# Population Needs Assessment

## BLUE SHIELD OF CA PROMISE HEALTH PLAN 2022

**Responsible Health Education and/or Cultural and Linguistics Staff**

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# Table of Contents

# I. Population Needs Assessment (PNA) Overview

## Introduction/Overview

Blue Shield of CA Promise Health Plan (Blue Shield Promise) Population Needs Assessment (PNA) fulfills APL 19-011 requirement by identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues. Blue Shield Promise uses available data which includes public domain California demographic information, census data, Blue Shield Promise administrative data, claims/encounter data. Also included is DHCS required data sources which include the most recent CAHPS survey results and DHCS Health Plan specific Blue Shield Promise Disparity data.

The goal of this assessment is to improve health outcomes and to ensure that Blue Shield Promise is meeting the needs of its members by:

- Identifying member health needs and health disparities.
- Evaluating health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns.
- Implementing targeted strategies for health education, C&L, and QI programs.

Based on findings, an Action Plan is developed as well as an update to the prior PNA Action Plan objectives.

## Procedure, Resources, and Methodologies

Promise collects, assesses, and incorporates data from its member population to guide the development of the PNA and inform priorities for Health Education, Cultural and Linguistic, preventive health chronic disease management programs, and quality improvement efforts. Data used for this analysis includes:

1. 2021 eligibility data
2. 2021 Medical claims and encounters data
3. 2021 Grievance information
4. 2020 DHCS Timely Access data
5. 2021 Language Assistance Program data
6. 2020 Plan specific Health Disparities Data
7. 2020 Healthcare Effectiveness Data and Information Set (HEDIS)
8. 2020 Consumer Assessment of Healthcare Provider and System Survey CAPHS survey data

The Member population was then segmented based on age, gender, race, ethnicity, and assessed by characteristics such as primary language, access to providers in the Members' preferred language, access to interpreters, disability status and other factors to identify gaps in care.

## Summary of Key Findings

Key findings identified through data from Quality Improvement, Health Education and Cultural and Linguistics follow:

- English identified as the preferred language, followed by Spanish as the second most preferred language.
- Among members who have reported their language preference as Spanish, Tagalog, Vietnamese, Arabic, Chinese, or Farsi, 88.39% live within 10 miles of a PCP who speaks their preferred language.
- Top three Member grievances related to cultural and linguistic services include Member perception of provider/provider office discriminating based on race/ethnicity, Interpreter not showing up for appointment, members dissatisfied with ASL Interpreter.
- Top five diagnoses in order of prevalence rank are (1), Contact with and (suspected) exposure to Covid 19 (2) Essential Hypertension (3), Exposure to other Viral Communicable Diseases (4) Chest Pain, unspecified (5) Unspecified Abdominal Pain
- Top five diagnoses in order of prevalence rank for Seniors and People with Disabilities (SPD) Members are (1) Essential Hypertension (2) Type 2 Diabetes (3) Chest Pain, unspecified (4) Shortness of Breath (5) Contact with and (Suspected) Exposure to COVID-19.
- Health Plan specific disparities perinatal data shows that 89.6% of Members meet the timeliness standard for prenatal care.
- CAHPS survey data shows that 50.22% of adults report getting the flu vaccine.
- CAHPS survey data shows that 71.9% of Members report their PCP always communicates well.
- DHCS disparities data shows that only 47.37% of Black/African American Members are controlling high blood pressure compared to 59.37% for all Members.
- CAHPS survey results for access to care for both Adult and Child show that 71.9% and 73.8 % respectively were able to get care quickly either always or usually. Rates are lower than the 2020 CAHPS data for adults Members and higher for child Members with overall measures of 79.3% and 73.2%, respectively.

## Major Objectives in the Workplan

Based on findings, the following objectives were identified

**Objective 1.** Increase the percentage of members who report that their doctor always communicates well from 71% to 75% by June 30, 2024. **Data Source: CAHPS**

**Objective 2)** Increase the percentage of Black/African American members who are controlling high blood pressure from 47.37% to 50% by June 30, 2024. **Data Source: Disparities Data**

**Objective 3.** Increase the percentage of members who receive an annual flu vaccine from 50.22% to 55% by June 30, 2024. **Data Source: CAHPS**

**Objective 4.** Increase the percentage of members who report getting an Interpreter when they need one from 75.8% to 80% by June 30, 2024. **Data Source: CAHPS**

## II. Data Sources:

A variety of data sources were used to identify the needs of Promise Membership. All data utilized for the 2022 Population Needs Assessment is the most recent available and is outlined below.

| Data Source | Description |
|---|---|
| **2020 Healthcare Effectiveness Data and Information Set (HEDIS)** | HEDIS is a comprehensive set of standardized performance measures developed and maintained by the National Committee of Quality Assurance (NCQA). These measures are designed to provide information on health plan performance. Select results from the 22020 HEDIS is presented. |
| **2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey** | Select data from Promise's 2020 Adult and Child CAPHS surveys is presented. |
| **2020 DHCS managed care health plan specific health disparities reports.** | Select health disparities data specific to Promise received from the Department of Health Care Services is presented. |
| **2021 Claims and Encounter Data (Tableau)** | **Disease Prevalence**<br>Disease prevalence for the top 10 major health conditions based on claims and encounter data is presented here. Data corresponds to January 1, 2021- December 31, 2021, timeframe. |
| **Member Surveys and Feedback** | **2021-2021Member Satisfaction Survey with Face-to-Face Interpretation**<br>This survey is conducted to assess levels of satisfaction among Members who received face to face interpretation and American Sign Language (ASL) interpreting services. Results are presented.<br>**2021 Member Advisory Committee**<br>Member Advisory Committee was engaged to help identify barriers to receiving flu vaccines as well as preferred locations for receiving vaccines. |
| **Additional Relevant Internal Data Sources** | **2021 Enrollment Data**<br>Data identifies Member's ethnicity and language preferences for January 1 – December 31, 2021.<br>**2021 Geo Access Language Reports**<br>The Quality Improvement Department generates geo access reports on language, which identify the percentage of primary care practitioners that meet the language and cultural needs of at least 95% of the population in each region. Report generated includes December 1, 2021 – March 31, 2022, timeframe. |

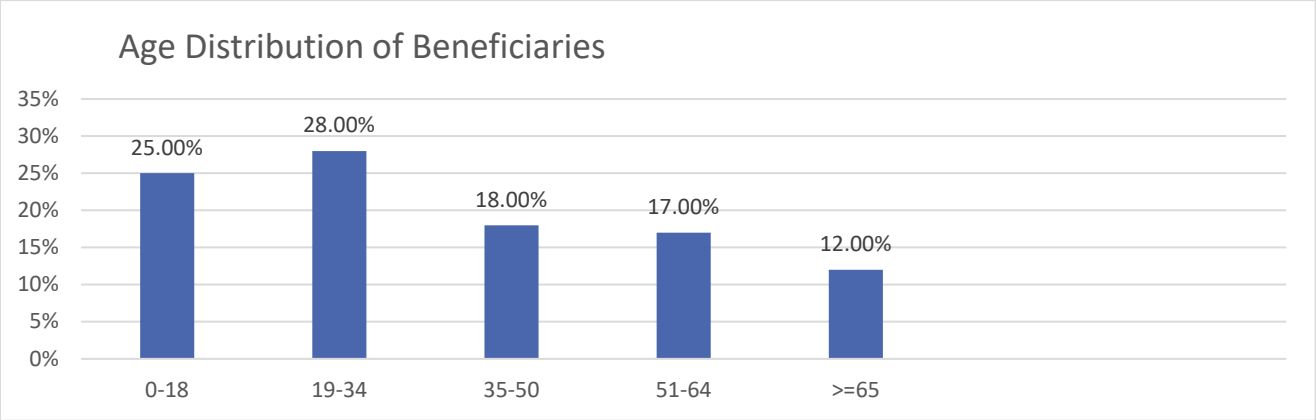
| | |
|---|---|
| | **2021 Analysis of C&L Grievances and Appeals**<br>This PNA report includes findings from 2nd and 4th quarter analysis of grievances and appeals related to cultural, ethnic racial needs and preferences, including religious preferences and linguistic services. |
| **Additional Relevant External Data Sources** | **San Diego County Data**<br>2021 Population of SD County 3,286,069<br>• 13.8% live below the poverty threshold.<br>• $39,737 per capita income<br>• 6.2 % under 65 years live with a disability.<br>• 88.0% over 25 years high school graduates<br>• 39.5% over 25 years bachelor's degree or higher<br>• 37.7 % over age 5 speak another language at home other than English.<br>Source:<br>https://www.census.gov/quickfacts/fact/table/sandiegocountycalifornia,CA/EDU685218#EDU685218<br><br>San Diego Poverty Level by Race/Ethnicity<br>Hispanic 16.4%<br>White 8.16%<br>Asian 10,95%<br>Black 19.93%<br>Source:<br>S1701: POVERTY STATUS IN THE PAST 12... - Census Bureau Table<br><br>**California Data**<br>More than a third of Californians are living in or near poverty. Nearly one in six (16.4%) Californians were not in poverty but lived close to the poverty line (up to one and a half times above it). All told, more than a third (34.0%) of state residents were poor or near poor in 2019. The share of Californians in families with less than half the resources needed to meet basic needs was 4.6%.<br>Poverty in California **- Public Policy Institute of** California |

## III. Key Data Assessment Findings

Member/Group Profile

**Age and Gender**

Females represent the majority gender and comprise 52.05% of the population, compared to males that make up the remaining 47.95%. Promise segmented demographic data by age which identified that the 19-34 age band represented the highest proportion of Members (28%), followed by 0-18 (25%), 35-50 (18%), 51-64 (17%) and 65 and older (12%).




Data source: Promise Membership Dashboard, 2021

### Seniors and Persons with Disabilities (SPD)

The most recent San Diego Medi-Cal membership data indicates a total of **22,108** SPD Members, with females being the majority gender at **54.47%** and males at **45.53%**. Most SPD Members fall into the 65 and older age category **(62.78%),** followed by ages 51-64 **(20.36%),** 35- 50 **(8.47%**), 19-34 **(5.70%),** and 0-18 **(2.69%).** Majority of the SPD members preferred English (56.78%), followed by Spanish (20.47%), and Unknown (13.91%).

Claims and encounter data were analyzed among SPD Members to identify the predominant conditions in which the SPD population are receiving healthcare. Table 1 outlines the findings.

**Table 1**

*Most Prevalent Encounters Among SPD Members*

| Rank | Condition | Number of Count |
|---|---|---|
| 1 | Essential Hypertension | 3,824 |
| 2 | Type 2 Diabetes Without Complications | 2167 |
| 3 | Chest Pain, Unspecified | 1,899 |
| 4 | Shortness of Breath | 1,498 |
| 5 | Contact with and suspected exposure to Covid-19 | 1,340 |
| 6 | Non-specific Abnormal findings of Lung Field | 1,153 |
| 7 | Abdominal Pain | 935 |
| 8 | UNSPECIFIED Chronic Obstructive Pulmonary Disease | 904 |
| 9 | TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA Type 2 Diabetes Mellitus with Hyperglycemia | 903 |
| 10 | COVID-19 | 882 |

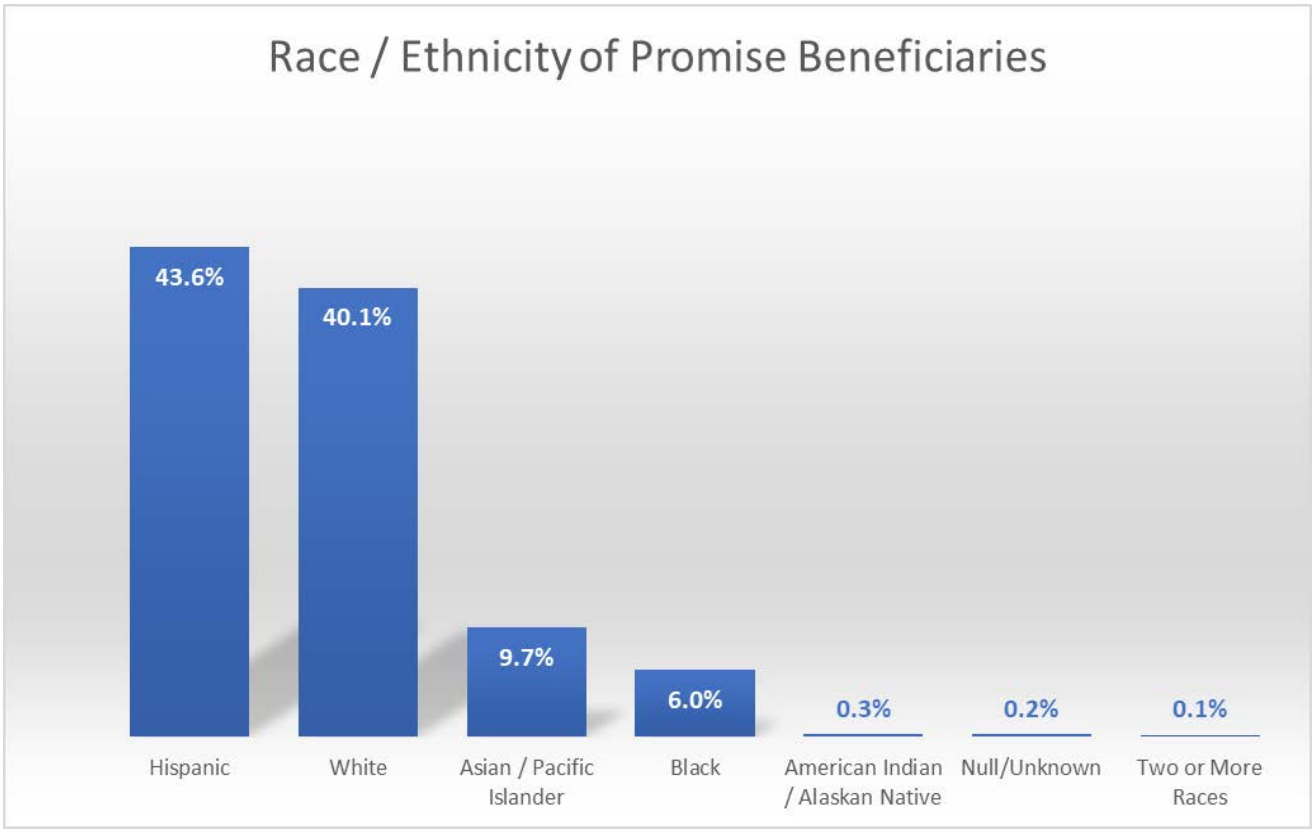
Data Source: Claims and Encounter Data, 2021

### Race/Ethnicity

Based on self-reported and imputed data, most Blue Shield San Diego Promise members in 2021 were Hispanic at 43.6%. The next largest racial group was White at 40.1%, then Asian or Pacific Islander at 9.7%, and then Black or African American at 6%. All other Blue Shield Promise members at less than 1% responded as American Indian or Alaskan Native, two or more races, or their race detail was unknown.

The 5 largest **ethnic** groups in **San Diego**, CA are White (Non-Hispanic) (42.6%), White (Hispanic) (22.8%), Asian (Non-Hispanic) (16.8%), Black or African American (Non-Hispanic) (5.82%), and Other (Hispanic) (4.66%). 39% of the households in San **Diego**, CA speak a non-English language at home as their primary language.

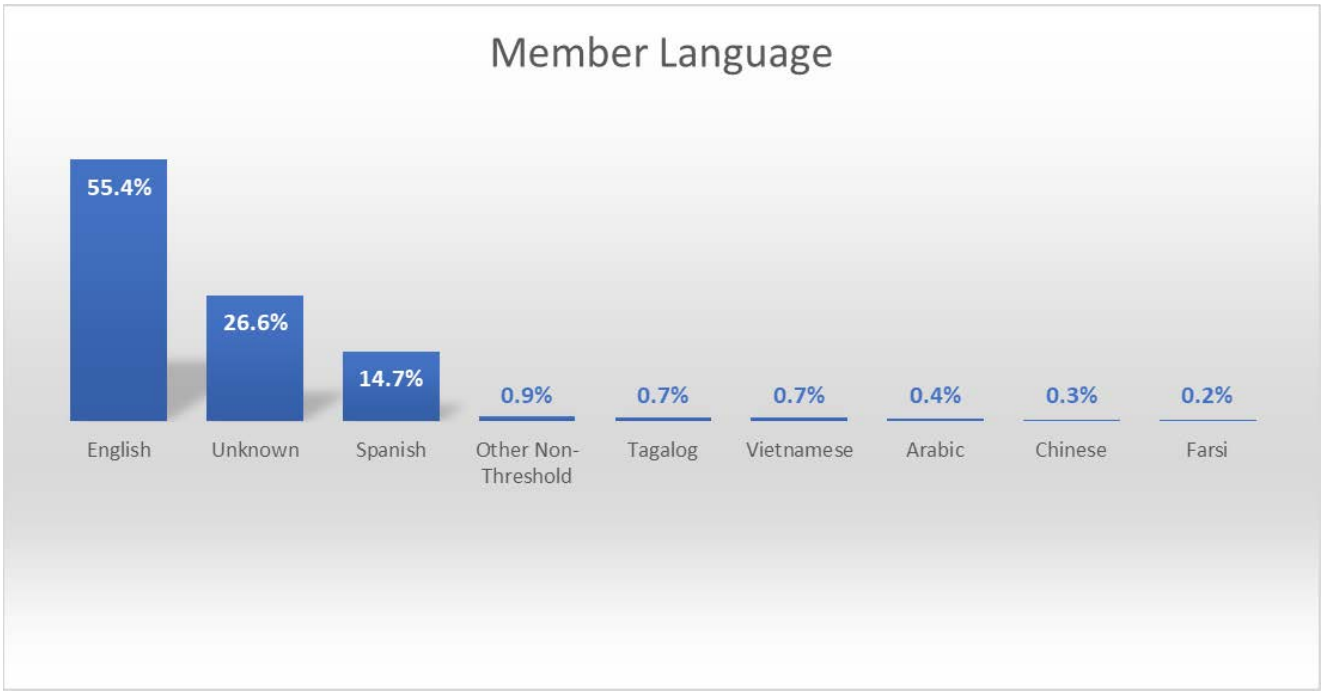
San Diego, CA | Data USA




Source: Promise Member Eligibility San Diego, 2021

### Language Preference

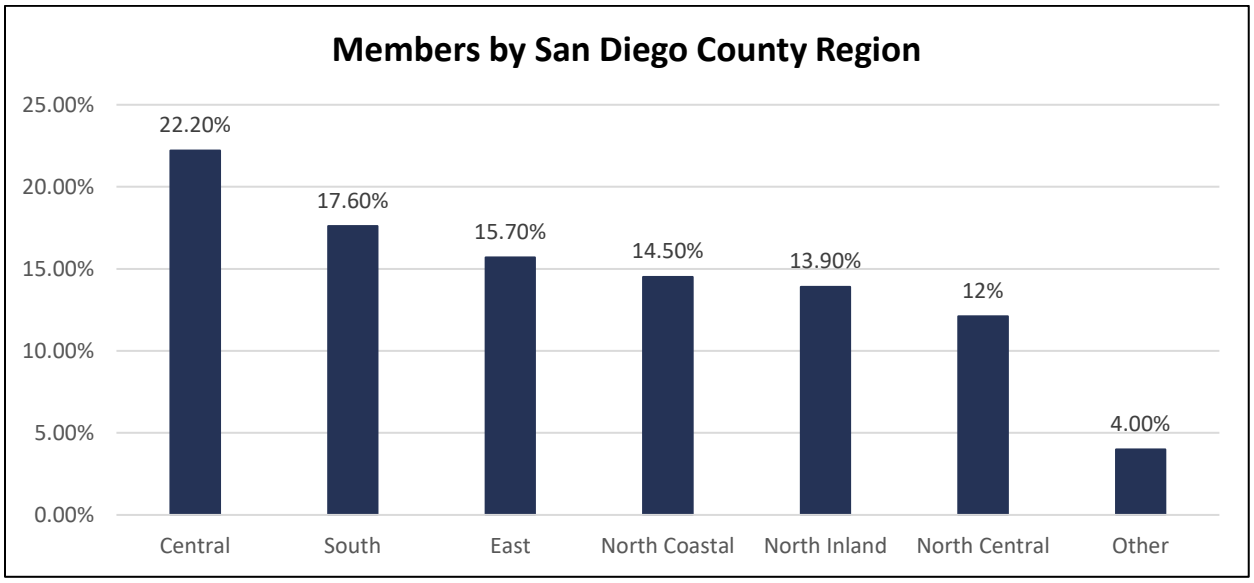
San Diego threshold languages are Arabic, Chinese, English, Farsi, Spanish, Tagalog, and Vietnamese. English was identified as the most preferred language, followed by Spanish as the second most preferred by Members. However, we have noticed through health education referrals that many Spanish speaking parents identify English as their preferred language if their minor child speaks English. Thus, there may be a higher number of adults that prefer speaking Spanish. Additionally, if the Member does not identify their preferred language, it defaults to English.

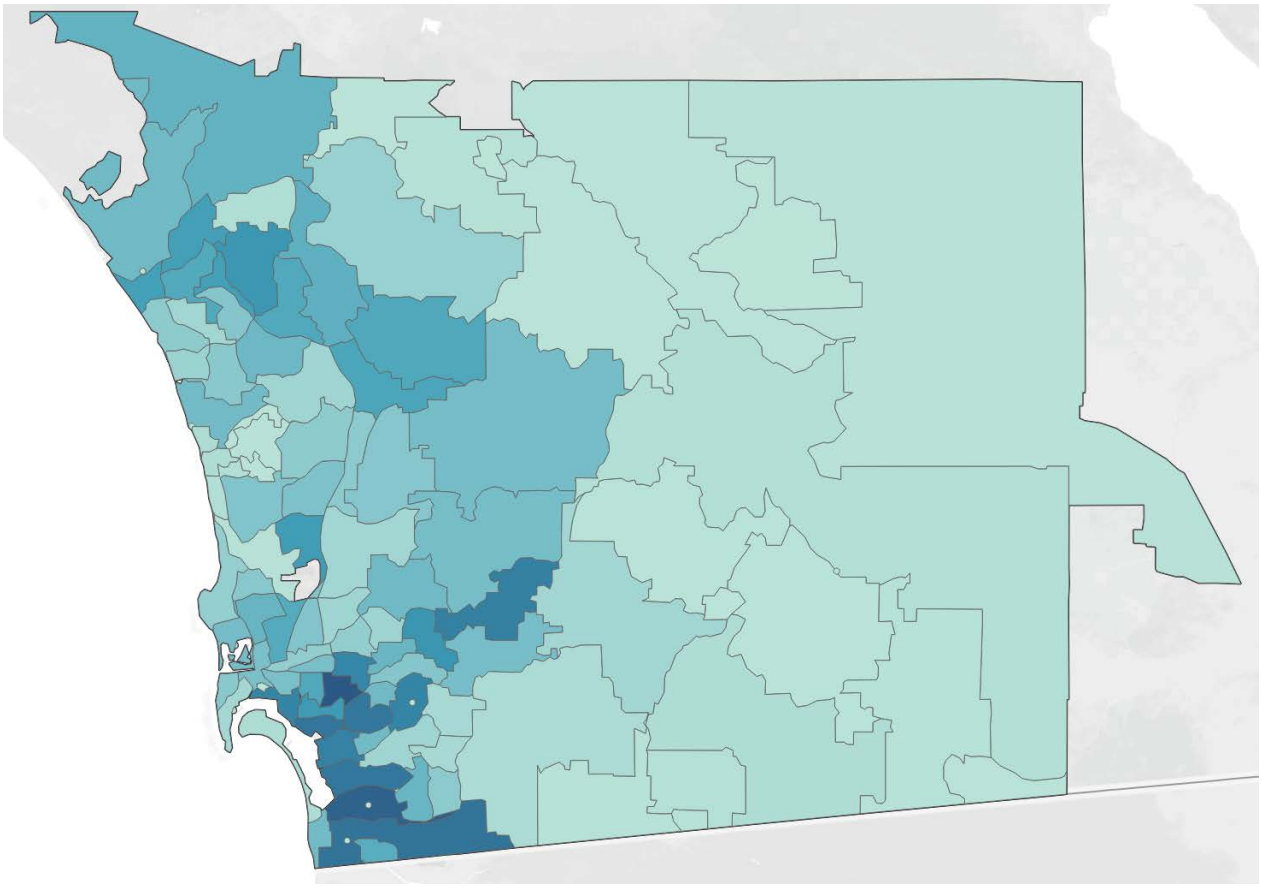



Source: Medi-Cal Member Eligibility, 2021

### Geographic Distribution

The chart below reflects the geographical distribution of members by San Diego County regions. The Central region has the highest proportion of member residency at 22.2%. The rest of the regions have similar distribution of members, ranging from 17.6% (South) to 12% (North Central). Membership density map below broken out by zip code and the proportion of membership within each zip code.





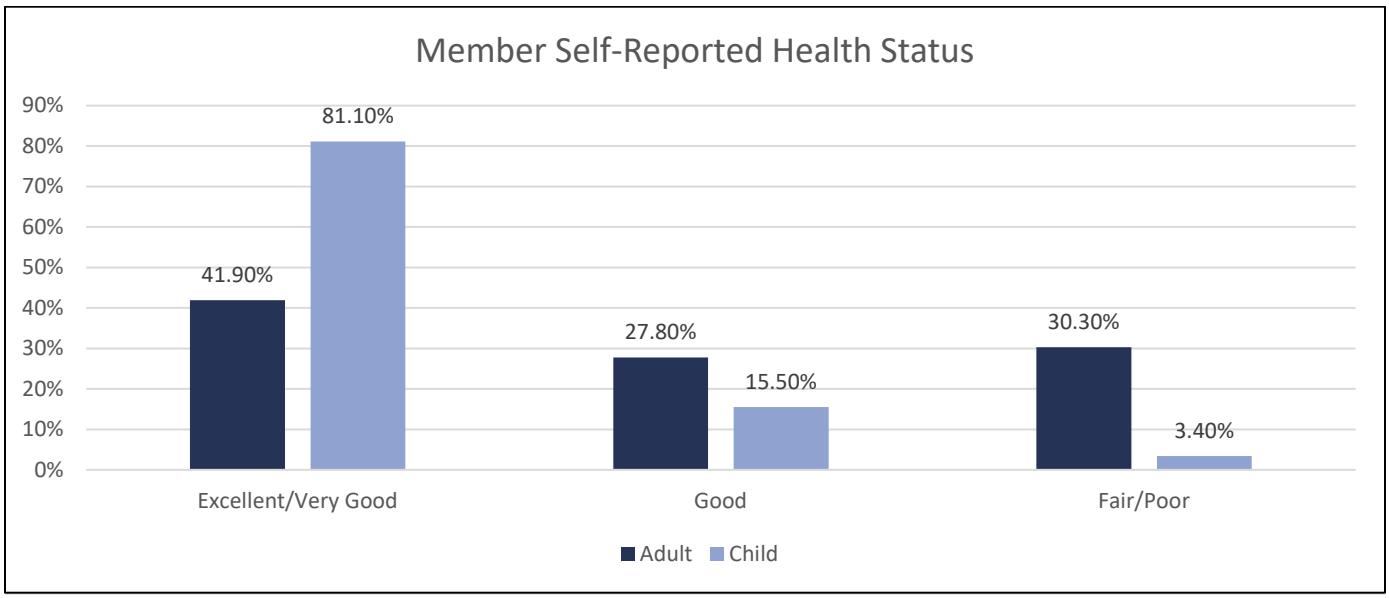

Source: Promise Membership Portal, 2021

### Member Health Status and Disease Prevalence

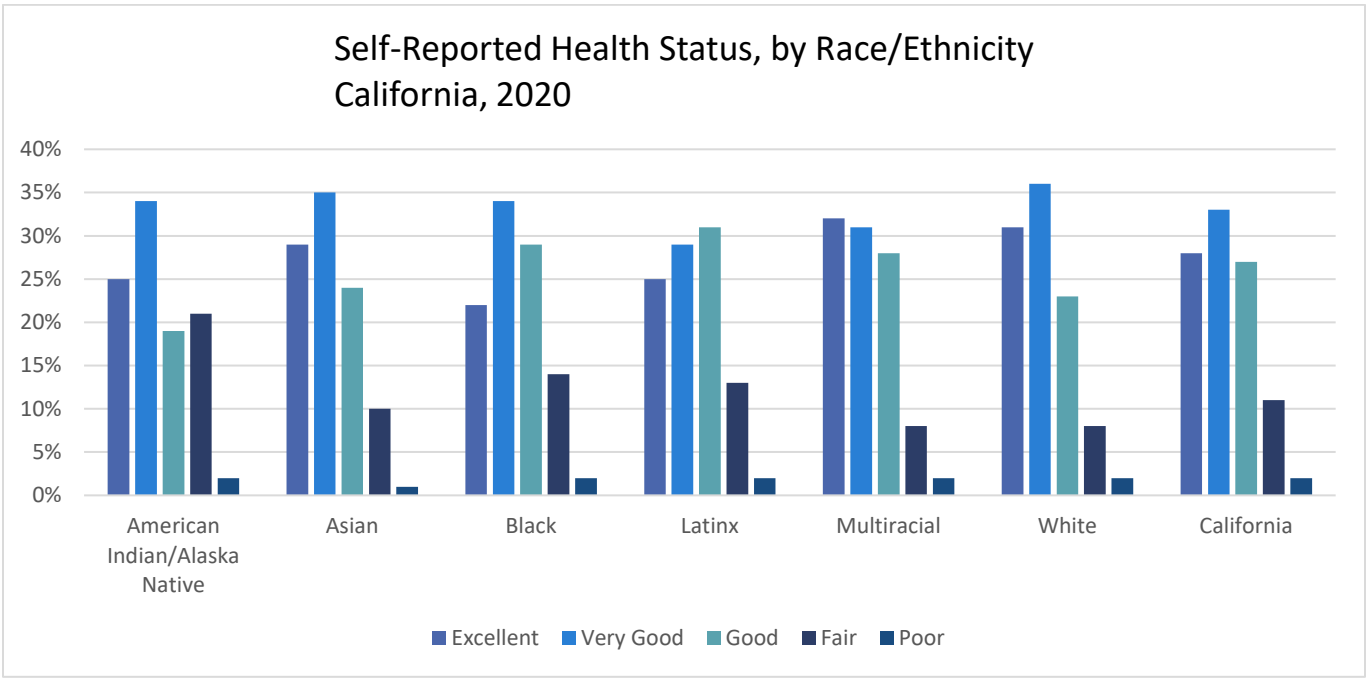
The 2020 CAHPS survey was used to analyze Member perception of their health status. CAHPS data reflects low self-reported health ratings among adult Medi-Cal Members. When adult Members were asked to rate their overall general health, 41.9% reported that their health was excellent or very good As expected, child Medi-Cal Members' health was reported to be more positive when compared to adults.

The 2021 California Health Interview Survey (CHIS) found a larger proportion of White and Asian respondents reported being in excellent or very good health 67% and 64% respectively, while American Indian/Alaskan Native 59%, Black 56% and Latinx 60% populations reported being in excellent or very good health. The worst self-reported health was reported by American Indian/Alaskan Native 23%, Black 16% and Latinx 15%.

According to Wu et al. BMC Public Health 2013, 13:320 http://www.biomedcentral.com/1471-2458/13/320, Self-reported Health is consistent with objective health status and can serve as a global measure of health status in the general population.




Source: CAHPS Adult and Child Surveys, 2021




Source: CHIS, UCLA Center for Health Policy Research, 2021

Furthermore, claims and encounter data were analyzed to identify the most prevalent health conditions among Members. In 2021, Suspected exposure to Covid 19 was the leading diagnosis, followed by Essential Hypertension, Exposure to other communicable diseases, Chest Pain, and unspecified Abdominal Pain.

**Table 2**

*Most Prevalent Health Conditions Among Health Plan Members*

| Prevalence Rank | Condition | Count |
|---|---|---|
| 1 | Contact with and (suspected Exposure to Covid 19) | 7,642 |
| 2 | Essential Hypertension | 3,663 |
| 3 | Contact with and (suspected) Exposure to Other Viral Communicable Diseases | 3,650 |
| 4 | Chest Pain, Unspecified | 3,406 |
| 5 | Unspecified Abdominal Pain | 2,260 |
| 6 | Type 2 Diabetes Mellitus Without complications | 1,986 |
| 7 | Shortness of Breath | 1,854 |
| 8 | Covid-19 | 1,831 |
| 9 | Other Chest Pain | 1,709 |
| 10 | Dietary Counseling and Surveillance | 1,607 |

Source: Claims and Encounter Data, 2021

## Access to Care

The 2021 Adult and Child CAHPS composite rate results were used to compare access for Medi-Cal Members. When asked about getting needed care, 78.5% of adult Members and 78.0 % of child Members' parents responded that they were able to get the care usually or always they needed. Rates are higher than 2020 CAHPS data for adult Members and lower for child Members with overall measures of 67.8% and 81.4%, respectively..

When asked about getting care quickly, 75.3% of adult Members and 82.3 % of child Members' parents responded that they were able to usually or always get the care quickly. Rates are lower than the 2020 CAHPS data for adults Members and higher for child Members with overall measures of 79.3% and 73.2%, respectively.

Furthermore, these composite results were segmented by age and race/ethnicity to measure how access to care differs among our population.

The following tables indicate the percentage of respondents within each age band that responded that they always or usually get needed care and get care quickly. Overall, when it comes to getting needed care and getting it quickly, adults ages 18-34 report lower percentages while adults ages 55 or older report the highest percentages.

| Access to Care (Adults) | Age Band | | | |
|---|---|---|---|---|
| | 18-34 | 35-44 | 45-54 | 55 or older |
| Getting needed care | 59.42% | 66.4% | 76.9% | 84.3% |
| Getting care quickly | 65.1% | 61.7% | 77.6% | 79.6% |

| Access to Care (Children) | Age Band (based on parental age) | | | |
|---|---|---|---|---|
| | ≤ 24 | 25-34 | 35-44 | 45 or older |
| Getting needed care | 90.0% | 77.2% | 69.1.% | 84.2% |
| Getting care quickly | 85.0% | 89.5% | 76.7% | 82.8% |

Data was further segmented by race/ethnicity among the adult and child population. The following tables reflect differences by race/ethnicity when comparing getting needed care and getting care quickly. The Other adult's category reports the highest rates for getting the needed care; however, when it comes to getting care quickly, African American/Black adults report the most favorable responses.

| Access to Care (Adults) | Ethnicity | | Race | | |
|---|---|---|---|---|---|
| | Hispanic/Latino | Not Hispanic/Latino | White | African American | Other |
| Getting needed care | 83.1% | 76.1% | 74.9% | 82.8% | 88.5% |
| Getting care quickly | 71.7% | 77.0% | 69.5% | 89.1% | 82.9% |

For children, parents of African American/Black children report the highest rates for getting needed care (grey), and parents of Not Hispanic/Latino children report the highest rated for getting care quickly (grey).

| Access to Care (Children) | Ethnicity | | Race | | |
|---|---|---|---|---|---|
| | Hispanic/Latino | Not Hispanic/Latino | White | African American | Other |
| Getting needed care | 73.2% | 84.0% | 84.5% | 90.0% | 77.5% |
| Getting care quickly | 75.4% | 91.9% | 80.7% | 84.6% | 81.7% |

The 2022 Geo Access survey data was used to assess total providers for each threshold language and Member access to providers in their preferred language and location. There has been decrease in providers (PCP) that speak San Diego threshold languages except for Vietnamese providers. See Table 4a and 4b. The top 6 threshold languages reported by members, aside from English, are Spanish, Tagalog, Vietnamese, Arabic, Chinese, and Farsi. Of the 21,527 members who prefer these non-English languages, 19,027 of them (or 88.39%) live within 10 miles of a PCP who speaks their preferred language. Notably, members whose primary language is Farsi have the lowest access to language-appropriate services with only 79.4% living within 10 miles of a PCP speaking Farsi. These numbers do not take into account 26.6% of members who have not reported their preferred language or 0.9% of members who speak non-threshold languages. These numbers also do not take into account whether members are assigned to a PCP near them who speak their language as their preferred PCP may have a full roster and not accepting new patients. See Table 5.

**Table 4a**

*Total Providers for each Threshold Language*

| Year | Total Providers per Threshold Language | | | | | | |
|---|---|---|---|---|---|---|---|
| | Arabic | Chinese | English | Farsi | Spanish | Tagalog | Vietnamese |
| **January 2021** | 35 | None | 869 | None | 462 | 57 | 32 |
| **January 2022** | 34 | 21 | 843 | 25 | 390 | 45 | 32 |
| **% Increase/Decrease** | **1 (2.85%)** | **21** | **26 (2.9%)** | **25** | **72 (15.5%)** | **12 (21.05%)** | **No Change** |

**Table 4b**

*Provider Rates per 1000 Members*

| 2022 | Arabic | Chinese | English | Farsi | Spanish | Tagalog | Vietnamese |
|---|---|---|---|---|---|---|---|
| **Providers** | 34 | 21 | 843 | 25 | 390 | 45 | 32 |
| **Rate of Providers per 1000 Members** | 61.04 | 62.87 | 12.29 | 90.58 | 21.38 | 51.37 | 36.99 |

**Table 5**

*Member Access to a PCP in their Preferred Language and ≤10-miles or 30 minutes*

| San Diego County Threshold Languages | Total Members | Total Number of Providers 2022 | Total Members with access to a PCP within ≤10-mile speaking the same language | Percent with access within ≤10-mile |
|---|---|---|---|---|
| Arabic | 555 | 34 | 553 | 99 6% |
| Chinese | 313 | 21 | 299 | 95.5% |
| English | 87,444 | 843 | 86,941 | 99.4% |
| Farsi | 252 | 25 | 220 | 79.4% |
| Spanish | 18,564 | 390 | 16,113 | 99.4% |
| Tagalog | 1,008 | 45 | 1,008 | 100% |
| Vietnamese | 835 | 32 | 834 | 99.9% |

Data Source: Medi-Cal Member Eligibility and approved Claims and Encounters, 2021

## Telephonic Interpretation

In 2021, the top-ranking languages requested for telephonic interpretation were Spanish 78.42%, Vietnamese 3.55% Tagalog 2.82%, Armenian 1.9%, Russian 1.88%, Arabic 1.8%, Korean 1.37%, Farsi 1.09%, Cantonese 0.94%., Other 3.15%. Refer to Table 6.

Services are consistently monitored through grievances, Customer Care department, and Vendor reports on access time. There were no gaps found in phone interpretation services. The numbers in the table below reflect the total number of telephonic interpreter calls and not unique member counts. Telephonic service calls reflect all usage throughout the company and are not limited to provider offices. The majority of the calls requiring Spanish interpretation are used internally at Blue Shield Promise. For example, even though Blue Shield Promise has Care Coordinators who speak Spanish, there are times when a member calls and a Spanish-speaking Care Coordinator is not available, so the Care Coordinator will use an interpreter.

**Table 6**

Member Usage of Over the Phone Interpreters

| Language | Total Calls | Percentage |
|---|---|---|
| Grand Total | 9137 | 100.0% |
| **SPANISH** | 7166 | 78.42% |
| **VIETNAMESE** | 324 | 3.55% |
| **MANDARIN** | 273 | 2.99% |
| **TAGALOG** | 258 | 2.82% |
| **ARMENIAN** | 182 | 1.99% |
| **RUSSIAN** | 171 | 1.88% |
| **ARABIC** | 165 | 1.8% |
| **KOREAN** | 124 | 1.37% |
| **FARSI** | 100 | 1.09% |
| **CANTONESE** | 86 | 0.94% |
| **OTHER (those less than 0.5%)** | 288 | 3.15% |

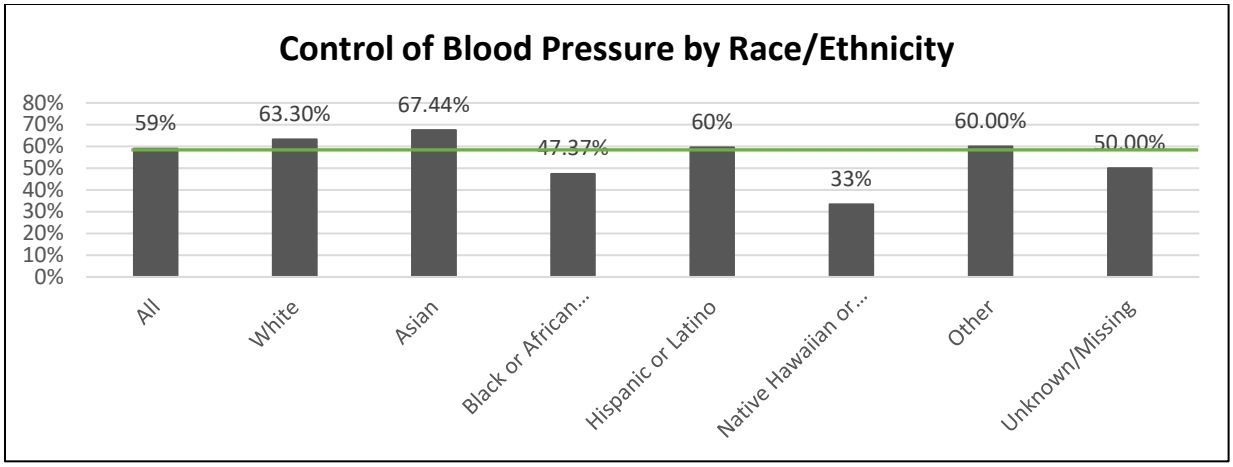
Data Source: Interpreter Vendor, 2021

## Health Disparities

Health Disparities regarding control of blood pressure (CBP) were assessed using the Department of Health Care Services MCP specific health disparities data. Differences were found between Racial/Ethnic groups. Black/African American members have a considerable gap compared to other Racial/Ethnic groups.

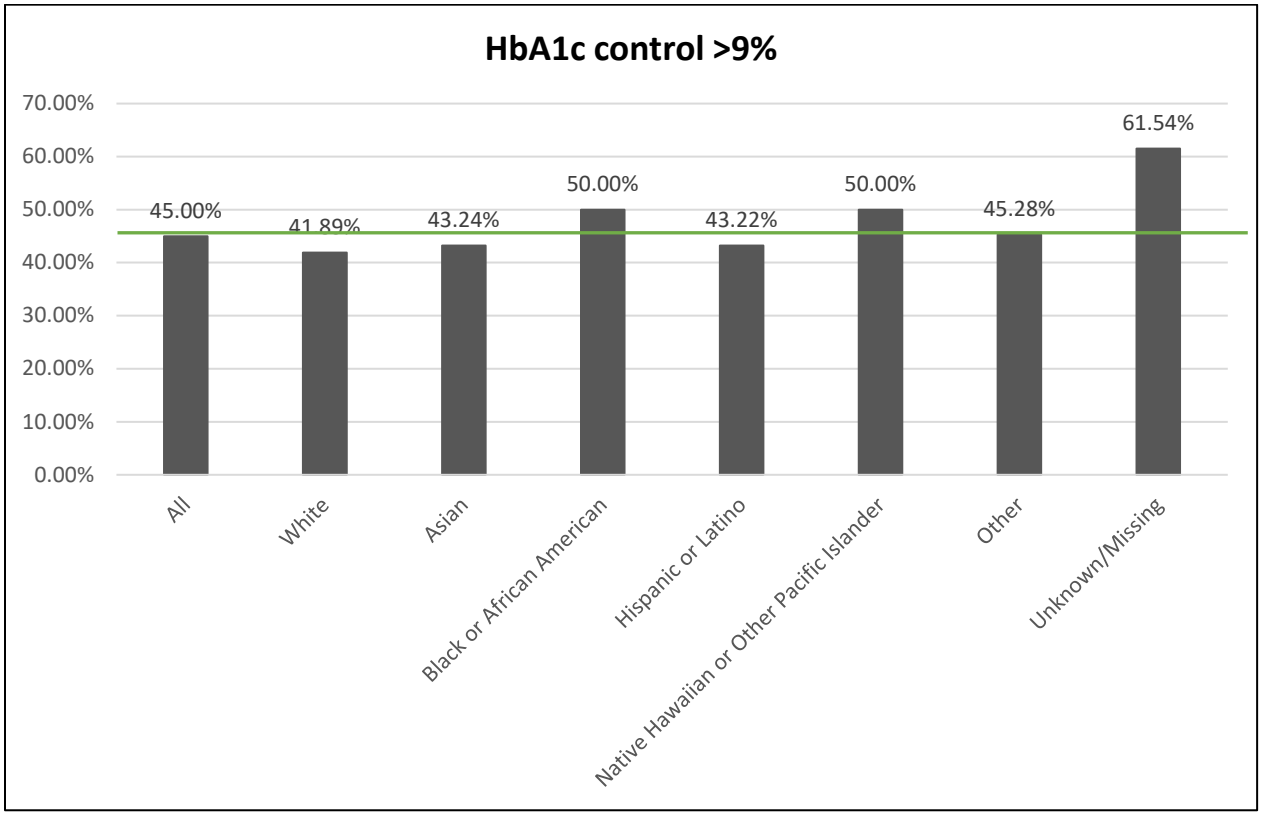
Only 47.37% of Black/ African American members are controlling their blood pressure compared to 67.44% of Asian members, 63.30% of White members, and 59.60% of Hispanic or Latino members.

The disparities identified across Racial/Ethnic groups for Blood Pressure control provide an opportunity for Blue Shield Promise to implement blood pressure control interventions.




Source: MCP Plan Specific Disparities Data, 2020

HbA1c control for A1c levels of greater than 9% were assessed using the Department of Health Care Services MCP specific health disparities data. Disparities between Racial/Ethnic groups were found in the level of diabetes control. White Members (41.89%) had better control reporting lower percentage of A1c levels of greater than 9% compared to African Americans (50%), Hispanic/Latino (43.22%), Asian (43.24 %), and Native Hawaiian or other Pacific Islander (50%). These disparities indicate the importance of continuing to collaborate with internal departments to develop programs to reduce disparities across our membership.

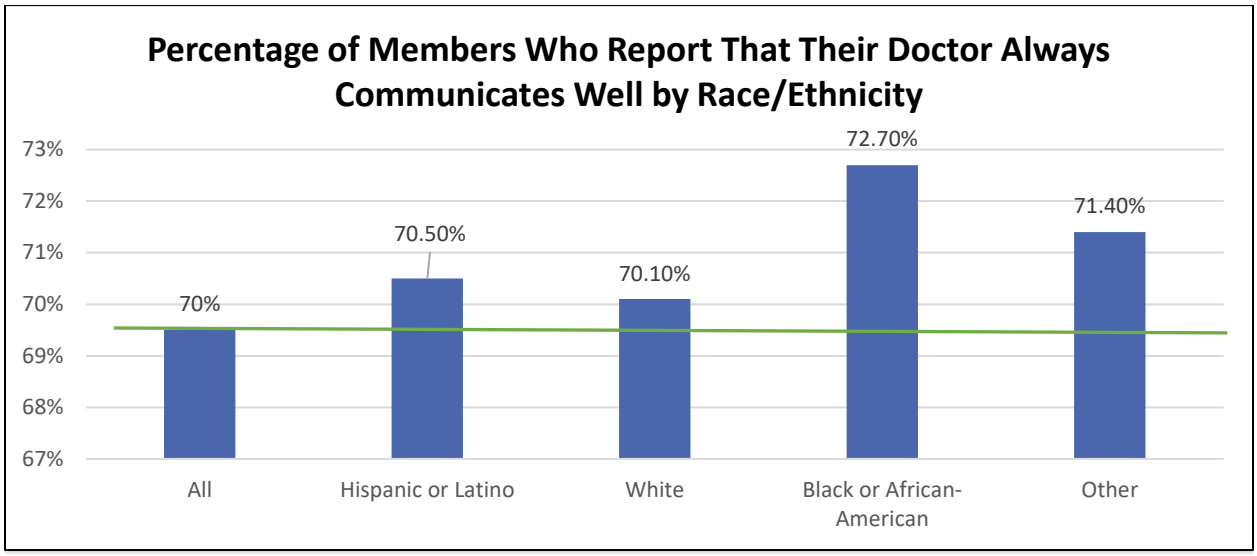



Source: MCP Plan Specific Disparities Data, 2020

## Health Promotion and Education

Health education gaps were assessed using the 2019 Adult and Child CAHPS summary rate results. When asked about health promotion and education, 81.3% of adult Members and 67.6 % of child Members' parents responded that they spoke with their health care provider about preventing illness. Overall, 2019 adult rates demonstrate an 11.3% increase compared to the previous year. However, child rates for 2019 demonstrate a slight decrease from the previous year and resulted in the 10$^{th}$ percentile which is significantly lower than the 2018 Quality Compass National Percentiles.

Furthermore, because communication is a component of the ability to discuss the prevention of illness, composite rates on how well doctors communicate were assessed for gaps. According to the 2020 Adult and Child CAHPS results, the percentage of adult members who reported that their doctor always communicates well was 71%. Health Educators are collaborating with internal health plan departments to implement strategies to improve doctor/member communication by implementing a robust plain language and health literacy Program. (Refer to Objective 1 under Action Plan).




Source: CAHPS, 2020

## Health Education, Cultural & Linguistics (Language Assistance), and Quality Improvement Program Gap Analysis

Health Education gaps were assessed through reviewing member surveys, member feedback about programs offerings. No gaps were identified.

Hypertension and diabetes both rank in the top five most prevalent chronic conditions for all members, including Seniors and People with Disabilities (SPD). Blue Shield Promise Health Educators address these two chronic conditions through providing members access to ongoing hypertension, diabetes, nutrition, weight management and smoking cessation Programs. Health Educators work closely with internal Promise departments and community partners to promote, deliver, and evaluate Programs. Members will continue to have the option of attending individual counseling or group Programs.

Additionally, the Plan offers the evidence-based Stanford Chronic Disease Self-Management Program in English, Spanish, Cantonese, and Mandarin. The Program addresses people with a variety of chronic

health conditions. It aims to build participants' confidence in managing their health and keep them active and engaged in their lives. Past participants have been requesting this program to start as soon as we are able to provide in-person programs. Since the Program is 2.5 hours for six weeks, members report that the support aspect of the program helps decrease depression. Past members develop relationships and support one another outside of the program.

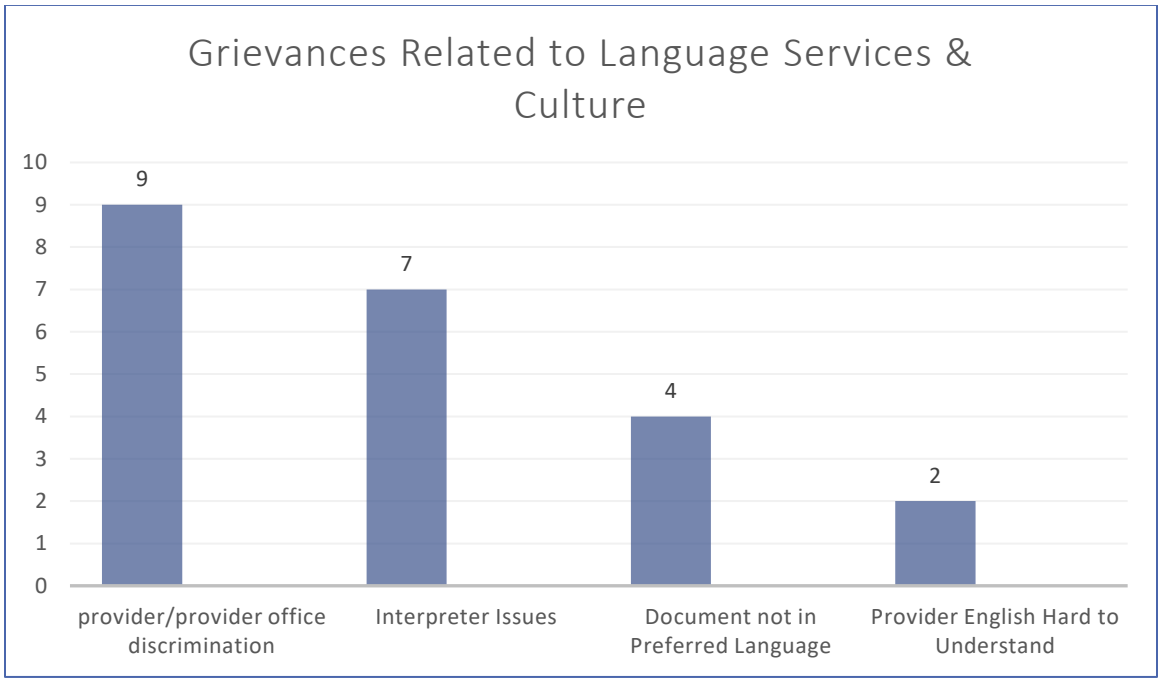
Cultural and Linguistic gaps were assessed through reviewing Geo Access Reports, Telephonic and Face to Face Interpreter reports and Grievance Reports related to language access.

No Cultural and Linguistic gaps were identified for over the phone Interpretation, Translation Process for vital documents meeting required timeframes, access to providers within 10 miles or 30 minutes of residence, and Language Assessment of bilingual staff for their proficiency in their non-English language.

Gaps were identified for member perception of discrimination by provider and office staff, ASL Interpreter not interpreting correctly or being rude, not receiving information in preferred language, and small number for difficulty understanding provider English. See analysis and solutions.

### Gaps Identified through Grievances

The Grievance Department shares all grievances related to language and cultural barriers with the Cultural and Linguistic Department. Departments work together to resolve issues. For 2021, we randomly selected 2nd and 4th quarter 2021 grievances related to language and culture to share for this report. There were twenty-two grievances related to member perception of Provider/Provider office discrimination, ASL Interpreter issues, document not in preferred language and Miscellaneous (provider English hard to understand, hard to get an appointment).




Source: Grievance Reports, 2021

### Gaps Identified

**Provider/Provider Office Discrimination**

There has been an increase in members filing grievances based on feelings of discrimination from provider and provider office staff based on race, ethnic and religious backgrounds.

To reduce disparities, Blue Shield Promise is working with health equity leaders and external stakeholders on strategies to analyze, track, monitor and reduce disparities across our network. Once we have analyzed our data, we will implement internal and external programs. We already have internal staff training in place and will extend these trainings to our provider network as well as develop new strategies to reduce disparities.

**Interpreter Issues**

Blue Shield Promise reduced the number of Interpretation vendors from five to one vendor about a year ago. Our current Vendor has the capacity to cover all geographic areas. A small group of members who had a relationship with our previous vendor feel that current ASL services does not measure up to their past ASL Interpreter. To preclude further grievances, our current vendor has consented to collaborating with the past vendor to arrange to use their ASL services for select members.

Additionally, there have been complaints from members about not receiving an interpreter when they request one. See objective 4 for action plan to remediate this type of complaint.

**Written Communication not in Preferred Language**

Members have complained about not receiving all documents in their preferred language.

Blue Shield Promise Information Technology (IT) department is updating Promise systems to improve our capabilities to provide ongoing information in the members' preferred language.

**Provider English Hard to Understand**

Members complained about their inability to understand their provider's English. Members are offered the opportunity to change their provider. If they are receptive Customer Care helps them change their current provider.

**2021 CAHPS and Disparities Data**
Gaps include Black/African American Members who are not controlling blood pressure, Members receiving flu shots, providers always communicating well with Members, and Members who report not getting an Interpreter when they need one. These gaps have several ongoing interventions as described below in Action Plan Update.

## IV. Social Determinants of Health

Public health professionals now know that the social and economic conditions where people live, and work affect individual and community health. These conditions range from access to healthcare to neighborhood safety and are closely connected to factors such as household income and educational attainment and are known as Social Determinants of Health.

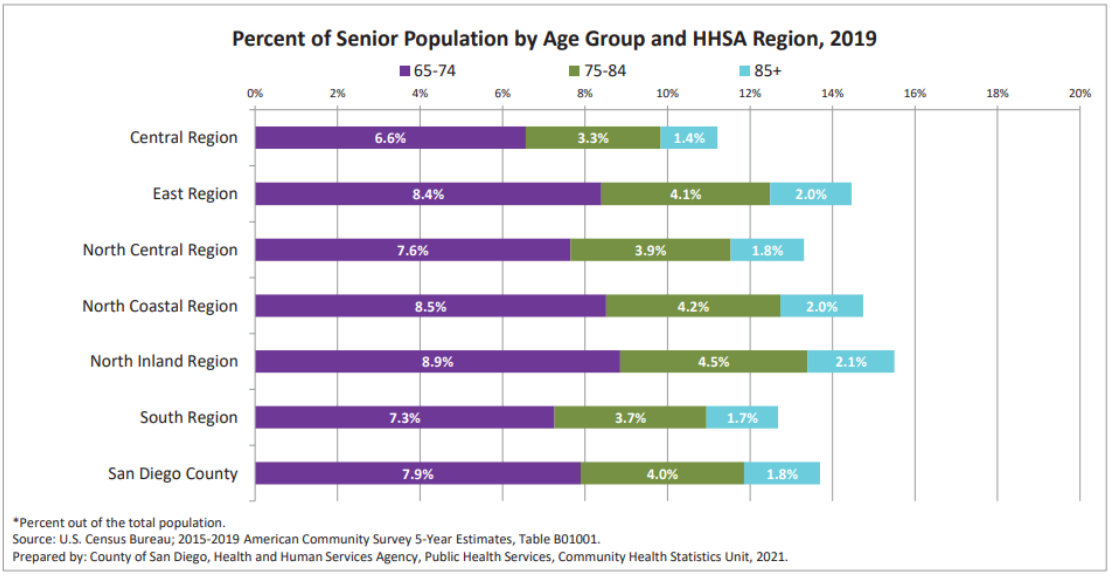
Blue Shield of California developed the Neighborhood Health Dashboard, which uses data intelligence from dozens of sources to create a comprehensive picture of a community's health including health outcomes, preventative health care, utilization and access, health behaviors, social risk factors, and environmental and economic health conditions. The goal is to provide support to community organizations, health advocates, hospitals, physicians, public health officials and policymakers to better understand the health of their neighborhoods and address the needs within their communities. The tool was developed in collaboration with mySidewalk and initially made available to Blue Shield's Community Health Advocates, including those serving in the Blue Shield of California Promise Health Plan Community Resource Centers. The Neighborhood Health Dashboard won the DHCS 2020 Innovation Award for addressing social determinants of health within the communities we support.

This section analyzes key indicators of public health in San Diego County obtained from various data sources within mySidewalk and the Neighborhood Health Dashboard, as well as the Live Well San Diego 2019-2021 Community Health Assessment. Data is not restricted to Promise Health Plan members and is inclusive of the entire San Diego County. This section examines the following key indicators for social determinants of health across San Diego County:

- Demographic profile
- Race-related barriers to health
- Standard of living and vulnerable populations
- Educational attainment
- Maternal and infant health
- Health rankings

**Demographic Profile:** San Diego County is the second most populous county in the State of California, accounting for approximately 8.4% of California residents.

- **Total Population**: According to the U.S. Census Bureau's American Community Survey, San Diego County was comprised of a diverse population of 3.3 million residents in 2020. There were nearly equal percentages of males and females.
- **Age Groups:** Our health needs change as we age. The majority of San Diego County residents were nonelderly adults (aged 25-64). Over one-third of San Diego County residents were aged 25-44, with another 20% between the ages of 45-64. The senior population makes up for 13.7% of the population (distribution by region below, U.S. Census Bureau ACS 5-year, 2015-2019).

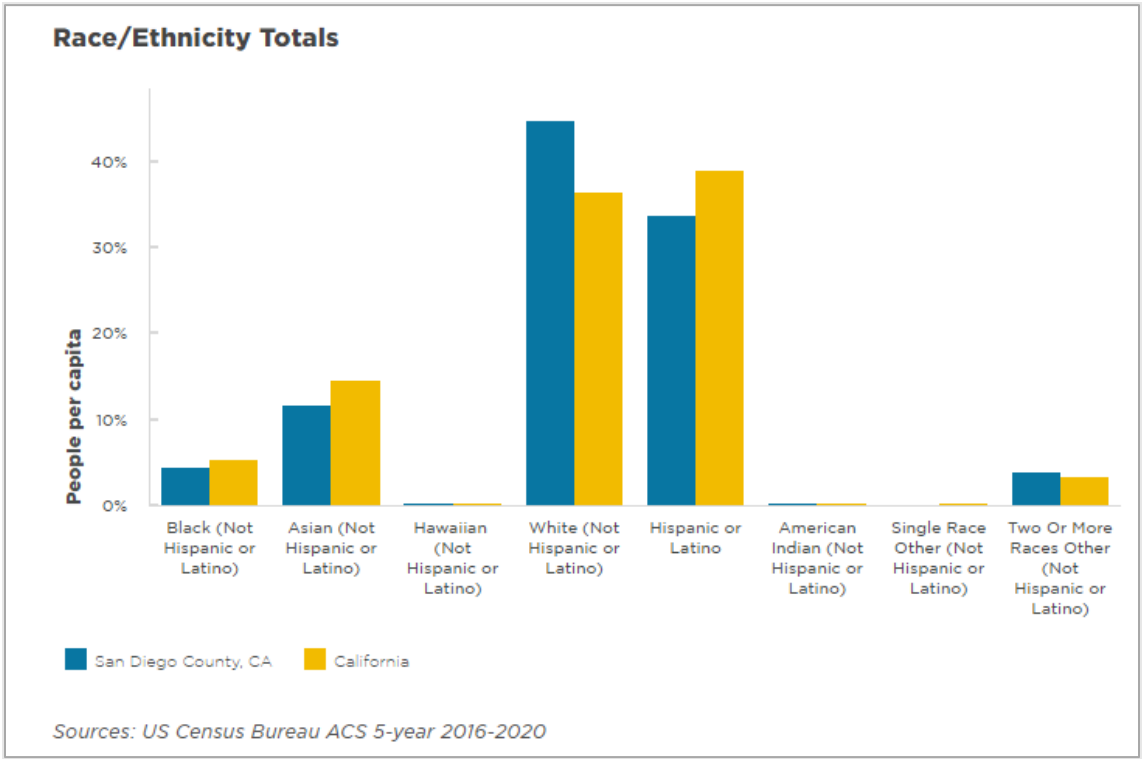



- **Disability Status**: Disabilities include physical difficulties, like trouble walking, and developmental and behavioral disabilities. We can build equity for people with disabilities by making it easier to access needed resources. 9.9% of the population in San Diego County is living with a disability, versus 10.7% of the total population of California (U.S. Census Bureau ACS 5-year, 2015-2019).
- **Veteran Status**: Those who have served in the Armed Forces often have unmet medical needs related to their service. Veterans experiencing homelessness or behavioral health needs face significant challenges to achieving health. Improving access to resources helps veterans achieve good health. Approximately one in ten San Diego residents are veterans (US Census Bureau ACS 5-year 2016-2020).
- **Undocumented Immigrants and Foreign Born:** Migrant workers and immigrants, including those who are undocumented, deserve good health. Culturally appropriate care given in our primary languages breaks down barriers to health care. So does challenging stigma and policies limiting who can access public health care. There are 170,500 undocumented immigrants in San Diego County (Public Policy Institute of California, 2013). 23% of the County population is foreign born (US Census Bureau ACS 5-year 2016-2020).
- **Limited English Proficiency:** People who have limited skill in English have a harder time finding quality care. Language barriers make health care stressful and add an extra step each time we need something as simple as a flu shot. 13.3% of the County population have limited proficiency in English (US Census Bureau ACS 5-year 2016-2020).

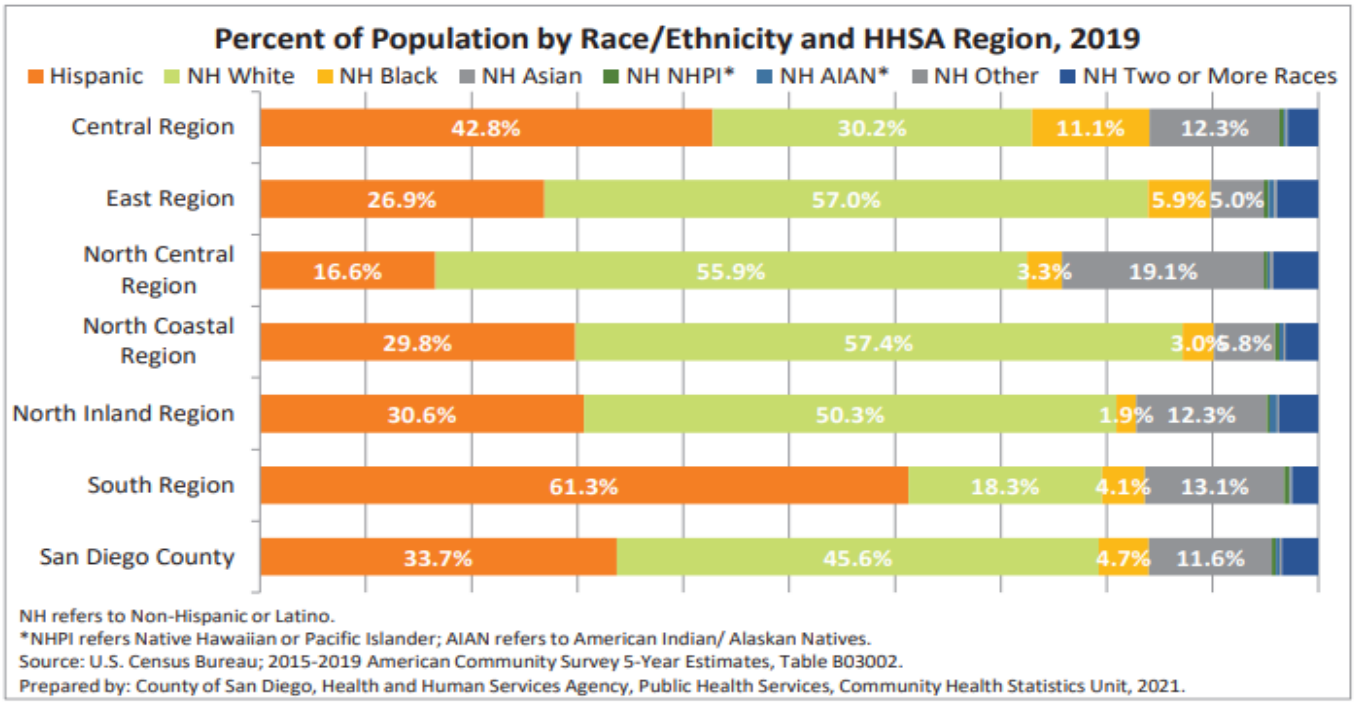
Race Related Barriers to Health: In many communities, People of Color (POC) face greater barriers to opportunity. These barriers are due in part to historical policies and patterns of development that have marginalized many communities of color. People facing poverty and other socioeconomic challenges face barriers to health regardless of their race. San Diego County has a 55% POC population.

- **Race/Ethnicity Totals**: To be able to make choices that support health and well-being, we need to have the opportunity. Centuries of discrimination have created inequities in who

has the opportunity to be healthy. Within the County, over one-third of residents were Hispanic (34%). Almost half were white (45%), 5% were black, and over 12% were Asian or Pacific Islander.

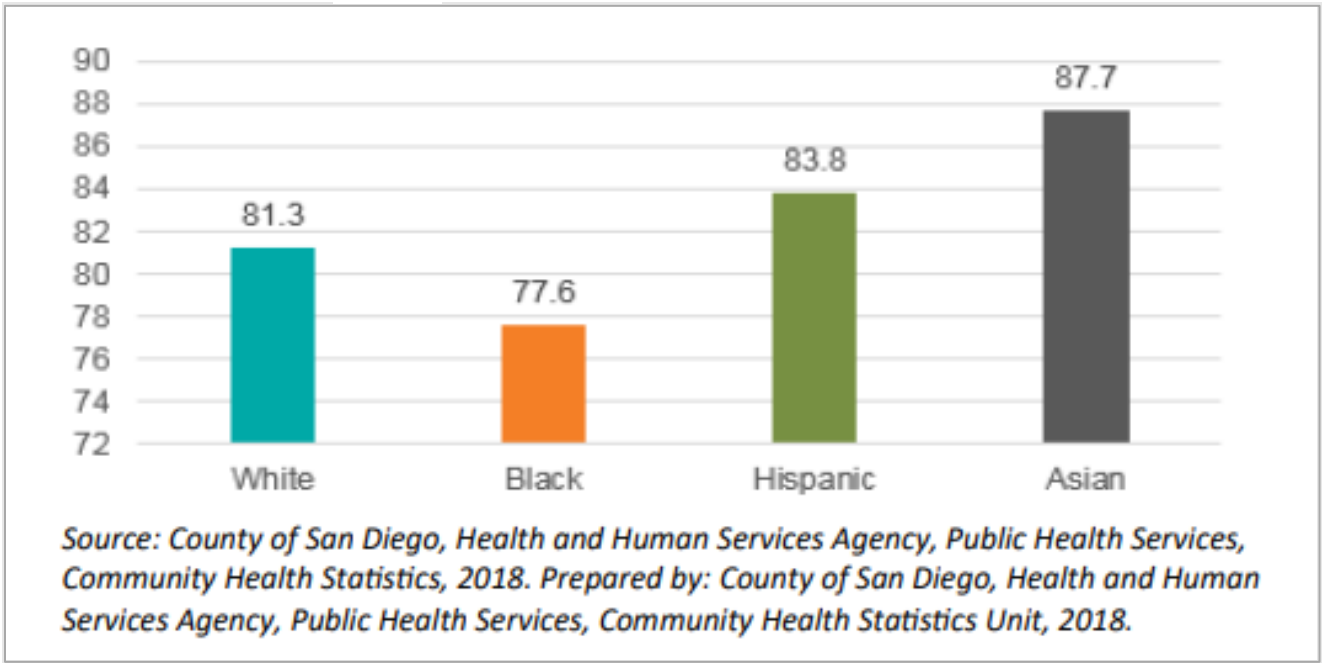



- **Race/Ethnicity Totals by Region**: Data from the US Census Bureau shows that the South Region of San Diego County had the highest percentage of Hispanic residents, with 61.3% of residents identifying as Hispanic. Central Region also had a large percentage of Hispanic residents, with 42.8% of residents identifying as Hispanic. Central Region also had the highest percentage of black residents (11.1%). North Central Region had the lowest percentage of Hispanic residents (16.6%), but also had the highest percentage of Asian/Pacific Islander residents (19.1%) (U.S. Census Bureau 2015-2019).

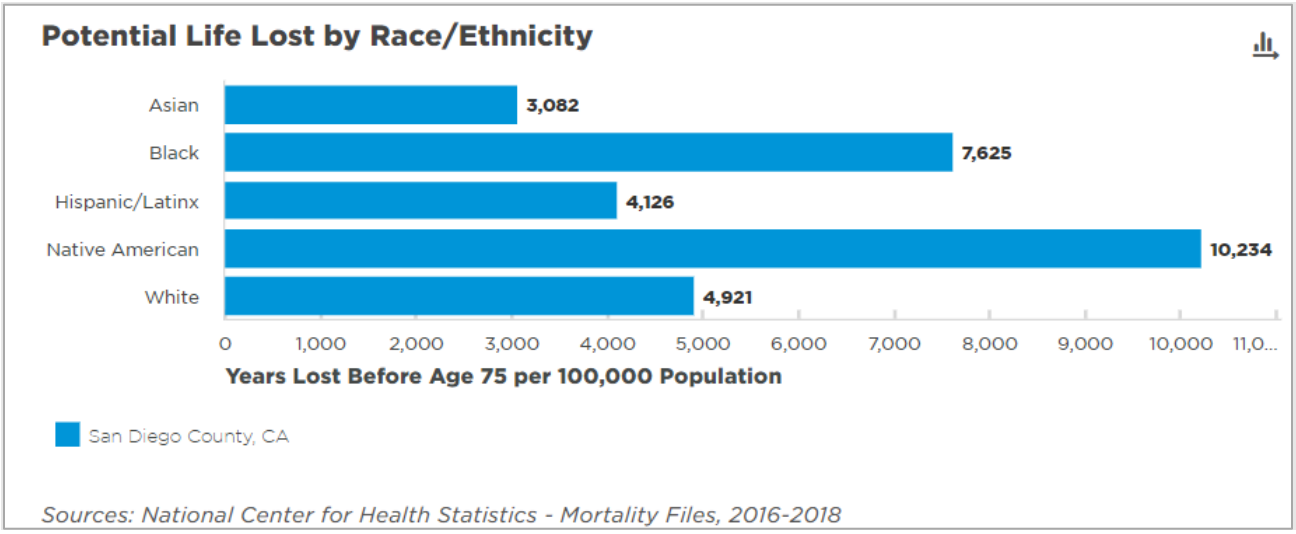



- **Life Expectancy:** When compared by race/ethnicity, Asian residents had the highest life expectancy, at87.7 years, which was higher than the County overall for all races. Hispanic residents also had a higher life expectancy than the County overall, at 83.8 years. Black residents had the lowest life expectancy, at 77.6 years.

**Life Expectancy by Race/Ethnicity, San Diego County, 2016**

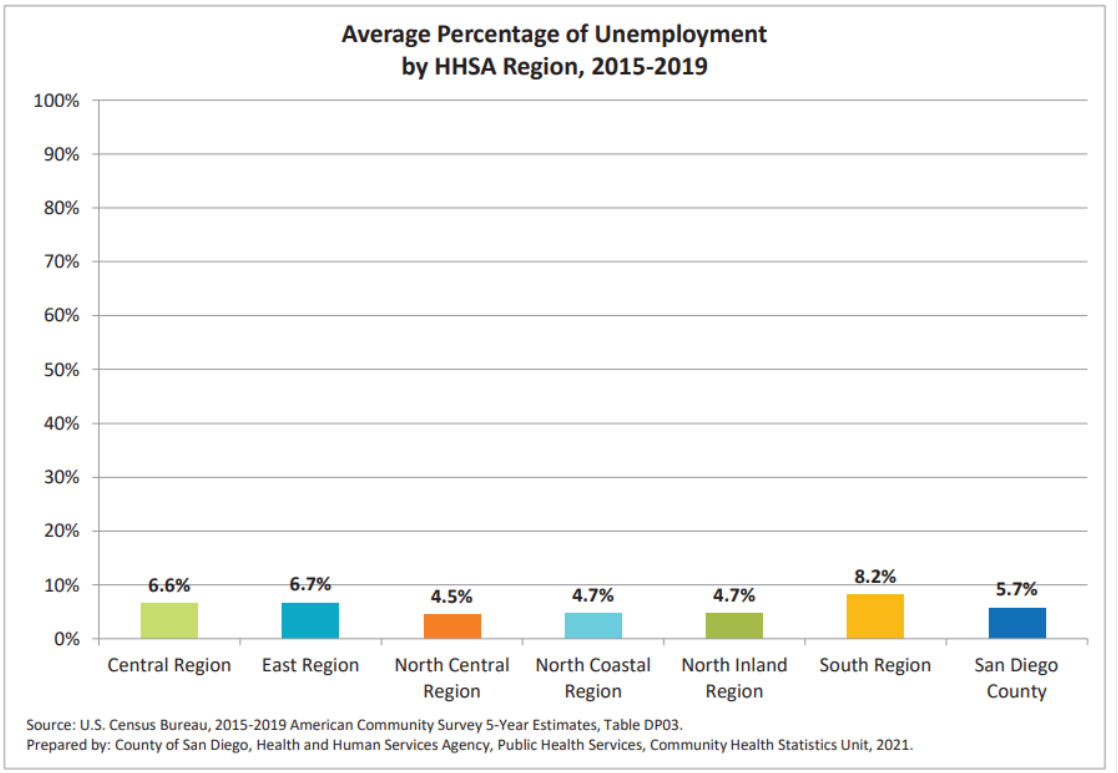


- **Life Lost Due to Early Death:** When someone dies early, we lose all the years that person would have lived had they reached the age of 75. When many people die early, we as a community lose their collective experience and wisdom. That loss is even more acute for People of Color with greater than average premature deaths. The Native American and African American community in San Diego experience significantly more potential life lost due to early death than the overall population.

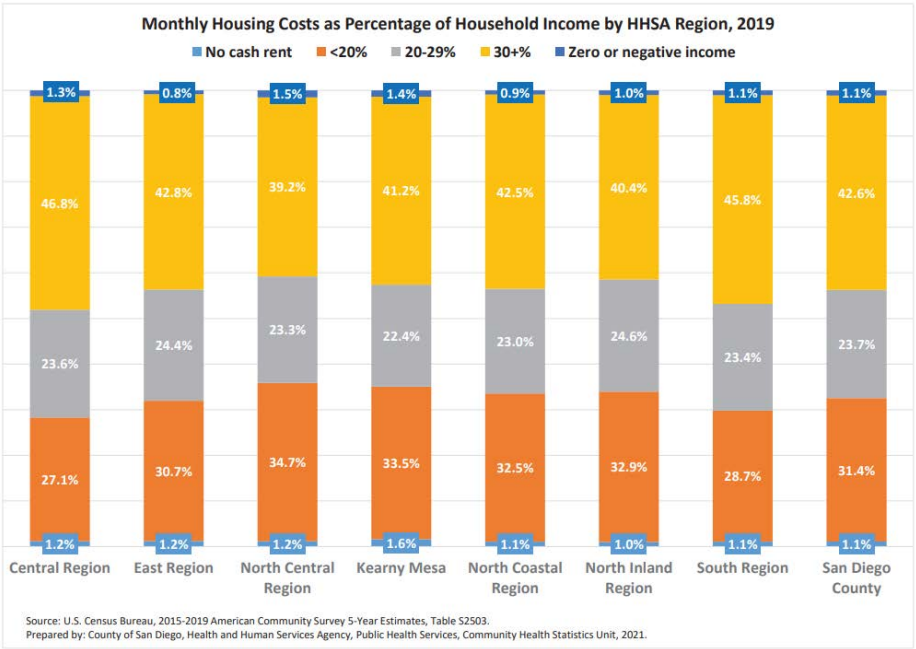



**Standard of Living and Vulnerable Populations:** Standard of living concerns residents having enough resources to live a quality life. Important indicators include the unemployment rate, as both having a steady job and making enough money to live a quality life are crucial to an individual's standard of living. San Diego County is an expensive place to live, and the cost of housing is higher than it is in most other urban areas across the United States. Income is measured by the percentage of individuals who spend less than 30% of their income on housing. Being able to afford adequate housing and still being able to afford other necessities (health care, food, transportation) measures an individual's ability to live well (Live Well San Diego).

- **Unemployment Rate:** Compared to the County overall, the South, East, and Central Regions had the highest percentages of unemployed adults (of those eligible and looking for work). The Region with the lowest unemployment percentage was the North Central Region, at 4.5%.




**Income**: Income is measured as the percentage of the population spending less than one-third of income on housing. Households who spend more than one-third of household income on housing may have difficulty paying for necessities such as food, transportation, or medical care. Nearly 43% of households spend over 30% of income on housing costs in San Diego County.

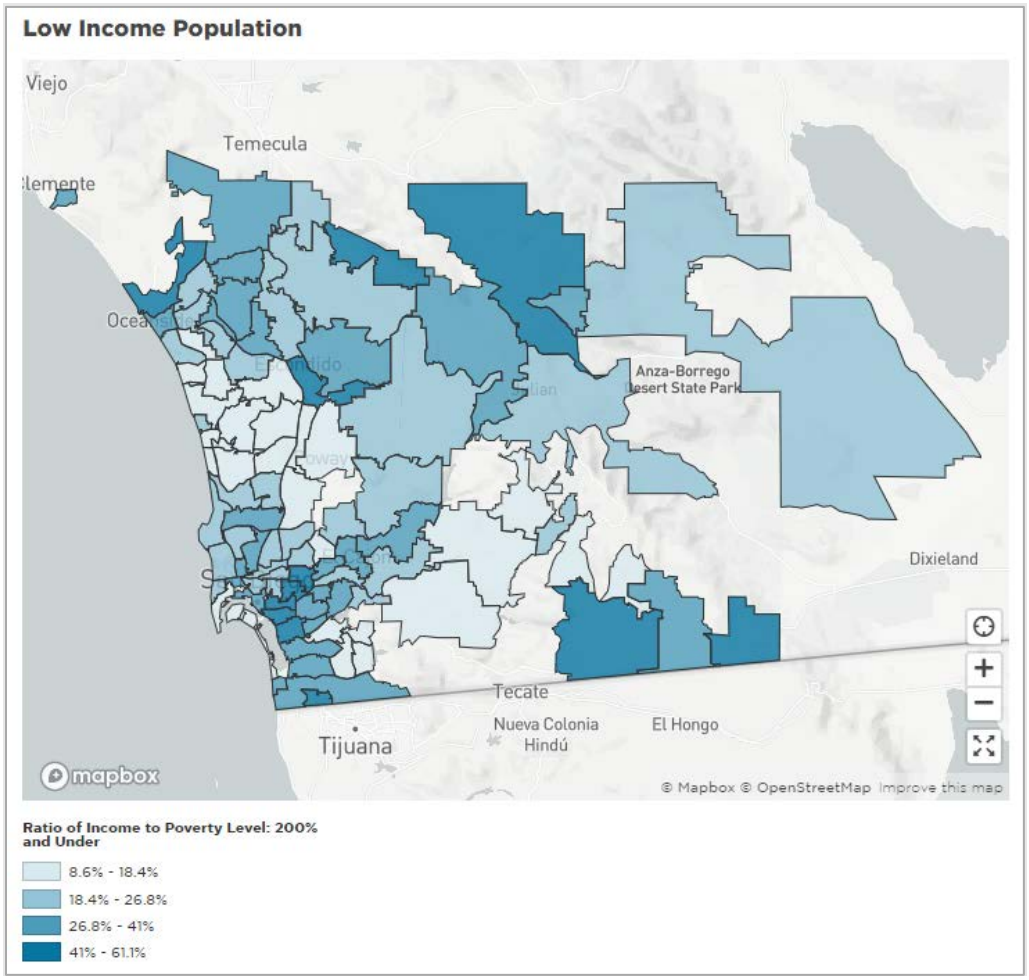


- **Low Income Populations:** The U.S. Census identifies individuals with a household income of up to 200% of the poverty level as low income. Low-income residents in communities with high income inequality face greater health risks. They are more likely to face barriers to healthy choices, such as longer distances to healthy food or affordable healthcare and are more likely to be exposed to environmental risks, such as low-quality housing. 26% of the County population is considered low income, and 11% live 100% below the federal poverty level. The map shows the zip the density of the low income population with an income to poverty level of up to 200%.

**26.2%**
**Ratio of Income to Poverty Level: 200% and Under - Low Income Population**
San Diego County, CA

**10.9%**
**Percent of Population Below Poverty Level**
San Diego County, CA

*Sources: US Census ACS 5-year*

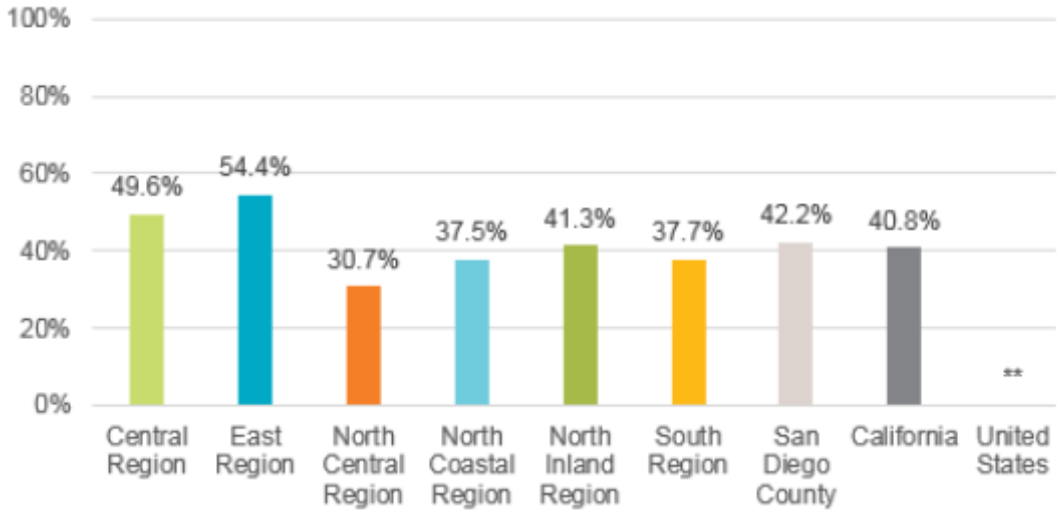



*Sources: US Census Bureau ACS 5-year 2016-2020*

- **Vulnerable Populations (Food Insecurity):** Food insecurity refers to individuals and families who are unable to afford enough food on a regular basis. In turn, they may not have access to

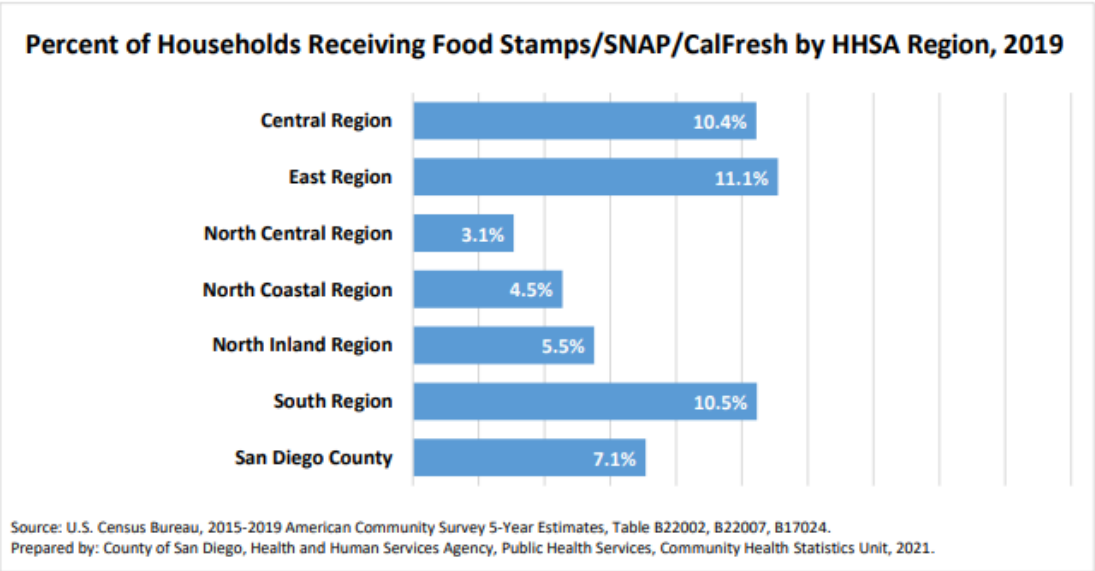
healthier foods essential for good nutrition, and this impacts the health and well-being of the population. Food insecurity is measured as the percentage of the low-income population who have reported an inability to purchase enough food on a regular basis. Of those living below 200% Federal Poverty Level in San Diego County, residents in Central and East Regions were more likely to experience food insecurity than the other Regions, or the County overall. The percentage of food insecurity was slightly higher in San Diego County (42.2%) when compared to the State of California overall (40.8%).

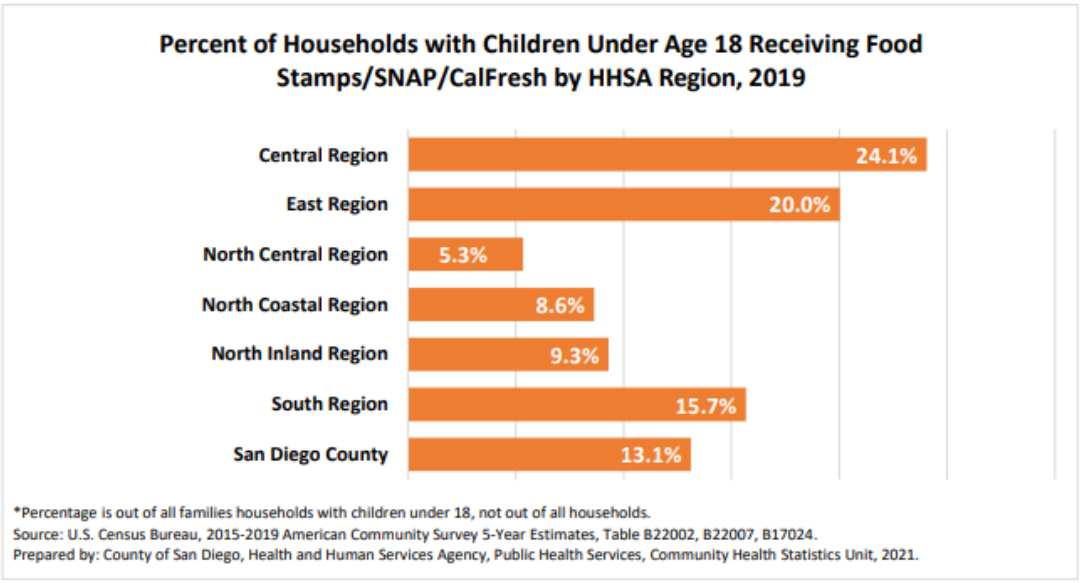
**Food Insecurity (Population Below 200% FPL) by HHSA Region,**




*** Data Not Available.*
*Note: Percent of adult population 200%FPL not able to afford food.*
*Source: 2014-2015 UCLA Center for Health Policy California Health Interview Survey (CHIS). Accessed 9/2017.*
*Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2018.*

- **Food Stamps/SNAP/CalFreah Receipt:** Supplemental Nutrition Assistance Program (SNAP) is a federally funded program aimed to increase the potential of a nutritious diet in low-income households. The purpose of this indicator is to provide estimates of the percent of households, households with children under 18 years of age, and of families that were receiving food stamps/SNAP/CalFresh. The number of households, households with children under 18 years of age, and of families are provided as reference. In San Diego County in 2019, 7.1% of all households reported receipt of SNAP. Of households with families who had children under 18 years of age living with them, 13.1% reported receipt of SNAP.




- **Health Insurance Coverage:** An individual's ability to live well is influenced by their ability to access the health care system, for both urgent medical issues and preventative care. This indicator measures the lack of health insurance for the nonelderly adult population, or those aged 18 to 64. Children and the elderly often are more likely to be eligible for public health insurance programs, such as Medi-Cal and Medicare, than those adults who fall between the ages of 18 and 64. About 92% of the civilian noninstitutionalized population in San Diego County had health insurance coverage and about 8% did not. The percentage of children under the age of 18 without health insurance coverage was about 4%.

**Uninsured Population in San Diego County**

| San Diego County, CA | |
|---|---|
| Uninsured Population (All Race/Ethnicities) | **7.6%** of Total Population |
| Age 18 and Under | **3.9%** of Population 18 and Under |
| White Alone, Not Hispanic or Latino | **4.1%** of White Alone Population |
| Hispanic or Latino | **13.1%** of Hispanic or Latino Population |
| Native Hawaiian and Other Pacific Islander | **7.9%** of Native Hawaiian and Other Pacific Islander Population |
| Asian | **5.2%** of Asian Population |
| Black or African American | **7%** of African American Population |
| American Indian and Alaska Native | **14.3%** of American Indian and Alaska Native Population |
| Multiracial | **8.8%** of Multiracial Population |
| Other Race | **13.9%** of Other Race Population |

*Sources: US Census Bureau ACS 5-year 2016-2020*

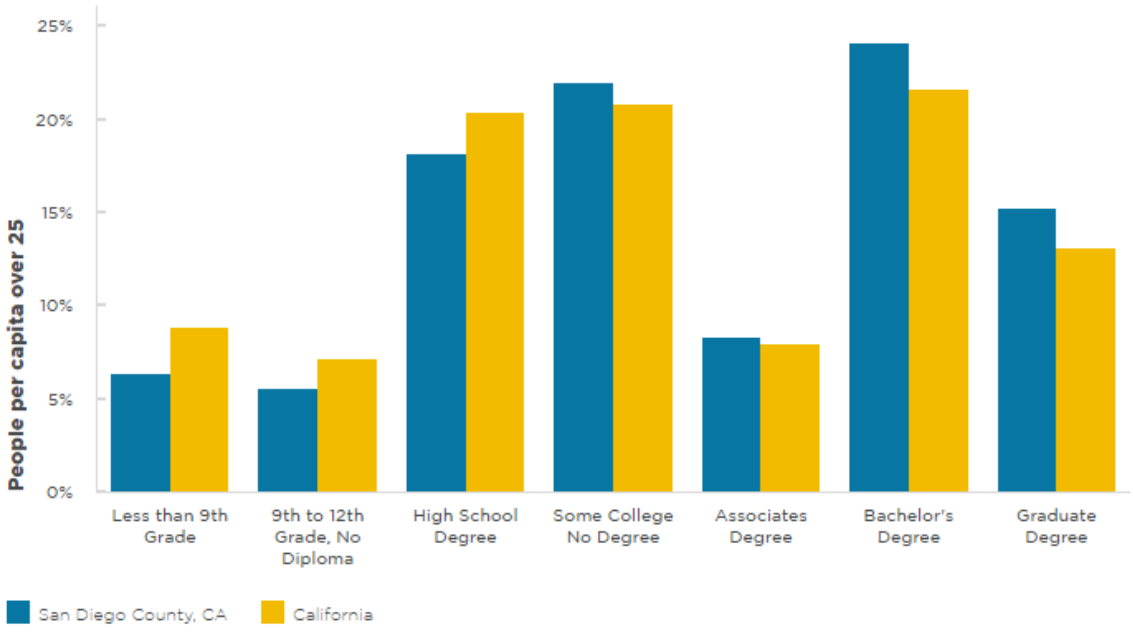
- **Knowledge and Educational Attainment:** Education improves nearly every factor impacting an individual's health. Literacy and the ability to understand health information is correlated with longer lifespans, greater educational attainment improves economic opportunity, and high school graduation is a critical predictor for whether an individual will be exposed to violent crime in their lifetime. Lifelong educational outcomes begin in preschool. Enrollment in a high-quality preschool or nursery school often predicts lifelong educational and health outcomes. About 60% of eligible youths are enrolled in nursery or preschool.

**Pre-School Enrollment**

| San Diego County, CA | People |
|---|---|
| Population Under Age 18 - Age 3 to 4 | **83,426** |
| Enrolled in Nursery or Preschool | **49,423** |

*Sources: US Census ACS 5-year*

**Educational Attainment**

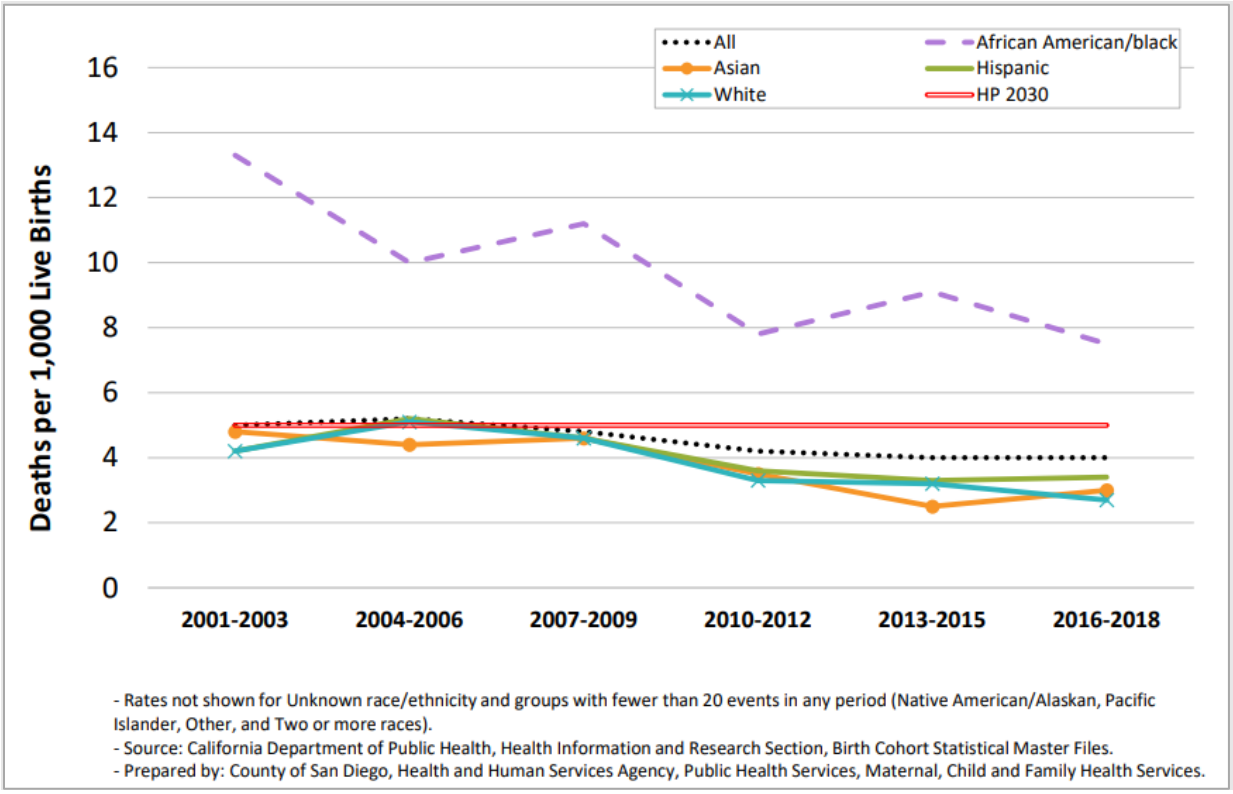



*Sources: US Census ACS 5-year*

**Maternal and Infant Health**: The Centers for Disease Control and Prevention (CDC) define infant mortality as the death of an infant before his or her first birthday, while defining the rate of infant mortality as the number of those infant deaths per 1,000 live births in the same year. In 2016, the top three causes of infant mortality in the United States were congenital malformations, low birth weight and Sudden Infant Death Syndrome. It is common practice to consider the infant mortality rate (IMR) as a representative indicator of population health. It is theorized that using IMR as an indicator might mirror other factors of population health such as social well-being, rates of illness and disease, economic development, general living conditions and others. It has also been used as a proxy measure for access and quality of pre-term and post-term medical care, for both the mother and infant (Live Well San Diego).

- **African American Infant Mortality**: It has long been observed that African American Infant Mortality (AAIM) has remained higher than for those who identified as white. For example, the County of San Diego's (CoSD) AAIM rate from 2016-2018 was about 7.5, compared to 2.9 for whites. This indicates that African American infants were over 2.5 times as likely to die within

their first year compared to whites. There are many factors that might explain this disparity; differences in access to medical care, low socioeconomic status, low educational status, substance abuse, racism, stress, and environmental issues. Programs like County of San Diego's Black Infant Health addresses all these factors to reduce infant mortality. Complications of pregnancy can occur both before and during pregnancy and may reflect barriers to the quality or access to medical care as well as social and economic factors experienced by black mothers in this population. The graph below shows infant mortality rates across several races/ethnicities in San Diego County (California Department of Public Health).




**County Health Rankings:** County Health Rankings looks at health factors and health outcomes by County across the United States. The comparison among counties provides context and shows that where an individual lives can have a significant impact on their health. The rankings are structured in such a way that a lower numerical rank (i.e., closer to one) means the indicator measured is "better" compared to the other counties within the State of California.

- According to the 2018 County Health Rankings report, San Diego County is 10th out of 57 ranked California counties on overall health outcomes (combined morbidity and mortality, measured by length and quality of life). San Diego County is ranked 20th out of 57 ranked California counties on overall health factors (combined health behaviors, clinical care, social and economic factors, and physical environment).

**Table 15. Health Rankings by Category Over Time, San Diego County, 2011-2018.**

| Year | Health Outcomes Overall Rank | Length of Life | Quality of Life | Health Factors Overall Rank | Health Behaviors | Clinical Care | Social and Economic Factors | Physical Environment |
|---|---|---|---|---|---|---|---|---|
| 2011 | 16 | 14 | 24 | 21 | 19 | 28 | 14 | 27 |
| 2012 | 18 | 17 | 24 | 22 | 22 | 28 | 17 | 32 |
| 2013 | 17 | 12 | 28 | 19 | 22 | 29 | 14 | 28 |
| 2014 | 18 | 12 | 26 | 18 | 20 | 27 | 15 | 25 |
| 2015 | 19 | 8 | 29 | 19 | 20 | 25 | 16 | 24 |
| 2016 | 14 | 10 | 20 | 18 | 16 | 26 | 16 | 34 |
| 2017 | 12 | 12 | 19 | 18 | 10 | 24 | 14 | 49 |
| 2018 | 10 | 8 | 14 | 20 | 18 | 26 | 14 | 49 |

*Source: County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/app/california/2018/rankings/san-diego/county/outcomes/overall/snapshot. Accessed May 20, 2018.*
*Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2018.*

**From 2011-2018, the Health Outcomes Overall Rank improved, moving from 16th to 10th.**


## V. Community Supports

Blue Shield Promise is well positioned to deliver on the promise of transformation that California Advancing and Innovating Medi-Cal (CalAIM) intends to achieve, including the delivery of Community Supports (CS) services. Blue Shield Promise is a leader in promoting health equity and the elimination of systemic barriers to access, and participates and invests in programs, plans and outcomes aligned with DHCS and CMS goals.

**2 Years Managing Health Homes Programs (HHP):** Since 2019, Blue Shield Promise has been a HHP partnering with DHCS and contracting with over 30 HHP providers in Los Angeles and San Diego counties. The HHP serves eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community based, long-term services and supports (LTSS) needed by eligible beneficiaries.

**Whole Person Care (WPC) Pilot:** Blue Shield Promise recognizes the foundational value of the WPC pilot as a precursor to the transformation that the DHCS seeks to achieve in CalAIM. We learned from the example of our county partners how critical it is to develop, train, and support the efforts to bridge care gaps and redress the pernicious impacts of housing insecurity and homelessness, particularly on populations already experiencing behavioral health challenges. One specific experience in the delivery of social services is a significant indicator of our success in CS services implementation:

- In San Diego, Blue Shield Promise's Social Services team is comprised of 20 professionals with field-based experience and deep roots in their communities. Trust-based relationships in the communities grant Blue Shield direct and immediate access to providers and partners. This mutual trust and respect lead to speed, efficiency, and effectiveness to address the complex needs of high-risk members. The Social Service team is connected to the resources that exist in each community. These deep relationships with current providers allow for a full understanding

of where there are gaps in services and acute needs for providers. Blue Shield Promise continues to invest in our self-funded Social Services Team through the ongoing training and scaling of the Community Health Workers (CHW) roles.

| Members Served in Los Angeles & San Diego | | |
|---|---|---|
| Year | Members | Percentage Increase |
| 2019 | 5,508 | - |
| 2020 | 8,883 | 62% increase from 2019 |
| 2021 | 10,700 | 20% increase from 2020 |

- As members are referred to the Social Services team, the most common types of SDoH needs include housing, transportation, behavioral health, and food insecurity and nutrition needs. The Social Services team connects our members to the services that they need. In addition to the lessons learned and the service to our members, our work teaches us about existing gaps in capacity and service.

**Recuperative Care:** Since 2019, Blue Shield Promise has offered recuperative care in San Diego and Los Angeles counties. These services are provided in San Diego by Father Joes Villages, PATH and Interfaith Community Services.

**Medically Tailored Meals (MTM):** Our early commitment to offering our members medically tailored meals came because of learning from the Food Is Medicine coalition that "nutrition is integral to people flourishing and to the treatment and management of diseases that threaten us." This concept aligns with what we observe while collaborating with providers, members, and stakeholders. Access to food and proper nutrition intersects with quality of life and overall health outcomes. Aside from our Social Services and Care Management teams providing members information and access to community resources to address food insecurity, we recognize a responsibility to take a more proactive approach to address food insecurity by directly contracting with a provider to pilot a food delivery service for our members. When the COVID-19 pandemic hit and the public health emergency provisions were implemented, we saw a shift in the types of social and supportive services that were needed for our members, due to factors such as safety precautions in congregate living communities such as recuperative care and the increased need for accessing food. Due to these shifts, from 2020 to 2021 utilization of recuperative Care services decreased and medically tailored meals increased.

The table below shows detail on the number of referral to social services, including recuperative care and medically tailored meals services with our partners from 2019 to 2021.

| Blue Shield Promise Members Served in 2019 – 2021 In-Lieu-of-Services (ILOS) | | | |
|---|---|---|---|
| | **2019** | **2020** | **2021** |
| National Health Foundation (Recuperative Care) | 23 | 17 | 10 |
| PATH (Recuperative Care) | 72 | 32 | 26 |
| Interfaith (Recuperative Care) | 20 | 17 | 16 |
| Father Joes (Recuperative Care) | | | 8 |
| Mama's Kitchen (Medically Tailored Meals) | | 43 | 56 |
| | | | |
| **Total Members Served in ILOS** | **115** | **109** | **116** |

## VI. Action Plan

| **Objective 1)** Increase the percentage of Members who report that their doctor always communicates well from 71% to 75% by June 30, 2024.<br>**Data Source: 2020** CAHPS | | | |
|---|---|---|---|
| **Strategies** | **Activities** | **Evaluation Methods** | **Target Completion Date** |
| **Strategy 1:** Increase the number of plain language and health literacy trainings with contracted providers. | • Promote and offer contracted providers a plain language and health literacy training. | Provider training evaluations.<br><br>Provider training attendance sheets. | June 30, 2024. |
| **Strategy 2:** Increase the number of plain language and health literacy trainings with medical group staff. | • Promote and offer medical group staff plain language and health literacy training in fall 2022 and 2023. | Medical group training evaluations.<br><br>Medical group training attendance sheets. | June 30, 2024. |
| **Strategy 3:** Increase the number of plain language and health literacy training with BSC staff. | • Promote and offer BSC staff on-going plain language and health literacy trainings through BSC online courses.<br>• Promote and offer biannual plain language writing workshops to BSC staff. | BSC staff training evaluations.<br><br>BSC staff training attendance sheets. | June 30, 2024. |
| **Strategy 4:** Encourage the use of printed and electronic health information at a sixth grade reading level by promoting | • Biannual contracted provider and medical group email reminders of the available resources | Annual HE audits. Email and blast fax confirmation sheets. | Ongoing throughout the year. |

| | | | |
|---|---|---|---|
| available resources and materials on the Blue Shield Promise website. | and materials on the BSC Promise website. | | |
| **Objective 2)** Increase the percentage of Members who receive an annual flu vaccine from 50.22% to 60% by June 30, 2024.<br>**Data Source:** 2020 CAHPS | | | |
| **Strategies** | **Activities** | **Evaluation Methods** | **Target Completion Date** |
| **Strategy 1:** Partner with key internal stakeholders across BSC to communicate to members the importance of receiving annual flu vaccine. | • Direct mailing to Members informing of the importance of receiving annual flu vaccine.<br>• Promote annual flu vaccine to Members via the Medi-Cal newsletter. | Internal communication governance tracking log.<br><br>Delivered Medi-Cal newsletter to target audience. | March 31, 2024<br><br>Summary of activities available at the beginning of March 2023. |
| **Strategy 2:** Increase member access to receiving flu vaccine by providing alternative flu vaccine clinics. | • Coordinate with internal departments to identify opportunities to promote and deliver flu vaccines through drive-thru clinics and pharmacy networks events. | Calendar of scheduled drive-thru flu vaccine clinics and events.<br><br>Completed flu vaccine consent forms. | March 31, 2024<br><br>Summary of activities available at the beginning of March 2023. |
| **Objective 3)** Increase the percentage of Black/African American Members who are controlling high blood pressure from 47.37% to 50% by June 30, 2024.<br>**Data Source:** 2020 CA DHCS Disparities Data | | | |
| **Strategies** | **Activities** | **Evaluation Methods** | **Target Completion Date** |
| **Strategy 1:** Collaborate with CBOs and providers to promote blood pressure management events and activities targeting the Black/African American population in San Diego County. | • Participate in at least two (2) community-based events/health fairs to promote heart healthy lifestyle in the Black/African American population.<br>• Offer and deliver at least two (2) hearty healthy lifestyle classes targeted at the Black/African American population at a CBO in San Diego County. | Community events/health fairs sign-in sheets and photos.<br><br>Heart healthy lifestyle class sign-in sheets and evaluations. | June 30, 2024 |
| **Strategy 2:** Provide targeted outreach interventions for Black/African American | • Offer and deliver at least two (2) hearty healthy lifestyle classes targeted at the Black/African | Heart healthy lifestyle class sign-in sheets and evaluations. | June 30, 2024 |

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| population on blood pressure management. | American population at a BSCPHP location in San Diego County.<br>• Target geographic areas that include high proportion of Black/African American Members who are identified as having high blood pressure and provide remote blood pressure monitoring services and education.<br>• Publish blood pressure management articles in Medi-Cal newsletter. | Individual health education counseling log and progress notes.<br><br>Published articles in Medi-Cal newsletters. | |
| **Objective 4)** Increase the percentage of Members who report getting an Interpreter when they needed one from 75.8% to 80% by June 30, 2024.<br>**Data Source:** 2020 CAHPS | | | |
| **Strategies** | **Activities** | **Evaluation Methods** | **Target Completion Date** |
| **Strategy 1**: Promote interpreter services to Members. | • Publish articles promoting interpreter services in Medi-Cal Member newsletter.<br>• Discuss the availability of interpreter services during Member all written telephonic, and face-to-face communications and interactions. | Published articles in Medi-Cal Member newsletters.<br><br>Interpreter disclaimer on all Member written communications.<br><br>Call scripts with language promoting interpreter services to members. | June 30, 2024 |
| **Strategy 2:** Promote interpreter services to network providers and BSC staff. | • Provide in-service training with BSC staff and network providers on the availability and how to access interpreter services.<br>• Distribute interpreter services posters to all network providers in San Diego County. | BSC staff and provider training evaluations.<br><br>BSC staff and provider training attendance sheets. Tracking log of poster distribution. | June 30, 2024 |

## VII. 2021/2022 Action Plan Update

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| **Objective 1.) Increase the percentage of Members who report that their doctor always communicates well from 71% to 78% by June 30, 2022.**<br><br>**Data Source:** CAHPS 2019 | **Progress Measure:** The percentage of Members who report that their doctor always communicates well increased from 71% in 2019 to 71.9% in 2021.<br><br>**Data Source**: CAHPS 2021<br><br>**Progress Toward Objective**: BSC Promise has been able to work toward improving provider/member communication by offering a network provider Health Literacy training and assigning BSC Promise member-facing staff an online health literacy/ plain language training course. |
| **Strategies** | |
| **Strategy 1.)** Increase the number of plain language and health literacy trainings with contracted providers. | **Progress Discussion**: BSC Promise offered a recorded health literacy training to all contracted providers in San Diego County on May 18, 2022. |
| **Strategy 2.)** Increase the number of plain language and health literacy trainings with medical group staff. | **Progress Discussion**: BSC Promise offered a recorded health literacy training to all contracted medical groups in San Diego County on May 18, 2022. BSC Promise also provided the medical groups health literacy resources and online training information via email in the 2nd quarter of 2022. |
| **Strategy 3.)** Increase the number of plain language and health literacy training with BSC staff. | **Progress Discussion**: All member facing BSC Promise staff were assigned the health literacy learning module "Improving Health Literacy for Blue Shield Members" and 263 staff members have successfully completed the module in May 2022. |
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| **Objective 2.) Increase the percentage of Members who receive timely prenatal care in the first trimester of their pregnancy from 83.6% to 90% in the pilot clinic by June 30, 2022.**<br><br>**Data Source:** 2019 MCP Specific Health Disparities Data<br><br>Blue Shield Promise will continue to implement timely prenatal care strategies, but activities will no longer be tracked by the PNA at this time. | **Progress Measure:** The percentage of Members who received timely prenatal care increased from 83.6% to 89.6% in the assessment period.<br><br>**Data Source**: 2020 MCP Specific Health Disparities Data<br><br>**Progress Toward Objective**: Objective 2 goal was met during the reporting period. BSC Promise's Quality Improvement Team implemented the Pregnancy Notification Form (PNF) pilot program at the Family Health Centers of San Diego. The program identified newly pregnant Members early to ensure prenatal care, specifically timely health care visits and provide support throughout their pregnancy. |

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| **Strategies** | |
| **Strategy 1.)** Form partnerships with Provider Groups for early notification of Member pregnancy and prenatal care. | **Progress Discussion**: BSC Promise Quality Improvement Team partnered with Family Health Centers of San Diego to implement the Pregnancy Notification Form (PNF) pilot program. The PNF program was launched on August 1, 2020, and 459 Members have completed the PNF to date. BSC QI Team will plan to implement the PNF beyond the Pilot Group. |
| **Strategy 2.)** Inform San Diego members and providers about the Due Date Plus app, which helps guide members through a healthy pregnancy. | **Progress Discussion**: BSC Promise Health Education published an article in the Fall 2021 Cares Health Talk newsletter informing members of the Due Date Plus (DDP) app. The newsletter was distributed to 75,693 Member households in San Diego County. New DDP promotional flyers have been distributed to all San Diego County provider groups. |
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| **Objective 3.) Increase the percentage of members who receive an annual flu vaccine from 52% to 75% by June 30, 2022.**<br><br>**Data Source:** CAHPS 2019 | **Progress Measure:** The percentage of members who received an annual flu vaccine decreased from 52% in 2019 to 50.2% in 2021. However, the member flu vaccine rates in 2021 was greater than the 2020 rate of 42.7%.<br><br>**Data Source**: CAHPS 2020, Claims data<br><br>**Progress Toward Objective**: BSC Promise implemented a comprehensive flu vaccine initiative to increase the percentage of Members who receive the vaccine. The initiative included improving member communication and access to the flu vaccine. |
| **Strategies** | |
| **Strategy 1.)** Partner with key internal stakeholders across BSC to communicate to Members the importance of receiving annual flu vaccine. | **Progress Discussion**: A direct mailing to remind and encourage Med-Cal Members to get their annual flu vaccine was completed in October 2021. Social media posts in Instagram and Facebook encouraging Members to get their annual flu vaccine were posted from August to November 2021. BSC Promise Health Education published an article in the Fall 2021 Cares Health Talk newsletter encouraging Members to get their annual flu vaccine. Customer Care IVR hold messaging encouraging Members to get their annual flu vaccine went live in November 2021. |
| **Strategy 2.)** Increase Member access to receiving flu vaccine by providing alternative flu vaccine clinics. | **Progress Discussion**: BSC Promise planned drive-up flu clinics for San Diego Medi-Cal Members in collaboration with Vista and Imperial Health Holdings clinics. The clinics were cancelled due to poor Member registration. BSC Promise will review the opportunity to provide San |

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| | Diego Medi-Cal members alternative flu vaccine clinics and events in 2022. |
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| **Objective 4.) Increase the percentage of Black/African American and Hispanic/Latino Members who receive timely prenatal care in the first trimester from 78.6% and 80%, respectively, to 82% by June 30, 2022.**<br><br>**Data Source:** 2019 MCP Specific Health Disparities Data<br><br>Blue Shield Promise will continue to implement prenatal care strategies aimed at Black/African and Hispanic/Latino Members, but activities will no longer be tracked by the PNA at this time. | **Progress Measure:** The percentage of Black/African American and Hispanic/Latino members who received timely prenatal care in the first trimester increased from 78.6% and 80%, respectively, to 93.75% and 88.79% in the reporting period.<br><br>**Data Source**: 2021 MCP Specific Health Disparities Data<br><br>**Progress Toward Objective**: Objective 4 goal was met during the reporting period.<br>BSC Promise Health Education team collaborated with BSC Promise Quality Improvement team to outreach to pregnant Black/African American and Hispanic/Latino Members identified through the Pregnancy Notification Form (PNF). A total of seven (7) Black/African American and Hispanic/Latino Members have been outreached to date. BSC Promise plans to expand the PNF program to six more provider groups in San Diego County in 2022. |
| Strategies | |
| **Strategy 1.)** Form partnership with Provider Groups for early detection of Member pregnancy and prenatal care. | **Progress Discussion**: BSC Promise partnered with San Diego Family Health Center to pilot the Pregnancy Notification Form (PNF) program. The program aims to identify newly pregnant members early to ensure prenatal care, specifically timely health care visits and provide support throughout their pregnancy. To date, a total of seventy-nine (79) Members have been identified for early prenatal care through the PNF at San Diego Family Health Center with seven (7) members identifying as Black/African American or Hispanic/Latino. BSC Promise plans to expand the PNF program to more provider groups in San Diego County in 2022. |
| **Strategy 2.)** Provide targeted outreach interventions for race/ethnicity groups below the timeliness of prenatal care average. | **Progress Discussion**: BSC Promise Health Education has provided telephonic prenatal education and resources to Black/African American and Hispanic/Latino Members identified through the PNF program. BSC Promise Health Education distributed an article in the Fall 2021 Cares Health Talk newsletter promoting the importance of early prenatal care and the Due Date Plus pregnancy mobile application. The newsletter was distributed to 75,693 (12,110 Spanish) member households in San Diego County. |

## VII. Stakeholder Engagement

The updated PNA will be shared with the Member Advisory (MAC) Committee. Promise also uses this meeting as an opportunity to get committee feedback on new Health Education and Cultural and Linguistic initiatives.

The committee is comprised of Members, internal Promise stakeholders and Community Based Organizations (CBOs). The CBOs represent the diverse Member population including Senior and Persons with Special Needs (SPD). These meetings are held quarterly. Before the COVID-19, these meetings were held in-person. In 2021 and 2022, these meetings are being held virtually.

Additionally, the updated PNA will be shared at 2022 meetings with our contracted providers, medical groups and internal employees through various platforms which may include one or more of the following: Provider quarterly meeting, Annual Training of Contracted Medical Groups, Provider Portion of Website, Written Communication, and Internal Meetings.