THE HIGH COST OF INEQUITY:

How Preventable Hospitalizations Harm Californians

Race, insurance coverage, and language barriers continue to shape who gets care—and who ends up in the hospital.

California Pan-Ethnic HEALTH NETWORK

CALIFORNIA BLACK HEALTH NETWORK

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Introduction

In 2022, more than 240,000 hospitalizations in California were potentially preventable through high-quality outpatient care, including preventive, primary, and specialty care [1]. These hospitalizations were mainly for chronic conditions, such as diabetes, heart failure, and chronic obstructive pulmonary disease (COPD).

Preventable hospitalizations contribute to high health care costs in California, as taking care of patients in hospitals is far more expensive than treating them in primary care or outpatient settings.

According to a recent UCLA study, "Each year in California, over $3.5 billion is spent on hospitalizations that would be potentially preventable with better outpatient care." [2]

California data from 2021 analyzed by CPEHN shows that the risk of a preventable hospitalization is influenced by a patient's race, ethnicity, spoken language, and insurance.

Californians covered by Medi-Cal have significantly higher rates of preventable hospitalization than those with private insurance.

Black Californians and American Indian or Alaska Native (AIAN) Californians have significantly higher rates of preventable hospitalization than Californians of other races and ethnicities, even when controlling for health insurance type and preferred language spoken.

Non-English Speaking Latine Californians and Asian American and Pacific Islander Californians have significantly higher rates of preventable hospitalization than English-speaking members of these racial and ethnic groups.

These disparities suggest that these groups are not receiving the preventive and primary care they need to manage their chronic conditions. And they are not accidental—they are the result of decades of structural racism in access, funding, and workforce design. Each of these preventable hospitalizations has a high cost, not only to the health care system but to the individual who must deal with the stress, disruptions, and financial consequences of a hospital stay and recovery (e.g., out of pocket health care costs, time away from work, childcare).

"This data shows what our community knows to be true: race matters. Black Californians face numerous barriers to optimal health outcomes, including inadequate primary care, provider bias and mistrust, lack of access to high quality specialty care, ineffective treatments, and adverse social and community conditions. When one of us lands in the hospital due to diabetes complications or other preventable health conditions, it impacts not only us but our family, community, employer, and all Californians who face challenges when interacting with the healthcare system, such as unnecessary increased health care costs. Systemic problems require systemic solutions. It's time to invest fully in primary care and to acknowledge and address the role that racism plays in healthcare outcomes."

Rhonda Smith,
Executive Director,
California Black Health Network

Preventing even some of these hospitalizations would result in both better health for Californians and reduced costs for state and federal governments, taxpayers, and health care consumers. If preventable hospitalization rates for Black Californians were reduced to those of White Californians, over **$126 million**[1] in costs could be saved per year [3]. On a similar note, if preventable hospitalization rates for Medi-Cal beneficiaries were reduced to those of private insurance, over **$437 million**[2] in costs could be saved per year [3]. Ultimately, taxpayers and anyone who buys health insurance bear the costs of preventable hospitalizations through taxes that cover the costs of Medi-Cal and Medicare and through higher insurance premiums and out-of-pocket spending.

It's critical to recognize that these cost savings cannot be achieved by cutting services or reducing access—especially for communities already facing structural barriers to care. On the contrary, the path to both better outcomes and lower costs lies in targeted investments that expand access to high-quality, culturally and linguistically responsive primary care. **Reducing access will only lead to more preventable hospitalizations and higher costs for everyone.**

To lower preventable hospitalization rates, California must ensure that all residents have access to high-quality outpatient care, including prevention, primary care, and continuity of care. Our policy recommendations focus on the investments and reforms needed to make that possible.

Strengthen Access to Culturally and Linguistically Responsive Primary Care

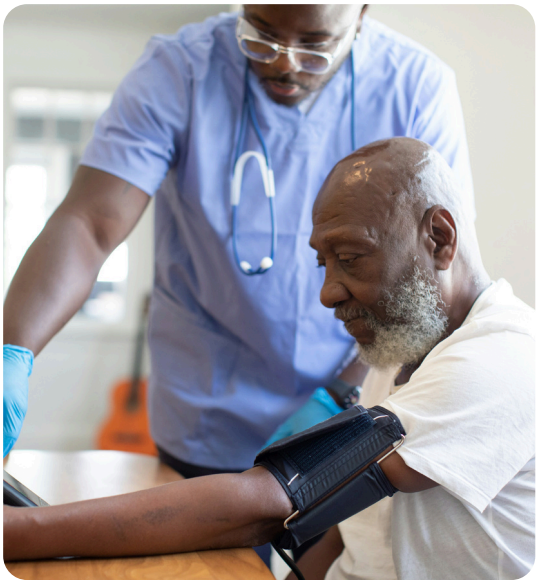
Ensure Health Care Coverage for All Californians

Improve Health Care Affordability

Improve Population Health

Californians Agree: We should invest more in healthcare for those who need it most.

Californians overwhelmingly support equitable access to health care and continued public investment in Medi-Cal. A February 2025 poll by the California Health Care Foundation found that **75% of Californians believe everyone in the state should have health insurance coverage, even if it means increasing federal spending** [4]. This sentiment spans across political affiliations with 91% of Democrats, 76% of Independents, and 50% of Republicans in agreement. Similarly 80% of Democrats, 75% of Independents, and 62% of Republicans agree that Medi-Cal should generally remain financed and run as it is today. Only 13% of Californians favor cuts to federal Medi-Cal funding, and **over half of all Californians view Medi-Cal as personally important to them and their families**. Californians overwhelmingly believe Medi-Cal is important to the state (91%), and findings make it clear the program is widely supported across party lines.



[1] *These cost estimates are based on 2009 California data, so they likely underestimate 2021 costs used in this analysis.* [2] *Ibid.*

Understanding the Data

What are preventable hospitalizations, and where does this data come from?

Preventable hospitalizations are hospital stays for specific conditions that could be prevented with high quality outpatient care. The preventable hospitalization rate discussed in this report is a composite measure of total hospitalizations for 12 diagnoses divided by the total number of hospitalizations. Rates for subpopulations are divided by the total number of hospitalizations for that population.

Preventable hospital diagnoses are: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, and urinary tract infection.

The 2021 data used in this report was sourced from "Social Drivers of Health and Preventable Hospitalizations", published by the California Department of Healthcare Access and Information (HCAI) [5]. For more information about the dataset and methods used for this analysis, see the appendix.

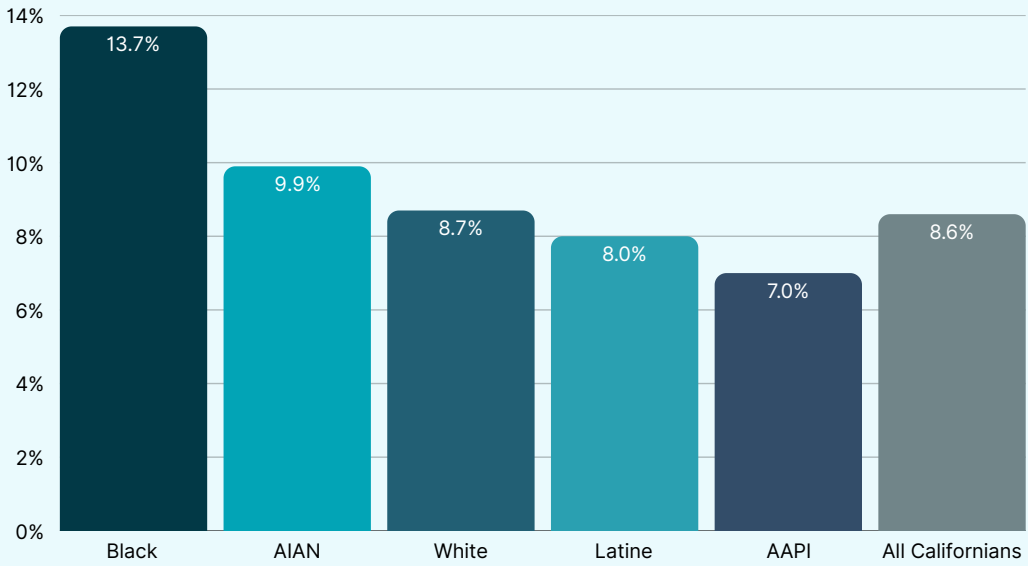
Race Matters

Race is a powerful predictor of who receives timely outpatient care and who ends up in the hospital for conditions that could have been managed in a primary care setting. These disparities are not the result of individual behavior, and there is no biological reason why one racial or ethnic group would be more likely to experience a preventable hospitalization. Instead, these patterns reflect the ongoing impacts of structural racism in health care access, provider distribution, and service quality. The data that follows shows how Black and American Indian or Alaska Native Californians face disproportionately high rates of preventable hospitalization across the state, even when controlling for insurance coverage and language spoken.

Black Californians have the highest rate of preventable hospitalizations among all races and ethnicities.

The preventable hospitalization rate among Black Californians statewide is nearly 14%, higher than the rates of Californians of all other races and ethnicities. American Indian or Alaska Native Californians (AIAN) Californians have the second highest preventable hospitalization rate (about 10%). **See Figure 1**. Addressing the systemic inequities driving these preventable hospitalizations is not only good health care policy—its an opportunity for cost savings. If the preventable hospitalization rate for Black Californians were reduced to those of White Californians, **$126 million** in costs could be saved per year [3].

Figure 1: Preventable Hospitalization Rate (%) by Race and Ethnicity Among Californians

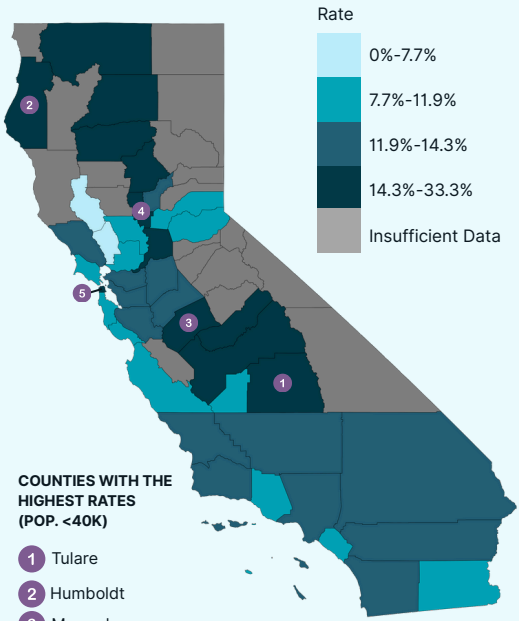


Being Black is associated with a 74% higher risk of being hospitalized for a preventable condition compared to being Latine or AAPI, and a 46% higher risk compared to being White. AIAN Californians have a 28% higher risk than Latine or AAPI Californians and a 9% higher risk than White Californians. See Appendix Table 1.

Preventable hospitalizations for Black Californians vary across the state.

Rates of preventable hospitalizations for Black residents varied across counties, although in nearly all counties Black residents have higher rates than the statewide average for all residents. **See Figure 2.** Of counties with sufficient data, Napa and Lake County are the only counties where Black residents have a preventable hospitalization rate (7.7%) that is lower than the statewide average (8.6%). Six counties have rates higher than 16%. Among these counties, the highest four have small populations of Black residents (less than 10,000), while both San Francisco and Fresno counties have larger populations of Black residents, about 41,500 and 47,000 respectively. Only five counties have rates of less than 10%, which is still higher than the statewide average for all Californians. In nearly every California county, more work needs to be done to ensure access to appropriate, high-quality primary care for Black residents with chronic conditions.

Figure 2: Preventable Hospitalization Rates (%) Among Black Residents, by County*

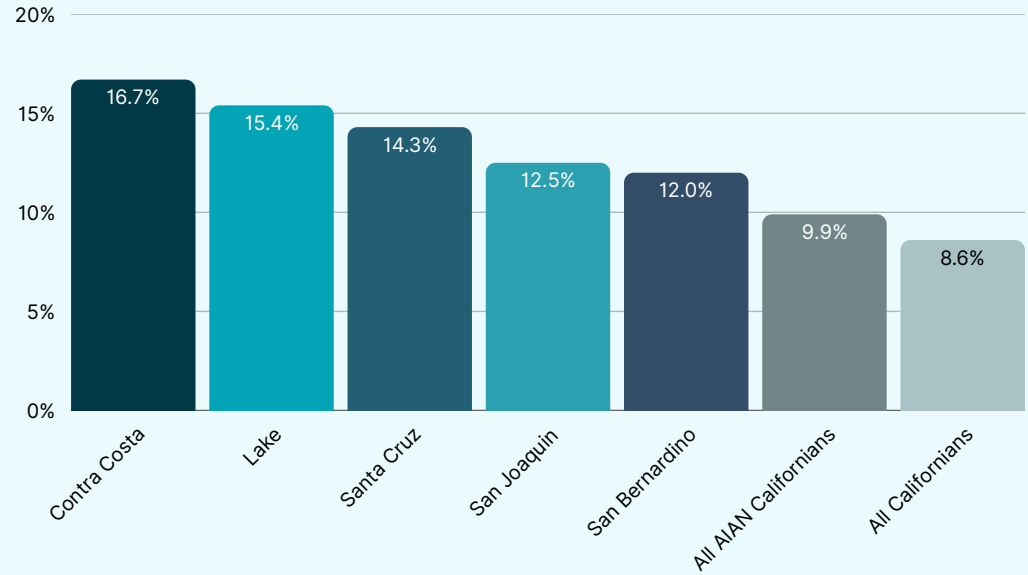


*See **Appendix Table 3** for list of rates (%) by county.

American Indian or Alaska Native (AIAN) communities suffer from disproportionately high rates of preventable hospitalization in many counties.

Given the smaller population of AIANs throughout California, only 20 of 52 counties have sufficient populations to calculate preventable hospitalization rates. Among these counties, five counties had preventable hospitalization rates of 12% or higher. **See Figure 3**. Notably, in a few Northern California counties (Contra Costa, Santa Cruz, Lake), preventable hospitalization rates for AIAN residents were seven or eight percentage points higher than the county average. There are also many rural areas in California with high concentrations of tribal lands and reservations, which may have higher rates of preventable hospitalization (part of a legacy of underinvestment and public health neglect), so additional studies of preventable hospitalization rates in these communities are critical.

Figure 3: Counties with Highest Preventable Hospitalization Rates (%) Among AIAN Residents



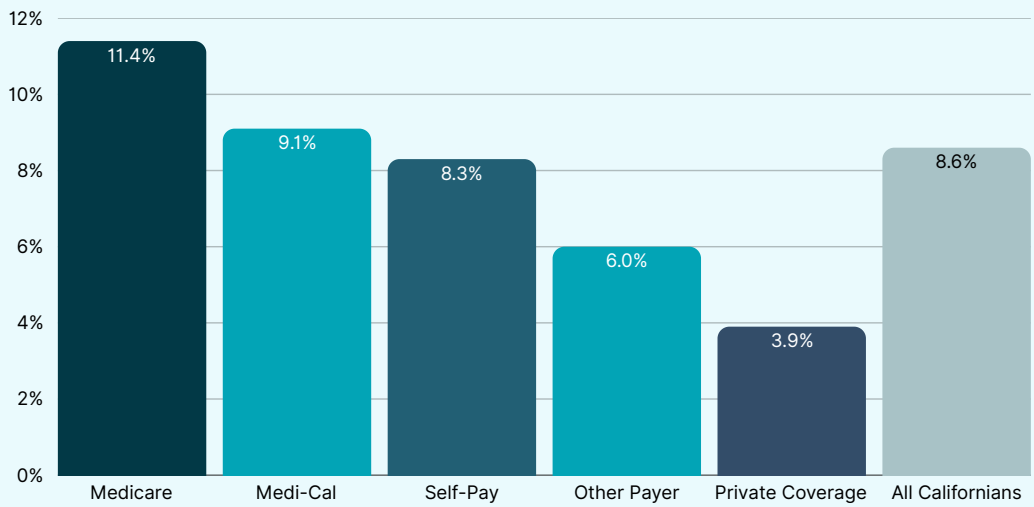
Payer Matters

Race is only one part of the story. Health care coverage—what kind of insurance a person has, or whether they have any at all—also plays a major role in determining who receives timely, preventive care and who ends up in the hospital. Insurance is often shaped by employment, immigration status, and income, all of which are deeply connected to historical and ongoing structural inequities. The next section explores how payer status—particularly being covered by Medi-Cal—affects the risk of preventable hospitalization in California.

Californians with Medi-Cal face three times higher risk of preventable hospitalization than those with private coverage.

The rate of preventable hospitalization differs considerably by payer. Individuals with private coverage have much lower rates (4%) than those with Medi-Cal coverage (9%) or with Medicare coverage (11%). **See Figure 4**. It is not surprising that Medicare's 65 and older population has the highest preventable hospitalization rate, given the complex health situations of older adults, many of whom have multiple chronic conditions.[3] The Medi-Cal rate being twice that of the private coverage rate indicates that many Californians with Medi-Cal are not receiving the outpatient care they need, including preventive and primary care as well as thorough coordination of care. This disparity also indicates an opportunity for cost savings; if the preventable hospitalization rate for Medi-Cal were reduced to the private coverage rate, **$437 million** in costs could be saved [3].

Figure 4: Preventable Hospitalization Rate (%) by Payer Among Californians



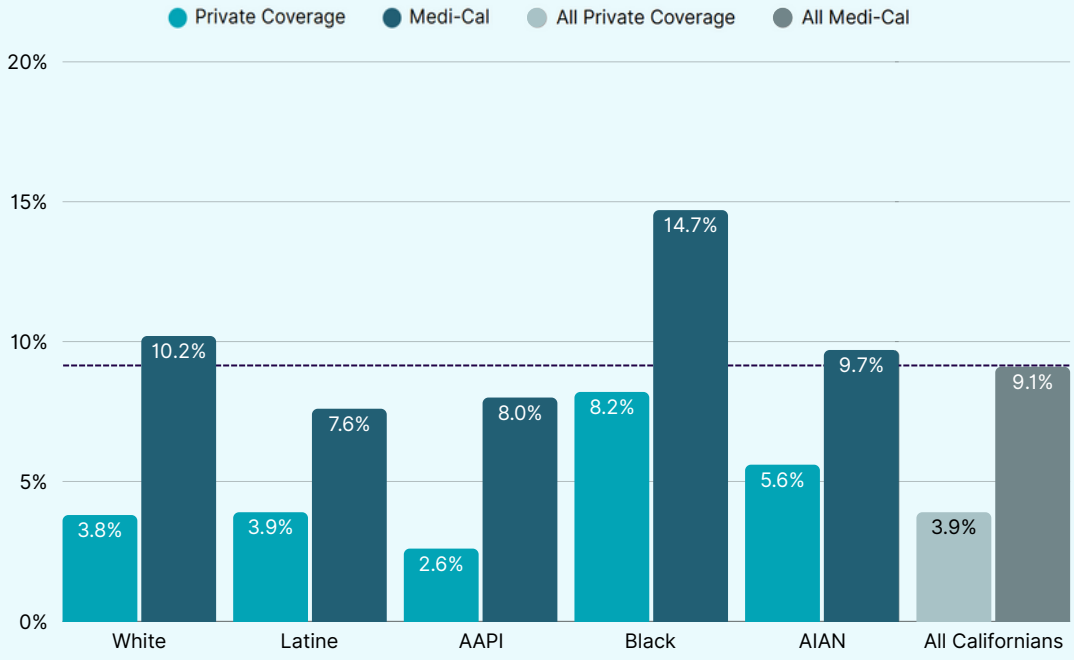
The expected risk of a preventable hospitalization is three times higher for Californians with Medi-Cal coverage than for those with private coverage (holding race and ethnicity and preferred language spoken equal). Conversely, having private insurance is associated with a lower risk of a preventable hospitalization. See Appendix Table 2.

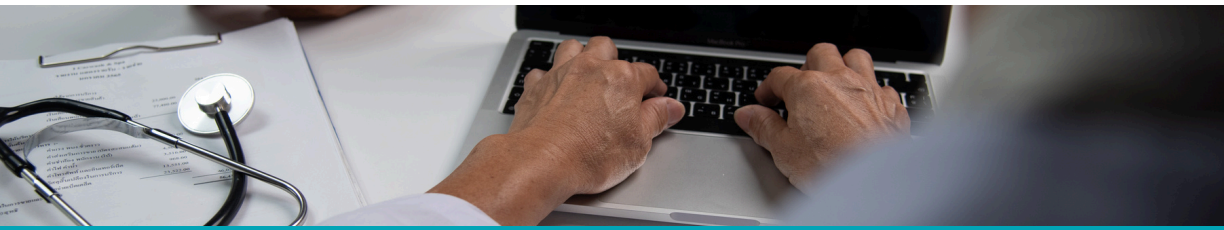
[3] *Preventing hospitalizations for older adults necessitates investments in and attention to better coordination of care in addition to ensuring access to primary care.*

Payer and race combined are very strong predictors of preventable hospitalizations.

Across all races and ethnicities, preventable hospitalization rates for those with Medi-Cal coverage are significantly higher than –often double or triple– the rates for those with private insurance. **See Figure 5.** Black Californians have both the highest preventable hospitalization rate when they have Medi-Cal coverage (14.7%) and when they have private insurance (8.2%). Preventable hospitalizations for Asian American or Pacific Islander residents show the largest disparity with Medi-Cal rates three times higher than those with private coverage, 8% vs 2.6%.

Figure 5: Preventable Hospitalization Rate (%) by Payer Among Californians





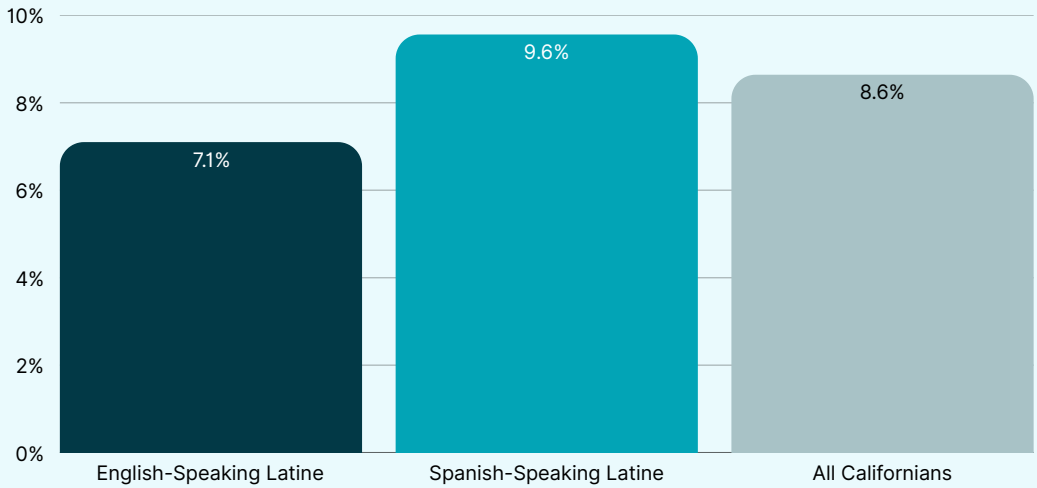
Language Matters

Alongside race and insurance status, language access is a critical—but often overlooked—determinant of health equity. When people can't communicate effectively with their providers, or don't receive care in the language they understand best, they are less likely to get the preventive services they need. Language access is a structural issue, and its impact on preventable hospitalizations is particularly stark for California's Latine and Asian American or Pacific Islander communities.

Spanish-Speaking Latine Californians Have Significantly Higher Rates of Preventable Hospitalization than English-Speaking Latine Californians

Although Latine Californians have a lower rate of preventable hospitalizations than Californians as a whole, Latines who prefer to speak Spanish have a significantly higher rate of preventable hospitalization than those who prefer to speak English. **See Figure 6**. Non-English speakers often struggle to access preventive health care services (including but not limited to primary care) in the language they are most comfortable speaking [6].

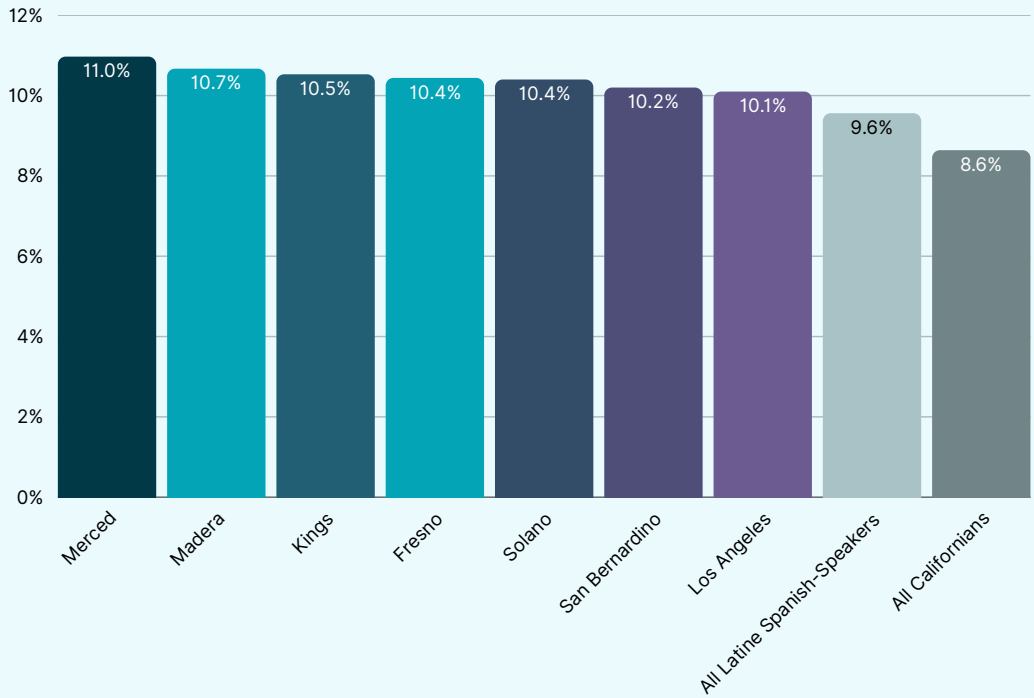
Figure 6: Preventable Hospitalization Rate (%) by Spoken Language Among Latine Californians



Preventable hospitalization rates for Spanish-speaking Latine residents vary across California counties

Eight counties have preventable hospitalization rates for Spanish-speaking Latine residents that are 10% or higher. **See Figure 7.** Notably, Los Angeles County with the largest population of Spanish-speaking Latine residents has a rate of 10.1%. In addition, several counties, including Solano, Napa, and Orange, have larger disparities between English and Spanish-speaking Latine residents than the state on average, highlighting especially large gaps in care access for Spanish speakers. Many of these counties have sizable Latine populations, especially Orange County. Counties in the Bay Area (Solano, Napa) and the Central Valley (Madera, Kings) also have larger-than-average disparities. These disparities highlight the need for better outpatient care for Spanish-speaking Californians, including ensuring access to in-language care and resources.

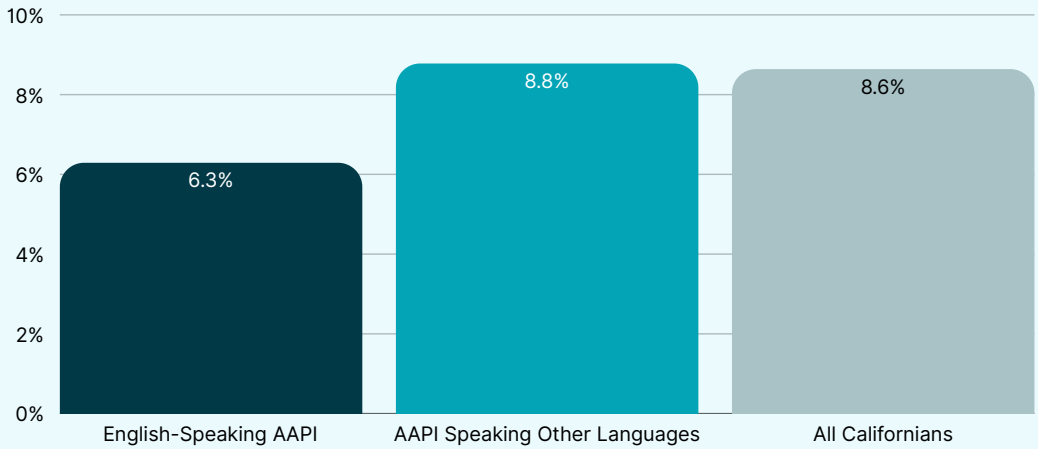
Figure 7: Counties with Highest Preventable Hospitalization Rates (%) Among Spanish-Speaking Latine Californians



Foreign Language-Speaking AAPI Californians Have Significantly Higher Rates of Preventable Hospitalization than English-Speaking AAPI Californians

Although Asian American or Pacific Islander Californians also have a lower rate of preventable hospitalizations than Californians as a whole, those who prefer to speak other languages (all languages other than English or Spanish, including all Asian languages) have a significantly higher rate of preventable hospitalization than those who prefer to speak English. **See Figure 8**.

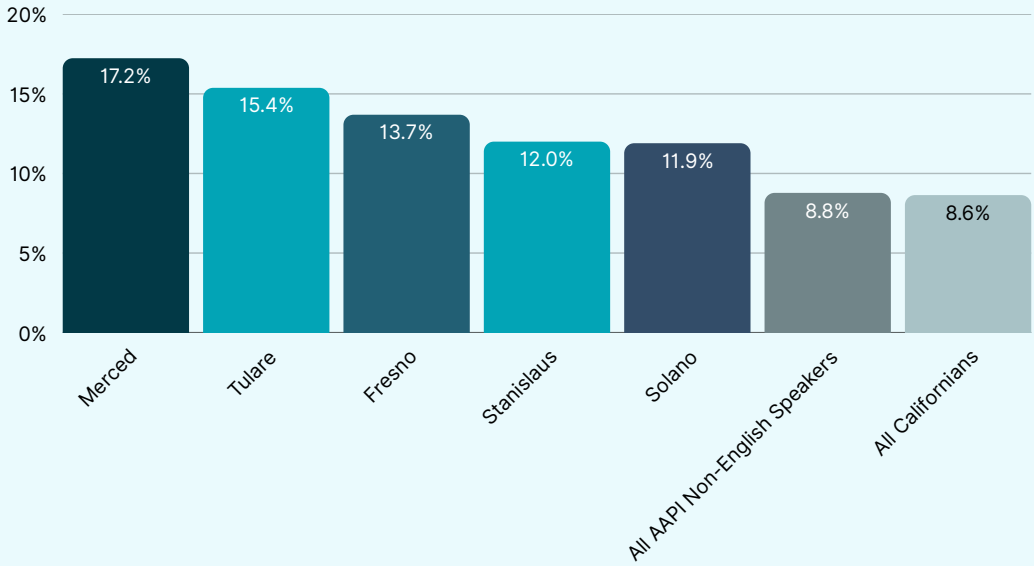
Figure 8: Preventable Hospitalization Rate (%) by Spoken Language Among AAPI Californians



Preventable hospitalization rates for non English-speaking AAPI Californians vary across the state

Four counties in the Central Valley (Merced, Tulare, Fresno, and Stanislaus Counties) have preventable hospitalization rates for non English-speaking AAPI Californians of 12% or higher. **See Figure 9**. A couple of counties in the Bay Area with large populations of non-English-speaking AAPI Californians (San Francisco and San Mateo) have rates of around 10%.

Figure 9: Counties with Highest Preventable Hospitalization Rates (%) Among Non-English Speaking AAPI Californians



Policy Recommendations

In California, Black and AIAN individuals, non-English speakers, and Medi-Cal recipients have disproportionately high rates of preventable hospitalizations. Black Californians are significantly more likely to be hospitalized for a preventable condition than any other racial or ethnic group; this persists regardless of insurance coverage and primary language spoken.

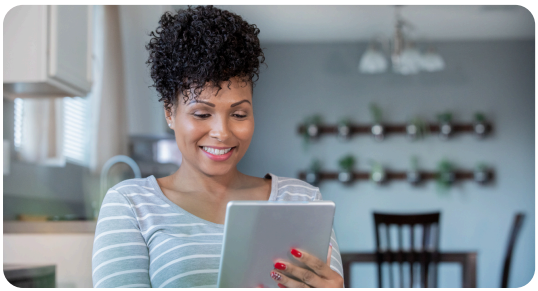
Lowering the preventable hospitalization rate for these marginalized groups requires addressing the underlying factors that keep people from accessing high-quality outpatient care. Today, in California, many barriers keep people from accessing the care that they need. Just as important is ensuring that the state's health care systems and providers deliver high-quality primary care and promote continuity of care for all Californians.

The California Pan-Ethnic Health Network (CPEHN) recommends the following areas as a focus for policymakers:

- **Strengthen Access to Culturally and Linguistically Responsive Primary Care**
- **Ensure Health Care Coverage for All Californians**
- **Improve Health Care Affordability**
- **Improve Population Health**

Strengthen Access to Culturally and Linguistically Responsive Primary Care.

Primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. Reducing preventable hospitalization rates requires ensuring accessible primary care (including care in accessible languages and sufficient primary care providers throughout the state), promotion of preventive care (vaccines, routine checkups, etc.), and reliable telehealth options (especially for rural Californians). California must:



Increase Primary Care Spending: Despite ample evidence demonstrating the benefits of primary care, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other high income countries. The California Office of Health Care Affordability (OHCA) has approved California's first benchmarks for increasing investment in primary care:

- An annual improvement benchmark: Calling for a 0.5 to 1 percentage point per year increase in primary care spending as a percentage of total health care spending for each health plan until 2033.
- A statewide investment benchmark: Calling for 15 percent of total health care spending to be spent on primary care by 2034, an amount that is more in line with what other high-income countries spend.

Now it is up to the industry and policymakers to hold our health systems accountable for reaching these important benchmarks.

Expand Access and Utilization of Telehealth: Telehealth has a tremendous potential to improve health outcomes for those who have historically lacked access to medical care. Research has shown that virtual visits are comparable to in-person visits for certain services and can ease patient burden in terms of transportation costs or lost wages due to time away from work. But this rapid deployment of technology for health care has not fully accounted for the needs of Black, indigenous, and people of color, including low-income, seniors, limited English proficient, persons with disabilities and those living in rural areas who experience digital barriers at higher rates [7]. Better data on telehealth access and utilization, disaggregated by race, ethnicity, language and other factors is needed to identify and address gaps. With telehealth use, the state should update alternative access standards as a potential strategy for improving patient/provider concordance. More broadly, California must strengthen its investment in broadband/fiber optics, and digital cellular technology, including direct reimbursement for language interpreter services, auxiliary aides and supports in order to ensure access to telehealth for all.

Invest in Culturally and Linguistically Responsive Care: Ample research has shown that racism and structural barriers in the health care system prevent Californians of color from achieving the health they actively seek. Nearly one in three Black Californians has been treated unfairly by a health care provider because of their race or ethnicity [8]. Evidence demonstrates that patients do better with racially, ethnically, and linguistically concordant providers, yet the racial and ethnic breakdown of California physicians is not representative of the state's population [9]. California state agencies must address workforce training needs, increase academic scholarship funding and student loan repayment programs and open earn-and-learn programs to a broader, more racially, ethnically diverse pool of applicants. Better data on actual numbers of providers, broken out by provider type, race, ethnicity, language and other factors, including at a more granular level are needed to set meaningful, concrete goals and objectives to strengthen the diversity of the provider pipeline.

Ensure Successful Integration of Community Health Workers, *Promotoras*, and Representatives (CHW/P/Rs): California recently added coverage for community health workers/*promotoras*/representatives (CHW/P/Rs) as a formal Medi-Cal benefit in 2022, recognizing their vital role in addressing health disparities and social drivers of health. However, despite its promise, the uptake and integration of this new benefit, whether in a community-based organization, health center or hospital, has been slow. California must provide adequate wages for CHW/P/Rs who are filling the gaps in patient/provider concordance today by maintaining the previously approved rate increase, and ensure greater transparency on how the benefit is being implemented (AB 403-Ortega). In addition, health care delivery systems may need technical assistance to meaningfully incorporate CHW/P/Rs and the specialized services they provide into care teams.

Sustain Investments in Care Coordination: California's health care delivery system is fragmented, particularly for Medi-Cal beneficiaries who must navigate across multiple complex managed care and fee-for-service delivery systems in order to access physical, oral, and behavioral health. With CalAIM, Medi-Cal has committed to providing more comprehensive primary health care and social services to marginalized populations. One specific program, the Enhanced Care Management Program for Adults at Risk for Avoidable Hospital or ED Utilization, specifically targets preventable hospitalizations. This program seeks to prevent avoidable hospital and ED use through whole-person care and comprehensive care management. In the last year, 66,585 Medi-Cal enrollees have received care through this Population of Focus. This program and others like it should be sustained and strengthened.

Maintain California's Progress Towards Universal Health Care Coverage.

It goes without saying that in order to receive the preventive, primary, and coordinated care needed to prevent unnecessary hospitalizations, Californians need health insurance coverage. While California's rate of insurance coverage is at an all-time high, that is now under threat. President Trump and the GOP are waging attacks on access to health care, affordability and consumer rights and protections, including cuts to Medicaid which could result in up to 5 million Californians losing their health care coverage, access to physical health, mental health, substance use, and dental services. These cuts would disproportionately impact Californians with low incomes, including children, seniors, persons with disabilities, immigrants, LGBTQ+, and women.

Oppose Attempts to Reinstitute Unfair Medi-Cal Exclusions Based on Immigration Status: California voters support providing health care for all Californians [10]. Thanks to several important policy changes, including ending unfair exclusions from Medi-Cal based on immigration status, close to 94% of all Californians are insured today down from a low of 85% prior to passage of the Affordable Care Act (ACA) [11]. Having health insurance means more Californians can schedule a routine doctor's appointment, seek preventive care for heart disease or diabetes, or access life-saving drugs for the treatment of asthma or mental health. Loss of coverage means children will be unable to see a doctor when they're sick, and many individuals will end up relying on more costly emergency room visits as their usual source of care.

Address Rising Health Care Costs and Improve Health Care Affordability.

Health care affordability has continued to deteriorate and is now a major barrier to accessing preventive care. In the last two decades, the cost of job-based coverage and deductibles have outpaced growth in workers' wages and household incomes [12]. More than half of Californians (53%) and nearly three in four with low incomes (74%) say that they or a family member skipped or delayed care due to cost in the past year [13]. Affordability problems like delaying or postponing care, trouble paying medical bills, and medical debt are significantly more prevalent for Black and Latino Californians [13].

Protect Consumers from High Health Insurance Premiums and Out of Pocket Costs: In California, average monthly premiums for families with employer-provided commercial health coverage nearly doubled over the last 15 years, from just over $1,000 in 2008 to almost $2,000 in 2023, more than twice the rate of inflation, according to an analysis of federal data by Kaiser Health News [14]. Covered California provides affordable health care coverage to over 1.8 million individuals and families without employer-based coverage who earn modest incomes. The federal Inflation Reduction Act (IRA), which expires at the end of 2025, includes enhanced premium subsidies that have kept premium prices stable and affordable for 2.37 million Californians. The IRA ensures access to primary care, thus avoiding more costly emergency room visits and hospitalizations for conditions which can be managed in outpatient settings. These enhanced subsidies must be continued.

Protect Consumers from Hospital Medical Debt: Hospital debt is the largest source of medical debt, with 73% of U.S. Adults with past-due debt owing some or all of it to hospitals [15]. An estimated 38% of California residents carry some type of medical debt; that figure climbs to more than half for low-income residents, according to the California Health Care Foundation [16]. Californians with any kind of medical debt are more likely to delay or skip care than those without medical debt, exacerbating health conditions and increasing the risk of preventable hospitalizations [16]. Hospitals are legally required to offer financial assistance to patients but oftentimes the process is confusing or inaccessible. California policymakers must pass AB 1312 (Schiavo), a CPEHN sponsored bill, which would require hospitals to prescreen patients for financial assistance without the need for an application ("presumptive eligibility") if they meet certain criteria such as being enrolled in Medi-Cal or Covered California.

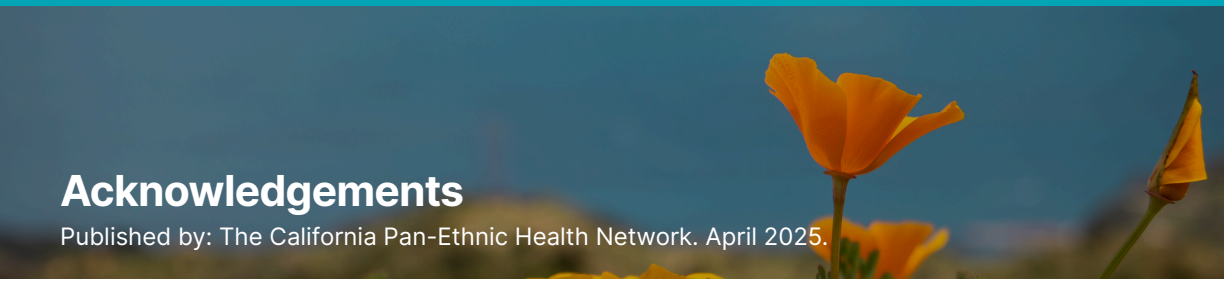
Contain California's Unsustainable Growth in Health Care Costs: In California, personal health care spending shot up 60% between 2010 and 2020, reaching $405 billion, or $10,299 per person, far out-pacing inflation, according to federal data [17]. California is home to some of the highest priced hospitals in the country. A national study found that 11 of the 19 highest priced hospitals were in California, including eight in Northern California which on average charged almost three times what Medicare pays [18]. In 2024, California's Office of Health Care Affordability approved the state's first cap on health industry spending increases, limiting growth to 3% by 2029. This spending growth target is based on the average growth rate of median household income from 2002-2022 and will help to slow the growth of health care spending so it is more in line with the incomes of California families. As a result, hospitals, doctors and health insurers will need to find ways to cut costs to prevent annual per capita spending from exceeding the target or face fines [19]. Industry leaders, must act now to reign in health care costs in order to reach this important benchmark.

Improve Population Health.

Although health spending in the United States is the highest in the world, our life expectancy is significantly shorter than that of other high-income nations, and racial and ethnic disparities are significant and pervasive. An effective health care system requires taking a more proactive approach to individual health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for defined populations. The goal should be to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. In order to improve population health, California must:

Strengthen Hospital Community Benefit Requirements and Investments: California's not-for-profit hospitals receive billions of dollars in tax exemptions and subsidies each year in exchange for describing, through a community benefit plan, the activities that the hospital has undertaken to address identified community needs, and the process taken to develop the plan in consultation with the community. Though detailed data is not publicly available, experts believe the total of nonprofit hospitals uncollected tax liabilities is at $2.6-$2.8 billion [20]. Moreover, a recent study estimates California tax exempt hospitals received a tax benefit of $3.159 billion in 2021 [21]. Prior to 2019, there was no standardized collection and reporting to help the public understand how hospitals fulfill these obligations. California has since aligned reporting with federal standards, with the first round due in 2025. Hospitals must now also submit annual equity reports to evaluate how well they serve patients. But more can be done. California should convene experts, including consumers, to develop community benefits spending minimums and recommendations for evidence-based interventions. Non-profit hospitals should be required to collaborate with local health jurisdictions, counties, and health plans to better align community benefits activities with regional needs. All hospitals, including for-profits, should be encouraged to contribute to a single community benefit fund to address regional and population needs, to improve health equity and outcomes for all.

Invest in Patient Safety for All: Racial discrimination and implicit bias continue to plague the health care industry [22]. Communities of color and other marginalized Californians are more likely to experience patient safety events than their white counterparts [23]. Patient safety events are a preventable incident that causes harm or injury to a patient when they receive health care, such as a medication error, surgical equipment left inside an individual or inadequate or negligent care that leads to adverse maternal health outcomes. CPEHN's bill AB 3161 (Bonta) the Equity in Health Care Act, co-sponsored by Black Women for Wellness Action Project and signed into law in 2024, will require hospitals to update their patient safety plans to include a process for addressing racism and discrimination in patient care. Continued monitoring and enforcement will be key to ensuring hospital safety plans translate into better care for patients, including after discharge.



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California Pan-Ethnic HEALTH NETWORK

The California Pan-Ethnic Health Network (CPEHN) is a BIPOC-led, multicultural, state policy organization, which seeks to advance health equity by dismantling structural racism and ensuring opportunity and health for all Californians. For 30 years, CPEHN has worked with a diverse network of community-based organizations across the state to identify and elevate community priorities to state policymakers. CPEHN is dedicated to building power with communities of color through policy advocacy, research, network and leadership building, and storytelling.

CALIFORNIA BLACK HEALTH NETWORK

CBHN is the only Black-led, statewide organization dedicated to advancing health equity for all African Americans and Black Immigrants. CBHN conducts outreach, education, and advocacy to address critical issues that lie at the intersection of racial justice, social justice, and environmental justice to advance health equity for Black Californians. We work to ensure that all Black Californians, regardless of their education, socio-economic class, zip code, sexual orientation, gender identity, homelessness, or immigration status have access to high-quality and equitable primary and behavioral healthcare and avoid unnecessarily succumbing to disease.

Design By: Sami S., X97 Labs

Appendix

About the Data

The data for this report is based on the dataset "Social Drivers of Health and Preventable Hospitalizations", published by the California Department of Healthcare Access and Information (HCAI). The data presents rates of preventable hospitalizations across each of California's 58 counties stratified by social drivers of health, including race and ethnicity, spoken language, insurance/payer, home value, income bracket, kitchen access, and park access [5].

HCAI defines the preventable hospitalization rate as the number of hospitalizations of adult patients for preventable reasons divided by the total number of adult hospitalizations. HCAI's list of preventable reasons includes diabetes and its complications, chronic obstructive pulmonary disease (COPD), heart failure, bacterial pneumonia, asthma, urinary tract infections (UTIs), hypertension, dehydration, and angina. Specific state prevention quality indicators (PQIs) include PQI #5 and #15 (COPD/asthma), PQI #7 (hypertension), PQI #8 (heart failure), PQI #1 (short-term diabetes complications), and PQI #2 (long-term diabetes complications).

Methods

The 2021 data used in this report was gathered from the HCAI "Social Drivers of Health and Preventable Hospitalization" dataset available on the California Health and Human Services (CalHHS) Open Data Portal [5].

Sample sizes and population counts were not available in this version of the dataset and were instead obtained from the data visualization dashboard of the same name available on HCAI's website [24].

County populations were obtained using data from the US Census Bureau [25].

Counties with a population of less than 40,000 people were omitted from report insights and the analysis by race and ethnicity (but were included in the Figure 2 map and accompanying appendix Table 3) due to small sample sizes and gaps in the data. Additionally, counties with a population size less than 100,000 people were omitted from the language and payer analyses (but not the analysis by race and ethnicity) due to gaps in the data. Throughout the visuals included in this report "All Californians" represents an estimate based on available data.

Multiple regression results were obtained using Microsoft Excel. The "Other" race and "Other Payer" variables were omitted from the analysis to avoid collinearity that would mask the individual effects within these categories.

The "Social Drivers of Health and Preventable Hospitalization Rates" dataset provides county-level preventable hospitalization rates by race and ethnicity alone, as well as in combination with a series of social drivers of health. The set includes six races and ethnicities, each mutually exclusive: Asian American or Pacific Islander (AAPI), Black, Hispanic, American Indian or Alaska Native (AIAN), Other, and White. CPEHN uses the term "Latine" to replace "Hispanic" when describing those of Latin American descent. The "Other" category includes those who are multiracial, decline to state their race, or are otherwise unrepresented by the other categories; the broad definition makes it difficult to draw conclusions about preventable hospitalization rates for this group. The "Other Languages" category includes languages other than English and Spanish, including Tagalog, Korean, Vietnamese, Mandarin, Cantonese, and Hindi.

Appendix (Continued)

Regression Output

Table 1: Multiple Regression Results for Race and Preventable Hospitalization

R (correlation coefficient) 0.664
R^2 0.425

Group	Coefficients	P-value
Intercept	0.0683	$2.115*10^{-40}$
Hispanic	0.00776	0.163
Black	0.0635	**$9.462*10^{-23}$**
White	0.0219	**0.000114**
Asian/Pacific Islander	0.00610	0.303
American Indian or Alaska Native	0.0289	**$3.485*10^{-5}$**
Sample Size	$-1.752*10^{-8}$	0.775

The results indicate a moderately strong relationship (r^2 = 0.43) between race and preventable hospitalizations. Black race, White race, and American Indian or Alaska Native race are significantly associated with a higher risk of preventable hospitalization ($p < 0.01$). Given a county, the expected preventable hospitalization rate for Black individuals in that county would be 4.2% (0.0635-0.0219) higher than for White individuals and 6.2% higher for Black individuals than Asian or Pacific Islander Individuals.

Table 2: Multiple Regression Results for Payer, Race, and Preventable Hospitalization

R (correlation coefficient) 0.775
R^2 0.594

Group	Coefficients	P-value
Intercept	0.0453	$5.203*10^{-17}$
Hispanic	0.00886	0.0531
Black	0.0681	**$8.791*10^{-39}$**
White	0.0185	**$5.321*10^{-5}$**
Asian/Pacific Islander	0.0109	0.0286
American Indian or Alaska Native	0.00893	0.296
Medi-Cal	0.0280	**$4.955*10^{-9}$**
Medicare	0.0608	**$4.654*10^{-34}$**
Private Coverage	-0.0214	**$9.143*10^{-6}$**
Self-Pay	0.0420	$4.525*10^{-12}$
Sample Size	$-2.098*10^{-7}$	0.116

The results indicate a strong relationship (r^2 = 0.59) between race, payer, and preventable hospitalizations. Black and White race remain strongly associated with higher rates of preventable hospitalization ($p<0.01$); regardless of insurance, Black individuals can expect preventable hospitalization rates 5-6% higher than individuals of any other race in a county. Medi-Cal and Medicare significantly increase the expected rate of preventable hospitalization, while Private Coverage significantly decreases it ($p<0.01$). Regardless of race, using Medi-Cal increases the expected rate of preventable hospitalization by 2.8%, while having private coverage decreases it by 2.1%.

Appendix (Continued)

Table 3: Preventable Hospitalization Rate (%) by County for Black Californians

County	Preventable Hospitalization Rate (%)	County	Preventable Hospitalization Rate (%)
Alameda	13.6	Orange	10.6
Alpine*	-	Placer	9.4
Amador*	-	Plumas*	-
Butte	15.6	Riverside	12.8
Calaveras	0	Sacramento	14.4
Colusa*	-	San Benito*	-
Contra Costa	13.9	San Bernardino	12.7
Del Norte*	-	San Diego	13.3
El Dorado*	8.3	San Francisco	17.4
Fresno	16.8	San Joaquin	13.2
Glenn*	-	San Luis Obispo	14.3
Humboldt	18.8	San Mateo	10.8
Imperial	11.8	Santa Barbara	14
Inyo*	-	Santa Clara	13.8
Kern	14.3	Santa Cruz	11.8
Kings	11.7	Shasta	15
Lake*	7.7	Sierra*	-
Lassen*	-	Siskiyou*	25
Los Angeles	12.6	Solano	11.8
Madera	15.2	Sonoma	12.1
Marin	11.1	Stanislaus	13.7
Mariposa*	-	Sutter	17.6
Mendocino*	-	Tehama*	33.3
Merced	18.4	Trinity*	-
Modoc*	0	Tulare	22.2
Mono*	-	Tuolumne*	-
Monterey	11.8	Ventura	9.3
Napa	7.7	Yolo	9.5
Nevada*	-	Yuba	14.3

*Counties excluded from multiple regression (small sample size or <40k population); - counties with no data or suppressed numbers.

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