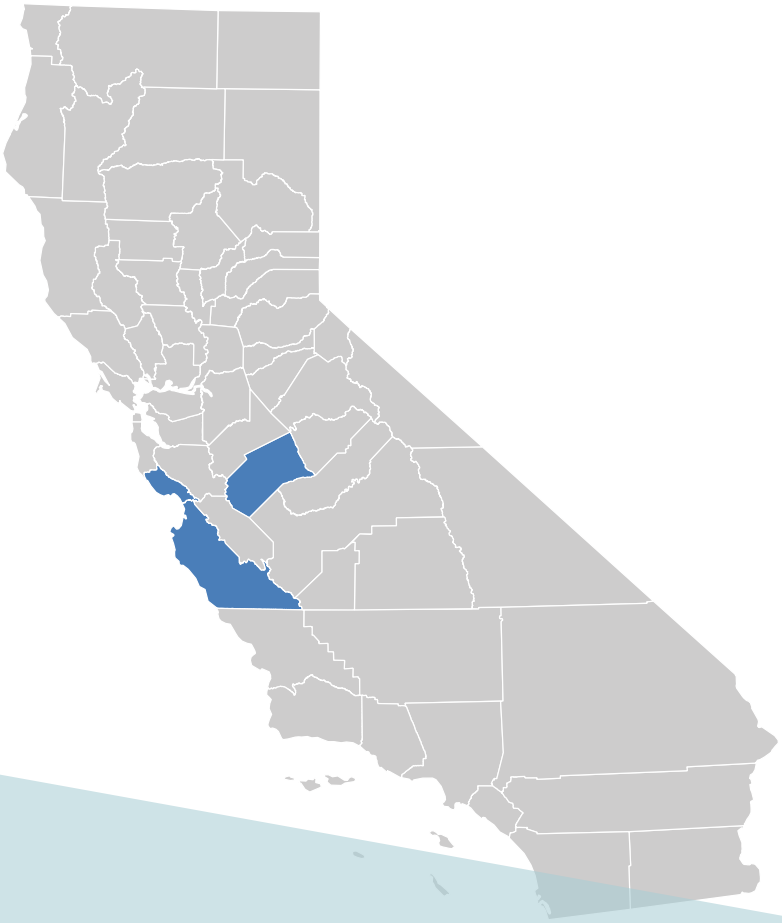
Medi-Cal

Health Education and Cultural and Linguistic Population Needs Assessment (PNA) 2022

Santa Cruz, Monterey, & Merced Counties Reporting Areas

July 11, 2022

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 346,693 Medi-Cal members in Merced, Monterey and Santa Cruz counties as of December 2021 (131,808 in Merced, 149,894 in Monterey and 64,991 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, progress and outcomes 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 2021 PNA report is being referenced as a comparison throughout this 2022 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 for calendar year 2021 is made up of adults ages 18-64 (53%), followed by children and teens ages 0-17 (46%), and

[1] This report excludes any data using IHSS members and members with Other Health Coverage as primary unless otherwise noted.

seniors ages 65 and older (1%), see Table 1 below. This continues the shift that was reported in the 2021 PNA report (2020 membership data) when children were the largest population for the plan at 51% but have dropped to 46% in 2021. Females make up a higher percentage than males (53% vs. 47%). Members with disabilities make up 4% 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 2% of the plan's child and teen Medi-Cal membership (Appendix A).

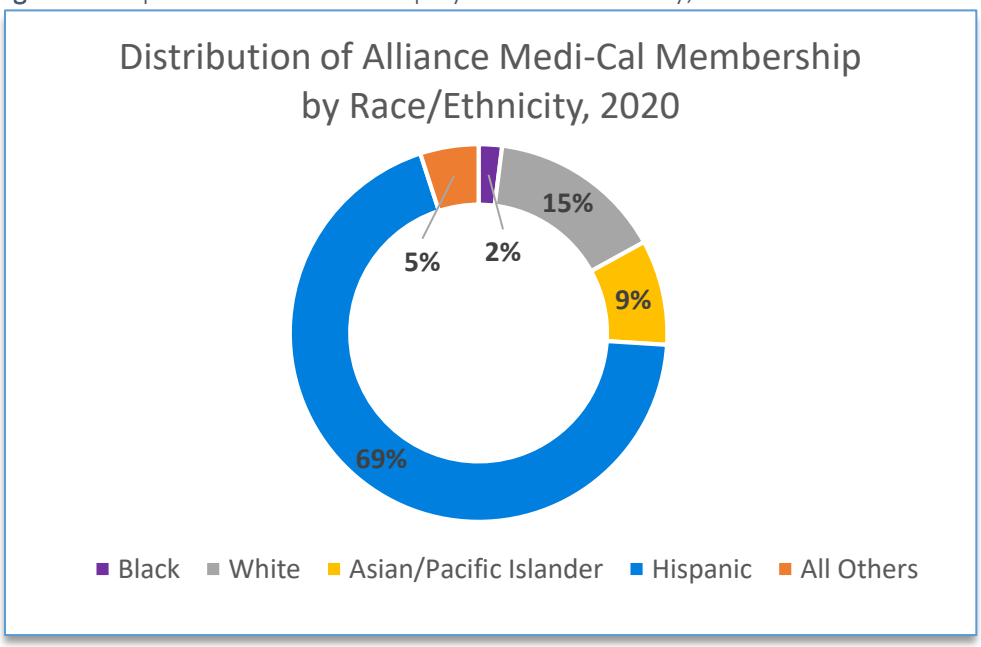
Table 1. Alliance Membership Distribution by County and Age Group, 2021

Age Group	Merced (N/%)		Monterey (N/%)		Santa Cruz (N/%)		Combined (N/%)	
0-1	5,320	2%	6,707	2%	2,110	1%	14137	4%
2-17	55,426	16%	67,208	19%	22,081	6%	144715	42%
18-44	52,070	15%	54,464	16%	27,062	8%	133596	39%
45-64	17,536	5%	19,164	6%	12,628	4%	49328	14%
65+	1,456	0%	2,351	1%	1,110	0%	4917	1%
Totals	131,808		149,894		64,991		333,388	

Source: Alliance Membership Data, 2021

A large majority of Medi-Cal members self-identify as Hispanic (69%), followed by White (14%), 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 2021 PNA report. While the Hispanic population still represents the highest ethnic population served in 2021, the percentage of Medi-Cal members report Spanish as their primary spoken language (44%) remains slightly lower than the percentage of members who prefer English (54%).

Figure 1. Proportions of Membership by Race and Ethnicity, 2021



Source: Alliance Membership Data, 2021

Data Sources and Methods

The 2022 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 Managed Care Accountability Sets (MCAS) (Measurement Year 2021), provider satisfaction survey, 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for member experience, and member surveys/interviews. Additional external data sources were accessed from 2020 DHCS Preventive Services Data, the California Health Interview Survey (CHIS); the California Department of Public Health (CDPH); and the US Department of Disease Prevention and Health Promotion, Healthy People 2030 (HP2030).

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 2021 was dedicated to managing the health and safety of patients and staff at the height of the COVID-19 pandemic. Members were also focusing on keeping themselves and family members safe. Results are discussed through the lens of the unique impacts to the health care system in 2021. Once the vaccine became available and the winter surge died down, there was a focus on opening schools and the economy. The Delta COVID surge in summer of 2021 took enormous resources for clinics to address.

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 176 providers responded to the survey (the 2021 survey was conducted between September and December).

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 (35%) when compared to Santa Cruz (29%) and Monterey County (32%).[i]

Food insecurity continues to be an area of focus for the Alliance. Of those surveyed through the 2022 PNA member outreach survey, 32% 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 24% 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 34% of members screen positive for food insecurity. A total of 10,813 members have been screened for food insecurity in the Alliance tri-county servicing area, a 25% increase when compared to the 2021 PNA report. In addition, the COVID-19 pandemic amplified the urgency to respond to food insecurity across the Alliance's service area.

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 illustrates the impact of the pandemic, a shift of healthcare resources and the fear of infection in the community. The overall count of ED visits has increased in 2021 by 17% since 2020 but that was following a drop of 27% in total ED visits from 2019 to 2020. In 2020 for all counties the PKPY rate was 383 per thousand member visits per year and in 2021 the overall rate increased to 415 PKPY; like the overall total ED visits, not returning to prepandemic levels, demonstrated by the rate of 542 PKPY ED visits in 2019, see Figures 5 and 6. The total number of ED visits radically decreased in Q2 of 2020 through Q1 of 2021 (Figure 6). As it relates to Diabetes this condition continues to be among the top 10 inpatient diagnoses for Alliance members (Table 3). Two of the three of the top ten diagnoses for ED visits are considered preventable or avoidable (Table 4) and COVID joined the top ten list of diagnoses in 2021. This difference in presence of COVID cases on the top ten list for 2021 and not 2020, can in part be attributed to the establishment of a COVID-19 ICD-10 diagnosis code later in 2020.

Many of the Alliance's preventive care rates compare favorably to national averages; Blacks have lower rates than Hispanics and Whites for several measures, including Well Infant Care 15 months, Well Child and Adolescent Care (3-21 years), and Members with Diabetes with A1c in >9 (Poor Control). Additional disparities occur between counties for some measures.

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 twice as likely as individuals without these barriers to reporting poor health status. Cultural beliefs may also impact communication between members and providers and affect a member's ability to follow a provider's instructions.

In the 2022 PNA member outreach survey (N=158), we continue to see findings that indicate health literacy is a challenge that most members shared. Members also shared that they had all the information they needed (40%) or did not need help from the Alliance (39%), followed by members being very satisfied and satisfied with the help they received from the Alliance in coordinating theirs or their child's care in the last 12 months (89%). In addition, the 2022 PNA member outreach survey indicated the top topics for which members are primarily interested in receiving information or help from the Alliance include:

- How to ask a question related to the health plan (30%) (2021-15%)
- How to choose a doctor (30%) (2021-17%)
- Transportation to get to doctor visits, pharmacy, and other services (29%)(2021-23%)
- Getting an appointment with a specialist (26%) (2021-23%)
- Who to call at night when sick (23%) (2021-34%)
- How to handle a chronic condition (22%) (2021-17%)

In addition, many participants were unaware of a few of the Alliance's benefits and services.

- 70% never called the Alliance Nurse Advice Line
- 48% were not familiar with the Alliance transportation benefit
- 75% have never heard about the Alliance's Health and Wellness Rewards Program

The 2022 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 determinant 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 2022 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

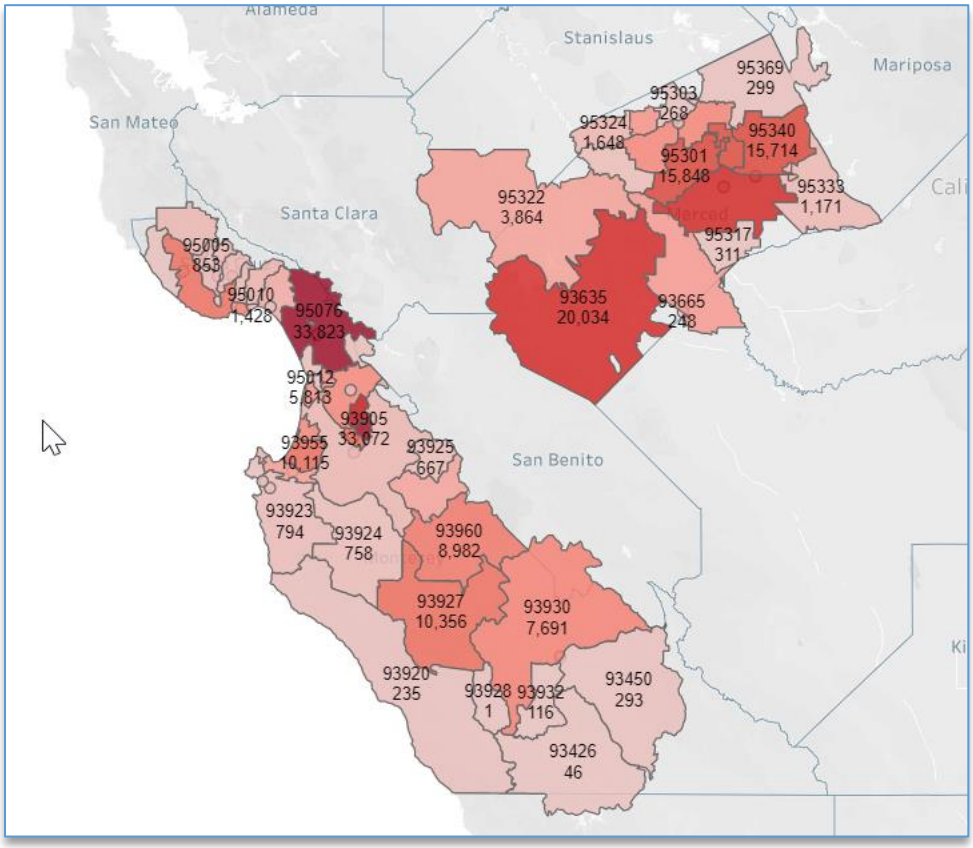
Since the completion of the 2022 PNA report, the Alliance has developed several interventions to address the identified gaps. Findings from the 2022 PNA report highlight areas of success, as well as areas of opportunities for improvement in the health plan. Based on the findings outlined in the 2022 PNA report, the following are key recommendations for the 2022-2023 planned actions for the Alliance tri-county servicing areas.

1. *Health Education/Quality Improvement*:
    a. By December 31, 2022, increase the percentage of members who report in CAHPS that they were 'usually' or 'always' able to get care quickly by 2%, from 81.7% (adult) 83.7% (adult) in all three service counties.
    b. By December 31, 2022, increase the percentage of members who report in CAHPS that they were 'usually' or 'always' able to get care quickly by 2%, from 86.6% (child) to 88.6% (child) in all three service counties.
2. *Cultural and Linguistic*:
    a. By June 30, 2023, increase staff/provider utilization of telephonic interpreting calls by 4% from 28,825 to 29,978 in all three service counties for Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members.
    b. By June 30, 2023, increase provider utilization of on-site face-to-face interpreting during medical visits by 4% 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:*
    a. 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% in Merced County.
    b. By June 30, 2023, increase the percentage of members who complete their childhood immunization rate (CIS-10) for 2 years old from 21.65% to 26.65% in Merced County.

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.

Figure 2. 2022 Membership by Zip Code and County



Source: Alliance Enrollment Files for 2021

The Alliance served 346,693 Medi-Cal members in Merced, Monterey and Santa Cruz counties as of December 2021 (131,808 in Merced, 149,894 in Monterey and 64,991 in Santa Cruz), see Figure 2. Since the 2021 PNA report, annual enrollment data show membership increased by 4% or 13,305 members. This includes members with at least one month of eligibility during the calendar year who may not have been continuously enrolled. However, member month data show membership increased between 2020 and 2021 amid the COVID-19 pandemic. It is expected membership may decrease in 2022 should redetermination of member eligibility go into effect this year following the declaration of the end of the pandemic.

3. Data Sources and Methods

2022 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 2021 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. Primary and Secondary Data Sources Used For the PNA

Population Needs Assessment Data Sources		
Source Name	**Source Description**	**Internal/External**
Claims 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 (1/1/2021-12/31/2021). Only finalized claims (paid or denied) are used from the Alliance data warehouse for dates of service of (1/1/2021-12/31/2021) unless otherwise noted.	Internal
Grievance and Appeals Data	In 2021 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, 2021. 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 March 22, 2022. Data is described in detail in the Membership Profile section. (Appendix A)	Internal
Managed Care Accountability Sets	Inovalon, an NCQA-certified vendor supported the Alliance in the Medical Record Review for Measurement Year 2021. The Alliance reported out on 10 Hybrid (chart review) measures and 30 administrative measures. Monterey and Santa Cruz counties are reported as a unit and Merced County separately. (Appendix B)	Internal
PNA Member Outreach Survey	In 2022, the Alliance administered a telephonic survey to members using standardized questions. A total of 158 surveys were completed. Bilingual English/Spanish/Hmong/other languages surveys were conducted to a random sample of 625 members who met the sample criteria. To generate interest and increase the likelihood of response, members who completed the survey won one $25 gift card. Of the 625 members on the list to call, a total of 158 were completed, for a response rate of 25%. See Section G for the analysis of the member survey results.	Internal
Beacon Health Options	Alliance contracted provider of mild-to-moderate behavioral health benefits. Used Beacon reporting to the Alliance for dates of service during calendar year 2021.	Internal
Member Outreach Campaigns	In 2021 and 2022, the Alliance launched a series of member outreach campaigns to connect, educate, and support members who were impacted by all the emergent issues (i.e. COVID-19). Outreach interventions range from live calls, mailing, member incentives, and outreach events via point-of-service activities.	Internal
Provider Satisfaction Survey	The Alliance conducts an annual Provider Satisfaction Survey in order to assess contracted providers' overall satisfaction with	Internal

	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 176 provider surveys were completed.	
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 2016-2020 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 Providers and Systems (CAHPS) Data	SPH Analytics, a NCQA-certified vendor conducted the survey of the Alliance members in 2021. The look back period is six months and the measurement period for the survey was between January 2020 and December 2021. The survey was administered in English and Spanish in Merced, Monterey and Santa Cruz Counties between April and July 2021.	External
California Department of Public Health (CDPH)	Provides a variety of health-related data including the chronic disease prevalence, birth/natality data (may include 2017-2019), and morbidity and mortality data by county (2018-2020).	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 (2022).	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. 2022 data was used.	External
DHCS MCP specific Health Disparities data	DHCS Central California Alliance for Health Disparities Data (2021).	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. MCAS 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 2021. This equates to 131,808 in Merced, 149,894 in Monterey and 64,991 in Santa Cruz. Comparisons to the 2021 PNA were made, where applicable.

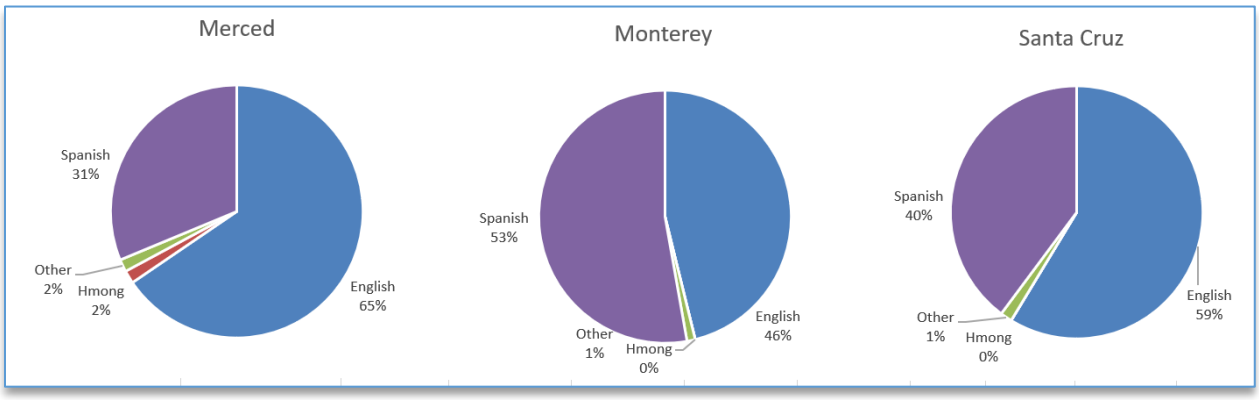
4. Key Findings

A. Membership Demographic Profile

Since the 2021 PNA report, the proportion of Medi-Cal members under age 18 has decreased across all three counties by approximately 2% in each county: 48% to 46% in Merced, 51% to 49% in Monterey, and 39% to 37% in Santa Cruz. Meanwhile, the proportion of members aged 18 to 64 years increased: 51% to 53% in Merced, 47% to 49% in Monterey, and from 59% to 61% in Santa Cruz, and. The decrease in pediatric membership may be attributed to the expansion of full scope Medi-Cal to young adults under the age of 26, regardless of immigration status. Additionally, Medi-Cal eligibility redetermination was held in most counties throughout the pandemic and more members may have remained in the plan also changing the age-distribution. The percent of members 65 and older was nearly unchanged, increasing by 0.1% % in all counties. Overall proportion of gender identification is unchanged since 2021 at 53% Female, 47% Male, source is Alliance enrollment files.

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 decreased from 2020 by 1% to 54%, while the percentage of those who'd prefer Spanish remained at 44%, see Figure 3 for county-specific findings. For details about SPD, WCM and Non-SPD populations by spoken language, see Appendix A's tables.

Figure 3. Alliance Membership Spoken Language by County, 2021



Source: Alliance Membership Data, 2021

Seniors and Persons with Disabilities (SPDs) account for 4% of the Alliance membership in Merced, Monterey and Santa Cruz counties and males make up the marginal majority (51%). Most of the SPD population is between the ages of 18 and 64 (62%), followed by ages 65 or older (20%). Hispanics represent 45% of SPDs, followed by Whites (23%) and Asian/Pacific Islanders (21%). This stratification is

noteworthy, given that the percentage of SPDs from each of these ethnic groups differs from their proportion of the overall membership.

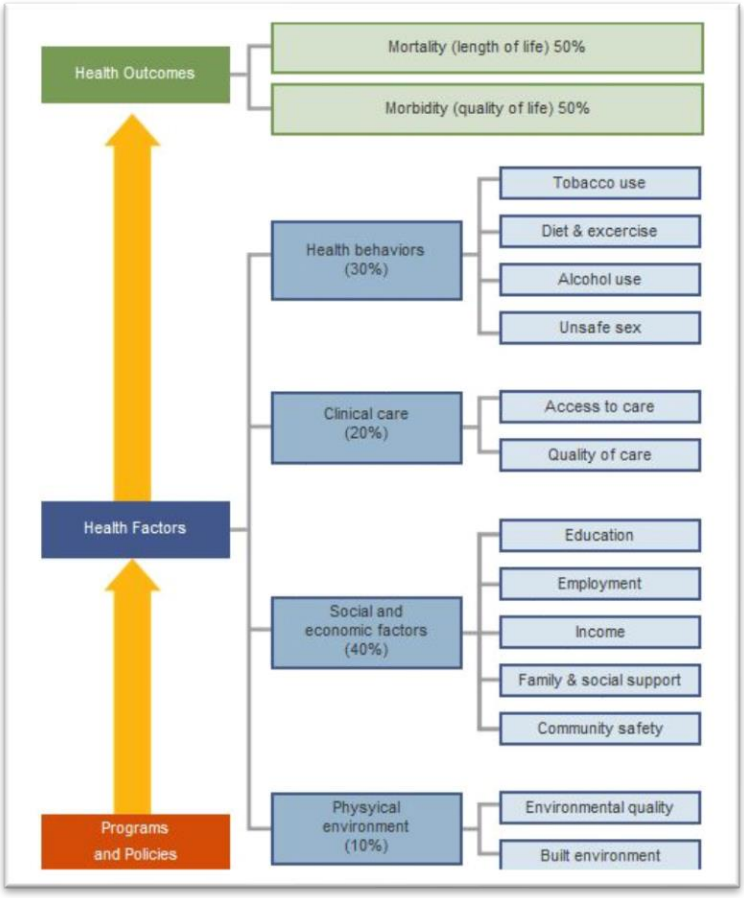
Through the WCM program, children up to age 21 can get the health care and services they need. There were 6,873 Medi-Cal members in 2021 who were receiving services through WCM, in the Merced County (2,781), Monterey County (3,084) and Santa Cruz County (1,008). Approximately three-quarters (74%) of WCM members are Hispanic, 12% are Asian/Pacific Islander, 9% are White, and 1% are Black. The age distribution of the WCM program members was 11% aged 1 year or less, followed by 74% ages 2 to 17 years and 15% ages 18 to 21 years.

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 2022 County Health Rankings data indicate that 27% of Merced residents rate their health as fair or poor, compared to 24% in Monterey and 18% in Santa Cruz.[iv] 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 4.6 in Merced compared to 4.1 in Santa Cruz and 4.2 in Monterey. These numbers are a slight improvement since the 2021 report, where Merced reported 5.0 days, Monterey 4.4 days, and Santa Cruz 4.3 days. Note that Robert Wood Johnson Foundation's County Health Rankings used 2019 data for their 2022 Health Rankings Report for this measure. With the statewide average at 3.9, all counties within the Alliance Service Area are at or higher count (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 5,700 years lost), with rates of 5,000 and 5,300 years lost in these counties respectively (years 2016-18 combined), while Merced's rate is significantly higher at 7,400 years lost for the same time period. All three counties increased in terms of the number of years of potential life lost. These data reflect 2018-2020 data and therefore may be reflecting life lost during the COVID pandemic. In terms of overall health rankings, Santa Cruz County ranks 11th (1st quartile) as determined by how long people live and how healthy people feel, while Monterey is in the second quartile (21th) and Merced is in the third quartile (38th), indicating significant differences in actual and perceived health between counties in the Alliance Service Area. We see these general markers of the health of a population also represented in our MCAS and CAHPS results and other data.

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 (14th), while Monterey (38th) is in the second and Merced in the third (56th out of 58 counties) (Source: RWJ County Rankings, 2022). 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.

Health Issues and Health Care Utilization

According to California Health Interview Survey (CHIS) the most prevalent chronic health conditions for (2016-20 combined) in the Medi-Cal populations in Merced, Monterey and Santa Cruz counties (all indicated respectively) include persons ever diagnosed with asthma (all ages) (14%, 12% and 13%), cardiovascular disease (adults 18 years+) (4%, 8% and 6%), diabetes (adults 18 years +) (16%, 9% and 9%), and adults needed help for emotional/mental health problems or use of alcohol/drug (19%, 23% and 37%). It is also critical to note that CHIS data found that adult members that were obese remains highest

in Merced (35%) and Monterey County (32%) and Santa Cruz (29%) is overall prevalent in the region (RWJF 2022 Health Rankings Report).

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.[v,vi] 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.

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, 2021

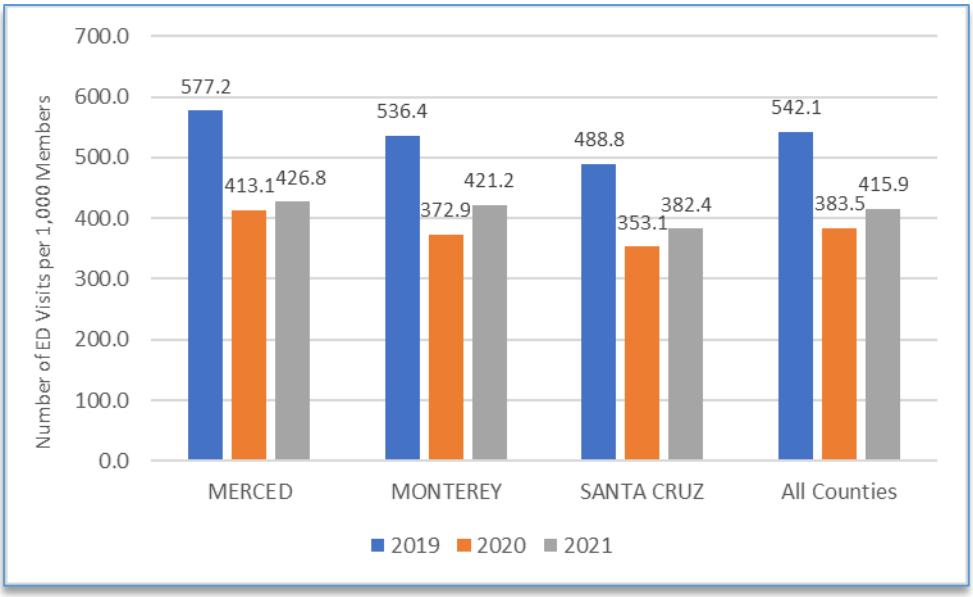
	Members 0-20 years of age		Members 21+ years of age	
County	Episode	Members	Episode	Members
MERCED	General presenting symptoms	8,201	Other arthropathy disorders	8,469
	Upper respiratory infections	7,804	Low back pain	6,939
	Refractive errors	4,621	Disorders of lipid metabolism	5,938
	Other arthropathy disorders	3,699	Hypertension	5,821
	Rhinitis	2,746	Diabetes w/no complications	5,580
MONTEREY	Upper respiratory infections	10,171	Disorders of lipid metabolism	7,546
	General presenting symptoms	9,773	Other arthropathy disorders	7,439
	Refractive errors	5,036	Diabetes w/no complications	7,368
	Other arthropathy disorders	3,764	Low back pain	6,396
	Anemia disorders	2,932	Hypertension	6,022
SANTA CRUZ	Upper respiratory infections	3,423	Other arthropathy disorders	4,587
	General presenting symptoms	3,418	Low back pain	3,414
	Refractive errors	1,752	Disorders of lipid metabolism	3,368
	Other arthropathy disorders	1,307	Diabetes w/no complications	3,354
	Obesity	1,187	Hypertension	3,008

Source: Alliance Claims Data, 2021

Emergency Room Visits

The rate of Emergency Department (ED) utilization among members in this region was 427 PKPY in Merced, 421 PKPY in Monterey and 416 in Santa Cruz (Alliance Claims Data, 2021). Figure 5 includes the PKPY rate of ED visits by County and Year prior and during the pandemic, 2019-2021. All counties had a significant drop in ED utilization that has begun to increase. The increase is less when viewed as a rate given the increase in membership that has occurred over the last three years. By comparison, Figure 5 reports out the rates of total ED visits by quarter in addition to the percent of visits that were considered avoidable or preventable.

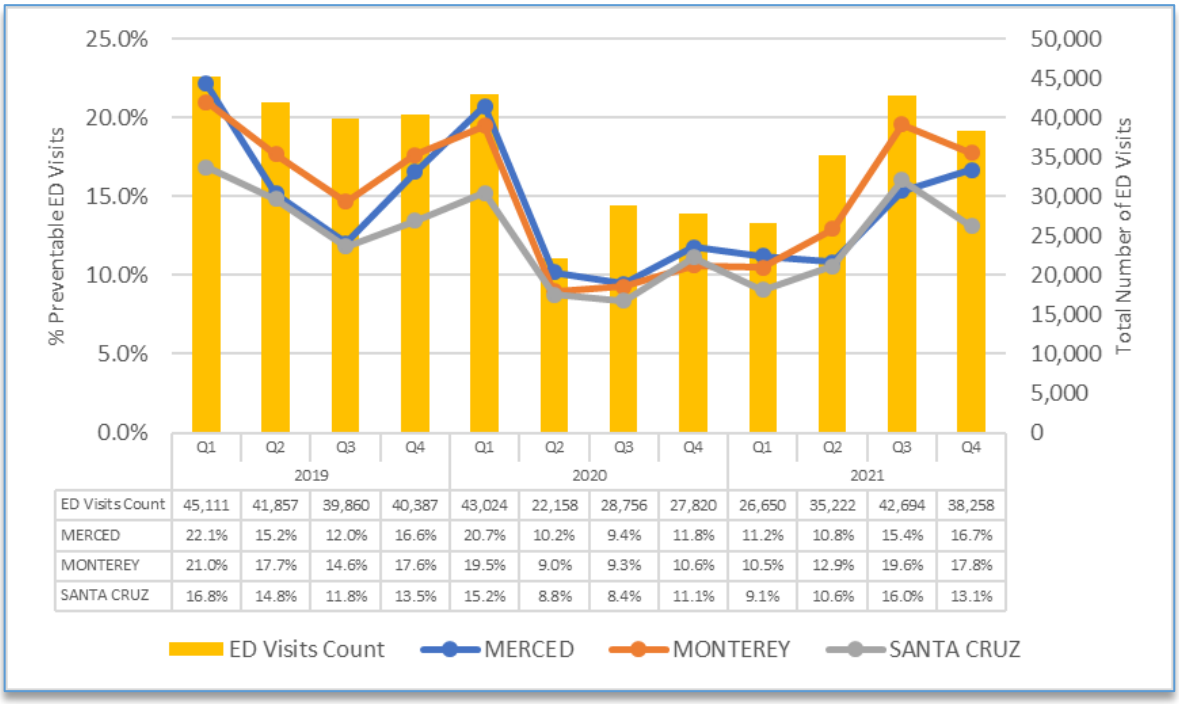
Figure 5. Emergency Department Visit Rates (PKPY) by County and Year, 2019-2021



Source: Alliance Claims Data, 2019-2021

The higher rate in Merced County holds true across most demographics and in the number of visits determined avoidable (14% Merced County, 16% in Monterey, and 13% in Santa Cruz,) based on an algorithm developed by New York University and was further developed by DHCS. The impact from COVID-19 pandemic is visible here in Figure 5 with decreased ED utilization across all three counties and is also impacting our avoidable ED rates (Figure 6). Santa Cruz County tended to have the lowest avoidable ED rates throughout the three-year period, with Monterey and Merced counties being more variable from quarter to quarter. The percent of avoidable ED visits in late 2021 have nearly returned to prepandemic levels for Monterey and Merced, where they are both above 15%. Our Care Based Incentive (CBI) Program continues to measure the rate of avoidable ED visits and encourages our primary care clinicians to identify members with frequent visits to the ED, especially those with avoidable diagnoses to engage with the primary care medical home and seek care first at the PCP's office, if not available urgent care services are available in many areas if the presenting health concern is appropriate for these settings.

Figure 6. Percent Preventable ED Visits and Total Number ED Visits by County and Year, 2019-2021



Source: Claims Data, 2019-2021

The most common ED diagnoses reported for all members during 2021 are shown in Table 4. 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. This year we have COVID-19 diagnoses making the top ten list. 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 mild and moderately acute health issues.

Table 4. Top Ten Most Common Primary Emergency Department Visit Diagnoses, 2021

Primary Diagnosis	Count
Acute Upper Respiratory Infections of Multiple and Unspecified Sites	5,897
Abdominal and Pelvic Pain	4,188
Viral Infection of Unspecified Site	2,808
Other disorders of urinary system	2,494
Dorsalgia	2,468
Acute Pharyngitis	2,187
Abdominal and pelvic pain	2,074
Covid-19	1,993
Headache	1,982
Pain in Throat and Chest	1,921

Source: Alliance Claims Data, 2021

Inpatient Admissions

Table 5 provides us with the top ten primary diagnoses for inpatient admissions during 2021 for our members. In this Table (5), we see mostly maternal child health admissions along with diabetes. These data only reveal the leading diagnosis, not illuminating the complete health status of the member represented by the data. Again, COVID is one of the leading conditions here in addition to reason for ED visits during 2021. It was postulated and has since been confirmed that during the pandemic, some health issues were not as commonly observed as cause for inpatient admission, i.e. cardiac events. This may account for the difference in the distribution of the leading diagnoses for admission during 2021.[vii]

Table 5. Most Common Primary Diagnoses for Inpatient Admissions, All Members, 2021

Diagnosis and Count of Admissions	
Liveborn Infants According to Place of Birth and Type of Delivery	2,371
Sepsis	2,178
COVID-19	790
Maternal Care for Abnormality of Pelvic Organs	721
Other Maternal Diseases Classifiable Elsewhere but Complicating Pregnancy, Childbirth, and the Puerperium	718
Late Pregnancy	573
Diabetes Mellitus	560
Premature Rupture of Membranes	437
Diabetes Mellitus in Pregnancy, Childbirth, and the Puerperium	376
Cholelithiasis	369

Source: Alliance Claims Data, 2021

MCAS Findings

MCAS MY2021 reported rates for Measurement Year (MY) 2021 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 reporting unit experienced high performance in key measures including Diabetes measure for HbA1c Control adolescent immunizations, postpartum care and Well Child Care that includes three measures, BMI measurement, nutrition counseling and physical activity counseling. Eight measures fell below the minimum performance level, one measure Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+) that is required by DHCS to meet this benchmark for this reporting unit.

In our Merced reporting unit, we have 10 HPLs, they are in prenatal and postpartum care. Eight of the MPLs are in measures where we are held to meeting that benchmark. Our measures falling below the MPL include childhood immunizations, and Well childcare: nutrition counseling and physical activity counseling (2 measures). These are preliminary rates as of this writing; final measure rates cannot be released publicly until September per our contract with NCQA.

As a health plan we are set up to report Santa Cruz and Monterey counties as one unit and Merced county as a separate unit. Our provider network continues to struggle to restart well childcare, and in 2021 while we had some progress in Santa Cruz and Monterey with measures, the rates of well infant care, 6 visits before 15 months of age are particularly challenging. We also lost ground for 15-30-month

olds needing at least two visits in both reporting units. Finally, both childhood and adolescent vaccination measures decreased again this year, Santa Cruz Monterey dropping below the HPL for childhood immunizations after achieving an HPL in 2020. Adolescent immunization rates dropped but in Santa Cruz-Monterey remained above the HPL and in Merced above the MPL.

Prenatal Care and Postpartum care rates have fluctuated in the last couple of years and not yet returned to prepandemic levels. Santa Cruz-Monterey unit's rate of timely prenatal care dropped by 4.5% between 2020 and 2021; Merced well outperformed Santa Cruz-Monterey in MY2021, with a rate of 92.7% compared to 88.65%. Post-partum care improved in both reporting units with a 5.5% increase for Santa Cruz-Monterey. Childhood Immunization is discussed further on in this section and the remaining pediatric measures in the health disparity section.

Rates for preventive services and chronic condition measures for 2021 remained mostly unchanged, Breast Cancer Screening in both reporting units remaining low, and in Merced below the MPL. Cervical Cancer Screening decreased in both reporting units but has remained above the MPL. This measure covers up to a five year look back and therefore perhaps less likely to be impacted by the pandemic at this time. Chlamydia Screening did increase in Santa Cruz-Monterey from 57.0% in 2020 to 61.0% in 2021. Merced's rate of Chlamydia screening dropped slightly and remains below the MPL.

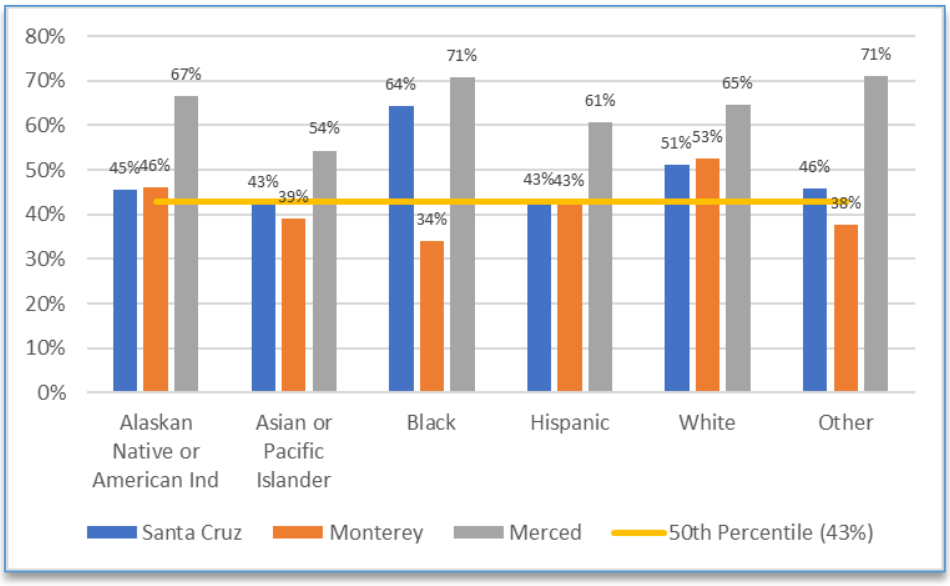
While there is a MCAS measure that looks at hypertension (CBP), the sample size was insufficient for stratification (see Appendix B). Comprehensive Diabetes Care (CDC) In the Comprehensive Diabetes Control measure the differences begin to emerge is with the proportion of members who are in poor control (or missing a test value), Figure 7 below. We were able to achieve an HPL in Santa Cruz-Monterey for HbA1c poor control at 30.7%. We were pleased to move the Controlling Blood pressure rates out of MPL in 2020 and both units are now above the MPL. Collecting data for this measure remains a challenge but were able to secure several charts where there was a telehealth appointment addressing HTN and the member was able to report out a self-measured blood pressure (Bp) from home. We are accepting data through the Provider Portal to supplement provider performance in this measure using HCPCS codes. In addition, DHCS has now added Bp cuffs as a pharmacy benefit for members which will support them to self-monitor their blood pressure.

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 the Alliance's access to data as well, the measure will place anyone without an A1c test value into the "poor control" category. Santa Cruz and Monterey counties have rates that are like each other for each of the racial/ethnic groups described in Figure 7. Black and Other populations in Monterey County have the lowest or best rates of HbA1c compliance across the region.

The Alliance again has worked on communication with Providers to ensure that they are aware of members with diabetes and their current screening and treatment information is on hand along with support from our Pharmacy Department. In addition to collecting data from regional laboratories, the Alliance requests that providers to submit data with point-of-care testing results for A1c values to ensure a comprehensive data set is created for each member through the provider's portal account.

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



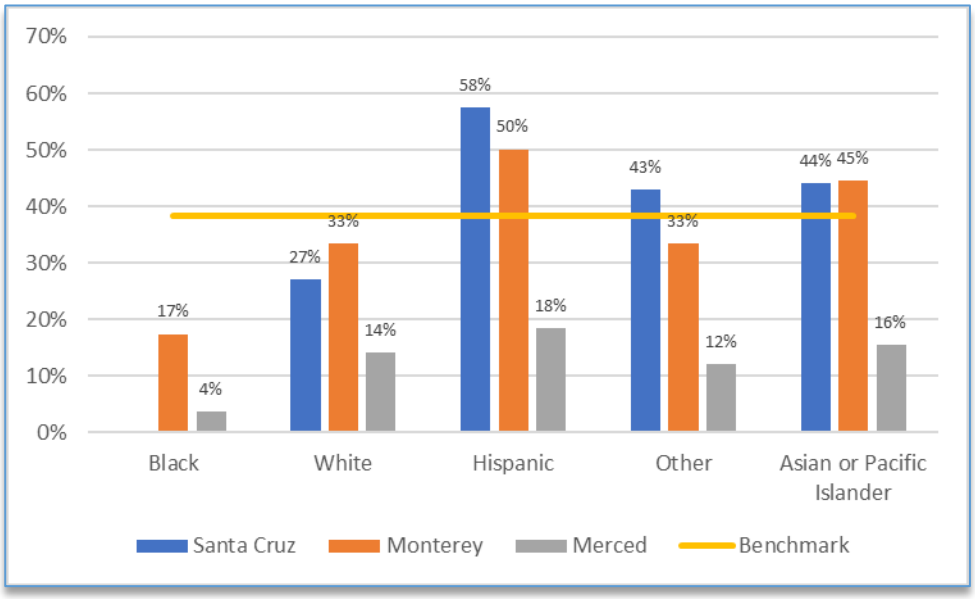
Source: MCAS MY2021 (Administrative data only)

Full MCAS MY2021 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]

The final MCAS measure in this section is that of Children Immunization Status, Combination 10 (All ACIP Recommended Vaccines) for Two Year Old's (CIS). CIS rates for MY2021 decreased from the prior year, Santa Cruz-Monterey reporting a rate of 51% and Merced County 18%, in 2020 those rates were 54% and 22%. These data below are administrative claims from 2021, no chart review data included and describe by county the CIS rates by race/ethnicity. 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, it has yet to join CAIR2 as of this writing. 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 8 indicates the disparities between the counties and by Race and Ethnicity. Members that identify as Black and White overall have the lowest rates regardless of county of residence. The struggle in Merced County to raise immunization rates despite the interventions mentioned above continues.

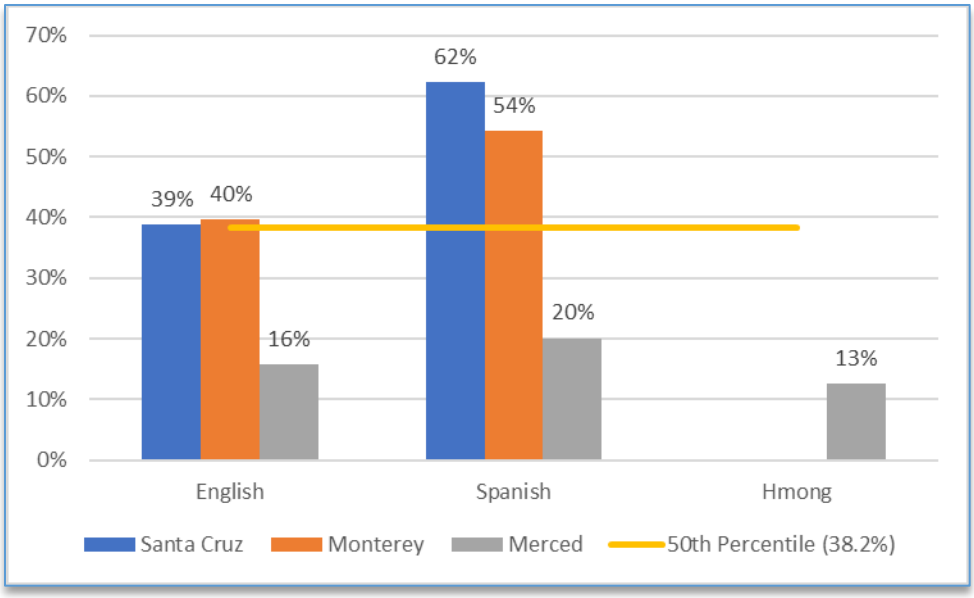
Figure 8. Childhood Immunization Status by County and Race/Ethnicity, MY2021



Source: MCAS MY2021 (Administrative data only)

We also examined CIS rates by the family's spoken language, as illustrated in Figure 9. Our Spanish-speaking families have the highest rates of vaccination coverage in all three counties, with Santa Cruz and Monterey well above the 50th percentile, the minimum performance level for Medi-Cal plans. Our English-speaking families over right at the 50th percentile in Santa Cruz and Monterey counties, but drop off significantly for Merced. The rates of compliance by race/ethnicity and language follow the same patterns as described in the statewide report, "2021 Preventive Services Report" published by the Managed Care Quality and Monitoring Division at the California Department of Health Care Services in June 2022. [ix]

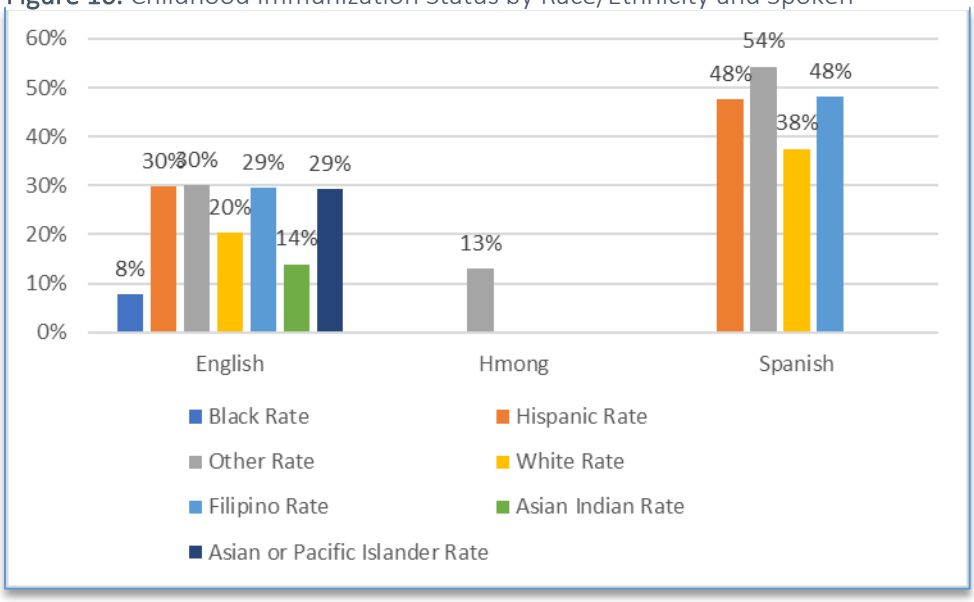
Figure 9. Childhood Immunization Status by County and Spoken Language, MY2021



Source: MCAS MY2021 (Administrative data only)

Finally, we examined our race/ethnicity data against spoken language because our race/ethnicity data does not adequate capture Hispanic members, when there is just one category captured in Figure 10. It also illustrates other races by their primary language. Some members may identify as White Hispanic, but this isn't fully captured by our enrollment files, it could show up as either White or Hispanic. Notably our Hispanic, White, Other and Filipino populations and the difference in rates by spoken language, Spanish-speaking families notably higher. Populations included where there were at least 11 members in that Race/Ethnicity and Language stratification. The COVID pandemic continues to have an impact on our childhood and adolescent immunization rates. Primary care clinics reduced hours, closed sites and shifted to care for those acutely ill with COVID. Parents also were concerned about seeking routine care and concerned about exposing their child to COVID. A recent study reported out that some pediatricians and even more family practice physicians stopped routinely vaccinating children 0-2 years of age during the pandemic. It was even more frequent among to stop vaccine delivery for older populations of children and adolescents, 4-18 years of age.[x,xi]

Figure 10. Childhood Immunization Status by Race/Ethnicity and Spoken



Source: MCAS MY2021 (Administrative data only)

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 2016 to 2020 (Table 6), 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. From the data in the 2021 PNA to this report, there has been a 5% increase in routine care for adults in Merced, nearly 13% increase in Merced and a 2% decrease in Santa Cruz, note the data used in this report included the time range used in the prior report (2018-2019). Rates of routine care utilization for all counties remain below those persons not covered by Medi-Cal.

Table 6. Reason for Last Dental Visit (Adult) by County and Medi-Cal Coverage Status, 2016-2020

Reason for last dental visit - Adults	Merced	Monterey	Santa Cruz
Routine Checkup or Cleaning (Covered by Medi-Cal)	54.9%	64.5%	60.3%
Routine Checkup or Cleaning (Not covered by Medi-Cal)	60.8%	73.0%	74.3%
Specific Problem (Covered by Medi-Cal)	32.3%	23.9%	34.5%
Specific Problem (Not covered by Medi-Cal)	26.2%	19.2%	15.3%
Both (Covered by Medi-Cal)	12.8%	11.7%*	5.2%*

Both (Not covered by Medi-Cal)	13.0%	7.8%	10.4%

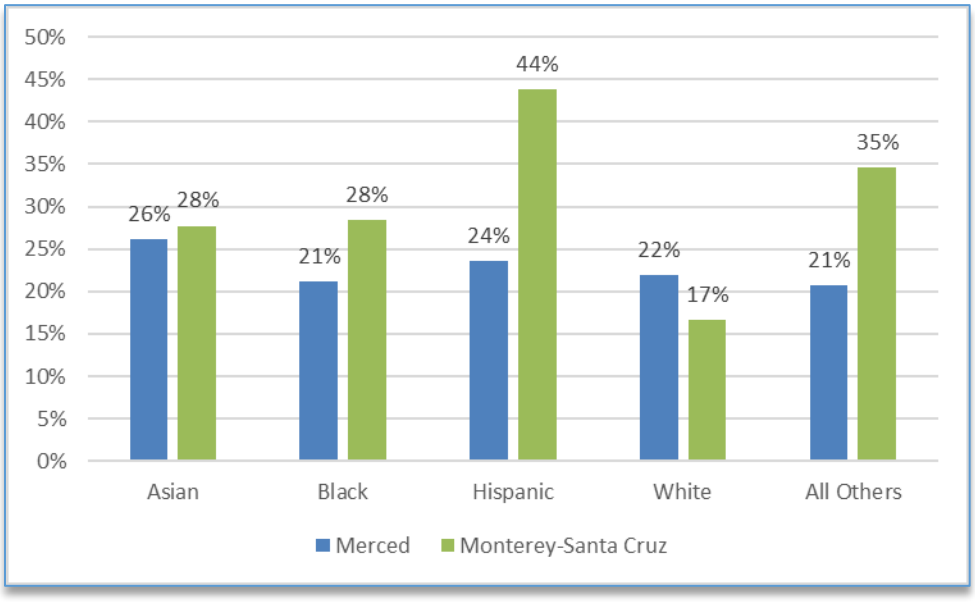
Source: CHIS 2016-2020 Combined. * statistically unstable.

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.

Using the Preventive Services Rate Sheet from DHCS, Figure 11 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 2021. Hispanic members in Santa Cruz-Monterey counties had the highest rates of dental fluoride application (44%) followed by All Others (35%), Black (28%), Asian (28%), and White members (17%), all rates decreased from measurement years 2019 to 2020. In comparison, Asian members in Merced County had slightly higher rates of application (26%) compared to Hispanic members (24%), followed by White (22%), All Others (21%), and Black Members (21%). By contrast, Merced children experienced an increased access between the years of 2019 and 2020 across all populations. The Alliance has included a measure for the application of dental fluoride in its Care Based Incentive (CBI) Program to normalize application by primary care providers since Medi-Cal members can be at higher risk for dental caries and it's a part of Bright Futures recommendations. Providers have engaged with local CHDP programs and used other resources to train staff on fluoride varnish application.

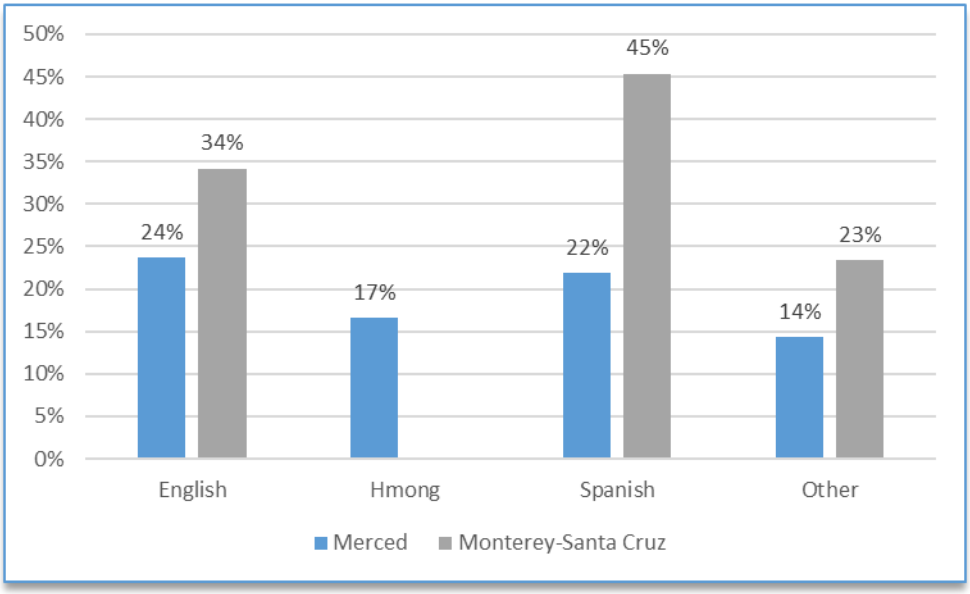
Figure 11. Dental Fluoride Application by County/Region and Race/Ethnicity, 2020



Source: RY2021 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 Santa Cruz-Monterey combined (45%) followed by English (34%), Other (23%). In Merced, English speakers lead with 24%, All Others at 23%, then Spanish followed at 22%, with Hmong (17%), speaking members (see Figure 12 below.)

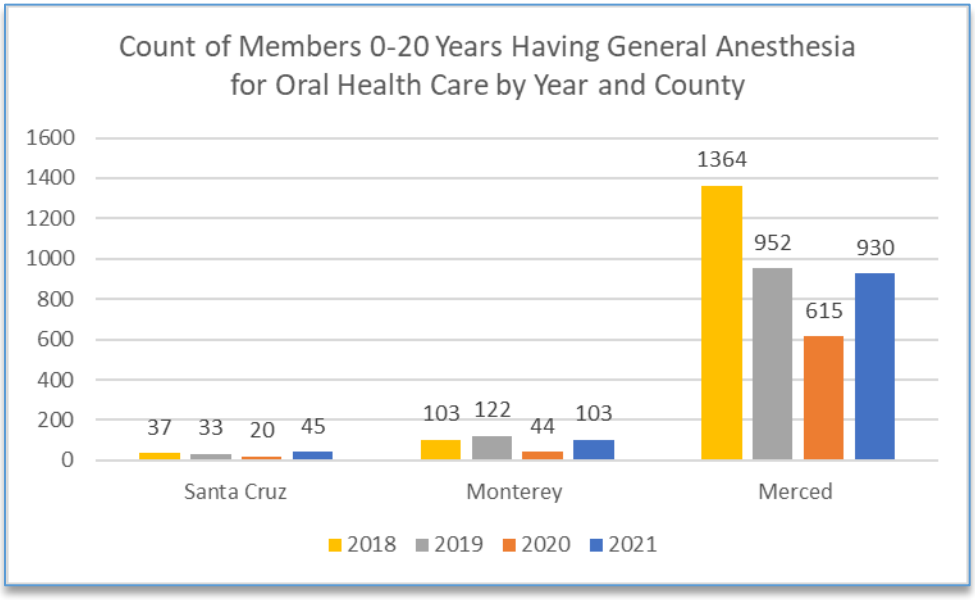
Figure 12. Dental Fluoride Application by Language, 2021



Source: RY2021 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 13 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 13. Members (0-20 years) with One or More Service of General Anesthesia for Dental Care, 2018-2021



Source: Claims Data, 2018-2021

Health Factors and Behaviors

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. Table 7 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). Tobacco use is higher among Medi-Cal covered adults, but there are not statistically significant differences between the rates even using a 5-year range of data.

Table 7. Current Smoking Status of Adults by Medi-Cal Status, 2016-2020

Current Smoking Status - Adults	Merced		Santa Cruz		Monterey	
	%	95% CI	%	95% CI	%	95% CI
Current smoker (Covered by Medi-Cal)	12.5*	4.2 - 20.9	20.0%	8.8 - 31.2	12.1*	5.0 - 19.2
Current smoker (Not covered by Medi-Cal)	9.6%	4.0 - 15.1	8.4%	3.8 - 13.1	9.5%	4.8 - 14.3
Not a current smoker (Covered by Medi-Cal)	87.5*	79.1 - 95.8	80.0%	68.8 - 91.2	87.9*	80.8 - 95.0
Not a current smoker (Not covered by Medi-Cal)	90.4%	84.9 - 96.0	91.6%	86.9 - 96.2	90.5%	85.7 - 95.2

*Statistically unstable. Source: CHIS Data, 2016-2020

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. As Table 8 shows, in 2021, 69% of surveyed Alliance adult members who use tobacco reported being advised by their provider to quit, 43% reported that they discussed the use of cessation medications with their provider, and 41% reported discussing cessation strategies other than medications. The greatest change in the data is the decrease by over 6% in providers discussing the use of cessation medications with members. While more than 2 out of 3 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:

Table 8. CAHPS Summary Rates for Adults, Smoking and Tobacco Use Cessation, 2021

Measure	2020	2021	2021 US Benchmark	2019 US %tile Rank
Advising Smokers and Tobacco Users to Quit	71.9%	69.1%	74.8%	Below 25
Discussing Cessation Medications	49.2%	42.6%	53.1	Below 25
Discussing Cessation Strategies	40.6%	41.8%	48.0%	Below 25th

Source: CAHPS 2021 Survey

Reproductive Health

Teen birth rates are an important health indicator for a population and have been linked to social determinants of health and their infants found to have lower educational achievement, lower income, higher unemployment and many other significant outcomes.xii Additionally, teenage pregnancy has been associated with health outcomes of low birth weight infants, preterm delivery, and other conditions.xiii A review of state birth data, available for births through 2020 shows that Santa Cruz County has one of the lowest teen birth rates in the state at 7.1 per 1,000 female population 15-19 years old (2018-2020), Table 9. California overall had an average of 15,268 teen births per year between 2018-2020, with a rate of 11.4. Monterey's teen birth rate was 20.9 and Merced's was 17.5 for this same time period. Note that both Merced and Monterey counties teen birth rates are statistically significantly higher than the overall state and Santa Cruz County's is statistically significantly lower. Note that these data (Table 9) reflect the entire populations for each county and are not specific to Medi-Cal members. These data present an opportunity to examine Alliance data in detail and partner with local public health and other agencies working to implement evidence-based programming to prevent teen pregnancy.xiv,xv

Table 9. Births to Adolescent Mothers, 15-19 Year Old by County, 2018-2020

County of Residence	2019 Female Population 15-19 Years Old	2018-2020 Total Live Births	2018-2020 Average Live Births	Age-Specific Birth Rate	95% Lower Confidence Interval	95% Upper Confidence Interval
Merced	12,192	690	230.0	18.9	17.5	20.3
Monterey	15,825	1,058	352.7	22.3	20.9	23.6
Santa Cruz	11,714	248	82.7	7.1	6.2	7.9
California	1,340,142	45,804	15,268.0	11.4	11.3	11.5

Source: California Department of Public Health, 2018-2020

Social Determinants of Health Indicators

In early 2022, DHCS issued an All Plan Letter to promote the collection of data on Social Determinants of Health using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding. These codes were listed in the document and 25 codes were identified as priority codes for collection. A query of all claims data for all SDOH codes submitted on paid claims for dates of service during the calendar year of 2021 found that 11,692 members had 1 or more Z-code on a claim(s). The codes highlighted in yellow are the priority codes defined by DHCS, Table 10.

Table 10. Social Determinants of Health ICD-10 Codes Reported for All Members, 2021

Code	Code Description	Total
Z59.00	Homelessness unspecified	2,164
Z64.0	Problems related to unwanted pregnancy	1,493
Z60.2	Problems related to living alone	677
Z63.8	Other specified problems related to primary support group	594
Z62.21	Child in welfare custody (non-parental family member, foster care)	510
Z56.0	Unemployment, unspecified	503
Z63.4	Disappearance/death of family member	483
Z65.8	Other specified problems related to psychosocial circumstances	471
Z55.9	Problems related to education and literacy, unspecified	467
Z65.9	Problem related to unspecified psychosocial circumstances	343

Source: Alliance Claims Data, 2021

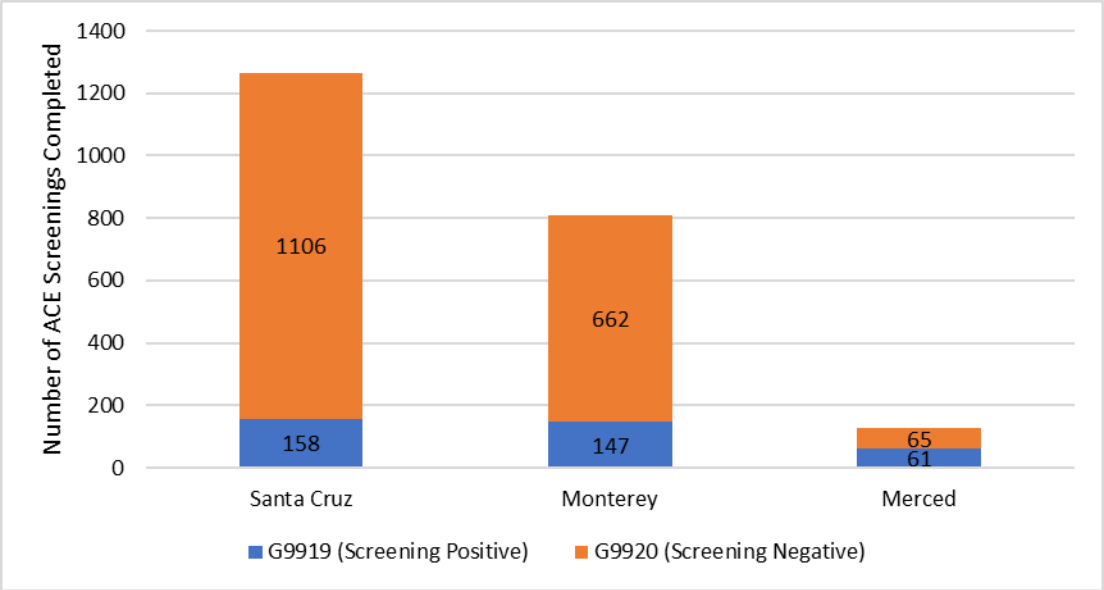
The most commonly reported SDOH ICD-10 code was “Homelessness” unspecified. We reported more extensively in the 2021 PNA report about homelessness and local counts have not been updated since our last report. Additionally, with the CalAIM Program being implemented, many of our homeless members are starting to receive Enhanced Case Management services and additional Community Support services that include housing services. The second most commonly reported code relates to unplanned pregnancy. About 30% of pregnancies in the United States are unplanned (2019 data).[xvi] The definition of unplanned pregnancy is “Percentage of women with a recent live birth who did not want to become pregnant or wanted to become pregnant later”. Unplanned pregnancy is most common in teens and young adults and persons living in poverty.[xvii] The risks and outcomes related to unplanned pregnancy can include poor outcomes for both the mother and the children from these pregnancies.xviii These data present an opportunity to further explore the Alliance population, available network services including supporting clinicians in empowering members to avoid unintended pregnancies and choose the time and circumstances for childbearing.[xix]

The remaining codes vary widely and represent prevalent challenges related to social determinants of health, education, employment and isolation.

Adverse Childhood Events Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example: experiencing violence, abuse, or neglect, witnessing violence in the home or community, or having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use problems, mental health problems, or instability due to parental separation or household members being in jail or prison. ACEs are linked to chronic health problems, mental illness, and substance use problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. About 61% of adults surveyed across 25 states reported they had experienced at least one type of ACE before age 18, and nearly 1 in 6 reported they had experienced four or more types of ACEs.[xx]

Starting in 2020, DHCS made screening for ACEs in children and adults a Medi-Cal benefit. Providers are required to be trained in order for screening claims to be reimbursed. Local engagement by primary care and behavioral health providers has varied widely in the Alliance network (Figure 14). The Alliance has added ACEs screenings of children to its Care Based Incentive Program for 2022 and will offer a fee-for-service incentive for clinician training starting in 2023. While the numbers are small, it is concerning that the percentage of positive screens is more than half of the total, while the positive screens reported from claims for members in Monterey and Santa Cruz County are 13% and 18% respectively. There is an opportunity to support our network clinicians in ensuring workflows and referral sources are available when these members are identified.

Figure 14. ACEs Screenings by Result and County, 2021



Source: Alliance Claims Data, 2021

Mortality Data: Leading Causes of Death

In addition to tracking trends of health care utilization, prevalence of health conditions, we also review the leading causes of death in the communities that we serve. Table 11 below outlines these conditions for each of the counties. The first four conditions are the same for each county, All Cancers, Coronary Heart Disease, Accidents, and Cerebrovascular Disease (Stroke). Following these conditions, Alzheimer's Disease, Chronic Lower Respiratory Disease, Lung Cancer, and Prostrate Cancer are the only conditions that also appear in all three lists. Merced County has six age-adjusted death rates that are statistically significantly higher than California overall, notably Coronary Heart Disease and Diabetes. Rate of deaths due to Alzheimer's Disease in Merced are significantly lower than the California rate. Merced and Santa Cruz county both have rates of death from Breast Cancer in their top ten lists.

Monterey County is overall like California's age-adjusted rates overall or significantly lower. Rates of deaths due to All Cancers, Coronary Heart Disease, Stroke, Alzheimer's Disease, Chronic Lower Respiratory Disease, Lung Cancer and Diabetes are all significantly lower than California overall. It like Santa Cruz County, features Drug Induced Deaths on its list of top ten.

Santa Cruz County rates like Monterey County are like that of California's with a few exceptions. Santa Cruz County's rates of Coronary Heart Disease, Stroke, Lung Cancer and Chronic Lower Respiratory Disease are all significantly lower than that of California's rates. Deaths due to Accidents is the one rate in Santa Cruz County's top ten list that is significantly higher than that of California.

These data offer another perspective on the health of our communities, which is especially relevant given the proportion of members in these communities that we serve. These causes of death offer the opportunity to consider the importance of the primary care provider, care coordination and follow up as conditions are diagnosed. Furthermore, it underscores the importance of focusing upstream on preventing and managing heart disease and diabetes. The Alliance works hard to identify members at risk of chronic conditions to prevent development of disease through its Health Programs. We also support providers with services to help members self-manage these chronic conditions.

Finally, a takeaway from the Monterey and Santa Cruz County rate of Drug Induced Deaths strengthens the argument for timely access to quality behavioral health services and ongoing monitoring of access to services.

Table 11. Leading Causes of Death by County (Three Year Average Age-Adjusted Death Rate), 2018-2020

Merced County: Top Ten Leading Causes of Death				
	2018-2020 Deaths (Total)	Age-Adjusted Death Rate	95% LCI	95% UCI
Deaths due to All Cancers	1,114	**146.1**	137.4	154.8
Deaths due to Coronary Heart Disease	717	**95.9**	88.8	103.0
Deaths due to Accidents (Unintentional Injuries)	390	**49.3**	44.4	54.3
Deaths due to Cerebrovascular Disease (Stroke)	299	40.7	36.0	45.3
Deaths due to Chronic Lower Respiratory Disease	286	**39.2**	34.6	43.7
Deaths due to Diabetes	243	**31.8**	27.8	35.9
Deaths due to Lung Cancer	223	**29.5**	25.6	33.4
Deaths due to Alzheimer's Disease	201	28.5*	24.6	32.5
Deaths due to Breast Cancer	83	20.2	16.1	25.1
Deaths due to Prostrate Cancer	66	20.1	15.4	25.7

Monterey County: Top Ten Leading Causes of Death				
	2018-2020 Deaths (Total)	Age-Adjusted Death Rate	95% LCI	95% UCI
Deaths due to All Cancers	1,640	112.4*	106.9	118.0
Deaths due to Coronary Heart Disease	710	47.7*	44.1	51.3
Deaths due to Accidents (Unintentional Injuries)	561	40.6	37.2	44.0
Deaths due to Cerebrovascular Disease (Stroke)	496	33.4*	30.4	36.4
Deaths due to Alzheimer's Disease	369	24.4*	21.9	27.0
Deaths due to Chronic Lower Respiratory Disease	344	23.3*	20.8	25.8
Deaths due to Lung Cancer	282	19.3*	17.0	21.6
Drug Induced Deaths	224	16.6	14.4	18.8
Deaths due to Diabetes	244	16.5*	14.4	18.6
Deaths due to Prostrate Cancer	98	15.5	12.6	18.9

Santa Cruz County: Top Ten Leading Causes of Death				
	2018-2020 Deaths (Total)	Age-Adjusted Death Rate	95% LCI	95% UCI
Deaths due to All Cancers	1,266	128.0	120.7	135.3
Deaths due to Coronary Heart Disease	510	53.0*	48.3	57.7
Deaths due to Accidents (Unintentional Injuries)	422	**48.6**	43.7	53.4
Deaths due to Cerebrovascular Disease (Stroke)	297	32.2*	28.5	36.0
Deaths due to Alzheimer's Disease	271	30.2	26.6	33.8
Deaths due to Lung Cancer	211	21.0*	18.1	23.9
Deaths due to Prostrate Cancer	86	20.9	16.5	26.0
Drug Induced Deaths	172	20.3	17.1	23.6
Deaths due to Chronic Lower Respiratory Disease	187	19.9*	17.0	22.8
Deaths due to Breast Cancer	94	17.5	14.0	21.6

Bolded text indicates rate is significantly higher than California's rate overall.
*Indicates rate is significantly lower than California's rate overall.
LCI=Lower Confidence Limit, UCI=Upper Confidence Limit

Source: California Department of Public Health, 2018-2020

A review of infant mortality data shows that overall, births during 2017-2019 that the counties are essentially the same as California overall; California 3.9, Merced 4.0, Monterey 3.9 and Santa Cruz 3.9 infant deaths per 1,000 live births. The counties were measured against the California Average rate and by the HP 2020 target of 6.0 infant deaths per 1,000 live births. California offers infant mortality by race/ethnicity, none of the three counties had more than 11 during the measurement period of 2017-2019. Black infant death rates for California was 7.6 infant deaths per 1,000. Black Infant mortality rates were reported as 7.6 for California, 0 for Santa Cruz, "M" for meeting the HP2020 target for Monterey County and as "NM" not met for Merced County. CDPH notes that the rate with a standard error greater than or equal to 23 percent are deemed unreliable which was noted for Monterey and Merced counties. For Hispanic Infant mortality there was no statistical difference between the individual county's death rates and the California rate overall. California's rate was 4.0, Merced was 3.8, Monterey 4.1, and Santa Cruz was 3.4 but noted as statistically unstable. Finally, for white infant deaths, the California rate was 3.0 and all three counties were reported as "M" with rates noted as having a standard error of >23 percent.

C. Access to Care

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 12 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 12. HPSA Shortage Areas: Count of Census Tracts by Service Type, County and Population, 2022

	Number of Census Tracts by County			
Service Type, Population and Region	Merced	Monterey	Santa Cruz	Grand Total
Dental Health				
MSSA/Firebaugh/Mendota	1			1
Low Income - MSSA/Ballico	8			8
Low Income/MFW - MSSA (Carmel Valley)		13		13
Low Income/MFW - MSSA/Salinas		32		32
Low Income - MSSA/King City		3		3
ME - MSSA/Prunedale		8		8
ME-MSSA Bradley/San Ardo		1		1
Mental Health				
Merced County	1			1
MSSA/Big Sur/Lucia		1		1
MSSA -Soledad		8		8
MSSA -Santa Cruz			25	25
MSSA/King City/San Ardo		4		4
LI-MFW/H/MSSA/Marina		13		13
LI-MFW-H/MSSAs/Prunedale/Salinas		40		40
Primary Care				
MSSA-Big Sur		1		1
MSSA/Los Banos	8			8
MSSA/Atwater	11			11
LI/MFW - MSSA Ballico/Delhi/Livingston	8			8
Low Income/Migrant FW/Prunedale		8		8
Low Income - MSSA/Merced Central	20			20
ME - MSSA/Soledad		8		8
ME MSSA - Le Grand/Planada	2			2
ME-MSSA /Salinas		32		32
Grand Total	59	172	25	256

MSSA: Medical Service Study Area (MSSA)

HPSA: Health Professional Shortage Area

Low Income (LI)

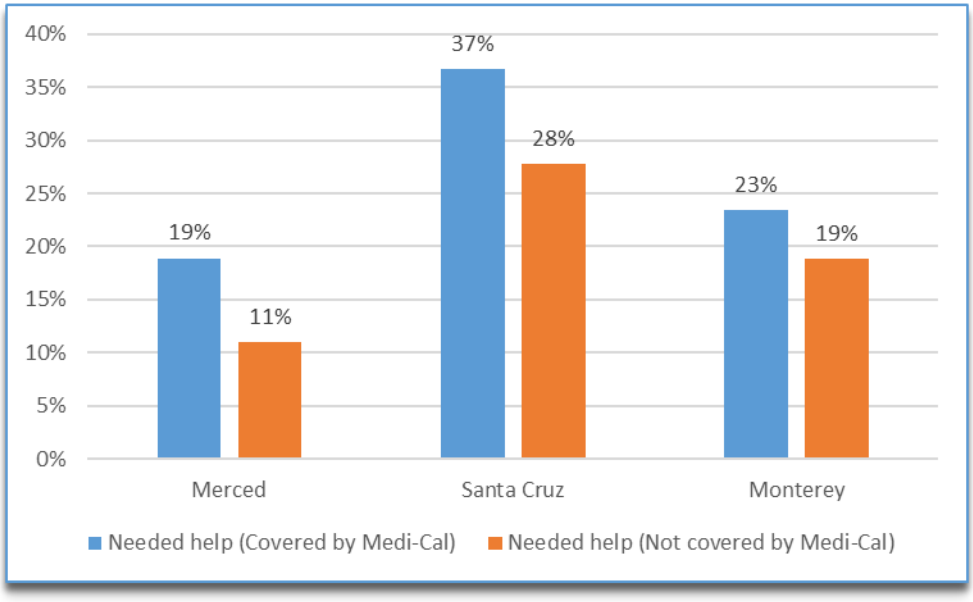
Legend:

MFW: Migrant Farm Worker
H: Homeless
ME: Medicaid Eligible Population

D. 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 15 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 15. Adults That Needed Help for Emotional/Mental Health Problems Compared by Medi-Cal Coverage and County, 2016-2020



Source: CHIS Data, 2016-2020

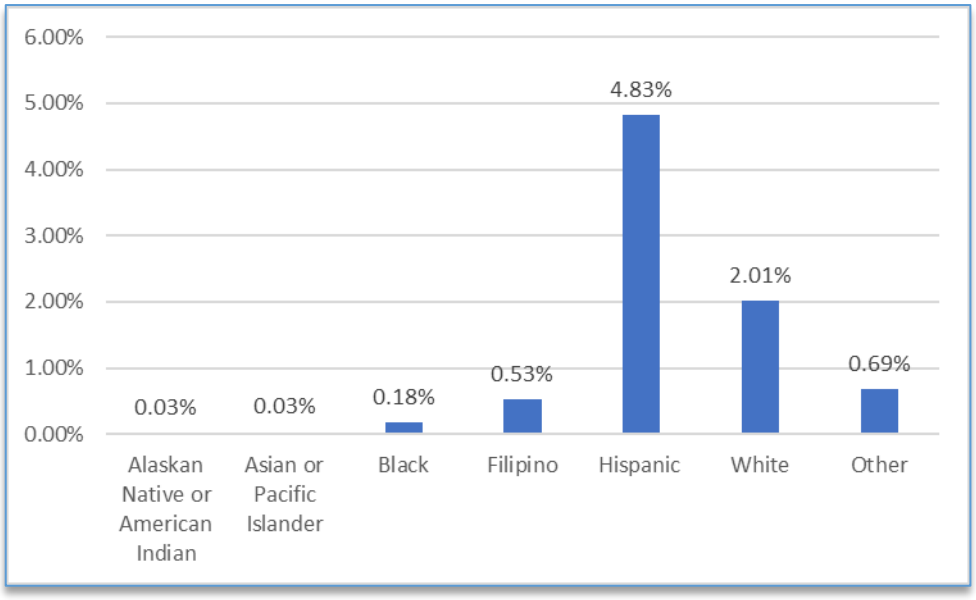
Member utilization is monitored through overall utilization rate, screening and kept appointments. Utilization rate described here, is the percentage of members who had at least one mental health visit per year, referred to as the penetration or utilization rate using a combination of Alliance and Beacon Claims. Beacon Health Options (Beacon) is contracted with CCAH to provide mild to moderate mental health services. In 2021, 8% of Alliance members had at least one mental health visit per year, therefore no change from 2020, where 8% at least one visit at either a primary care or behavioral health provider. Members living in Santa Cruz continue to have the highest rates of utilization of behavioral health services in the both the physical health and behavioral health network settings at 13%, Monterey is at 7%, and Merced at 7% (Table 13). These rates are calculated on the number of unique utilizers and the average monthly membership by county. Similar methodology is used to calculate utilization by Race/Ethnicity, Figure 16. Members reporting race as Hispanic proportionally have much higher utilization of services, and the rates of utilization are similar across the three counties; Merced at 4.2% for 2021, Monterey at 4.8% and Santa Cruz at 5.0%.

Table 3. Behavioral Health Utilization in the Primary Care and Behavioral Health Networks by County, 2021

Program County	Monthly Average Membership	Unique Utilizers	Utilization Rate
Merced	135,650	8,817	6.5%
Monterey	168,759	11,654	6.9%
Santa Cruz	73,704	9,384	12.7%
Total	378,114	29,785	7.9%

Source: Alliance and Beacon Claims Data, 2021

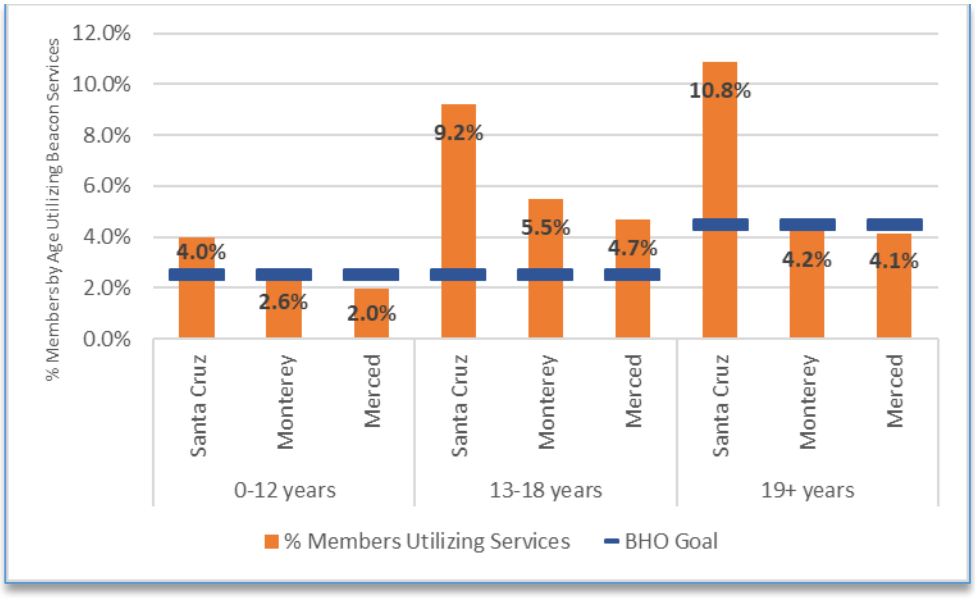
Figure 16. Mental Health Utilization Rates (Number of Visits per Average Members per Month) by Race/Ethnicity, 2021



Source: Alliance and Beacon Claims Data, 2021

Reviewing Beacon Health Options Report there is a similar trend of uptake across the three counties, here displayed by county and age group in Figure 17. These data come from the 2021 Q4 Beacon Report which describes the utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12-month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Beacon services from that same County and age cohort within each quarter. Beacon has described the goals for utilization by age group, 2.5-4.0% for 0-12-year olds and for 13-18-year olds, and 4.5-6.5% for 19 years and older. The data described in Figure 17 outlines the percent of members by age and county and indicates (blue bar) the Beacon goal for that age group. Santa Cruz County meets the Beacon goals for all age groups. Monterey County meets it for the pediatric population but not the adult. Merced County fails to meet the goal for the 0-12-year olds and the 19+ or adult populations.

Figure 17. Beacon Health Option Service Utilization by Age Group and County, 2021



Source: Beacon Health Options Reporting, 2021

Comparing the percentages of adults that indicated that they needed help for mental health or drug/alcohol use issues illustrated in Figure 17 is one way to describe the demand for services. While the data is using a five-year period, the demand for services has remained high in Santa Cruz year over year. The actual utilization of services appears to follow the same pattern, highest utilization in Santa Cruz where there is the highest demand, followed by Merced and Monterey with significantly less demand and as our annual report indicates about half the utilization. Regardless, opportunities remain to continue to work towards increased access across all counties and for all age and racial/ethnic groups.

E. Member Satisfaction

The Alliance relies on both member survey data and grievance system data to assess member satisfaction. Unfortunately, Beacon did not have 2021 Member Satisfaction results available as of this writing. Routine appointment access within 10 days (Source: Beacon) for 2021 was just 73.1% for 2021 days (an increase of 10.6% from the previous year (2020), 62.5%). There were only 2 requests for urgent appointments reported for Q1 for 2021 which were both met. Monitoring of member grievances reveals that grievances have remained below Beacon's one grievance per 1,000 members from throughout 2021. Just 91.5% of member grievances were resolved within the required 30-day timeframe throughout this time period (Goal: 100%). Additional reporting notes responsiveness on telephone access for 2021, 92.3% of calls were answered within 30 seconds (Goal >95%), call abandonment was quite low at 0.7% (Goal <5%) and met the goal for average speed of answered calls ≤30 seconds at 16.2 seconds average for the year.

Overall member survey results in 2020 and 2021 indicated opportunities for improvement. Because of this, Beacon continues to have an open Corrective Action Plan with the purpose of improving improve member satisfaction a working to ensure care coordination with Primary Care.

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

- Provider education regarding access and availability standards.
- Active recruitment of providers based on specialty, cultural/linguistic and geographic needs, and expansion of telehealth.
- Exploration of a follow-up text messaging program with membership to determine if members were able to secure an appointment or whether members need further assistance.

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. 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.

F. 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 5.1 in 2021 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 survey were administered in English and Spanish between April and July 2021. It used a two-wave mail methodology with a phone follow up to non-respondents. The survey response information is summarized in Table 14. The response rate for the 2021 survey was lower in comparison to the response rate for the 2020 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 4. DHCS Required CAHPS Medi-Cal Member Survey Response, 2021

	Adult	Child
Sample Size	1,350	1,650
Number of Ineligible Surveys	15	3
Number of Completed Surveys	248	306
Response Rate	18.6%	18.6%

Source: 2021 CAHPS Alliance Results

The CAHPS Health Plan Survey 5.1 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 2021. There were 168 plans that submitted Adult results to NCQA's Quality Compass with CAHPS Medicaid adult data and 183 Plans submitted data with child data. The California benchmark for the adult survey is made up of 19 health plans and the child survey includes 14 plans. It is important to note that not all plans reported out on every measure to create these benchmarks. The 2021 summary rate for adult comparison with the 2020 summary rate and with the 2021 Quality Compass benchmarks is presented in Table 15.

Table 5. CAHPS Summary Rates for Adults, 2021

Composite/Measure/Attribute	2021	2020	2021 CA Benchmark	2021 CA %tile Rank	2021 US Benchmark
Getting Needed Care	85.3%	83.0%	79.2%	Above 90th	83.6%
Getting Care Quickly	84.5%[1]	80.3%	75.2%	Above 90th	81.8%
How Well Doctors Communicate	89.3%	90.8%	89.4%	25th – 50th	92.2%
Health Plan Customer Service	88.9%	89.0%	86.9%	50th – 75th	88.9%
Rating of Health Care	79.1%	69.7%	75.3%	50th – 75th	77.6%
Rating of Personal Doctor	82.1%	78.7%	80.8%	50th – 75th	83.2%
Rating of Specialist	77.8%	82.2%	81.7%	Below 25th	83.6%
Rating of Health Plan	79.8%	75.6%	76.3%	50th – 75th	78.3%

Source: 2021 CAHPS Alliance Results

In comparison to the 2020 summary rate, the following five composites showed an increase in rate for 2021: *Getting Needed Care, Getting Care Quickly*, *Rating of Personal Doctor, Rating of Health Plan and Rating of Health Care*. The following composites/ratings showed a decrease in rate for 2021 in comparison to the 2020 rate: *How Well Doctors Communicate, Coordination of Care, Health Plan Customer Service, and Rating of Specialist.* For all composites and ratings, 2021 summary rates of Rating of Health Plan and Rating of Health Care were statistically significant in its increase, the remaining were not statistically significantly lower/higher than 2020 summary rates.

The 2021 summary rate for child and comparison with the 2020 summary rate and with the 2021 Quality Compass benchmarks is presented in Table 16.

Table 6. CAHPS Summary Rates for Children, 2021

Composite/Measure/Attribute	Summary Rate and Percentile Ranking				
	2021	2020	2021 CA Benchmark	2021 CA %tile Rank	2021 US Benchmark
Getting Needed Care	83.4%	80.4%	83.6%	50th – 75th	85.7%
Getting Care Quickly	83.1%	86.8%	80.7%	Above 75th	86.9%
How Well Doctors Communicate	93.5%	92.6%	92.8%	50th – 75th	94.4%
Health Plan Customer Service	91.0%	91.2%	87.3%	Above 90th	88.3%
Rating of Health Care	87.1%	82.0%	88.7%	Below 25th	88.9%
Rating of Personal Doctor	92.1%	88.8%	90.3%	Above 75th	90.6%
Rating of Specialist*	83.3%	83.1%	N/A*	N/A*	87.4%
Rating of Health Plan	88.8%	86.5%	87.8%	50th – 75th	86.7%

**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.*

Source: 2021 CAHPS Alliance Results

In comparison to the 2020 summary rate, the following six composites showed an increase in rate for 2021: *Getting Needed Care, How Well Doctors Communicate, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, and Rating of Health Plan. and.* In comparison to the 2019 summary rate, the following four ratings showed a decrease in rate for 2020: Getting Care Quickly and Health Plan Customer Service. For all composites and ratings, 2020 summary rates were not statistically significantly lower/higher than 2019 summary rates.

The 2021 Survey included custom questions for both child and adult respondents about access to care for both routine and acute care needs. For the adult custom question, "In the last 6 months, how many days did you have to wait for an appointment for a check-up or routine care?" 75.4% of responses met the DMHC Timely Access Standard of 10 Business Days for Routine Care Appointment compared to 79.9% in 2020. Similarly, the child custom question, "In the last 6 months, how many days did your child have to wait for an appointment for a check-up or routine care?", 77.9% meet the DMHC Timely Access Standard of 10 Business Days for Routine Care Appointment compared to 80.1% in 2020.

The QIPH team also added questions about acute care access that also showed decreases in timely access to care. The adult care question, "In the last 6 months, when you needed care for an illness, injury, or condition, how long did you have to wait between trying to get the care and seeing a provider?" found that 56.9% meet the DMHC Timely Access Standard of 48 Hours for Urgent Care Appointment when

compared to 63.6% in 2020. Again, the child question, "In the last 6 months, when your child needed care for an illness, injury, or condition, how long did your child have to wait between trying to get the care and seeing a provider?" showed the results were that 75.2% meet the DMHC Timely Access Standard of 48 Hours for Urgent Care Appointment compared to 85.0% in 2020. All members were experiencing a significant decrease in access to care when either an acute or both a routine need arose.

G. Health Disparities and Inequities

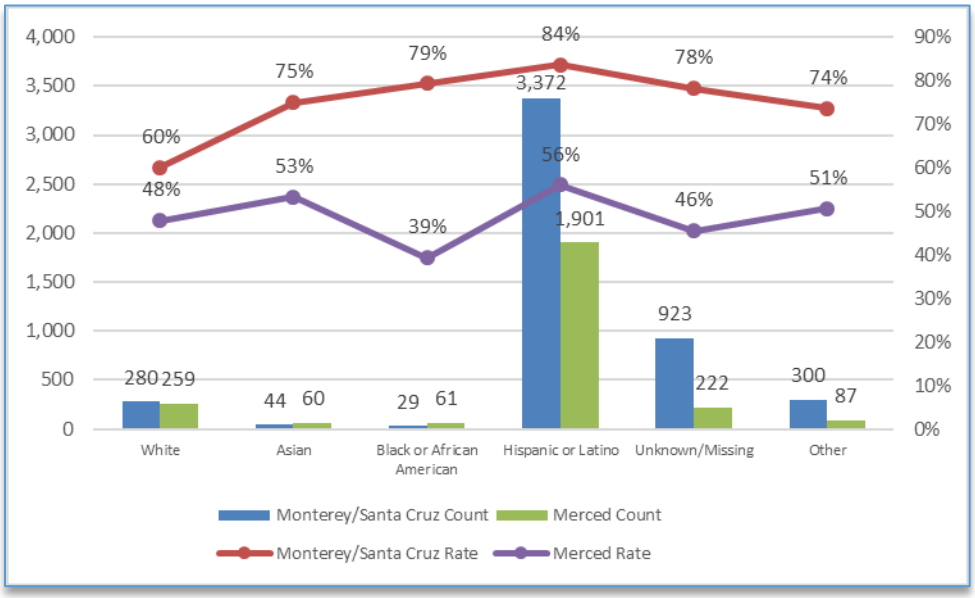
Children and Adolescents

Evaluation for disparities in health measures for children and adolescent was completed using the DHCS measurement year 2020 Preventives Service Report rate sheets and MCAS Measurement Year 2021 data. The Preventive rate sheets contain data specific to the Alliance for measures that assess the utilization of preventive services by pediatric members: *Blood Lead Screening and Dental Fluoride Varnish*. Fluoride Varnish data from this report was reported above in the Oral Health Section, including Figures 11 and 12. Results were reviewed as the data was initially reported, Santa Cruz and Monterey counties combined, and Merced County reported separately.

Blood Lead Screening

The review of the Lead Screening (LSC) Measure from MCAS in the Preventive Services report for measurement year 2020 reveals a stark difference between the two reporting units, Monterey-Santa Cruz and Merced. Overall screening for Monterey-Santa Cruz was 81%, Merced was 54%. In both units our Hispanic population had the highest rates and the largest population sizes, Figure 18 below. Notably the white population has the lowest rate in Monterey-Santa Cruz, and one of the lowest rates in Merced. The Black population (N=61) while small had the lowest screening rate in Merced. Neither reporting unit met the minimum of >10 members in the Native Hawaiian or Other Pacific Islander nor the American Indian or Alaska Native to be included in this report. These racial/ethnic group distributions of performance follow the same trends observed in the statewide "2021 Preventive Services Report".

Figure 18. Lead Screening in Children (LSC) by Reporting Unit and Race/Ethnicity, MY2020



Source: DHCS Preventive Services Report, 2020

Blood lead screening results by spoken Language showed that our Spanish-speaking members in Monterey-Santa Cruz had an 88% screening rate as compared to a 69% screening rate in Merced. The English-speaking population in Monterey-Santa Cruz had a 73% screening rate compared to a 49% screening rate in Merced. Finally, the only other spoken language with a minimum population of 11 was that of the Hmong population in Merced, they had a screening rate of 62%, higher than the overall Merced population but still behind the Spanish-speaking population.

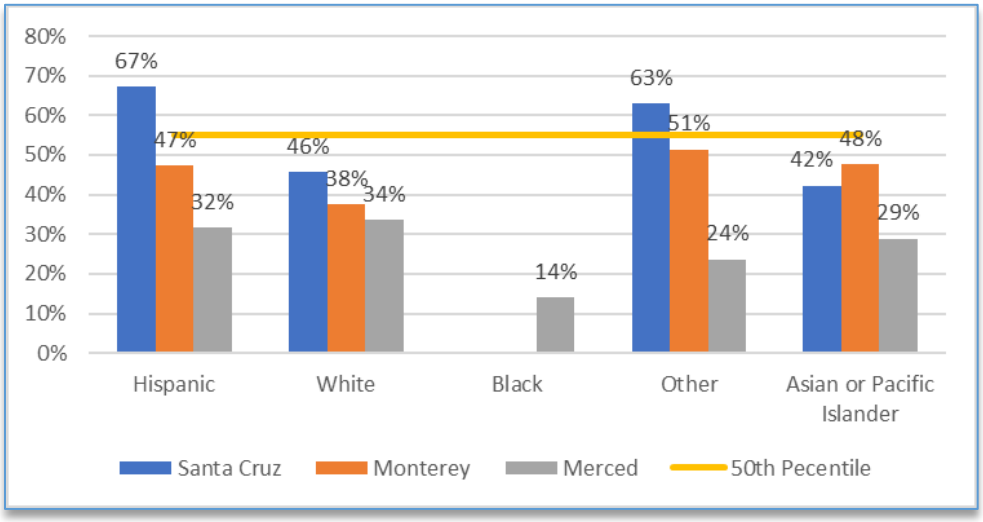
The Alliance added Blood Lead Screening to its Care Based Incentive Program in 2021 as unpaid "exploratory" measure. Providers have been able access rosters of their members and their current lead screening status including a history of available lab results. The roster includes lab data is collected routinely through major laboratories and complied with the monthly data from the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB). Primary care provider's LSC screening rates are reported to them quarterly on their provider profile and compared to benchmarks and their peer's performance. Our facility site review nurses review for these screenings as they complete medical record reviews during facility site reviews. Providers have been challenged by the recall of blood lead test kits which allowed a quick capillary sample to be collected and measured in the office. These test kits had a recall that was initiated in mid-2021 and supplies have just become more available as of this writing. During the shortage, providers switched to ordering venous blood draws for these infants and young children at laboratories, but few followed through per anecdotal clinician reports.

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), 2021

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 but have improved since 2019 and has increased to 43% for 2021. Less than half of the eligible Alliance pediatric membership received six or more visits prior to their 15th month in 2021. Overall rates by County show Merced County at 31%) Monterey at 47% and Santa Cruz at 63%.

Figure 19 below displays the percentage of visits stratified by race/ethnicity and county. Hispanic infants had the highest rates (67%) in Santa Cruz County had the two groups that exceeded the 50th percentile, Hispanics (67% and Other racial/ethnic groups at 63%). All others fell below the 50th percentile. Monterey County's highest rate reports was in members identified as other racial/ethnic groups, Asian or Pacific Islanders, and Hispanics. All Merced county groups fell well below the 50th percentile for this measure, with their Black population lowest of all at 14%. There were fewer than 11 Black infants in both Santa Cruz and Monterey counties.

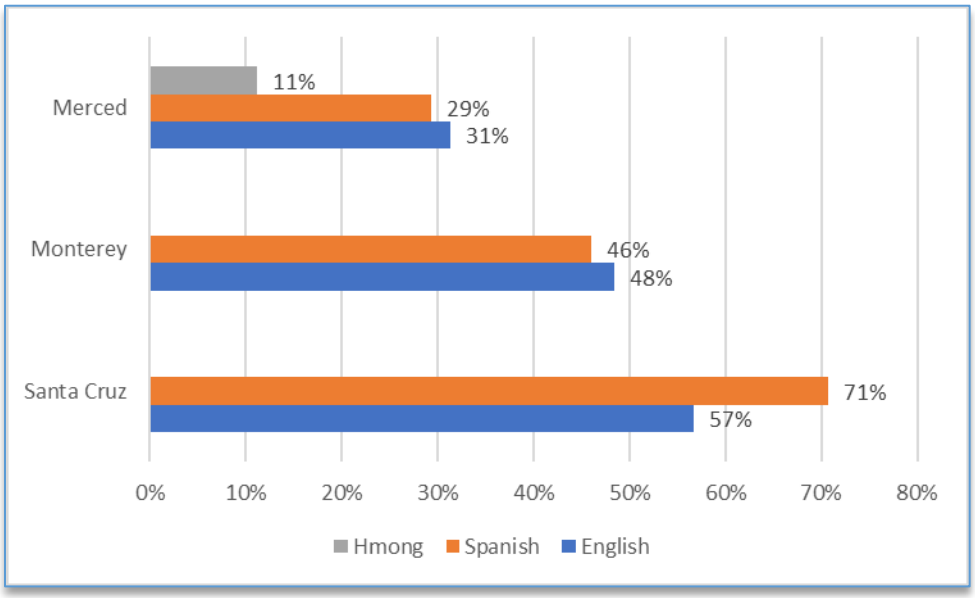
Figure 19. Well Child Visits (6+) by 15 Months by Race/Ethnicity and County/Region, 2021



Source: MCAS MY2021 administrative data.*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 20 below, infants in the Spanish speaking group had the highest compliance rate in Santa Cruz (71%). In Monterey, 48% and Merced (31%) counties members in English speaking families had higher rates followed by infants in the Spanish spoken language groups (46% vs 29%). In Merced County, infants in the Hmong speaking group had the lowest rate of compliance (11%). Hmong was not reported as a spoken language for infant members in Santa Cruz/Monterey.

Figure 20. Well Child Visits by 15 Months (6 Visits) by Spoken Language and County*, 2021



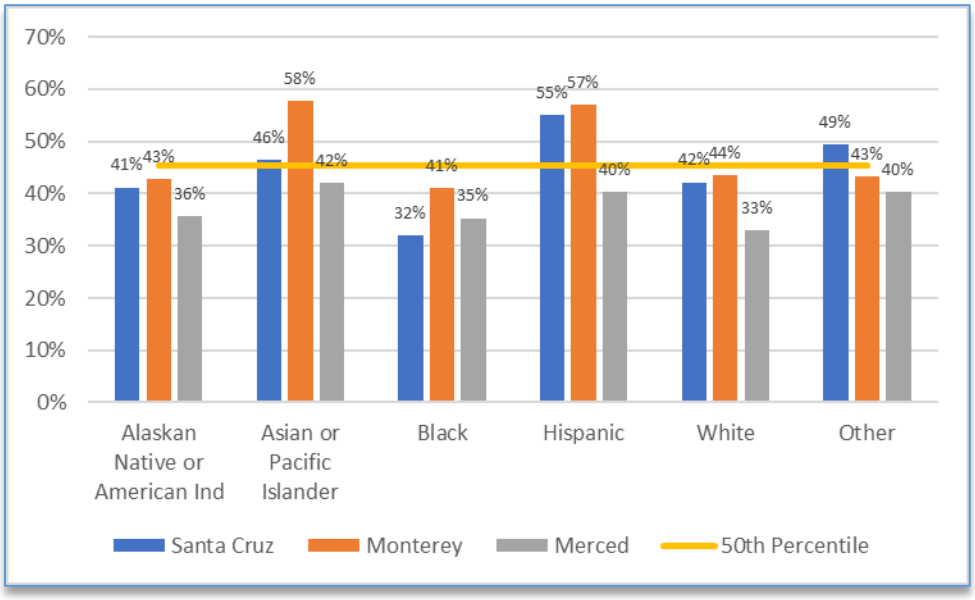
*Spoken language groups included if denominator was >10 members. Source: MCAS MY2021 administrative data

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, 54% of eligible child and adolescent Alliance members ages 3-21 had at least one well child visit in 2021, with Merced County at 40%, Monterey 56%, reporting an overall higher rate of compliance (52%).

Figure 21 below displays the percentage of *WCV* visits stratified by race/ethnicity and county. As shown, Asian or Pacific Islander and Hispanic children and adolescents in Monterey had the highest rates of visits overall (58% and 57% respectively, followed by Hispanic and Other in Santa Cruz County. ", "Other" (55%), Asian (51%), Black (47%), Native Hawaiian/Other Pacific Islander (46%), White (44%), and American Indian (42%). In Merced, Asian, Hispanic and "Other" children and adolescents both had the highest compliance rates. Alaskan Native/Native American, Black and finally White children and adolescents in Merced County had the lowest rates of compliance overall, at 36%, 35% and 33%, respectively. Although White children and adolescents in Merced County represent a large proportion of members in the denominator and a priority population for preventive care in Merced County. Understanding the root cause of these disparities will take time to uncover.

Figure 21. Child and Adolescent Well-Care Visit Rates by Race/Ethnicity and County, 2021

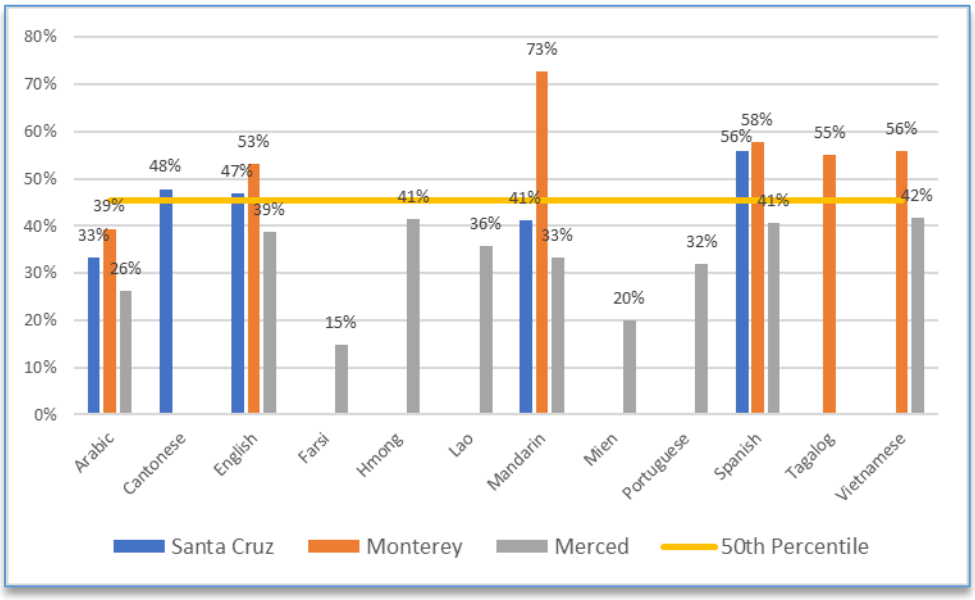


**Racial/ethnic groups included if denominator was >10 members*
Source: MCAS MY2021 administrative data

As shown in Figure 22, members in Monterey whose spoken language was listed as Mandarin had the highest overall rate of WCV compliance (73%), the next highest rates were also in Monterey for Spanish speakers at 58% and Vietnamese speakers at 56%. Santa Cruz rates ranged from 33% in Arabic speakers to 56% in Spanish speakers. Santa Cruz had 5 different populations where there was 11 more members and was the only county with a large enough population of Cantonese speakers. Monterey had six different languages, again with Arabic speakers with the lowest rate at 39% ranging up to Mandarin speakers at 73%. Monterey was the only county with a large enough population of Tagalog speakers.

Merced County rates ranged from 15% of Farsi speakers completing well child and adolescent visits up to 42% of Vietnamese children. Merced had nine different language groups, with Farsi (15%), Hmong (41%), Lao (36%), Mien (20%) and Portuguese (32%) speakers being unique to this county. Merced's largest populations completing well child and adolescent visits speak English (39%) and Spanish (41%).

Figure 22. Child and Adolescent Well-Care Visit Rates by Spoken Language* and County, 2021



*Spoken language where at least 11 members spoke the language in their county.
Source: MCAS MY2021 administrative data

H. 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[xxi]. 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[xxii]. 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[xxiii]:

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 2021 Alliance Merced, Santa Cruz, and Monterey counties MCAS 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 2021 MCAS measure, see results in Table 17. 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 7. Select MCAS 2021 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. (Well Child Visits for 12-17-year olds)	82.6%	57.3%	42.8%
Cancer -C-09 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.	84.3%	65.6%	63.6%
Diabetes -7 Increase the proportion of persons with diagnosed diabetes whose blood pressure is under control. (MCAS MY 2021)	57.0%	54.0% *	53.3%*
Diabetes – 5 Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent	16.2%	37.2%	43.3%
Mother, Infant, and Child Health - MICH-08 Increase the proportion of pregnant women who receive early and adequate prenatal care.	80.5%	93.2%*	91.7%*
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%	84.9%	81.6%
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%	79.8%*	70.6%*
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%	82.5%*	72.0%*

Sources: Healthy People 2020 (US DHHS, Office of Disease Prevention and Health Promotion) and MCAS measures for MY2021.

Low health literacy, cultural barriers, and limited English Proficiency have been coined the "triple threat" to effective health communication by The Joint Commission[xxiv]. 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.

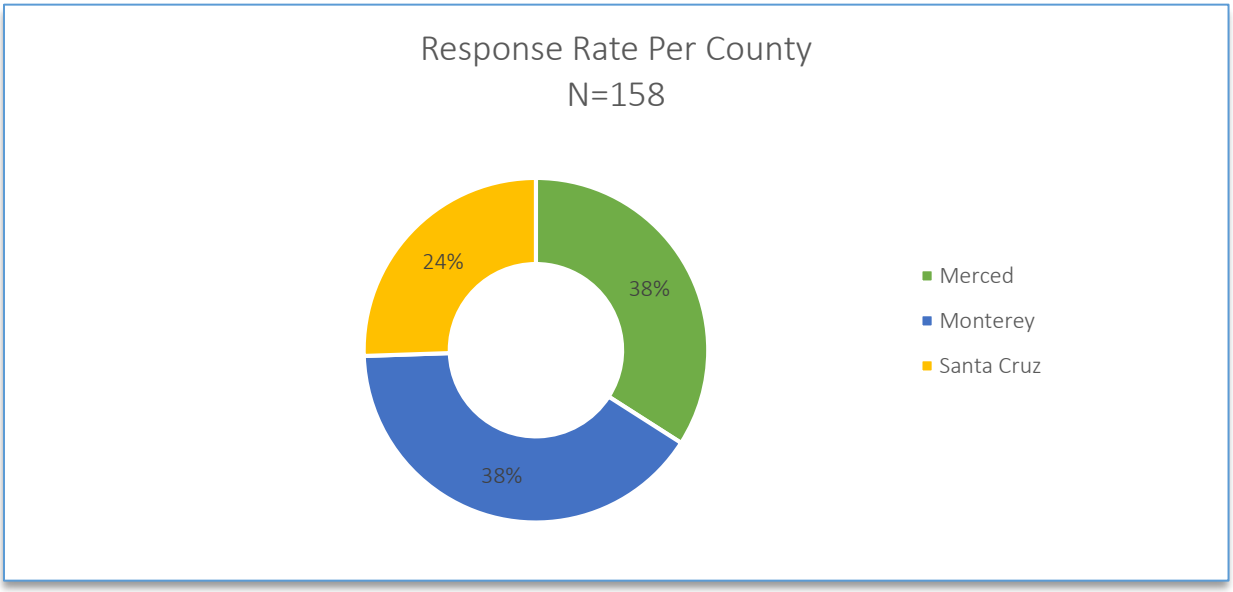
To further assist in identifying Medi-Cal members' perceptions, preferences, and behaviors as it relates to health education and cultural and linguistic services, the Alliance conducted a PNA member outreach survey in 2022. A total of 625 members were outreached by phone to complete the survey in June 2022. The Alliance used a standardized survey that consisted of 25 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). The survey was available in English, Spanish, Hmong, and other languages. A total of 158 surveys were completed for an overall response rate of 25%. The response rate for the PNA Member Outreach Survey aligns with the usual Alliance member survey rate and is higher compared to the 13% response rate from the previous year. We found that this can be attributed to when the outreach calls were done in the previous year. From April-May 2021, members were coping with several COVID-19-member outreach efforts, and many members declined the survey. Therefore, to ensure a higher response rate in 2022, a total of 158 Target® gift cards in the amount of $25 were given to participants who completed the survey. Table 18 represents the response rates by type of respondent, age, language, survey type, adult's identity, and if they experienced homelessness. Figure 23 illustrates survey response rates broken down by county.

Table 8. PNA Member Outreach Survey Completed by Member (N=158), 2022

Age Group	Combined (N/%)	
Under 18	37	23%
18-24	11	7%
25-34	23	15%
35-44	15	9%
45-54	27	17%
55-64	36	23%
65+	9	6%
Totals	158	
Language	**Combined (N/%)**	
English	101	64%
Spanish	55	35%
Hmong	1	.50%
Other	1	.50%
Totals	158	
Survey Type	**Combined (N/%)**	
Adult	120	76%
Child	38	24%
Totals	158	

Adults Identity	Combined (N/%)	
Male	45	31%
Female	97	67%
Trans Male	2	1%
Trans Women	0	0%
Gender queer / gender non-conforming	2	1%
No responses	12	
Totals	158	
Experienced homelessness in the past 12 months	**Combined (N/%)**	
Yes	18	11%
No	140	89%
Totals	158	

Figure 23. PNA Member Outreach Survey Response by County, 2022



Overall, all participants responded being 89%% very satisfied and 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 decrease in comparison to the rate for the 2021 survey (95%). About 80% of participants shared that their health beliefs do not go against their PCPs advice. This is a slight decrease in comparison to the rate for the 2021 survey (90%). In addition, the top topics for which respondents are most interested in receiving information or help from the Alliance include:

- How to ask a question related to the health plan (30%) (2021-15%)
- How to choose a doctor (30%) (2021-17%)
- Transportation to get to doctor visits, pharmacy, and other services (29%)(2021-23%)
- Getting an appointment with a specialist (26%) (2021-23%)
- Who to call at night when sick (23%) (2021-34%)
- How to handle a chronic condition (22%) (2021-17%)

Participants from the PNA outreach member survey also expressed various 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 the majority (70%) of participants indicated that the materials they received from the Alliance provide information that is easy to understand and in their preferred language. This is an increase when compared to the previous survey conducted in 2021 (61%). When asked if the materials they received from the Alliance were provided in their preferred language, most members answered yes (89%).

In addition, many participants were unaware of a few of the Alliance's benefits and services.

- 70% never called the Alliance Nurse Advice Line
- 48% were not familiar with the Alliance transportation benefit
- 75% have never heard about the Alliance's Health and Wellness Rewards Program

Regarding oral health, 46% of respondents had seen the dentist in the last six months, 33% within seven months to a year, and 24% had not seen a dentist for more than two years. Members expressed the lack of coverage for dental services (unable to afford/no insurance), waiting for an appointment, and the need for coverage to expand. 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. To address 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 19 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 9. 2022 PNA Member Outreach Survey Key Findings by SDOH Indicator

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. • Difficulty setting up accessing the transportation benefit • *Member voice*: "We really rely on the insurance to help us get our appointments. Having [the transportation] service is vital to his health care" "not enough drivers for transportation services"

Education	Health Literacy • Not enough Hmong-speaking doctors • Members continue to express that the complex terms were challenging to understand • Members continue to express not being literate and are unable to read information sent by the Alliance (i.e. 2nd – 3rd grade reading level) • *Member voice*: "I have a hard time filling out forms"
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 (the wait time for the next appointment is far out) • Need a quick reference phone guide with phone numbers to connect with someone • Lack of dental coverage and needing assistance with finding a dentist • *Member voice*: o "They don't have many facilities to seek children mental health and need more qualified mental health providers. I am having a hard time coordinating my care" o *"Child with autism; he fears going to the doctors"* 2. Quality of Care: • Members expressed that some doctors do not give members enough time to explain their health concerns/discomforts • Members expressed seeing multiple providers and a lack of communication between providers • *Member voice*: "The challenge I have is communicating with the doctor's office. Too long to hear back from the clinic, it can be challenging to get through" 3. Cultural and Linguistic: • A few members (13%) expressed using a family member or friend to interpret for them during a doctor visit. • Members felt more comfortable using a family member or friend as an interpreter. They were more trusting with this approach and included family in the visit. • *Member voice*: *"my daughter goes to the appointment with me and it was easier for her to help me"*

In addition, to augment our knowledge of existing culturally and linguistically services, health education, and health plan needs from Medi-Cal members' perspectives, the following surveys were analyzed.

Key findings from the surveys and responses to questions include:

Perceived health needs and expectations – Based on the 2022 PNA member outreach survey data and the CAHPS data, access to care appears to be an issue for Alliance members. The 2022 PNA member outreach survey identified problems related to access, including:

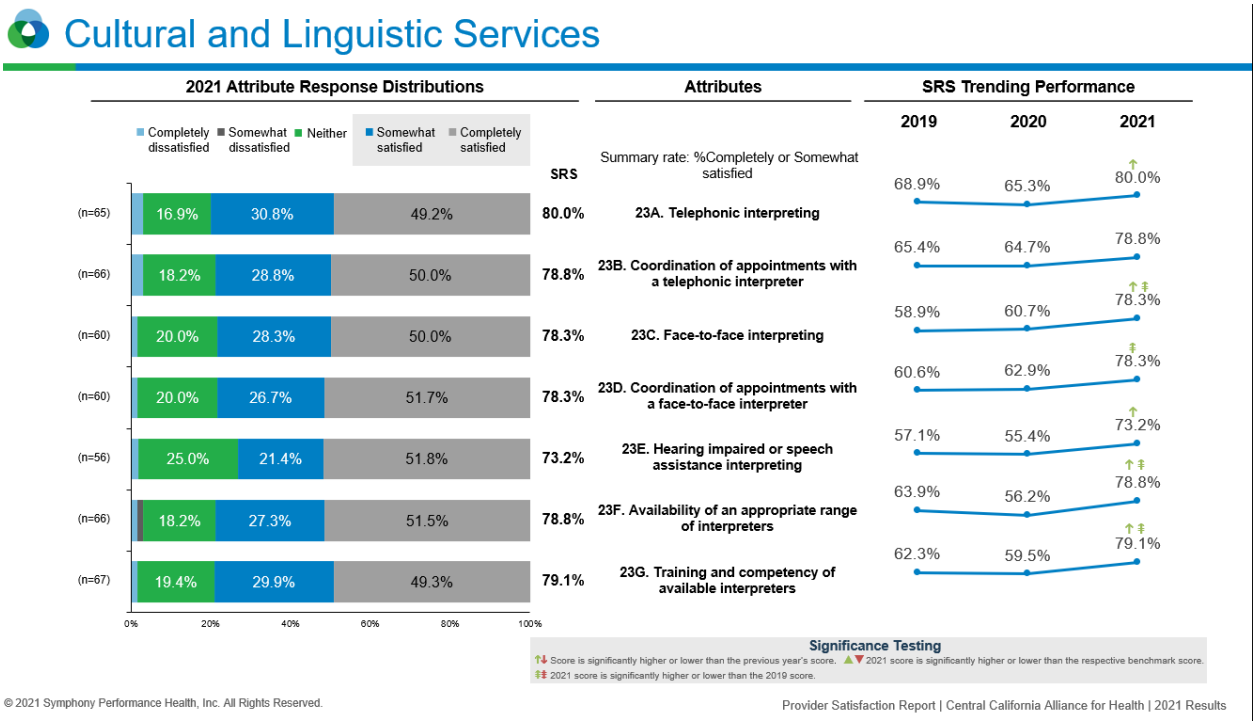
- "Not enough appointment times at doctors' offices and clinics" 33% (2021-19.15%)
- "Not enough clinics and doctors nearby" 31% (2021-21.28%) both frequently mentioned when members were asked what they thought were important health concerns
- "Not enough behavioral health services nearby" 25% (2021-11%)

- "How to ask a question related to the health plan" 30% 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," showed improvement scores of 83.0% and 80.3% for adults compared to the previous PNA report. The scores significantly increased for children compared to the previous PNA report (76.9% and 80.9%), 80.4%, and 86.8%, respectively.

The Alliance conducts an annual Provider Satisfaction Survey to assess contracted providers' overall satisfaction with core health plan operations. Yearly results are used to assess providers' awareness of Alliance resources, inform future initiatives and educational opportunities for the provider network, and provide insight into where the Alliance can focus improvement efforts in conjunction with other health plan data. In 2021, 1,051 eligible providers were surveyed, with a provider response rate of 17%. When providers were asked about their satisfaction with the Alliance Cultural and Linguistic Services, we've had a significant increase compared to previous years. Figure 24 illustrates providers' responses to five cultural and linguistic services questions.

Figure 24. Provider Satisfaction Report, 2021



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.

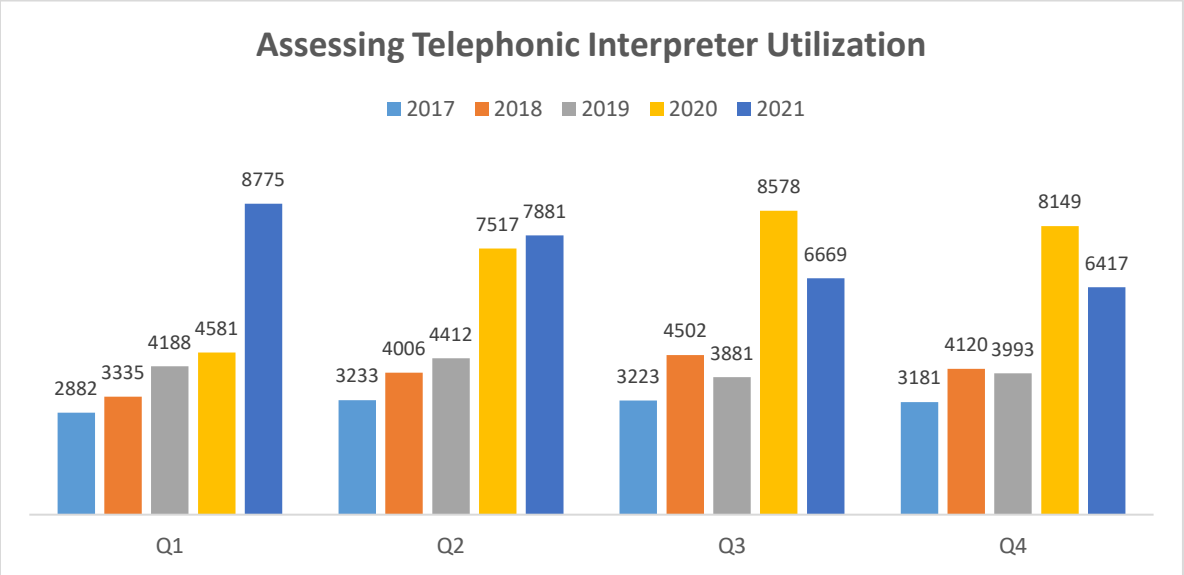
Reported language needs –The Alliance is committed to helping bridge cultural and linguistic differences and ensures that all members have access to health care providers and services in their language of choice. The overall utilization of telephonic interpreting services has significantly increased among network providers, Alliance staff, and contracted Alliance vendors using the Alliance Language Assistance

Service Program. A total of 29,742 telephonic interpreting services calls were reported for 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 3% increase compared to the measuring year 2020 (28,825). This increase can be attributed to the shift in how members accessed their medical care. In 2020, members resumed their health care journey via telehealth and telephonic options. Figure 25 illustrates utilization volume.

When members were asked how well their language needs are being met by their PCPs, the 2022 PNA member outreach survey findings indicated that members (23%) get an interpreter when needed during their visit to their doctor's office. A decrease when compared to the PNA member outreach done in 2021 (40%), and about 43% expressed not needing an interpreter. Additionally, more participants reported (85%) never used a family member or friend to interpret for them during their PCP visit. A 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 to increase 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 to communicate with their patients telephonically in 2021, Spanish, Vietnamese, Mandarin, Arabic, and Hmong. The overall utilization of telephonic interpreting services continues to increase among providers, Alliance staff, and contracted Alliance vendors using the service.

Figure 24. Alliance Telephonic Interpreter Provider/Alliance Staff Utilization by Quarter and Year, 2021



Source: Telephonic interpreting vendor utilization reports, 2017-2021

In addition, the Alliance has been monitoring various indigenous languages within our service areas. There is a lack of data sources that accurately capture the different indigenous languages/variants spoken. This is mainly due to the demographic data that is shared by the state, as the Medi-Cal enrollment application does not capture indigenous languages/variants. However, through the Alliance Language Assistance Services for interpreting services, we've been able to identify this population and meet their linguistic needs by providing qualified interpreters, both telephonically and in person (face-to-

face). During the COVID-19 pandemic, only telephonic interpreting services for indigenous languages have been provided and utilized. As we resume care in the office, we will see a shift back to providers requesting in-person (face-to-face) interpreting services. Figure 26 illustrates 2021 utilization rates for indigenous language telephonic interpreting. The utilization count is based on the number of telephonic encounters. These counts could include duplicate members depending on the number of medical visits they had.

Figure 26. Total Number of Indigenous Language Utilized via the Alliance Language Assistance Services by Telephonic Interpreting Vendor, 2021

Indigenous Languages					
2021	Chatino	Mixteco	Triqui	Zapoteco	Grand Total
Grand Total	2	254	131	1	388

Source: Telephonic interpreting vendor utilization report, 2021

To ensure that the interpreting services are provided to Alliance members, ongoing monitoring and evaluation that includes input from primary stakeholders are 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 service that truly improves the LEP member's experience when receiving covered services.

Availability and accessibility of health information – Some of the most significant 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[xxv] 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 reporting poor health status. Cultural beliefs may also impact communication between patients and providers and affect a patient's ability to follow a provider's 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 received 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 survey also showed that the majority (85%) of participants indicated that the materials they received from the Alliance provide information that is easy to understand and in their preferred language (87%).

Overall, members continue to express that specific terminology is challenging to understand. It was also identified that a few members are illiterate and cannot 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. Several 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. This may lead to a variety of adverse 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[xxvi] when examining the effects of the use of pictures on health communication messaging to patients. This suggests that adding pictures to enhance written and spoken instructions can increase attention, comprehension, recall, and adherence to messaging. Overall, research shows that all patients benefitted from using pictures, but those 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 23,000 member calls in 2021, including those that come through the Alliance's toll-free Health Education Line, see Appendix C for a list of Alliance Health Education and Disease Management programs.

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 February-April in 2021. A total of 688 Alliance members were classified as at 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 provide a human connection to potentially isolated people, 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.

The campaign, spearheaded by the Health Services Division and Your Health Matters, worked 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 that Alliance members highly valued the importance of being available to members during a crisis.

Once COVID-19 vaccines were released, staff focused on promoting vaccinations at local events and coordinating with local community-based organizations. The Alliance participated in the DHCS COVID Vaccination Incentive Plan that measured plans on specific target populations starting in 2021. The Alliance performed well, increasing the overall vaccination rate from August 29, 2021, to March 6, 2022, by ten percentage points.

I. 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 contrast, the Alliance ensures access to primary, emergent, and inpatient care and strives to do so in a culturally sensitive approach. Unfortunately, according to most population health

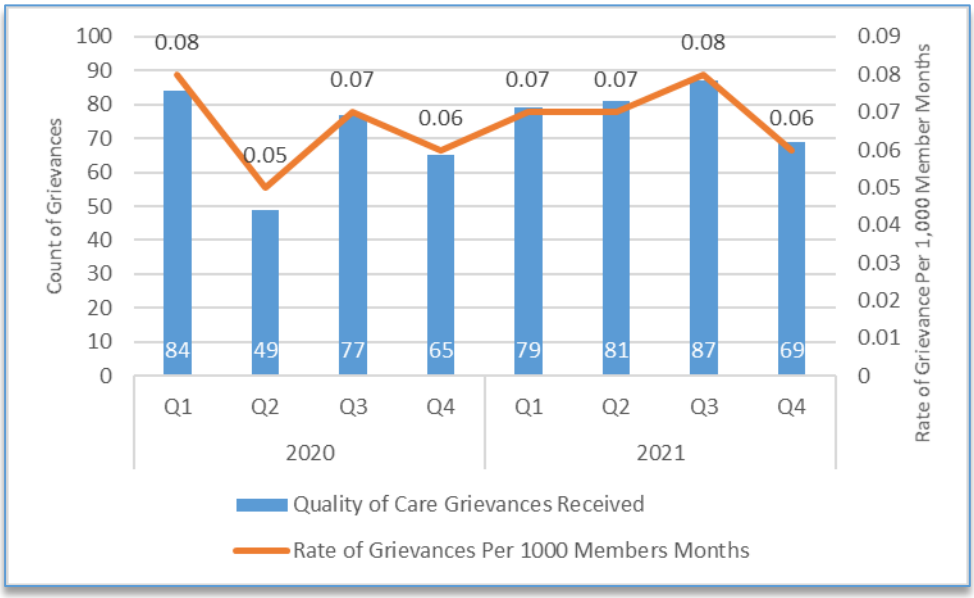
models, including the one described in Figure 4 produced by RWJF, health factors and outcomes will remain largely unchanged until programs and policies are sufficiently modified to support our most vulnerable members.

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 utilized. 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

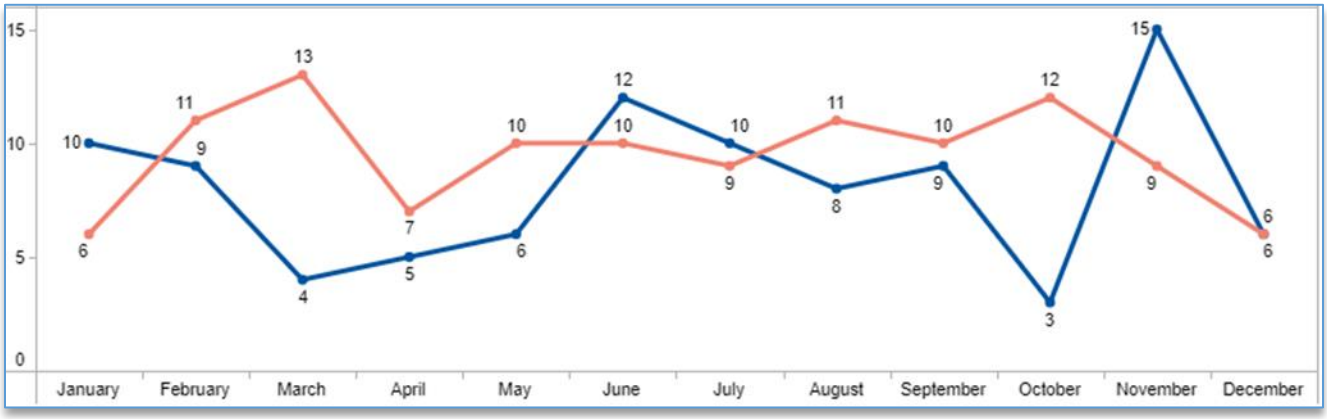
Approximately 2,248 appeals and grievances were received in 2021. While this is an increase over the 1,820 reported in 2020, the rate of total grievances per 1,000 members per month was relatively stable, 0.04 in 2020 and 0.05 in 2021. There were 316 Quality of Care Grievances (QOC), which is an 15% increase over 2020 (Figure 27). Again, despite the increase in QOC grievances, the rate remained stable at 0.7 for both years. There were 114 grievances made on behalf of Whole Child Model members (Figure 28). 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 25. Alliance Quality Grievances by Quarter, Count and Rate PKMM, 2020-21



Source: Alliance internal Grievance Department Reporting

Figure 26. Whole Child Model Grievances and Appeal by Month and Year, 2020-2021



Source: Alliance internal Grievance Department Reporting, 2020-2021

5. Action Plan

Based on the findings outlined in this report, the following table presents key recommendations and 2022-2023 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.

A. 2022 Action Plan Table

Health Education/Quality Improvement:	**Objective**
	1. By December 31, 2022, increase the percentage of members who report in CAHPS that they were 'usually' or 'always' able to get care quickly by 2%, from 81.7% (adult) to 83.7% (adult) in all three service counties. 2. By December 31, 2022, increase the percentage of members who report in CAHPS that they were 'usually' or 'always' able to get care quickly by 2%, from 86.6% (child) to 88.6% (child) in all three service counties. **Data Source:** *2021 CAHPS Data and 2022 PNA Member Outreach Survey*
	Strategies
	• 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%. • 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**
	1. By June 30, 2023, increase staff/provider utilization of telephonic interpreting calls by 4% from 28,825 to 29,978 in all three service counties for Limited English Proficiency (LEP) and Deaf and/or Hard of Hearing members. 2. By June 30, 2023, increase provider utilization of on-site face-to-face interpreting during medical visits by 4% 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:** *2022 PNA Member Outreach Survey and Cultural and Linguistic Utilization reports*
	Strategies

	• 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. • 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. • Develop provider trainings/videos on cultural competency to ensure Alliance providers can communicate effectively with Alliance members and produce optimal patient education outcomes.
Health Disparity	Objective
	1. 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% in Merced County. 2. By June 30, 2023, increase the percentage of members who complete their childhood immunization rate (CIS-10) for 2 years old from 21.65% to 26.65% in Merced County. Data Source: *2021 MCAS Data and 2021 DHCS Health Disparities Data*
	Strategies
	• Increase member/provider education about seeking preventative care, focusing on pediatric care in the first three years of life. • 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). • 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: *2021 CAHPS Data and 2021 PNA Member Outreach Survey*	Progress Toward Objective: The Alliance 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: a 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 Adults and 5.2% for children, 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% • 2021 Actual: Adult 84.5%, Child 83.1%

		Data source: 2017-2021 CAHPS Data **Activities:** completed at the time of this PNA report • See Figure 29. under the 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.* **Data Source:** *Mental Health Data and Alliance Behavioral Health Evaluation Report, Beacon Utilization Reports, DHCS Bulletins, and Internal Staff Reports.*	**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 reach out to providers and conducts interviews to learn more about their experiences with telehealth and better understand their perspectives on how telehealth practices impact their work and engagement with members. 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% • 2021 Actual: 8.40% **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. 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 29. under the Access to Care section
Cultural and Linguistic	Strategy 3.) *Identify one (1) essential health plan materials to field-test to assess members' ability to access and utilize health plan information to make informed decisions by December 31, 2021.* Data Source: *2021 PNA Member Outreach Survey and 2021 Member Outreach Campaigns*	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 is being provided. Progress Measure: To support MCAS childhood immunization 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 providers 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 services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. <u>Telephonic Interpreter Services Utilization:</u> The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 29,742 telephonic interpreting services calls were reported for CY 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). **This is a 3% increase when compared to the previous year (2020; 28,825).** <u>Face-to-Face Utilization:</u> As for face-to-face interpreting services, we had a total of 1,414 provider requests that were coordinated in CY 2021 across the Alliance's service areas. **This is a 25% increase when compared to the previous year (2020; 1,127).** This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during the COVID-19 pandemic, and members are resuming care in person.

		Translation Services Utilization: **In CY 2021 (718) utilization of translation service increased by 51% compared to the previous CY 2020 (475).** Member communications have increased dramatically due to COVID-19-related information, benefit changes, website maintenance, ECM, Medi-Cal Rx, Grievance, and NOA's. The C&L team provided support in translation coordination, readability/suitability review, and quality control (QC) reviews to meet DHCS guidelines and delivery timeframes. This could be due to the multiple efforts 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 providers 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 29. under the Cultural and Linguistic section
Health Education	**Strategy 4.)** *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:** *2021 Healthier Living Program Assessment*	**Progress Toward Objective:** The Alliance launched its first Healthier Living Program (HLP) virtual workshop with members in 2021. The Alliance's Healthier Living Program (HLP) is an evidence-based self-management program originally developed at Stanford University. It is designed to help Alliance members diagnosed with chronic conditions gain self-confidence in their ability to control their symptoms and understand how their health problems affect their lives. The program focuses on issues that are common for individuals suffering from chronic conditions, such as pain management, nutrition, exercise, stress reduction, emotions, and communicating with doctors. Traditionally, the HLP workshops were held in-person at community locations for Alliance members in our tri-county servicing areas. Due to COVID-19, the Alliance modified this program to be offered over the phone and now virtually.

		The telephonic HLP workshops are led by trained Alliance Health Education staff, and the workshops consist of six 1-hour sessions, and virtual workshops consist of six 2.5-hour sessions. During the HLP workshops, Alliance members create weekly action plans that include goal setting around managing their chronic condition(s) and healthier living. Each week, the Alliance Health Educators work with members to review the weekly action plans and discuss successes and challenges. The HLP allows members to also receive support and share ideas with other members who are experiencing similar life challenges living with a chronic condition. In CY 2021, QHP staff conducted a total of 9 HLP workshops. Marjory of participating Alliance members (65%) self-reported improvements in the ability to manage their chronic conditions after the workshops. Progress Measure: • Q1-2021: 75% • Q2-2021: 67% • Q3-2021: 56% • Q4-2021: 65% Activities: completed at the time of this PNA report • See Figure 29. under the Quality Improvement/Health Education section
Quality Improvement	Strategy 5.) *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 MCAS Data, 2020 DHCS Preventive Rate Sheet, 2021 DHCS Health Disparities Data*	Progress Toward Objective: MCAS 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 be 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 MCAS MY2021 findings. The Alliance is examining all pediatric health activities historical 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 would be modified to extend the time period to complete all activities that are planned. Activities: completed at the time of this PNA report • See Figure 29. Under the Health Disparities section

Figure 29. PNA Action Plan Review and Updated Activities, 2020-2022

Target Audience	Topic	Message/Content	Delivery Channel	Communication Date
Member	Behavioral Health	**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	Nov-20
Member	Behavioral Health	**BH Benefit Flyer (Adolescents)** 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.	Mail	Dec-20
Member	Access to Care	**Member Newsletter** Article: Timely Access	Newsletter	Mar-21
Provider	Access to Care	**Provider Newsletter** Article: Appointment Wait Standards	Newsletter	Mar-21
Member	Behavioral Health	**Member Newsletter** Article: Is COVID-19 bringing your teen down? Shared BH Benefit Flyer (Adolescent) Flyer	Newsletter	Jun-2021
Member	Access to Care	**New NAL Member Incentive Flyer** Promotion of NAL with contact details	Flyer	Jun-21
Member	Access to Care	**Sept Provider Bulletin** Promotion of Nurse Advice Line (NAL) via full page Flyer	Bulletin	Sept-2021
Member	Access to Care	**New Member Welcome Packet** Includes Health & Wellness Resource Flyer and Alliance Quick Reference Guide	Welcome Packet	Ongoing
Member	Access to Care	**December Member Newsletter** NAL Article	Newsletter	Dec-2021
Member	Behavioral Health	**Member Newsletter** Q4: Maternal Mental Health	Newsletter	Dec-2021
Member	Access to Care	**Member Newsletter** CAHPS Member Satisfaction Survey (2022)	Newsletter	Dec-2021
Provider	Behavioral Health	**Provider Bulletin** Q4: Maternal Mental Health	Bulletin	Dec-2021
Provider	Access to Care	**Provider Website** Article: Timely Access	Website	Ongoing

Member	Access to Care	**NAL Campaign** Promotion of Member Incentive NAL Flyer	Campaign	Ongoing (Sept-Nov)
Member	Access to Care	**Flu Campaign** Mass distribution General Flu Prevention postcard and promotion of Second Flu Shot Member Incentive Flyer	Campaign	Ongoing (Sept-Oct)
	Access to Care	**Postcard** Focused on NAL for distribution to all member households	Postcard	Sept-2021
Member	Access to Care	**Website Promotion - NAL** Big focus on promotion of NAL in member website section via Social Media and via banner on Website Landing Page or pop up (winter months)	Website	Ongoing throughout the year
Member	Behavioral Health	**Social Media Post - Your Mental Health Matters.** Mental Health Matters. With your Alliance health plan, you can get services like: - Individual or group therapy - Visits with a Psychiatrist - Psychological testing - Treatment related to autism (ages 3-20) - Emotional support during and after pregnancy through the child's first year of life	Social Media	Mar-2022
Member	Behavioral Health	**Mental Health Awareness Month –. May 2022.** **'Are you struggling with your mental health'** Promote mental health awareness via social media channels and promote mental health services we offer.	Social Media	May-2022
Member	Behavioral Health	**Website Promotion - Mental Health Services** 'Feeling sad or Anxious'? - Banner on landing page You are not alone. Get mental health services today. Learn More Link takes to Behavioral Health Care Page	Website	Mar-2022
Member	Access to Care	**Member Newsletter (Mar 2022) - Volume 28, Issue 1** Article: Initial Health Assessment: What it is and why it is important	Newsletter	Mar-2022
Member	Access to Care	**Member Newsletter (Mar 2022) - Volume 28, Issue 1** Article Transportation services What it is and how it works	Newsletter	Mar-2022
Member	Access to Care	**Member Newsletter (Mar 2022) - Volume 28, Issue 1** Article How to avoid missing your doctor appointments	Newsletter	Mar-2022
Member	Access to Care	**Member Newsletter (Mar 2022) - Volume 28, Issue 1** Article Getting an appointment	Newsletter	Mar-2022

		How long should you have to wait?		
Member	Access to Care	**Provider Bulletin - March 2022** Article Get to know Enhanced Care Management (ECM) All providers in the Alliance's contracted network can refer ECM/CS members.	Bulletin	Mar-2022
Provider	C&L	**Provider Newsletter** Article: Alliance Language Assistance Services How to communicate better with their members	Newsletter	Mar 2021
Member	C&L	**Member Newsletters** Article: Alliance's Language Assistance Services Advertise C&L services	Newsletter	Mar-2021 Jun-2021
Provider	C&L	**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	Jun-2021
Employee	C&L	**Inter Departmental Trainings** Health Equity & Health Literacy - Pharmacy - UM - CCC	In Person	Q3 2021 -Q2-2022
Member	C&L	**Audio Interpreting Services SOFT Launch** Placeholder	Handout	Q4-2021
Member	C&L	**Member Newsletter (March 2022) - Volume 28, Issue 1** Article Alliance's Language Assistance Services	Newsletter	Mar-2022
Provider	C&L	**Provider Bulletin - March 2022** Article Alliance's Language Assistance Services	Bulletin	Mar-2022
Member	C&L	**Member Newsletter (June 2022) - Volume 28, Issue 2** Article: American Sign Language (ASL) interpretation services at no charge to you	Newsletter	Jun-2022
Provider	C&L	**Provider News Flash - June 2022** Topic: Indigenous Interpreter Services Update	Newsletter	Jun-2022
Provider	C&L	**Provider Bulletin - June 2022** Article: Communicating with members who are deaf or hard of hearing	Bulletin	Jun-2022
Member	C&L	**Member Newsletter - Sept 2022** Q3 Article: Health Literacy	Newsletter	Sept-2022

Provider	C&L	**Provider Bulletin - Sept 2022** Q3 Article	Bulletin	Sept-2022
Member	Health Disparity	**Member Mailing** EPDST Pediatric DHCS Campaign Phase I (0-2.99 ages)	Mail	Nov-2020
Member	Health Disparity	**Member Mailing** EPDST Pediatric DHCS Campaign Phase II (3-6.99 ages)	Mail	Nov-2020
Member	Health Disparity	**Member Newsletter** Article: What is lead screening for children and why is it important? Steps to make your home safer from lead	Newsletter	Mar-2021
Member	Quality Improvement/Health Education	**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	Jun-2021
Member	Health Disparity	**Robocalls** Topic: EPDST Pediatric DHCS & COVID-19 Campaign Phase III (18-20.99 ages)	Robo Call	Jun-2021
Member	Health Disparity	**Robocalls** Topic: EPDST Pediatric DHCS & COVID-19 Campaign Phase III (7-17.99 ages)	Robo Call	Jun-2021
Member	Quality Improvement/Health Education	**Member Newsletter** Immunizations Back to School	Newsletter	Jun-2021
	Quality Improvement/Health Education	**The Beat** Article: on Immunizations and Back to School	The Beat	Aug-2021
Provider	Quality Improvement/Health Education	**Provider Newsletter** Immunizations Back to School	Bulletin	Sept-2021
Member	Quality Improvement/Health Education	**Provider Virtual Immunization Training** The Alliance is partnering with the California Department of Public Health (CDPH) to host an Immunization virtual training for our network. Topics: • County updates • Vaccines for Children (VFC) updates • COVID-19 Vaccine training with Steven Vantine, Education Consultant with CDPH	Webinar	Sept-20121 Mar-2021 Jun-2021
Member	Health Disparity	**EPSDT Preventative Health - Adolescent Mailings** Include Well Child & Immunization Member incentive flyers	Mail	Q4-2021

Provider	Quality Improvement/Health Education	**Provider eNewsletter - Issue 30 Virtual Immunization Training on April 27** The Alliance is partnering with the California Department of Public Health (CDPH) to host an immunization training for providers in Merced, Monterey and Santa Cruz counties.	Newsletter	Mar-2022
Provider	Quality Improvement/Health Education	**Provider Virtual Immunization Training** The Alliance is partnering with the California Department of Public Health (CDPH) to host an Immunization virtual training for our network. Topics: - Immunizations & Well Child Visits	Webinar	Apr-2022
Member	Quality Improvement/Health Education	**Member Newsletter (June 2022) - Volume 28, Issue 2** Article #1: Quality, award-winning care for your child	Newsletter	Jun-2022
Member	Quality Improvement/Health Education	**Member Newsletter (June 2022) - Volume 28, Issue 2** Article#2: Back-to-school immunizations	Newsletter	Jun-2022
Member	Quality Improvement/Health Education	**Member Newsletter (June 2022) - Volume 28, Issue 2** Article: Staying healthy—well-care visits for teens	Newsletter	Jun-2022
Provider	Quality Improvement/Health Education	**Provider Bulletin (June 2022)** Article 2022 immunization updates	Bulletin	Jun-2022
Provider	Health Disparity	**Provider Bulletin (June 2022)** Article Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Bulletin	Jun-2022

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 20 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 20. Stakeholder Engagement

Stakeholder	Engagement Method	Date of Completion
Alliance Population Needs Assessment Stakeholder 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	May 2022
Alliance Member Services	• Presented PNA information using a PowerPoint presentation • Gathered feedback and input from individual internal stakeholders	May 2022

Advisor Workgroup Meeting	• Incorporated stakeholder feedback and input, if any into the PNA	
Alliance Medi-Cal Members	• Conducted a telephonic member outreach survey with Alliance Medi-Cal members from all three (3) service counties (N= 158) on the following topics: ▪ Health Plan Services ▪ Health Plan Member Materials ▪ Primary Care Provider & Cultural and Linguistic Services ▪ Social Determinates of Health • Gathered feedback and input from individual Alliance members • Incorporated member feedback and input from the survey data results into the PNA	June 2022

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 21.

Table 21. 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 2022 - Q2 2023
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 2022 - Q2 2023
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 2022
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 2022

Alliance Member Services Advisory Group (MSAG)	• As a follow-up, present PNA findings and action plans using a PowerPoint presentation to external stakeholders	Q4 2022 - Q2 2023
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 2022
Whole Child Model Family Advisory Committee (WCMFAC)	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2022 - Q2 2023
Physicians Advisory Group (PAG)	• Present PNA information, findings, and action plans using a PowerPoint presentation to external stakeholders	Q4 2022 - Q2 2023
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 2022 - Q2 2023
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 2022 - Q2 2023

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	13,352	4.10%
2-17	137,950	42.33%
18-44	128,417	39.41%
45-64	44,312	13.60%
65+	1,842	0.57%
Grand Total	**325,873**	100.00%

B. Plan's Members by Age Group and Ethnicity

Ethnicity	Age Group	Member Numbers
Black	0-1	155
	2-17	2,365
	18-44	3,647
	45-64	1,573
	65+	87
Black Total		7,827
All Others	0-1	1,121
	2-17	4,732
	18-44	9,067
	45-64	3,698
	65+	281
All Others Total		18,899
Asian or Pacific Islander	0-1	3,310
	2-17	12,495
	18-44	10,462
	45-64	5,051
	65+	927
Asian or Pacific Islander Total		32,245
White	0-1	868
	2-17	12,684
	18-44	22,938
	45-64	12,746
	65+	706
White Total		49,942
Hispanic	0-1	8,683
	2-17	112,431
	18-44	87,428

	45-64	26,154
	65+	2,889
Hispanic Total		**237,585**
Not Provided	2-17	2
	18-44	47
	45-64	106
	65+	27
Not Provided Total		**182**
Unknown	2-17	6
	18-44	7
Unknown Total		13
Grand Total		**346,693**

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

Spoken Language	Age Group	Member Numbers
English	0-1	8,217
	2-17	68,221
	18-44	81,736
	45-64	28,676
	65+	1,695
English Total		**188,545**
Hmong	0-1	39
	2-17	700
	18-44	1,018
	45-64	438
	65+	29
Hmong Total		**2,224**
Other	0-1	139
	2-17	872
	18-44	1,266
	45-64	1,286
	65+	479
Other Total		**4,042**
Spanish	0-1	5,742
	2-17	74,922
	18-44	49,576
	45-64	18,928
	65+	2,714
Spanish Total		**151,882**
Grand Total		**346,693**

D. Plan's Members by Age Group and County		
County	Age Group	Member Numbers
MERCED	0-1	5,320
	2-17	55,426
	18-44	52,070
	45-64	17,536
	65+	1,456
MERCED Total		**131,808**
MONTEREY	0-1	6,707
	2-17	67,208
	18-44	54,464
	45-64	19,164
	65+	2,351
MONTEREY Total		**149,894**
SANTA CRUZ	0-1	2,110
	2-17	22,081
	18-44	27,062
	45-64	12,628
	65+	1,110
SANTA CRUZ Total		**64,991**
Grand Total		**346,693**

Table 2. A-F. SPD Population

A. Plan's Members by SPD Aid Category		
Aid Category	Member Numbers	% of Total Membership
Blind	198	1.32%
SPD	14,807	98.62%
Unknown	9	0.06%
Grand Total	**15,014**	100.00%

B. Plan's Members by Age Group and SPD Aid Category			
Age Group	Aid Category	Member Numbers	% of Total Membership
0-1	SPD	66	0.44%
0-1 Total		66	0.44%
2-17	Blind	26	0.17%
	SPD	2,500	16.65%

2-17 Total		2,526	16.82%
18-44	Blind	109	0.73%
	Disabled	4,222	28.12%
18-44 Total		4,331	28.85%
45-64	Blind	61	0.41%
	SPD	4,951	32.98%
45-64 Total		5,016	33.41%
65+	Blind	2	0.01%
	SPD	3,068	20.43%
	Unknown	5	0.03%
65+ Total		3,075	20.48%
Grand Total		15,014	100.00%

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

Ethnicity	Aid Category	Member Numbers	% of Total Membership
Black	Blind	12	0.08%
	SPD	843	5.61%
Black Total		855	5.69%
All Others	Blind	6	0.04%
	SPD	832	5.54%
	Unknown	1	0.01%
All Others Total		839	5.59%
Asian or Pacific Islander	Blind	31	0.21%
	SPD	3,129	20.84%
	Unknown	2	0.01%
Asian or Pacific Islander Total		3,162	21.06%
White	Blind	52	0.35%
	SPD	3,412	22.73%
	Unknown	3	0.02%
White Total		3,467	23.09%
Hispanic	Blind	97	0.65%
	SPD	6,590	43.89%
	Unknown	3	0.02%
Hispanic Total		6,690	44.56%
Unknown	SPD	1	0.01%
Unknown Total		1	0.01%
Grand Total		15,014	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	Blind	132	0.88%
	SPD	8,893	59.23%
	Unknown	5	0.03%
English Total		9,030	60.14%
Hmong	Blind	6	0.04%
	SPD	299	1.99%
Hmong Total		305	2.03%
Other	Blind	11	0.07%
	SPD	1,184	7.89%
	Unknown	1	0.01%
Other Total		1,196	7.97%
Spanish	Blind	49	0.33%
	SPD	4,431	29.51%
	Unknown	3	0.02%
Spanish Total		4,483	29.86%
Grand Total		15,014	100.00%

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

County	Aid Category	Member Numbers	% of Total Membership
MERCED	Blind	111	0.74%
	SPD	6,479	43.15%
	Unknown	3	0.02%
MERCED Total		6,593	43.91%
MONTEREY	Blind	59	0.39%
	SPD	5,288	35.22%
	Unknown	5	0.03%
MONTEREY Total		5,352	35.65%
SANTA CRUZ	Blind	28	0.19%
	SPD	3,040	20.25%
	Unknown	1	0.01%
SANTA CRUZ Total		3,069	20.44%
Grand Total		15,014	100.00%

F. Plan's Members by Gender and SPD Category

Gender	Aid Category	Member Numbers	% of Total Membership
F	Blind	87	0.58%
	SPD	7,244	48.25%
	Unknown	6	0.04%
F Total		7,337	48.87%
M	Blind	111	0.74%
	SPD	7,563	50.37%
	Unknown	3	0.02%
M Total		7,677	51.13%
Grand Total		15,014	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	775	11.28%
2-17	5,069	73.75%
18-21	1,029	14.97%
Grand Total	6,873	100.00%

B. Plan's Members by Ethnicity

Ethnicity	Member Numbers	% of Total Membership
Black	98	1.43%
All Others	242	3.52%
Asian or Pacific Islander	851	12.38%
White	603	8.77%
Hispanic	5,079	73.90%
Grand Total	6,873	100.00%

C. Plan's Members by Spoken Language

Row Labels	Member Numbers	% of Total Membership
English	3,098	45.07%
Hmong	37	0.54%
Other	113	1.64%
Spanish	3,625	52.74%
Grand Total	6,873	100.00%

D. Plan's Members by County

Row Labels	Member Numbers	% of Total Membership
MERCED	2,781	40.46%
MONTEREY	3,084	44.87%
SANTA CRUZ	1,008	14.67%
Grand Total	6,873	100.00%

E. Plan's Members by Zip Zone

Row Labels	Member Numbers	% of Total Membership
APTOS	43	0.63%
ATWATER / WINTON	497	7.23%
CAPITOLA	13	0.19%
FREEDOM	88	1.28%
LIVINGSTON / DELHI	269	3.91%
MERCED	1,072	15.60%
PLANADA / LEGRAND	100	1.45%
SAN LORENZO VALLEY	68	0.99%
SANTA CRUZ	184	2.68%
SOQUEL	20	0.29%
THE WESTSIDE	708	10.30%
Unknown	3,145	45.76%
WATSONVILLE	666	9.69%
Grand Total	6,873	100.00%

F. Plan's Members by Gender

Row Labels	Member Numbers	% of Total Membership
F	3,254	47.34%
M	3,619	52.66%
Grand Total	6,873	100.00%

Tables 4 A-F. Entire Population

A. Plan's Members by Age Group		
Age Group	Member Numbers	% of Total Membership
0-1	14,137	4%
2-17	144,715	42%
18-44	133,596	39%
45-64	49,328	14%
65+	4,917	1%
Grand Total	346,693	100.00%

B. Plan's Members by Ethnicity and Age Group			
Ethnicity	Age Group	Member Numbers	% of Total Membership
Black	0-1	155	0.05%
	2-17	2,365	0.71%
	18-44	3,647	1.06%
	45-64	1,573	0.46%
	65+	87	0.02%
Black Total		7,827	2.32%
All Others	0-1	1,121	0.34%
	2-17	4,732	1.26%
	18-44	9,067	2.36%
	45-64	3,698	0.97%
	65+	281	0.08%
All Others Total		18,899	5.01%
Asian or Pacific Islander	0-1	3,310	1.10%
	2-17	12,495	3.40%
	18-44	10,462	2.84%
	45-64	5,051	1.45%
	65+	927	0.27%
Asian or Pacific Islander Total		32,245	9.06%
White	0-1	868	0.33%

	2-17	12,684	3.82%
	18-44	22,938	6.73%
	45-64	12,746	3.76%
	65+	706	0.20%
White Total		49,942	14.83%
Hispanic	0-1	8,683	2.95%
	2-17	112,431	33.76%
	18-44	87,428	23.97%
	45-64	26,154	7.29%
	65+	2,889	0.76%
Hispanic Total		237,585	68.73%
Race Not Provided	2-17	2	0.01%
	18-44	47	0.00%
	45-64	106	0.03%
	65+	27	0.01%
Not Provided Total		182	0.05%
Unknown	2-17	6	0.00%
	18-44	7	0.00%
Unknown Total		13	0.00%
Grand Total		346,693	100.00%

C. Plan's Members by County and Age Group

County	Age Group	Member Numbers	% of Total Membership
MERCED	0-1	5,320	1.53%
	2-17	55,426	15.99%
	18-44	52,070	15.02%
	45-64	17,536	5.06%
	65+	1,456	0.42%
MERCED Total		**131,808**	**38.02%**
MONTEREY	0-1	6,707	1.93%
	2-17	67,208	19.39%
	18-44	54,464	15.71%
	45-64	19,164	5.53%
	65+	2,351	0.68%
MONTEREY Total		**149,894**	**43.24%**
SANTA CRUZ	0-1	2,110	0.61%
	2-17	22,081	6.37%
	18-44	27,062	7.81%
	45-64	12,628	3.64%
	65+	1,110	0.32%
SANTA CRUZ Total		**64,991**	**18.75%**
Grand Total		**346,693**	100.00%

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

Spoken Language	Age Group	Member Numbers	% of Total Membership
English	0-1	8,217	2.37%
	2-17	68,221	19.68%
	18-44	81,736	23.58%
	45-64	28,676	8.27%
	65+	1,695	0.49%
English Total		**188,545**	**54.38%**
Hmong	0-1	39	0.01%
	2-17	700	0.20%
	18-44	1,018	0.29%
	45-64	438	0.13%
	65+	29	0.01%
Hmong Total		**2,224**	**0.64%**
Other	0-1	139	0.04%
	2-17	872	0.25%
	18-44	1,266	0.37%
	45-64	1,286	0.37%
	65+	479	0.14%
Other Total		**4,042**	**1.17%**
Spanish	0-1	5,742	1.66%
	2-17	74,922	21.61%
	18-44	49,576	14.30%
	45-64	18,928	5.46%
	65+	2,714	0.78%
Spanish Total		**151,882**	**43.81%**
Grand Total		**346,693**	**100.00%**

E. Plan's Members by Gender and Age Group

Gender	Age Group	Member Numbers	% Total Membership
F	0-1	7,005	2.02%
	2-17	70,847	20.44%
	18-44	75,601	21.81%
	45-64	26,813	7.73%
	65+	3,000	0.87%
F Total		**183,266**	**52.86%**
M	0-1	7,132	2.06%
	2-17	73,868	21.31%
	18-44	57,995	16.73%

	45-64	22,515	6.49%
	65+	1,917	0.55%
M Total		163,427	47.14%
Grand Total		346,693	100.00%

Appendix B: MCAS MY2021 Results

Central California Alliance for Health
NCQA HEDIS Measures - MY2021 Rates

				MY2021 Final Rates		MY2021 NCQA Benchmarks		
	Measure Acronym	Held to MPL?	Performance Measure	SCMON	MERC	50th Percentile	75th Percentile	90th Percentile
Hybrid Measures	CBP	Y	Controlling High Blood Pressure	55.99%	59.02%	55.35	62.53%	66.79
	CCS	Y	Cervical Cancer Screening	61.70%	62.77%	59.12	63.66%	67.99
	CDC-H9	Y	HbA1c- Poor >9 *(inverse)*	30.67%	41.73%	43.19	38.37%	34.06
	CIS-10	Y	Childhood Immunizations - Combo 10	50.98%	18.25%	38.20	45.50%	53.66
	IMA-2	Y	Immunizations for Adolescents - Combo 2	54.52%	37.71%	36.74	43.55%	50.61
	PPC-PRE	Y	Timeliness of Prenatal	88.65%	92.70%	85.89	89.29%	92.21
	PPC-PST	Y	Postpartum Follow Up	90.39%	84.18%	76.40	79.56%	83.70
	WCC - BMI	Y	Weight Assessment and Counseling - BMI	93.91%	83.91%	76.64	82.73%	87.18
	WCC - N	Y	Counseling for Nutrition	89.25%	67.53%	70.11	76.64%	82.48
	WCC - PA	Y	Counseling for Physical Activity	86.02%	64.37%	66.18	72.81%	79.32
			Count Below 50th	0	3			
			Count Above 50th	3	4			
			Count Above 75th	1	1			
			Count Above 90th	6	2			

				MY 2020 Final Rates		MY2021 Final Rates		MY2020 vs. MY2021		MY2021 NCQA Benchmarks		
	Measure Acronym	Held to MPL?	Performance Measure	SCMON	MERCED	SCMON	MERC	SCMON %Δ	MERCED %Δ	50th Percentile	75th Percentile	90th Percentile
Administrative Measures	ADD-C&M	N	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and	56.06%	52.00%	49.06%	35.00%	-7.00% ↓	##### ↓	55.96	62.44	67.61
	ADD-Init	N	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase*Not held to MPL	48.41%	47.21%	44.97%	41.09%	-3.44% ↓	-6.12% ↓	44.51	49.12	55.99
	AMM-Acute	N	Antidepressant Medication Management - Effective Acute Phase Treatment	61.86%	58.10%	61.03%	61.44%	-0.83% ↓	3.34% ↑	56.66	61.83	67.74
	AMM-Cont	N	Antidepressant Medication Management - Effective Continuation Phase Treatment	43.71%	38.98%	42.17%	41.25%	-1.54% ↓	2.27% ↑	40.28	45.61	52.49
	**AMB-ED	N	Emergency Department Visits/1000MM	32.15%	35.32%	36.39%	36.49%	4.24% ↑	1.17% ↑	40.96	47.80	56.18
	AMR	N	Asthma Medication Ratio	75.32%	73.15%	77.25%	72.36%	1.93% ↑	-0.79% ↓	64.78	70.67	75.32
	APM-B	N	Blood Glucose Testing	100.00%	25.00%	0.00%	33.33%	###### ↓	8.33% ↑	48.49	53.78	61.62
	APM-BC	N	Blood Glucose and Cholesterol Testing	0.00%	0.00%	0.00%	0.00%	0.00% ↔	0.00% ↔	30.58	36.84	44.58
	APM-C	N	Cholesterol Testing	0.00%	0.00%	0.00%	33.33%	0.00% ↔	##### ↑	31.99	39.16	46.71
	BCS	Y	Breast Cancer Screening	56.38%	54.13%	53.96%	50.10%	-2.42% ↓	-4.03% ↓	53.93	58.70	63.77
	CHL	Y	Chlamydia Screening in Women	57.04%	52.04%	61.00%	50.79%	3.96% ↑	-1.25% ↓	54.91	61.75	66.15
	FUA - 7 Day	N	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	4.32%	4.68%	5.45%	3.61%	1.13% ↑	-1.07% ↓	13.36	17.66	22.98
	FUA - 30 Day	N	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	8.09%	5.51%	9.67%	5.54%	1.58% ↑	0.03% ↓	21.31	26.22	32.60
	FUM - 7 Day	N	Follow-Up After Emergency Department Visit for Mental Illness	11.87%	39.69%	13.90%	23.83%	2.03% ↑	##### ↓	38.55	49.49	61.36
	FUM- 30 Day	N	Follow-Up After Emergency Department Visit	25.27%	48.65%	26.52%	30.20%	1.25% ↑	##### ↓	53.54	64.59	74.39
	PCR	N	Plan All Cause Readmissions	17.57%	14.22%	17.69%	15.53%	0.12% ↑	1.31% ↑	9.910	10.980	12.180
	SSD	N	Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antiphsychotic Meds	100.00%	100.00%	97.62%	100.00%	-2.38% ↓	0.00% ↔	76.64	79.70	82.53
	*W30-2+	Y	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	83.18%	62.39%	72.90%	55.14%	-10.28% ↓	-7.25% ↓	70.67	76.12	82.82
	W30-6+	Y	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	44.21%	34.76%	51.09%	31.06%	6.88% ↑	-3.70% ↓	54.92	61.25	68.33
	*WCV	Y	Child and Adolescent Well-Care Visits	50.14%	37.76%	56.29%	41.19%	6.15% ↑	3.43% ↑	45.31	53.83	61.97
			Count Below 50th	5	6	4	9					
			Count Above 50th	1	3	6	2					
			Count Above 75th	3	1	1	1					
			Count Above 90th	3	2	3	2					
			Small Denominator Measure <100	5	5	5	5					

*No Benchmarks in MY2020
**AMB-ED is an informational measure and benchmarks hold no weight.

Central California Alliance for Health
DHCS Measures – MY2021 Rates

DHCS Measures

Measure Acronym	Age Stratification	Hybrid to MY21?	Performance Measure	MY2020 SCMOM	MY2020 MERCED	MY2021 SCMOM	MY2021 MERCED	MY2020 vs. MY2021 SCMOM Δ		MY2020 vs. MY2021 MERCED Δ	
AMM	18-64	No	Acute Phase Treatment	61.82%	57.92%	60.70%	61.32%	-1.12%	↓	3.40%	↑
AMM	65+	No	Acute Phase Treatment	64.52%	71.43%	79.49%	NR	14.97%	↑	n/a	
AMM	18+	No	Acute Phase Treatment	NR	NR	61.03%	61.44%	n/a		n/a	
AMM	18-64	No	Continuation Phase Treatment	43.69%	39.03%	41.70%	41.30%	-1.99%	↓	2.27%	↑
AMM	65+	No	Continuation Phase Treatment	45.16%	35.71%	42.17%	NR	-2.99%	↓	n/a	
AMM	18+	No	Continuation Phase Treatment	NR	NR	69.23%	41.25%	n/a		n/a	↑
BCS	50-64	No	Breast Cancer Screening	56.96%	54.26%	54.96%	50.49%	-2.00%	↓	-3.77%	↓
BCS	65-74	No		49.22%	51.16%	42.43%	42.92%	-6.79%	↓	-8.24%	↓
BCS	50-74	No		NR	NR	53.96%	50.10%	n/a		n/a	
CDC	18-64	Yes	HbA1c Poor Control >9	37.67%	42.71%	31.32%	41.92%	-6.35%	↓	-0.79%	↓
CDC	65-75	Yes	HbA1c Poor Control >9	30.43%	63.64%	20.83%	33.33%	-9.60%	↓	-30.31%	↓
CDC	18-75	Yes	HbA1c Poor Control >9	NR	NR	30.67%	41.73%	n/a		n/a	
COB	18-64	No	Concurrent Use of Opioids and Benzodiazepines	12.51%	8.79%	10.70%	7.76%	-1.81%	↓	-1.03%	↓
COB	65+	No		4.26%	2.78%	9.80%	6.45%	5.54%	↑	3.67%	↑
CCW	15-20	No	Most or Moderately Effective Method of Contraception (MMEC)	16.97%	16.82%	16.27%	14.96%	-0.70%	↓	-1.86%	↓
CCW	21-44	No	Most or Moderately Effective Method of Contraception (MMEC)	29.10%	26.62%	29.11%	25.42%	0.01%	↑	-1.20%	↓
CCW	15-20	No	Long Acting Reversible Method of Contraception (LARC)	3.60%	2.80%	3.14%	2.17%	-0.46%	↓	-0.63%	↓
CCW	21-44	No	Long Acting Reversible Method of Contraception (LARC)	6.55%	4.92%	6.29%	4.43%	-0.26%	↓	-0.49%	↓
CCP	15-20	No	Most or Moderately Effective Method of Contraception (MMEC) - 3 Days	11.40%	0.53%	8.99%	1.74%	-2.41%	↓	1.21%	↑
CCP	21-44	No	Most or Moderately Effective Method of Contraception (MMEC) - 3 Days	13.28%	8.86%	11.94%	9.16%	-1.34%	↓	0.30%	↑
CCP	15-20	No	MMEC - 60 Days	43.65%	36.70%	42.45%	39.53%	-1.20%	↓	2.83%	↑
CCP	21-44	No	MMEC - 60 Days	45.38%	38.99%	43.18%	38.50%	-2.20%	↓	-0.49%	↓
CCP	15-20	No	Long Acting Reversible Method of Contraception (LARC) - 3 Days	10.75%	36.70%	7.91%	0.58%	-2.84%	↓	-36.12%	↓
CCP	21-44	No	Long Acting Reversible Method of Contraception (LARC) - 3 Days	5.69%	0.13%	4.97%	0.38%	-0.72%	↓	0.25%	↑
CCP	15-20	No	LARC - 60 Days	24.10%	13.30%	24.82%	10.47%	0.72%	↑	-2.83%	↓
CCP	21-44	No	LARC - 60 Days	18.24%	8.79%	17.11%	9.74%	-1.13%	↓	0.95%	↑
CBP	18-64	Yes	Controlling High Blood Pressure	55.68%	53.75%	55.97%	58.87%	0.29%	↑	5.12%	↑
CBP	65-85	Yes		42.00%	45.83%	56.25%	NR	14.25%	↑	n/a	
CBP	18-85	Yes		NR	NR	55.99%	59.02%	n/a		n/a	
DEV	Age 1	No	Developmental Screening in the First Three Years of Life	10.11%	10.61%	14.04%	20.56%	3.93%	↑	9.95%	↑
DEV	Age 2	No		29.38%	18.95%	30.36%	22.05%	0.98%	↑	3.10%	↑
DEV	Age 3	No		26.39%	15.07%	29.18%	17.41%	2.79%	↑	2.34%	↑
DEV	Ages 1-3	No		NR	NR	26.29%	19.89%	n/a		n/a	
FUA	18-64	No	7-Day Follow-Up	NR	NR	5.41%	3.59%	n/a		n/a	
FUA	18-64	No	30-Day Follow-Up	NR	NR	9.88%	5.64%	n/a		n/a	
FUA	18+	No	7-Day Follow-Up	NR	NR	5.41%	3.59%	n/a		n/a	
FUA	18+	No	30-Day Follow-Up	NR	NR	9.87%	5.64%	n/a		n/a	
CDF	12-17	No	Screening for Depression and Follow-Up Plan	16.85%	4.10%	18.03%	4.39%	1.18%	↑	0.29%	↑
CDF	18-64	No		4.13%	3.07%	6.41%	3.39%	2.28%	↑	0.32%	↑
CDF	65+	No		2.67%	1.55%	3.61%	2.15%	0.94%	↑	0.60%	↑
OHD	18-64	No	Use of Opioids at High Dosage in Persons Without Cancer	3.21%	2.61%	3.14%	2.46%	-0.07%	↓	-0.15%	↓
OHD	65+	No		5.26%	1.00%	5.13%	NR	-0.13%	↓	n/a	

Note: If NR is displayed in place of the rate, this indicates the denominator was too small (i.e., <30) to

Appendix C: Alliance Health Education Services

Since the completion of the 2022 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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