are being met by their PCPs, the PNA member outreach survey findings indicated that 61% of members either always (13%), sometimes (35%), and usually (13%) get an interpreter when needed during their visit with at their doctor's office. Additionally, more participants reported (91%) that they never used a family member or friend to interpret for them during their PCP visit. Significant increase in the use of the Alliance telephonic interpreting services can be attributed to the Alliance Cultural and Linguistic and Provider Services teams, who has implemented several efforts in increasing the Alliance network providers/Alliance staff familiarity with the Alliance Language Assistance Services Program.

In the tri-county area, the following top four languages were predominately requested by Alliance providers in order to communicate with their patients telephonically in 2020 were Spanish, Vietnamese, Hmong, and Mandarin. The overall utilization of telephonic interpreting services continues to increase among providers, Alliance staff, and contracted Alliance vendors using the service.

Figure 22. *Alliance Telephonic Interpreter Provider/Alliance Staff Utilization by Quarter and Year, 2020*



In order to ensure that the interpreting services are provided to Alliance members, ongoing monitoring and evaluation that includes input from primary stakeholders is conducted periodically. On the individual level, this includes LEP members, Alliance staff, and interpreters themselves. On an institutional level, this includes contracted providers and their staff. This input is also obtained through the Provider Satisfaction Survey. Community input is important in assisting the Alliance in designing an interpreter services that truly improves the LEP member's experience of when receiving covered services.

Overall, there is an opportunity to explore options for increasing provider awareness and usage of the Alliance Cultural and Linguistic (C&L) resources. The C&L team continues to implement several efforts in increasing the Alliance network provider's familiarity with the Alliance Language Assistance Services Program. During the 2020 annual provider satisfaction survey, it showed the following results (a total of N=1,028 providers participated and the survey) when compared to the prior year 2019.

- 65% of providers are satisfied with telephonic interpreting and coordination of appointments with a telephonic interpreter.
- 23% of respondents reported they have not used telephonic interpreting, some due to lack of need and a small number (9 respondents) due to lack of awareness of the service.
- Primary care respondents are more satisfied overall than specialty care respondents with C&L services.

Results indicate satisfaction with Cultural and Linguistic services provided by the Alliance, however there is a need to explore options for increasing provider awareness and usage of the Alliance Cultural and Linguistic tools and services.

Availability and accessibility of health information – Some of the greatest disparities in health literacy occur among racial and ethnic minority groups from different cultural backgrounds and those who do not speak English as a first language. Results from the National Assessment of Adult Literacy[xvi] demonstrated that Hispanic adults (24%) have the lowest average health literacy scores of all racial/ethnic groups, followed by blacks. People with low health literacy and Limited English Proficiency are twice as likely as

individuals without these barriers to report poor health status. Cultural beliefs may also impact communication between patients and providers and affect a patient's ability to follow a providers instructions.

In the 2021 Member Insight Survey, when members were asked how they would like to receive information from the Alliance (phone, email, mail, text), by phone (50%), was the top choice, followed by mail (44%), and then email (6%). Additionally, when asked how likely are you to access care through different settings outside of the doctor's office? Some members indicated they would access care through more than one method, mobile clinic (44%), school (29%), and outreach fair (26%). Participants from the PNA outreach member survey expressed a wide variety of experiences and health education needs. Overall, all participants responded being 98% satisfied with the help they receive from the Alliance in coordinating theirs or their child's care in the last 12 months. The culturally bound beliefs, values, and preferences a person holds influence how a person interprets healthcare messages. The PNA member outreach surveyed also showed that majority (85%) of participants indicated that the materials they received from the Alliance provides information that is easy to understand and in their preferred language (87%). In addition, members who participated in the PNA member outreach survey also indicated that:

- Information from the Alliance needs to be more clear, concise, easier to understand and in the form of a pamphlet, phone application, or a friendly-user website
- Alliance benefits should be explained in-person
- Information should be provided using bigger font

In addition, both the 2021 PNA member outreach survey (13%) and the 2021 Member Insight Study (13%) had similarly finings that indicated health literacy being a challenge that most members shared.

Overall, members continue to express that certain terminology are challenging to understand. It was also identified that there are a few members who are illiterate and are unable to read information sent by the Alliance. According to Healthy People 2030, low overall literacy may impact health literacy; however, the relationship between them is complex. For example, an individual may have high overall literacy and still have low health literacy. A number of factors impact health literacy including a patient's receipt of appropriate written health communication materials, ability to accurately interpret written health-related information, and communication with providers. When individuals receive written health communication materials that don't match their reading level, education is not effective. May lead to a variety of negative health outcomes for the member. As a result, improvements in health practice that address low health literacy are needed to reduce disparities in health status. "Experts recommend that practices assume all patients and caregivers may have difficulty comprehending health information and should communicate in ways that anyone can understand." The literature also indicates that pictures in general facilitate comprehension of information in low literacy populations[xvii] when examining the effects of the use of pictures on health communication messaging to patients. This suggests that by adding pictures to enhance written and spoken instructions it can increase attention, comprehension, recall, and adherence to messaging. Overall, research shows that all patients benefitted from the use of pictures, but that low-literacy patients were the most likely to benefit.

Access to health education services – The Alliance provides a variety of health education services and information to members. The Alliance Health Educators logged over 33,000 member calls in 2020, including those that come through the Alliance's toll-free Health Education Line, see Appendix H for a list of Alliance Health Education and Disease Management programs. Type of information requested to learn

more about also varied by county, Table 21 outlines the top three requested items per county provided by the Alliance Your Health Matters initiatives, including the COVID-19 member outreach efforts.

Table 21. *Your Health Matters Surveys Results N=90, 2020*

County	Top 3 Items Requested
Merced	Alliance benefits, Transportation, Dental
Monterey	Alliance benefits, Care Management (WCM), Transportation
Santa Cruz	Transportation, Alliance Benefits, Dental

COVID-19 Member Outreach Campaign

The COVID-19 Member Outreach Campaign (MOC) was developed in response to our most vulnerable members needing increased support during this pandemic. The MOC was conducted between the months of Feburary-April in 2021. A total of 688 Alliance members were classified as higher risk for severe illness as a result of the COVID-19 virus. Higher risk members include members ages 16 and older who had underlying medical conditions. The top – the highest risk – were contacted by Alliance staff over the phone. These staff members provided a human connection to those who are potentially isolated, educate members about resources available to them and prevent deterioration of underlying conditions by addressing health concerns and/or barriers to care while on the call. Alliance nurses were also called upon to monitor these members through follow-up calls.

In addition, in 2020, the Alliance launched a series of member outreach campaigns to connect, educate, and support members who were impacted by all of the emergent issues (i.e. COVID-19, wildfires, air quality, water shut-offs, and PSPS events). A total of 131,113 members were outreached. Outreach interventions range from live calls, mailing, and robocalls. As of December 31,2020, the COVID-19 Member Outreach Campaign has reached 131,113 members. During these calls, we've identified that:

- Members' appreciate the phone call and are grateful that the Alliance was checking in on them
- A few members shared that their children are helping them setup telehealth video visits
- Members' expressed concerns over PPE, masks, hand sanitizer, and paper towels
- Members' also expressed needing direct services such as help with purchasing food and supplies for home
- Members' were worried about going outside and expressed financial hardships
- Alliance staff realized that seniors are more isolated, stressed, and needed additional follow-up calls vs. younger adults (non-CCS) as they were usually reporting they were doing fine
- Alliance staff also saw a trend in that several members were reporting that they didn't know the Alliance had a NAL service

The campaign, spearheaded by the Health Services Division and Your Health Matters, was intended to augment current Alliance member outreach programs and is only one part of a more concerted overall effort to reach our members through available channels. The key takeaway was the importance of being available to members during a time of crisis was highly valued by Alliance members.

H. Other Key Findings

The Alliance serves members living in extreme poverty across our three counties, some are thriving, perhaps due to their zip code or other critical factors, but most are not "living" with any measurable quality of life. By contract the Alliance ensures access to primary care, emergent services and inpatient

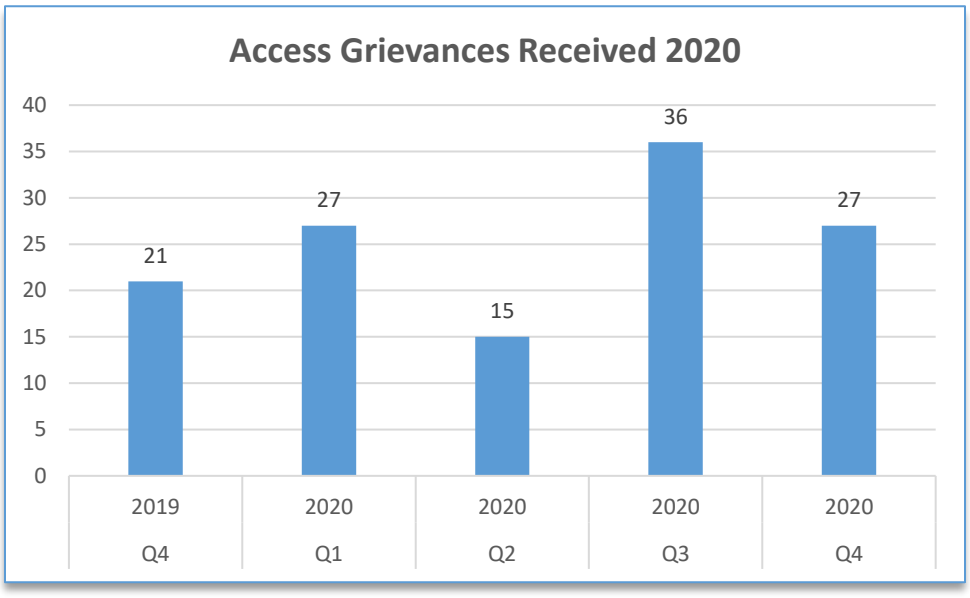
care and strives to do so in a culturally sensitive approach. Unfortunately, according to most population health models, including the one described in Figure 4 produced by RWJF, health factors and outcomes will remain largely unchanged until programs and policies are sufficiently modified to support our most vulnerable members.

In addition, some of the barriers Medi-Cal managed health care plans face when addressing health disparities and Social Determinants of Health (SDoH) is that DHCS does not require a standardized way to collect SDoH data from individual providers and medical groups, which results can vary. The Alliance primarily relies on provider coding to capture member SDoH data. However, the code sets for SDoH are not comprehensive, and we see differences in the definitions applied by providers when using these codes, as well as the number of providers utilizing. Moreover, provider coding is only effective at capturing SDoH data for members who are accessing care, and many members experiencing SDoH may be underutilizing medical care. There are other barriers such as cultural barriers, which may lead to underreporting.

Grievances

Trends in Accessibility Grievances remained stable in 2020 with a slight decrease of 1% in the rate of Access Grievances compared to membership months through Q4 2020 and a decrease of 11.5% in total Access Grievance case volume. Access Grievances account for approximately 6% of total Grievances in 2020. Although this percentage is lower than prior years, the decreased portion of case volume is primarily attributed to increases in other case types such as transportation services. See Figure 29 below.

Figure 29. *Alliance Grievance by Quarter, 2020*



Approximately 1,830 appeals and grievances were received in 2020 (Figure 31) of which 96 of these grievances were on behalf of Whole Child Model members (Figure 30). The two most common issues were transportation and related to Whole Genome Sequencing requests. Because of the clinical concern

of this grievance, staff reviewed the type of genetic testing being requested and worked closely with those clinicians requesting whole genome sequencing.

Figure 30. *Whole Child Model Grievances and Appeal, 2020*

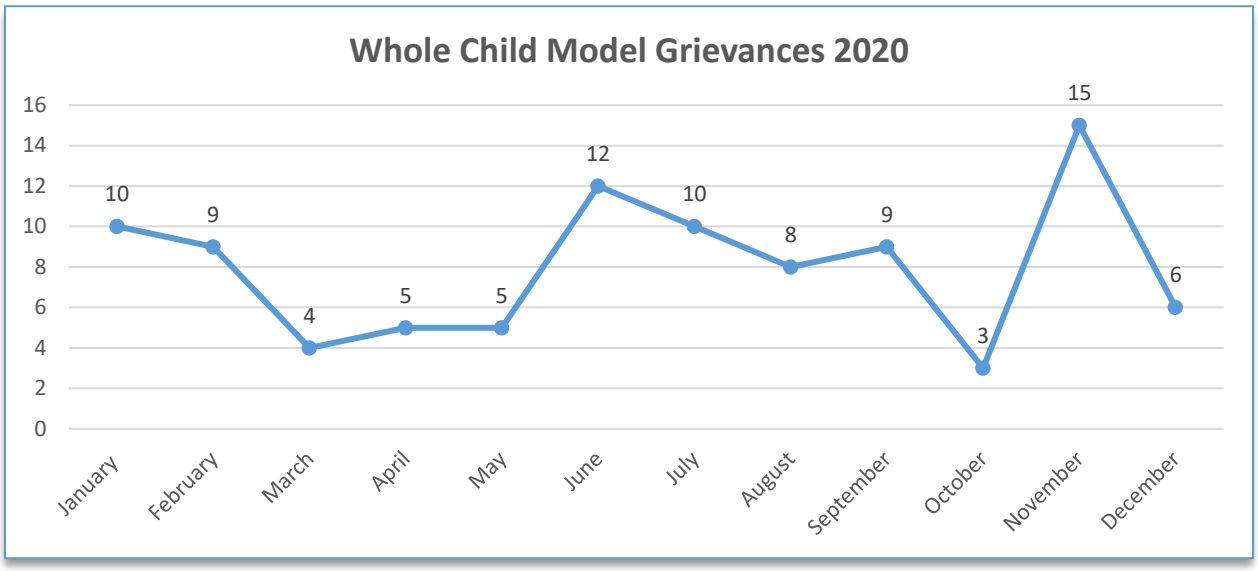
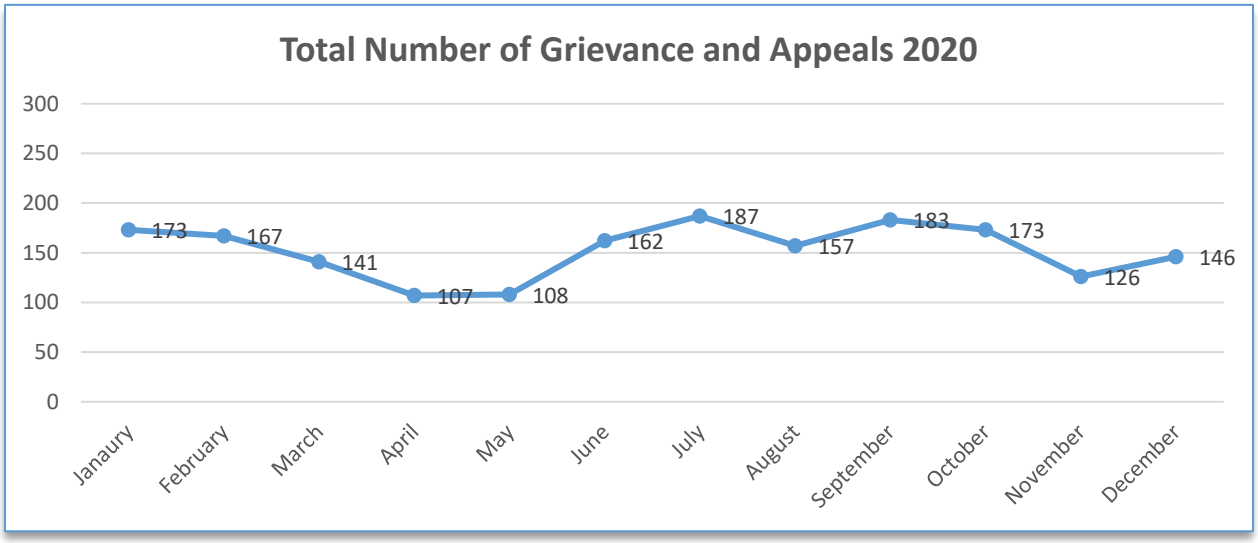


Figure 31. *Total Number of Grievance and Appeals, 2020*



5. Action Plan

Based on the findings outlined in this report, the following table presents key recommendations and 2021-2023 planned actions for the Alliance tri-county servicing areas. When compared by child, adult, and SPDs, PNA findings indicate similarities across these three groups. There are however differences when comparing the finding by language and by county. Interventions differ by county and by language accordingly. Alliance staff used National Association of City and County Health Officials (NACCHO) Guide for prioritization, selecting the "Multi-voting Technique" with two groups of Alliance Leadership.[xviii] The intent was to provide a very high level review of the health issues facing our membership (Appendix C)

and engage staff to ensure that other structural issues or other health issues could be named even without immediate primary data.

A. 2021 Action Plan Table

Access to Care	Objective
	By December 31, 2022, increase the percentage of members who report in CAHPS they were 'usually' or 'always' able to get care quickly by 2%, from 81.7% (adult) and 86.6% (child) to 83.7% (adult) and 88.6% (child) in all three service counties. Data Source: *2020 CAHPS Data and 2021 PNA Member Outreach Survey*
	Strategies
	1. Increase the percentage of members utilizing care for Behavioral Health services across all members living in Merced and Monterey County to address current geographical disparities by at least 1%. 2. Work on communication opportunities to promote the Nurse Advice Line and the Urgent Access Visits through provider and member outreach efforts.
Cultural and Linguistic	Objective
	By December 31, 2022, increase staff/provider utilization of telephonic interpreting calls by 4% from 28,825 to 29,978 and provider utilization of on-site face-to-face interpreting during medical visits from 1,127 to 1,172 in all three service counties for Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members. Data Source: *2021 PNA Member Outreach Survey, 2021 Member Insight Survey, Cultural and Linguistic Utilization reports*
	Strategies
	1. Develop a health literacy intervention focused on creating health plan materials to include a style guide, glossary of terms, and disseminate to internal departments that develop health plan information. 2. Identify one (1) essential health plan materials to field-test to assess member's ability to access and utilize health plan information to make informed decisions. 3. Develop provider trainings/videos on cultural competency to ensure Alliance providers are able to communicate effectively with Alliance members and produce optimal patient education outcomes.
Health Education/ Quality Improvement	Objective
	By December 31, 2021, at least 50% of Healthier Living Program participants will have reported "Good/Very Good/Excellent" in their ability to manage their chronic health condition(s). Data Source: *2020 HEDIS Data, and 2021 PNA Member Outreach Survey*
	Strategies
	1. Increase education referrals to the Alliance Health Services programs by promoting these services amongst the Alliance network providers. 2. Collaborate with community partners in helping members gain skills and confident in self-managing their diabetes.
Health Disparity	Objective
	By June 30, 2023, increase the percentage of members who attend their well-child visits (W30) in the first 30 months by 5% from 62.39% to 67.39% and their childhood immunization rate (CIS-10) for 2 years old from 21.65% to 26.65% in Merced County. Data Source: *2020 HEDIS Data and 2020 DHCS Health Disparities Data*
	Strategies

	1. Increase member/provider education about seeking preventative care, focusing on pediatric care in the first three years of life. 2. Increase member outreach on seeking preventative care, by including ethnicity data and prioritizing those members who have not utilized services (reduce ethnic disparities through targeted outreach). 3. Support Primary Care Providers in following the Advisory Committee for Immunization Practices (ACIP).

B. Action Plan Review and Updated Table

Focus Area	Objective	Strategies
Access to Care	Objective 1.) *Increase the percentage of members reporting timely access to care in all three service counties for CAHPS by 2% by December 31, 2022.* Data source: *2020 CAHPS Data and 2020 PNA Member Outreach Survey*	Progress Toward Objective: The 2018-2020 Strategic Plan serves as the Alliance's roadmap to measure success in the priorities of Access to Care, Member Wellness, and Promotion of Value. One of the Strategic Plan Goals identified focused on timely access to care: 5% increase in adult and child members indicating they are usually or always able to get care quickly by 2020. The Alliance met the goal for the child survey, but not for the adult survey. Barriers to meeting this goal include limited access to care due to avoidance and stay at home orders during the COVID-19 pandemic, especially for high-risk populations. Progress Measure: Increased the 2017 baseline rate of adult and child members indicating they are usually or always able to get care quickly by 3.6% for Adult and 5.2% for Child, from 76.7% to 80.3% and 81.6% to 86.8%, respectively. • 2017 Baseline: Adult 76.7%, Child 81.6% • 2018 Actual: Adult 73.7%, Child 82.4% • 2019 Actual: Adult 76.3%, Child 80.9% • 2020 Actual: Adult 80.3%, Child 86.8% • 2020 Goal: Adult 81.7%, Child 86.6% Data source: 2017-2020 CAHPS Data Activities: completed at the time of this PNA report • See Figure 31. under Access to Care section
Behavioral Health	Objective 2.) *Increase the percentage of members utilizing care for Behavioral Health services across all members living in Merced and Monterey County to address current geographical disparities by 5% by December 31, 2021.*	Progress Toward Objective: Behavioral Health objective has been modified to 1%, in addition, we've retired this objective and placed it under the "Access to Care Objective" for the 2021 PNA Action Plan as a strategy. Progress Measure: During COVID-19, the Alliance has seen an increase of members utilizing telehealth services for mild-to-moderate behavioral health needs. Beacon continues to outreach to providers and conduct interviews with the goal of learning more about their experiences with telehealth and to better understand their perspective of how telehealth practices impact their work and engagement with members.

	Data Source: *Mental Health Data and Alliance Behavioral Health Evaluation Report, Beacon Utilization Reports, DHCS Bulletins, and Internal Staff Reports.*	The Alliance will continue to share findings as we review the feedback from providers. In addition, in 2020, the Alliance updated the behavioral health webpage for members, to include more information about how to access services. In addition, flyers on behavioral services can now be accessed via the webpage and are shared with Alliance contracted providers via clinic meetings and other community meetings. In addition, Beacon recently provided an in-service to Monterey County Behavioral Health staff on how to make referrals to them for Alliance members who need access to mild-to-moderate behavioral health services. Lastly, the Alliance has seen an uptick in members needing to access eating disorder services. Alliance staff are working closely with County BH partners, Beacon, and eating disorder providers to assist members in receiving care. Behavioral Health Utilization Summary (tri-county service) • 2018 Baseline: 7.72% • 2019 Actual: 8.41% • 2020 Actual: 8.44% Data source: 2018-2021 Tableau Alliance Reports Modified Goal: Increase the percentage of members utilizing care for Behavioral Health services across all members living in Merced and Monterey County to address current geographical disparities by 1% by December 31, 2021. Activities: completed at the time of this PNA report • Beacon held a webinar on Telehealth Documentation 101: Bridging the Virtual Gap. Eighty three percent of the providers reported being satisfied or highly satisfied with the content, and 83% stated they would recommend the training to another provider. • Beacon holds weekly webinars for providers and some recent topics covered include Social Determinants of Health: Treatment implications, COVID-19: Exposure to Secondary Trauma and Provider Resiliency, and Suicide: Prevention and Care during COVID-19. • Also, see Figure 31. under Access to Care section
Cultural and Linguistic	Strategy 3.) *Identify one (1) essential health plan materials to field-test to assess member's ability to access and utilize health plan information to make informed decisions by December 31, 2021.*	Progress Toward Objective: The Cultural and Linguistic team continues to work with our language assistance services vendors to ensure continuity of access to telephonic and on-site face-to-face interpreting services for our Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members during their medical visits with the provider. On-going provider/member communication regarding the availability of telephonic language assistance services are being provided. Progress Measure:

	Data Source: *2020 PNA Member Outreach Survey and 2019 Your Health Matters Survey*	In an effort to support HEDIS childhood immunizations efforts, the Alliance has identified the need to develop a new member health education material. The Alliance has developed an Infant Wellness Map health education material and has invited Alliance parents to give us feedback on it. We asked for feedback on the content, layout, and design of the material. This will help inform what Alliance parents think about the material before we distribute the handout to provider and members. Currently working with internal teams on reviewing interviews and making improvements to the material. **Other supporting work (addressing health literacy):** Language Assistance Services Trends: The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 8,775 telephonic interpreting services calls were reported for measuring Q1 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 92% increase when compared to the previous Q1 2020 (4,581). As for face-to-face interpreting services, we had a total of 337 provider requests that were coordinated in Q1 2021 across the Alliance's service areas. This is a 28% decrease when compared to the previous Q1 2020 (471). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during a telehealth visit. This has emerged as a need due to COVID-19 as many of our provider's transition to telehealth visits in 2020 that may include phone and video options and may no longer require to have a qualified interpreter to be present. **Data source:** 2020-2021 Alliance Language Assistance Services Reporting **Modified Goal:** By December 31, 2022, increase staff/provider utilization of telephonic interpreting calls by 4% from 28,825 to 29,978 and provider utilization of on-site face-to-face interpreting during medical visits from 1,127 to 1,172 in all three service counties for Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members. **Activities:** completed at the time of this PNA report • See Figure 31. under Cultural and Linguistic section
Health Education	**Strategy 4.)** *Identify specific educational programing resources aimed at preventing health complications amongst members with Diabetes as measured through 2021 (MY) HEDIS and as demonstrated by managing historic levels of*	**Progress Toward Objective:** Update on HEDIS MY2020 Performance. The Comprehensive Diabetes Control Measure, HbA1c Poor Control (>9%) indicator has a 50th Percentile of 37.47% (reverse measure, lower is better). Santa Cruz-Monterey reported 37.24% and Merced 43.30%. Because measure specifications include the stipulation that evidence of HbA1c testing without an included test value is determined to be in poor control; a critical strategy to improve performance is

	performance or achieving the 50th percentile, whichever is highest by June 30, 2022. Data Source: *2019 HEDIS Data, 2018-2019 Member Engagement Environmental Scan, and 2019 Living Better with Diabetes Program Needs Assessment*	to continue to close the data gap with more HbA1c test results in addition to the improvement of the patient's clinical management and education to support effective self-management of their condition. Progress Measure: It was identified during the PNA action plan update that this goal will be modified to extend the time period to complete all activities that are planned. Modified Goal: By December 31, 2021, at least 50% of Healthier Living Program participants will have reported "Good/Very Good/Excellent" in their ability to manage their chronic health condition(s). Activities: completed at the time of this PNA report • See Figure 31. under Quality Improvement/Health Education section
Quality Improvement	Strategy 5.) *Increase the rates for well-child visits in the first 30 months of life and childhood immunizations for 2-year old's as measured through 2021 (MY) HEDIS and as demonstrated by managing historic levels of performance or achieving the 50th Percentile, whichever is highest by June 30, 2022.* Data Source*: 2019 HEDIS Data, 2019 DHCS Preventive Rate Sheet, 2019 DHCS Health Disparities Data*	Progress Toward Objective: HEDIS Measurement Year 2020 Findings, an update: Geographic disparities between Santa Cruz-Monterey region and the County of Merced persist. Well Child Visits for Age 15 to 30 months – Two or More Visits. The 50th Percentile for this measure is not yet benchmarked due to being a new NCQA measure. Santa Cruz-Monterey Reported 83.18%, Merced County reported 62.39%. Childhood Immunization Status (CIS), Combination 10 has a 50th Percentile of 37.47%. The CIS results were 53.66% for Santa Cruz-Monterey (Met 90th Percentile goal) and 21.65% for Merced County. The Alliance will maintain the goal of achieving at least the 50th Percentile for both regions and measures by June 30, 2022 using HEDIS MY2021 findings. The Alliance is examining all pediatric health activities historic and currently in process in Merced County to determine next steps for interventions. Progress Measure: It was identified during the PNA action plan update that this goal will be modified to extend the time period to complete all activities that are planned. Modified Goal: By June 30, 2023, increase the percentage of members who attend their well-child visits (W30) in the first 30 months by 5% from 62.39% to 67.39% and their childhood immunization rate (CIS-10) for 2 years old from 21.65% to 26.65% in Merced County. Activities: completed at the time of this PNA report • See Figure 31. Under Health Disparities section

Figure 32. PNA Action Plan Review and Updated Activities

Target Audience	Message/Content	Delivery Channel	Communication Date (Month/Year)
Access to Care			
Member	**BH Benefit Flyer (Adults)** Title: Member Behavioral Health COVID "Feeling Sad or Anxious?" We are here for you. The Alliance works with Beacon to connect you to mental health services and support.	Flyer	11/20
Member	**BH Benefit Flyer (Adolescents)** Title: Member Behavioral Health COVID "Feeling Sad or Anxious?" We are here for you.	Mailing	12/20
Member	**Member Newsletter** Article: Timely Access	Newsletter	03/21
Provider	**Provider Newsletter** Article: Appointment Wait Standards	Newsletter	03/21
Member	**Member Newsletter** Article: Is COVID-19 bringing your teen down? Shared BH Benefit Flyer (Adolescent) Flyer	Newsletter	06/21
Member	**New NAL Member Incentive Flyer** Promotion of NAL with contact details	Flyer	06/21
Member	**New Member Welcome Packet** Includes Health & Wellness Resource Flyer and Alliance Quick Reference Guide	Welcome Packet	Ongoing
Cultural & Linguistic			
Provider	**Provider Newsletter** Article: Alliance Language Assistance Services How to communicate better with their members	Newsletter	03/21
Provider	**Provider Newsletter** Article: Alliance language assistance services The Alliance offers the following services to our providers, eligible members and Alliance staff at no cost:	Newsletter	06/21
Member	**Member Newsletters** Article: Alliance's Language Assistance Services Advertise C&L services	Newsletter	03/21 & 06/21
Quality Improvement/Health Education			
Member	**Member Flyer** Promoted Healthier Living Program Workshop for members that have a chronic health condition	Flyer	03/21
Provider	**Provider Bulletin** Article: Promotion of Alliance Health Education and Disease Management Programs during COVID-19	Newsletter	12/21
Provider	**Provider Bulletin** Article: Promoted Healthier Living Program for members that have a chronic health condition	Newsletter	03/21
Member	**Healthier Living Program Banner** Promotion and link to Healthier Living Program on website landing page	Website	07/21
Health Disparity			

Target Audience	Message/Content	Delivery Channel	Communication Date (Month/Year)
Member	**Member Mailing** EPDST Pediatric DHCS Campaign Phase I (0-2.99 ages)	Mailing	11/20
Member	**Member Mailing** EPDST Pediatric DHCS Campaign Phase II (3-6.99 ages)	Mailing	11/20
Member	**Member Newsletter** Article: Back to School Immunizations. The start of a new school year is almost here, and your child may need to be vaccinated before going back to school.	Newsletter	06/21
Member	**Member Newsletter** Article: What is lead screening for children and why is it important? Steps to make your home safer from lead	Newsletter	03/21
Member	**Robocalls** Topic: EPSDT Pediatric DHCS & COVID-19 Campaign Phase III (7-17.99 ages)	Robocalls	06/21
Member	**Robocalls** Topic: EPSDT Pediatric DHCS & COVID-19 Campaign Phase III (18-20.99 ages)	Robocalls	06/21
Member	**Member Newsletter** Article: Immunizations Back to School	Newsletter	06/21
Member	Member Mailing EPDST Pediatric Early Childhood (15 months)	Mailing	Monthly
Member	Member Mailing EPDST Pediatric Newborn and Infant (4 months)	Mailing	Monthly

6. Stakeholder Engagement

The Alliance used a variety of methods to engage both internal and external stakeholders in providing feedback and input into the PNA. Table 22 below provides a list of different engagement methods used to engage stakeholders on the PNA and describes the method of engagement with stakeholder and date of completion of these methods.

Table 22. *Stakeholder Engagement*

Stakeholder	Engagement Method	Date of Completion
Alliance Population Needs Assessment Stakeholder Kick-Off Meeting	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	January 27, 2021
Alliance Population Needs Assessment	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders	March 1, 2021

Stakeholder Meeting	• Incorporated stakeholder feedback and input, if any into the PNA	
Alliance Population Needs Assessment Stakeholder Meeting: Regional Operations	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	March 10, 2021
Alliance Population Needs Assessment Stakeholder Meeting: Provider Services	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	March 11, 2021
Alliance Population Needs Assessment Stakeholder Meeting: Beacon and Community Care Coordination	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	March 23, 2021
Alliance Population Needs Assessment Stakeholder Meeting: Strategic Development	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	March 24, 2021
Alliance Population Needs Assessment Stakeholder Meeting: Operational Excellence	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders • Incorporated stakeholder feedback and input, if any into the PNA	March 2, 2021
Alliance Medi-Cal Members	• Conducted a telephonic member outreach survey with Alliance Medi-Cal members from all three (3) service counties (N= 91) on the following topics: ▪ Access to Care ▪ Interpreting Services ▪ Health Education • Gathered feedback and input from individual Alliance members • Incorporated member feedback and input from the survey data results into the PNA	April 30, 2021

Additional stakeholder engagement will continue to be carried out and the PNA findings will be shared to educate impacted internal Alliance departments, internal and external work groups, contracted health care providers, and other community organization workgroups. The timing and dissemination methods with stakeholders are provided below in Table 23.

Table 23. *Stakeholder Dissemination Methods*

Stakeholder	Dissemination Method	Timing

Alliance Contracted Network Providers	• Educate Alliance contracted network providers on the PNA findings using the following method(s):
	  • Write articles in the Alliance Quarterly Provider Bulletin
	  • Post the full PNA Report on the Provider Website
	  • Incorporate the PNA findings into Provider Workshops/In-Service Trainings
	  • Write memos in the Provider Fax Blasts
		Q4 2021 - Q2 2022

Alliance Medi-Cal Members	• Educate Alliance Medi-Cal members on the PNA findings using the following method(s): • Write articles in the Alliance Quarterly Member Newsletter	Q4 2021 - Q2 2022
Continuous Quality Improvement Committee (CQIC)	• As a follow-up, present PNA findings and action plans using a PowerPoint presentation to internal and external stakeholders which included the Alliance network providers	Q3 2021
Alliance Continuous Quality Improvement Work Group-Interdisciplinary (CQIW-I)	• As a follow-up, present PNA findings and action plans using a PowerPoint presentation to internal stakeholders	Q4 2021
Alliance Member Services Advisory Group (MSAG)	• As a follow-up, present PNA findings and action plans using a PowerPoint presentation to external stakeholders	Q4 2021
Alliance Continuous Quality Improvement Work Group (CQIW)	• As a follow-up, present PNA findings and action plans using a PowerPoint presentation to internal stakeholders	Q4 2021
Whole Child Model Family Advisory Committee (WCMFAC)	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2021

Physicians Advisory Group (PAG)	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2021
Tri-County Women, Infants, and Children (WIC) Community Work Group	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2021
Tri-County Comprehensive Perinatal Services Program (CPSP) Community Work Group	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2021

Appendices

Appendix A: Membership Tables

Tables 1 A-D. Non-SPD and Non-WCM Members

A. Plan's Members by Age Group

Age Group	Member Numbers	% of Total Membership
0-1	15061	4.82%
2-17	136741	43.72%
18-44	118162	37.78%
45-64	41299	13.20%
65+	1522	0.49%
Grand Total	**312785**	**100.00%**

C. Plan's Members by Age Group and Ethnicity

Ethnicity	Age Group	Member Numbers
Black	0-1	169
	2-17	2234
	18-44	3252
	45-64	1102
	65+	42
Black Total		**6799**
All Others	0-1	1088
	2-17	4042
	18-44	7638
	45-64	2819
	65+	79
All Others Total		**15666**
Asian or Pacific Islander	0-1	3445
	2-17	10241
	18-44	8454
	45-64	3843
	65+	231
Asian or Pacific Islander Total		**26214**
White	0-1	1038
	2-17	12108
	18-44	21298
	45-64	10521
	65+	407
White Total		**45372**
Hispanic	0-1	9321
	2-17	108114
	18-44	77490

	45-64	22905
	65+	737
Hispanic Total		**218567**
Not Provided	18-44	24
	45-64	109
	65+	26
Not Provided Total		**159**
Unknown	2-17	2
	18-44	6
Unknown Total		**8**
Grand Total		**312785**

D. Plan's Members by Age Group and Spoken Language

Spoken Language	Age Group	Member Numbers
English	0-1	8801
	2-17	63288
	18-44	74103
	45-64	23245
	65+	844
English Total		**170281**
Hmong	0-1	49
	2-17	700
	18-44	928
	45-64	240
	65+	6
Hmong Total		**1923**
Other	0-1	143
	2-17	706
	18-44	945
	45-64	782
	65+	69
Other Total		**2645**
Spanish	0-1	6068
	2-17	72047
	18-44	42186
	45-64	17032
	65+	603
Spanish Total		**137936**
Grand Total		**312785**

E. Plan's Members by Age Group and County		
County	Age Group	Member Numbers
MERCED	0-1	5520
	2-17	51192
	18-44	45405
	45-64	13885
	65+	421
MERCED Total		**116423**
MONTEREY	0-1	7254
	2-17	64426
	18-44	48420
	45-64	16810
	65+	760
MONTEREY Total		**137670**
SANTA CRUZ	0-1	2287
	2-17	21123
	18-44	24337
	45-64	10604
	65+	341
SANTA CRUZ Total		**58692**
Grand Total		**312785**

Table 2 A-I. SPD Population

A. Plan's Members by SPD Aid Category		
Aid Category	Member Numbers	% of Total Membership
Aged	2589	17.08%
Blind	208	1.37%
Disabled	12357	81.54%
Grand Total	**15154**	**100.00%**

B. Plan's Members by Age Group and SPD Aid Category			
Age Group	Aid Category	Member Numbers	% of Total Membership
0-1	Disabled	78	0.51%
0-1 Total		**78**	**0.51%**
2-17	Blind	31	0.20%
	Disabled	2517	16.61%
2-17 Total		**2548**	**16.81%**

18-44	Blind	113	0.75%
	Disabled	4243	28.00%
18-44 Total		4356	28.74%
45-64	Aged	1	0.01%
	Blind	59	0.39%
	Disabled	5187	34.23%
45-64 Total		5247	34.62%
65+	Aged	2588	17.08%
	Blind	5	0.03%
	Disabled	332	2.19%
65+ Total		2925	19.30%
Grand Total		15154	100.00%

C. Plan's Members by Ethnicity and SPD Aid Category

Ethnicity	Aid Category	Member Numbers	% of Total Membership
Black	Aged	15	0.10%
	Blind	10	0.07%
	Disabled	834	5.50%
Black Total		859	5.67%
All Others	Aged	153	1.01%
	Blind	9	0.06%
	Disabled	697	4.60%
All Others Total		859	5.67%
Asian or Pacific Islander	Aged	576	3.80%
	Blind	36	0.24%
	Disabled	2826	18.65%
Asian or Pacific Islander Total		3438	22.69%
White	Aged	141	0.93%
	Blind	55	0.36%
	Disabled	3390	22.37%
White Total		3586	23.66%
Hispanic	Aged	1704	11.24%
	Blind	98	0.65%
	Disabled	4608	30.41%
Hispanic Total		6410	42.30%
Unknown	Disabled	2	0.01%
Unknown Total		2	0.01%
Grand Total		15154	100.00%

D. Plan's Members by Member's Spoken Language and SPD Aid Category

Spoken Language	Aid Category	Member Numbers	% of Total Membership
English	Aged	509	3.36%
	Blind	140	0.92%
	Disabled	8604	56.78%
English Total		9253	61.06%
Hmong	Aged	7	0.05%
	Blind	7	0.05%
	Disabled	312	2.06%
Hmong Total		326	2.15%
Other	Aged	350	2.31%
	Blind	11	0.07%
	Disabled	866	5.71%
Other Total		1227	8.10%
Spanish	Aged	1723	11.37%
	Blind	50	0.33%
	Disabled	2575	16.99%
Spanish Total		4348	28.69%
Grand Total		15154	100.00%

E. Plan's Members by Program County and SPD Category

County	Aid Category	Member Numbers	% of Total Membership
MERCED	Aged	731	4.82%
	Blind	115	0.76%
	Disabled	5825	38.44%
MERCED Total		6671	44.02%
MONTEREY	Aged	1303	8.60%
	Blind	60	0.40%
	Disabled	3947	26.05%
MONTEREY Total		5310	35.04%
SANTA CRUZ	Aged	555	3.66%
	Blind	33	0.22%
	Disabled	2585	17.06%
SANTA CRUZ Total		3173	20.94%
Grand Total		15154	100.00%

F. Plan's Members by Zip Zone and SPD Category

Zip Zone	Aid Category	Member Numbers	% of Total Membership
APTOS	Aged	28	0.18%
	Blind	1	0.01%
	Disabled	107	0.71%
APTOS Total		**136**	**0.90%**
ATWATER / WINTON	Aged	132	0.87%
	Blind	22	0.15%
	Disabled	1007	6.65%
ATWATER / WINTON Total		**1161**	**7.66%**
CAPITOLA	Aged	23	0.15%
	Blind	2	0.01%
	Disabled	73	0.48%
CAPITOLA Total		**98**	**0.65%**
FREEDOM	Aged	19	0.13%
	Blind	4	0.03%
	Disabled	91	0.60%
FREEDOM Total		**114**	**0.75%**
LIVINGSTON / DELHI	Aged	148	0.98%
	Blind	8	0.05%
	Disabled	388	2.56%
LIVINGSTON / DELHI Total		**544**	**3.59%**
MERCED	Aged	223	1.47%
	Blind	59	0.39%
	Disabled	2977	19.64%
MERCED Total		**3259**	**21.51%**
PLANADA / LEGRAND	Aged	20	0.13%
	Blind	1	0.01%
	Disabled	114	0.75%
PLANADA / LEGRAND Total		**135**	**0.89%**
SAN LORENZO VALLEY	Aged	46	0.30%
	Blind	1	0.01%
	Disabled	250	1.65%
SAN LORENZO VALLEY Total		**297**	**1.96%**
SANTA CRUZ	Aged	135	0.89%
	Blind	13	0.09%
	Disabled	1025	6.76%
SANTA CRUZ Total		**1173**	**7.74%**
SOQUEL	Aged	10	0.07%
	Disabled	77	0.51%
SOQUEL Total		**87**	**0.57%**
THE WESTSIDE	Aged	175	1.15%
	Blind	20	0.13%
	Disabled	962	6.35%
THE WESTSIDE Total		**1157**	**7.63%**

Unknown	Aged	1322	8.72%
	Blind	67	0.44%
	Disabled	4402	29.05%
Unknown Total		5791	38.21%
WATSONVILLE	Aged	308	2.03%
	Blind	10	0.07%
	Disabled	884	5.83%
WATSONVILLE Total		1202	7.93%
Grand Total		15154	100.00%

G. Plan's Members by Gender and SPD Category

Gender	Aid Category	Member Numbers	% of Total Membership
F	Aged	1698	11.20%
	Blind	95	0.63%
	Disabled	5599	36.95%
F Total		7392	48.78%
M	Aged	891	5.88%
	Blind	113	0.75%
	Disabled	6758	44.60%
M Total		7762	51.22%
Grand Total		15154	100.00%

H. Plan's Members by Gender

Gender	Member Numbers	% of Total Membership
F	7392	48.78%
M	7762	51.22%
Grand Total	15154	100.00%

I. Plan's Members by Chronic Conditions (Note: A member can have more than 1 Chronic Conditions)

Chronic Condition	Member Numbers	% of Total Membership
Mental Illness	6112	28.64%
Hypertension	4806	22.52%
Diabetes	2964	13.89%
Substance Use Disorder	2341	10.97%
Asthma	1564	7.33%
COPD	1063	4.98%
Chronic Heart Failure	889	4.17%

Coronary Artery Disease	653	3.06%
Chronic Liver Disease	532	2.49%
Traumatic Brain Injury	212	0.99%
Dementia	202	0.95%
Grand Total	21338	100.00%

Tables 3 A-F. Whole Child Model Membership

A. Plan's Members by Age Group

Age Group	Member Numbers	% of Total Membership
0-1	820	12.57%
2-17	4794	73.49%
18-44	909	13.94%
Grand Total	6523	100.00%

B. Plan's Members by Ethnicity

Ethnicity	Member Numbers	% of Total Membership
Black	110	1.69%
All Others	193	2.96%
Asian or Pacific Islander	878	13.46%
White	582	8.92%
Hispanic	4760	72.97%
Grand Total	6523	100.00%

C. Plan's Members by Spoken Language

Row Labels	Member Numbers	% of Total Membership
English	2957	45.33%
Hmong	37	0.57%
Other	90	1.38%
Spanish	3439	52.72%
Grand Total	6523	100.00%

D. Plan's Members by County

Row Labels	Member Numbers	% of Total Membership
MERCED	2634	40.38%
MONTEREY	2994	45.90%
SANTA CRUZ	895	13.72%
Grand Total	**6523**	**100.00%**

E. Plan's Members by Zip Zone

Row Labels	Member Numbers	% of Total Membership
APTOS	33	0.51%
ATWATER / WINTON	466	7.14%
CAPITOLA	12	0.18%
FREEDOM	76	1.17%
LIVINGSTON / DELHI	262	4.02%
MERCED	1031	15.81%
PLANADA / LEGRAND	83	1.27%
SAN LORENZO VALLEY	55	0.84%
SANTA CRUZ	167	2.56%
SOQUEL	18	0.28%
THE WESTSIDE	661	10.13%
Unknown	3057	46.86%
WATSONVILLE	602	9.23%
Grand Total	**6523**	**100.00%**

F. Plan's Members by Gender

Row Labels	Member Numbers	% of Total Membership
F	3056	46.85%
M	3467	53.15%
Grand Total	**6523**	**100.00%**

Tables 4 A-F. Entire Population

A. Plan's Members by Age Group

Age Group	Member Numbers	% of Total Membership
0-1	15897	4.77%
2-17	143244	42.97%
18-44	123254	36.97%
45-64	46546	13.96%
65+	4447	1.33%
Grand Total	**333388**	**100.00%**

B. Plan's Members by Ethnicity and Age Group

Ethnicity	Age Group	Member Numbers	% of Total Membership
Black	0-1	181	0.05%
	2-17	2379	0.71%
	18-44	3546	1.06%
	45-64	1549	0.46%
	65+	83	0.02%
Black Total		**7738**	**2.32%**
All Others	0-1	1129	0.34%
	2-17	4211	1.26%
	18-44	7867	2.36%
	45-64	3223	0.97%
	65+	261	0.08%
All Others Total		**16691**	**5.01%**
Asian or Pacific Islander	0-1	3668	1.10%
	2-17	11341	3.40%
	18-44	9468	2.84%
	45-64	4838	1.45%
	65+	892	0.27%
Asian or Pacific Islander Total		**30207**	**9.06%**
White	0-1	1084	0.33%
	2-17	12743	3.82%
	18-44	22432	6.73%
	45-64	12534	3.76%
	65+	651	0.20%
White Total		**49444**	**14.83%**
Hispanic	0-1	9835	2.95%
	2-17	112567	33.76%
	18-44	79910	23.97%
	45-64	24293	7.29%
	65+	2534	0.76%
Hispanic Total		**229139**	**68.73%**

Race Not Provided	18-44	24	0.01%
	45-64	109	0.03%
	65+	26	0.01%
Not Provided Total		**159**	**0.05%**
Unknown	2-17	3	0.00%
	18-44	7	0.00%
Unknown Total		**10**	**0.00%**
Grand Total		**333388**	**100.00%**

C. Plan's Members by County and Age Group

County	Age Group	Member Numbers	% of Total Membership
MERCED	0-1	5840	1.75%
	2-17	53937	16.18%
	18-44	47791	14.33%
	45-64	16360	4.91%
	65+	1318	0.40%
MERCED Total		**125246**	**37.57%**
MONTEREY	0-1	7669	2.30%
	2-17	67275	20.18%
	18-44	50139	15.04%
	45-64	18305	5.49%
	65+	2151	0.65%
MONTEREY Total		**145539**	**43.65%**
SANTA CRUZ	0-1	2388	0.72%
	2-17	22032	6.61%
	18-44	25324	7.60%
	45-64	11881	3.56%
	65+	978	0.29%
SANTA CRUZ Total		**62603**	**18.78%**
Grand Total		**333388**	**100.00%**

D. Plan's Members by Spoken Language and Age Group

Spoken Language	Age Group	Member Numbers	% of Total Membership
English	0-1	9247	2.77%
	2-17	66474	19.94%
	18-44	77432	23.23%
	45-64	27287	8.18%
	65+	1558	0.47%

English Total		**181998**	**54.59%**
Hmong	0-1	52	0.02%
	2-17	738	0.22%
	18-44	1014	0.30%
	45-64	433	0.13%
	65+	36	0.01%
Hmong Total		**2273**	**0.68%**
Other	0-1	172	0.05%
	2-17	798	0.24%
	18-44	1203	0.36%
	45-64	1281	0.38%
	65+	467	0.14%
Other Total		**3921**	**1.18%**
Spanish	0-1	6426	1.93%
	2-17	75234	22.57%
	18-44	43605	13.08%
	45-64	17545	5.26%
	65+	2386	0.72%
Spanish Total		**145196**	**43.55%**
Grand Total		**333388**	**100.00%**

E. Plan's Members by Zip Zone and Age Group

Zip Zone	Age Group	Member Numbers	% Total Membership
APTOS	0-1	69	0.02%
	2-17	761	0.23%
	18-44	1231	0.37%
	45-64	616	0.18%
	65+	45	0.01%
APTOS Total		**2722**	**0.82%**
ATWATER / WINTON	0-1	1096	0.33%
	2-17	10320	3.10%
	18-44	8222	2.47%
	45-64	2891	0.87%
	65+	236	0.07%
ATWATER / WINTON Total		**22765**	**6.83%**
CAPITOLA	0-1	42	0.01%
	2-17	411	0.12%
	18-44	541	0.16%
	45-64	351	0.11%
	65+	39	0.01%
CAPITOLA Total		**1384**	**0.42%**
FREEDOM	0-1	166	0.05%
	2-17	1574	0.47%

	18-44	1164	0.35%
	45-64	448	0.13%
	65+	35	0.01%
FREEDOM Total		**3387**	**1.02%**
LIVINGSTON / DELHI	0-1	550	0.16%
	2-17	5371	1.61%
	18-44	4387	1.32%
	45-64	1723	0.52%
	65+	223	0.07%
LIVINGSTON / DELHI Total		**12254**	**3.68%**
MERCED	0-1	2296	0.69%
	2-17	20152	6.04%
	18-44	20058	6.02%
	45-64	6633	1.99%
	65+	477	0.14%
MERCED Total		**49616**	**14.88%**
PLANADA / LEGRAND	0-1	153	0.05%
	2-17	1713	0.51%
	18-44	1303	0.39%
	45-64	541	0.16%
	65+	35	0.01%
PLANADA / LEGRAND Total		**3745**	**1.12%**
SAN LORENZO VALLEY	0-1	139	0.04%
	2-17	1362	0.41%
	18-44	2166	0.65%
	45-64	1233	0.37%
	65+	109	0.03%
SAN LORENZO VALLEY Total		**5009**	**1.50%**
SANTA CRUZ	0-1	491	0.15%
	2-17	4515	1.35%
	18-44	8224	2.47%
	45-64	4143	1.24%
	65+	288	0.09%
SANTA CRUZ Total		**17661**	**5.30%**
SOQUEL	0-1	44	0.01%
	2-17	435	0.13%
	18-44	707	0.21%
	45-64	407	0.12%
	65+	25	0.01%
SOQUEL Total		**1618**	**0.49%**
THE WESTSIDE	0-1	1450	0.43%
	2-17	13718	4.11%
	18-44	10707	3.21%
	45-64	3865	1.16%
	65+	295	0.09%
THE WESTSIDE Total		**30035**	**9.01%**

Unknown	0-1	7770	2.33%
	2-17	67874	20.36%
	18-44	53420	16.02%
	45-64	19085	5.72%
	65+	2176	0.65%
Unknown Total		**150325**	**45.09%**
WATSONVILLE	0-1	1631	0.49%
	2-17	15038	4.51%
	18-44	11124	3.34%
	45-64	4610	1.38%
	65+	464	0.14%
WATSONVILLE Total		**32867**	**9.86%**
Grand Total		**333388**	**100.00%**

F. Plan's Members by Gender and Age Group

Gender	Age Group	Member Numbers	% Total Membership
F	0-1	7900	2.37%
	2-17	69963	20.99%
	18-44	70449	21.13%
	45-64	25324	7.60%
	65+	2718	0.82%
F Total		**176354**	**52.90%**
M	0-1	7997	2.40%
	2-17	73281	21.98%
	18-44	52805	15.84%
	45-64	21222	6.37%
	65+	1729	0.52%
M Total		**157034**	**47.10%**
Grand Total		**333388**	**100.00%**

Appendix B: HEDIS MY2020 Results

Central California Alliance for Health
MY 2020 (Final Rates)

	Measure Acronym	Held to MPL?	Performance Measure	SCMON	MERCED	NCQA Benchmarks 50th Percentile	NCQA Benchmarks 90th Percentile
Hybrid Measures	CBP	Y	Controlling High Blood Pressure	54.01%	53.28%	61.80	72.75
	CCS	Y	Cervical Cancer Screening	65.55%	63.66%	61.31	72.68
	CDC-H9 *(inverse)*	Y	HbA1c- Poor >9 *(inverse)*	37.24%	43.30%	37.47	27.98
	CIS-10	Y	Childhood Immunizations - Combo 10	53.66%	21.65%	37.47	52.07
	IMA-2	Y	Immunizations for Adolescents - Combo 2	59.49%	38.34%	36.86	50.85
	PPC-PRE	Y	Timeliness of Prenatal	93.15%	91.67%	89.05	95.86
	PPC-PST	Y	Postpartum Follow Up	84.93%	81.61%	76.40	84.18
	WCC - BMI	Y	Weight Assessment and Counseling - BMI	87.10%	88.56%	80.50	90.77
	WCC - N	Y	Counseling for Nutrition	82.48%	72.02%	71.55	85.16
	WCC - PA	Y	Counseling for Physical Activity	79.81%	70.56%	66.79	81.02
Administrative Measures	ADD-C&M*	Y	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	56.06%	52.00%	54.73	67.98
	ADD-Init*	Y	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase*Not held to MPL	48.41%	47.21%	42.95	55.33
	AMB-ED	N	Emergency Department Visits/1000MM	32.15%	35.32%	58.14	78.02
	AMM-Acute	Y	Antidepressant Medication Management - Effective Acute Phase Treatment	61.86%	58.10%	53.57	64.29
	AMM-Cont	Y	Antidepressant Medication Management - Effective Continuation Phase Treatment	43.71%	38.98%	38.18	49.37
	AMR	Y	Asthma Medication Ratio	75.32%	73.15%	62.43	73.38
	APM-B	Y	Blood Glucose Testing	100.00%	25.00%	54.42	69.66
	APM-BC	Y	Blood Glucose and Cholesterol Testing	0.00%	0.00%	35.43	56.34
	APM-C	Y	Cholesterol Testing	0.00%	0.00%	37.08	58.40
	BCS	Y	Breast Cancer Screening	56.38%	54.13%	58.82	69.22
	CHL	Y	Chlamydia Screening in Women	57.04%	52.04%	58.44	71.42
	PCR	N	Plan All Cause Readmissions	17.57%	14.22%	No B/Mark	No B/Mark
	SSD	Y	Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antiphsychotic Meds	100.00%	100.00%	82.09	87.91
	W30-2+	Y	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	83.18%	62.39%	No B/Mark	No B/Mark
	W30-6+	Y	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	44.21%	34.76%	No B/Mark	No B/Mark
	WCV	Y	Child and Adolescent Well-Care Visits	50.14%	37.76%	No B/Mark	No B/Mark
		Beneath 50th Percentile		4	7		
		Above 50th Percentile		10	11		
		Exceeds the 90th Percentile		4	0		
		No Report Due to Small Denominator		4	4		

Appendix C: Membership Tables (Homelessness)

Tables 3 A-E. Homeless Membership

A. Plan's Homeless Members by Age Group		
Age Group	Member Numbers	% of Total Membership
0-1	562	2.21%
2-17	6978	27.39%
18-44	12810	50.28%
45-64	5062	19.87%
65+	66	0.26%
Grand Total	**25478**	**100.00%**

B. Plan's Homeless Members by Ethnicity		
Ethnicity	Member Numbers	% of Total Membership
Black	2123	8.33%
All Others	1307	5.13%
Asian or Pacific Islander	1524	5.98%
White	6845	26.87%
Hispanic	13679	53.69%
Grand Total	**25478**	**100.00%**

C. Plan's Homeless Members by Spoken Language		
Row Labels	Member Numbers	% of Total Membership
English	22683	89.03%
Hmong	103	0.40%
Other	185	0.73%
Spanish	2507	9.84%
Grand Total	**25478**	**100.00%**

D. Plan's Homeless Members by County

Row Labels	Member Numbers	% of Total Membership
MERCED	14071	55.23%
MONTEREY	8213	32.24%
SANTA CRUZ	3194	12.54%
Grand Total	25478	100.00%

E. Plan's Homeless Members by Gender

Row Labels	Member Numbers	% of Total Membership
F	11768	46.19%
M	13710	53.81%
Grand Total	25478	100.00%

Appendix D: Alliance Health Education Services

Since the completion of the 2020 PNA, the Alliance has array of health education services. The following table provides a snapshot of the existing programs, many of which also include an incentive for participation:

Program Name	Program & Member Incentive Description
Breastfeeding & Breast Pump Support (BBPS)	Members are given access to breastfeeding education, support, and referrals. Alliance moms are eligible for a free breast pump every three years if either mom or baby has medical issues that prevent nursing at the breast or if the mother is returning to work or school and wants to continue breastfeeding. We provide these benefits to members to promote the health of the child and the mother, as well as to foster the bond that occurs between mother and child during breastfeeding.
Healthy Breathing for Life (HBL)	Members ages 5-64 diagnosed with asthma. Health Educators follow-up with high risk members (acuity 3) and assess member's (parent/guardian for minors) knowledge about asthma and asthma medication use. Members are also referred to the Alliance Clinical Health Education providers for additional asthma self-management support.
Healthy Moms and Healthy Babies (HMHB)	***Early Prenatal and Postpartum Care:*** Health Educators follows up with members and educate members regarding breastfeeding, pediatric immunizations, importance of well-child visits, regular OB visits, postpartum visits, etc. Members will be mailed health education materials and are referred to other resources (such as WIC, and childbirth/breastfeeding classes), as appropriate. • Members are entered into a raffle for a chance to receive a $25 gift card for completing a prenatal visit within the first trimester of pregnancy. • Members who attend a postpartum care visit with their PCP within 21 to 56 days after the birth of the baby receive a $25 gift card.
Healthy Breathing for Life (HBL)	Members ages 5-64 diagnosed with asthma. Health Educators follow-up with high risk members (acuity 3) and assess member's (parent/guardian for minors)

	knowledge about asthma and asthma medication use. Members are also referred to the Alliance Clinical Health Education providers for additional asthma self-management support.
Healthier Living Program (HLP)	The Alliance's Healthier Living Program (HLP), based on the Stanford's Chronic Disease Self-Management Program (CDSMP), is designed to help Alliance members diagnosed with chronic condition/s, gain self-confidence in their ability to control their symptoms and how their health problems affect their lives. The program focuses on problems that are common to individuals suffering from any chronic condition, such as pain management, nutrition, exercise, medication usage, emotions, and communicating with doctors. The HLP is facilitated by two trained individuals (Health Educators) and the workshops cover 17 hours of material over six-week period. Members ages 18 and older. A $50 gift card is provided to members who complete all six sessions.
Healthy Weight for Life (HWL)	Members ages 2-18 whose Body Mass Index (BMI) is at or above the 85th and are identified as high risk (Acuity 3) are contacted by a Health Education Coordinator, who helps the members or family identify measurable goals that support the adoption of a healthier lifestyle. Members identified as acuity 1 or 2 receive health education information and are encouraged to contact us for additional support. In addition to the telephonic intervention, members are invited to participate in a series of workshops modeled after the National Triple P program on healthy eating and active living. The Triple P program is a comprehensive, evidence-based, multi-level-parenting program designed to strengthen families by promoting positive relationships, help parents promote healthily social-emotional development in their children, teach parents simple and effective strategies for handling everyday parenting challenges with an additional focus on promoting children's physical health and managing childhood obesity. Members who complete all 10 weekly workshop session can receive a Target gift card up to $100 for attending.
Live Better with Diabetes (LBD)	Members (ages 18 to 75) diagnosed with DM Type 1 or 2, missing any screenings are contacted by the Health Educators and are referred to the Alliance Clinical Health Education providers for additional support diabetes self-management support.
Tobacco Cessation Support Program (TCSP)	The Alliance is committed to supporting members' who wish to stop smoking and/or using tobacco products. To accomplish this, the Alliance provides tobacco cessation benefits and services that support prevention and cessation of tobacco use. The Alliance Health Educators respond to member inquiries and will assist members with access and/or referrals to community tobacco cessation resources.
Wellness that Works Program (WWSP)	The Alliance WWSP has a limited number of scholarships available to provide vouchers for eligible members to attend WW. Only members with Alliance as their primary insurance are eligible for the scholarship. Members must have a BMI of 30 or above and must be at least 18 years old to participate in the scholarship program. Length of program three (3) months and the Alliance only pays the weekly meetings. Please note that this is a one-time benefit only.

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