2023 Population Needs Assessment

CONTRA COSTA HEALTH

October 2024

Contents

Background and Objectives

Population Needs Assessments (PNA) are essential tools for understanding the unique health and social service needs of communities, particularly among vulnerable and underserved groups. By systematically identifying gaps in services, barriers to access, and specific health risks within a population, needs assessments provide data-driven insights that can guide strategic planning, resource allocation, and program development. Such assessments are critical for creating more equitable and responsive health and social systems that address the root causes of health disparities and improve overall community well-being.

This report focuses on Contra Costa Health Plan's (CCHP) Medi-Cal population, a group impacted by diverse health, economic, and social factors that shape their health outcomes and utilization patterns. Recent data indicate that residents within this population experience high rates of disparities among health conditions, compounded by significant barriers to accessing healthcare and other essential services. Factors such as socioeconomic status, geographic location, racial and ethnic background, and education level contribute to these disparities and are associated with poorer health outcomes, reduced life expectancy, and a diminished quality of life.

The goals of this PNA are:

- Identification of Key Health and Social Challenges: Understanding prevalent health conditions, health system utilization patterns, and social drivers impacting health outcomes, including housing stability, transportation, and access to nutritious food.
- Evaluate Disparities: Identify disparities in health conditions and health utilization patterns as it relates to race, ethnicity, age, gender, and disability.
- Service Gaps and Barriers to Access: Evaluating current health and social service resources to identify existing gaps and barriers that prevent community members from receiving necessary care and support.
- Data-Driven Recommendations for Policy and Program Planning: Providing actionable recommendations that are grounded in data to inform future program planning, partnerships, and funding strategies.
- Community Perspectives and Needs: Capturing community voices to gain a deeper understanding of perceived health needs, service utilization patterns, and barriers directly from the population served.

The findings from this report will help inform the development of targeted interventions and will support local healthcare providers, policymakers, and community organizations in making informed decisions to meet the evolving needs of CCHP members. This needs assessment aims to lay a foundation for addressing social divers of health and promoting

health equity within the community. By identifying priority areas and opportunities for improvement, stakeholders can work together to build a healthier, more resilient, and inclusive community for all residents.

Methods

Data Sources

CCHP utilizes various data sources to assess the needs of our member population. Data are integrated from several sources into a centralized data warehouse and then visualized in a Population Health Dashboard that allows for near-real time member information. Data are incorporated from the following sources:

1. Medical and behavioral health claims
2. Pharmacy claims from pharmacy provider
3. Laboratory results
4. Health appraisal forms, such as Health Information Forms (HIF) sent to new members, Health Risk Assessments (HRA), Depression screenings, and Social Drivers of Health screenings conducted within the provider network and reported through supplemental data
5. Epic electronic health records (EHR) which include demographic data including race, ethnicity, language, sexual orientation, and gender identity
6. Case management data from Compass Rose module in Epic EHR
7. Electronic health information exchange (HIE) via Epic CareEverywhere
8. Department of Health Care Services (DHCS) plan data feed and health disparities data
9. Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS)
10. Homeless Management Information System (HMIS) data
11. Social Services data
12. California Immunizations Registry (CAIR2)
13. Detention and Criminal Justice data

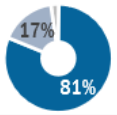
Additionally, CCHP reviews secondary data sources such as US Census Bureau data and aggregated data from Contra Costa Public Health presented on the Contra Costa Health Data Atlas. These sources present a community and contextual view, in addition to the member level data presented above.

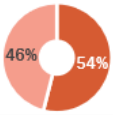
Data presented in this report are reflective of the member population as of December 31, 2023.


Med & BH claims
CAIR2
Pharmacy claims
HMIS
Laboratory results
Centralized Population Health Data Infrastructure
DHCS Plan Data Feed
Health appraisal forms
Care Everywhere (HIE)
Case Mgmt Data
Epic EHR

Population Demographics and Characteristics

Characteristic	Features	Number	Percentage
Product Line	Commercial	6,588	
	Medi-Cal	223,643	
	SPD	45,806	
Gender	Female	145,331	
	Male	123,906	
	Non-Binary	81	
Age	0 to 5	25,421	9.4%
	6 to 12	33,552	12.5%
	13 to 17	25,350	9.4%
	18 to 21	18,448	6.8%
	22 to 65	137,880	51.2%
	65+	27,569	10.2%
Race	American Indian/Alaska Native	495	0.2%
	Asian	29,311	10.9%
	Black	31,320	11.6%
	Latino	104,013	38.6%
	More than 1 Race	4,605	1.7%
	Native Hawaiian/Pacific Islander	1,978	0.7%
	Other/Unknown	11,275	4.2%
	White	42,678	15.8%
Languages Spoken	English	179,945	68.2%
	Spanish	63,931	24.2%
	Mandarin (Spoken Only)	1,920	0.7%
	Vietnamese	1,854	0.7%
	Dari	1,720	0.7%
Region	Central	74,984	27.8%
	East	113,641	42.2%
	West	77,791	28.9%
	Unknown	2,902	1.1%





Membership Profile

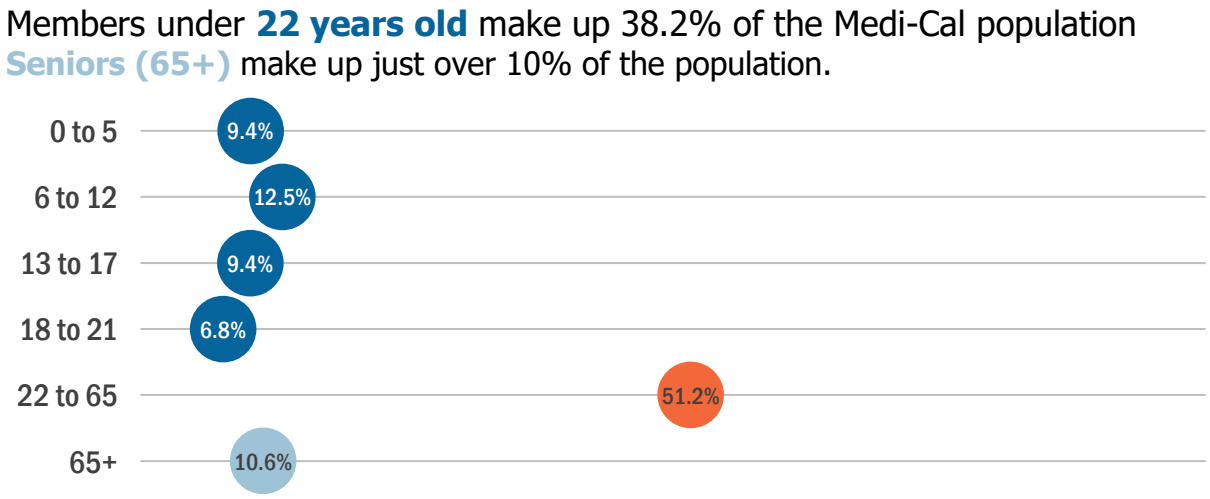
As of December 2023, 269,318 Medi-Cal members were enrolled with Contra Costa Health Plan. The overall Medi-Cal population has increased 87% since 2019 and the Seniors and Persons with Disabilities (SPD) subpopulation increased 84.3%, from 24,680 to 45,473. The SPD population increased nearly 50% from 2022 to 2023. CCHP membership exhibited large changes in membership for several reasons. During the COVID-19 Public Health Emergency, Medi-Cal eligibility redetermination was paused to allow members to keep healthcare coverage. Also in 2023, members who were dually eligible for Medicare and Medi-Cal and had been previously elected Fee-for-Service (FFS) Medi-Cal were transitioned

to Managed Care Plans (MCPs) like CCHP. Finally, previously carved-out Long-Term Care services were incorporated into CCHP.

Contra Costa County has an estimated population of 1,162,648, with approximately 258,051 children and 904,597 adults. Using these estimates, CCHP serves nearly one-quarter of all county residents overall; when stratifying by age, CCHP serves 18.4% of adults in the county and approximately one-third of the children.

Age

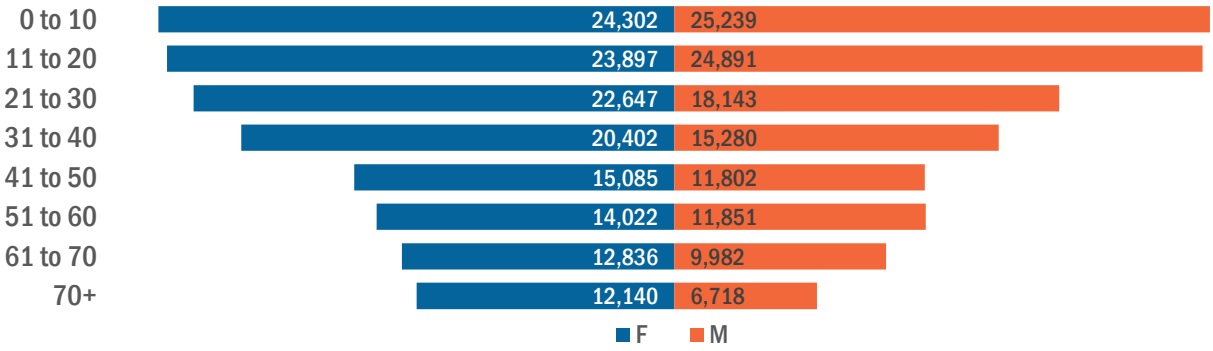
CCHP's membership skews younger, with 38.2% of members under age 22 and 51.2% between 22 and 65. These demographics suggest a strong need for pediatric and preventative care services to support this younger population.



Gender

Overall, women make up 54.0% of the CCHP population. Members with unknown or non-binary gender makes up 0.03% of the Medi-Cal population. In patients older than 70, women make up nearly two-thirds of the patient population. The higher proportion of women, particularly among members over 70, suggests a need for targeted resources in women's health and geriatric care, aligning services to meet the specific needs of this demographic.

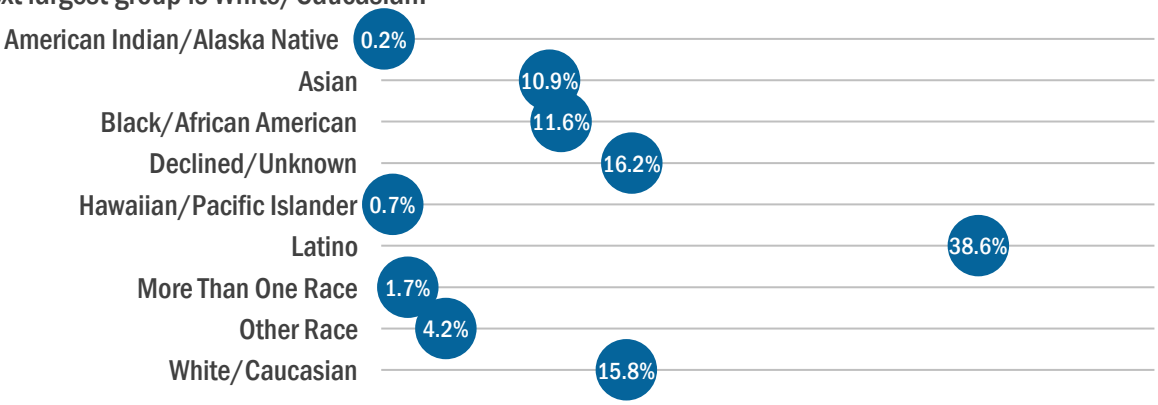
In adults, women make up a larger share of the population compared to men.
The gender distribution of children is about equal.



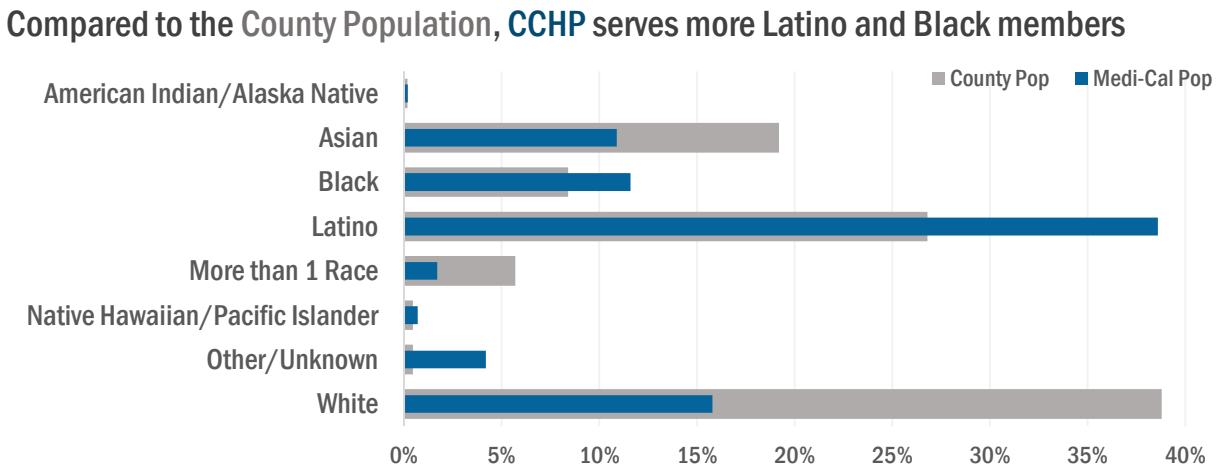
Race/Ethnicity

CCHP serves a diverse population, with over one-third of the population identifying as Hispanic/Latino. While patients with Declined/Unknown race make up the next largest population at 16.2%, this is overall a small percentage of unknown race and well under the National Committee for Quality Assurance (NCQA) threshold of 20% for utilizing imputed race/ethnicity data.

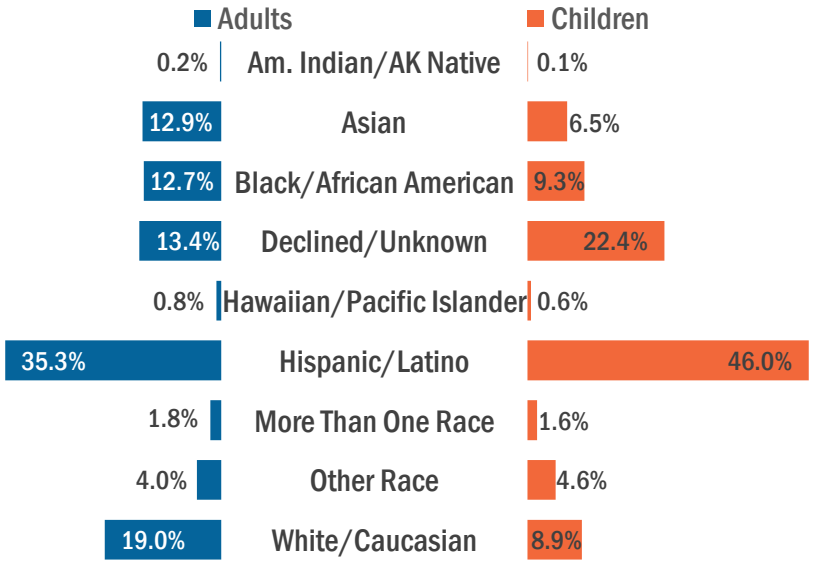
Latinos make up the largest proportion of CCHP membership.
The next largest group is White/Caucasian.



When comparing the demographics of the CCHP population to the County population as a whole, CCHP serves a higher percentage of Latino and Black members. White, Asian, and Multiracial members make up a smaller proportion of the CCHP population compared to the overall county population.



The CCHP population shows demographic differences between children and adults. Hispanic/Latino members comprise the largest portion of both age groups, particularly among children (46%), highlighting the importance of culturally relevant pediatric services. The proportion of Asian and White members increases significantly in the adult population (from 6.5% to 12.9% for Asians and from 8.9% to 19% for Whites). Black membership also increases slightly from childhood to adulthood (9.3% to 12.7%), suggesting a stable but slightly growing representation in older age groups. These demographic differences suggest the need to tailor health services to meet the cultural and age-specific needs of each group.

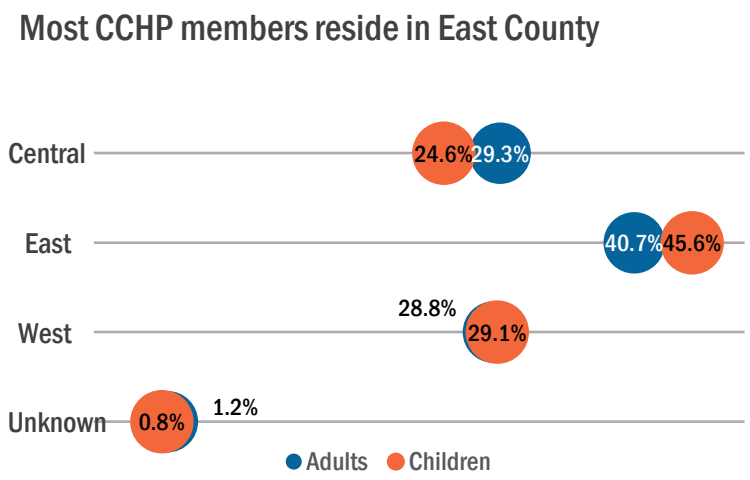


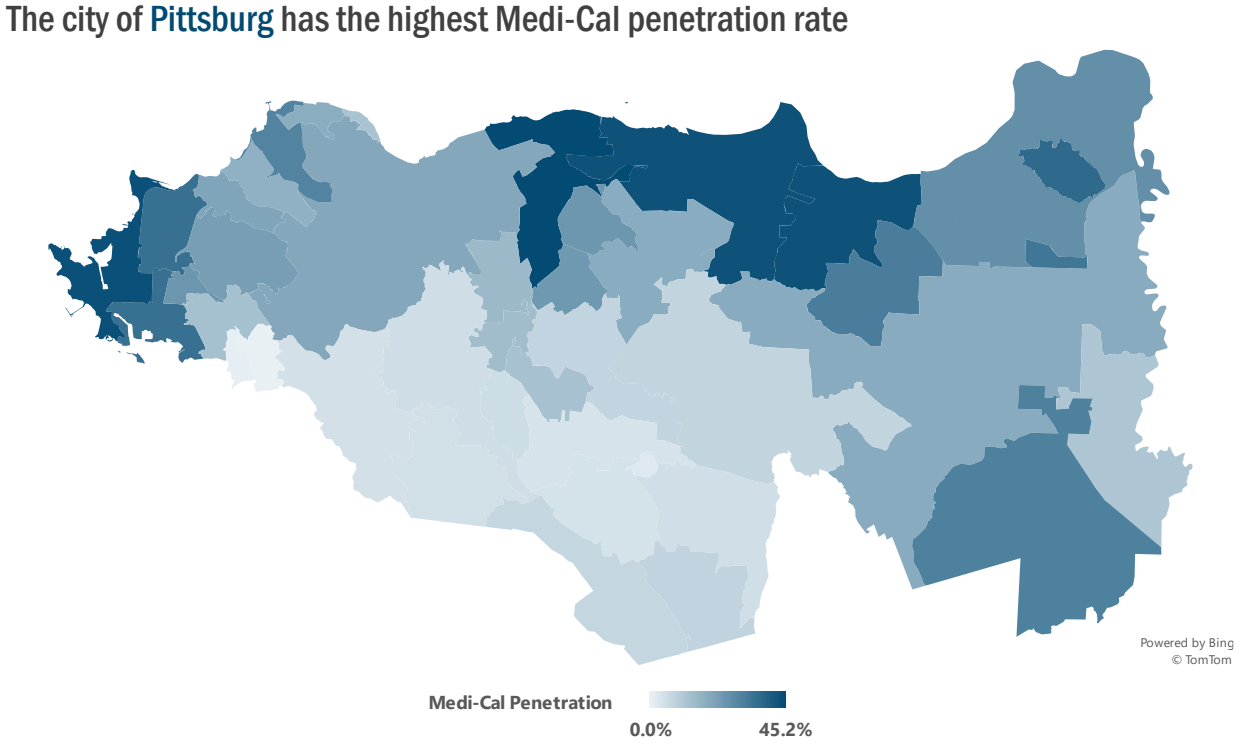
Geographic Distribution

The top five cities members reside in are Pittsburg, Antioch, San Pablo, Concord, and Richmond. Pittsburg represents the highest with 43,367 CCHP Medi-Cal members. The median household income for Pittsburg is $90,233, approximately 18% lower than the median income for the entire county. The overall poverty rate for Pittsburg is 9.9%, slightly higher than the overall Contra Costa County poverty rate of 8.3% but less than the state average of 12.1%.

Contra Costa County is generally divided into three main regions, Central County, East County, and West County. Concord makes up the largest city within Contra Costa County, with a population of 125,410 residents per the 2020 U.S. Census. The (3) geographic regions and their respective cities are listed below:

- Eastern region covers (4) cities: Pittsburg/Bay Point, Antioch, Oakley, Brentwood
- Central region covers (10) cities: Lafayette, Moraga, Orinda, Walnut Creek, Pleasant Hill, Concord, Clayton, Martinez, Danville, San Ramon
- Western region covers (5) cities: El Cerrito, Richmond, San Pablo, Pinole, Hercules



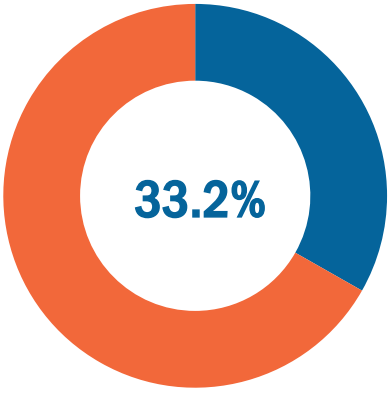


CCHP compares the number of Medi-Cal members residing in each zip code to the number of residents by zip code according to US Census data in order to identify areas with the proportion of members. The Medi-Cal penetration rate is the highest in Pittsburg, Antioch, and Richmond. The penetration rates are lowest in South Central County, in areas of San Ramon, Danville, and Lamorinda.

Primary Language and Limited English Proficiency (LEP)

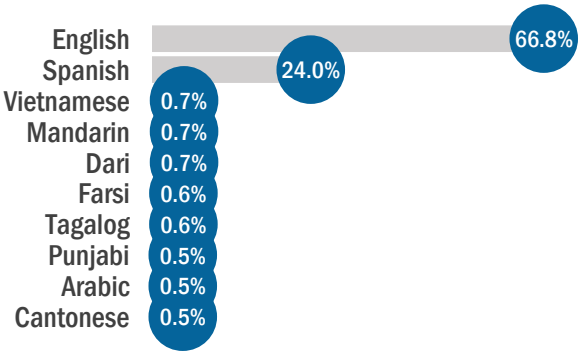
Nearly two-thirds of the CCHP population (33.2%) speak a language other than English. After English, the second most common language spoken by CCHP members is Spanish, representing 24%. Other languages spoken include Vietnamese, Mandarin, and Dari, each making up about 0.7%.

The highest concentrations of limited English proficient (LEP) members in Contra Costa County are in the cities of Pittsburg, Concord, Richmond and San Pablo. These areas may have additional needs for language support and tailored resources to address distinct cultural and literacy requirements within the LEP population



Speak a Language Other Than English

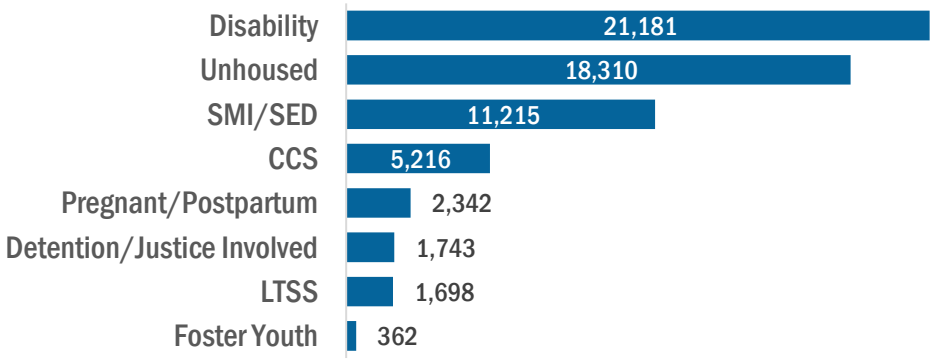
Nearly one-quarter of the CCHP population speaks Spanish



Special Populations

CCHP recognizes that certain populations may have different needs compared to the overall Medi-Cal population. CCHP examines certain special subpopulations to determine what needs these patients may have and how to address any identified care gaps.

The largest special populations of note are members with a disability and unhoused members.



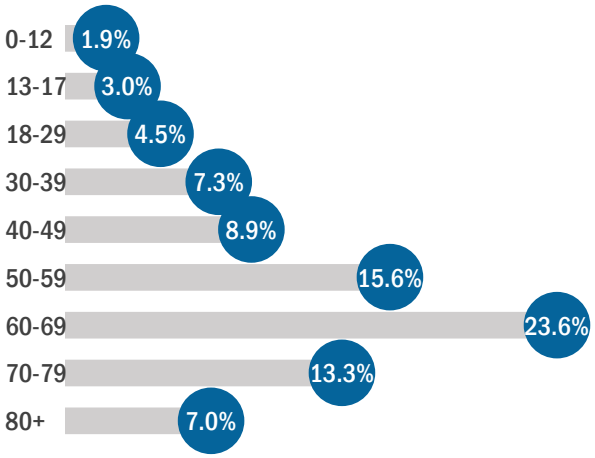
Disability

Members with a disability represent 7.9% of the overall CCHP population. Members ages 60-69 have much higher rates of disability compared to other age groups. Nearly a quarter of members with a disability are HUD and HRSA homeless[1], indicating a critical need for

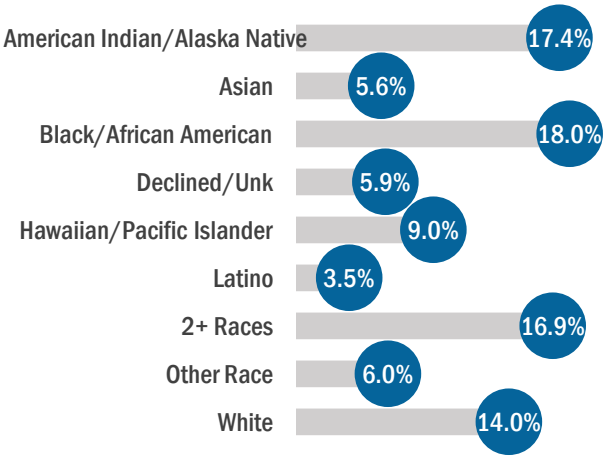
[1] HUD definition of homeless: individuals or families who lack a fixed, regular, and adequate nighttime residence, meaning: (1) Has a primary nighttime residence that is a public or private place not meant for human habitation; or (2) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements or (3) Is exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that

targeted services that ensure individuals with a disability have access to permanent housing. There are disparities among racial groups with Black/African Americans having the highest percentage of members with a disability at 18%. Latinos and Asians had the lowest representation with 3.5% and 5.6% respectively.

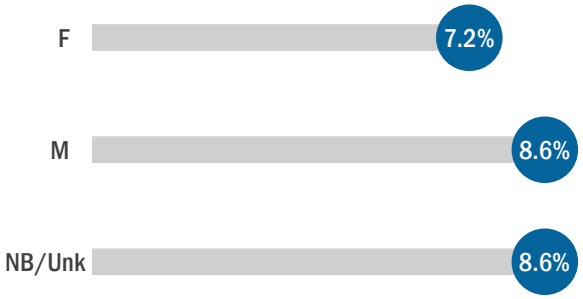
Nearly one quarter of members 60-69 have a disability.



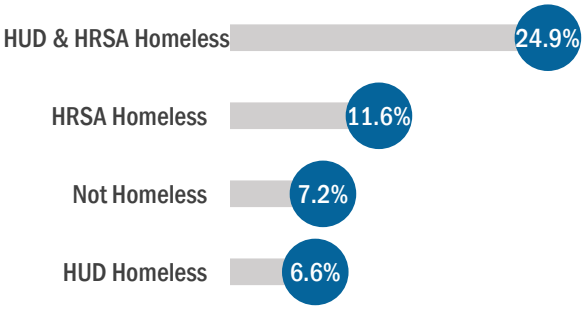
Black and American Indian/Alaska Native members have higher rates of disability.



Men and non-binary+unknown genders have higher rates of disability compared to women.



Nearly one quarter of members with a disability are also HUD/HRSA Homeless

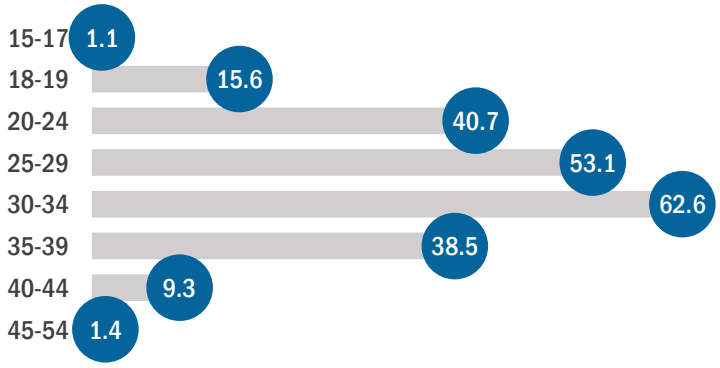


institution. The HRSA definition of homeless includes those who are at risk of homelessness, those who are currently homeless, and those who are currently living in shelters or temporary housing.

Pregnant/Postpartum

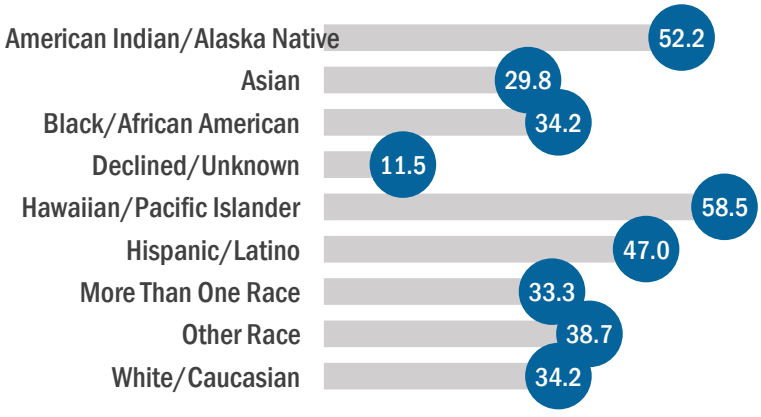
In 2023, there were 2,342 deliveries in the CCHP population. The age of delivery spans from 15 to 45, with an average age of 29 years. Notably, half of all deliveries occur in women aged 25-34 and around 25% of deliveries qualify as "geriatric," indicating a significant proportion of births occur in individuals aged 35 and older. The overall fertility rate in women ages 15-44 was 36.3 per 1,000 female members.[2] This trend remains true for all age groups except ages 40-44 where CCHP is higher and 45-54 where CCHP is equal to the CDC. These trends highlight a lower overall fertility rate in the CCHP population compared to national averages, with notable differences across age groups. Further analysis could help clarify factors contributing to these patterns.

Members ages 30-34 have the highest birth rates per 1,000 members.



Among adolescents, there were 53 births to teens aged 15-19, yielding a CCHP-specific birth rate of 6.7 per 1,000 females in this age group. This is lower than the national rate of 15 per 1,000 for teens, suggesting relatively lower teen birth rates locally. These rates reflect a relatively low incidence of teen births in the CCHP population compared to national figures, along with a notable proportion of births occurring in women aged 35 and older. These patterns suggest distinct age-related needs within the CCHP maternity population, particularly in managing adolescent and 'geriatric' pregnancies.

Hawaiian/Pacific Islanders and American Indian/Alaska Native members give birth at higher rates compared to other CCHP members

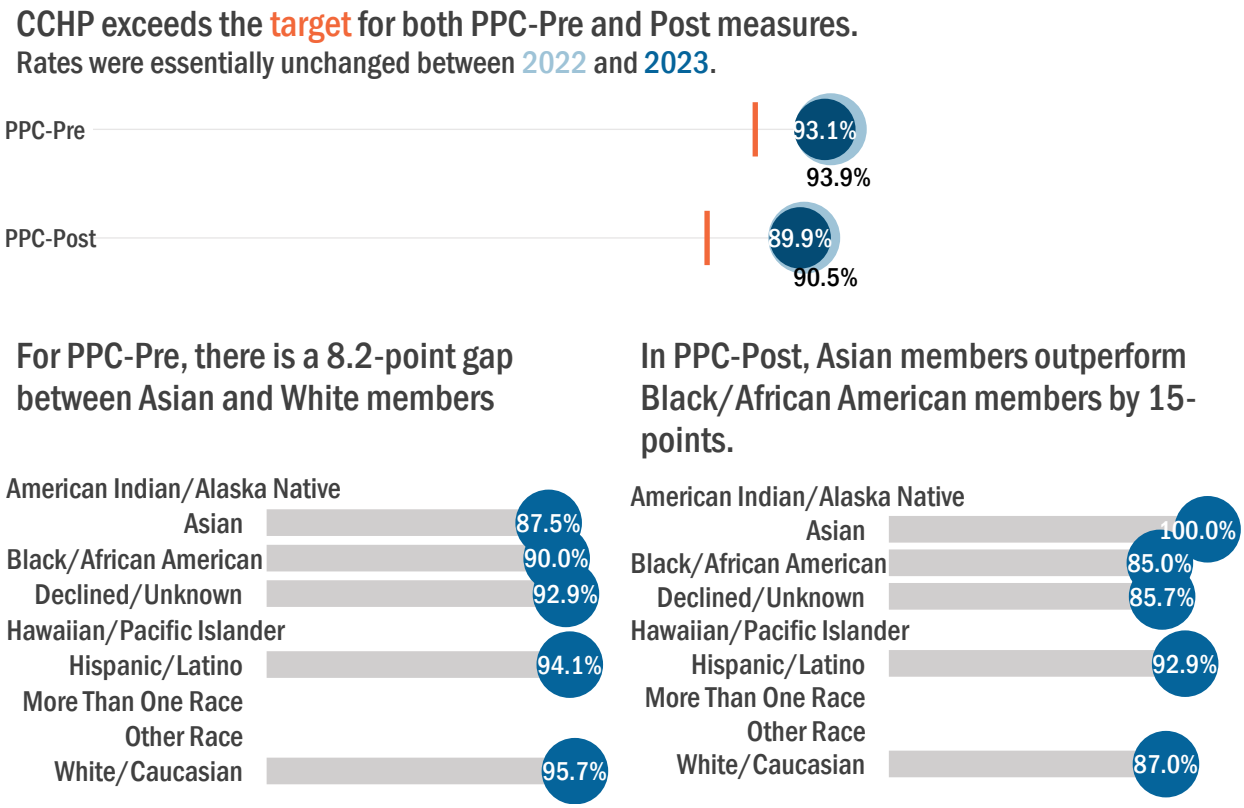


Over one-third of CCHP's member population identifies

[2] This is below the Centers for Disease Control's (CDC) rate of 54.4.

as Hispanic/Latino, making this demographic the largest contributor to overall births. Hawaiian/Pacific Islanders and American Indian/Alaskan Natives exhibit the highest birth rates, at 58.5 and 52.2 per 1,000, respectively.

CCHP is consistently in the 90th percentile for Prenatal and Postpartum Care (PPC), highlighting continuous efforts in this priority population. However, there are differences in prenatal and postpartum care rates among races, with Black/African American members experiencing lower rates compared to other races. While Asian members have the lowest prenatal visit rate, they experience the greatest postpartum follow-up rates.

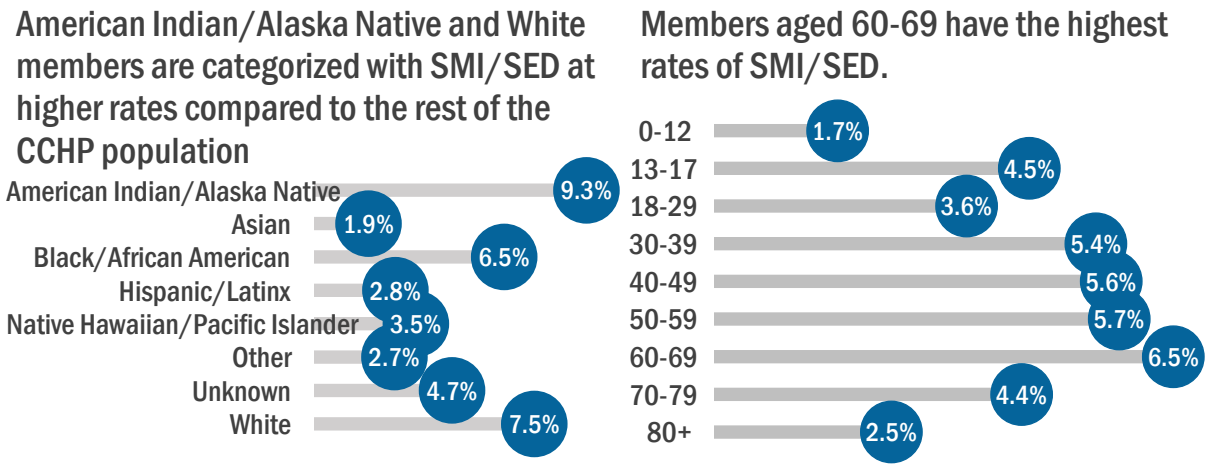


CCHP offers Enhanced Care Management (ECM) for the Birth Equity Population of Focus (POF), which includes members who identify as Black/African American, Pacific Islander, and American Indian/Alaska Native. In addition, pregnant members may also qualify for ECM if they meet the Mental Health/Substance Use or Homeless POF eligibility criteria. The Birth Equity POF is meant to address disparities in maternal health outcomes noted across the state. Utilization of ECM among eligible pregnant members is low, with only 5% currently enrolled. In addition to low rates of ECM enrollment, utilization of doula services is also significantly low.

Serious Mental Illness/Serious Emotional Disturbance

CCHP identifies SMI/SED based on specific mental health diagnosis (e.g. Psychosis, Bi-Polar Disorder, etc.) as well as those members that are receiving Specialty Mental Health (SMH) services from Contra Costa County Behavioral Health. Approximately 4.2% of CCHP's Medi-Cal population are identified with either Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

Rates are higher amongst American Indian/Alaska Native and White, at 9.3% and 7.5% respectively. Asian members and members with other race have the lowest rates of SMI/SED at 1.9% and 2.7% respectively. Members aged 60-69 have the highest rates of SMI/SED and members aged 30-59 have rates higher than other age groups. Children ages 0-12 have the lowest rates of SMI/SED. These trends highlight a segment of the CCHP population with complex health needs and elevated mental health service requirements.

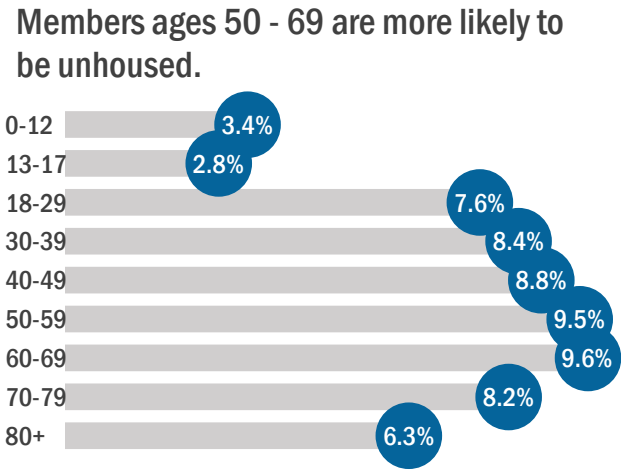


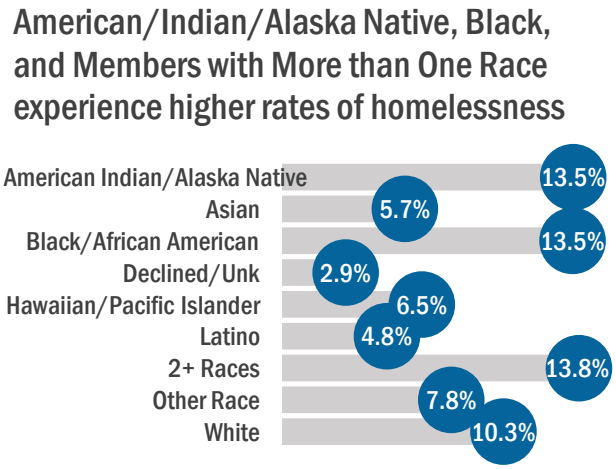
Homeless

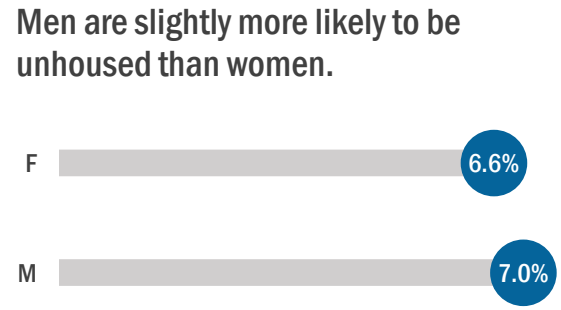
CCHP identifies members experiencing homelessness through various data points, including screenings, residence in shelters, relevant diagnoses, and enrollment in community homeless programs. Both US Department of Housing and Urban Development (HUD) and the US Department of Health Resources and Services Administration (HRSA) definitions of homelessness are applied to capture individuals living on the street as well as those without stable housing.

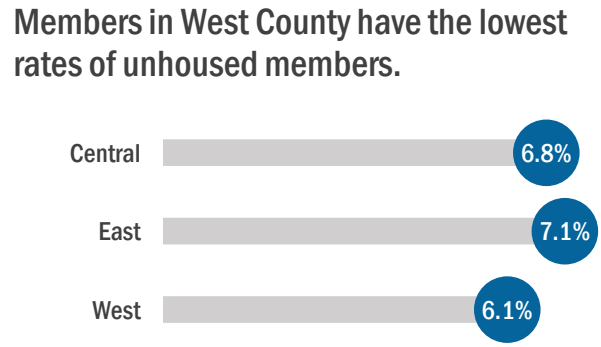
Currently, 18,310 CCHP members, or 6.8% of enrollees, are experiencing homelessness or have in the last twelve months. Among this population, gender distribution is balanced, with 7.0% of males and 6.6% of females identified as homeless. Black/African American, American Indian/Alaska Native, and individuals identifying as multi-race represent a disproportionately high percentage of members experiencing homeless, comprising 13.5% - 13.8%. Regionally, the East has the highest number of homeless members at 8,119 or

7.1%, however it is not significantly higher than the Western and Central regions which have 6.1% and 6.7% respectively.







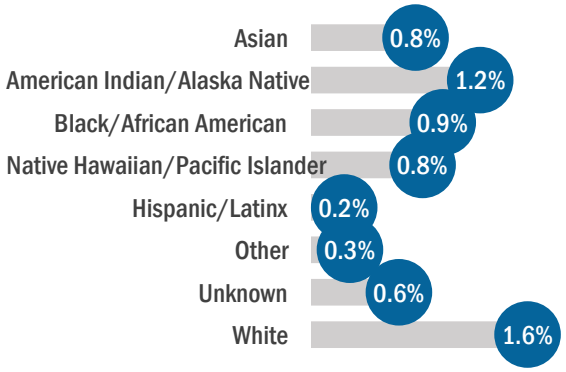


Long Term Services and Support

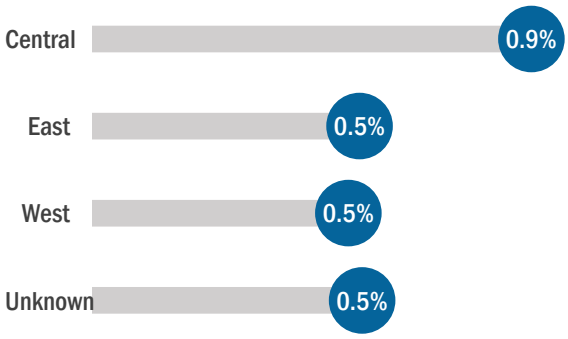
CCHP defines Long-Term Services and Supports (LTSS) as a set of services designed to support high-risk seniors and persons with disabilities (SPD), including Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). LTSS also includes members who have had one or more long-term care (LTC) stays in the past 90 days, as well as those who received Home Health (HH) services within the same period.

As of December 2023, CCHP had 1,698 patients utilizing LTSS. Within this population, White patients account for 53.0% of those receiving services. Additionally, LTSS usage rates among White members are 1.6%, and 1.2% among American Indian/Alaska Native members. Interestingly, 0.9% of patients who live in Central County are enrolled in LTSS, nearly double the rate of patients enrolled in other regions of the county.

White and American Indian/Alaska Native members utilized LTSS at higher rates.



Patients who reside in Central County are more likely to be LTSS recipients.

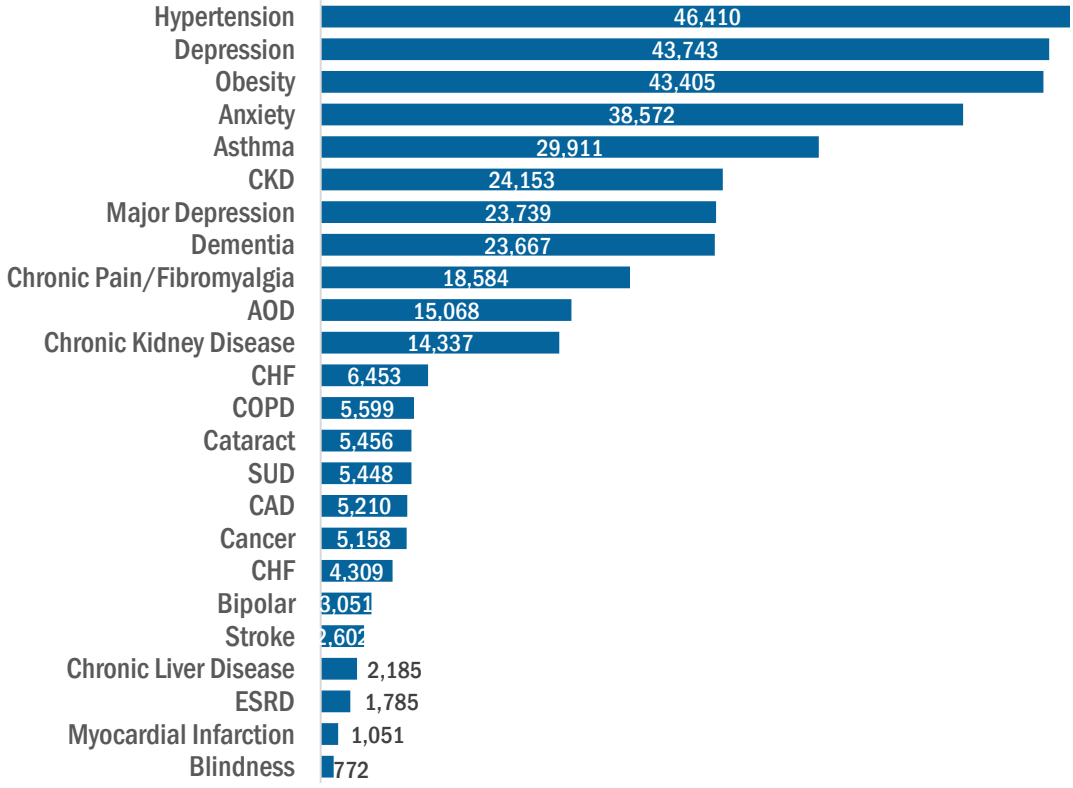


Health Status and Disease Prevalence

Chronic Conditions and Comorbidities

CCHP utilizes claims and electronic health record data to determine the conditions that are present in the Medi-Cal population. Hypertension, depression, obesity, anxiety, and asthma are the top five conditions in the CCHP population. CCHP will examine the unique needs required for some of the most prevalent chronic conditions in the population.

Hypertension and depression are the most common diseases in the CCHP population

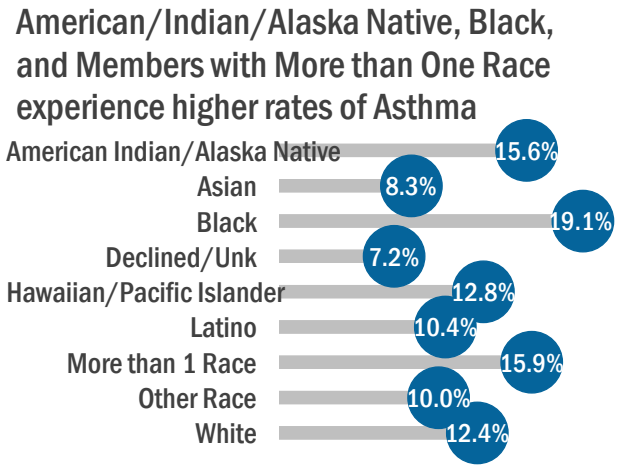


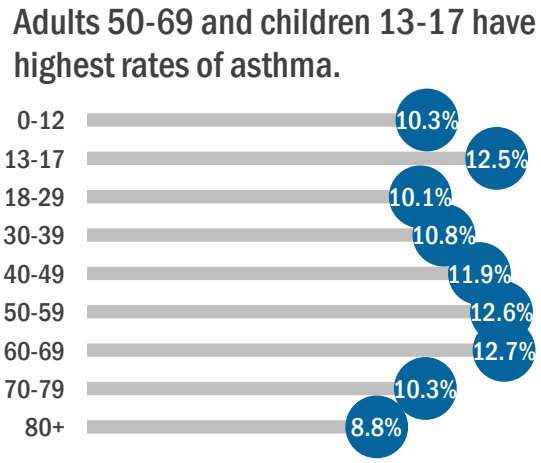
Asthma

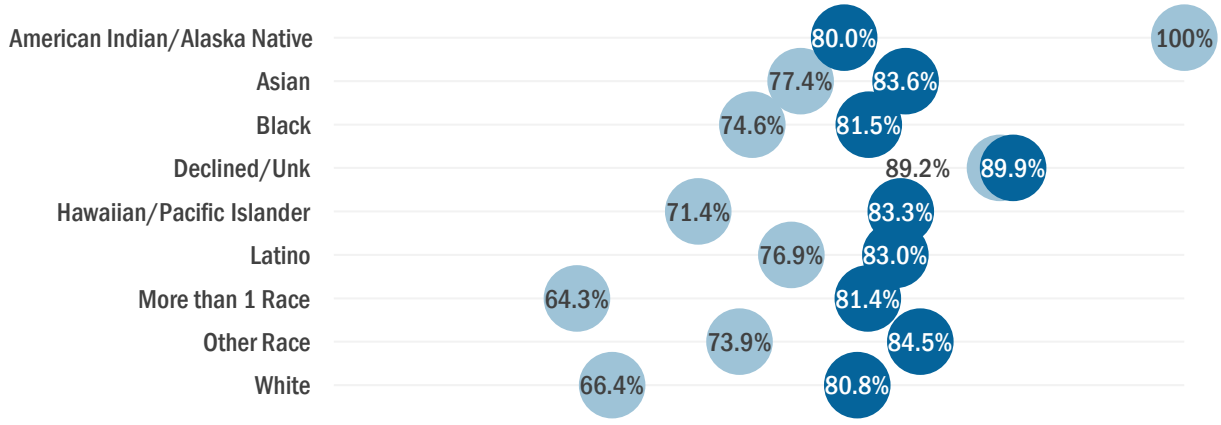
Asthma is a key health concern for the CCHP population, with an 11.1% prevalence rate, exceeding the national rate of 7.7%. In comparison to the county as a whole, 19.7% of adults in Contra Costa County had asthma, higher than the state average of 16.7%. Significant disparities persist among racial and ethnic groups, with Black/African American members experiencing the highest asthma prevalence at 19.1%—a 3.5% gap compared to the next highest group, American Indian/Alaska Native members at 15.6%.

Asthma rates vary by age, with members aged 13-17 and 50-69 having the highest prevalence around 12.5%. This age-related pattern suggests that addressing asthma within these groups may require different approaches, considering the varied health challenges adolescents and older adults may face.

To better assess asthma medication adherence, Asthma Medication Ratio (AMR), a HEDIS measure, evaluates the use of controller medications relative to rescue medications. The 2023 rates show improvements in medication adherence across all racial and ethnic groups except American Indian/Alaska Native members. This suggests that while asthma management strategies have been effective for certain populations, there remains a gap in medication adherence for American Indian/Alaska Native members, highlighting disparities in asthma care.

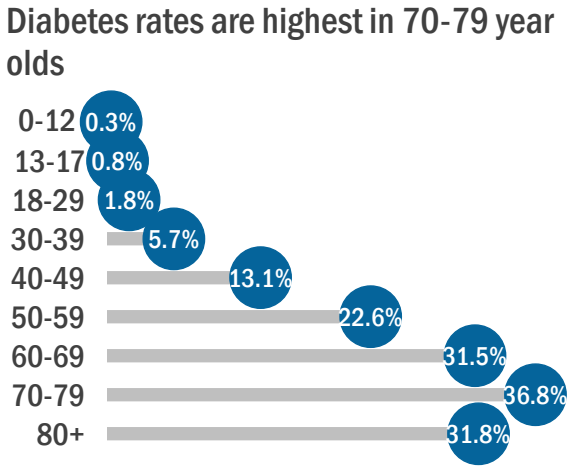


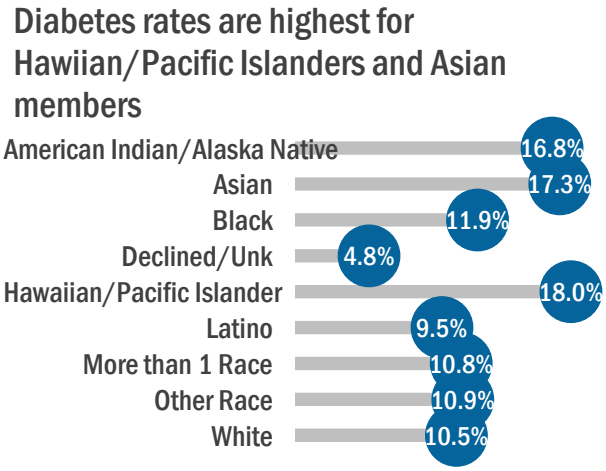




Diabetes

Among CCHP members, 27,911 have a diabetes diagnosis, representing a prevalence rate of 10.4%, slightly higher than the CDC's diagnosed national average of 8.9%. In Contra Costa County as a whole, 13.0% of adults have diabetes and 11.8% of adults in California have been diagnosed. The upward trend in both overall prevalence and severity of diabetes among CCHP members reflects an increasing health concern, particularly with a notable 24.9% of members exhibiting A1c levels above 8.0% and 15.4% with severe levels above 9.0%.

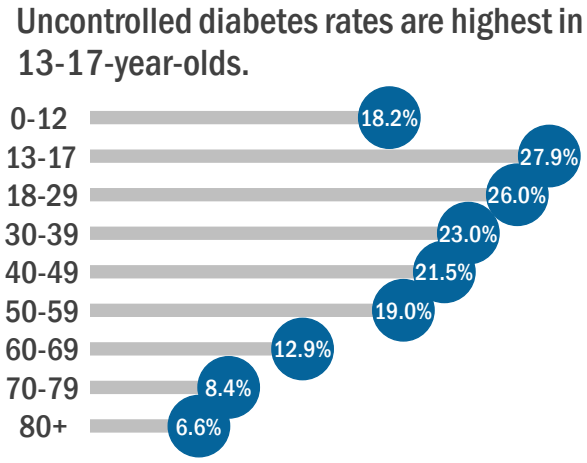


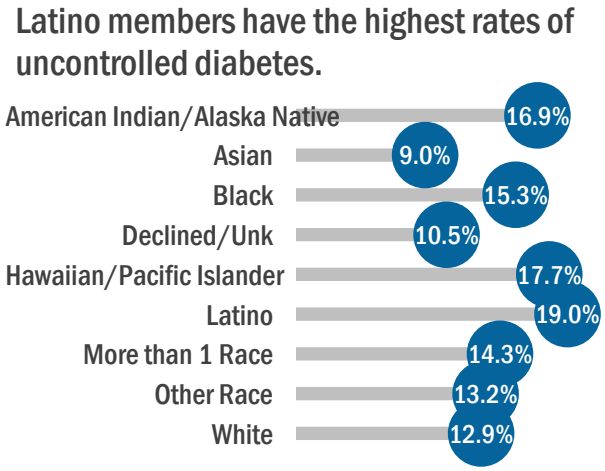


These trends are pronounced among American Indian/Alaska Native, Asian, and Hawaiian/Pacific Islander members, all with prevalence rates over 16%, followed by Black/African American members at 11.9%, while other racial and ethnic groups show rates around approximately 10%. Severity rates mirror this pattern, though Asian groups

have a lower rate of severe diabetes, with Latino members exhibiting the highest severity rate at 19%.

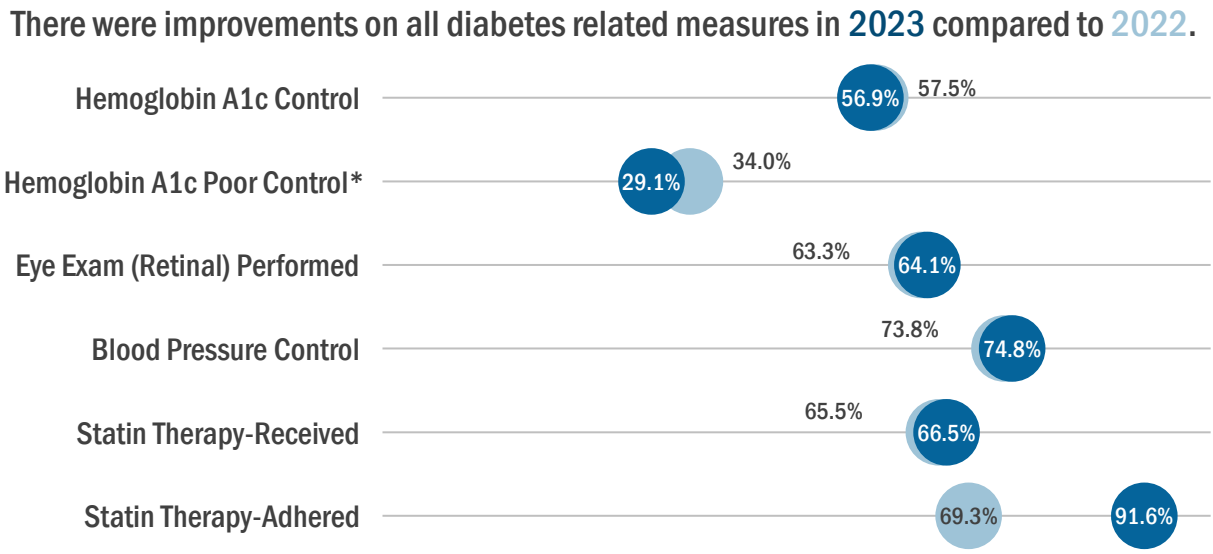
While diabetes prevalence is highest among members aged 60-80+, younger populations are also significantly impacted, with about 25% of diabetic members aged 13-49 experiencing severe diabetes. These data highlight the broad impact of diabetes across age groups and racial/ethnic communities, pointing to potential challenges in managing high A1c levels, particularly among high-risk populations.





CCHP has high rates of diabetes management, reflected in annual HEDIS reporting. The HEDIS diabetes measures assess various aspects of diabetes care quality. Blood Pressure Control (BPD) evaluates the percentage of diabetic patients whose blood pressure is well-managed, while the Hemoglobin A1c Poor Control (HBD-PC) measure identifies patients with A1c levels above 9.0%, indicating poorer glycemic control. The Hemoglobin A1c Control (HBD-C) measure tracks the percentage of diabetic patients with A1c levels below 8.0%, reflecting successful blood sugar management. The Statin Therapy measures monitor both the initiation and adherence rates for statins among diabetic patients to help prevent cardiovascular complications. Eye Exam (Retinal) Performed (EED) assesses annual retinal screenings for early detection of diabetic eye disease, a critical preventive measure.

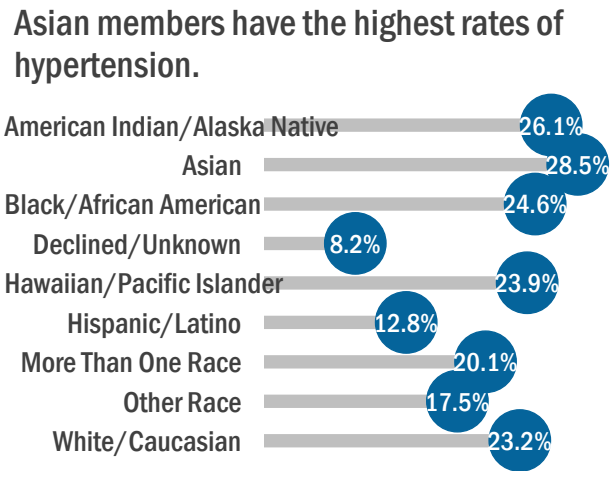
CCHP ranks in the 90th percentile nationally for key diabetes care measures, including Blood Pressure Control for Patients with Diabetes (BPD), Hemoglobin A1c Poor Control measure (HBD-PC), and Statin Therapy Adherence (SPD-Adhered). CCHP ranks lower and in the 50th percentile nationally for Eye Exam (Retinal) Performed (EED), Hemoglobin A1c control (HBD-C), and Statin Therapy Received.

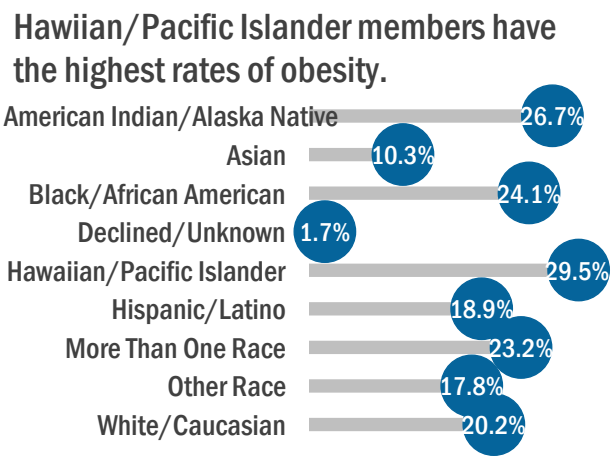


Cardiovascular Disease

Cardiovascular disease remains a health concern for Contra Costa Health Plan (CCHP), particularly among populations with obesity and hypertension. Current data reveals that 17.2% of CCHP members are diagnosed with hypertension, and 16.1% of CCHP members are living with obesity.

Groups of interest are American Indian/Alaska Native, Black/African American, and Hawaiian/Pacific Islander members, who exhibit the highest prevalence rates for both hypertension and obesity, highlighting immediate action to address their needs.

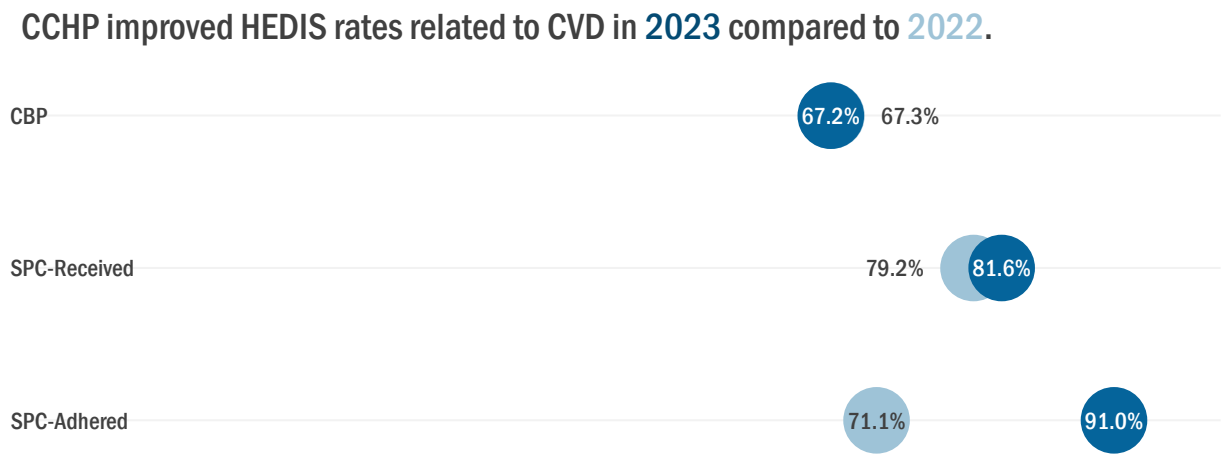


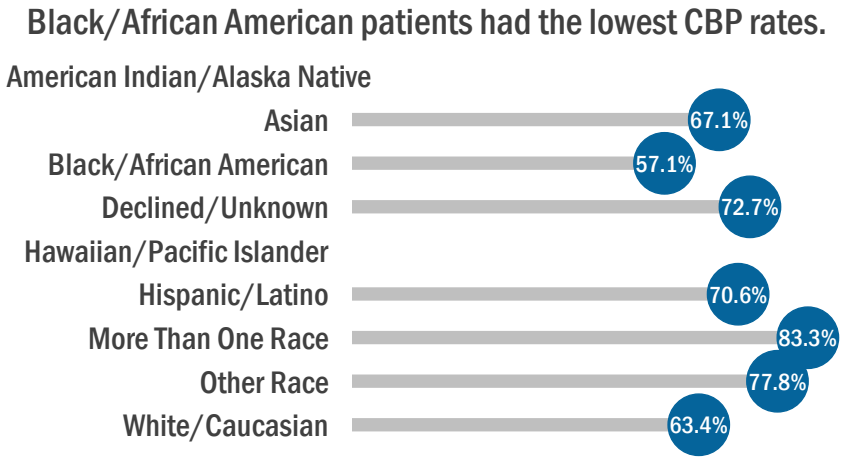


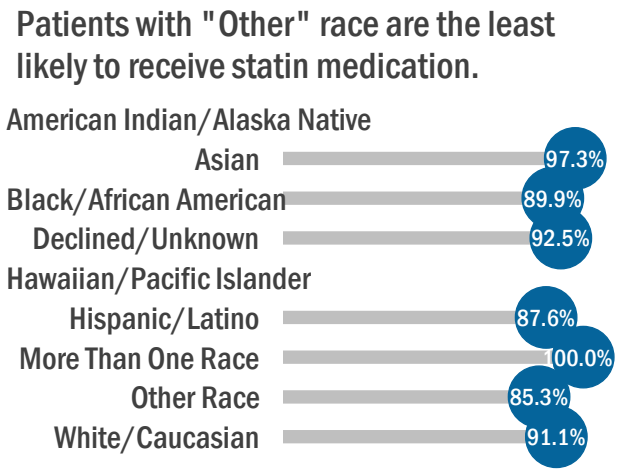
CCHP's performance on the Controlling Blood Pressure (CBP) HEDIS measure, which tracks the percentage of members with hypertension who maintain controlled blood pressure levels, currently stands at 67.3%, placing it in the 50th percentile nationally. Blood pressure

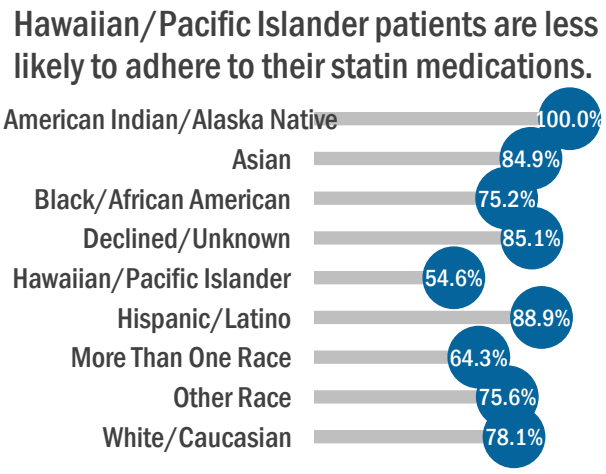
control rates show variation across member demographics, with Black/African American members having the lowest control rate at 57.1%. These variations in blood pressure control across populations provide insight into where additional attention may be beneficial to support hypertension management in specific groups.

Another key HEDIS measure, Statin Therapy for Patients with Cardiovascular Disease (SPC), assesses both the rate of statin prescriptions received and adherence among eligible members. CCHP ranks in the 50th percentile nationally for the percentage of eligible members who receive statin therapy, suggesting there may be gaps in the initiation of this treatment. Among those who do receive statins, however, CCHP ranks in the 90th percentile for adherence, indicating high levels of commitment to the prescribed therapy. This data highlights differences in treatment initiation versus ongoing management, with strong adherence rates once therapy begins.





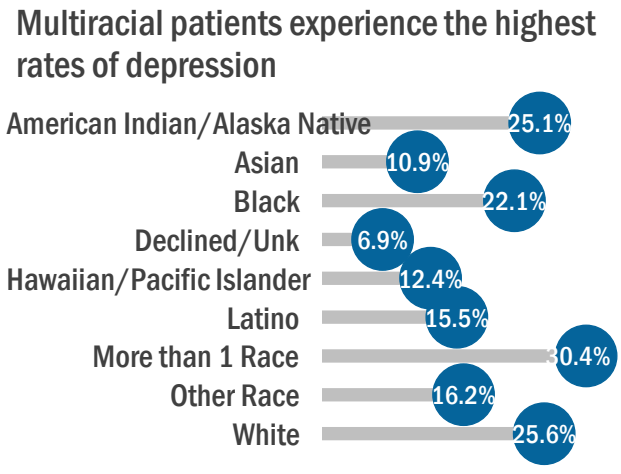


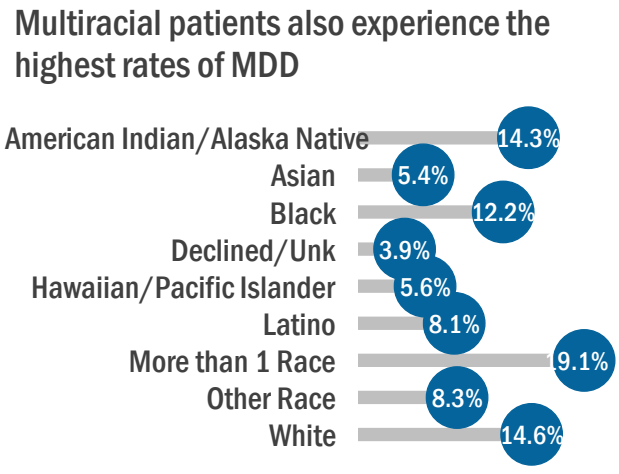


Behavioral Health

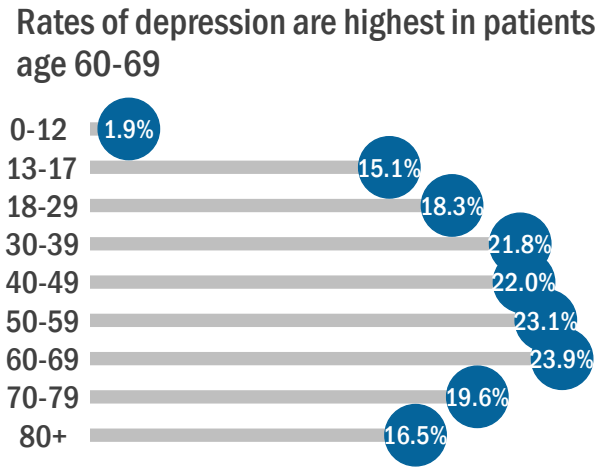
Behavioral health conditions are some of the most prevalent conditions in the CCHP population. Anxiety and depression are the most common mental health conditions, with 14.4% and 16.2% of members having a diagnosis. Approximately 8.6% of members have Major Depressive Disorder (MDD), a more persistent and debilitating form of depression. Finally, 5.6% of members have a diagnosis of substance use disorder (SUD).

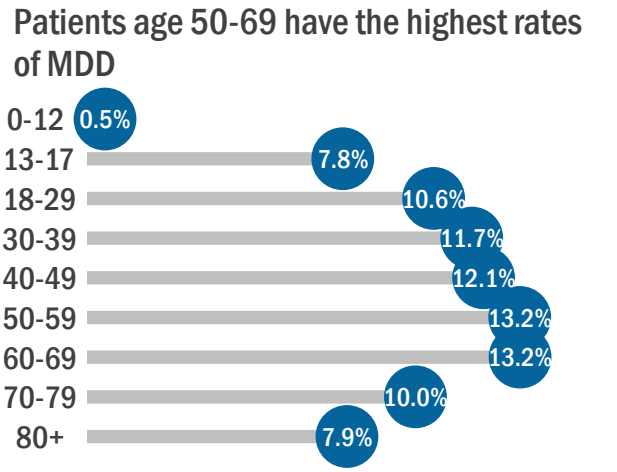
The prevalence of depression among CCHP members also varies significantly across racial and ethnic groups. Members identifying as “More than 1 Race” experience the highest prevalence of depression at 30.4%, followed by White members and American Indian/Alaska Native, both at about 25%. Black/African American members follow at a rate of 22.1% while Latino, Hawaiian/Pacific Islander, and Asian members experience the lowest rates. The prevalence of MDD mirrors these rates.

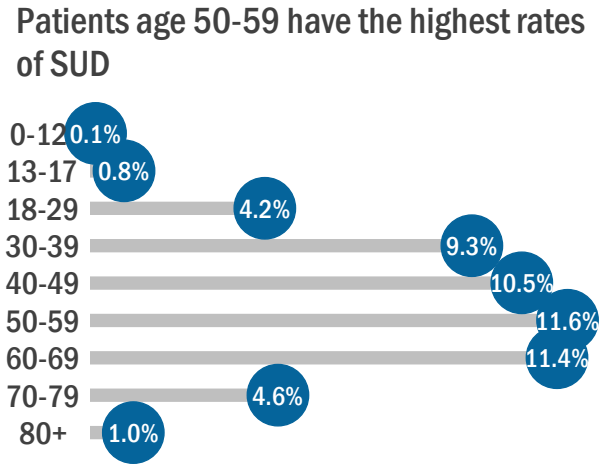


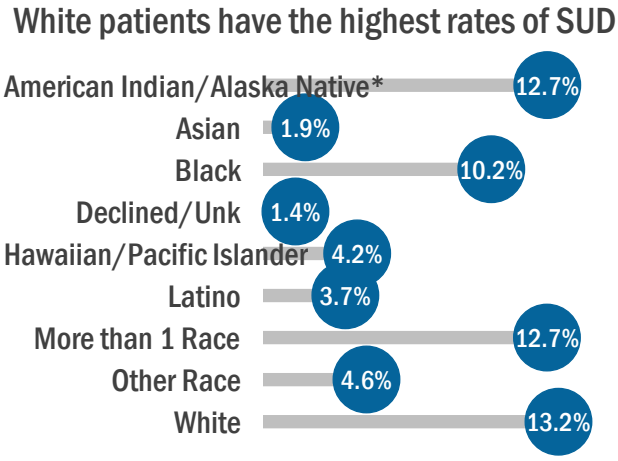


Age-related trends indicate that members aged 30-69 have the highest rates of depression and elevated rates of SUD, suggesting potential intersections with these conditions being co-occurring in this demographic.

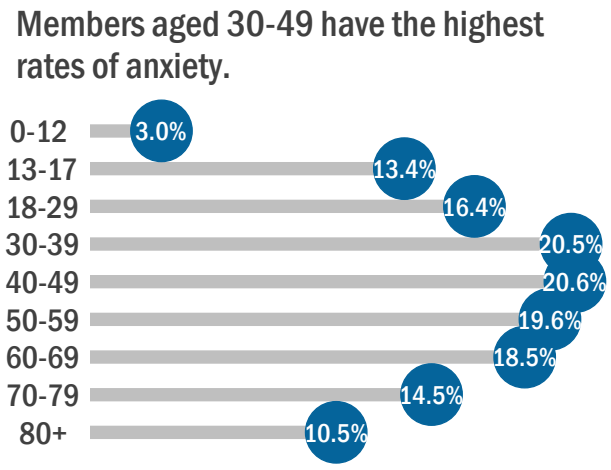


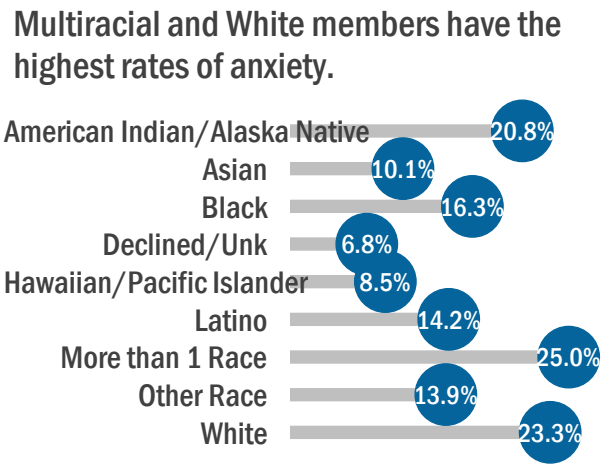




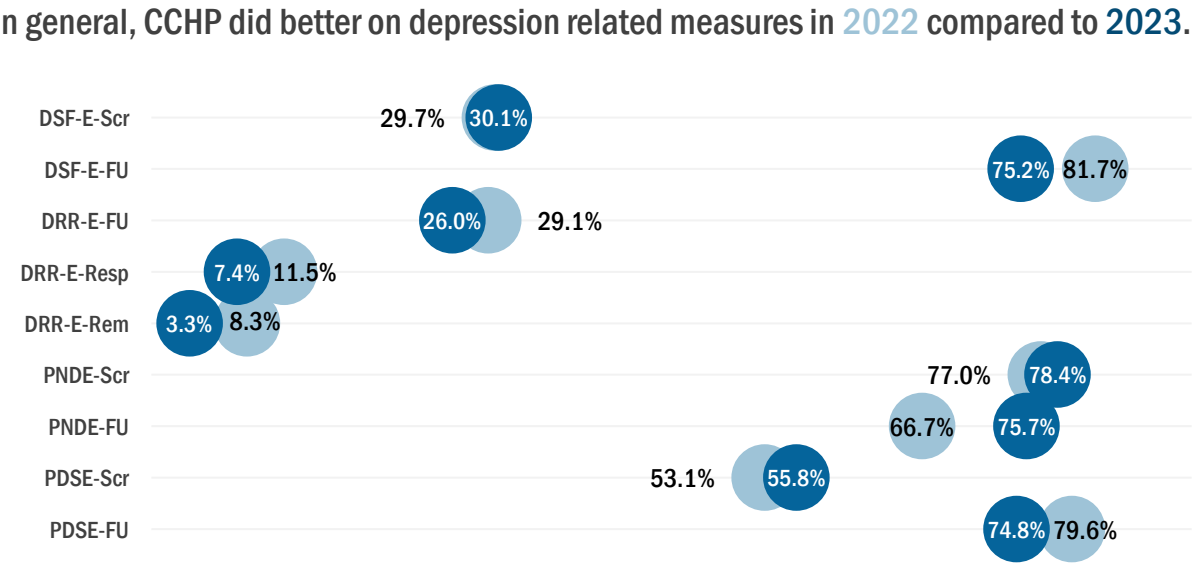


When looking at members with anxiety, members ages 30-49 experience anxiety at greater rates compared to the rest of the CCHP population. Multiracial members and White members experience the highest rates of anxiety, with 25.0% and 23.3%, respectively.





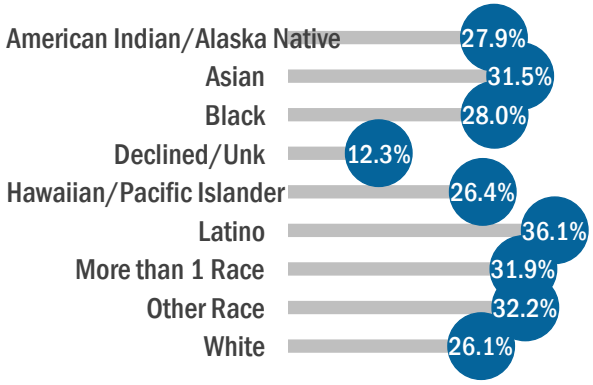
In terms of CCHP's behavioral health performance, several HEDIS measures are used to assess the effectiveness of depression care. These include Depression Screening and Follow-Up (DSF), Depression Remission and Response (DRR), Postpartum Depression Screening and Follow-Up (PND), and Postpartum Depression Screening and Follow-Up (PDS).



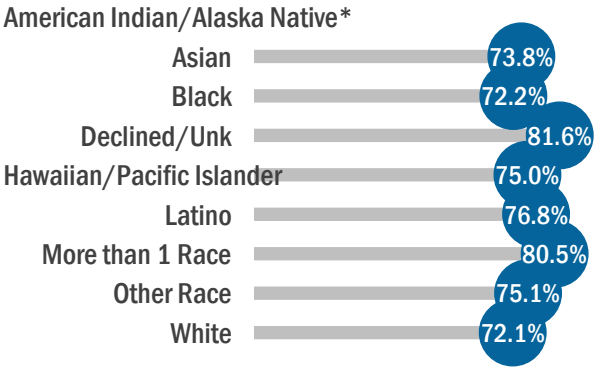
As newer measures, no national benchmarks are available for Depression Screening and Follow-Up and Depression Remission and Response. For Postpartum and Prenatal Depression Screening, CCHP's screening rates are ranked in the 90th percentile, indicating strong performance, while follow-up care is ranked in the 50th percentile for prenatal care and 75th percentile for postpartum care. Across the entire population, we see that Hawaiian/Pacific Islander and White members are screened at lower rates, and there is relatively minimal variation in follow-up care after a positive depression screening when stratified by race and ethnicity. These rankings reflect a mix of high performance in some areas and opportunities for improvement in others, with the potential to impact overall

depression management across the population.

White and Hawaiian/Pacific Islanders are screened for depression at lower rates.



There is relatively little variation in follow-up rates among races.



Healthcare Utilization

Ambulatory Care

Pediatrics

The HEDIS and CMS Child Core Measures focus on evaluating the effectiveness of healthcare for children, emphasizing preventive care, immunizations, and screenings. Key measures include Childhood Immunization Status (CIS), which tracks the percentage of children who receive the recommended immunizations by their second birthday, and Well-Child Visits (W30), which measures the percentage of children who have had a well-child visit by thirty months. Developmental Screening (DEV) assesses children who are screened for developmental delays, and Lead Screening (LSC) tracks the percentage of children who are screened for lead exposure. These measures help monitor the timely delivery of essential care in early childhood. Well-Child Visits (WCV) for children and adolescents aged 3 to 21, assesses the frequency of preventive visits, as well as Immunizations for Adolescents (IMA-2), which tracks the immunization status for adolescents. Topical Fluoride Application (TFL-CH) monitors the application of fluoride treatments for children ages 1 to 20 to prevent dental decay. These measures provide a comprehensive overview of pediatric care, highlighting both strengths and opportunities for improvement.

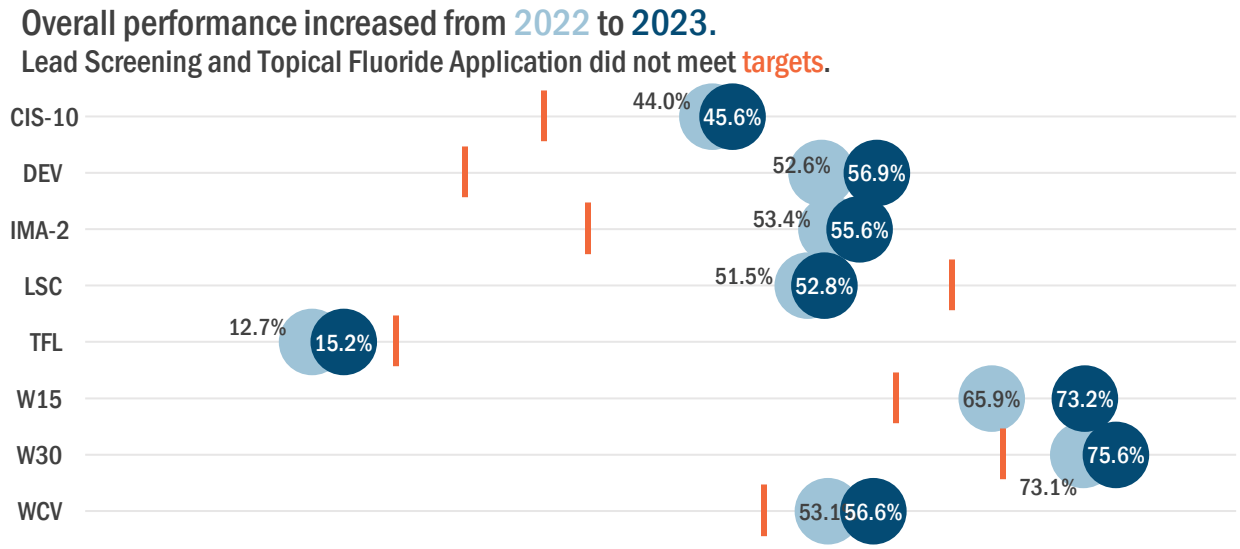
CCHP consistently meets or exceeds national benchmarks in all pediatric measures, ranking in the 90th percentile for well care visits in the first 30-months of life (W30), childhood immunization status, combination 10 (CIS-10), and immunization for adolescents, combination 2 (IMA-2). However, racial disparities reveal areas for improvement, particularly in Childhood Immunization Status, Lead Screening (LSC), and Topical Fluoride application (TFL-CH).

Black/African American members trail significantly behind in childhood immunization rates, with only 24.9% of children meeting the recommended immunization schedule. Members identifying as more than one race follow at 35%, reflecting a notable 10% gap.

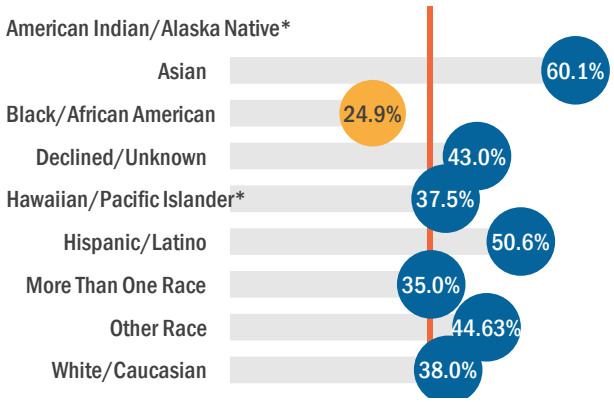
While the lead screening rate increased from 2022, CCHP still did not meet the 5oth percentile in 2023. This remains a significant area for improvement, with only Asian and Hispanic/Latino groups meeting the 50th percentile target. Black/African American members have the lowest screening rate at 44.7%.

Topical Fluoride application (TFL) remains another national benchmark where CCHP underperforms, with an application rate of 15.2%. This marks a slight improvement from the previous year's rate of 12.7%. Hawaiian/Pacific Islander and Black/African American members have the lowest rates at 8.0% and 10.0%.

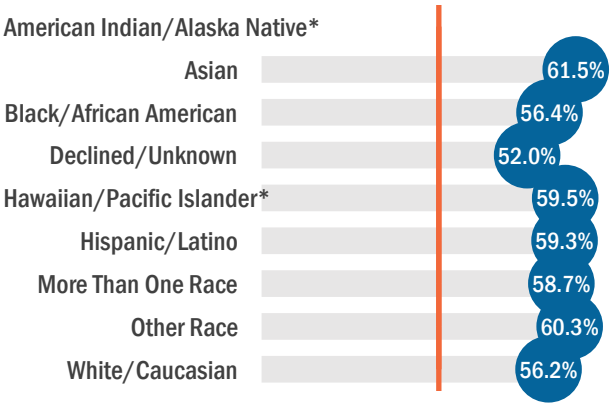
While CCHP exceeds the targets for Well Care Visits 0-15 months, 15-30 months, and 3-21 years, there are racial disparities present in each measure. In children 0-15 months, Black/African American and Other race children have an 11.7-point gap to group with the highest rate. In children 15-30 months, Hawaiian/Pacific Islander children do not meet the minimum performance level. Black/African American children also see a significant gap in performance on this measure. Finally, in children ages 3-21, Hawaiian/Pacific Islander children do not meet the target for well care visits.



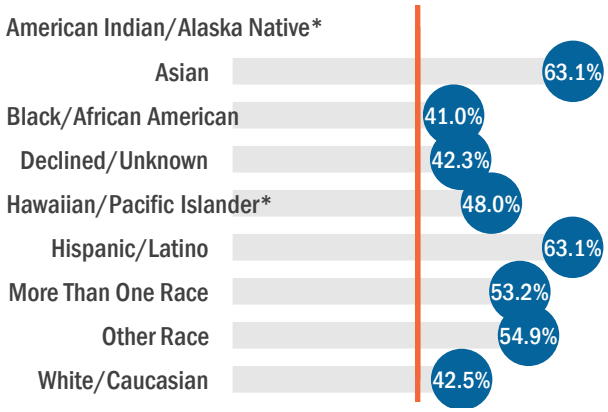
Childhood Immunization Status



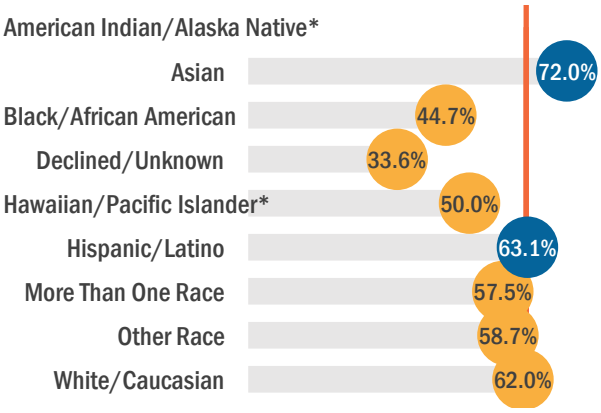
Developmental Screening



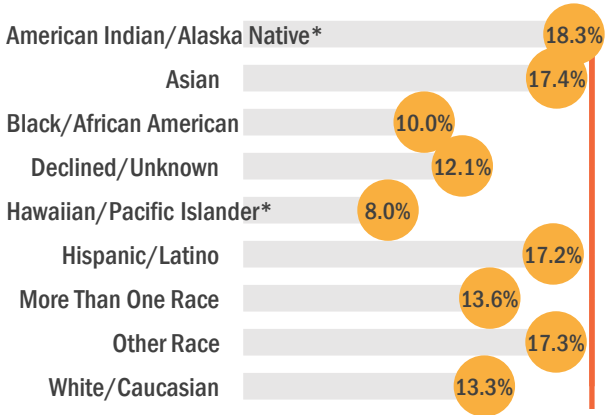
Immunization Status for Adolescents



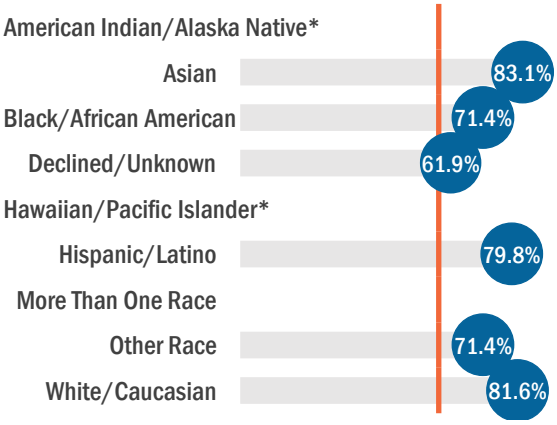
Lead Screening in Children

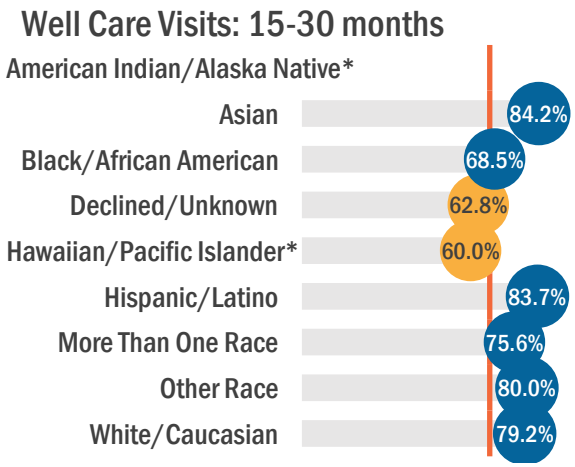


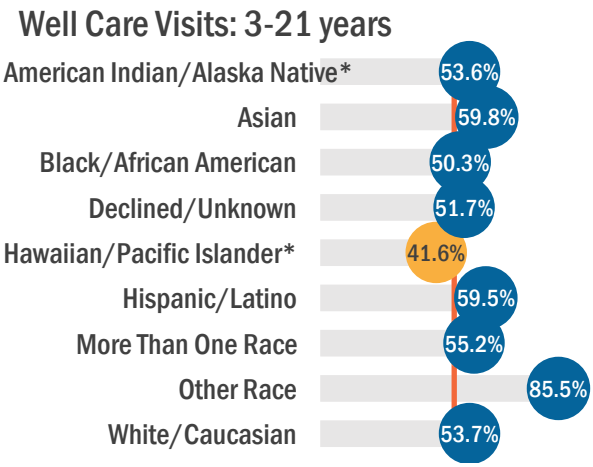
Topical Fluoride Application



Well Care Visits: 0-15 months

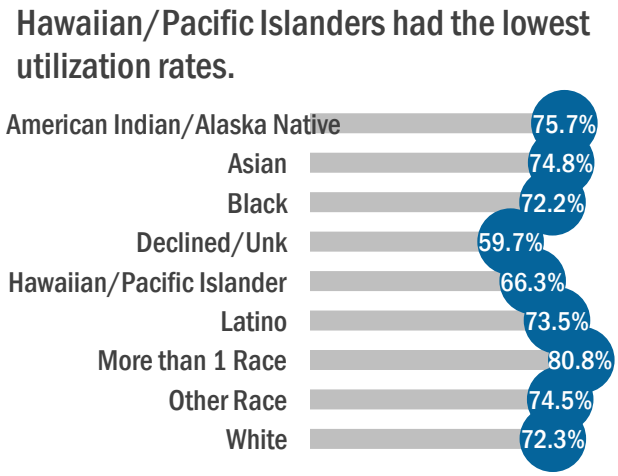


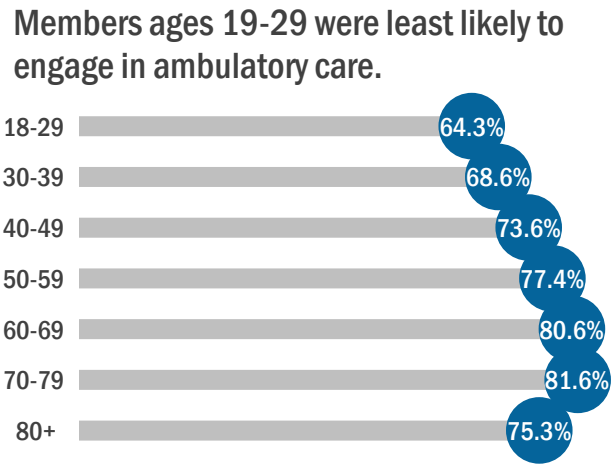


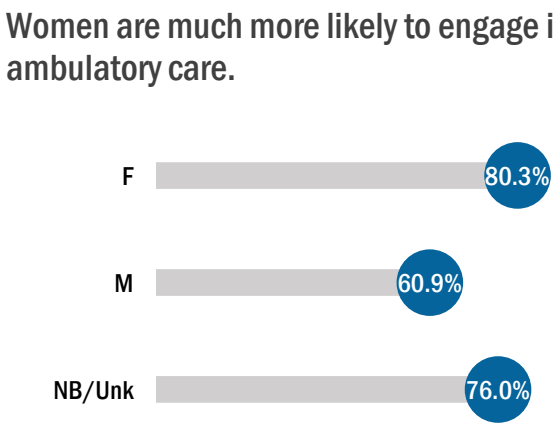


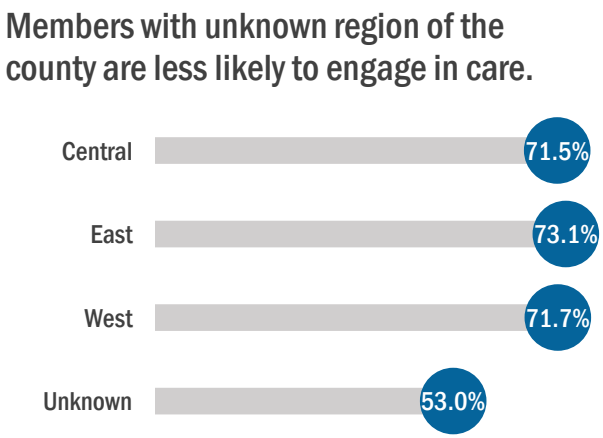
Adults

CCHP utilizes several HEDIS measures to track adult preventive care. The Adult's Access to Preventive/Ambulatory Health Services (AAP) measures the percentage of members with an ambulatory or preventive care visit within the past year. The 2023 AAP rate of 72.0% falls just 0.9% short of the 50th percentile national benchmark. While racial disparities in visit rates are not as pronounced, significant variations appear across age and gender groups. Young adults aged 18-29 have the lowest utilization rate at 64.3%, followed by adults aged 30-39 at 68.6%. Additionally, there is a substantial gap between male and female members, with males trailing by 19.4%, at only 60.9%.

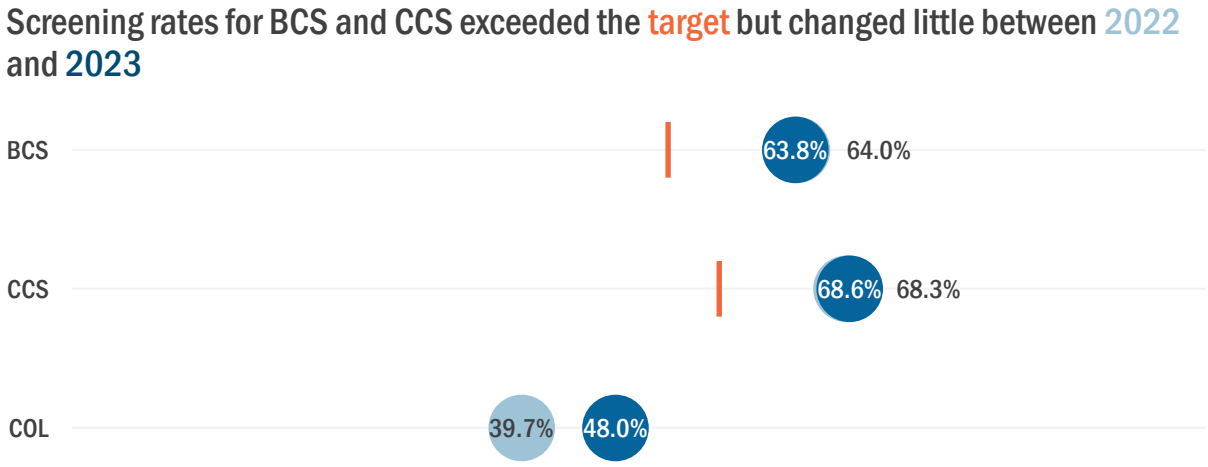


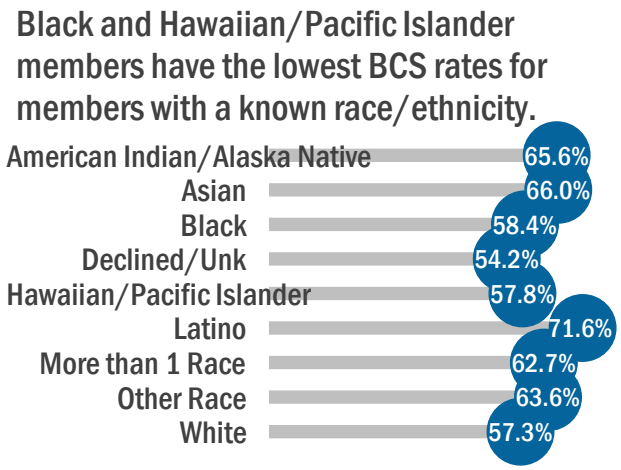


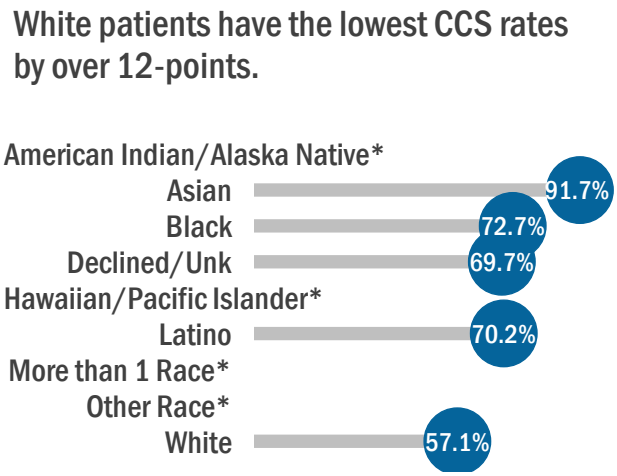




Cancer screening enables early detection and improves long-term health outcomes. CCHP tracks cancer screening, with a focus on cervical cancer screening, breast cancer, and colorectal cancer. CCHP's rate for breast and cervical cancer screening rank at the 90th percentile nationally. The rate for breast cancer screenings (BCS) among CCHP members is 64%, with Black/African American, Hawaiian/Pacific Islander, and White, members experiencing rates below 59%. Cervical cancer screening (CCS) rates are higher at 68.6%, yet White members show a significantly lower rate of 57.1%. Colorectal cancer screening (COL) has an overall screening rate of 48.0%. As a newer HEDIS measure for the Medicaid population, this measure does not have a benchmark for 2023.

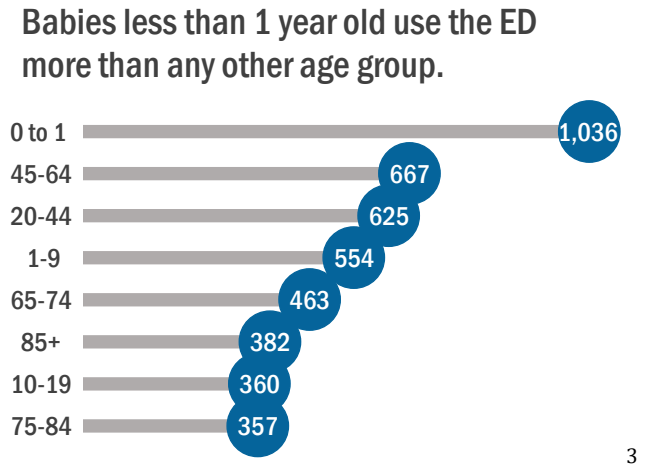






Emergency Department

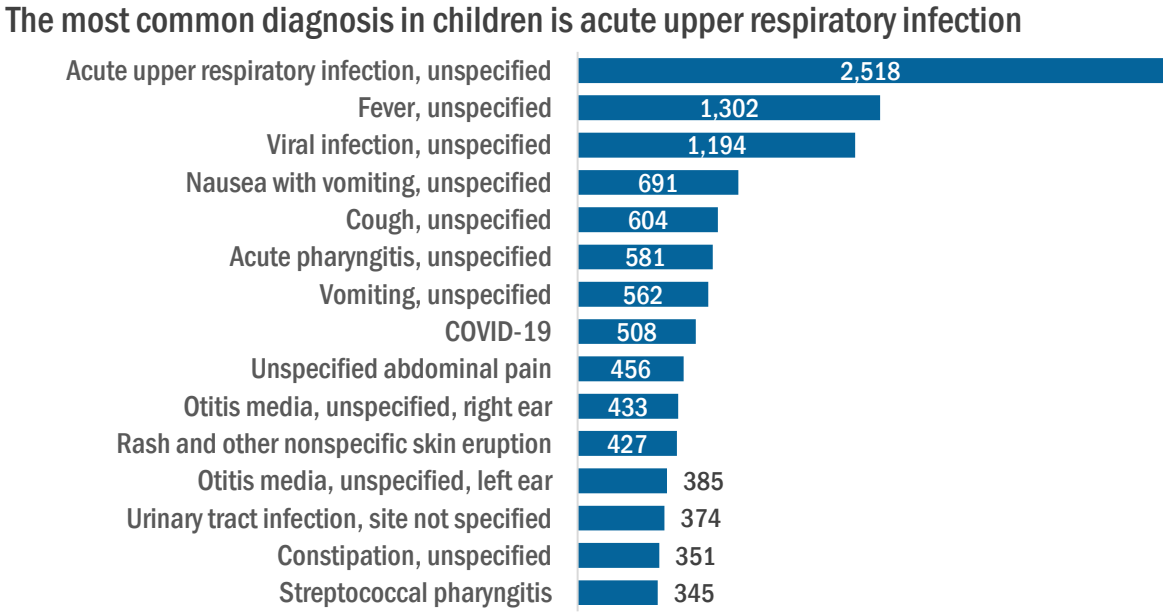
Emergency Department (ED) utilization rates provide data into how often members seek care outside of routine ambulatory services. CCHP tracks overall ED visits using the Ambulatory Care (AMB-ED) HEDIS measure. CCHP's ED utilization stands at 563 visits per 1,000 member years. The highest ED utilization rate is among children aged 0-1, with 1,036 visits per 1,000 member years.

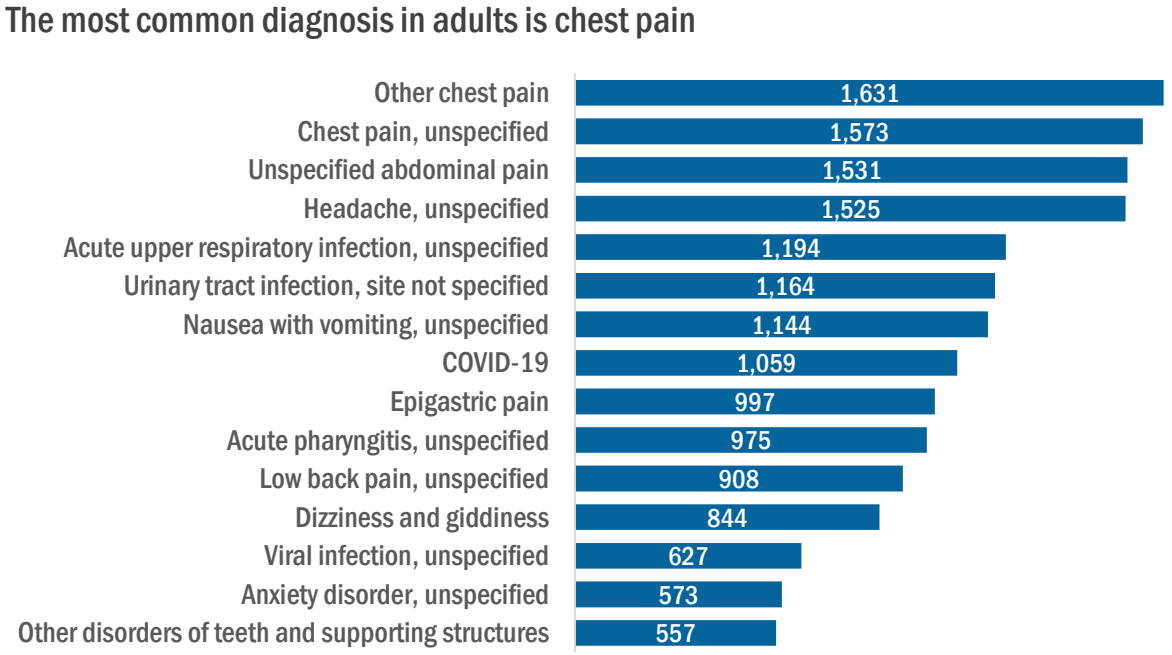


[3]

[3] Rate is per 1,000 member years.

Among all children, the most common diagnoses are acute upper respiratory infections (URIs), followed by unspecified fevers and viral infections. The most common diagnosis among all adults is chest pain, followed by abdominal pain and headaches.



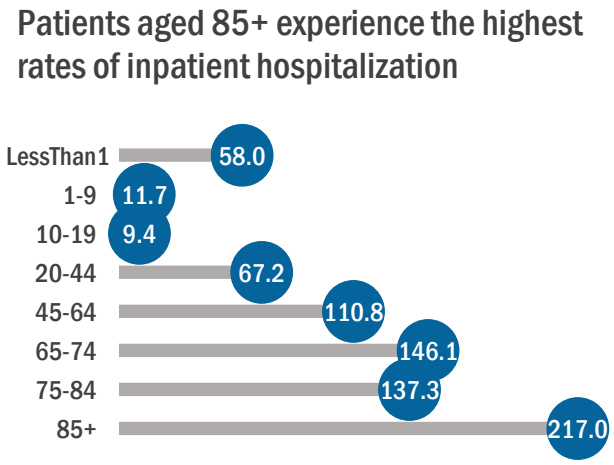


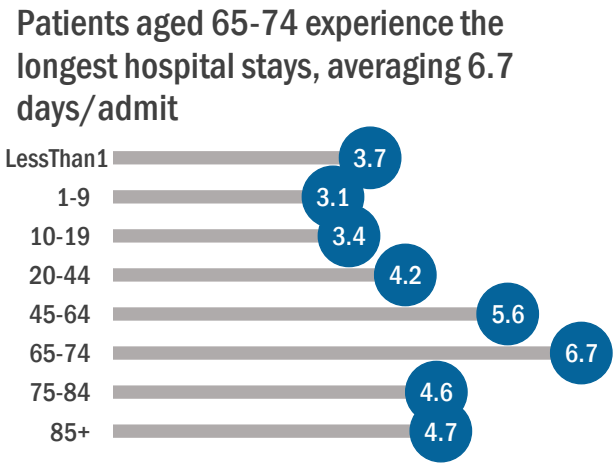
Over 65,000 members utilized the ED in 2023, with 25,000 members visiting the ED multiple times. There were over 3,000 members defined as being high utilizers of ED, having more than 5 ED visits in 12-month timeframe. Women were more likely to have

multiple ED visits in a year, and amongst adult groups, the most frequent ED users are 45-64 and 20-45.

Inpatient Hospitalizations

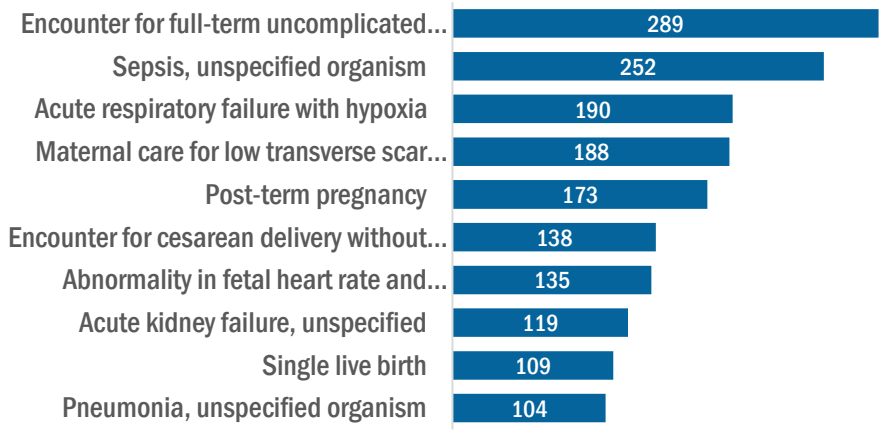
Inpatient hospitalization data provides data on the frequency and duration of hospital stays within CCHP's member population. CCHP uses the Inpatient Utilization (IPU) and All Cause Readmission (PCR) HEDIS measures to track admission data. In the adult population, older adults aged 85 and above represent the highest admission rates, while among the pediatric population, children under the age of 1 have the highest admission frequency. Compared to healthplans acorss the country, CCHP is in the 33rd percentile for the total inpatient discharges per 1,000 member years. Overall, the average length of stay is 4.9 days, placing CCHP in the 33rd percentile for this metric as well. For this measure, a lower performance rate is better, indicating that patients are not hospitalized as frequently nor for as long as at other comparable health plans.





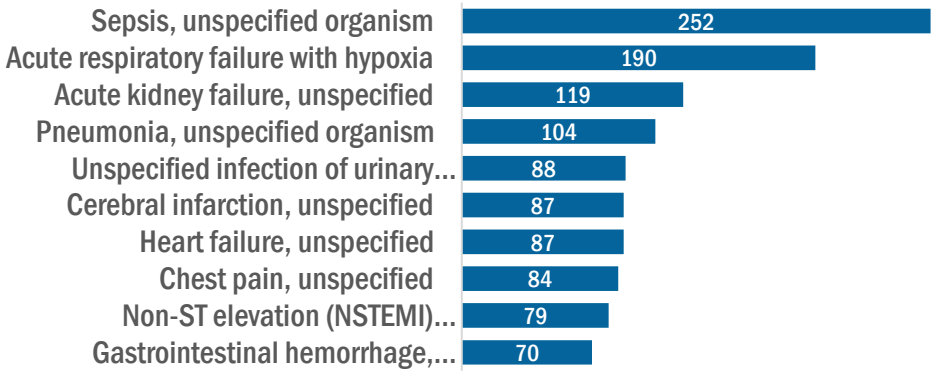
For adults, maternal-related care accounts for approximately 24.8% of adult discharges. CCHP experiences fewer maternity related discharges compared to other health plans, however the length of stay (LOS) is average compared to national health plans. Excluding maternal care, the leading causes of adult admissions include sepsis and acute respiratory failure (ARF) with hypoxia.

6 of the top 10 adult discharge diagnoses are related to maternal health.



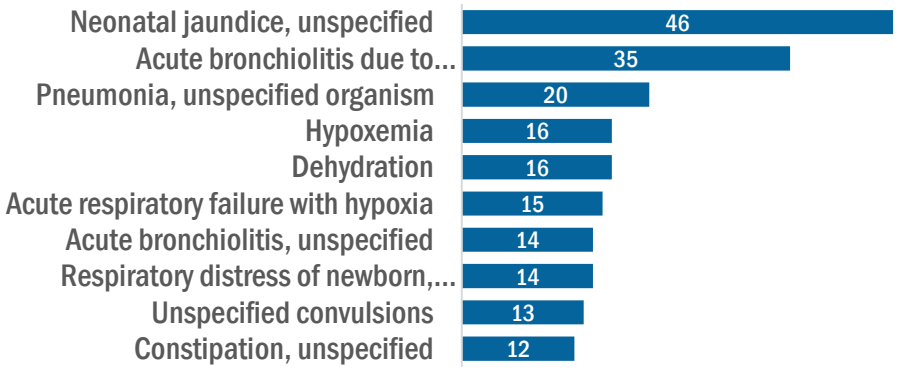
Sepsis remains one of the leading causes of inpatient admissions nationwide, with a significant impact on patient outcomes, particularly in vulnerable populations. Given its complexity and the range of factors involved, addressing the burden of sepsis requires ongoing attention at multiple leavels of healthcare.

Sepsis and acute respiratory failure are the top reasons for inpatient hospitalization when maternity discharges are excluded.



For children, the most frequent reasons for admission include jaundice and acute bronchiolitis due to respiratory syncytial virus. The top 10 discharge diagnoses for children account for 24.1% of all pediatric discharges. Interestingly, since the start of the COVID-19 pandemic, COVID-19 dropped out of the top 10 diagnoses in 2023, dropping to 11th overall excluding admissions related to pregnancy.

Neonatal jaundice and RSV bronchiolitis are the most common reasons for peditric hospitalization.

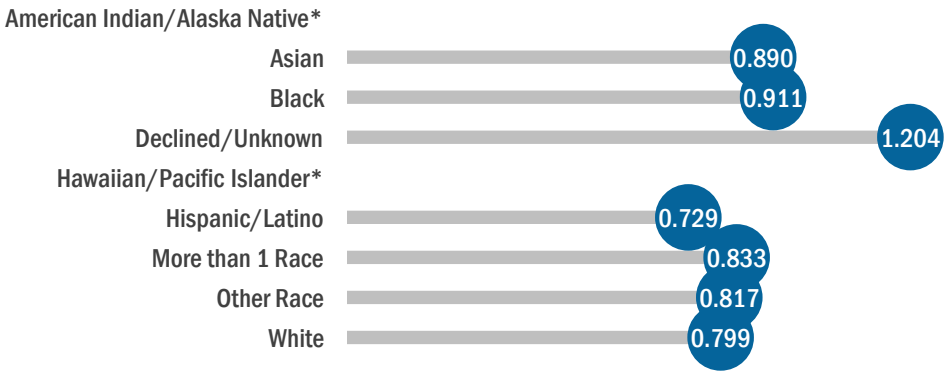


Hospital Readmissions

CCHP monitors hospital readmissions to determine any opportunities for improvement. The CCHP observed/expected readmission ratio of 0.824 indicates that CCHP saw fewer readmissions than expected. This continues a downward trend in observed/expected readmissions over time and places CCHP in the 90th percentile nationally in terms of readmissions.

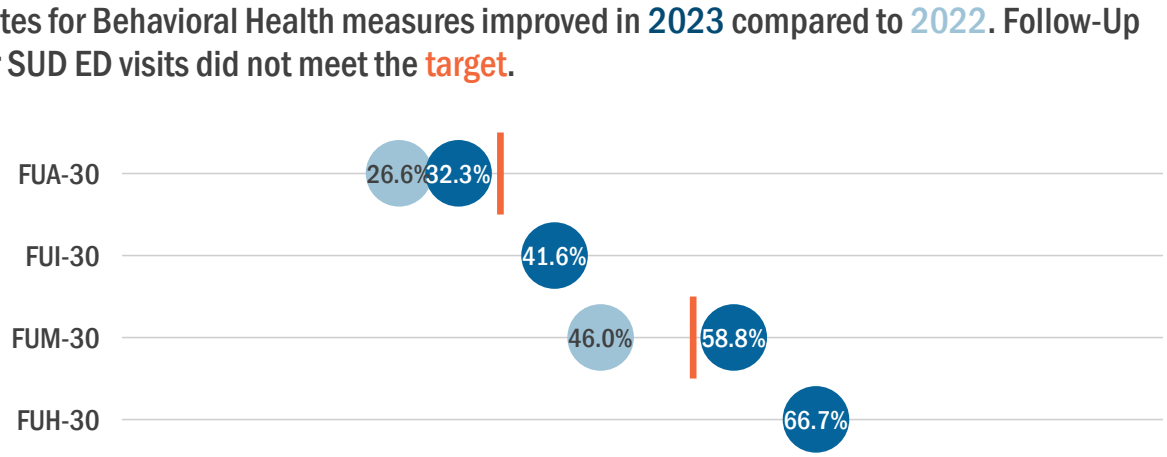
While CCHP performs well on the PCR measure overall, racial disparities exist. Latino patients have the lowest ratio of observed/expected readmissions and places in the 95th percentile nationally. Black/African American patients saw the lowest performance of patients with a known race on this measure; however, still had fewer readmissions than expected and ranked in the 66th percentile nationally. Patients whose race is unknown or declined to provide a race experience more hospital readmissions than expected, with a ratio of 1.204, indicating over 20% more admissions than expected.

Only patients with Declinied/Unknown race experienced more readmissions than expected.



Behavioral Health Emergency Department Visits and Hospitalizations

Emergency department visits and hospitalization for behavioral health conditions, such as mental health crises and substance use disorders, are closely monitored due to their significant impact on both immediate and long-term health outcomes. CCHP utilizes the Follow-Up after ED for AOD 30-Day (FUA-30), Follow-Up after High-Intensity Care for Substance Use Disorder 30-Days (FUI-30), Follow-Up after ED for Mental Illness 30-Day (FUM-30), and Follow-Up after Hospitalization for Mental Illness 30-Day (FUH-30) measures to monitor utilization of follow-up care after high intensity behavioral health services. Overall, CCHP ranks low in individuals with substance use linking to follow-up care most emergency department visits. There were significant improvements in the linkages for members utilizing the emergency department for mental health, increasing from 46% in 2022 to 58.8% in 2023.



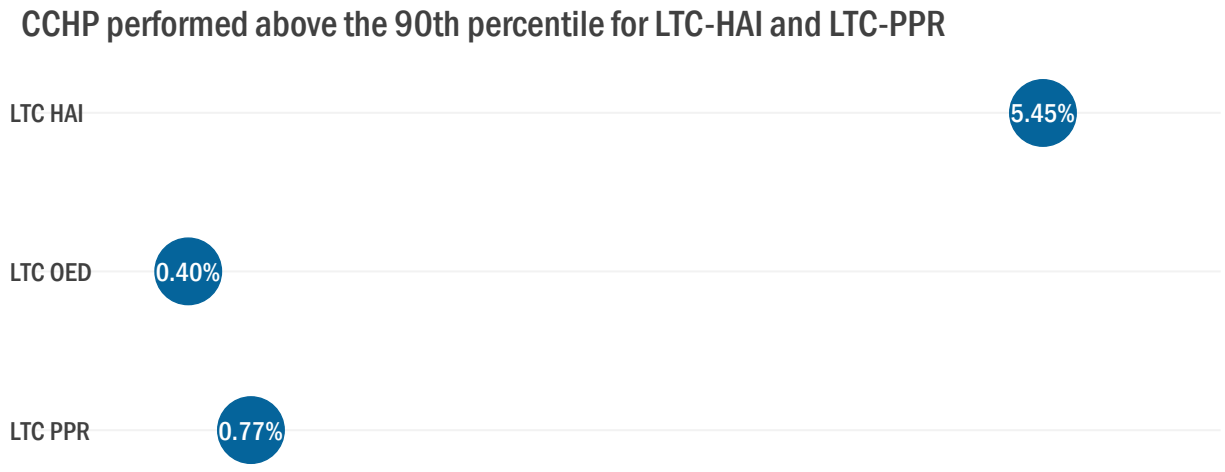
Long Term Care

Long Term Care (LTC) was introduced as a carved-in benefit to Medi-Cal starting in 2023. Members residing in long-term care settings often have more complex healthcare needs, which can impact their overall health outcomes. CCHP is reporting on the following Long-Term Care (LTC) measures for the first time in 2023:

- Number of Outpatient ED visits per 1,000 Long-Stay Resident Days (LTC-OED): measures the number of Emergency Department visits for patients who are residing in long-term care.
- Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (LTC-HAI): the number of inpatient hospitalizations from a healthcare associated infection in SNF patients.

- Potentially Preventable 30-Day Post-Discharge Readmission Measure (LTC-PPR): discharged SNF patients who were readmitted to an inpatient hospitalization between 2- and 30-days post SNF discharge.

In 2023, CCHP had better Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization and Potentially Preventable 30-Day Post-Discharge Readmission Measure rates compared to the national average for these measures. CCHP had a worse performance in the LTC-OED measure compared to national average. CCHP's performance on the Outpatient ED Visits per 1,000 Long Stay Resident Days measure is below both state and national averages, suggesting a need for target improvements in reducing unnecessary emergency department visits among long-term care residents.



Care Management Services

To improve the overall health of members and address unnecessary utilization, CCHP offers different levels of case management services to patients with complex needs. Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit. CCHP offers Complex Case Management (CCM) to those with multiple chronic conditions needing management, as well as case management specifically targeted for Transitional Care Management. Lastly, CCHP's care coordination case management address short-term episodic case management for lower-acuity members.

CCHP takes a whole-person approach to offering Enhanced Care Management (ECM), ensuring that ECM addresses the clinical and non-clinical needs of high-need and/or high-cost Members in distinct Populations of Focus, and that ECM is community-based, interdisciplinary, high-touch, and person-centered. In 2023, CCHP served 6,488 members in Enhanced Care Management. The overall uptake rate for ECM services in December 2023 was 35.0%, the uptake rate ranged from a low of 12.0% for the child/youth incarceration population of focus to a high of 88.9% for children/youth with a history with child welfare.

The CCHP Case Management unit served 981 patients in 2023, with nearly two-thirds of cases being Transitional Care Services episodes. Approximately 20% of case management episodes were for Complex Case Management.

Care Management Program	Enrolled
ECM Population of Focus	6,488
Adult Homelessness Individual	1,081
Adult High Utilizer	836
Adult SMI/SUD	806
Adult Incarceration Transition	490
Child/Youth High Utilizer	453
Child/Youth CCS/WCM	149
Child/Youth SED/CHR	138
Child/Youth Homelessness Family	71
Adult Homelessness Family	56
Child/Youth Welfare Hx	48
Child/Youth Incarceration Transition	32
Adult LTC	30
Adult Nursing Facility Transition	30
Child/Youth Homelessness Unaccompanied	30
Case Management	981
Hospital Transitions	634
Complex Case Management	200
CCS Transitions	147

Additionally, CCHP provides access to Community Health Workers (CHWs) to help members with care coordination and system navigation, health education, and advocacy. In 2023, 2,472 CHW services were provided to CCHP members.

Social Drivers of Health

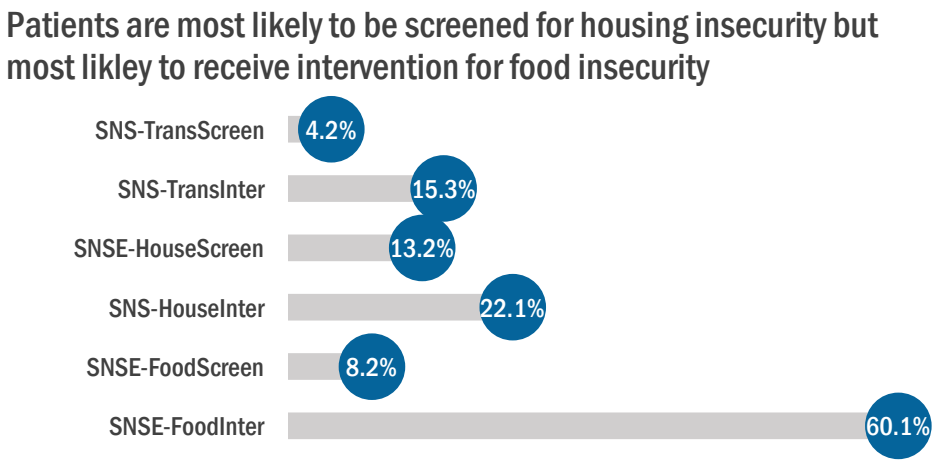
In addition to demographic factors like housing status, foster care, and history of incarceration, social drivers such as food insecurity, transportation access, and housing instability further shape health outcomes for CCHP's Medi-Cal population. These social

drivers are closely interconnected: challenges in one area can often impact other aspects of daily life, collectively influencing individuals' access to healthcare, ability to adhere to treatment, and overall well-being. This section examines data on screening and intervention efforts in these areas, highlighting the foundational role of social drivers in determining health trajectories within this population.

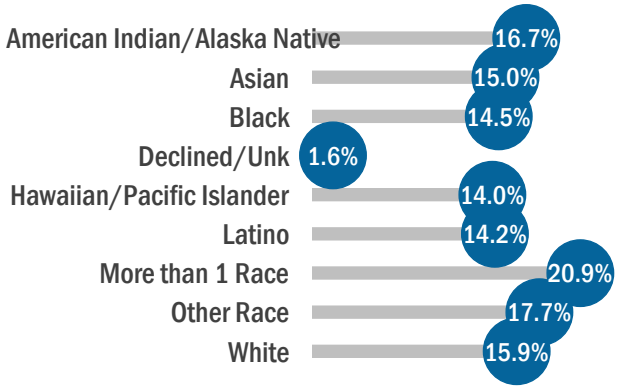
Food Insecurity, Transportation, Housing

Effective screenings for social determinants of health are crucial as they identify the specific needs of members, enabling connection to appropriate resources. CCHP is in the 90th percentile nationally for Social Needs Screening questions pertaining to housing, food insecurity, and transportation.

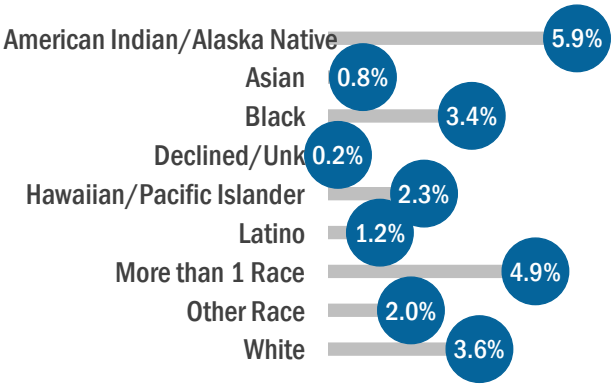
Currently, screening rates are lower for transportation (4.24%) and food insecurity (8.23%), while the intervention rates for unmet needs stand at 15.32% and 60.14%, respectively. Notably, Latino members experience some of the lowest screening rates for these measures.



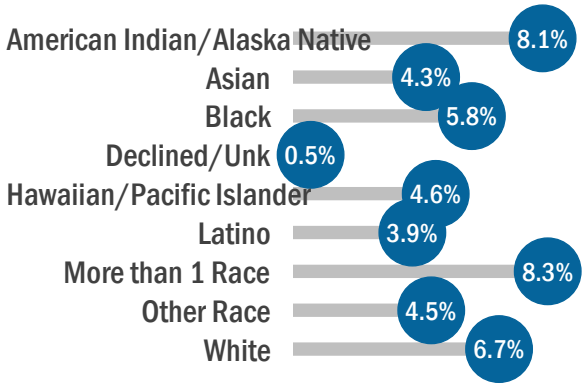
Patients with More than 1 Race had the highest housing insecurity screening rates.



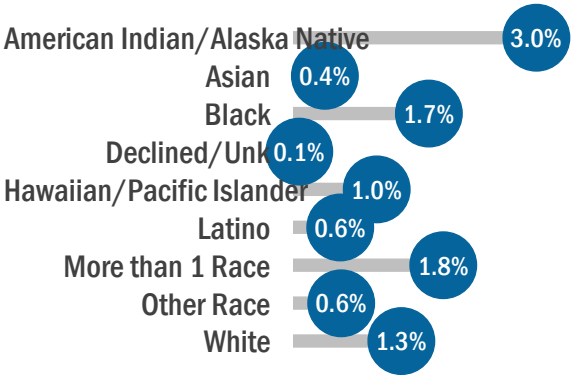
American Indian/Alaska Native members had the highest rates of housing insecurity.



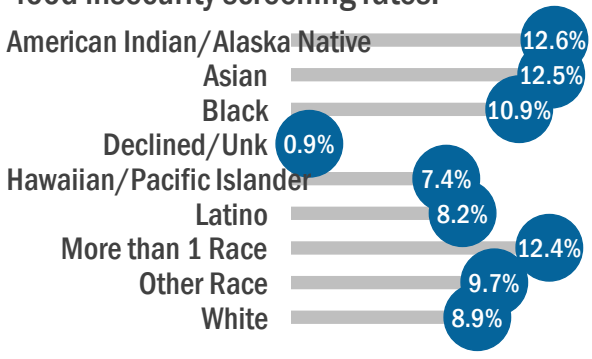
Multiracial patients had the highest screening rates for transportation needs.



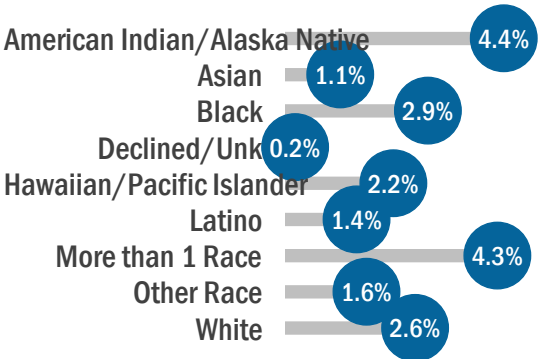
American Indian/Alaska Native had the highest rates of transportation needs



Of patients with a known race/ethnicity, Hawaiian/Pacific Islanders had the lowest food insecurity screening rates.



American Indian/Alaska Native had the highest rates of food insecurity.



Conclusion

This assessment of CCHP's Medi-Cal population highlights both the strengths and gaps within current healthcare delivery, quality, and access. While CCHP has achieved strong performance in several preventive measures and consistently strives to meet state and federal targets, disparities in health outcomes persist across racial, ethnic, and social demographics. The findings from this population needs assessment underscore the complex and interconnected factors influencing the health and well-being of CCHP members. Through a comprehensive analysis of quantitative data, CCH members have high rates of chronic disease, significant health disparities, and social drivers of health. These challenges impact not only individual member outcomes but also the broader social and economic vitality of the community.

Addressing the identified needs requires a multi-faceted approach that involves collaboration among healthcare providers, community-based organizations, government agencies, and the community itself. Moreover, enhancing access to preventive and primary care services, addressing social drivers of health, and fostering partnerships to fill gaps in services will be essential for creating a more equitable and sustainable support network for CCHP members.

This needs assessment lays the groundwork for targeted programs and policy changes aimed at improving health outcomes and quality of life for CCHP members. By addressing these identified needs with data-driven strategies and a commitment to community engagement, stakeholders can work collectively toward building a healthier, more resilient community for all residents. Continued collaboration and investment in these areas will be essential for fostering long-term positive change and closing the gaps in health and social service equity.