Population Needs Assessment Report

UnitedHealthcare Community Plan of California

Report Year 2021

Responsible Health Education and/or Cultural and Linguistics Staff

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I. Population Needs Assessment Overview

The Population Needs Assessment (PNA) Report assesses UnitedHealthcare Community Plan of California's (UHCCP CA) strategic efforts to develop health education, culturally competent and linguistically appropriate services, as well as continuous quality improvement programs while reducing health disparities among the diverse populations we service in San Diego County among our Medi-Cal beneficiaries.

The Plan is committed to address any health disparities associated with UHCCP CA member's age, gender, geographic distribution, race and ethnicity, language and disability; and overall, social determinants of health to reduce health disparities and improve our member's quality of health and the community they live in.

UHCCP CA will utilize this report on an annual basis as a means of incorporating findings from various health plan data evaluations, identifying disparate populations. The PNA is the responsibility of the Clinical Quality Manager who oversees member engagement, health education, and cultural and linguistic programs. The Plan Chief Medical Officer and Director of Clinical Quality and Health Equity maintain oversight of the Population Health programs including member engagement, health education, and cultural and linguistics. The Clinical Quality Manager attends the quarterly California Department of Health Care Services, Health Education and Cultural and Linguistics Workgroup.

The Population Needs Assessment Report will address the Plan's initial Action Plan Goals and Objectives including:

1. Recognition of diversity among health plan members.
2. Knowledge of disease prevalence in specific diverse populations.
3. Continuous development of programs and policies that address the needs of diverse and disparate populations.
4. Ongoing program evaluation to improve and meet changing needs while monitoring the effectiveness of current programs.
5. Data analysis to identify gaps in health and establishing dashboards capable of identifying disparity in diverse populations.
6. Provider and staff training to create awareness of cultural diversity.
7. Encouraging Community Advisory Committee (CAC), Provider Advisory Committee (PAC), and Public Policy Committee (PPC) input on relevant issues.

UHCCP CA will use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA. These will include, but not limited to, the data set and surveys below:

<u>Data Sets</u>

1. Beneficiary demographics
2. Claims and encounter data
3. Health Disparities Report (Individual MCP level disparity data)
4. Member Level Data (MLD) Report
5. Member Grievance and Appeals
6. County data
7. Member Health Status Indicators

<u>Surveys and Studies</u>

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data
2. Provider Satisfaction Survey
3. Member Satisfaction Survey or Net Promoter Score (NPS)
4. Quality studies

5. Community Advisory Committee (CAC) Member feedback
6. Provider Advisory Committee (PAC) Provider feedback
7. Public Policy Committee (PPC) Member and Provider feedback

II. Data Sources

As aforementioned, UHCCP CA will use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA. These will include, but not limited to, the data set and surveys defined below:

Data Sources/Sets

1. Beneficiary demographics: California State 834 enrollment files as of December 31, 2020.
2. Claims and encounter data: ICD-10 codes received via member claims. Includes all claims within the split data year. Top diagnoses reflect the unique number of members who had the given diagnoses as a primary, secondary, or tertiary diagnosis as of July 1, 2020.
3. Health Disparities Report: Measurement Year (MY) 2019/Report Year (RY) 2020, individual MCP level disparity data detailed care gap report by race/ethnicity, gender, language, age.
4. HEDIS® report as submitted to NCQA for Reporting Years 2019 and 2020.
5. Member Level Data (MLD) Report: validated individual member data as of year-end 2020.
6. Member Grievance and Appeals: Cultural, linguistics, or discrimination related grievance and appeals suggestive of disparity from January 1, 2020 to December 31, 2020.
7. County data: most recent published health statistics that describe health behaviors, diseases, and injuries for specific populations, in addition to health trends and comparisons to national target.
8. Member Health Status Indicators: health plan measures of illnesses and diseases from claims and encounter data for the measurement year.

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data: CAHPS® 5.0H survey conducted from February 7, 2020 through May 29, 2020.
2. Provider Satisfaction Survey (PSS): a provider satisfaction survey assesses provider satisfaction and access. The PSS is conducted to meet the Department of Managed Health Care (DMHC)'s Timely Access and the California Department of Insurance (CDI's) Network Adequacy requirement.
3. Member Satisfaction Survey or Net Promotor Score (NPS): a member satisfaction survey that is completed over the telephone by a contracted vendor. The NPS survey helps UHCCP CA improve the overall member experience based on member responses and qualitative feedback.
4. Quality studies: 2019 HEDIS® Annual Report; 2020 Annual Assessment of Network Adequacy Report; 2020 CAHPS® Report; 2020 Health Education Class Evaluation Report; and 2020 Population Health Management (PHM) Report, among others.
5. CAC Member feedback held throughout 2020
6. PAC Provider feedback held throughout 2020
7. PPC Member and Provider feedback held throughout 2020

III. Key Data Assessment Findings

1. Membership/Group Profile

The PNA includes stratification of members based upon age, gender, race/ethnicity, geographic distribution, language, and Medicaid eligibility categories.

Membership is further broken down to include physical and behavioral health diagnoses, as well as an assessment of the needs of children and adolescents, disabled members, and members with serious and persistent mental illness (SPMI) [see Section 2. Health Status and Disease Prevalence].

The demographic data (age, gender, language, and ethnicity) is member self-reported data and is received on a monthly basis via State 834 enrollment files. Children and adolescents are defined by the state as individuals under the age of 21. Eligibility and disability categories are designated by the State Medicaid agency and are also provided to the plan via the monthly State 834 files. Demographic, eligibility, and disability categories are current as of December 31, 2020.

Age and Gender

2020 Number of Members by Age and Gender			
Age	**Male**	**Female**	**Total**
0 - 20	3,106	2,764	5,870
21 - 40	3,900	4,583	8,483
41 - 60	2,056	1,916	3,972
61+	689	882	1,571
Total	**9,751**	**10,145**	**19,896**

Data Source: California State 834 Files

Data Analysis

The predominant age group is members aged 21-40 at over 42.64% of the membership. The predominant age/gender groups are males ages 21-40 (19.61%) and females ages 21-40 (23.03%). The predominant gender group overall is female, which accounts for 50.99%, just over half of the overall membership. UHCCP CA's membership grew by 7,732 members between year-end 2019 to year-end 2020, however the age and gender distribution remain similar between years.

Geographic Distribution

UHCCP CA serves San Diego County, which is divided into four geographic regions, including: Central County, East County, North County, and South County. To further define the four major geographic regions some of the major cities for each region include but are not limited to the following: Central County (San Diego, Del Mar, Poway, La Jolla); East County (El Cajon, Santee, La Mesa, Lemon Grove); North County (Escondido, Oceanside, San Mateo, Vista); and South County (San Ysidro, National City, Chula Vista, Imperial Beach).

2020 Number and Percent of Members by San Diego County Region		
Region	**Number**	**Percent**
Central	7659	38.50%
North	5299	26.63%
East	3480	17.49%
South	3306	16.62%
Other	152	0.76%
Total	**19,896**	**100.00%**

Data Source: California State 834 Files

Data Analysis

The geographic distribution by region is consistent with 2019. Data analysis indicates that the predominant San Diego County Region with highest membership is within the Central County region which accounts for 38.50% of the overall membership when compared to the other San Diego County regions. Of note, the category "Other" indicates membership that do not live in San Diego County and are outliers to the current data, comprising of 0.76% of the overall membership.

The top 5 zip codes in Central County include 92105, 91911, 92113, 92114, and 92126. These were also the most populous member zip codes for Central Region in 2019.

Top 5 Zip Codes, Central Region			
Zip Code	**City**	**Member Count**	**Rate**
92105	**San Diego, City Heights**	626	24.85%
91911	San Diego, College Grove	505	20.05%
92113	San Diego, Logan Heights	488	19.37%
92114	San Diego, Encanto	478	18.98%
92126	San Diego, Mira Mesa	422	16.75%
Total	**N/A**	**2,519**	**100.00%**

Data Source: California State 834 Files

The most populated zip code was 92105, San Diego, City Heights. City Heights is known for its diversity, a dense urban community of 95,000 living in approximately 6.5 square miles within San Diego. Poverty, unemployment, child obesity, asthma, and violence are some key problems this community faces (California Endowment, 2020).

City Height's average yearly income for a family of four is between $19,393 and $24,400, within the range of the federal poverty level of $22,050. The Unemployment in City Heights is 20.5%, roughly twice the County of San Diego average of 11% (California Endowment, 2020).

With about 42.4 percent of City Heights residents are foreign born. City Heights racial and ethnic makeup is as follows: 54% Latino, 19% Asian or Pacific Islander, 13% African American, 12% White, and 2% Other (California Endowment, 2020).

Additionally, San Diego has 36.3 acres per 1,000 residents dedicated to parks and green space, a density well above the median for all cities. However, it is estimated that City Heights only has 1.52 acres of park per 1,000 residents, creating urgency to move fitness projects and identify locations for activity and wellness through health plan sponsored programs, particularly for our youth (California Endowment, 2020).

Health Plan Eligibility Categories and Social Determinants

2020 Number and Percent of Members by Eligibility Categories		
Eligibility Categories	**Total Number**	**% of Total Membership**
CA California Children Services	149	0.75%
CA California Children Services RADY	54	0.27%
CA CCS/GHPP	1	0.01%
CA Duals	463	2.33%
CA Genetically Handicapped Persons Program	1	0.01%
CA In Home Supportive Services Program	53	0.27%

CA Long Term Care Program	12	0.06%
CA Seniors and Persons with Disabilities	767	3.86%
CA Seniors and Persons with Disabilities RADY	25	0.13%
CA TANF	17253	86.72%
CA TANF RADY	1118	5.62%
Grand Total	**19,896**	**100.00%**

Data Source: California State 834 Files

Data Analysis

Members who are eligible for Temporary Assistance for Needy Families (TANF/TANF RADY) in and of itself indicate a member is at or near the poverty level. Overall, 92.34% of plan members are TANF eligible. That is nearly the entire membership population. These members have unique socioeconomic stressors related to issues with housing, food, transportation, employment, and health literacy. These results are consistent with reporting year 2019.

Race/Ethnicity

2020 Number and Percent of Members by Race/Ethnicity		
Race/Ethnicity	**Number**	**Percent**
Other	7597	38.18%
Hispanic	5466	27.47%
Caucasian/White	4817	24.21%
Black	1213	6.10%
Unknown	611	3.07%
Asian Pacific American	96	0.48%
Native America	96	0.48%
Total	**19,896**	**100.00%**

Data Source: California State 834 Files

Data Analysis

The predominant racial group among the membership is “Other” at 38.18% of the total membership, followed by the second largest predominant racial group, Hispanic at 27.47%. A diverse racial/ethnic membership was identified at the plan, remaining consistent over both reporting years 2019 and 2020.

Language

2020 Number and Percent of Members by Language		
Language	**Number**	**Percent**
English	17235	86.63%
Spanish	1727	8.68%
Mandarin	210	1.06%
Miscellaneous	197	0.99%
Cantonese	137	0.69%
Arabic	97	0.49%
Tagalog	80	0.40%
Farsi	67	0.34%
Vietnamese	49	0.25%
Russian	35	0.18%
Korean	16	0.08%
Chinese	13	0.07%
Cambodian	11	0.06%

Portuguese	6	0.03%
Sign Language	5	0.03%
French	4	0.02%
Laotian	4	0.02%
Japanese	2	0.01%
Thai	1	0.01%
Grand Total	**19,896**	**100.00%**

Data Source: California State 834 Files

Data Analysis

The predominant preferred languages identified other than English (86.63%), included Spanish at 8.68% among the membership. Also observed, was that the additional non-English languages meet the California Department of Health Care Services (DHCS) identified San Diego County threshold languages including Arabic (0.49%), Tagalog (0.40%), and Vietnamese (0.25%) are among the top ten languages identified in 2020. Other languages identified among the top ten are Mandarin (1.06%), Miscellaneous (0.99%), Cantonese (0.69%), Farsi (0.34%), and Russian (0.18%). One notable difference between the previous year is the increase in reported language for Mandarin, Cantonese, Miscellaneous and Farsi.

Membership Summary

The key findings the Population Needs Assessment identified that the predominant San Diego County Region with highest membership is within the Central County region which accounts for 38.50% of the overall membership when compared to the other San Diego County regions. Furthermore, 92.34% plan members are TANF eligible. That is nearly the entire membership population who are at or near the poverty level.

These members have unique socioeconomic stressors related to issues with housing, food, transportation, employment, and health literacy that impede them from going to a regular doctor visit or take care of their overall health. Additionally, the most common health issues seen in adults were primarily hypertension, chest pain, and hyperlipidemia. The most common diagnoses seen among adolescents and children were acute upper respiratory infection, routine child exams, immunizations, and cough.

As such, it is important to ensure that when developing health education, culturally competent, linguistically appropriate services, and continuous quality improvement programs are not a “one-size fits all”. There is a need to make programs more tailored to targeted audiences and explore various communication channels to meet membership needs. Such programs may include taking a more digital approach, like the use of developing and delivering text messaging initiatives to our predominantly English-speaking members’ ages 21 to 40 years old who expect more of an expedited process for accessing care. These recommendations will ensure overall improved health outcomes among membership and increased member satisfaction.

2. Health Status and Disease Prevalence

A. Population Health Management Study

In 2020, UHCCP CA conducted a Population Health Management study to assess top in-patient and out-patient diagnoses by age, disability, and Severe or Persistent Mental Illness (SPMI). Clinical data is reported based upon ICD-10 codes received via member claims and includes all claims within the split data year. Top diagnoses reflect the unique number of members who had the given diagnoses as a primary, secondary, or tertiary diagnosis during July 1, 2019 and June 30, 2020. The table below demonstrates data yielded from that study.

Top Diagnoses

Top Five Out-Patient Diagnoses - Based on unique count of members with the diagnosis			
Top Diagnoses Child/Adolescent (2-19)		**Top Diagnoses Ages 20 and over**	
2019	**2020**	**2019**	**2020**
Routine Child Exam	Routine Child Exam	General Adult Medical Exam	General Adult Medical Exam
Acute Upper Respiratory Infection	Immunization	Primary Hypertension	Primary Hypertension
Acute Pharyngitis	Acute Upper Respiratory Infection	Chest Pain	Chest Pain
Screening for Disease of the Blood	Child Health Exam w/Abnormal Finding	Routine GYN Exam	Hyperlipidemia
Screening Disorders	Cough	Abdominal Pain	Encounter in Specified Consultation
Top Dx of Members with SPMI		**Top Dx of Members with Disabilities**	
2019	**2020**	**2019**	**2020**
Major Depressive Disorder	Major Depressive Disorder Single	Primary Hypertension	Primary Hypertension
Anxiety Disorder	Major Depressive Disorder Recurrent	Illness Unspecified	Encounter for Immunizations
Major Depressive Disorder Recurrent	Anxiety Disorder	General Adult Medical Exam	Illness Unspecified
General Adult Medical Exam	Encounter for Immunizations	Type 2 Diabetes Mellitus	Type 2 Diabetes Mellitus
Primary Hypertension	Primary Hypertension	Immunizations	General Adult Medical Exam

Data Source: SMART Data Warehouse/Claims

Top Five Inpatient Diagnoses - Based on unique count of members with the diagnosis			
Top Diagnoses Child/Adolescent (2-19)		**Top Diagnoses Ages 20 and over**	
2019	**2020**	**2019**	**2020**
Acute Respiratory Failure	Single Live Infant Delivery	Single Live Infant Delivery	Single Live Infant Delivery
Mild Persistent Asthma	Acute Appendicitis	Sepsis Unspecified Organism	Sepsis Unspecified Organism
Acute Bronchiolitis	Lobar Pneumonia	Acute Kidney Failure	Primary Hypertension
Failure to Thrive (Child)	Perforation Tympanic Membrane	Unspecified Convulsions	Acute Kidney Failure
		Abdominal Pain	Acute Respiratory Failure
Top Dx of Members with SPMI		**Top Dx of Members with Disabilities**	
2019	**2020**	**2019**	**2020**
Unspecified Psychosis	Unspecified Psychosis	Unspecified Psychosis	Unspecified Psychosis
Chest Pain	Chest Pain	Chest Pain	Chest Pain
Other Nonspecific Abnormal Finding	Other Nonspecific Abnormal Finding	Other Nonspecific Abnormal Finding	Other Nonspecific Abnormal Finding
Major Depressive Disorder	Major Depressive Disorder	Major Depressive Disorder	Major Depressive Disorder
Encounter Adjustment Management	Encounter Adjustment Management	Encounter Adjustment Management	Encounter Adjustment Management

Data Source: SMART Data Warehouse/Claims

The Plan identified that the most common health issues seen in adults were hypertension and chest pain. The most common diagnoses seen among adolescents and children were routine child exam and acute upper respiratory infection. Prenatal and Newborn needs are addressed through the Healthy First Steps program, which aims to identify pregnant women as early as possible with a goal of achieving the best health outcomes for pregnant women and newborns through the first year of life. Relevant needs of healthy adults and children are inherently linked to overall social determinants of health including but not limited to securing safe housing, adequate access to food, education, employment, and health care. These needs are then impacted by socioeconomic status, social & family support systems, language, and health literacy.

Members with an array of disabilities make up 4% of the population. Subpopulations of members with disabilities include Seniors and Persons with Disabilities (SPD) and Age Blind Disabled (ABD). There are two types of disabilities; cognitive and medical/physical and it is not uncommon for people to have both types. The disabled face unique challenges inside their homes as well as out in the community. Many require assistance with personal as well as social activities of daily living, safe housing, transportation, home modifications and assistive devices for communication. Members with disabilities and/or chronic illnesses require additional community support such as identifying federal or state program eligibility and getting enrolled, assistance managing their conditions along with navigating the health care system and transportation to appointments. People with multiple chronic illnesses may experience suboptimal health outcomes which result in increased health care expenses and often cause anxiety and depression. Together these factors negatively impact both the length and quality of life for people living with chronic illness. Prevalent diagnoses among these members include, chest pain unspecified, primary hypertension, and type 2 diabetes mellitus.

Members with Serious and Persistent Mental Illness (SPMI) are also a particularly vulnerable population with unique issues. The biggest and most frequently overlooked obstacle being the social stigma associated with mental illness. The stigma around mental health and illness continues to be a factor for those affected, not to seek or continue treatment. An analysis of this membership showed prevalent diagnoses that include both medical and behavioral conditions of major depressive disorder, anxiety disorder, primary hypertension, chest pain, and psychosis. Although each specific disorder has unique challenges, they share a common thread of causing impairment to function, along with emotional and/or physical pain, which may result in increased utilization of emergency services. This common thread disrupts life, interferes with healthy function in family, work and community and creates an increased risk in mortality. UHCCP CA connects members to case management resources with the appropriate behavioral health services, in order to reduce delays or gaps in care as well as to prevent duplication of services.

The Plan supports a case management program, focused on identification and care coordination for the high cost and high-risk membership. In 2019 and 2020, this team primarily focused efforts on members with frequent readmissions, working to ensure follow up appointments, pharmacy adherence and access to DME and home health as needed. The Plan also participates in the Health Home Program, with 5 Health Homes which implemented in July 2019. The members eligible for Health Home services include members facing homelessness, members with frequent emergency room (ER) or inpatient utilization, members with chronic medical conditions and/or Serious Mental Illness. During 2019 and 2020 over 800 members were identified as qualifying for Health Homes. Through outreach, which in 2020 was primarily telephonic due to pandemic restrictions, the Health Homes were able to enroll and actively manage 100 members. Preliminary data suggest that ER utilization drops to nearly zero following engagement by the Health Home care manager. Long term data regarding improvement in health outcomes or reduction in cost of care is not available yet. In 2021 this program is transitioning to Enhanced Care Management (ECM), and in preparation the Plan intends to have 4 FQHC based ECM programs, 2 community programs that previously served the County's Whole Person Care Pilot population, and 2-3 additional community programs with specific competence in certain populations of focus. The ECM program will have additional tools available to assist members who have barriers to improving health through the In Lieu of Services (ILOS) that are being provided by the Plan. The Plan sought input from the County prior to determining which ILOS to offer. County recommended focus on housing and food security. As

a result, the Plan intends to offer Recuperative Shelters, Sober Houses, Medically Tailored Meals, Housing Navigation, Housing Sustaining Services and Housing Deposits. In future reports, the demographics of the ECM identified and engaged members will be carefully reviewed to identify cultural and linguistic barriers to successful engagement in case management.

In 2020, DHCS awarded UHCCP CA two (2) Behavioral Health Integration (BHI) grants in 2020. This program offers fiscal incentives to providers who work to improve physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's (MCP) network, using culturally and linguistically appropriate teams with expertise in primary care, substance use disorder conditions, and mental health conditions who deliver coordinated comprehensive care for the whole patient. The goal of the BHI Incentive Program is to increase network integration in partnership with an MCP, in this case, UHCCP CA. The two grant projects will focus exclusively on the following:

- La Maestra Family Clinic, Inc. will implement a fully integrated model of behavioral health care services alongside comprehensive diabetes care to adolescents and adults at the organization's main clinic site. La Maestra will identify patients who are diagnosed with Serious Mental Illness and have HbA1c levels greater than 9% through cooperation of WSS and the diabetes clinic. Once patients are identified, case managers will work with them to start diabetes prevention and management services. La Maestra currently provides the American Diabetes Association (ADA) Diabetes Self-Management Training (DSMT) program to patients diagnosed with diabetes (Type I or Type 2 diabetes) to improve health, self-efficacy, and motivation to improve their lifestyle and overall wellbeing. Patients will also be provided health education including nutrition counseling, information about onsite exercise classes including Zumba and yoga, and cooking demonstrations. Patients identified as having poor control of their HbA1c levels will be referred to the onsite Optometrist, Dr. Dora Doan, to check for potential diabetic retinopathy. Also, La Maestra will refer these patients out to a podiatrist to check for nerve damage or vascular diseases in the patients' extremities. La Maestra will use NextGen Electronic Health Records (EHR) and i2i Tracks, population health management software, to track patient data and SBIRT numbers. With the integration of AUDIT and DAST screening tools into the EHR, La Maestra's behavioral health and substance abuse staff will be able to easily track screenings, results, and the need for brief intervention or referral to treatment. Full implementation of behavioral health integration will be measured by both quantitative and qualitative data.

- Vista Community Clinic (VCC) will implement a BHI project targeting Maternal Mental Health and Substance Abuse. The project's purpose is to engineer a comprehensive pathway that ensures that every woman presenting for perinatal services is screened for mental health disorder and substance use disorder concerns in a culturally and linguistically relevant manner, in the context of providing comprehensive perinatal services.

The grant projects will run through 2022. Progress and outcomes will be summarized in the next annual PNA.

B. Health Homes Program

The Plan participates in the Medi-Cal Health Home Program to improve member outcomes and reduce overall health care costs, with 5 contracted Health Homes implemented in July 2019 with extensive practice transformation training, data sharing and support to the providers. This program provides 3 tiers of care coordination services based upon member established goals to increase access to care and social service supports, better manage chronic symptoms, and promote self-empowerment. The members eligible for Health Home services include members facing homelessness, members with frequent ER or inpatient utilization, members with specific state defined chronic medical conditions and/or Serious Mental Illness or SUD diagnosis.

During 2019 and 2020 over 1,607 members were identified as qualifying for Health Homes. Through outreach, which in 2020 was primarily telephonic due to pandemic restrictions, the Health Homes were able to enroll and actively manage 114 members. Preliminary data suggest that ER utilization drops to nearly zero following engagement by the Health Home care manager. Long term data regarding improvement in health outcomes or reduction in cost of care is not available yet.

The United licensed clinical practice transformation team monitors total cost of care, all cost utilization including behavioral health data received from DHCS, quality measures, program turnover rates and readmissions. Monthly data is provided to each practice to ensure that targeted and prioritized outreach occurs or that high cost utilizers are managed with more rigor. Routine joint operating committee meetings are held to review data and to work through barriers or concerns with each practice.

In 2021 this program is transitioning to Enhanced Care Management (ECM), and in preparation the Plan intends to have 4 FQHC based ECM programs, 2 community programs that previously served the County's Whole Person Care Pilot population, and 2-3 additional community programs with specific competence in certain populations of focus.

The ECM program will have additional tools available to assist members who have barriers to improving health through the In Lieu of Services (ILOS) that are being provided by the Plan. The Plan sought input from the County prior to determining which ILOS to offer. County recommended focus on housing and food security. As a result, the Plan intends to offer Recuperative Shelters, Sober Centers, Medically Tailored Meals, Housing Navigation, Housing Sustaining Services and Housing Deposits. In future reports, the demographics of the ECM identified and engaged members will be carefully reviewed to identify cultural and linguistic barriers to successful engagement in case management. The populations of focus include the following categories:

ECM Populations of Focus: Summary

Adults	Children/Youth up to 21
1) Individuals and families experiencing Homelessness;	
2) High Utilizers;	2) High utilizers;
3) Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD);	3) SED, identified to be at Clinical High Risk (CHR) for psychosis or experiencing a First Episode of Psychosis;
4) Incarcerated and Transitioning to the Community;	
5) At risk for Institutionalization and Eligible for LTC;	5) Enrolled in CCS / CCS Whole Child Model (WCM) with Additional Needs beyond CCS;
6) Nursing facility Residents Transitioning to the Community.	6) Involved in Child Welfare (including those with a history of involvement, and foster care up to 26).

Data Source: Department of Health Care Services Enhanced Care Management

Definitions for each of these populations of focus are either defined by DHCS now (https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Key-Design-Implementation-Decisions.pdf) or will be defined by DHCS later.

C. COVID-19 Membership Data Analysis

In Quarter 2, 2020, UHCCP CA conducted a preliminary analysis of available claims and hospital admission data to identify potential health disparities among members who tested positive for COVID-19. At the time of data collection, there were a total of 15 members identified as testing positive for COVID-19. Their demographic information was analyzed based on age, gender, language, ethnicity, and zip code.

As data was limited during the first data analysis due to the availability of complete claims data during the preliminary analysis, UHCCP CA conducted an additional analysis after the conclusion of 2020. The data showed during calendar year 2020, there were a total of 423 members identified who were diagnosed as positive with COVID-19. As the most known risk factors is ethnicity, an analysis was conducted focusing on these demographic elements.

Members with a Positive COVID-19 Diagnosis by Ethnicity		
Ethnicity	**Positive Cases**	**%**
Unknown	170	40.19%
Hispanic	142	33.57%
Caucasian/White	85	20.09%
African American	23	5.44%
Native American	2	0.47%
Pacific Islander	1	0.24%
Total	**423**	**100.00%**

Data Source: Facets/Claims 2020

Data Analysis

The data identified the most prevalent ethnicities with positive COVID-19 diagnoses were among Unknown (40.19%), Hispanic (33.57%), Caucasian/White (20.09%), followed by African American (5.44%). There is no clear outlying ethnicity with more cases identified compared to overall UHCCP CA membership or San Diego county data. These ethnicity rankings mirror the ethnicity rankings of our overall membership. These rankings are also similar to those of COVID-19 cases in San Diego county (San Diego County "COVID-19 by Race and Ethnicity", 2021), with the exception of Unknown ethnicity. However, the accuracy of health plan data for Unknown ethnicity is a known barrier.

When compared to CDC analysis of Race/Ethnicity COVID-19 case prevalence, there is some alignment as their rankings also demonstrate the most prevalent as Hispanic/Latino. UHCCP CA membership data does not align with the CDC's next most prevalent ethnicities which are American Indian or Alaskan Native, Black or African American, Caucasian/White, followed by Asian (National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, 2021).

Members with a Positive COVID-19 Diagnosis by Age		
Age	**Positive Cases**	**%**
0-3	21	4.96%
4-10	15	3.55%
11-18	22	5.20%
19-30	133	31.44%
31-45	107	25.30%
46-65	115	27.19%
65-80	7	1.65%
81+	3	0.71%
Total	**423**	**100.00%**

Data Source: Facets/Claims 2020

Data Analysis

The data for UHCCP CA members with COVID-19 cases illustrates it is more common among those between ages 19 to 65. This aligns with the CDC data which shows that COVID-19 is most prevalent among individuals between aged 18-64, who are twice as likely to contract the virus that those in other age groups (National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, 2021). This age range also represents the majority of health plan membership.

D. Utilization Review – Outpatient, Mental Health, Emergency Department, Immunizations and Well Child Visits.

UHCCP CA performed an analysis to assess utilization, comparing March and April 2019 to March and April 2020. Claims in five categories (Outpatient, Mental Health, Emergency Department, Immunizations and Well Child Visits) were reviewed and data was sorted by Age, Gender, Race, and Member's Preferred Language. Figure 1 below reflects the year-over-year change from 2019 to 2020. A significant reduction in claims was identified in all 5 categories. Further assessment revealed disparities across Age, Gender, Race, and Member's Preferred Language.

Data Source: Claims 2020

Outpatient Claims

Overall, the Plan experienced a 75.4% decline in Outpatient claims. The data was assessed to identify any differences in Race, Preferred Language, Gender, and Age. When assessing race, the largest declines were among Hispanic members with a 79.38% decline in outpatient claims. Adversely, a significant increase in Outpatient claims was observed amongst Asian Pacific American and Native American members. Additional rates are reported below.

Race	Percent Decline
Asian Pacific American	492.16%
Native American	234.90%
Hispanic	-79.38%
Other	-71.16%
Unknown	-66.69%
Caucasia/White	-64.13%
African American	-48.98%

Data Source: Claims 2020

When assessing Preferred Language, the largest declines were among Sign Language and French with a 100% decline in Outpatient claims for each. Adversely, a significant increase in Outpatient claims was observed amongst members whose Preferred Language was Cambodian. Additional rates are reported below.

Preferred Language	Percent Decline
Cambodian	221.89%
Russian	2.86%
Cantonese	1.54%
French	-100.00%
Sign Language	-100.00%
Vietnamese	-99.74%
Arabic	-93.17%
Mandarin	-82.98%
English	-74.66%
Portuguese	-69.34%
Korean	-68.16%
Farsi	-67.81%
Chinese	-54.02%
Spanish	-45.73%
Tagalog	-43.76%
Miscellaneous (Other)	-19.75%
Laotian	-
Thai	-

Data Source: Claims 2020

While rates amongst Gender decreased by 76.54% for males and 71.29% for females, there was no significant difference between males and females. A decrease was observed across all Age Bands with ages 5-12 experiencing the highest rate of declines in Outpatient claims. Additional rates are reported below.

Age Band	Percent Decline
Age 0-1	-78.59%
Age 1-4	-78.63%
Age 5-12	-81.98%
Age 12-18	-9.92%
Age 18-25	-39.54%
Age 25-35	-49.15%
Age 35-45	-80.42%
Age 45-55	-57.84%
Age 55-65	-59.60%
Age 65-75	-85.67%
Age 75+	-44.80%

Data Source: Claims 2020

Mental Health

Overall, the Plan experienced a 39.78% decline in Mental Health claims. The data was assessed to identify any differences in Race, Preferred Language, Gender, and Age. When assessing race, the largest declines in Mental Health Claims were among Hispanic members and amongst members whose preferred language was Spanish. The Plan also observed a significant difference in declined Mental Health claims by Gender. The decrease in males was 58.94% while the decrease amongst females was 1.46%. When assessing Age, the age band 12-18 had the greatest decline with a 100% decrease in Mental Health claims.

Emergency Department

Overall, the Plan experienced a 60.47% decline in Emergency Department claims. The data was assessed to identify any differences in Race, Preferred Language, Gender, and Age. All races except Asian Pacific American experienced a decline in Emergency Department claims with a 53%-68% decline. Rates are reflected below.

Race	Percent Decline
Asian Pacific American	3.46%
Native American	-68.80%
Caucasian/White	-65.45%
Other	-63.15%
African American	-55.66%
Unknown	-54.67%
Hispanic	-53.92%

Data Source: Claims 2020

When assessing Preferred Language, the largest declines were among Sign Language, Portuguese, and Vietnamese with a 100% decline in Emergency Department claims for each. Notably, a decrease was observed across all Languages. Additional rates are reported below.

Preferred Language	Percent Decline
Portuguese	-100.00%
Sign Language	-100.00%
Vietnamese	-100.00%
Arabic	-86.86%
Unknown	-86.86%

Cantonese	-77.01%
Tagalog	-77.01%
Mandarin	-72.41%
Spanish	-63.26%
English	-60.07%
Miscellaneous (Other)	-35.62%
Farsi	-31.02%
Cambodian	-
Russian	-
French	-
Chinese	-
Thai	-
Korean	-
Laotian	-

Data Source: Claims 2020

Emergency Department claims amongst Gender decreased by 65% for males and 56% for females. When assessing Age, all age bands reported a decrease in Emergency Department claims ranging from 35% - 82%. Additional rates are reported below.

Age Band	Percent Decline
Age 0-1	-82.25%
Age 1-4	-66.84%
Age 5-12	-74.56%
Age 12-18	-70.99%
Age 18-25	-36.61%
Age 25-35	-60.32%
Age 35-45	-55.90%
Age 45-55	-64.04%
Age 55-65	-65.31%
Age 65-75	-62.77%
Age 75+	-35.62%

Data Source: Claims 2020

Immunizations

Overall, the Plan experienced a 75.94% decline in Immunization claims. The data was assessed to identify any differences in Race, Preferred Language, Gender, and Age. Most notably, all categories experienced a decline in Immunization claims. This data confirms similar declines in immunization administration as published by the California Department of Public Health. Rates are reflected below.

Race	Percent Decline
Asian Pacific American	-100.00%
Native American	-100.00%
Unknown	-84.67%
Other	-77.82%
Hispanic	-75.48%
Caucasian/White	-72.26%

African American	-63.21%
Preferred Language	Percent Decline
Arabic	-100.00%
Mandarin	-89.39%
Farsi	-84.67%
Cantonese	-80.84%
Spanish	-78.78%
English	-74.99%
Tagalog	-72.41%
Chinese	-
Cambodian	-
French	-
Korean	-
Laotian	-
Miscellaneous (Other)	-
Portuguese	-
Russian	-
Sign Language	-
Thai	-
Vietnamese	-
Unknown	-
Gender	Percent Decline
Male	-76.25%
Female	-75.73%
Age	Percent Decline
Age 0-1	-100.00%
Age 1-4	-
Age 5-12	-
Age 12-18	-
Age 18-25	-60.15%
Age 25-35	-71.96%
Age 35-45	-57.69%
Age 45-55	-86.20%
Age 55-65	-82.07%
Age 65-75	-93.10%
Age 75+	-54.02%

Data Source: Claims 2020

Well Child Visits

Overall, the Plan experienced a 75.94% decline in Well Child Visit claims. The data was assessed to identify any differences in Race, Preferred Language, Gender, and Age. Most notably, all categories experienced a decline in Well Child Visit claims. Rates are reflected below.

Race	Percent Decline
African American	-100.00%
Caucasian/White	-94.59%

Hispanic	-79.77%
Unknown	-77.01%
Other	-71.26%
Asian Pacific American	-
Native American	-
Preferred Language	Percent Decline
Farsi	-100.00%
Tagalog	-100.00%
Russian	-100.00%
English	-80.52%
Spanish	-71.26%
Arabic	-
Cambodian	-
Cantonese	-
Chinese	-
French	-
Korean	-
Laotian	-
Mandarin	-
Miscellaneous (Other)	-
Portuguese	-
Sign Language	-
Thai	-
Vietnamese	-
Unknown	-
Gender	Percent Decline
Male	-77.70%
Female	-84.30%
Age	Percent Decline
Age 0-1	-54.02%
Age 1-4	-77.01%
Age 5-12	-90.49%
Age 12-18	-85.63%
Age 18-25	-88.50%
Age 25-35	-86.86%
Age 35-45	-
Age 45-55	-
Age 55-65	-
Age 65-75	-
Age 75+	-

Data Source: Claims 2020

Summary

As demonstrated above, utilization declines were observed across each type of service assessed. Differences were observed across specific groups such as race, preferred language, gender, and age. These utilizations declines are attributed to the Safer at Home orders issued by the California Governor on March 19, 2020.

Following this order, many provider practices altered operations such as reducing routine medical care, offering only COVID-related and/or visits to address acute conditions. Californians remained in the home, only leaving for critical needs such as grocery shopping or essential work.

These declines confirm a decrease in well child visits and immunization administration. This decline will negatively impact the UHCCP CA's HEDIS® rates for measurement year 2020. In response, the Plan developed a series of campaigns to increase well child visits and immunization administration. Such campaigns included a live telephone call to pediatric members to remind them of the importance of maintaining well child visits. The Plan developed a series of campaigns to launch in 2021 as the Safer at Home orders are lifted and provider practices resume operations and/or adapt to a new reality of care delivery.

The findings in this study were presented to UHCCP CA's Quality Management Committee. Activities were implemented to address low utilization. UHCCP CA's Quality team developed a custom report in which the Plan will monitor newly enrolled members and the rate of establishing care with a Primary Care Provider (PCP). UHCCP CA continuously shares membership reports with a set of high-volume PCPs so they can identify new members and establish care, thereby connecting members to needed care such as preventive care screenings, immunizations, and chronic disease management. Additionally, UHCCP CA publishes the Patient Care Opportunity Reports (PCOR) on a monthly basis and makes available to each unique provider practice. These reports contain gap in care data for a select set of HEDIS® measures. Providers can use the PCOR to identify members with gap(s) in care and recall members as needed.

3. Access to Care

A. Provider Satisfaction Survey (PSS)

In 2020, UHCCP CA conducted a Provider Satisfaction Survey fielded by a third-party market research vendor, The Center for the Study of Services (CSS), an independent survey research organization. The Plan included two language assistance program questions using a 5-point Likert scale ranging from: Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied, Not Applicable (N/A) or Unknown. The language assistance program questions were as follows:

1) Your patient's access to the Language Assistance Program for:
    a. Interpreter services
    b. Translation services
2) UHC's Language Assistance Program and the:
    a. Coordination of appointments with an interpreter?
    b. Availability of the appropriate range of interpreters?
    c. Training and competency of the available interpreters?

The Center for the Study of Services (CSS) faxed the survey to all 1,949 UHCCP CA contracted Primary Care Physicians (PCPs) and Specialists. Providers were asked to complete the survey and fax responses back to CSS by November 6, 2020. Final reports were provided to the Plan on November 6, 2020.

Of those 1,949 Providers, 199 (10%) (146 PCPs and 53 Specialists) completed the survey. An assessment of all results was completed by the Quality department. All analyses were separated into Primary Care Physicians and Specialists-level results.

In 2018, UHCCP CA established a goal of 80% satisfaction and continued that goal for subsequent surveys. To measure satisfaction, answers of Very Satisfied and Satisfied were included in the numerator. The Plan met or

exceeded that goal, as outlined in the table below, for all Language Assistance Program related questions (3a. to 4c.) below.

Provider Satisfaction Survey				
	Primary Care Physicians (n=146)		Specialists (n=53)	
Questions: How satisfied are you with…	2019 % Satisfied/ Very Satisfied (Goal: 80%)	2020 % Satisfied/ Very Satisfied (Goal: 80%)	2019 % Satisfied/ Very Satisfied (Goal: 80%)	2020 % Satisfied/ Very Satisfied (Goal: 80%)
1. The referral and/or prior authorization process to obtain covered services?	93%	95%	88%	100%
2a. Your patients' timely access to urgent care?	90%	98%	80%	100%
2b. Your patients' timely access to non-urgent primary care?	91%	96%	100%	100%
2c. Your patients' timely access to non-urgent specialty services?	90%	96%	100%	100%
2d. Your patients' timely access to non-urgent ancillary diagnostic and treatment services?	87%	96%	83%	100%
2e. Your patients' timely access to non-urgent behavioral health care?	79%	94%	100%	100%
3a. Your patient's access to the Language Assistance Program for interpreter services?	89%	90%	100%	100%
3b. Your patient's access to the Language Assistance Program for translation services?	90%	90%	100%	100%
4a. UHC's Language Assistance Program and the coordination of appointments with an interpreter?	82%	90%	100%	100%
4b. UHC's Language Assistance Program and the availability of the appropriate range of interpreters?	82%	94%	100%	100%
4c. UHC's Language Assistance Program and the training and competency of the available interpreters?	82%	92%	100%	100%

Data Source: Provider Satisfaction Survey 2020

Data Analysis

The 2020 PSS results indicated the following:

a. ***Primary Care Physicians*** indicated increases in satisfaction for access to interpreter services by 1%, training and competency of available interpreters by 10%, and coordination of appointments with an interpreter by 8%. Access to interpreter services had the greatest increase from 2019 in the

Language Assistance Program and the availability of the appropriate range of interpreters with a reported 94% in 2020 compared to a reported 82% in 2019, a 12% increase. There were no decreases in satisfaction from 2019 to 2020. Although the patient access to Language Assistance Program for translation services question remained unchanged from 2019 to 2020, at 90%.

b. ***Specialists*** indicated 100% provider satisfaction with their patient's access to the Language Assistance Program services. All scores remained the same at 100% when compared to 2019 data.

Overall, the most significant barrier with the MY2019 Provider Satisfaction Survey was receiving a completed survey back from the Plan's PCPs and Specialists. As noted in the Analysis section above, only 10% of the eligible population returned the completed survey to UHCCP CA's contracted survey vendor.

This low participation rate presents several missed opportunities for Providers to submit feedback to the Plan and advocate for their patients' unmet needs in areas including the referral/authorization process, timely access to care, and language assistance services. Improved participation in, and response rate to, the PSS provides a platform from which provider needs can be better understood and meaningful changes can be launched for the UHCCP CA Members and Providers.

It should be noted that lack of participation could be an impact of the COVID-19 pandemic. Providers are seeing patients via telehealth due to the pandemic and may be working remotely. This may have caused them to have missed a survey that was faxed to their office. Also, utilization of healthcare services overall saw a decrease in 2020 due to COVID-19.

B. Annual Assessment of Network Adequacy

Annually, UHCCP CA reviews multiple sources of data, such as network adequacy, to assess the cultural, ethnic, racial and linguistic needs of its membership to determine if member cultural needs and preferences are being met. Practitioner data is compared against the results of member data to determine if any gaps exist. When gaps are identified, a qualitative analysis is conducted to identify opportunities for improvement and adjust the network, as needed.

An assessment of the Network Cultural Report was conducted for the measurement period of 2020. The Network Cultural Report includes practitioner self-reported language data collected during the initial credentialing process. Language information is reported/updated every three years during the recredentialing process and may be updated between cycles at the practitioner's request. Information is stored and pulled from the Network Database (NDB). Data is current as of 2020 and includes a sample size of 4,304 total network practitioners. Variances in the practitioner/member comparison of greater than negative 5 percent is presented in the table below.

Practitioner/Member Language Comparison

Total Network Practitioners	4,304

Types of Language	**% Speaking Spanish**	**% Speaking Other Indo-European**	**% Speaking Other Asian and Pacific Languages**	**% Speaking Other Languages**
Practitioner %	7.88%	5.69%	3.39%	1.16%
Member %	28.77%	4.56%	10.05%	1.10%

Practitioner/Member Difference	**-20.89%**	**1.13%**	**-6.66%**	**0.06%**

Data Source: Network Cultural Report – July 1, 2019 to June 30, 2020

The assessment of the data of the practitioner language indicates the practitioner network has adequate physicians who speak the 'Other Indo-European' and 'Other Languages'. Based upon UHCCP CA language line data (Table 4), the top ethnicities were Hispanic/Latino, Mandarin, and Vietnamese. There is a gap in Spanish and Asian/Pacific languages between members and practitioners. Practitioners speaking Spanish was 20.89 percentage points less than the number of members who speak Spanish. Practitioners who speak Asian/Pacific languages were 6.66 percentage points less than the number of members who speak Asian/Pacific languages. A further analysis of members and practitioners who speak Spanish and Asian/Pacific languages was reviewed. There are 10.88% of members who speak only Spanish, however several members who speak Spanish (28.77%) also speak English (17.89%). There are 167 PCPs and 172 specialists who speak Spanish. There are 10.05% of members who speak Asian and Pacific languages. Of these members who speak Asian/Pacific languages, 5.50% also speak English and 4.55% who speak only Asian/Pacific languages. There are 80 PCPs and 66 specialists who speak Asian/Pacific languages. The Plan has an adequate number of practitioners who speak Spanish and Asian/Pacific languages to treat its membership. There are 339 practitioners who speak Spanish and 146 speaking Asian/Pacific (Mandarin).

UHCCP CA works diligently to contract with providers and specialists who represent cultures representative of the Plan's Medi-Cal population. While UHCCP CA did not have an insufficient number of Chinese language speaking providers the Network Department reviewed providers within Federally Qualified Health Centers (FQHC) and confirmed providers within the FQHCs spoke Chinese languages. Through this review, the Network Department was able to update their records to ensure adequate representation and compliance with State regulation. The Plan will continue to outreach to providers and assess their linguistic capabilities with the intent of providing a culturally and linguistically appropriate provider network. In addition, UHCCP CA makes available interpreter services to members in need of a provider who meets their cultural and linguistic needs.

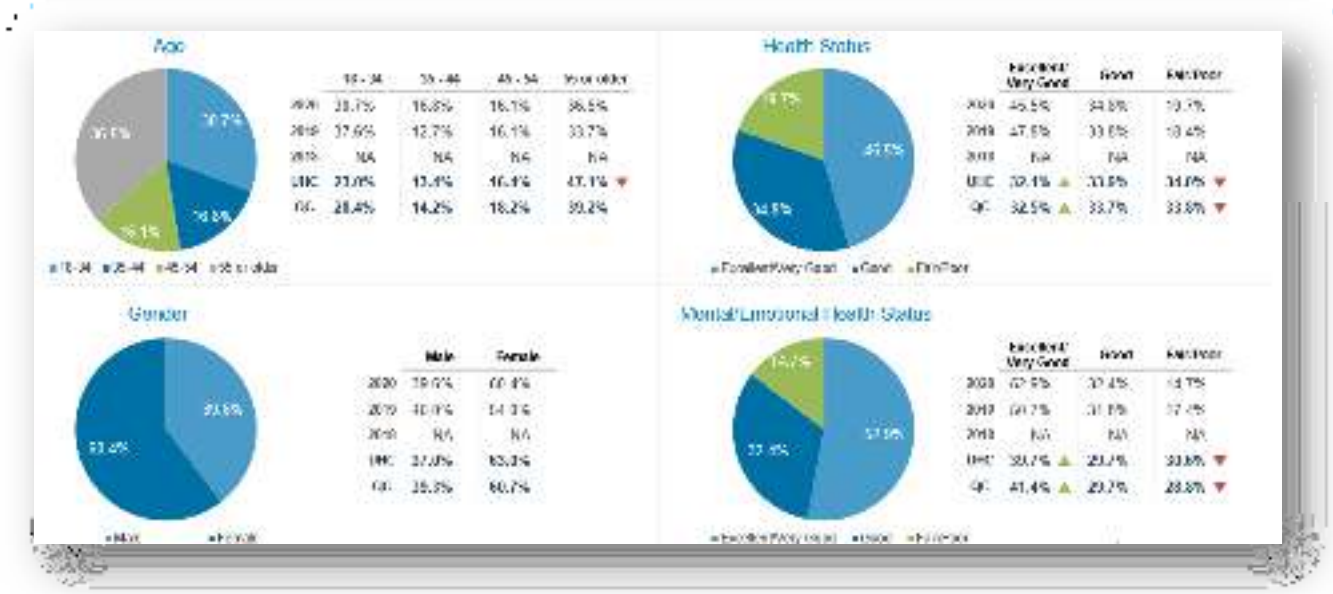
UnitedHealthcare continually supports our practitioners in their efforts to provide culturally appropriate care by providing cultural competency training and language services to effectively communicate with our members. Language assistance is available to help providers communicate with members. Services include a telephone language line and in-person interpreters. UHCCP CA offers Relay services (TTY) to assist members who are deaf or hard-of-hearing. We also have tools to promote cultural awareness and assist practitioners in recognizing and treating health disparities. Practitioners are notified of the availability of tools via the Network Bulletin. Tools are located at https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html

C. UnitedHealthcare Community Plan of California CAHPS® Survey

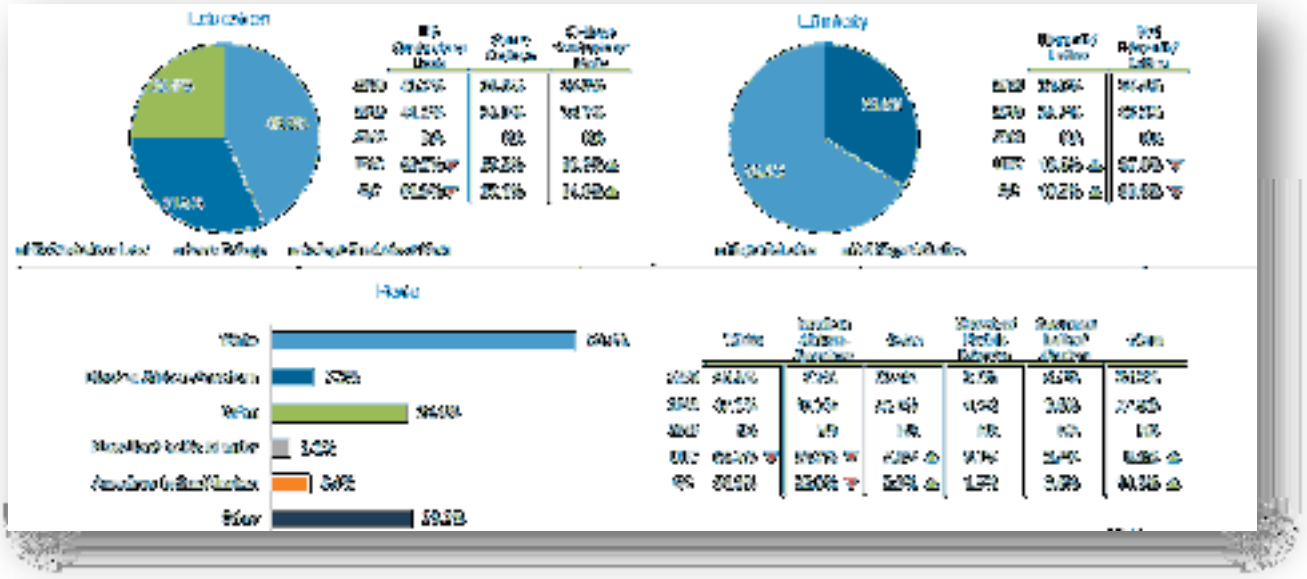
UnitedHealthcare Community Plan of California CAHPS® Survey

UHCCP CA participated in its second CAHPS® survey from February 7, 2020 through May 29, 2020. The Survey was used to accurately capture customer feedback and expand on the scope of information gathered relative to quality of care issues. UHCCP CA surveys member satisfaction with access to practitioners who speak their language and understand their culture via CAHPS®®. The CAHPS® vendor followed NCQA protocol to achieve survey responses from the demographic characteristics of the Plans member population. The survey

demographics of respondents for this survey are detailed in the tables below.



Data Source: CAHPS reports



Data Source: CAHPS reports

Surveys were collected via a mail and phone methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who had been continuously enrolled in the plan for at least five of the last six months of the measurement year. There were 1,596 eligible members and 141 (102 mail and 39 phone) members completed the survey.

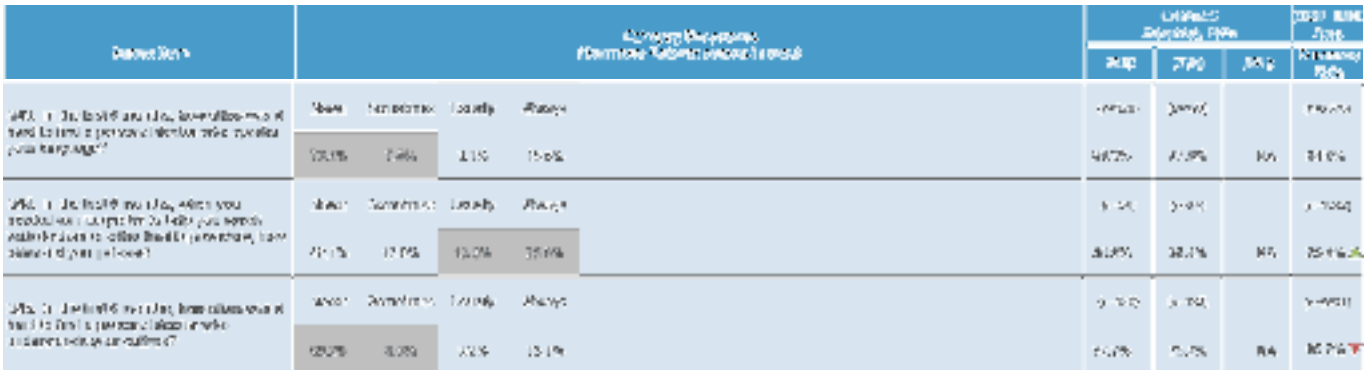
Additionally, respondents were given the option of completing the survey in Spanish. Two telephone surveys were completed in Spanish and none were completed by mail. UHCCP CA partnered with the National Population Health, UnitedHealthcare Clinical Services team to identify the survey questions and targeted population, and plan operations for survey delivery and analysis of the results.

Participants were asked to share their perspectives in the following areas:

- Health Plan Overall
- Health Care Overall
- Personal Doctor Overall
- Specialist Overall
- Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Shared Decision-Making Health Promotion and Education Coordination of Care

As such, the following supplemental questions were selected to identify language or cultural barrier(s):

1) Hard to find a doctor who speaks your preferred language
2) Got an interpreter when needed
3) Hard to find a doctor who understands your culture



Data Source: CAHPS reports

UHCCP CA developed improvement actions and were able to assess important aspects of members' healthcare needs based on comments from adult consumers across the country with health insurance coverage. Comments that were reflective of health education and promotion, language, or cultural needs included:

I. *"To me it's all about clarity. It's important that benefits be detailed in understandable language."*
II. *"My doctors really go out of their way for my health needs. I get follow-up calls and receive information about nutrition in the mail that I did not expect. This is the result of the conversation that I had with my doctor during my appointment. I thought that was very nice and showed that my doctor is attentive to what I say and cares about not only my health but me as a person."*
III. *"The doctor was helpful in explaining my situation and made the right medication choice to take care for my needs."*
IV. *"Take more time to talk to me, follow-ups by email or phone would be great too."*
V. *"My doctor is very caring and mostly listens to/believes me, which I feel can be a problem with doctors when they don't do these things."*
VI. *"I visited a foot specialist that said nothing to me after his exam. He did not offer me any advice or information, just submitted a short report to my primary."*
VII. *"My doctor always goes over things on my visit and answers my questions fully and in easy-to-understand language."*
VIII. *"After that appointment, she called to follow up and to make sure I understood everything that the other doctor found. She was fantastic!"*

IX. *"When I was scheduled for a specific procedure and didn't quite understand what it entailed, my doctor would draw a diagram to demonstrate what would take place."*
X. *"My physician told me to take the prescriptions as needed. She even handed me a guide as to how many times I should take it and the span of time I will have to take the prescription. She mentioned also the effect and implications of the medication."*
XI. *"I didn't find any forms hard, but they were repetitive. They asked the same questions, birthday, age, etc., over and over again. I wish they would make forms that didn't require having to put in the same thing on every page."*
XII. *"The materials should list what providers I can see in the network or out of the network, and how that will affect my coverage."*
XIII. *"I had a customer service representative that was very kind and patient with me. All of my questions I had related to my health plan were answered and explained in detail. I felt welcomed and appreciated."*

Additionally, it is worth noting that the Medical Assistance with Smoking and Tobacco Use Cessation was the only section in which all questions were rated below the 8th percentile.

i. Q: Advising smokers and tobacco users to quit
ii. Q: Discussing cessation medications
iii. Q: Discussing cessation strategies

Out of 1,596 eligible members, 141 (8.8%) completed the CAHPS Survey. This was a decrease from 2019, which had a 13% response rate. Response rate is an important indicator of quality and this low level of participation suggests considerable challenges for UHCCP CA. It is important to note that sampling bias may result which can lead to questionable reliability and validity of survey results.

The onset of the COVID-19 pandemic presented UHCCP CA with unique challenges and limitations in administering the 2020 CAHPS® 5.0H Medicaid Adult Survey. As such, determining next steps while also considering these survey results, provides UHCCP CA with thoughtful opportunities for improvement. Additionally, only English surveys were mailed to members to complete. If a member spoke Spanish, they had to request the survey in Spanish to complete. UHCCP CA believes that the low Spanish survey completion rate (6%) is not an enough representation of the network. UHCCP CA also has members who speak other primary languages such as Arabic, Tagalog, and Vietnamese. Since surveys were not available in those languages, those member perspectives were not included, which may have an impact on ratings as well.

Looking forward, UHCCP CA remains deeply committed to providing coordinated and collaborative activities and initiatives that promote services for members that are accessible, of high quality, and contribute to positive health outcomes in a cost efficient and effective manner. Based upon the 2020 CAHPS® 5.0H Medicaid Adult Survey for MY 2020, UHCCP CA took steps towards improvement. These include:

- Forming a workgroup to address opportunities for improvement.
- Launching monthly meetings effective September 15, 2020.
- Monitoring trends of grievances related to specialist availability.
- Working with UHC call center and quality improvement specialists to assist providers and clinics with referral management
- Working with Contracting team to add both primary care and specialists to the network.
- Presenting findings at Q3 Quality Management Committee meeting (09/24/2020).

Planned long-term strategies include:

1. Place outbound practice-level phone calls to assess appointment availability among high-impact and high-volume specialty providers.
2. Create member-centric material encouraging healthier living and strong patient-provider relationships and provide to UHCCP CA membership.

3. Develop resources containing broad-based improvement strategies and enhancement recommendations for contracted providers and provider office staff.
4. Work with FQHCs to enhance and encourage onsite wellness activities and other social supports

UHCCP CA will conduct ongoing analysis and evaluation of services and interventions provided to members. Persistent, close, and thoughtful examination of qualitative and quantitative feedback will occur to better understand how it can better meet the needs of the UHCCP CA membership. The next CAHPS® member survey will be completed in 2021.

D. Member Satisfaction Survey, or Net Promoter Score (NPS)

UHCCP CA conducted a member satisfaction survey via the Net Promotor Score (NPS) during 2020. The objectives of the NPS member satisfaction survey are as follows:

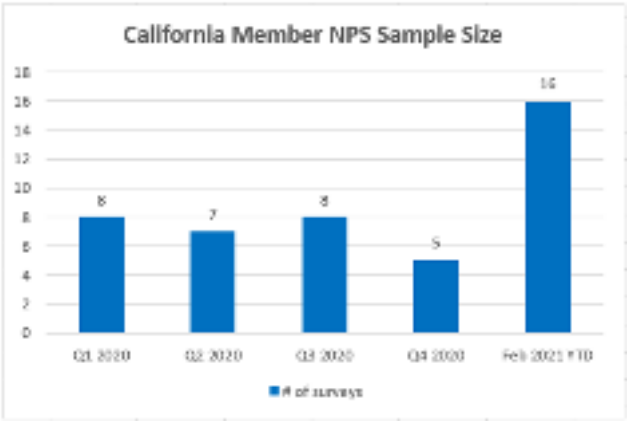
- To expand the UHC focus on member perceptions and experiences;
- To support the growth of member intimacy through easy access to member perception insights; and
- To establish metrics that show UnitedHealthcare's true performance change at the macro level, with the ability to also cut data by micro views

The NPS member satisfaction surveys are completed over the telephone by a contracted vendor, Burke, Inc., an independent market research. The telephone surveys are conducted on a monthly basis and results are published quarterly. The telephone surveys are available in English and Spanish. Members were called by an interviewer on behalf of UHCCP CA over the telephone to ask the member about their overall satisfaction with the Plan and services. Members had the opportunity to respond to two specific questions regarding UHCCP CA's cultural and linguistic services. Below is the question asked by the interviewer for response:

Please tell me how you would rate your health plan on each of the following statements. For each statement, please use a scale from 0 to 10, where 0 means poor and 10 means excellent.

a. *"Gives you materials that are easy to understand"*
b. *"Helps you clearly understand your plan"*

UHCCP CA received 28 responses from the member satisfaction survey conducted throughout 2020. Data analysis indicates that the sample size per quarter were too small (less than 30 responses) to be statistically significant. Below are the NPS Scores per quarter throughout 2020 and YTD 2021. Of note, the tables provide comparative data to other UHC markets.



Data Source: California Member NPS Sample Size

2021 YTD Results:

State Level NPS—Medicaid 1 of 2

UnitedHealthcare

State	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
AZ	71	73	82	66	68	64	67	81	63	56	58	70	76	66	70	61	68
CA	-	-	13	-	-	-29	-	-	13	-	-	40	13	-29	13	40	9
CO	38	84	60	93	53	48	40	67	48	4	64	72	53	65	51	67	54
FL	29	59	61	84	52	82	57	64	60	56	57	58	50	73	60	57	60
HI	-	-	55	-	-	55	-	-	68	-	-	42	56	55	68	42	55
KS	74	65	80	80	87	65	59	59	79	65	48	43	73	77	66	52	67
LA	74	84	79	77	84	77	76	84	72	78	68	78	72	80	77	75	76
MD	71	86	60	50	83	87	81	58	51	77	65	48	66	83	57	63	82
MI	66	56	68	63	59	71	76	56	85	45	57	46	63	64	73	50	82
MO	67	69	61	58	75	68	74	71	71	71	67	47	69	67	72	62	66
MS	72	84	60	84	72	80	77	82	72	66	77	71	65	72	77	72	72

NPS is listed as the primary number with the smaller text below representing the sample size.

Scores listed in red have a sample size of less than 30 and, as a result, are likely to be more volatile from reporting period to reporting period (even at a sample size of 20, one member moving from a 9 (promoter) to a 6 (detractor) on the "likelihood to recommend" question can swing the NPS score by 10 pts). **They are only listed to give directional reference and should not be used as official scores.**

2021 Medicaid State NPS

ST	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Goal
AZ	73	78	-	-	-	-	-	-	-	-	-	-	75	-	-	-	75	70
CA	-	25	-	-	-	-	-	-	-	-	-	-	25	-	-	-	25	17
CO	53	73	-	-	-	-	-	-	-	-	-	-	63	-	-	-	63	57
FL	59	60	-	-	-	-	-	-	-	-	-	-	59	-	-	-	59	62
HI	-	100	-	-	-	-	-	-	-	-	-	-	100	-	-	-	100	58
KS	73	66	-	-	-	-	-	-	-	-	-	-	70	-	-	-	70	69
KY	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	50
LA	82	71	-	-	-	-	-	-	-	-	-	-	77	-	-	-	77	78
MD	63	53	-	-	-	-	-	-	-	-	-	-	58	-	-	-	58	64
MI	61	53	-	-	-	-	-	-	-	-	-	-	57	-	-	-	57	64
MO	76	65	-	-	-	-	-	-	-	-	-	-	71	-	-	-	71	68
MS	79	68	-	-	-	-	-	-	-	-	-	-	73	-	-	-	73	74
NC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	50
NE	91	53	-	-	-	-	-	-	-	-	-	-	73	-	-	-	73	63
NJ	52	70	-	-	-	-	-	-	-	-	-	-	60	-	-	-	60	59
NV	52	31	-	-	-	-	-	-	-	-	-	-	42	-	-	-	42	63
NY	58	71	-	-	-	-	-	-	-	-	-	-	64	-	-	-	64	55
OH	62	56	-	-	-	-	-	-	-	-	-	-	59	-	-	-	59	62
PA	55	61	-	-	-	-	-	-	-	-	-	-	58	-	-	-	58	59
RI	63	60	-	-	-	-	-	-	-	-	-	-	62	-	-	-	62	61
TN	69	63	-	-	-	-	-	-	-	-	-	-	66	-	-	-	66	75
TX	77	63	-	-	-	-	-	-	-	-	-	-	71	-	-	-	71	81
VA	57	47	-	-	-	-	-	-	-	-	-	-	52	-	-	-	52	58
WA	68	54	-	-	-	-	-	-	-	-	-	-	61	-	-	-	61	52
WI	60	73	-	-	-	-	-	-	-	-	-	-	66	-	-	-	66	62

Data Source: State Level NPS – Medicaid

2020 Results:

UHCCP CA conducted an analysis in 2020 for an average NPS score. Overall, results indicate that the total NPS member sample size of 28 resulted in an NPS of 9 which demonstrated to fall significantly below the enterprise Medicaid goal, NPS 67.

Per the NPS Comparative Results 2019-2021 in the table below, when members were asked to rate whether or not the Plan "Has written materials that are easy to understand", the score was 64%, a 14% increase rate compared to the year prior; and when asked to rate the Plan on "Helps me clearly understand my plan," the score was 57%, a 9% increase rate compared to the year prior. The table below highlights the percent of scores ranked from 9 or 10 on a 10-point Likert scale. There were no pertinent issues identified to health education, cultural and linguistics, or language assistance based on member responses. Historically, UHCCP CA identified limitations to the Member Satisfaction Survey conducted as less than 30 members responded from quarter to quarter, and the data and trending is limited to test for statistically significant results.

Data Source: NPS Comparative Results 2019 - 2021

In addition to the scores on these questions, UHCCP CA gives members the opportunity to provide any qualitative feedback that can help us better serve our members. This feedback was reviewed, and no issues were identified pertinent to our health education, cultural and linguistics, and language assistance programs from all related questions asked on the telephone survey.

4. Health Disparities

A. <u>Analysis of DHCS Health Disparities Rate Sheets</u>

Per Supplement to All Plan Letter 19-017 Quality and Performance Improvement Requirements, DHCS selects a set of performance measures, referred to as MCAS measures to evaluate the quality of care delivered by a

Managed Care Plan (MCP) to its beneficiaries. The MCAS measures are comprised of select Centers for Medicare and Medicaid Services' (CMS) Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets). Many of these measures are also part of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®). Although 2017 data was not reported, UHCCP CA did report 2018 HEDIS rates which serve as baseline data for NCQA measures. All rates were tracked and trended for comparative analysis for 2018, 2019, and 2020 measurement years.

In addition to the Plan's analysis, the Health Services Advisory Group (HSAG) created a health disparities data file using reported HEDIS® rates for all Managed Care Plans (MCP) on behalf of the CA DHCS. The CA DHCS provided all health plans with their specific health disparities data for reporting year (RY) 2020 reflecting measurement year (MY) 2019 and member level DHCS demographic information with stratified rates. The data file included a compilation of unweighted Medi-Cal Managed Care Accountability Set (MCAS), a set of performance measures that DHCS selects for annual reporting by Medi-Cal MCPs indicator data collected for a reporting year.

Due to the COVID-19 pandemic, both the CA DHCS and the National Committee for Quality Assurance (NCQA) allowed MCPs to rotate hybrid measures, such as, reporting (MY) 2018 audited hybrid rates for (MY) 2019. As a result of these allowances, the CA DHCS confirmed that not all MCPs provided member-level information in the patient-level detail files for (RY) 2020 (MY) 2019. Given the differences in how each MCP reported their hybrid measures for (RY) 2020 (MY) 2019 and the missing member level information in the member level detail files for some MCPs, the CA DHCS and HSAG limited the 2019–2020 Health Disparities analysis to 10 administrative MCAS indicators.

Results for each HEDIS® measure reported in 2018, 2019, and 2020 are reflected in the table below. Of the 33 total measures reported, 8 (24%) measures increased from the 2019 baseline rates. For Measurement Year 2019, 18 measures, UHCCP CA met nine (9) of these measures including: AMM- Acute, AMM-Cont, CHL, CDC-H9, CBP, PPC-Pre, PPC-Post, WCC-BMI. Of the 19 MCAS measures reported for Measurement Year 2020, 8 (42%) measures met the MPL of the HEDIS® 50th percentile. This was a slight decrease from the 9 of 18 (50%) measures met for Measurement Year 2019.

C&S Accreditation Measures		State Measure Yes/No	Rate/Accreditation Percentile HEDIS® Year				YOY Change (2019-2020)	2020 Goal	2020 Goal Met/ Not Met
			2017	2018	2019	2020			
Antidepressant Medication Management (AMM)	Acute Phase Treatment	Yes	N/A	66.67	63.30	54.91	↓8.39	53.57	Met
	Continuation Treatment	Yes	N/A	33.33	41.28	36.99	↓4.29	38.18	Not Met
Ambulatory Care: Emergency Department (ED) Visits (AMB-ED)		No	N/A	N/A	N/A	N/A	N/A	58.14	N/A
Concurrent Use of Opioids and Benzodiazepines (COB)		No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Asthma Medication Ratio (Total Rate) (AMR)		Yes	NA	N/A	85.71	57.58	↓28.13	62.43	Not Met
Screening for Depression and Follow-Up Plan (CDF)		No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Breast Cancer Screening (BCS)		Yes	N/A	N/A	33.33	53.57	↑20.24	58.82	Not Met
Cervical Cancer Screening (CCS)		Yes	N/A	45.83	50.61	52.55	↑1.94	61.31	Not Met

C&S Accreditation Measures		State Measure Yes/No	Rate/Accreditation Percentile HEDIS® Year				YOY Change (2019-2020)	2020 Goal	2020 Goal Met/ Not Met
			2017	2018	2019	2020			
Childhood Immunization Status (Combination 10) (CIS)		Yes	N/A	0.00	27.27	40.27	↑13.00	37.47	Met
Chlamydia Screening in Women (Total Rate) (CHL)		Yes	N/A	66.67	68.57	62.05	↓6.52	58.44	Met
Controlling High Blood Pressure (CBP)		Yes	N/A	63.54	64.44	55.96	↓8.48	61.80	Not Met
Comprehensive Diabetes Care (CDC)	Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%)	Yes	N/A	47.54	33.65	43.09	↑9.44	37.47	Not Met
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)		Yes	N/A	100	92.59	85.57	↓7.02	82.09	Met
Follow-Up for Children Prescribed ADHD Medication (ADD)	Initiation	No	N/A	N/A	0.00	28.57	↑28.57	42.95	SD
	Continuation	No	N/A	N/A	N/A	0.00	0.00	54.73	SD
Immunizations for Adolescents (Combination 2) (IMA)		Yes	N/A	N/A	29.82	28.85	↓0.97	36.86	Not Met
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total) (APM)		Yes	N/A	N/A	N/A	SD	N/A	35.43	N/A
Contraceptive Care—All Women (CCW)	Long Acting Reversible Contraception (LARC)	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Most or Moderately Effective Contraception (MMEC)	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care—Postpartum Women (CCP)	LARC – 3 Days	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	LARC – 60 Days	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	MMEC – 3 Days	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	MMEC – 60 Days	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal	Yes	N/A	75.34	89.01	87.85	↓1.16	89.05	Not Met
	Post-Partum	Yes	N/A	56.16	74.87	79.76	↑4.89	76.40	Met
Developmental Screening in the First Three Years of Life (DEV)		No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Plan All-Cause Readmissions (PCR)		No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Use of Opioids at High Dosage in Persons Without Cancer (OHD)		No	N/A	N/A	N/A	N/A	N/A	N/A	N/A

C&S Accreditation Measures		State Measure Yes/No	Rate/Accreditation Percentile HEDIS® Year				YOY Change (2019-2020)	2020 Goal	2020 Goal Met/ Not Met
			2017	2018	2019	2020			
Weight Assessment and Counseling for Nutrition, Physical Activity for Adolescents (All Three Rates) (WCC)	WCC – BMI Percentile – Total	Yes	N/A	74.78	86.13	83.57	↓2.56	80.50	Met
	WCC – Counseling for Nutrition - Total	Yes	N/A	67.83	77.62	72.51	↓5.11	71.55	Met
	WCC – Counseling for Physical Activity – Total	Yes	N/A	64.35	74.94	71.78	↓3.16	66.79	Met
Well-Child Visits in the First 30 Months of Life (W30) – Total (New in 2020 – Formally known as W15)		Yes	N/A	N/A	N/A	28.78	↑28.78	N/A	Not Met
Child and Adolescent Well-Care Visits (WCV) (New in 2020 – Combination of AWC & W34)		Yes	N/A	N/A	N/A	22.94	↑22.94	N/A	Not Met

Data Source: HEDIS® report as submitted to NCQA for Reporting Years 2019 and 2020

Furthermore, UHCCP CA conducted a data analysis of the (RY) 2020 health disparities data file. The data reflects a limited set of UHCCP CA's HEDIS® priority measures due to the COVID-19 allowances allowed by the CA DHCS and NCQA. Note that analysis of data for Measurement Year 2020 was pending at time of preparing this report as final rates were validated in June 2021 and submitted to NCQA in mid-June. The Plan can report the RY 2021 MCAS measures falling below the MPL as follows:

1) Antidepressant Medication Management – Continuation Treatment
2) Asthma Medication Ratio
3) Breast Cancer Screening
4) Cervical Cancer Screening
5) Controlling High Blood Pressure
6) Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)
7) Metabolic Monitoring for Children and Adolescents on Antipsychotics Well-Child Visits in the 3rd 4th 5th & 6th Years of Life
8) Prenatal and Postpartum Care – Timeliness of Prenatal
9) Child and Adolescent Well-Care Visits (MPL not released by DHCS)
10) Immunizations for Adolescents – Combo 2
11) Well-Child Visits in the First 30 months of Life (MPL not released by DHCS)

UHCCP CA focused on analyzing health disparate populations among the following HEDIS® priority measures that each MCP is held accountable for to the MPL, including: AMM-Acute, AMM-Cont, AMR, BCS, and CHL. The MPL was based on the CA DHCS MCAS for MCPs RY 2020 (MY 2019).

The Plan categorized the HEDIS® priority measures under the following chronic disease illness and preventive care measures including behavioral health, asthma, and women's health measures. The Plan also completed a data analysis of additional measures that may contribute to the identification and findings of health disparities population(s).

a. **Behavioral Health HEDIS® Measures**

Antidepressant Medication Management: Acute Phase Treatment (AMM-Acute). UHCCP CA met the MPL for the measure AMM-Acute with an overall care gap closure of 89.01%. Among the 109 members that had a HEDIS® care gap for this measure, members were predominantly 18-64 years of age. UHCCP CA observed a higher denominator of females (n=67; 64.18%) compared to their counterpart, males (n=42; 61.90%) with a higher HEDIS® care gap closure rate of 64.18% compared to males, 61.90%. The population for this measure comprised of predominantly English-speaking members (n=97; 63.92%) whose race and/or ethnicity was predominantly identified as Other (n=39; 82.05%), or White (n=36; 61.11%).

	Numerator	Denominator	Rate
AMM–Acute			
Age			
18–64 Years	63	101	62.38%
65+ Years	6	8	75.00%
Gender			
F	43	67	64.18%
M	26	42	61.90%
Language			
English	62	97	63.92%
Spanish	3	5	60.00%
Chinese	1	3	33.33%
Arabic	1	2	50.00%
Farsi	1	1	100.00%
Other	1	1	100.00%
Race/Ethnicity			
Other	32	39	82.05%
White	22	36	61.11%
Hispanic or Latino	7	21	33.33%
Asian	5	8	62.50%
Black or African American	3	4	75.00%
American Indian or Alaska Native	0	1	0.00%
Total			
All	69	109	63.30%

Data Source: DHCS Health Disparities Rate Sheet

Antidepressant Medication Management: Continuation Phase Treatment (AMM-Cont). UHCCP CA met the MPL for the measure AMM-Cont with an overall care gap closure of 41.08%. Among the 109 members that had a HEDIS® care gap for this measure, members were predominantly 18-64 years of age. UHCCP CA observed a higher denominator among female members (n=67; 41.79%) compared to their counterpart, males (n=42; 40.48%) with a slightly higher HEDIS® care gap closure rate of 41.79% compared to males, 40.48%. The population for this measure comprised of predominantly English-speaking members (n=97; 42.27%) whose race and/or ethnicity was predominantly identified as Other (n=39; 53.85%), or White (n=36; 44.44%).

	Numerator	Denominator	Rate
AMM–Cont			

Age			
18–64 Years	40	101	39.60%
65+ Years	5	8	62.50%
Gender			
F	28	67	41.79%
M	17	42	40.48%
Language			
English	41	97	42.27%
Spanish	2	5	40.00%
Chinese	1	3	33.33%
Arabic	0	2	0.00%
Farsi	1	1	100.00%
Other	0	1	0.00%
Race/Ethnicity			
Other	21	39	53.85%
White	16	36	44.44%
Hispanic or Latino	4	21	19.05%
Asian	1	8	12.50%
Black or African American	3	4	75.00%
American Indian or Alaska Native	0	1	0.00%
Total			
All	45	109	41.28%

Data Source: DHCS Health Disparities Rate Sheet

b. Asthma HEDIS® Measure

Asthma Medication Ratio (Total Rate) (AMR). UHCCP CA neither met nor did not meet the MPL for the AMR total measure. The sample size was too small to determine applicability (<30); therefore, the measure was not applicable and non-reportable to the CA DHCS. However, UHCCP CA observed that among the 7 members that had a HEDIS® care gap for this measure, members were predominantly 19-50 years of age. UHCCP CA observed a higher denominator among male members (n=5; 80.00%) compared to their counterpart, females (n=2; 100.00%)); however, there was a higher HEDIS® care gap closure rate of 100.00% compared to males, 80.00%. The population for this measure comprised of predominantly English-speaking members (n=7; 42.27%) whose race and/or ethnicity was predominantly identified as White (n=5; 80.00%) or Other (n=2; 100.00%).

	Numerator	Denominator	Rate
AMR–Tot			
Age			
5–11 Years	2	2	100.00%
19–50 Years	4	5	80.00%
Gender			
F	2	2	100.00%
M	4	5	80.00%
Language			

English	6	7	85.71%
Race/Ethnicity			
White	4	5	80.00%
Other	2	2	100.00%
Total			
All	6	7	85.71%

Data Source: DHCS Health Disparities Rate Sheet

c. Women's Health HEDIS® Measure

Breast Cancer Screening (BCS). UHCCP CA neither met nor did not meet the MPL for the BCS measure. The sample size was too small to determine applicability (<30); therefore, the measure was not applicable and non-reportable to the CA DHCS. However, UHCCP CA observed that among the 3 members that had a HEDIS® care gap for this measure, female members were predominantly 50-64 years of age. There was an overall HEDIS care gap closure rate of 33.33%. The population for this measure comprised of predominantly English-speaking members (n=3; 33.33%) whose race and/or ethnicity was predominantly identified as White (n=2; 50.00%).

	Numerator	Denominator	Rate
BCS			
Age			
50–64 Years	1	3	33.33%
Gender			
F	1	3	33.33%
Language			
English	1	3	33.33%
Race/Ethnicity			
White	1	2	50.00%
Asian	0	1	0.00%
Total			
All	1	3	33.33%

Data Source: DHCS Health Disparities Rate Sheet

Chlamydia Screening in Women (Total Rate) (CHL). UHCCP CA met the MPL for the measure CHL with an overall care gap closure of 68.57%. Among the 245 members that had a HEDIS® care gap for this measure, female members were predominantly 21-24 years of age with a HEDIS® care gap closure rate of 68.57%. The population for this measure comprised of predominantly English-speaking members (n=202; 67.82%) whose race and/or ethnicity was predominantly identified as Other (n=79; 69.62%), or Hispanic or Latino (n=71; 77.46%).

	Numerator	Denominator	Rate
CHL–Tot			
Age			
16–20 Years	60	90	66.67%
21–24 Years	108	155	69.68%
Gender			
F	168	245	68.57%

Language			
English	137	202	67.82%
Spanish	24	33	72.73%
Other	4	4	100.00%
Chinese	1	3	33.33%
Tagalog	1	2	50.00%
Korean	1	1	100.00%
Race/Ethnicity			
Other	55	79	69.62%
Hispanic or Latino	55	71	77.46%
White	35	57	61.40%
Asian	9	20	45.00%
Black or African American	12	14	85.71%
Unknown/Missing	2	3	66.67%
Native Hawaiian or Other Pacific Islander	0	1	0.00%
Total			
All	168	245	68.57%

Data Source: DHCS Health Disparities Rate Sheet

B. Additional HEDIS® Measures Considered to Identify Health Disparate Populations

UnitedHealthcare Community Plan of California (UHCCP CA) is committed to address any health disparities associated with our member's age, gender, address, race and ethnicity, language and disability; and overall, social determinants of health to reduce health disparities and improve our member's quality of health and the community they live in. In a deliberate effort to enhance health plan offerings and potentially tailor health education, cultural and linguistic, and member engagement program planning to disparate groups for the upcoming year 2021, an analysis was conducted to identify any such opportunities (Refer to Health Education and Cultural and Linguistics Programs Health Disparities Study, 2021).

The following measures were selected for additional analysis based on not having met the MPL for either measurement year 2019 or 2020.

1) Adolescent Well Care Visits
2) Cervical Cancer Screening
3) Childhood Immunization Status – Combo 10
4) Immunizations for Adolescents – Combo 2
5) Well-Child Visits in the 3rd 4th 5th & 6th Years of Life
6) Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits

Results for each analysis are reported below. Specifically, the Plan assessed statistical significance between populations for Demographic categories such as age, race and ethnicity.

Adolescent Well Child (AWC).
All demographic categories with a rate lower than the overall AWC HEDIS rate were found *not statistically significant at p<.05.*

Demographic categories were tested again for statistical significance determined at p<.10. Only one category, Age Band 16-20 was found to be statistically *significant with a p-value of .078893.* This indicates

that members in this age band are less likely to complete their well child examination than other age bands observed and there may be opportunity to target this group with a tailored intervention.

Cervical Cancer Screening (CCS).
All demographic categories with a rate lower than the overall CCS HEDIS rate were tested for statistical significance determined at p<.05. Only one category, Age Band 21-25, was found to be *statistically significant with a p-value of .000017.* This indicates that members within this age band are less likely to complete their cervical cancer screening than other age bands observed, presenting opportunity for tailored intervention.

Demographic categories were tested again for statistical significance at p<.10. *Two categories were found to be statistically significant; Age Band 21-25 with a p-value of .000017 and Age Band 36-40 with a p-value of .097007.* This indicates that members within these age bands are less likely to complete their cervical cancer screening than other age bands observed, presenting opportunity for tailored intervention.

Childhood Immunization Status (CIS). All demographic categories with a rate lower than the overall CIS-10 HEDIS rate were found to be *not statistically significant at p<.05.*

Demographic categories were tested again to assess significance at a p-value <.10 and were also found to be *not statistically significant at p<.10.*

Immunizations for Adolescents – Combo 2 (IMA-2).
All demographic categories with a rate lower than the overall IMA-2 HEDIS rate were found *not statistically significant at p<.05.*

Demographic categories were tested again for statistical significance at p<.10 and were also found *not statistically significant at p<.10.*

Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life (W34).
All demographic categories with a rate lower than the overall W34 HEDIS rate were found to be *not statistically significant at p<.05.*

Demographic categories were tested again to assess significance at a p-value <.10 and were also found to be *not statistically significant at p<.10.*

Well-Child Visits in the First 15 Months of Life – Six or more visits (W15).
All demographic categories with a rate lower than the overall W15 HEDIS rate were found *not statistically significant at p<.05.*

Demographic categories were tested again for statistical significance at p<.10 and were also found *not statistically significant at p<.10.*

Overall results do not indicate statistically significant results to indicate health disparities between compliant and noncompliant members for the selected HEDIS measures of focus. While there were three age groups among the selected measures which did show statistical significance, when comparing the other demographic components of each population the results are still parallel to the overall member population. Based on these analyses, we can conclude that populations noted as non-compliant for the specific measure are not less or more likely to close the gap based on the following demographic categories including age, gender, race, ethnicity, language, enrollment and zip code.

Data Analysis

UHCCP CA has experienced noteworthy membership growth; however, the population is still quite small. This can be a limitation when analyzing per HEDIS measure. Due to these smaller populations, UHCCP CA will continue its strategy to engage members while being cost effective in addressing care gaps to target all members with care gaps rather than based on specific demographic categories per measure whenever possible. Through 2021, UHCCP CA will continue to monitor demographic data within health education, cultural and linguistic, and member engagement program initiatives to keep sight of opportunities for future programs.

Based on these results, the Plan has identified 2019 and 2020 HEDIS® results as a Key Finding. Specifically, the Plan has identified a need to focus on member engagement using a variety of culturally and linguistically appropriate programs that are offered in the member's preferred language and include language and images that are representative of the culture in which members can identify. Refer to the Action Plan table.

5. Health Education, C&L, and/or Quality Improvement Program Gap Analysis

The following sections contain summaries of Health Education, Cultural and Linguistic, and Quality Improvement programs and interventions that were implemented during the measurement period.

A. Access to Care

The quantitative and qualitative data UHCCP CA analyzed was derived from various access to care surveys, such as the member and provider satisfaction surveys. Data analysis demonstrated that there are gaps in our services, including the way we conduct our surveys to our members. It was an identified gap in service to only have our NPS surveys conducted by representatives that do not speak their language nor understand their culture; members are not satisfied with taking a survey over the phone in a different language that is not their preferred language.

Currently, our NPS surveys and CAHPS® surveys are only available in English and Spanish. The Plan will continue to explore solutions to increase NPS and CAHPS® surveys, including providing an opportunity to complete the survey in the member's preferred language. Members have also expressed an interest to have more simplified versions of member informing materials that are currently 100 to 200 pages in length. UHCCP CA will continue to work to simplify communication with our members and ensure a different format is available for download that better aligns with the newly released California Department of HealthCare Services All Plan Letter (APL) 19-003 "Provider Informing Materials to Medi-Cal Beneficiaries in an Electronic Format" released on May 2, 2019. The APL provided Medi-Cal managed care health plans with clarification and guidance regarding the provision of the Provider Directory, Formulary and Member Handbook to Medi-Cal members, materials that are lengthy documents. Going forward having these available for electronic download may improve satisfaction and effectiveness to meet the member's needs.

Additionally, the Plan's 2019 CAHPS®® survey results indicate members were not satisfied with the Plan's network and ability to provide access to practitioners who both spoke the member's language and understood their culture. The result for satisfaction with access to practitioners who spoke the member's language did not meet the goal by 2.22 percentage points. UHCCP CA works to contract with providers and specialists who represent cultures representative of the Plan's Medi-Cal population. Challenges have been identified to contract including delays with the Medi-Cal enrollment process and credentialing limitations bar UHCCP CA from credentialing certain providers who might otherwise meet culture and/or linguistic needs. Certain FQHCs in San Diego County only contract as an IPA and have not been able to be added to the network due to our contracting and reimbursement model. The Plan is working on modifications to our claims system to allow for capitation agreements. Once complete, the Plan will be able to add additional FQHC's who have culturally and linguistically

diverse providers. The Plan will continue to outreach to providers and assess their linguistic capabilities with the intent of expanding a culturally and linguistically appropriate provider network. UHCCP CA makes available interpreter services at any point of health care delivery to members in need of a provider who meets their cultural and linguistic needs.

B. Language Needs

With such a diverse membership population, UHCCP CA identified gaps in services beyond providing interpretation over the phone. Specifically, these areas were identified: ensuring prompt provision of interpreter services by maintaining a multi-cultural and multi-linguistic call center; including multiple languages as part of the workflow process for conducting surveys with third party vendors; offering surveys beyond only English and Spanish to at least meet at minimum San Diego County's five identified threshold languages: English, Spanish, Tagalog, Vietnamese, and Arabic; and ensuring UHCCP CA contracts with diverse providers and specialists who represent cultures and languages representative of the Plan's Medi-Cal population. UHCCP CA has partially met our goals of providing cultural and linguistic availability to our members by significantly expanding the network since the inception of the Plan in 2017. Most recently, several Federally Qualified Health Centers, specialists, and Indian Health Services, have also been added to the network. Many of these new additions are verified to speak our member's languages. Additionally, UHCCP CA makes available interpreter services to members in need of a provider who meets their cultural and linguistic needs. Services include a telephone language line and in-person interpreters. UHCCP CA offers Relay services (TTY) to assist members who are deaf or hard-of-hearing. However, UHCCP CA also identified the need for on-demand video interpretation.

C. Cultural and Linguistic Competency

One of the needs that our members have reported is to have more providers who represent their culture and meet their language needs. If the clinician and the patient do not speak the same language, the availability and choice of interpreters is crucial to getting the member to visit the doctor's office and have a successful interaction. UHCCP CA has a large Hispanic or Latino and Spanish speaking population, as mentioned earlier. Culturally, when this population seeks primary care, building rapport with the patient is very important as it begins with an "exchange or pleasantries" or small conversation before moving on to taking down the patient's medical history and the physical exam. A personalism becomes an important quality patients seek in Providers for their care and will often expect health care personnel to be warm and personal. Members often express a strong need to be treated with dignity (Gallagher-Thompson, Talamantes, Ramirez, Valverde, 1996; Villa et al., 1993). As such, cultural and linguistic competency training is important to the success of Providers becoming more aware of who they serve while delivering the upmost respect in their care to our members. UHCCP CA offers tools to promote cultural awareness and assist practitioners in recognizing and treating health disparities. Practitioners are notified of the availability of tools via the Network Bulletin. Tools are located at https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html

D. Health Education

Through the health disparities analysis, UHCCP CA identified a need to educate our members in preventive care, illness and disease, and self-care management. More education, awareness and preventive practices need to be culturally and linguistically targeted at the Asian and Hispanic or Latino populations in order to improve the current health status. Additionally, the plan identified a need to develop health education materials that address the topics of contraception, pre-pregnancy planning/pregnancy prevention and complementary/alternative medicine. Thus, successful health education programs will need to include the following characteristics: use of cultural and linguistics community representatives/interpreter, or peer health educators; use of cultural lay health workers/interpreters, peer health educators; interventions that bridge the identified language and cultural gaps; decrease of cultural health barriers among our diverse populations to improve their health knowledge about chronic disease conditions and incorporating preventive health strategies; a more tailored

approach to a diverse audience (Tran & Hinton, 2010). Based on this research and feedback obtained from members, the Plan developed a Health Education program including classes, programs, and member engagement.

a. **Health Education Classes**

In 2020, UHCCP CA continued health education classes on the topics of Chair Yoga, a Cooking Demonstration, Child Health, Women's Health, COVID-19 Update, and Diabetes. As in 2019, due to staffing and budget limitations, UHCCP CA partnered with Champions for Health (CFH), a not-for-profit Live Well San Diego Speaker's Bureau organization whose focus is improving health and changing the lives of San Diego County residents. Champions for Health offered tailored presentations for all audience ages and interests and recruited expert speakers for the health education classes. Unlike the previous calendar year, 2019, UHCCP CA was unable to offer in-person health education classes due to the COVID-19 public health emergency. As a result, health education classes were planned and offered via a virtual platform, Zoom, and the plan's CFH partners provided their expertise in the delivery of virtual health education classes. A total of 12 health education classes were offered in English and Spanish on various weekdays during the early afternoon hours.

UHCCP CA tracked and trended class attendance. Overall, attendance was low, a total of 23 participants among all 12 health education classes (n= 4 UHCCP CA members; n=19 non-members). When compared to 2019, the total participants increased only slightly from 19 to 23, with number of members remaining the same (n=4).

During registration for the classes, participants were prompted to answer a series of questions:

- Q1: Contact Information – Name, Home Address, Email Address, and Phone Number
- Q2: Are you a member of UnitedHealthcare Community Plan of California? (You do not need to be a member to participate)
- Q3: Do you wish to be contacted by United Healthcare for future events?
- Q4: How did you hear about this event? (for example, a food drive, through work, etc.)

Overall results indicate that a total of 59 members and non-members registered to the health education classes. Among the 59 members, 48 (81%) registrants were predominantly English speaking compared to 11 (19%) Spanish speaking registrants. The top three predominant zip codes among our registrants were in the cities of San Diego (92114, 92130) and Chula Vista (91910). Additionally, below are the findings from Questions 2 and 3 of the survey. Results indicate that all 59 registrants responded to these questions. For Question 2, "Are you a member of UnitedHealthcare Community Plan of California?" A total of 18 registrants indicated they are a UHCCP CA member compared to 28 non-members. A total of 11 registrants indicated they do not know if they are a UHCCP CA member, and 2 registrants chose not to answer. For Question 3 "Do you wish to be contacted by UnitedHealthcare for future events?" a total of 37 registrants indicated they would like to be contacted by UHCCP CA; a total of 20 registrants indicated they do not want to be contacted by UHCCP CA for future events; 0 registrants responded they did not know; and 2 registrants chose not to answer.

Results indicate low class participation rate and shows underutilization of the services offered during Quarter 4, 2020. This could be attributed to the impact of COVID-19. UHCCP CA had originally planned to conduct in-person health education classes; however, due to the public health emergency, the Plan shifted implementation of in-person classes to a digital platform, Zoom. UHCCP CA will need to consider the digital divide and digital setting exhaustion during COVID-19 for calendar year 2021. We also considered that class-like settings may not be preferred by the members and community. Certainly, lack of awareness of this new offering also contributed to low participation. Although participation rates

may have been low for both calendar years 2019 and 2020, UHCCP CA observed great attendance in the Chair Yoga and Cooking Demonstration classes for this reporting year. These classes were the most popular topics among our members and non-members when compared to other topics offered. UHCCP CA will consider expansion of these and similar interactive topics for calendar year 2021. Additionally, there is a need to expand health education class promotion via mailing. Such mailings should be conducted in a timely manner and take into consideration a series of mailings or frequency-based mailing rather than a single mass mailing based on feedback from stakeholder committee members.

In conclusion, the study results indicate a low-class participation rate and shows underutilization of the services offered. Some of the barriers identified include:

1) Impact of COVID-19 and state public health emergency;
2) Lack of awareness of the health education classes offered;
3) Offer more interactive classes in between high priority topics, such as Zumba, yoga, cooking classes.

Despite low attendance, member feedback indicates value in continuing to offer the health education classes to our members and non-members. The health education classes keep our members engaged and there is a great opportunity for growth. Based on member feedback obtained at the UHCCP CA Consumer Advisory Committee, the Plan will offer a mailing to members informing them of the annual Health Education class schedule.

UHCCP CA will continue to partner with CFH for the calendar year 2021 and offer similar topics. Due to the continued public health emergency and impact of COVID-19, UHCCP CA and CFH will continue to implement the classes via Zoom. Additionally, the UHCCP CA Quality Department will explore options for cost effective mailings to better engage our members; as well as, offer UHCCP CA branded swag to all class attendees. These changes will help solution for a greater participation rate and impact on closing HEDIS care gaps.

b. **Diabetes Prevention Program**

In 2019, the DHCS released the All Plan Letter – 18-018 Diabetes Prevention Program. As a result, UHCCP CA partnered with Solera Health, Inc., a third-party vendor in March 2019, to deliver and facilitate the Diabetes Prevention Program for our Medi-Cal members on behalf of the Plan. The DPP was successfully and fully implemented in June 2019 and offers the DPP in-person, online and/or digitally. The DPP is offered in English and Spanish, and most recently Solera Health, Inc. has partnered with the Multicultural Health Foundation to expand their DPP provider network by searching for appropriate class locations where the target audience resides and expanding offering the DPP in Tagalog. The Multicultural Health Foundation is a non-profit organization that brings health justice and wellness to the multicultural communities of San Diego County by focusing resources on the most vulnerable populations with community-based wellness strategies, social-clinical interventions, and research that will lead to the elimination of racial and ethnic health disparities.

Since the inception of the DPP through December 2020, UHCCP CA had a total of 125 members who have committed or have an interest in participating in the program.

Overall, the demographic enrollment demonstrates a larger participation rate among females (67%) versus males (33%). The median age of participants is 18-44 years old (45.6%) compared to their counterparts 45-64 years old (50.9%), 65-74 years old (1.8%), and 75+ (1.8%). Data demonstrates that the average physical activity within weeks 1-9 is 196 minutes, an increase from 100 minutes as of year-end 2019. The average weight loss at week 9 is 1.7%, a 0.9% increase from 2019.

Data for year-end 2020 demonstrates that a majority of DPP participants selected to engage with an online DPP provider with 78 compared to 47 members who have committed to an on-site DPP Provider. Of those who committed to an online DPP provider 48 have attended their first core session, 18 attended their first 4 core sessions and 8 attended 9 total core sessions. A total of 5 participants achieved their 5% weight loss goal, zero achieved 9%, and 0 continued to complete 2 core maintenance sessions. Of those who committed to an on-site DPP provider 9 have attended their first core session, 5 attended their first 4 core sessions, and 1 attended 9 total core sessions. Furthermore, of the on-site participants 5 achieved their 5% weight loss goal and 0 achieved 9% weight loss or continued to complete core maintenance sessions.

Due to the COVID-19 public health emergency, Solera Health Inc. suspended their on-site class offerings for the remainder of 2020; however, when comparing the proportion of participants selecting online versus on-site sessions between 2019 and 2020, the data does not demonstrate a significant increase in online participation that may be attributed to COVID-19.

During the Quarter 4 2020, Health Education and Cultural and Linguistics Committee (HECL) meeting, the committee requested an analysis of inpatient costs of members who have participated in the DPP since program start. Inpatient claim and cost data were compared year over year between 2019 and 2020 to identify any trends and results were presented at the Q1 2021 HECL meeting. Although the claims observed were higher in total and average cost, the reasons for hospitalization varied and the member volume was very low. After analysis, there was no correlation made to delay of the onset of Diabetes to compare to the effectiveness of the DPP program. The average cost over 2019 and 2020 was $1,057.53 which is not significantly more than the average cost per member of the DPP program per member at full utilization ($775.00). With these findings, UHCCP CA will not actively monitor this data to assess program effectiveness in the future and instead defer to the performance data provided by Solera Health Inc.

Hospitalization and Cost Comparison Among Enrolled DPP Participants

Data Analysis:

- # of members participating in DPP
- Among these participating DPP members, how many have had inpatient claim(s)
- # of Claims
- Calculate Total Cost
- Calculate Average Cost per member
- Year-over-year

Results:

- No correlation with delay/onset of Diabetes was observed to compare effectiveness of the DPP program
- The average cost per member is almost relative to the total cost of the DPP ($775.00) if a member would complete all sessions including the maintenance sessions

DPP Participant Inpatient Claims and Costs

	2019	2020	Total
DPP Participants*	30	27	57
wIP Claims	6	4	10
# of IP Claims	62	40	102
Avg. IP Claims Per Mbr	7.75	10	10.2
Total Paid	$1,270.93	$6,304.40	$10,575.33
Avg. Paid Per Mbr	$ 530.67	$1,576.10	$ 1,057.53

*19 members completed 1st milestone in 2020, 8 began program in 2019 but continued participation in 2020

Data Source: Claims data January 2019 to December 2020

c. **Tobacco Cessation Program**

Since the inception of the plan in 2017, UHCCP CA has actively promoted the California Smokers' Helpline (1-800-NO-BUTTS) referral and support services. The health plan has had the opportunity to promote the helpline through our member newsletters, health education materials, health plan website, provider newsletter, provider manual, stakeholder meetings (CAC, PAC, and PPC), as well as provided promotional campaigns within a Provider Toolkit project to ensure provider offices are aware of the Medi-Cal service available to our members at no cost.

In partnership with the California Smokers' Helpline, a 2019 baseline report was generated for health plan review and analysis. The report includes self-reported information provided by UnitedHealthcare Medi-Cal beneficiaries participating in the tobacco cessation program. The California Smokers' Helpline collects the data during the intake process.

UHCCP CA conducted an analysis of the data report and identified a total of 137 members participated in the program during 2020, 21 more participants than 2019. The demographic enrollment demonstrates a larger participation rate among females (51.1%) compared to their counterpart, males (48.2%). The largest age group of participants is 65+ years old (48.2%), compared to their counterparts 45-64 years old (36.5%), 25-44 years old (13.1%), 18-24 years old (2.2%), and <18 (0%). Data also indicates that there is a larger participation rate among Caucasian/White members (53.3%), compared to their counterparts, Black/African-American (16.8%); Hispanic/Latino (10.2%); Asian-American/Pacific Islander (2.9%); American Indian/Alaska Native (1.5%); Multi-racial (11.7%); and Other/blank/refused (3.6%). The predominant languages spoken among participating members are English (94.2%) and Spanish (4.4%), and there was a small percentage reported as Other/Blank/Refused (1.5%). Furthermore, the most reported educational level among participants is Some college (48%), compared to their counterparts whose educational level are High school diploma (24.8%); College degree or higher (22.6%); 9th-12th grade, no diploma (13.9%); Less than 9^{th} grade (2.9%); and Blank/Refused to answer (0.7%). These findings demonstrate consistency with member demographic data between 2019 and 2020.

Participants are asked if they have any behavioral and/or physical conditions during the intake process. Findings indicate that program participants have a behavioral health condition including anxiety (38.0%); bipolar disorder (17.5%); depression (40.1%); Schizophrenia (10.9%); and/or Substance Use Disorder (11.7%). Participants have also indicated they have a physical condition such as High Blood Pressure (59.1%); Diabetes (19.7%); Heart Attack (13.9%); and/or Stroke (8.0%). Although there is a noted decrease in participants reporting anxiety and diabetes and an increase in participants reporting Substance Use Disorder, these findings are not statistically significant at $p<.05$. The most reported conditions are consistent between 2019 and 2020.

Participants are also asked their referral source into the program, data demonstrated that most participants self-refer to the program due to mailings and television media. UHCCP CA analyzed the zip code data and noted some data limitations to self-reporting affecting the data results. For example, UHCCP CA only serves San Diego County; however, the zip code analysis indicated there were participants who indicated they are UnitedHealthcare Medi-Cal beneficiaries and lived throughout CA. Although San Diego is still the most reported individual county (n=30), the remaining 107 members reported living in another CA county. This data limitation was also noted in 2019 results.

UHCCP CA will continue to collaborate with the California Smokers' Helpline and explore various ways we can better communicate with our members about the program to increase program participation rates.

E. Quality Improvement Efforts

UHCCP CA partnered with UnitedHealthcare's National Quality team to implement a variety of member engagement programs. DHCS requires a program proposal be sent for review including a packet of member materials and program operations. Any program containing a member incentive requires a formal proposal and evaluation plan using the required Member Incentive form. All programs were approved for implementation by the DHCS. The following programs were implemented in 2020. A description of each program and outcomes are as follows:

a. **Interactive Voice Recording (IVR) Calls.**

In 2019, IVR Calls were placed to members during the months of May through December for the following HEDIS® care gaps: Adolescent Well Care (AWC), Asthma Medication Ratio (AMR), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Comprehensive Diabetes Care Eye Exam (CDC-eye), Comprehensive Diabetes Care HemoglobinA1c (CDC- HT), Comprehensive Diabetes Care Nephropathy (CDC- Neph), Childhood Immunization Status (CIS-Combo#3), Immunizations for Adolescents (IMA), Lead Screening in Children (LSC), Prenatal and Postpartum Care (PPC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children and adolescents (WCC), Well-Child Visits in the first 15 months of life (W15), Well-Child Visits in the third, fourth, fifth and sixth years of life (W34). Calls were placed in English and Spanish per the member's preferred language. A total of 2,247 calls were placed to eligible members. This program was expected to increase HEDIS® rates by 10%. UHCCP CA found this program to be moderately effective as 2,247 calls were successfully placed to members, 35.07% contact rate. When compared against 2018 data, this program had a +4.25% contact rate increase; however, this rate could have been attributed to a larger number of telephone calls placed compared to 2018 due to participation in additional HEDIS® measures. And as seen in 2018, in 2019, the program reporting was unable to indicate how effective the program was in connecting members to their PCP to close gaps in care. Any awareness and education, however, is helpful in messaging to members that they are due for care. This program will continue in 2020.

In 2020, IVR Calls were placed to members during the months of January through May, and on hold from June to August due to COVID-19. IVR calls resumed in September for the following HEDIS® care gaps: Adolescent Well Care (AWC), Controlling High Blood Pressure (CBP), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD), Chlamydia Screening in Women (CHL), Comprehensive Diabetes Care Eye Exam (CDC-eye), Comprehensive Diabetes Care HemoglobinA1c (CDC-HT), Childhood Immunization Status (CIS-Combo 3), Immunizations for Adolescents (IMA), Lead Screening in Children (LSC), Prenatal and Postpartum Care (PPC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children and adolescents (WCC), Well-Child Visits in the first 15 months of life (W15), Well-Child Visits in the third, fourth, fifth and sixth years of life (W34). Calls were placed in English and Spanish per the member's preferred language. A total of 1,194 calls were placed to eligible members. This program was expected to increase HEDIS® rates by 10%. UHCCP CA found this program to be moderately effective as calls were successfully placed to members, 20.27% contact rate. When compared against 2019 data, this program had a -14.8% contact rate decrease; however, this rate could have been attributed to the program being placed on hold for 3 months due to COVID-19. And as seen in 2019, the program reporting was unable to indicate how effective the program was in connecting members to their PCP to close gaps in care. Any awareness and education, however, is helpful in messaging to members that they are due for care. This program will continue in 2021.

b. **Live Calls.** Live calls were placed to members by a third party vendor on behalf of UHCCP CA during the months of January through December 2020 for the following HEDIS® care gaps: AWC, BCS, Children & Adolescents' Access to Primary Care Practitioners four indicators (CAP-1224, CAP-256, CAP-711, CAP-1219),

CBP, CCS, CDC, CIS, IMA, LSC, PPC, and W34. Calls were placed in English and Spanish per the member's preferred language. A total of 8,272 calls were placed to eligible members, 2.63% net new appointment rate in 2020.

c. **Member Rewards.** In 2018, UHCCP CA offered Member Rewards in the form of $25 gift cards to members who close care gaps for the following measures: Adolescent Well-Care Visits (AWC), Breast Cancer Screening (BCS), Comprehensive Diabetes Care (CDC), Cervical Cancer Screening (CCS), and Well-Child Visits in the third, fourth, fifth, and sixth years of life (W34). Eligible members receive a mailer noting their eligibility for the gift card if they visit their PCP and can show evidence of closing the specific gap(s) in care. The member must obtain the required documentation and return the form and evidence to the program vendor. This created a barrier to members and redemption rates reflected low utilization. Just 1.7% of eligible members sent a Member Reward mailing had redeemed their gift card. In 2018, this program was not found to make a significant impact on HEDIS® rates. The Member Rewards program implemented in 2019, however, had an increased member incentive amount of $25 to $50 per care gap closure. The redemption process cannot be revised so the Plan attempted to increase the dollar amount in hopes of incenting the extra steps for the members to submit the completed form and evidence. A total of 2,412 letters were mailed and just 1.53% of eligible members sent a Member Reward mailing had redeemed their gift card. Data indicates that there was a -0.17% reduction rate among the overall redemption rate. Provider practices will continue to be informed of the Member Rewards program offered through our National Clinical Quality Population Health Management team. Providers can use the program to support outreach efforts and encourage appointment visits. Secondly, they will also be aware of the form when members ask for the required documentation. Additionally, in 2020, UHCCP CA is exploring partnership opportunities with a provider network clinic to pilot distribution of gift cards at the clinic site, removing the attestation form return to the vendor and reconciliation of claim data that delays the member from receiving their gift card.

d. **HealPros.** An In-Home A1c testing conducted by a non-clinical HealPros technologist. UHCCP CA eligible members will receive a telephone call by a live HealPros call agent offering the in-home screenings they are due for. A HealPros non-clinical Technologist will come to the eligible member's home to provide in-home screenings. HealPros targets the following HEDIS® measures: Comprehensive Diabetes Care: Eye Exam, Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (CDC-HT), Comprehensive Diabetes Care: Medical Attention for Nephropathy. The technologist will administer a retinopathy and nephropathy screening, the member self-administers HgbA1c test with a finger stick test kit and urine test. The HealPros technologist will collect the test and return package. UHC credentialed Providers will review screening results. A results letter will be sent to the member. The member will be encouraged to go to their Primary Care Practitioner (PCP) office in-person for continued care. Additionally, a copy of the results will be given to the member's identified PCP. Since the program launched in October 2020, 210 eligible members have been called (40.3% successful contact, 55.4% successful appointments scheduled), and a Diabetic Retinopathy Exam has been completed by 21 members for a completion rate of 67.4% and 1 A1c test resulted. This program will continue in 2021 encouraging members to close their care gaps.

e. **Healthy First Steps.** An online, interactive incentive program designed to help pregnant women and new mothers with prenatal, postpartum, and well-baby care. The Baby Blocks Program aims to improve prenatal, postpartum, and well-baby care, drive member engagement, and close gaps in care for specific Healthcare Effectiveness Data and Information Set (HEDIS®) measures including Frequency of Ongoing Prenatal Care (FPC), Prenatal and Postpartum Care (PPC), Lead Screening in Children (LSC), and Well-child visits in the first 15 Months of Life (W15). A program mailer is sent to all eligible members encouraging them to enroll into the program, and program mailers sent to newly identified pregnant members on a weekly basis thereafter. The program rewards women for visiting the doctor and reporting the information online during their pregnancy and their baby's first 15 months of life. Once women sign up for Healthy First

Steps, they can access an interactive board that shows their prenatal visits, along with opportunities to earn rewards for following a prenatal visit schedule, and continuous educational information provided. Using a game-like interface, moms can track appointments and receive email and/or text message appointment reminders. Members are offered eight incentives for completing key visits throughout their pregnancy and the first 15 months of her baby's life. Claims data are verified against the participants' reported online information of completed doctor visits (or completed blocks). Additionally, system triggers are in place that flags certain activities for review.

In 2020, the Baby Blocks program participation rate was 76.7% (n=66; n=86 eligible members) indicating an increased program participation rate of +3.5% from one year to the next. The Baby Blocks program is continuously monitored and reviewed at the Health Education and Cultural and Linguistics Committee (HECL) and Quality Management Committee (QMC). Committee attendees have an opportunity to review the program and discuss methods to increase participation. Additionally, UHC enterprise program owners identified opportunities for improvement. As a result, the digital rewards program was integrated with the telephonic Healthy First Steps program under one program name, Healthy First Steps, and was successfully implemented in June 2020. UnitedHealthcare offers numerous maternity programs that are not integrated. This program integration allows for a simplified member experience, consolidated member outreach, and increased program participation rates. As such, the newly integrated Healthy First Steps includes updated member engagement materials and digital content. The Health Plan's Clinical Quality team has reviewed the updated materials and received formal approval from the state. Additional trainings regarding the program and updates will continuously be provided to ensure program awareness and marketing efforts. In 2021, the Health Plan's Clinical Quality team will continue to integrate monitoring and quality improvement efforts with different audiences to ensure the upmost program awareness to drive increased participation rates.

f. **Early and Periodic Screening, Diagnostic and Treatment (ESPDT) IVR Calls**. UHCCP CA implemented EPSDT IVR calls in November 2018. A total of members under the age of 21 and/or parents/legal guardians were outreached to during 2020 through IVR calls to remind them to see their provider for their well child checkup. The IVR script also includes the importance of immunizations, lead screening and dental care. In 2020, UHCCP CA achieved a contact rate of 22.06%, a -10.75% reduction rate from 2019. EPSDT IVR calling answering machine rate was 51.98%. The EPSDT IVR call will continue in 2021 and the quarterly rates will continue to be reported to the Health Education and Cultural and Linguistics (HECL) Committee.

g. **Flu Vaccine Email.** This campaign was targeted for members in the Flu HEDIS® measure. A member engagement digital email was sent to eligible members to remind them to get their annual flu shot. This email is sent out two times per year, once in Quarter 4 and a reminder flu email in Quarter 1 of the following year. These emails were sent in English, Spanish, and other preferred languages upon request. In 2019, UHCCP CA participated in the January 2019 and October 2019 flu vaccine email campaigns. In January 2019, a total of 1,982 emails were sent to our members. The delivery rate was 96.87% with an open rate of 24.53%. Additionally, UHCCP CA participated in the October 2019 flu vaccine email, a total of 2,082 emails were sent. The delivery rate was 98.46% with an open rate of 25.76%. Overall, in 2019, a total of 4,064 flu vaccine emails were sent to members. The delivery rate of 97.67% and an open rate of 25.16%. In November 2020 the Flu Vaccine email was sent to 9,325 members. The delivery rate was 82.03.% with an open rate of 26.95%. When comparing 2019 against 2020 date, the Plan identified a -15.64% decreased delivery rate, and a +1.79% increased open rate. The decrease in delivery can be attributed to only one flu email sent to members in 2020 as opposed to two emails previously in 2019.

h. **Women's Health Email.** The Women's Health Email was sent to members in August 2020 who were eligible for Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) HEDIS® measures. A member engagement digital email was sent to eligible members to remind them to get their breast cancer screening, cervical cancer screening, annual well woman exam, and encourage participation in the Baby

Blocks Program (if applicable, and only sent to a subset of the targeted eligible member population who was also eligible for the Baby Blocks Program). The digital email was sent to eligible members once during 2020 using the email address on file with the health plan. There were two different versions depending on the target audience, one for women of childbearing age promoting the Baby Blocks program, CCS and BCS; and to older women of non-childbearing age, CCS and BCS. There were 1,785 emails sent out to eligible members. These emails were sent in English, Spanish, and other preferred languages upon request. The delivery rate was 98.26% with an open rate of 42.30%.

i. **ConsejoSano.** ConsejoSano is a vendor offering culturally and linguistically appropriate health education messaging to health plan members. UHCCP CA partnered with ConsejoSano to deliver member engagement campaigns for a series of select HEDIS® measures that did not meet the MPL in RY 2019 such as CCS, CDC, CBP, and Well-Child Visits. ConsejoSano performed member outreach in the form of e-mails, mailers, and live calls in 2020 and 2021. ConsejoSano conducted outreach to 5,223 unique members in 2020, with an engagement rate of 37.79% indicating members were successfully contacted and/or the member opened e-mails. Engagement was defined as the number of unique members who made an appointment while on the call, or the member had already scheduled an appointment. The reported engagement rate for 2020 was 27.44%. A reported 9.55% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls. Notably, ConsejoSano provides live telephonic agents who are fluent in languages such as Spanish, Arabic, Vietnamese, and Tagalog. Member feedback indicated satisfaction with the call agents. Specifically, one member reported how pleased he was to speak to a representative in his preferred language, Tagalog. He noted how that call agent helped him coordinate care with his Primary Care Physician. ConsejoSano has proven to help decrease language barriers and increase access to care.

j. **Pfizer Vaccine Adherence for Kids (VAKs).** Pfizer sponsored Child Immunization interactive voice recordings (IVR) and postcards will be sent to eligible members to encourage well child visits and childhood immunizations. Pfizer Vaccine Adherence for Kids (VAKs) targets the following HEDIS® measures: Childhood Immunization Status (CIS – 3), Well-Child Visits in the first 15 months of life (W15), and Well Child Visits 3-6 years (W34). The program launched in November 2020 with a total of 1,043 outbound calls, of those calls 61 were authenticated for a 5.85% contact rate. In addition to the IVR calls, 98 postcards were mailed to members to encourage well child visits and childhood immunizations. The low contact rate can be attributed to the program only launching for two months in 2020. This program will continue in 2021 with IVR calls and postcards.

k. **LetsGetChecked.** Offers In-Home Lead and A1c testing kits mailed to eligible members. Eligible UHCCP CA members will receive a letter informing the UHCCP CA member that they are due for a screening. It will include information regarding why the UHCCP CA member should receive a screening, how to order the test, and how to complete the test. The UHCCP CA member will have the option to order the test by a phone call, text message, or online. An interactive voice recording (IVR) messaging will then prompt the UHCCP CA member to enter an 8-digit code to complete the order. The in-home testing kit arrives at the eligible member's home with clear directions and materials to complete the sample collection. The kit is returned in a pre-paid envelope directly to the lab. The sample collection is then processed with results sent to the member and primary care provider. A Let'sGetChecked nurse follows up on the lab results. LetsGetChecked targets the following HEDIS® measures: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (CDC-HT) and Lead Screening in Children (LSC). The program launched in December 2020 for Lead Screening only. Opt-In letters were sent to 242 eligible members, and 20 members opted in to participate in the program. However, no members returned the test kits resulting in a 0% participation rate. Low participation rates can be attributed to not receiving timely state approval for the program delaying the launch dates and only allowed the program to be implemented for one month in 2020. The A1c testing portion of the program didn't launch in 2020 due to issues with the online portal. UHCCP CA

plans to continue the LetsGetChecked program for both In-Home Lead and A1c testing in 2021.

F. Other Health Plan Campaigns

UHCCP CA developed a strategic plan to expand member engagement programs in 2019 as a means of increasing HEDIS® performance rates. As such, the following were additional programs implemented by the Quality Department.

a. **Member Gift Card Program.** In December 2020, UHCCP CA observed that several HEDIS® Preventive Care measures were well below the Minimum Performance Level (MPL). UHCCP CA's Quality team received feedback from several practices requesting an incentive to encourage the member to complete preventive care screenings. In response, UHCCP CA developed an intervention to engage members and offer a $50 Wal-Mart gift card reward for completing preventive care visits. As such, UHCCP CA implemented a Member Gift Card program in which gift cards are provided by the provider practice at the point of care for the following measures: Cervical Cancer Screening (CCS), Breast Cancer Screening (BCS), Chlamydia Screening (STI),Diabetes HbA1c testing (CDC-HT), Well Child Visit in the first 30 months of life (W30), Child and Adolescent Well-Care Visits (WCV), Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA-2). Since the program launch in December 2020, there were a total of six participating provider practices and nine gift cards distributed. Due to the program only launching for one month in 2020, the number of gift cards distributed was not substantial. At the time of program implementation there were 2,420 eligible members among the participating practices. The rate of distribution in 2020 was 0.37% compared to the national "Member Rewards" program that previously had a 1.7% distribution rate in 2019. The gift card program will continue through 2021 and will be open to additional provider offices interested in participating.

d. **HEDIS Preventive Letters.** Preventive letters are sent to eligible adult and pediatric members with an open care gap. The preventive letter engages the member, alerts the member of any outstanding care gap(s), and provides instructions on how to close their open care gaps. Members whose preferred language was noted as English or Spanish and who have existing care gaps as of July 10, 2020 will be targeted with the Preventive Care Letter. HEDIS Preventive Letters targeted the following HEDIS® measures: Cervical Cancer Screening (CCS), Breast Cancer Screening (BCS), Comprehensive Diabetes Care - Poor Control (CDC-H9), Controlling High Blood Pressure (CBP), Asthma Medication Ratio (AMR), Well Child Visits in first 15 months of life (W15), Well Child Visits in 3, 4, 5, 6 years of life (W34), Well Child Visits – Counseling for Physical Activity, Well Child Visits – Counseling for Nutrition, Well Child Visits BMI Percentile (WCC), Childhood Immunizations – Combo 10 (CIS-10), Immunizations for Adolescents – Combo 2 (IMA-2) and Adolescent Well Care Visit (AWC). In September 2020, 5,005 members were mailed letters, 9% (493) of letters were returned and 8% (461) of care gaps were closed. The results indicate that there was a challenge with obtaining correct addresses for members considering that 493 (9%) letters were returned. Nine percent of members not receiving the preventive letters makes a big impact on care gap closure. As demonstrated in the results, 10 (77%) out of the 13 measures increased their rates and 3 (23%) measures decreased. It should be noted that COVD-19 may have impacted members scheduling and/or attending their preventive care appointments. However, the Plan wanted to communicate to members that preventive care is still important and provider offices are taking the steps to make sure the office is following proper safety protocol to ensure the safety of their staff and patients. The plan will consider sending preventive letters in 2021.

e. **Food Insecurity Initiative (Infant Formula).** Many UHC members have been negatively impacted by the COVID-19 virus, either by exposure, infection, loss of income, etc. Food is a key social determinant of health significantly impacting a member's ability to care for themselves and their family members. UHCCP CA has received reports of food shortages, including infant formula, in local grocery stores. UHCCP's Case Management team has launched a new program for moms unable to access baby formula. The baby

formula initiative is a short-term program limited to members impacted by or homebound due to COVID-19. Eligible members were less than 12 months of age and all had a date of birth on, or after, March 1, 2019. This age group was selected because 12 months of age and younger is considered formula-appropriate age, if not breastfeeding. UHCCP CA staff implanted a call script and began placing outbound calls to identified eligible members. UHCCP CA staff successfully reached 27 of the 334 eligible members (8.1%). 12 members 44.4% accepted support, the need was clear and evident. Of the 334 eligible members, UHCCP CA did not make live contact with 307 members (91.9%). A high percentage of voicemails left for the member's parent/guardian presents a missed opportunity to provide support and resources to members and families during the COVID-19 crisis. Providing infant formula, that may be currently difficult to access or altogether unavailable, is one strategy that UHCCP CA implemented to support members in their efforts to maintain their health during the COVID-19 pandemic. This intervention revealed a Key Finding that the Plan needs to remain agile in providing services to address members' immediate needs, specifically working to address barriers with food insecurity. Refer to the Action Plan table.

d. **Preventing Isolation in Older Adults- COVID-19 Call Campaign.** California has been impacted in many ways due to COVID-19. While the California stay-at-home order is in place, older members and other at-risk members, especially those living alone, will likely need their Managed Care Plans (MCPs), as well as family, friends, neighbors and community, to help them maintain basic needs like groceries, prescriptions, and much-needed social interaction and connection. In accordance with the All Plan Letter (APL) 20-009, issued on April 20, 2020, United Healthcare Community Plan of California (UHCCP CA) created an outreach call campaign focused on older adult members (60+) to ensure they receive the following:

1) Telehealth, when medically appropriate;
2) Continuity of medical and behavioral health services;
3) Basic needs, health care, mental health, and safety from abuse and neglect;
4) Additional supportive services and resources.

Members were asked a series of questions to ensure they've been receiving the care they need as well as making sure their basic needs are being met. Additional resources were offered to members such as the Friendship Line, Aging and Adult services, Alzheimer's Helpline, American Association of Retired Persons (AARP), and the Fraud Watch Network Helpline. If members needed additional help, a referral to Case Management would be made for coordination of care. There was a total of 1,073 eligible members for the call campaign. Of those eligible members, 583 (54%) were female and 490 (46%) were male. Eight-hundred forty-seven (79%) members were between the ages of 60-70, 162 (15%) were between the ages of 71-80, and 64 (6%) were between the ages of 81-96. Additionally, 704 (66%) identified English as their preferred language and 194 (18%) identified Spanish as their preferred language. The remaining 175 (16%) identified their preferred language as one of the following: Arabic, Cantonese, Chinese, Farsi, Japanese, Korean, Mandarin, Portuguese, Russian, Tagalog, Thai, or Vietnamese. Language Line was utilized for members that did not identify English as their preferred language.

Contact with 81 (8%) of members was made, of the 81 live calls 64 (79%) members completed the call campaign questions. The members that were contacted declined needing any help with basic needs during the pandemic. Many were utilizing the help of family members or neighbors. Overall, members were grateful to receive a call from the health plan offering assistance. The plan was unable to contact, 992 (92%) members in total. A voicemail was left for 896 (90%) of members. It was difficult to get members to answer their phone, as 992 (92%) were unreachable. The Quality Coordinator also noticed that many voicemails were set for the member's residence and may not have been home during the daytime when UHCCP CA tried to contact them or may not typically answer calls made to their home phone.

UHCCP CA will continue to look for more ways of supporting the community during this public health crisis, especially the older adult and at-risk members. UHCCP CA is continually working at improving contact information for members and has been tracking valid and invalid numbers. The tracking will help improve contact information for members.

Although UHCCP CA was able to partner with UnitedHealthcare's National Quality team to implement a variety of member engagement programs with the utilization of different vendors we encountered interpretation and translation issues. There were many challenges with addressing the need of providing these programs in additional languages other than English and Spanish; at minimum the San Diego County threshold languages English, Spanish, Tagalog, Vietnamese, and Arabic. Some contracting national vendors did not offer the programs beyond English and Spanish. In such instances, the Plan would have to mitigate the issue by including interpretation and/or translation services into the process workflow and offered the English version as the default language for those members that spoke another language other than Spanish to ensure we met the minimum language assistance program compliance requirements. The Plan would include the LanguageLine Solutions phone number via the Plan's Member Services Department to access interpreter services to be added to telephone call scripts. The Plan also ensured to include the appropriate Notice of Non-Discrimination, non-discrimination statement and taglines to any collateral materials. Contrary to the aforementioned issue, there were national vendors who did offer additional languages for interpretation and translation; however, adding additional languages to the program and set-up fees were very costly to consider and implement for the Plan's smaller populations who spoke a language other than English or Spanish; minimum the remaining San Diego County threshold languages: Tagalog (0.69%), Vietnamese (0.50%), and Arabic (0.43%). The additional cost and set-up fees were considered against rates of return on investment. Thus, at minimum, UHCCP CA incorporated interpretation and translation services into the process workflow and offered the English version as the default language for those members that spoke another language other than Spanish to ensure compliance requirements were minimally met.

The Plan's Quality Department quickly learned that not all programs offered by the National Quality Department are not a "one-size fits all" and there is a need to make it more tailored to our targeted audience. As such, other challenges the Plan encountered included offering text messaging programs. The Plan's largest population is predominantly English-speaking members ages 21 to 40 years old; this much younger working class population expect more of an expedited process for accessing care; considering a more digital approach for delivery of clinical programs since it is no longer common to have a land line and have moved to having only a mobile cellphone. However, a text messaging approval form was released from the state DHCS to ensure all Medi-Cal health plans are meeting all digital compliance requirements for text messaging communication with our members. The Plan would need to develop a policy and procedure to ensure we met the requirements, submit the policy through internal Plan committees for review and approval, and filed with the state prior to implementing a text messaging campaign. UHCCP CA will explore text messaging opportunities to meet our membership needs.

e. Quality Improvement Plan-Childbirth Disparities in African American Women

UHCCP CA conducted a study on health disparities potentially connected to birth outcomes of African American women who are, as a whole, identified as at higher risk of adverse outcomes during and following childbirth, including premature birth, fetal and infant mortality, the intent of this study was to identify any existing disparities and to develop and implement programs to alleviate them. Results for various categories are summarized below.

Race and Ethnicity

African American mothers were not statistically more likely to have a diagnosis that would indicate a potentially high-risk pregnancy, such as diabetes, hepatitis or hypertension. They were also not statistically more likely to experience an inpatient stay or experience general complications during pregnancy. Ethnicity was also not an indicating factory delivery method, such as C-section or vaginal, or in birth outcome. This suggests that ethnicity did not play a statistically significant role in the immediate health outcomes for pregnant women and babies enrolled in the Health Plan, particularly for the conditions analyzed in this study.

Language

The most common languages spoken by members in this sample were English (spoken among 305 participants) and Spanish (spoken among 54 participants). Further analysis did not indicate a statistically significant difference in delivery method between the two groups. This suggests English as a second language is not a risk factor for delivery via C-section among plan members.

Delivery Type

African American women were not statistically more likely or less likely to deliver via C-section than non-Hispanic white women. This was expected, given the low incidence of chronic conditions, younger age group and low incidence of general pregnancy complications among members in the sample.

Low Birth Weight:

Although African American babies in this study exhibited a higher percentage of Low Birth Weight than non-minority babies, a Chi- square analysis resulted in a p-value of .268701. These results were not statistically significant at an alpha level of 0.05. African American mothers were also not statistically more likely to have a diagnosis that would indicate a potentially high-risk pregnancy, such as diabetes or hypertension.

Maternal Chronic Conditions:

African American women in this sample were not statistically more likely to experience general complications during pregnancy. They were also not statistically more likely to have a chronic or pregnancy-related condition. Approximately 2/3 of African- American women in the sample gave birth between ages 20-29, which may have served as a protective factor against medical conditions.

Remaining Factors

As a result of lack of information on the dates of inpatient stays and whether they occurred before or after delivery, no conclusions were drawn for this variable. Other variables, such as occurrence of cancer, asthma and hypertension were also not analyzed due to low incidence of these conditions in the sample. Additional information is needed to guide the Health Plan on action/follow up items needed in these areas.

The findings in this study suggests a need for additional identification and care management services for pregnant women with complex needs. Increased completion of the OBRAF (OB Risk Assessment Forms) among UHCCP OB providers could assist care management in identifying these members in need of support.

Challenges

There were several challenges with the data available for this study. One of the most significant challenges is the large percentage of mothers with an ethnicity coded as “Other” or “Unknown.” In a study that is looking

at health disparities, having ethnicity data is of the utmost importance. Nearly half (42%) of the sample had an ethnicity captured as Other or Unknown. This may have resulted in many members identifying as African American, Asian American, Caucasian/White, Hispanic, or Native American to be overlooked and excluded from our analysis. The absence of known ethnicity data for many of our members may have contributed to bias or findings that are not well generalized to the overall population.

Another challenge with this study is that it is limited to claims data, which does not capture the member's overall experience with their provider or close calls. It also does not capture members that return for inpatient stays more than a month after childbirth. Adverse outcomes following childbirth that occur more than 30 days after delivery will not be captured on the report or in this study. There may have been additional variables not included on the data set that could have been overlooked.

Finally, small population sizes may have significantly impacted the ability to draw reliable conclusions from the observed data. Although some ethnicities look to be disproportionately affected by conditions and outcomes, we were unable to support those findings with statistical validation due to the small number of women impacted. Future Health Plan growth and larger population sizes to draw from may provide further opportunity for continued research and more reliable results from hypothesis testing. This is especially important for our plan, as our results are not aligned with more widespread research and findings. Future studies could also build onto this study by collecting feedback from members, post-delivery, for information on their experience with their OB provider. This could provide critical information on member experience and satisfaction that is not available through claims data, such as feeling respected and heard by providers.

This focused study revealed a Key Finding for the Plan. UHCCP CA identified an opportunity to develop a Population Health approach to identifying and managing member needs for an expanded set of conditions such as members with Diabetes and Hypertension. Similar studies can be conducted to assess utilization, impact, and characteristics impacting specific populations (age, race, ethnicity, preferred language, etc.) by condition. Focused studies such as these can lead to custom interventions that are data-driven and address the unique needs of UHCCP CA members. Refer to the Action Plan table for additional details.

G. Other

a) Discrimination, Cultural and Linguistics Grievances and Appeals

The Plan's Quality Department Clinical Quality Manager and Clinical Quality Analyst work closely and engage with the Appeals and Grievance teams to manage these grievances, monitor these closely and have a process in place to route and close all issues appropriately. Discrimination, Cultural and Linguistics Grievances and Appeals are presented at the Health Education, Cultural and Linguistics Committee, and Quality Management Committee at least quarterly. The Plan monitors complaints and grievances related to language services and looks for trends on a quarterly basis. These are also included in routine quarterly reporting of total complaints and grievances to the DMHC. During calendar year 2020 there was one (1) grievance identified in the category of Cultural, Linguistic, or Discrimination. This grievance was reported to the plan during quarter 4, 2020 and will be included in the 2020 Language Assistance Program Annual Evaluation which is in progress and will be presented to health plan committees in quarter 3, 2021.

b) Disenrollment Survey

As part of the UHCCP CA's member satisfaction and growth strategies, the Plan surveys members who have disenrolled with UHCCP CA, and tracks and trends disenrollment reasons over time. Below are the top disenrollment reasons members opt to leave UHCCP CA and tracked for calendar year 2020:

2020 Disenrollment Reasons by Month														
Reason	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Grand Total**	**Rate**
Beneficiary Preference-HP Did Not Cover Needs	27	44	35	17	35	51	43	46	42	32	40	12	424	24.04%
Could Not Choose Doctor I Wanted	16	30	24	12	13	42	36	40	50	37	34	14	348	19.73%
Did Not Choose This Plan	9	7	15	8	15	20	17	18	13	22	9	3	156	8.84%
Disenrollment	0	1	2	0	0	0	0	0	0	0	0	0	3	0.17%
Doctor Did Not Meet Beneficiary Needs	5	3	3	3	3	9	15	10	8	8	2	0	69	3.91%
Emergency Disenroll	6	12	14	8	10	17	16	13	13	16	9	3	137	7.77%
Indian Health Coverage	6	0	0	1	1		1	0	0	0	0	0	9	0.51%
Medical Exemption	0	2	0	0	1	2	1	0	0	0	0	0	6	0.34%
Medical/Dental Exemption	0	1	0	0	0	0	0	0	0	0	0	0	1	0.06%
Moving Out Of County	1	1	6	1	2		3	5	7	2	4	0	32	1.81%
No Reason Checked	33	45	30	31	32	28	29	35	24	32	25	3	347	19.67%
Other Reason	14	29	17	10	18	29	23	17	27	11	17	4	216	12.24%
Too Far To Go	1	1	2	1	2	3	4	1	0	1	0	0	16	0.91%
Grand Total	**118**	**176**	**148**	**92**	**132**	**201**	**188**	**185**	**184**	**161**	**140**	**39**	**1764**	**100.00%**

Data Source: Disenrollment Data Report January 2020 to December 2020

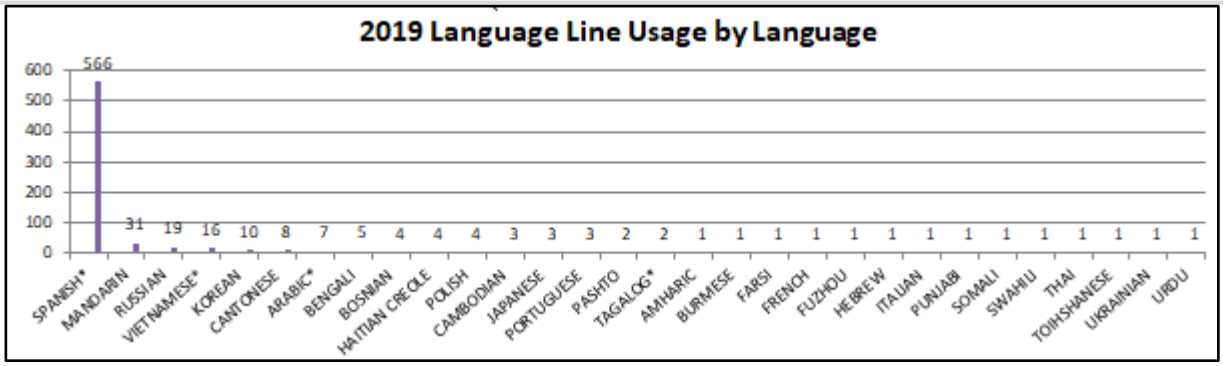
The data indicates that the top three reasons for disenrolling with the UHCCP CA are "Beneficiary Preference- HP Did Not Cover Beneficiary's Needs," 24.04%, "Could Not Choose Doctor I Wanted," 19.73%, and "No Reason Checked," 19.67%. Also noted, is that January 2020 counts are low; however, this is due to the date range of the report that is based on "effective date". Limitations to this data were identified including not capturing reasons for all type of reasons for disenrollment, only those identified by the DHCS with Maximus system for tracking, and that it only provides the count of responses and nothing further.

c) Language Line Interpreter Utilization

1. **Telephone Calls**

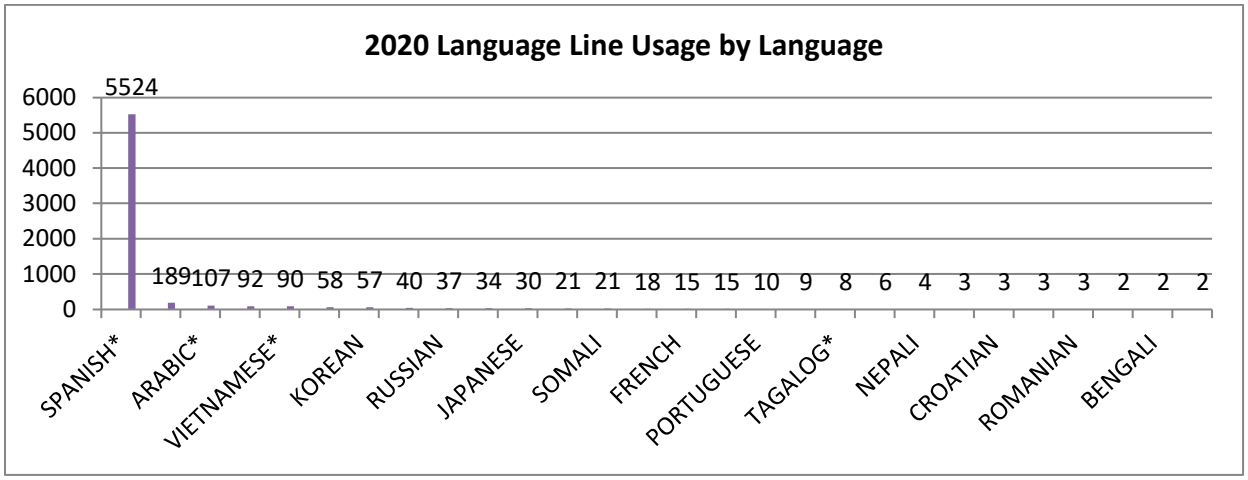
UHCCP CA contracts with the external vendor LanguageLine Solutions, who employs certified interpreters. Employees are assessed for language proficiency skills and are required to participate in an interpreter certification program to provide interpretation services. LanguageLine Solutions assess, track and monitor employee proficiency testing and training. LanguageLine Solutions is the only provider who has a true certification program validated through external industry experts and who maintains a documented process for certifying medical interpreters through testing and training.

UHCCP CA monitors LanguageLine Solutions usage by language and presents the data to the Health Education and Cultural and Linguistics Committee on a quarterly basis. The tables below represent comparison data from 2019 (January 1, 2019 to December 31, 2019) and 2020 (January 1, 2020 to December 31, 2020).



Data Source: Language Line Usage Reports

In 2019, data indicates that the top three languages handled by LanguageLine Solutions are predominantly for Spanish calls (n=566), followed by Mandarin (n=31), and Russian (n=19).



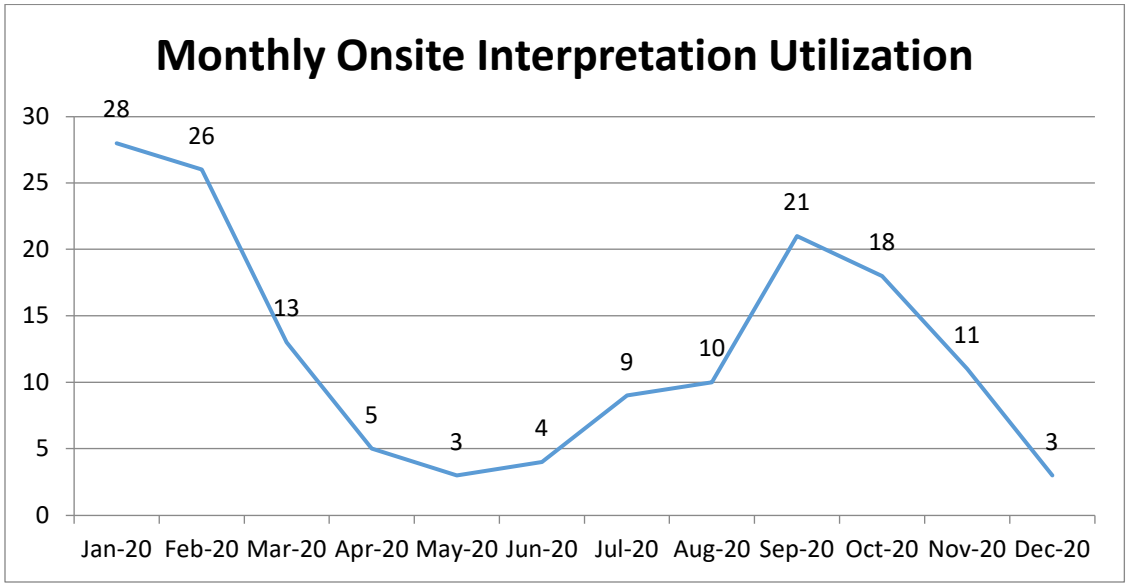
Data Source: Language Line Usage Reports

By comparison, in 2020, data indicates that the top three languages handled by LangaugeLine Solutions are predominantly for Spanish calls (n=5,524), followed by Arabic (n=189), and Cantonese (n=92).

Overall, data indicates unreliable sources of information as reported on LanguageLine reports. Trends have been investigated and the causes have been unexplained to date. The Member Services team has identified a gap entailing that the team involved in this data collection has been disbanded. They worked diligently to identify a new team to champion this data set moving forward. As a result, the Plan will continue to monitor this data closely with the understanding that the unreliability of data means that comparison of year over year is not reasonable.

2. **Onsite Interpretation**

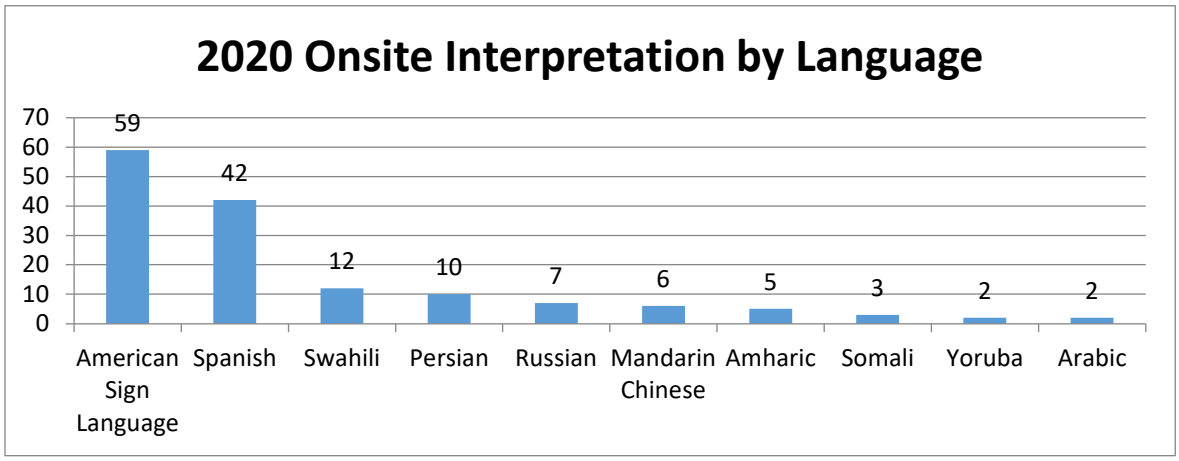
To improve access to care in the provider office, UHCCP CA offers onsite interpretation. As such, the table below demonstrates the monthly onsite interpretation utilization from January 2020 to December 2020. Data indicates that utilization of onsite interpreters fluctuated over time. At its highest peak in January 2020, utilization was at 28 onsite interpreters provided for the month, and at its lowest utilization, 3 onsite interpreters were utilized during the month of December 2020.



Data Source: Language Line Usage Reports

Data for all of 2020 indicates that the largest onsite interpreter languages requested were for American Sign Language(n=59), Spanish (n=42), and Swahili (n=12).

Table: LanguageLine Solutions Onsite Interpretation by Language



Data Source: Language Line Usage Reports

IV. Action Plan

1) Action Plan Table

UHCCP CA will focus on the following Action Plan as outlined below to improve health outcomes for Plan members. The Plan identified opportunities to address Key Findings as presented in this report. The proposed programs will be designed to impact health disparities among targeted eligible members.

2021-2022 PNA Action Plan Table
HEDIS® Preventive Care Campaigns Addressing Health Disparities
Objective: UHCCP CA will deliver culturally appropriate member campaigns to reach a larger percent of the member population (whose preferred language is that other than English) increasing the total number of HEDIS® measures meeting the MPL for Measurement Year from 8 total measures in 2020 to 10 total measures in 2021 by June 1, 2022. **Data Source:** HEDIS® member level data and ConsejoSano Utilization Reports
Strategies
1.) Develop a series of Member Engagement programs in partnership with ConsejoSano to address awareness of preventive care services that may impede the member's ability to complete a PCP visit.
2.) Develop culturally and linguistically appropriate member outreach campaigns including member materials and telephone scripts translated into the County Threshold languages.
3.) Target eligible members (in their preferred language) with an open care gap and coordinate appointment scheduling.
Mom's Meals, a food insecurity project
Objective: Increase the PPC HEDIS® measure by 10%, from 79.86% [HEDIS® MY2020] to 89.86% by supporting food security for postpartum care for the maternal health population with the utilization of Mom's Meals by December 31, 2022. **Data Source:** HEDIS® member level data and Mom's Meals Utilization Reports
Strategies
1.) Offer Mom's Meals to eligible members with a delivery discharge in 2021-2022.
2.) Provide home delivered meals to high-need members who are most likely to suffer negative health outcomes due to poor nutrition or food insecurity including health education messaging to complete the post-partum visit.
3.) Provide health education to all members receiving services, reiterating the importance of the post-partum visit.
Integrate Population Health Management Focus (Hypertension)
Objective: Increase the CBP HEDIS® measure by 10%, from 55.96% [HEDIS® MY2020] to 65.96% by implementing a more integrated population health management approach to our members by December 31, 2022. **Data Source:** HEDIS® member level data and HEDIS® Prospective Reports
Strategies
1.) Create member engagement materials and health education self-management materials and tools.
2.) Connect members to available resources as needed by offering interpretation services, transportation to the member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs.
3.) Conduct member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits.
4.) Integrate Pharmacist review of clinical measures to assess medication history and opportunities to inform providers of medication history and pharmacy fill activities.

2) Action Plan Review and Update Table

The table below presents an update from the Action Plan as documented in the RY 2020 Population Needs Assessment.

2020 PNA Action Plan Review and Update Table	
Enhanced HEDIS® Call Campaign - a "Concierge-like" Program	
Objective 1.) Increase HEDIS® care gap closure by 20% by December 31, 2020 using a concierge-like program addressing any social determinants of health that may impede the member's ability to complete a PCP visit. **Data source:** HEDIS® member level data	**Progress Measure:** ***UHCCP CA partnered with vendor, ConsejoSano, who performed cultural and linguistically appropriate member outreach in the form of e-mails, mailers, and live calls in 2020 and 2021. ConsejoSano conducted outreach to 5,223 unique members in 2020, with an engagement rate of 37.79% indicating members were successfully contacted and/or the member opened e-mails. The reported engagement rate for 2020 was 27.44%. A reported 9.55% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls. UHCCP CA will conduct a thorough analysis of the HEDIS care gap closure rate and the effectiveness of the program in Q3 2021.*** **Data source:** HEDIS® member level data and ConsejoSano Utilization Reports
	Progress Toward Objective: In 2020, UHCCP CA partnered with ConsejoSano to deliver a *HEDIS® Call Campaign - a "Concierge-like"* Program. ConsejoSano is a vendor offering culturally and linguistically appropriate health education messaging to health plan members. ConsejoSano would deliver member engagement campaigns for a series of select HEDIS® measures that did not meet the MPL in RY 2019 such as CCS, CDC, CBP, and Well-Child Visits. However, due to the COVID-19 pandemic and competitive priorities, the program successfully launched in Q4 2020. Due to the delayed launch and limited data, UHCCP CA was unable to determine the effectiveness of the program. Thus, UHCCP CA will continue to partner with ConsejoSano in 2021. An in-depth analysis of the effectiveness of the program will be conducted in Q3 2021 and will be referenced as the *HEDIS® Preventive Care Campaigns Addressing Health Disparities.*
Strategies	
Strategy 1.) Target eligible members with an open care gap and coordinate appointment scheduling.	**Progress Discussion:** UHCCP CA provided ConsejoSano with a targeted list for eligible members with an open care gap for the select HEDIS® measures. As such, ConsejoSano performed member outreach in the form of e-mails, mailers, and live calls in 2020 and 2021. ConsejoSano conducted outreach to 5,223 unique members in 2020, with an engagement rate of 37.79% indicating members were successfully contacted and/or the member opened e-mails. Engagement was defined as the number of unique members who made an appointment while on the call, or they had already scheduled an appointment. The reported engagement rate for 2020 was 27.44%. A reported 9.55% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls. UHCCP CA continues to partner with ConsejoSano in 2021.

Strategy 2.) Connect members to available resources needed to close their care gaps by offering interpretation services, transportation to the member's appointment, and address any other social determinant of health need, such as meals or other priority needs.	**Progress Discussion:** ConsejoSano provides live telephonic agents who are fluent in languages such as Spanish, Arabic, Vietnamese, Tagalog. Member feedback indicated satisfaction with the call agents. Specifically, one member reported how pleased he was to speak to a representative in his preferred language, Tagalog. He noted how that call agent helped him coordinate care with his Primary Care Physician. ConsejoSano has proven to help decrease language barriers and increase access to care. For any additional services, such as transportation, The ConsejoSano agent connects the member with a UHCCP CA call center agent. In turn, the UHCCP CA call center agent addresses any other member need. UHCCP CA continues to partner with ConsejoSano in 2021.
Mom's Meals, a food insecurity project	
Objective 1.) Increase HEDIS® care gap closure by 10% for postpartum care, comprehensive diabetes care – Hemoglobin A1c, and reduce hospital readmission rates by 5% among our high-risk populations with the utilization of Mom's Meals. **Data source:** HEDIS® member level data	**Progress Measure:** ***The implementation of the Mom's Meals food insecurity project has been deferred to 2021. Therefore, no data is currently available to determine effectiveness of the program.*** **Data source:** HEDIS® member level data and Mom's Meals Utilization Reports **Progress Toward Objective:** The onset of the COVID-19 pandemic presented UHCCP CA with unique challenges and limitations. UHCCP CA had to address many competitive priorities and focused on COVID-19 responses. As such, UHCCP CA was unable to implement the Mom's Meals food insecurity project as planned in 2020. Instead, at the peak of the COVID-19 pandemic, the health plan refocused its efforts on an Infant Formula food insecurity initiative to address the impact of food and infant formula shortage reports in local grocery stores. Refer to Other Health Plan Campaigns, Food Insecurity Initiative (Infant Formula). As a result, UHCCP CA will continue to successfully plan implementation of the Mom's Meals food insecurity project in 2021 through 2022. However, the objective and strategies have changed to target the health plan's maternal health population who meet eligible criteria. Refer to the 2021-2022 PNA Action Plan table for a detailed description.
Strategies	
Strategy 1.) Offer Mom's Meals to eligible members with a delivery discharge, hospital readmission, and for high risk Diabetics.	**Progress Discussion:** UHCCP CA is currently working to contract with the vendor, Mom's Meals. However, UHCCP CA has changed its objective and strategies. UHCCP CA will focus on offering the Mom's Meals program to the health plan's eligible maternal health population. Refer to the 2021-2022 PNA Action Plan table for a detailed description.

Strategy 2.) Provide home delivered meals to high-need members who are most likely to suffer negative health outcomes due to poor nutrition or food insecurity.	**Progress Discussion:** In partnership with Mom's Meals, UHCCP CA will continue to plan to provide home delivered meals to high-need members who are most likely to suffer negative health outcomes due to poor nutrition or food insecurity including health education messaging to complete a post-partum visit. Refer to the 2021-2022 PNA Action Plan table for a detailed description.
Integrate Population Health Management focus (Diabetes, Hypertension, Asthma, Post-Partum)	
Objective 1.) Increase HEDIS® care gap closure by 10% by implementing a more integrated population health management approach to our members diagnosed with diabetes, hypertension, asthma, and postpartum care. **Data source:** HEDIS® member level data	**Progress Measure:** ***Limited data is available to infer a correlation between an increase in HEDIS® care gap closure rate and an integrated population health management approach to our members diagnosed with diabetes, hypertension, asthma, and postpartum care.*** **Data source:** HEDIS® member level data and HEDIS® prospective reports
	Progress Toward Objective: In 2020, UHCCP CA conducted a study on health disparities potentially connected to birth outcomes of African American women who are, as a whole, identified as at higher risk of adverse outcomes during and following childbirth, including premature birth, fetal and infant mortality, the intent of this study was to identify any existing disparities and to develop and implement programs to alleviate them. The study examined the prenatal/postpartum claims of UHCCP CA members who gave birth to babies in the measurement period. Data was analyzed to assess differences in race, ethnicity, language, delivery type, complications, and low birth weight. However, findings indicate that the population was very small to infer any significant impact nor draw reliable conclusions from the observed data. Refer to Quality Improvement Plan-Childbirth Disparities in African American Women. Additionally, the focused study revealed a Key Finding for the Plan. UHCCP CA identified an opportunity to develop a Population Health approach to identifying and managing member needs for an expanded set of conditions such as members with diabetes, hypertension, and asthma. Similar studies can be conducted to assess utilization, impact, and characteristics impacting specific populations (age, race, ethnicity, preferred language, etc.) by condition. Focused studies such as these can lead to custom interventions that are data-driven and address the unique needs of UHCCP CA members. Refer to the 2021-2022 PNA Action Plan table for a detailed description.
Strategies	

Strategy 1.) Create member engagement materials and health education self-management materials and tools.	**Progress Discussion:** The plan will continue to develop a Population Health approach to identifying and managing member needs for an expanded set of conditions such as members with diabetes, hypertension, and asthma. This will allow the plan to create custom interventions for the set of conditions that include member engagement materials and health education self-management materials and tools. Refer to the 2021-2022 PNA Action Plan table for a detailed description.
Strategy 2.) Connect members to available resources as needed by offering interpretation services, transportation to the member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs.	**Progress Discussion:** The plan will continue to develop a Population Health approach to identifying and managing member needs for an expanded set of conditions such as members with diabetes, hypertension, and asthma. This will allow the plan to create custom interventions for the set of conditions that include connecting the member to available resources such as interpretation services, transportation to member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs. Refer to the 2021-2022 PNA Action Plan table for a detailed description.
Strategy 3.) Conduct member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits.	**Progress Discussion:** The plan will continue to develop a Population Health approach to identifying and managing member needs for an expanded set of conditions such as members with diabetes, hypertension, and asthma. This will allow the plan to create custom interventions for the set of conditions that include member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits. Refer to the 2021-2022 PNA Action Plan table for a detailed description.

V. Stakeholder Engagement

The Plan utilizes Stakeholder Engagement to impact the PNA. Groups such as the Consumer Advisory Committee, Provider Advisory Committee, and Public Policy Committee are engaged and provide valuable feedback from a member and provider perspective.

1) Consumer Advisory Committee (CAC)

UHCCP CA provides the Consumer Advisory Committee (CAC) with an opportunity to provide input on various health plan activities that may impact the PNA. UHCCP CA provides findings of the PNA, solicits input from the CAC, discusses opportunities for improvement for health plan activities and provides updates to the CAC with progress made towards PNA goals.

In 2020, UHCCP CA's CAC meetings were engaged to provide feedback on some of the health plan activities that would impact results to the PNA. UHCCP CA's Director, Marketing & Community Outreach held a total of four (4) CAC meetings hosted in English and Spanish. These meetings were held in November 2020 via the web-based platform, WebEx, due to limitations presented by the ongoing COVID-19 public health emergency.

At each CAC meeting, the Clinical Quality Manager had the opportunity to promote the Diabetes Prevention Program benefit and encourage interested members to take the eligibility quiz, discussed the 2020 Member Engagement program offerings with a highlight on the new ConsejoSano campaigns, and provide an overview of the 2020 Population Needs Assessment and findings. The Clinical Quality Manager took the opportunity to garner any feedback on other programs or enhancements members would like to see in 2021.

Some feedback received included suggestions of additional topics for future virtual health education classes such as, staying positive during COVID-19, meditation, relaxation, breathing, stress management, and healthy activities for those with physical limitations. Members also suggested to increase promotion of the health education classes through more mailings and postings shared on social media sites. One member stated that she attended various virtual health education classes and enjoyed them. Members were reminded that mailings were sent to promote the classes in September 2020 and encouraged to keep an eye out for additional mailings in 2021. Members were also informed that the class schedule was posted to the health plan public website but access to social media is currently limited. Overall, UHCCP CA identified a need for developing tailored health education topics on contraception, pre-pregnancy planning/pregnancy prevention as well as complementary/alternative medicine; and investing in more frequent member engagement activities to promote the plan's heath education class events.

2) Provider Advisory Committee (PAC)

UHCCP CA can ensure contracted health care providers, practitioners, and allied health care personnel receive pertinent information regarding the PNA findings and member needs through the PAC and HEDIS® monthly meetings held with all FQHC's contracted with the Plan.

In 2020, UHCCP CA conducted four (4) PAC meetings held on the following dates: February 20, 2020, June 18, 2020, August 13, 2020, and November 8, 2020. UHCCP CA's Clinical Quality Manager had the opportunity to present on all pertinent health education and cultural and linguistic programs updates that are pertinent to PNA findings and member needs. Some of the regular agenda items discussed throughout the year include cultural, linguistics and discrimination related grievances and the Diabetes Prevention Program updates. Below are some of the meeting discussion and feedback received from the PAC meetings.

During the Quarter 1, 2020 meeting (February 20, 2020), the Clinical Quality Manager included a summary on the health education care packages stating that 1,816 boxes were mailed, and a telephonic survey was conducted to gather member feedback on the care packages. The Clinical Quality Manager reviewed "My Birth Matters" stating that this campaign is designed to encourage meaningful conversations between patients and their care team about avoiding C-sections unless they are needed. The campaign includes: four animated videos (2 minutes each), patient-facing My Birth Matters webpage, and downloadable print materials in several languages. Additional updates provided included regular standing agenda items discussed throughout the year including cultural, linguistics and discrimination related grievances and the Diabetes Prevention Program updates.

During the Quarter 2, 2020 meeting (June 18, 2020), the Clinical Quality Manager provided an update stating that Healthy First Steps integration will take place on June 18th, 2020. The Clinical Quality Manager stated that UHCCP CA will partner with ConsejoSano to design culturally diverse member-facing campaigns that provide personalized engagement, navigation, and education services to members on a scheduled basis. Campaigns will include a 2-way SMS messaging (pending operations to meet state and federal Telephone Consumer Protection Act (TCPA requirements), secure email, mailers, and live outbound calls as needed. They will target different topics including pediatric wellness, women's health, diabetes, maternal health, and annual well care. They will be available in English, Spanish, Tagalog, and Arabic. Additional updates provided included regular standing agenda items discussed throughout the year including cultural, linguistics and discrimination related grievances and the Diabetes Prevention Program updates.

During Quarter 3, 2020 meeting (August 13, 2020), the Clinical Quality Manager advised the committee that there are Virtual Health Education Classes being offered in English and Spanish. Topics for the classes include Childhood Health, Women's Health, Cooking Class, and Diabetes.

Furthermore, additional updates provided included regular standing agenda items discussed throughout the year such as cultural, linguistics and discrimination related grievances and the Diabetes Prevention Program updates.

During Quarter 4, 2020 PAC meeting (November 8, 2020), the Clinical Quality Manager presented on the ConsejoSano campaigns stating that the vendor is delivering member-facing campaigns targeting members who have not yet seen their doctor for a pediatric wellness exam, women's health screenings (like a pap smear), diabetes, maternal health care, and/or annual well care. Campaigns are offered through email, mailers, and live outbound calls in the members' preferred language. Additional updates provided included regular standing agenda items discussed throughout the year including cultural, linguistics and discrimination related grievances and the Diabetes Prevention Program updates.

Finally, UHCCP CA conducts monthly HEDIS® meetings with all FQHC's that are contracted with the Plan. This additional meeting allows for more discussion on PNA activities in findings, including on topics related to health education programs such as the Diabetes Prevention Program, Baby Blocks program (Healthy First Steps), health education care package quality initiative, and health education classes.

3) Public Policy Committee

UHCCP CA conducts a standing Public Policy Committee (PPC). The committee meets at least quarterly throughout the year. Members and UHCCP CA contract network providers can attend the PPC meetings to learn about the plan, county and DHCS state policy updates. PPC meeting attendees have the opportunity to provide input, feedback regarding the PNA activities, findings, and any member needs. There were four (4) PPC meetings held on March 12, 2020; June 11, 2020; September 10, 2020; and December 10, 2020. During all PPC meetings, the Clinical Quality Manager can provide health education and cultural and linguistics updates regarding the Diabetes Prevention Program, health education resource library, interpreter and translation services, and DHCS all plan policy letters (APLs). Below are some of the meeting discussion items and updates received from the PPC meetings.

During the March 12, 2020 meeting, the Clinical Quality Manager provided an update of the Diabetes Prevention Program (DPP), a coaching program for people at risk for diabetes. Services are provided through Solera Health, a contracted provider. The Clinical Quality Manager stated member-facing materials have been updated to be more inclusive and members are referred to the DPP via providers calling member services. The most current data indicates 95 members have committed to participating in the DPP, including 32 members having completed the enrollment process. Notably, 69% of participants are female and the median age falls within the 18-44 age group. Next steps include receiving data from in-person classes, collaborating with Solera Health to incorporate Fitbit training, and addressing other customer service opportunities for improvement. Other discussion items included APL/Policy updates and transition of Baby Blocks to Healthy First Steps.

During the June 11, 2020 meeting, UHCCP CA's Chief Executive Officer, Chief Medical Officer and the Director of Clinical Quality Manager engaged committee attendees and lead the discussion around the COVID-19 public health emergency. The discussion focused on California-specific data, local response efforts and partnerships, and long-term initiatives. Members gave updates on their experiences and observations surrounding COVID-19. UHCCP CA clinical leadership provided education on general and antibody testing. Additionally, the Clinical Quality Manager had the opportunity to provide relevant DPP updates.

During the September 10, 2020 meeting, UHCCP CA provided COVID-19 public health emergency updates. Clinical leadership provided member education and provider billing information. Clinicians discussed best practices, including appropriate antibody testing. The Clinical Quality Manager Shared DPP updates; notably, the utilization of telehealth services and implementation of CDC-recommended guidelines. To continue connecting with members, UHCCP CA is exploring texting options by partnering with ConsejoSano to design culturally diverse member-facing campaigns. The goal is to provide personalized engagement, navigation, and education services to members on different topics such as pediatric wellness, women's health, diabetes, maternal health, and annual well care. Other modes of communication include secure email, mailers, and live outbound calls as needed. Services will be available in English, Spanish, Tagalog, Arabic, and Vietnamese.

During the December 10, 2020 meeting, clinical leadership provided COVID-19 updates including prevention guidelines and common symptoms, testing sites resources, San Diego County data and statistics, and vaccine updates. The Clinical Quality Manager provided a status update on UHCCP CA's plan to manage notifications/invites to members for various upcoming initiatives; specifically, adding more frequent mailings for health education materials and quality initiatives. Going forward into 2021, UHCCP CA is offering an electronic quarterly member newsletter. Members are notified via a postcard that includes a link to the newsletter. Members may also call into member services and request a written copy. By offering the newsletter in different formats, members have more options and can choose the format best suited to meet their needs.

VI. PNA Reporting and Oversight

Results and key findings of the PNA will be presented to the UHCCP CA Quality Management Committee and Health Education and Cultural and Linguistics Committee in Quarter 3, 2021. The Clinical Quality Manager will manage the 2021-2022 PNA Action Plan, updating outcomes as they become available. A summary of the PNA will be presented to the Provider Advisory Committee, Consumer Advisory Committee, and Public Policy Committee. Members and providers will have an opportunity to provide feedback to enhance the delivery of population management programs. UHCCP CA will incorporate feedback into the RY 2022 PNA as applicable.

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