Population Needs Assessment

May 2024

Contents

I. Population Needs Assessment Overview

Partnership HealthPlan of California is a not-for-profit, Medi-Cal managed care plan (MCP), serving 14 counties in Northern California with a membership size of about 660,800 as of December 2023.[1] On January 1, 2024, Partnership added 10 new counties to its service area. Partnership is one of California's 6 County Organized Health System (COHS) managed care plans endorsed by the County Boards of Supervisors. Most Medi-Cal beneficiaries are assigned automatically to Partnership, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and beneficiaries in skilled nursing facilities. In addition, dual-eligible Medicare-Medicaid members are assigned to Partnership as a secondary line of coverage. In 2023, Partnership provided primary and specialty health services through a contracted network of community providers, medical groups, an integrated HMO (Kaiser Permanente), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Centers, local hospitals (acute and other), skilled nursing facilities, pharmacies, and ancillary providers.[2] As of January 2024, Partnership will no longer contract with Kaiser Permanente due to the statewide Kaiser Transition to an individual Medi-Cal managed care plan.

Each year, Partnership reviews and analyzes the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population per the requirements of both the California Department of Health Care Services (DHCS) as well as the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). Partnership collects, integrates, and assesses data from its member population to develop and inform the PNA, which then drives Partnership's Population Health Management Strategy along with the Cultural & Linguistics Program Strategy and their associated work plans. Data sets used for Partnership's 2024 PNA include Partnership Member Enrollment data, Local Community Needs Assessments, County Health Rankings and Roadmaps data, Small Area Income and Poverty and Estimates (SAIPE) data, U.S. Census Bureau data, published articles, reports from the Centers for Disease Control and Prevention (CDC) and California Department of Public Health, Partnership Integrated Claims and Encounter data, Healthcare Effectiveness Data and Information Set (HEDIS®) results, Consumer Assessment of Healthcare

[1] Partnership Membership Dashboard, 2023
[2] Partnership Quality and Performance Improvement Program Description, 2023

Providers and Systems (CAHPS) survey data, Health Disparities data from Partnership's "Reducing Health Care Disparities" report, Timely Access data, Partnership Grievance and Appeals data, and internal Human Resources reports. Member enrollment data is further segmented by age, gender, race/ethnicity, primary language, geographic distribution, and other factors, to identify gaps in services and health disparities.

Population Health staff completed the analyses and made the decisions included in the report, with cross-departmental input and approval solicited as needed. The writing staff consist of these positions:

Position Title	Department
Manager	Population Health
Sr. Health Educator	Population Health
Health Educator	Population Health

A. Summary of Key Findings

Partnership's membership remained relatively stable in 2023. The member redetermination process, resulting from the winding down of the COVID-19 Public Health emergency, caused some small fluctuations. At the close of 2023, Partnership served approximately 660,800 members throughout 14 counties. In 2024, Partnership will no longer contract with Kaiser Permanente, will fully operationalize its 10-county expansion, and the Medi-Cal redetermination process will continue. Partnership's membership is expected to continue to fluctuate as a result. The 2024 Population Needs Assessment draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

1. Summary of Findings

Local community needs assessments identified a variety of priority areas of need by domains of Social Determinants of Health (SDoH), including:

- Healthcare access and quality: insufficient access to healthcare, mental health, substance use disorder and prenatal care services
- Economic stability: economic instability and unstable housing
- Neighborhood and built environment: lack of access to healthy foods and opportunities to exercise, higher rates of violence, unintentional injury, fire threat, and challenges with transportation
- Social and community context: higher rates of adverse childhood experiences (ACEs)

Other data sources confirm that while all of Partnership's counties have concerns about the number of available providers (including primary care, dental care, specialty care, mental/behavioral health, and substance use care), concerns are heightened in the rural and frontier regions.

Many members require help with transportation to and from provider visits; a need that grows more prevalent in remote areas where provider offices may be far from members' homes. Transportation issues include having to travel long distances (including to other counties) for care, and not having a vehicle, friend, or ride service available for transportation. Almost all counties have a lack of affordable and quality housing, and many individuals who qualify for housing assistance cannot find a place to rent. Homelessness remains constant since 2023's PNA throughout many of the counties.

In 2023, there were 14 wildfires in Partnership's regions, contributing to loss of available housing and possible adverse pulmonary and cardiovascular effects. Compounding these environmental factors are lifestyle choices like smoking. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties, and some smokers start as early as elementary school.

Partnership uses claims and encounter data to approximate disease prevalence among its members. In 2023, hypertension and tobacco use were the 2 most common conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety and trauma/stress. Telehealth utilization for behavioral health has increased since 2022, allowing more members to access this important service. Breast cancer screening rates and cervical cancer rates in the northern counties also continue to underperform. Furthermore, the White population continues to have the highest number of mental health visits compared to other groups. Sonoma County had the highest number of visits during 2023.

To determine if there are health disparities within the overall population served, Partnership reviewed Measurement Year 2022 (MY 2022) Health Plan Accreditation final measure samples by race/ethnicity, gender, and language. Black/African Americans had the lowest controlled blood pressure measures compared to the White population. The White population and the male population had a significantly higher rate of poor diabetes control compared to other groups and compared to women, respectively. Finally, the White, Black/African American, and Native Hawaiian/Other Pacific Islander groups had lower rates of successful completion of child and adolescent well care visits; the English-speaking group and the male population performed worse on this measure compared to other similar groupings.

2. Summary of Planned Actions

Partnership works closely with provider and community resources to ensure members have access to a wide range of services. This PNA revealed opportunities for action by addressing needs in the following areas: organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education/culture and linguistics.

In 2023, Partnership hired a new Northeast Regional Director to provide organizational representation and to act as a regional liaison in Shasta, Modoc, Siskiyou, Trinity, Lassen, and Tehama counties. Partnership also created and filled the position for an Eastern Regional Director to provide similar oversight in 9 of the 10 new expansion counties. Partnership also added 2 key roles within the organization to address pervasive concerns and new areas of focus. In 2023, Partnership hired a Director of Health Equity to ensure organizational activities are conducted equitably and mitigate health disparities. Partnership also added an Associate Director of Workforce Development to create a long-term plan for recruiting and retaining health care workers within Partnership's service area. Partnership continues to work closely with provider groups and training organizations to develop a pool of community health workers (CHWs) and doulas to ensure Partnership members receive the best possible care.

To address social and environmental concerns, Partnership is leveraging state funds. Initiatives like the California Advancing and Innovating Medi-Cal (CalAIM), the Community Supports service, Enhanced Care Management, and Homeless and Housing Incentive Program (HHIP) provided means for managed care plans to offer grant funding to address housing concerns. While the HHIP measurement period ended in October 2023, the program will continue until March 2024. In 2024, Partnership also plans to offer scholarships to Sacramento City College's Community Health Worker (CHW) Certificate Program to help create employment opportunities in the local communities. In another effort to support the unhoused, Partnership prepared 6,430 backpacks with essential supplies for 23 participating counties that had their Point-in-Time (PIT) count complete by January 2024.

One of the ways Partnership provides support for members living in fire-prone areas is by creating a Fire and Disaster Reporting email inbox for member- and provider-facing departments within Partnership. This internal inbox notifies departments of disasters so Partnership staff are prepared to support members in their time of need. In 2023, Partnership also mailed out Disaster Preparedness booklets and an Emergency Kit Pocket Cards to vulnerable g members in all 14 counties to keep them prepared for natural disasters. In another intervention, Partnership worked with a local elementary school to pilot a tobacco education and prevention training to promote a smoke-free

future. Partnership's Population Health Department also added questions about smoking behavior to the outbound call campaign scripts for all campaigns.

Partnership is exploring multiple approaches to address chronic conditions and disparities among subpopulations. In the beginning of 2023, Partnership collaborated with providers and other community agencies to provide member education and referrals for individuals recently diagnosed with hypertension. One of the ways Partnership provides support to members for chronic conditions is by conducting telephonic outreach to offer a self-management tool through the Healthy Living Tool. In 2022, Partnership's Pharmacy department created an asthma management program where staff outreach to provide support to the parents of children who had a recent Emergency Department (ED) visit with an uncontrolled asthma diagnosis code. Two other pilots are still in progress; addressing colorectal and cervical cancer screenings – these pilots are proving to be successful, resulting in increased numbers of members testing. Partnership also continues to contract with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and to health centers that do not have ready access to mammography services. Other recent interventions included weekly ADHD new start reports to identify Partnership primary members aged 6-12 years old that had filled a new ADHD medication to provide better support to members with this diagnosis.

American Indian/Alaska Native populations face many health disparities. Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area, to decrease known health disparities between American Indian and non-American Indian members. Partnership has been an active participant in several such efforts.

Building off successful programs from prior years, Partnership performed outreach to all willing members from pregnancy through age 6, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teens for vaccinations and wellness visits. Partnership allocated staff, incentive dollars, and time to collaborate with schools and public health officials, which resulted in school-based clinics, poster contests, and other marketing strategies to promote childhood wellness care.

Partnership developed a multi-pronged approach to recruit and retain providers, with oversight from the Board of Governors, and in collaboration with state and national initiatives. For example, Partnership started a Provider Recruitment Program in January 2024, which focuses on helping the contracted network recruit and retain high-quality health professions in Partnership counties; this program has new incentives, including

sign-on bonuses. Partnership is also launching a new Provider Retention Initiative (PRI) Pilot. The PRI is intended to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. The hope is to preserve institutional knowledge and clinical leadership in Partnership networks. In 2023, Partnership also formed a work group that researched resources to help providers operate facilities that are more physically accessible for seniors and members with disabilities. To further promote access, Partnership will continue to collaborate with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services.

Partnership will create member-facing videos on several topics in 2024 to help educate members in a more interactive way. Topics include preventive care, vaccines safety and efficacy, mental health, and women's health.

II. Data Sources

A. Overview of Procedures, Resources, and Methodologies

Partnership collects, integrates, and assesses data from its member population to develop the PNA and various related activities. Partnership uses this data to determine the profile and needs of its member population, which may include, but is not limited to:

- Member demographics such as age, language (including limited English proficiency), race/ethnicity, and geographic location
- Local community needs assessments
- Social Determinants of Health (SDoH), drawn from County Health Rankings
- Service utilization, based on integrated claims and encounter data
- Health conditions and health-related behaviors, based on Partnership's HEDIS data
- Timely Access Data
- Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities, and members with serious mental illness or serious emotional disturbance (SMI/SED), based on member demographics, and integrated claims and encounter data
- Member satisfaction or lack thereof, based on CAHPS data and member grievance data

- Partnership's Reducing Health Care Disparities Report (i.e. 2023 Health Disparities data)

1. 2023 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2023. This data includes the total number of individuals enrolled in Medi-Cal and assigned to Partnership by eligibility group. Through daily and monthly releases, DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans based on their service areas. This data includes member-level characteristics such as race/ethnicity, age, gender, language, and eligibility indicators for seniors and persons with disabilities, pediatric conditions, and those living in long-term care facilities.

2. Local Community Needs Assessments

The Community Needs Assessment section was compiled using publically available Community Health Assessment (CHA) and Local Community Health Needs Assessment (CHNA) reports from the counties. Some of Partnership's counties have CHA reports in progress, set to be released in the near future. The reports were published in different years (2022 and 2023).

3. 2023 County Health Rankings and Roadmaps

The County Health Ranking and Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The 2023 Annual County Health Rankings uses the most currently available data to measure a range of vital health factors, such as air pollution, adult smoking, severe housing problems, physical inactivity, food environment index (access to healthy foods). County Health Rankings also typically includes measures such as high school graduation rates, obesity, unemployment, income inequality teen births, and more. The rankings are modeled after a view of population health that highlights the many factors that influence one's health. If these factors improve, communities thrive and reduce health disparities for subpopulations. The rankings are determined by:

- Health Outcomes: The overall ranking in health outcomes measures the general health of county residents. They reflect the physical and mental well-being of residents within a community through measures representing length of life and quality of life.
- Health Factors: The overall ranking in health factors represents many things that influence quality of life and how long we live. Health factors represent circumstances or behaviors that can be modified to improve the length and

quality of life for residents. They are predictors of how healthy our communities can be in the future.

4. 2023 Partnership Integrated Claims and Encounter Data

Partnership's Health Analytics team manages an integrated data set, including medical, behavioral, laboratory results, and services directly reimbursed by the state (e.g., pharmacy claims). The 2023 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services. The data set documents both the diagnosed clinical conditions, and the services and items received by beneficiaries to treat these diagnosed conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. Partnership's paid claims, laboratory results, and encounter data are integrated with state-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims, claims from our delegated managed behavioral healthcare organization (Carelon Behavioral Health), and claims from members previously assigned to Kaiser for medical and mental health services.

5. 2023 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a comprehensive set of standardized performance measures. These measures were established by the National Committee for Quality Assurance (NCQA) and are designed to allow reliable comparisons of health plan performance. The methodology for each HEDIS measure is described in the annual HEDIS Technical Specifications corresponding to the measurement year. DHCS selects some of these HEDIS measures to be used as annual performance measures for Managed Care Plans; these are referred to as the Managed Care Accountability Set (MCAS). See Appendix A for the HEDIS Regional Performance Report Year 2023, Measurement Year 2022. DHCS has designated 4 HEDIS performance reporting regions for Partnership: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake). As of January 1, 2024, Partnership added 10 new counties and a fifth, Eastern reporting region. The new counties included in the Eastern region are Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, and Yuba, with Tehama County being added to the Northeastern region counties. Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile of the national NCQA HEDIS performance for Medicaid and varies by each measure. In addition to the MCAS measures, Partnership collects data plan-wide for NCQA HEDIS measures required for NCQA Accredited Medicaid Managed Care Plans, referred to as the HealthPlan Accreditation (HPA) reporting population. Partnership

uses annual HEDIS results to evaluate clinical quality outcomes in a standardized way, and to evaluate health inequities for our members by race, ethnicity, language, and geographic region.

6. 2023 Timely Access Data

Partnership's Provider Relations department gathers Timely Access data through an annual survey. This survey identifies the time before providers' third next available appointments for adult and pediatric primary care, newborn visits, and urgent care visits. This survey is used to evaluate appointment care access for Partnership members.

7. 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In alignment with the National Committee for Quality Assurance (NCQA), Partnership has selected Press Ganey (PG) to perform member surveys to capture information about member experiences with the health plan and their respective health care. These surveys inform health care organizations about patients' or their families' experiences with their health care providers and plans, including hospitals, home health agencies, doctors, health and drug plans, and other provider types. The CAHPS surveys ask adult and child members to provide feedback in multiple categories, such as: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Coordination of Care, Ease of Filling Out Forms, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Rating of Health Plan, and Effectiveness of Care Measures. This report will focus on the composite scores for Rating of Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist measures for both adults and children. The CAHPS survey measurement year (MY) or period is for 2022 (July 1, 2022 – December 31, 2022) and the reporting year is 2023.[3]

8. 2023 Health Disparities Data

In 2023, Partnership convened a multidisciplinary team to assess for health disparities in our member population as part of a grand analysis to produce the HE 6: Reducing Healthcare Disparities report. This analysis looked at race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis. Partnership utilized measurement year 2022 (MY 2022) Health Plan Accreditation final measure samples (n=254 to 397 members) to evaluate each of the clinical measures of focus later described in the health disparities

[3] SHP Analytics, 2023

section. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation plan-wide summary of performance report. Partnership's HEDIS vendor, Inovalon, provided the random member sample generated for each measure, along with member race/ethnicity demographic information. Inovalon is classified as a direct data source. This report provides data on health disparities specific to Partnership members.

B. Other Data Sources

In addition to the specific sources listed above, Partnership integrates data from member-reported health appraisals, data collected through health services programs and case management activities, as well as member feedback following participation in a Partnership intervention. Internal staff development, including mandated training courses, is monitored through Partnership's Learning Management System (LMS).

Partnership regularly reviews published research in areas impacting our population. Partnership leaders and clinicians subscribe to journals that describe evidence-based care, and promising practices to implement among members with complex needs and those with behavioral health or substance use disorders. These journals include research that addresses SDoH, health equity, and population health management strategies. Partnership also reviews national data sources, such as the CDC and the US Preventive Services Task Force to track national trends and align ourselves with emerging care protocols. For demographic information in our various regions, we reference United States Census Bureau reports and the SAIPE State and County Estimates for 2022.

C. Population Segmentation

After reviewing Partnership's overall population needs, the member population is segmented into subpopulations with similar needs and characteristics. Each of these subpopulations are further assessed to identify any additional needs and disparities. This process pulls information from a variety of reports that may include but are not limited to member demographics, health/risk assessments, laboratory results, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as reports and analyses of over and under-utilization of care. Partnership reviews population segmentation on an annual basis to evaluate for disparities, potential inequities, and to ensure that all populations are served. However, a number of factors may influence Partnership to conduct additional reviews of population segmentation, such as state findings, natural disasters, and standard business practices.

In addition to evaluating member needs, Partnership also analyzes programs and activities no less than annually. Partnership uses the results to inform and refine its

interventions, including those activities and resources to address health care disparities, and evaluate whether Partnership and community resources are sufficient to address member needs.

III. Key Findings

A. Member Demographics

1. Membership/Group Profile

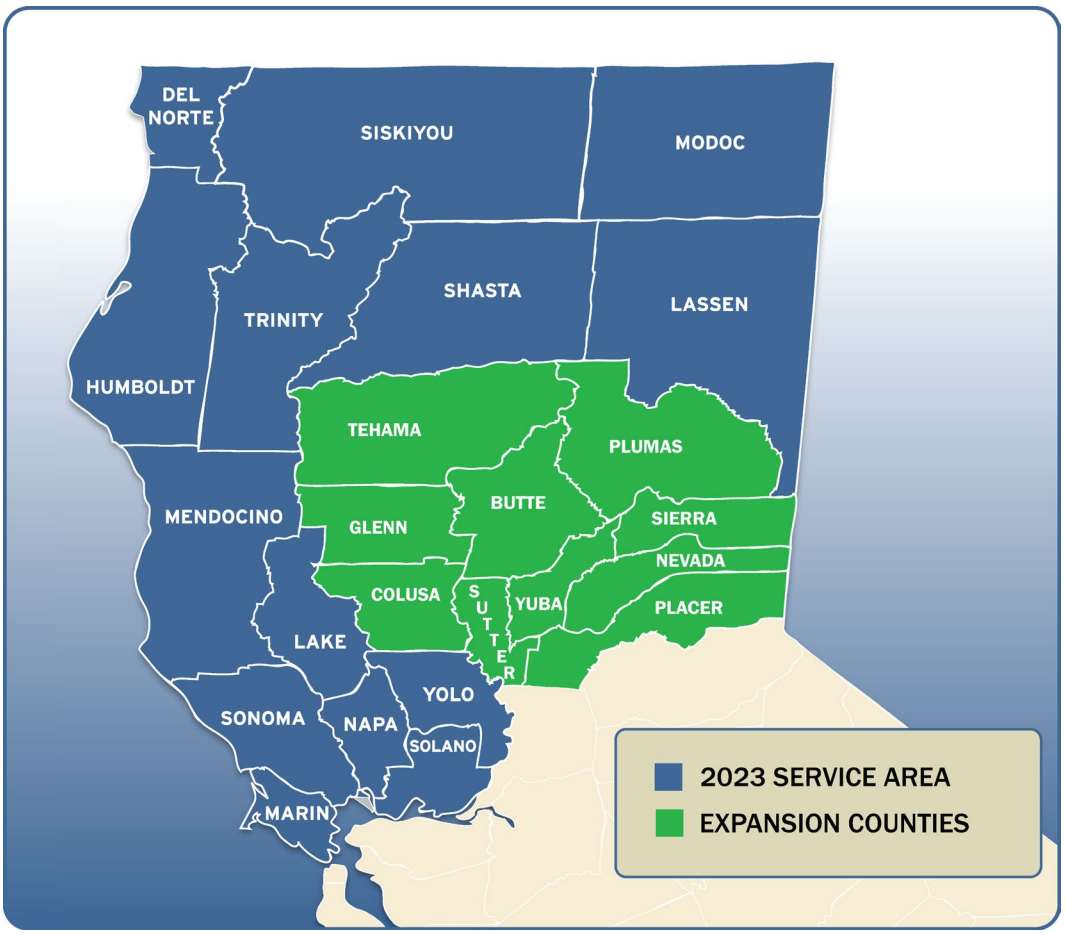
While member demographic information can fluctuate month to month, at the close of 2023, Partnership served approximately 660,800 Medi-Cal beneficiaries in 14 counties in Northern California. Partnership primarily serves children and adults under the age of 65. In 2023, Partnership served approximately 410,250 adults and 250,550 children. In 2024, Partnership will also work to ensure that previously uninsured individuals, or individuals transitioning to full-scope Medi-Cal maintain their existing Primary Care Provider (PCP) assignments to the maximum extent possible.[4] This new Department of Health Care Services requirement expands eligibility for full-scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS).

2. Geographic Distribution

Partnership's service area includes Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo Counties. Partnership's 4 regional offices are centrally located in Fairfield, Redding, Santa Rosa, and Eureka. In January 2024, Partnership added 10 new counties to our service area: Tehama, Glenn, Colusa, Butte, Sutter, Yuba, Plumas, Sierra, Nevada and Placer. Partnership will also open 2 new regional locations in Placer and Butte counties as part of this 10-county expansion.

[4] All Plan Letter - 23-031 Medi-Cal Managed Care Plan Implementation Of Primary Care Provider Assignment For The Age 26-49 Adult Expansion Transition

Figure 1: Map of Partnership Counties as of January 2024

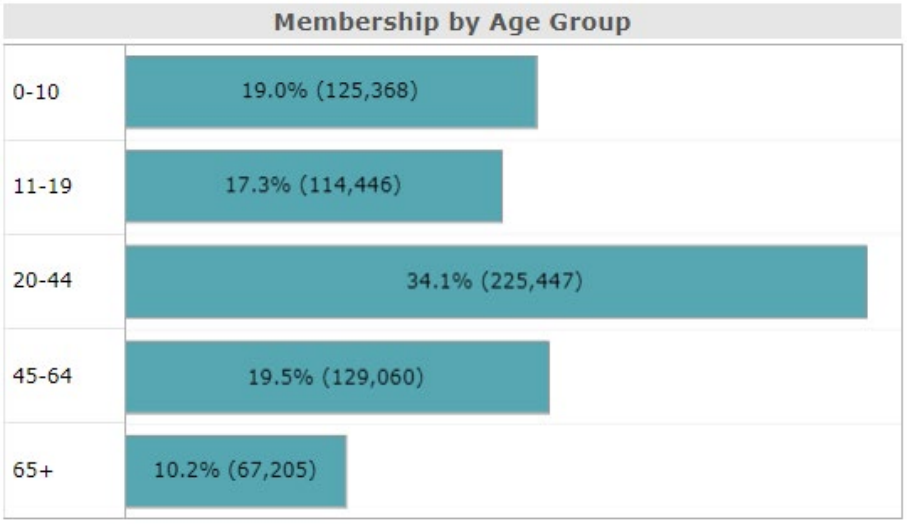


Partnership, 2023

3. Age and Gender

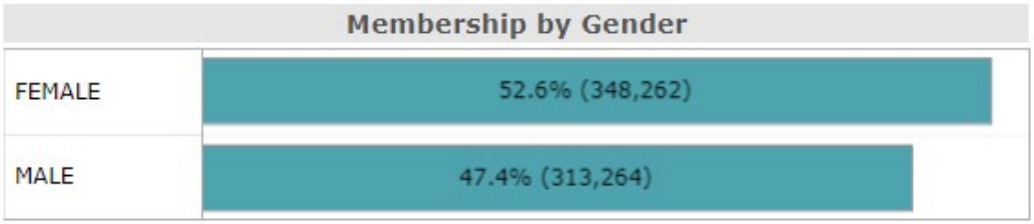
According to December 2023 Partnership enrollment data, 19% of members are ages 0-10, 17.3% of members are ages 11-19, 34.1% of members are ages 20-44, 19.5% of members are ages 45-64, and 10.2% of members are ages 65 and older. There were 7,735 babies born to Partnership members during 2023. In addition, 52.5% of members are female while 47.5% are male.

Figure 2: 2023 Partnership Membership by Age Group



Source: December 2023 Member Enrollment Data, Partnership

Figure 3: 2023 Partnership Membership Gender

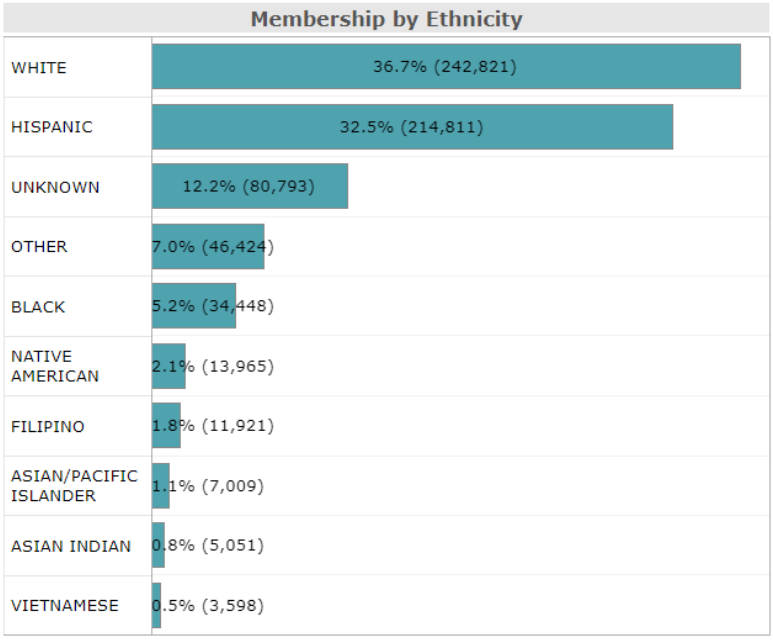


Source: December 2023 Member Enrollment Data, Partnership

4. Race/Ethnicity

The largest ethnic groups across all 14 counties are White (36.7%) and Hispanic (32.5%). Figure 4 illustrates the racial and ethnic composition of Partnership's members as of December 2023.

Figure 4: 2023 Partnership Membership by Race/Ethnicity

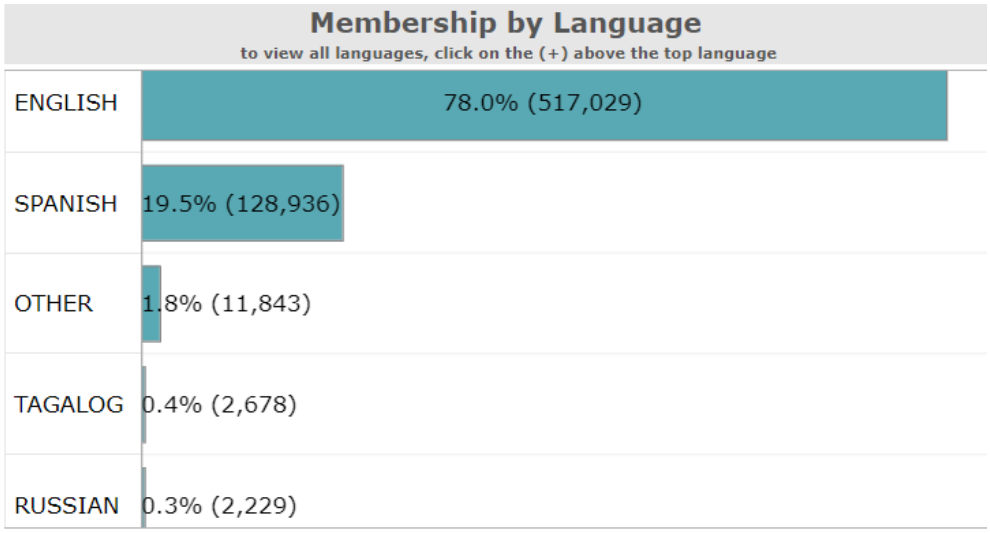


Source: December 2023 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2023 enrollment data, 77.9% of members identify as English speaking and 22.1% identify as limited English proficiency (LEP). Partnership has 3 threshold languages – Spanish, Russian, and Tagalog. Members identifying as Spanish speaking total 19.6%. Russian and Tagalog speakers account for 0.7% of LEP members, while 1.8% of the population speaks a language other than the 3 threshold languages.

Figure 5: 2023 Partnership Membership by Primary Language

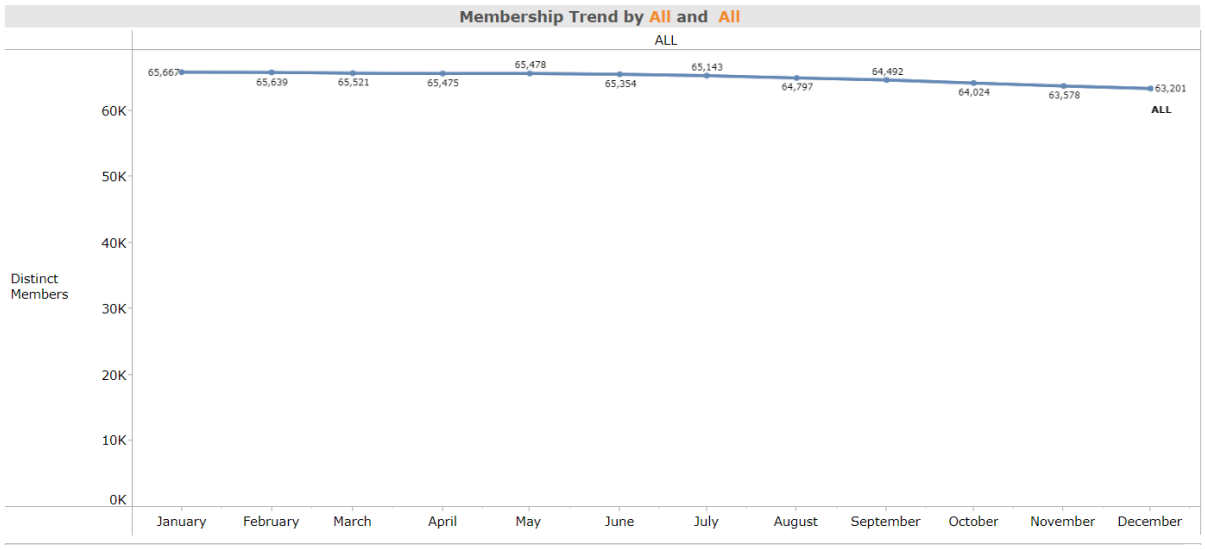


Source: Partnership's December 2023 Member Enrollment Data

6. Disability

Based on December 2023 Partnership enrollment data, approximately 63,201 members are disabled as shown in Figure 6. Furthermore, 5,872 of all disabled members are ages 0-20; 44,469 are ages 21-64; and 12,860 are ages 65 and older. Finally, 32,293 of all disabled members are males while 30,908 are females.

Figure 6: 2023 Partnership Membership Disability Category Trend



Source: Partnership's December 2023 Member Enrollment Data

IV. Local Community Needs Assessment

A. Summary of Local Community Needs Assessments

At the end of 2023, Partnership had a 14 county service area with a diverse demographic makeup of residents. As of January 1, 2024, Partnership expanded its service area to include the following 10 new counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Tehama Sierra, Sutter and Yuba. Assessments of the expansion counties will be included in the 2025 PNA.

A review of each Partnership County's Community Health Assessment showed diverse priority need areas, and gaps in services or care. Partnership works to align its current activities in response to the priority needs of each county. The Local Community Health Assessment section was compiled using publically available Community Health Assessment (CHA) and Community Health Needs Assessment (CHNA) reports from 14 counties. The reports were published primarily in 2022 and 2023 by Local Health Jurisdictions and non-profit hospitals in Partnership's service area. Although the 14 county service area is geographically expansive and ethnically diverse, there were common priority needs mentioned across each county, many of which could be categorized as SDoH.

The most prevalent SDoH issues across all 14 counties can be grouped into the Healthy People 2030 categories of: health care access and quality; economic stability; neighborhood and built environment; and social and community context.[5] Each of these categories can significantly impact the health of our members. Issues in health care access and quality include insufficient access to mental health/substance use services, and inadequate prenatal care. Lack of access to timely health care limits a person's ability to get the appropriate care and medicines they need to stay healthy. Many of the residents in the 14 counties face economic instability and lack of stable housing. Economic instability is a root cause for many poor health outcomes, as it greatly limits one's ability to access resources to meet basic needs. Issues with the neighborhood and built environment include challenges with transportation, lack of access to healthy foods/opportunities to exercise, higher rates of violence and unintentional injury, and the risk of fire threat. These are all known factors that can contribute to an environment that can make it challenging to stay healthy. Lastly, some of these communities also faced issues with their social/community context including higher rates of adverse childhood experiences (ACEs). Higher rates of ACEs is a known cause for many negative health outcomes later in life.

[5] Healthy People 2030 Social Determinants of Health

1. Del Norte County

Del Norte completed their last Community Health Assessment (CHA) in 2019.[6] This report revealed certain socioeconomic disparities such as lower household income compared to the rest of the state, underemployment, and higher levels of poverty, especially among children, ethnic communities, and those with less education. Other areas of disparity are around food access, including higher rates of food insecurity among children, and lack of access to healthy foods among adults. Lack of affordable housing and limited transportation options continue to be a concern. Insufficient mental health and dental providers, long appointment wait times, lack of trust in providers, and rural geography all limit Del Norte County from having sufficient access to primary and specialty care. Residents also continue to struggle with paying for healthcare, are not always able to find services they can afford, and over-utilize the emergency department. Del Norte County was cited as having the highest need for mental health services in the state of California and struggles with a variety of behavioral health concerns, including substance and tobacco abuse. Del Norte also faces a variety of chronic health conditions, especially among the low-income population, and challenges for residents who are pregnant, including inadequate prenatal care, worse pregnancy outcomes, higher rates of substance use compared to California, higher rates of teen births, and lower rates of vaccinations and breastfeeding. Finally, Del Norte has higher violence and unintentional injury related death rates compared to the state average. The county is working on their next set of CHA and CHIP reports.

Del Norte possesses several strengths, including strong civic engagement, environmental hazard safety standards generally being met, and most residents participating in physical activity. Furthermore, Del Norte county has seen lower rates of infant mortality compared to the state, and lower rates of sexually transmitted infections.

2. Humboldt County

Humboldt's last CHA was completed in 2018.[7] While that CHA show a range of community health concerns, Humboldt released an Enhanced Community Health Assessment in 2022 which focused on the Oral Health Assessment and the Youth Report on Substance use in Humboldt County.[8] The Oral Health Assessment discussed individuals who had complex health or behavioral health conditions, and housing and transportation concerns which impact accessing needed care. This report also identified a lack of access to routine dental care among the population surveyed, with over 90% of respondents stating they had challenges with accessing dental services. The oral health

[6] 2019 Del Norte County Community Health Assessment
[7] 2018 Humboldt County Community Health Assessment
[8] 2022 Enhanced Humboldt County Community Health Assessment

report shared that many of the barriers are due to financial constraints, travel challenges, and lack of providers which has led to a higher number of visits to the emergency room among adults. The Youth Report on Substance Use in Humboldt County is based on a survey called "Your Thoughts on Substance Use in Humboldt." The survey showed responders in Humboldt were largely concerned with the uptake of alcohol and drug use as a means to cope with ACEs. Respondents also expressed the need for community to better support against substance use, and the need for additional substance use prevention.

3. Lake County

Lake County's most recent CHA was completed in 2022.[9] Their priority areas are access to care, health risk behaviors, and mental health. Access to care included timely treatment, travel distances, transportation challenges, availability of treatments, provider retention, and high usage of the Emergency Department due to a lack of urgent care providers. Health risk behaviors include unhealthy eating, lack of physical activity, excessive screen time, tobacco and substance use, maternal and child health concerns, and concerns around preventive healthcare. Mental health concerns include the possible increase of domestic violence, self-medication to address poor mental health, stigma around seeking mental health care, lack of mental health providers, no health insurance, substance use, crime, unemployment, higher rates of suicide, intentional self-harm, and substance use overdoses.

4. Lassen County

As of December 2023, Lassen County has never conducted a CHA. However, they are working on their Community Health Assessment, and have secured a contractor to carry out the process. This process commenced in December 2023.

Other local health assessments have been completed. According to Banner Health's 2022 CHNA by Banner Lassen Medical Center, Lassen county has the following priority needs: access to care, chronic disease management and behavioral health.[10] The same document outlines Lassen County's areas of strength, which are health behaviors (physical inactivity and sexually transmitted diseases), clinical care (uninsured and dentists), and social and economic factors (unemployment and income inequality).

[9] 2022 Lake County Community Health Assessment
[10] 2022 Banner Health Community Health Needs Assessment

5. Marin County

Marin County completed their last CHA in 2022.[11] This assessment showed that, compared to any other racial and ethnic group, the African American population had the lowest life expectancy, highest premature deaths, and highest percent of babies with low birth weight. The report also showed that Hispanic residents had a higher percentage of the population living in poverty, the highest number of uninsured people, and lower educational attainment and third grade reading and math levels compared to all other racial and ethnic groups. Median income data showed that the lowest median income was among the Black population, despite higher levels of educational attainment than Hispanic residents. Other top health concerns were around meeting basic/functional needs such as housing, jobs/income, and education; access to quality primary health care such as insurance coverage, differences in health insurance rates by race and ethnicity, and preventable hospitalizations; access to mental/behavioral health and substance use services to prevent overdose deaths, and death by self-harm; access to community connections; structural racism; and increased community connectedness to prevent suicide rates, excessive drinking, and school suspensions.

6. Mendocino County

According to the 2023 Mendocino County Community Health Improvement Plan (CHIP), the overall priority areas identified were: maternal health, adolescent health, disparities in the Indigenous communities; and serious health and safety concerns that were a result of SDoH.[12] Maternal health outcomes were poorer due in part to the county's remote geographical area, which makes it difficult to attend appointments. Maternal health outcomes were also poorer due in part to the historical trauma and mistrust felt by the local Indigenous population. Adolescent health outcomes were worse due to motor vehicle accidents, gun violence and assault, drug overdose, and higher rates of ACEs (due in part to high rates of poverty).

7. Modoc County

Modoc County released their last Community Health Needs Assessment (CHNA) in January 2024.[13] Modoc's CHNA identified issues such as poverty, unemployment, educational attainment, access to healthcare, rates of the uninsured, and lack of providers. It found a high prevalence of risk behaviors, chronic disease, and poor

[11] 2022 Marin County Community Health Assessment
[12] 2023 Mendocino County Community Health Improvement Plan
[13] 2024 Modoc County Community Needs Assessment

physical and mental health contributing to higher rates of disability and earlier death than in California overall.

8. Napa County

Napa County completed their last CHA at the end of 2023.[14] Napa's CHA identified 5 top health priorities. Listed in ranked order (from highest to lowest), they are housing, behavioral health, access to health services, racial equity and LBGTQIA+ inclusion, and economic stability.

9. Shasta County

According to the Dignity Health 2022 CHNA, Shasta county highlighted these areas as priority needs: access to mental/behavioral health and substance-use services, access to basic needs such as housing, jobs, and food, access to quality primary care health services, access to specialty and extended care, increased community connections, safe and violence-free environment, system navigation, injury and disease prevention and management and access to functional needs.[15]

10. Siskiyou County

Siskiyou County released their last CHNA in 2022.[16] Siskiyou county identified multiple high priority health needs including: access to mental/behavioral health and substance use; injury and disease prevention management; access to basic needs such as housing, jobs, and food; access to primary, specialty/extended care, and dental care; concerns around healthy eating and exercise; concerns around access to functional needs such as transportation and maintaining conditions that allow individuals with disabilities to remain mobile; and the need for safe/violence free environments. Other themes that arose were around strengthening community relationships and improved workforce infrastructure. Siskiyou was able to identify 112 resources with potential to help meet the needs of the county service area.

11. Solano County

Solano County's CHIP was released in January 2023.[17] The 2020 Community Health Assessment that serves as the basis for this CHIP identified 8 health needs as top concerns in the county. In order, they were: challenges to maintaining economic security; lack of access to safe and secure housing; challenges to accessing care; worse educational indicators compared to California; higher rates of domestic violence

[14] 2023 Napa County Community Needs Assessment
[15] 2022 Community Health Needs Assessment, Dignity Health Mercy Medical Center, Redding
[16] 2022 Siskiyou County Community Health Needs Assessment
[17] 2023 Solano County Community Health Improvement Plan

hospitalizations, injury deaths (intentional and unintentional), and violent crimes; higher rates of opioid use and suicide ideation compared to the state average; barriers to eating healthy and living an active lifestyle; and poor maternal and infant health outcomes. The CHIP identified 4 strategic issues, which were: behavioral health, access to care, maternal and infant health, and housing stability.

12. Sonoma County

Sonoma County released their joint Community Health Assessment and Improvement Plan in 2023. Sonoma County assessed 12 priority health needs on the subjects of climate change, healthy food access, economic security and housing, education, structural racism, access to clinically and culturally responsive care, coordinated systems of care, chronic disease prevention, communicable disease prevention, youth mental health, adult mental health, and substance use. The Improvement Plan outlines 4 priority areas for action: to address structural and institutional racism, improve community members' connection to resources, improve system of care coordination, and strengthen capacity of mental health and substance use services.[18]

13. Trinity County

Trinity County is set to complete their CHA in mid-2024. However, Trinity County released a Health Equity Assessment that highlights some of the needs of the county.[19] Main drivers of health inequity identified were poverty, isolation, limited economic opportunity, and infrastructure challenges (including lack of affordable housing, which can perpetuate other inequities). Some other health disparities highlighted include a high percentage of families living below the federal poverty level; inadequate access to a supermarket; high risk of living in a wildfire-prone area; highest rates of childcare cost burden compared to the rest of California; twice the rate of premature death when compared to the state as a whole, including the highest rates of suicide in the state, and higher rates of deaths related to unintentional injuries. Other concerns were around educational disparities; a limited number of primary care providers and dentists; specialty care, including difficulty obtaining referrals, difficulty getting care, and more costly visits to the emergency room; high rates of incarceration; lower rates of internet access compared to California; higher rates of violent crime compared to California; and shorter life expectancy compared to California, including higher rates of suicide among the White population, higher rates of death from unintentional injuries among the White population, motor vehicle collisions and overdose. The assessment revealed that about 1 in 5 Trinity County residents had 1 or more disabilities with higher rates among American Indian/Alaska Native residents; higher rates of risk-adjusted hospitalizations

[18] 2023 Sonoma County Community Health Assessment and Improvement Plan
[19] 2023 Trinity County Health Equity Assessment

due to chronic conditions; transportation limitations; technology limitations, and inadequate and unequal insurance coverage. Finally, there were concerns around Trinity's geographical landscape; limited resources such as housing, reproductive and sexual health, and mental health; lack of local resources like staff and providers; government distrust and independent culture; and promotion of unhealthy behaviors. This assessment revealed that "older adults" and "adolescents and young adults" experienced the most inequities. Over half of Trinity County community members also identified economic instability and the physical environment as a root cause of inequity. Finally, there are many middle and working class families who do not qualify for social services, despite experiencing economic hardship.

Despite the many concerns in Trinity County, the community has several assets, including shorter commute times among a third of Trinity County, and successful interventions that focus on: partnerships and collaborations across sectors, securing dedicated professionals, mobile and field based services, building trust, and building programs that fit the community. Interventions that have potential to improve health equity include "meeting people where they are," working on accessible services, targeting root causes, having robust communication with micro communities, increasing health education about disease risk and prevention, incentives to attract providers, and securing funds to support efforts. In addition, Trinity has unique strengths such as pride, personal identity, personal responsibility, resourcefulness, a deep sense of community, small close-knit ties, willingness to help, and the natural environment.

14. Yolo County

Yolo County's most recent CHA was completed in 2023.[20] It revealed 11 significant health needs. These needs include: access to resources to meet basic needs such as housing, jobs and food; the need for mental/behavioral health and substance use care; prevention for injury and disease; opportunities for healthy behaviors like healthy eating and exercise; access to primary, specialty, extended care, and dental care; guidance through the healthcare system; a need for community; safe places to live, and access to functional needs such as transportation. Other areas of concern are around homelessness, poverty, housing costs, disparities in education, and life expectancy.

Yolo County has a variety of assets. They have some of the highest vaccination rates in their area due to strong community connection; 367 resources to support mental and physical health needs such as farmer's markets, neighborhoods, and trails; a variety of trusted leaders and institutions; great schools; and good jobs.

[20] 2023-2025 Yolo County Community Health Assessment

B. Social Determinants of Health (SDoH)

Social Determinants of Health, also known as, "social influencers of health," as defined by the World Health Organization (WHO), are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics."[21] Healthy People 2030 offers several examples of SDoH including income, polluted air, access to healthy foods and physical activity, and Safe housing.[22]

Standardized collection of individual member SDoH is not available. There is no validated means of using diagnosis codes or claims data reliably to indicate 1 or more social determinant of health, and the data is quite incomplete; therefore, it is not useful for meaningful analysis. Instead, Partnership uses the Small Area Income and Poverty Estimates (SAIPE) State and County Estimates for 2022, County Health Rankings & Roadmaps data, and local, publically available Community Health Assessment reports to understand the drivers that influence the health of our population. We use this data, along with data provided by our county public health agencies, provider partners, and community-based organizations, to gain insight into the needs of our members and the communities where they live. This helps foster collaborative efforts with local agencies in order to improve the social supports that help meet the needs of our members.

1. Income

Income plays a major role in SDoH, specifically as it relates to health outcomes. More income often leads to better health outcomes, and vice versa. Below is a table detailing the income among Partnership's different counties.

Table 1: SAIPE State and County Estimates 2022

Partnership Northern Region	Median Household Income	Partnership Southern Region	Median Household Income
California	***$91,517***	***California***	***$91,517***
Del Norte	$57,297	Lake	$51,848
Humboldt	$57,660	Marin	$135,960
Lassen	$60,308	Mendocino	$63,621
Modoc	$51,166	Napa	$98,580
Shasta	$66,312	Solano	$92,711
Siskiyou	$51,593	Sonoma	$96,312
Trinity	$49,485	Yolo	$82,359

Source: United States Census Bureau 2023

[21] World Health Organization, Social determinants of health: Key concepts, 2013.
[22] Healthy People 2030, Social Determinants of Health

2. Air Pollution and Wildfires

In 2023, 14 wildfires in Partnership's regions burned more than 176,443 acres. With the increasing rate of wildfires in California, there is an increased possibility of impacts on Partnership's covered counties health. Fires increase the possibility of adverse pulmonary effects such as chronic bronchitis, asthma and decreased lung function.[23] Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

County Health Rankings and Roadmaps measures air pollution as the average daily density of fine particulate matter in micrograms per cubic meter. Across the state of California, this measure was 7.1 in Reporting Year 2023 (Measurement Year 2019). The Partnership County with the highest rates of air pollution is Solano at 9.0.

Table 2: Air Pollution – Particulate Matter by Partnership County in 2023

Partnership Northern Region	Air Pollution - Particulate Matter	Partnership Southern Region	Air Pollution - Particulate Matter
California	***7.1***	***California***	***7.1***
Del Norte	6.1	Lake	3.1
Humboldt	6.8	Marin	6.4
Lassen	6.0	Mendocino	6.0
Modoc	5.8	Napa	5.9
Shasta	6.6	Solano	9.0
Siskiyou	5.8	Sonoma	5.7
Trinity	5.3	Yolo	7.7

Source: *2023 County Health Rankings & Roadmaps*

Table 3 shows how many fires occurred and the amount of acreage burned in each county in 2023.

[23] Environmental Protection Agency (EPA), 2023

Table 3: Number of Wildfires and Acreage Burned by Partnership County in 2023

Partnership County	Number of Fires in 2023	Acres Burned in 2023
Del Norte	1	95,107
Humboldt	1	50,198
Lake	2	49
Lassen	0	0
Marin	0	0
Mendocino	0	0
Modoc	0	0
Napa	2	117
Shasta	3	200
Siskiyou	2	22,609
Solano	1	36
Sonoma	0	0
Trinity	2	8,127
Yolo	0	0
Total	**14**	**176,443**

Source: 2023 Fire Season Incident Archive | CAL FIRE

3. Adult Smoking

According to the CDC, cigarette smoking continues to be a main cause of preventable conditions such as disease, disability, and death among the U.S. population. The California Department of Public Health stated in their "2023 Results of the 2022 California Youth Tobacco Survey" that 6.6% of California high school respondents used tobacco in the last 30 days since completing the survey.[24] Vaping also continues to be a concern. Reponses showed that 22.8% of California high school respondents report being exposed to second hand vapor in a car or room in the last 2 weeks, and about a third (34.3%) shared that they were exposed to secondhand vapor outdoors.

Smoking affects almost every organ of the human body; it can also cause cancer in various parts of the body. Smoking can be a contributing factor to a variety of diseases including: cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Secondhand smoke can also increase the risk for health concerns.[25] With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate youth and parents on the harmful effects of tobacco use.

[24] 2023 California Department of Public Health Results of the 2022 California Youth Tobacco Survey
[25] Center for Disease Control and Prevention. Secondhand Smoke.

County Health Rankings and Roadmaps data say that on average, 9% of adults in Reporting Year 2023 (Measurement Year 2020) were current smokers in California. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties; rates of smoking in Partnership counties ranged from as low as 9% to as high as 18%.

Table 4: 2023 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate	Partnership Southern Region	Adult Smoking Rate
California	***9%***	***California***	***9%***
Del Norte	18%	Lake	17%
Humboldt	16%	Marin	9%
Lassen	17%	Mendocino	15%
Modoc	17%	Napa	11%
Shasta	15%	Solano	12%
Siskiyou	16%	Sonoma	12%
Trinity	18%	Yolo	12%

Source: 2023 County Health Rankings & Roadmaps. Red indicates higher than California average adult smoking rate.

4. Physical Inactivity

Low physical activity relates to several diseases such as diabetes, cancer, hypertension, cardiovascular disease, and premature mortality. Physical activity can improve sleep, cognitive ability, and bone and musculoskeletal health. Physical activity not only affects individuals, but also communities.[26]

The 2023 County Roadmaps and Rankings measure physical inactivity as the percentage of adults age 18 and over reporting no leisure time physical activity, with higher values indicating less time for physical activity. In Reporting Year 2023 (Measurement Year 2019), the California state average was 21%. In Partnership covered counties, Del Norte (24%), Lassen (23%), Lake (23%), (Modoc 22%), and Trinity (22%) had physical inactivity rates higher than the state average. Mendocino (21%), Solano (21%), Siskiyou (21%), and Humboldt (21%) were the same as the state average. Napa (19%), Sonoma (19%), and Marin (14%) had rates of physical inactivity better than the state average.

[26] Center for Disease Control and Prevention. Physical Inactivity

Table 5: 2023 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity	Partnership Southern Region	Physical Inactivity
California	***21%***	***California***	***21%***
Del Norte	24%	Lake	23%
Humboldt	21%	Marin	14%
Lassen	23%	Mendocino	21%
Modoc	22%	Napa	19%
Shasta	20%	Solano	21%
Siskiyou	21%	Sonoma	19%
Trinity	22%	Yolo	20%

Source: 2023 County Health Rankings & Roadmaps. Red indicates higher than California average.

5. Severe Housing Problems

There are about 181,399 unhoused people in California as of November 2023.[27] Additionally, 26% of California's households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.[28] Severe housing problems continues to be a huge issue in California. In Reporting Year 2023 (Measurement Year 2019), many of Partnership's service area members experienced severe housing problems, especially in counties such as Humboldt (25%), Mendocino (25%), Yolo (23%), Shasta (22%), Marin (22%), Napa (22%), and Sonoma (22%). Partnership's Southern Region experiences higher levels of severe housing problems, which may be due to its proximity to the San Francisco Bay Area and Sacramento.

Table 6: 2023 Rate of Severe Housing Problems by Partnership County

Partnership Northern Region	Severe Housing Problems	Partnership Southern Region	Severe Housing Problems
California	***26%***	***California***	***26%***
Del Norte	19%	Lake	20%
Humboldt	25%	Marin	22%
Lassen	14%	Mendocino	25%
Modoc	13%	Napa	22%
Shasta	22%	Solano	21%
Siskiyou	18%	Sonoma	22%
Trinity	19%	Yolo	23%

Source: 2023 County Health Rankings & Roadmaps.

[27] HUD 2023 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations
[28] 2023 County Health Rankings

6. Food Environment Index

The food environment index includes access to healthy foods and food insecurity. Food insecurity is defined "as a household-level economic and social condition of limited or uncertain access to adequate foods."[29] Many areas across Partnership's 14 counties are designated as food deserts, which are areas where healthy and fresh foods are not readily available for people to access. In these places, processed foods high in sugar, sodium, fat, and additives make up most of what is available. Some communities lack food pantries or other supplemental food options, further limiting access to healthy foods.

The food and environment index is a measure that accounts for access to healthy foods. This measure considers 3 factors: the distance someone lives from a grocery store or supermarket, locations to purchase healthy food in most communities, and someone's inability to access healthy food because of high costs.[30] According to the County Health Rankings and Roadmaps measures Reporting Year 2023 (Measurement Year 2020), on a scale from 0 (worst) to 10 (best), California scored on the higher end at 8.8 for its food and environment index. Partnership counties with the highest scores were Marin (9.2, higher than California), Napa (8.8), and Solano (8.7), and Sonoma (8.7). The counties with the lowest scores were Modoc (6.3), Del Norte (6.4), and Siskiyou (6.6). This data suggests the more rural a county is, the more difficulty there is in accessing healthy foods.

Table 7: 2023 Food Environment Index (FEI) in Partnership Counties

Partnership Northern Region	FEI	Partnership Southern Region	FEI
California	***8.8***	***California***	***8.8***
Del Norte	6.4	Lake	7.6
Humboldt	7.3	Marin	9.2
Lassen	7.6	Mendocino	7.4
Modoc	6.3	Napa	8.8
Shasta	7.3	Solano	8.7
Siskiyou	6.6	Sonoma	8.7
Trinity	6.8	Yolo	8.4

Source: 2023 County Health Rankings & Roadmaps.

[29] Healthy People 2030, Food Insecurity
[30] County Health Rankings, Food Environment Index

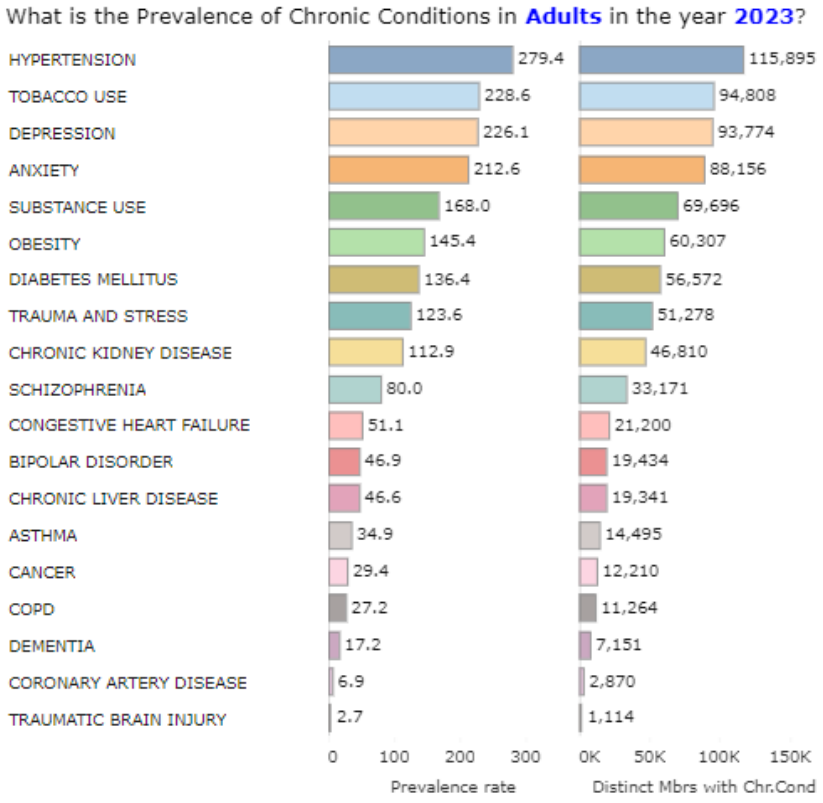
C. Disease Prevalence

1. Chronic Disease

The 2023 Partnership Integrated Claims and Encounter data highlighted many chronic diseases that are prevalent in adults and children. Chronic diseases can be defined as conditions that last 1 year or more and either require continuing medical attention, limit day-to-day living, or both. Partnership bases estimates of chronic disease prevalence on claims and encounter data, while recognizing the limitations of this data to represent the true prevalence of disease. True prevalence of chronic disease is higher than that which is captured and coded through claims.

Figure 7 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (279.4 per 1000 adult members), Tobacco use (228.6 per 1000 adult members), Depression (226.1 per 1000 adult members), Anxiety (212.6 per 1000 adult members), Substance Use (168.1 per 1000 adult members), and Obesity (145.4 per 1000 adult members).

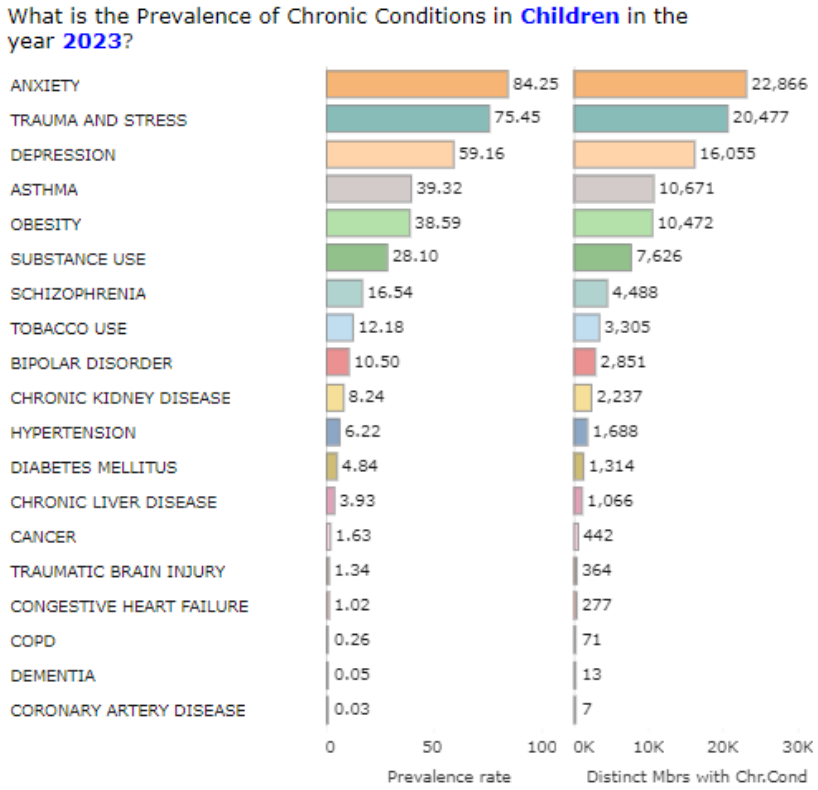
Figure 7: 2023 Adults Chronic Conditions Prevalence Data Per 1000 Members



Source: 2023 Partnership Integrated Claims and Encounter Data, Partnership

Figure 8 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (84.26 per 1000 members), Trauma and Stress (75.46 per 1000 members), Depression (59.16 per 1000 members), Asthma (39.32 per 1000 members) Obesity (38.59 per 1000 members), and Substance Use (28.10 per 1000 members).

Figure 8: 2023 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2023 Partnership Integrated Claims and Encounter Data, Partnership

2. HEDIS® Scores

Partnership uses HEDIS measure performance to assess how well the health plan is providing preventive care and serving members with chronic diseases. The DHCS Minimum Performance Level (MPL) is set at the 50th percentile of HEDIS performance amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for Reporting Year 2023 (Measurement Year 2022). Partnership has 4 reporting regions for HEDIS measures: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake). In 2024, Partnership added a new Eastern Reporting Region for the 10 new counties. Reporting on these new counties will be included in the 2025 PNA.

a. Controlling High Blood Pressure

Hypertension is a risk factor for conditions such as heart disease and stroke; these conditions are the first and fifth leading causes of death in the United States, respectively.[31] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 59.85% for the 2023 Reporting Year (2022 Measurement Year).[32] In the 2023 reporting year, all reporting regions were at or above the MPL for controlling high blood pressure.

b. Comprehensive Diabetes Care

The HEDIS MPL around the Comprehensive Diabetes Care measure indicator for poor diabetes control (HbA1c level >9%) was set at the 50th percentile of 39.9% for the 2023 Reporting Year (2022 Measurement Year). This measure is HEDIS's only measure where lower scores are considered better; this is because performance is inversely related to the percentage reported. Partnership's Northern Region Performance for this indicator went below the MPL with a performance of 33.75% and 33.42% in the Northeast and Northwest regions, respectively. Partnership's Southern Region Performance for Comprehensive Diabetes Care also went below the MPL with a performance of 35.94% and 31.19% in the Southeast and Southwest regions, respectively. These scores indicate that all of Partnership's reporting regions performed better than the HEDIS MPL for this indicator.[33]

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[34] yet, it is estimated that only 8% of adults 35 years and older in the United States get all recommended preventive care services.[35] Getting preventive care helps prevent disease and premature death by using preventive screening tests such as colorectal and breast cancer screening for adults, tracking of child development milestones, and various vaccinations for all ages. It is of utmost importance to help people comprehend the importance of getting preventative care in a timely manner to stay healthy and reduce health inequities. Partnership believes this work is foundational to help our members and our communities stay healthy.

---

[31] Center for Disease Control and Prevention (CDC), 2020
[32] Partnership Health Plan of California HEDIS Measures, 2023
[33] Partnership Health Plan of California HEDIS Measures, 2023
[34] Health.gov Healthy People 2030 Literature Summary, n.d.
[35] Borsky A., et. al., 2018

(1) Adult Cancer Screening

Timely cancer screenings are a major component of preventive care for adult members. Partnership annually monitors and assesses 3 cancer metrics. Breast cancer and cervical cancer screenings are metrics that are a part of both the DHCS MCAS and NCQA health plan accreditation measure sets. Colorectal cancer screening is a HEDIS measure and is assessed as part of the Primary Care Provider Quality Improvement Program (PCP QIP), Partnership's largest pay-for-performance program; it is also part of initiatives to encourage appropriate testing for early detection of colon cancer.

There was some improvement in breast cancer screenings in comparison to the previous measurement year. The DHCS-specified MPL was set at the 50th percentile of 50.95% for the 2023 Reporting Year (2022 Measurement Year). The Northeast and Northwest were still below the MPL standing at 45.63% and 41.44%, respectively. However, the Southeast and Southwest were above the MPL standing at 58.18% and 56.40%, respectively.[36]

Cervical Cancer Screening showed similar changes. The MPL for this measure set at the 50th percentile of 57.64% for the 2023 Reporting Year (2022 Measurement Year). The Northeast (54.01%) and Northwest (55.04%) continued to perform below the MPL. In the Southern regions, the Southeast and Southwest were above the MPL at 65.82% and 67.25%, respectively. There was an increase in both Southern regions in comparison to the previous measurement year.[37]

(2) Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. Well-child visits track growth and milestones, opening the door for parents to address any questions or concerns they may have around their child's health. Children who are not protected by vaccines are more likely to contract and pass on certain diseases.[38] A recent study identified common barriers to getting to well-child visits, including difficulty in requesting time off from work, childcare, and other stressors.[39] Addressing social determinants of health plays an important role for improving attendance of well-child visits.

The MPL for Childhood Immunizations Status (CIS-Combo 10) was set at the 50th percentile of 34.79% for the 2023 Reporting Year (2022 Measurement Year). For children ages 0-2 who received all the recommended immunizations by the time they

[36] Partnership Health Plan of California HEDIS Measures, 2023
[37] Partnership Health Plan of California HEDIS Measures, 2023
[38] Center for Disease Control and prevention (CDC), 2024
[39] Wolf et. al., 2020

turned 2 years old, the Northeast (18.49%) and Northwest (23.84%) continued to perform below the MPL while the Southeast (46.47%) and the Southwest (41.61%) regions performed above the MPL.

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 35.04%. The proportion of adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was below in the Northeast and Northwest regions, 18.73% and 24.82% respectively. The Southeast and Southwest regions were above the MPL, 51.34% and 49.64% respectively.

3. Behavioral Health

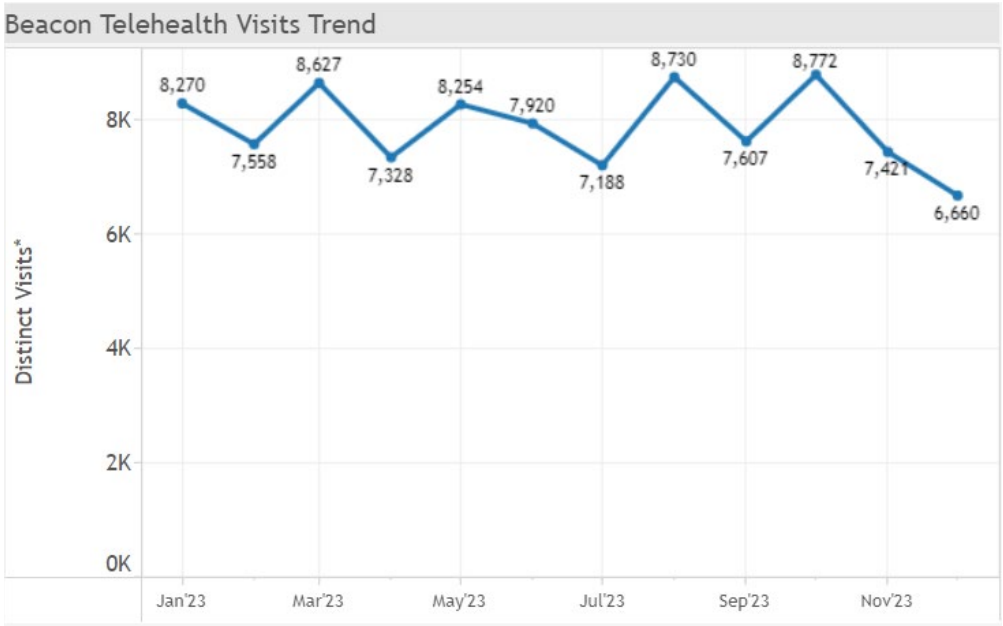
Partnership's overall strategy to address the comprehensive needs of our members requires effectively addressing their behavioral health needs, including both mental health and substance abuse disorders. In June 2020, the CDC reported that 40.9% of adults struggled with mental or behavioral health, serious mental illness or serious emotional disturbance (SMI/SED), or substance use issues; these difficulties were more prevalent among non-White individuals. The CDC further reported that 10.7% of those surveyed reported suicidal thoughts in the last 30 days, with the percentage at 25.5% among 18 to 24 year olds.[40]

a. Telehealth Utilization for Behavioral Health

Carelon Behavioral Health had a total of 93,335 telehealth services provided across Partnership's counties in 2023, with the highest volume taking place in March (8,610 visits). Lower numbers in the month of December are likely due to lag in claims reporting at the time of authoring.

[40] Center for Disease Control and Prevention, 2020

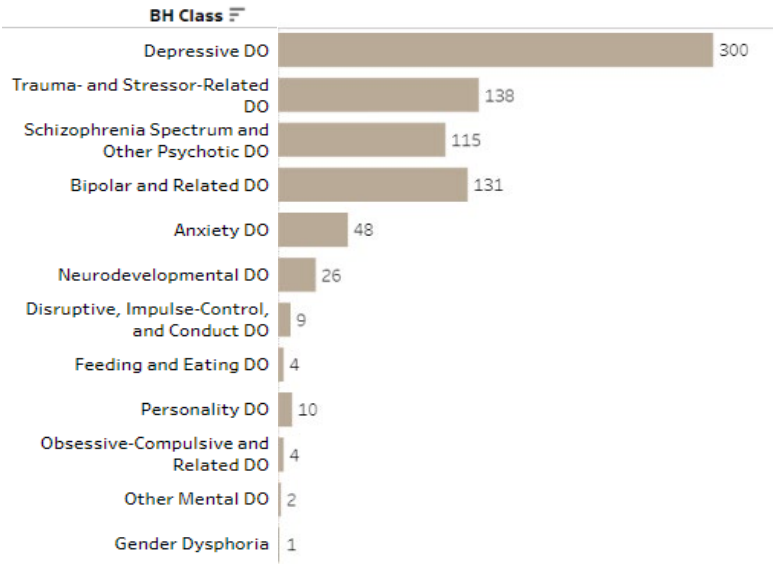
Figure 9: 2023 Carelon/Beacon Telehealth Visits Trend



Source: 2023 Beacon Mental Health Claims and Encounter Data, Partnership

All Partnership members are eligible for non-specialty mental health services. Individuals with serious mental illness or serious emotional disturbance (SMI/SED) whose treatment needs require hospitalization, or more intensive services, are referred to the County Mental Health Plans for care.

Figure 10: 2023 Behavioral Health Diagnoses (Carelon/Beacon and the Counties)

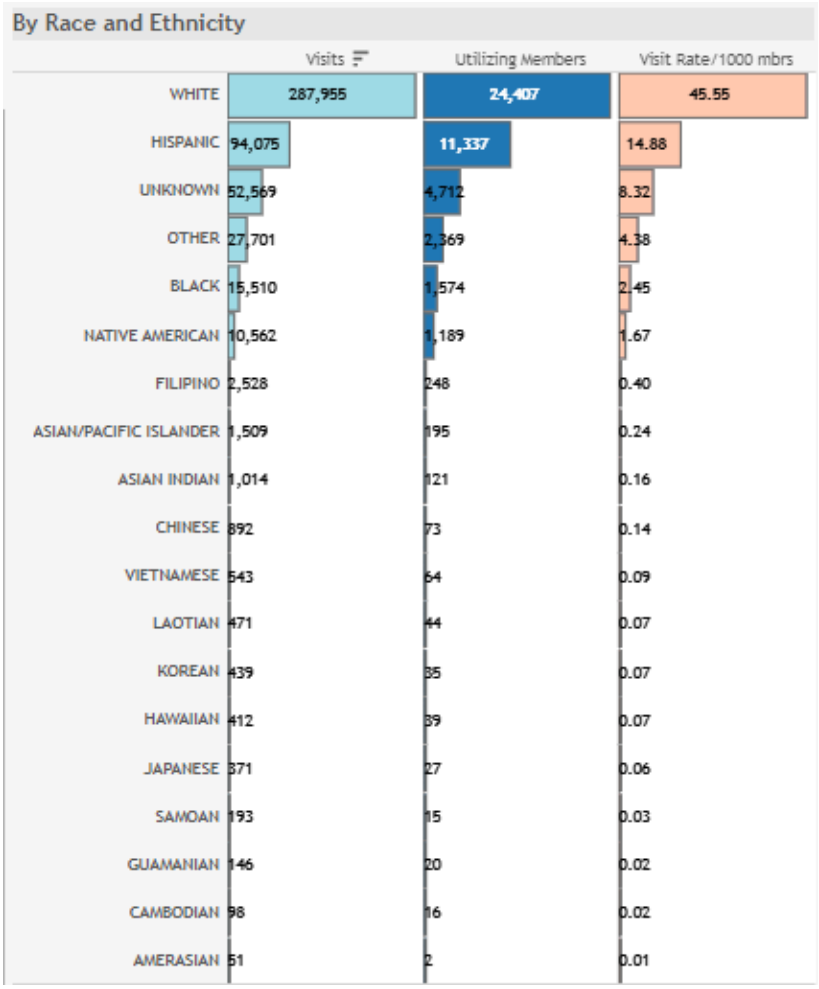


Source: 2023 Mental Health Claims and Encounter Data, Partnership

b. Mental Health Illness and SMI/SED

In 2023, 44,465 Partnership members utilized mental health services from Partnership's delegated managed behavioral healthcare organization, Carelon Behavioral Health (formerly known as Beacon Health Options) in 480,965 distinct visits. In the same year, 2,275 Partnership members utilized mental health services from Indian Health Services in 16,100 distinct visits. According to Carelon data, female members had a higher number of Carelon visits, representing 343,067 visits compared to 153,972 by male members. As shown in Figure 11, access to Carelon's services by race/ethnicity is not distributed proportionately among Partnership's demographics. White members represented 287,955 of Carelon visits while only making up 36.7% of Partnership's total population. The Hispanic population made up the second largest utilization group, at 19.6% of Carelon visits while representing 32.5% of the total Partnership's population.

Figure 11: 2023 Beacon Services Utilization by Race and Ethnicity



Source: 2023 Beacon Mental Health Claims and Encounter Data, Partnership

In 2023, Kaiser had a total of 53,435 claims from 8,796 utilizing members for mental health services.

4. Substance Use Disorder Services

In July 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use treatment services on behalf of participating counties. DMC-ODS is an innovative program administered through Mental Health Plans, providing organized and comprehensive substance use disorder (SUD) care for Medi-Cal enrollees. This effort is referred to as the Partnership's Wellness and Recovery Program, or the "Regional Model." Seven Partnership counties opted to participate: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. Additional counties including Marin, Napa, and Yolo participate in DMC-ODS through county operated programs, with 2024 Expansion counties Nevada and Placer also participating. Lake and Sonoma County anticipate beginning DMC-ODS programs in July 2024.

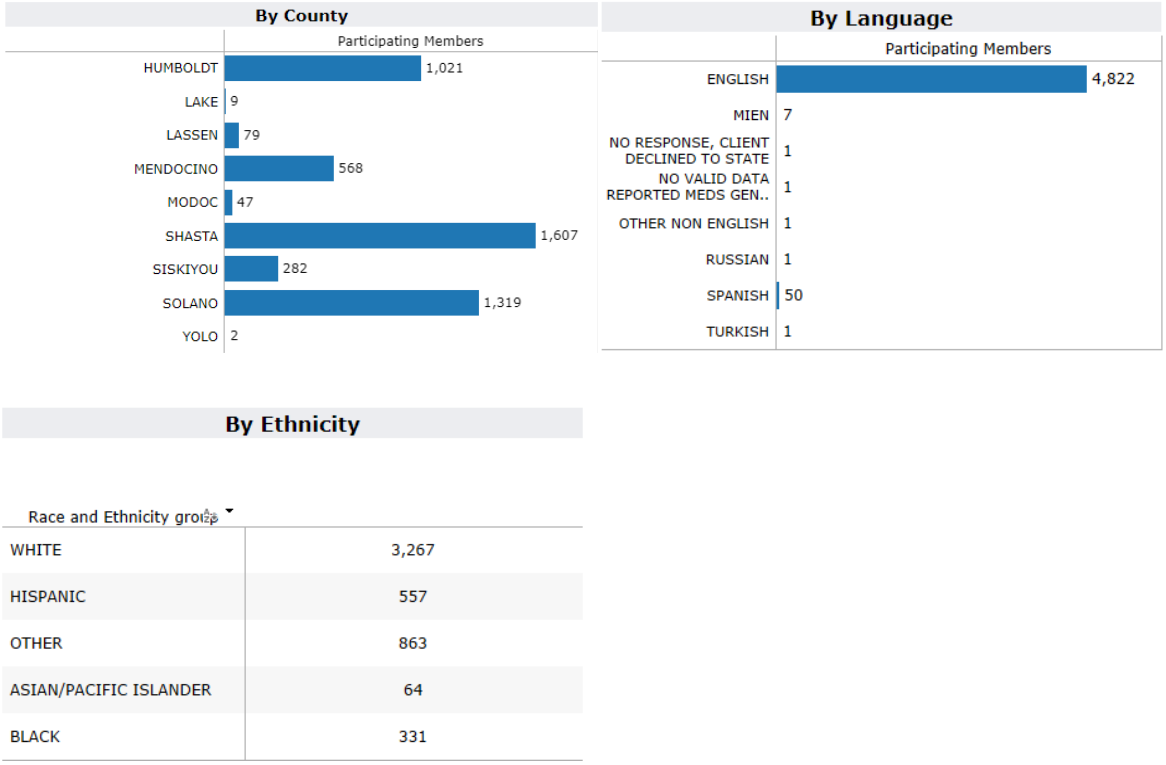
The range of services offered through the Wellness & Recovery Program includes:

- Outpatient treatment
- Intensive outpatient
- Detoxification services (withdrawal management)
- Residential treatment
- Medication for Addiction Treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)

Services are accessible through contracted Drug Medi-Cal providers and are available to Medi-Cal recipients who meet the medical necessity criteria as determined by the American Society of Addiction Management (ASAM).

In 2023, there were a total of 4,974 members participating in the Wellness & Recovery program, with the highest numbers in Shasta 1,639 and Solano 1,330 counties. The majority of participating members were English-speakers at 4,926 or 99%, and 3,340 or 67% of participants identified as White. Partnership works with providers and partners in all 24 counties to provide integrated physical health and SUD services to the Medi-Cal population.

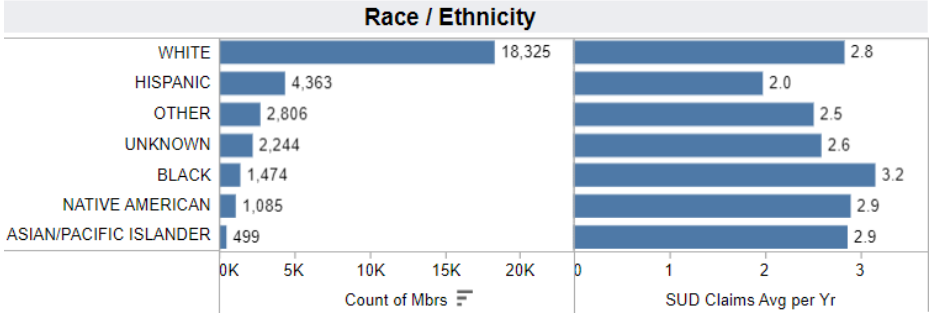
Figure 12: 2023 Participation in Wellness and Recovery Services



Source: 2023 Partnership Integrated Claims and Encounter Data

With the exception of the Wellness and Recovery Program, Partnership provides limited care options for treating members diagnosed with SUD. In 2023, 30,796 members had a diagnosed SUD. The substances most frequently used by these members were alcohol, opioids and stimulants. Men were slightly over-represented with this diagnosis; 51.6% (15,895) of members with a SUD were male and 48.4% (14,901) were female, compared to Partnership's general membership of 47.4% male and 52.6% female. The White population had the highest number of SUDs, 18,325; 4,363 members were Hispanic; 1,474 were Black; 1,085 were Native American; and 499 were Asian/Pacific Islander.

Figure 13: 2023 SUD by Race and Ethnicity



Source: 2023 Substance Use Disorder Data, Partnership

D. Access to Care

There are many barriers to accessing health care within the general population, but populations in rural communities and in low-income areas are more significantly affected. Such barriers include, but are not limited to, access to fewer health care providers, cultural and linguistic challenges, broadband access for telehealth, and transportation challenges. Health literacy challenges can also contribute to a person's ability to access and use health care services.

1. Provider Availability

Lack of PCP availability is the most common barrier for Partnership members wanting to attend annual checkups and get routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the population to primary care providers in Reporting Year 2023 (Measurement Year 2020).

For California as a whole, the ratio of individuals to providers reported in Reporting Year 2023 (Measurement Year 2020) is 1,230:1. As of December 2023, in Partnership's Northern Region (indicated with "N" in Figure 14 below), all of the counties underperformed when compared to the California ratio. Lassen and Trinity counties have the least availability of providers to the population with Lassen at a ratio of 3,750:1 and Trinity at a ratio 3,050:1. In Partnership's Southern region (indicated with "S" in Figure 14), multiple counties performed better compared to the California ratio, including Mendocino (1,130:1), Marin (680:1), Sonoma (990:1), Napa (1,010:1), and Yolo (820:1). In spite of these countywide numbers, Partnership contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

Figure 14: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,230:1	
County	**Ratio**
Marin (S)	680:1
Yolo (S)	820:1
Sonoma (S)	990:1
Napa (S)	1,010:1
Mendocino (S)	1,130:1
Solano (S)	1,230:1
Siskiyou (N)	1,240:1
Shasta (N)	1,320:1
Del Norte (N)	1,550:1
Humboldt (N)	1,690:1
Modoc (N)	1,750:1
Lake (S)	2,220:1
Trinity (N)	3,050:1
Lassen (N)	3,750:1

Source: County Health Rankings, 2023: Green indicates that compared to 2022, provider availability improved (i.e. there were less patients per provider). Red indicates that compared to 2022, provider availability worsened (i.e. there were more patients per provider).

Partnership's recent Grand Analysis Report on Network Access also revealed that between January 1, 2022, and December 31, 2022, 41% of standard member grievances and 42% of appeals and second level grievances were related to provider access. This same report also revealed that between April 2022 to March 2023, Partnership met its goal of less than 20 referrals per 1,000 members for out-of-network requests.[41]

Physical access at provider facilities has been a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing of a facility's physical accessibility is through a Physical Accessibility Review Survey (PARS), which tracks any changes in a facility's physical accessibility. Physical access is categorized as either "Basic" or "Limited." A facility categorized as "Basic" has met all 29 critical elements used to identify a site's capability of accommodating members who are seniors and/or persons with disabilities. Elements, or domains, include parking, the exterior and interiors of the building, the restroom(s), and the exam room(s). If a facility

[41] Partnership HealthPlan of California Grand Analysis: Network Access: Assessment of Network Adequacy, 2023

is categorized as “Limited,” it is missing 1 or more of the domains. As of December 2023, 39 out of 82 inspected facilities were categorized as Limited; and 43 were categorized as Basic.[42]

2. CAHPS Health Care Performance

The CAHPS survey gives members an opportunity to give feedback about their ability to access care and their satisfaction with the care received. The CAHPS survey measure year or period is 2022 (July 1, 2022 – December 31, 2022) and the reporting year is 2023. Compared to 2022, the CAHPS Adult Summary Scores for the 2023 reporting year increased in most areas such as rating of health plan, getting needed care, ease of filling out forms, rating of health care, how well doctors communicate, coordination of care and rating of personal doctor (see table 8). While not listed in the table below, customer service also showed an increase from 87.2% in 2022 to 88.6% in 2023 (shown later in table 15).

The exceptions to these increasing rates are the scores for areas of getting care quickly and rating of specialist, which decreased from 72.9% in 2022 to 69.5% in 2023 and 66.7% in 2022 to 64.4% in 2023, respectively. The increases in certain measures in table 8 suggest that compared to 2022, adult members are happier overall with their health care. Since trust between a patient and provider is a key element to positive health outcomes,[43] a positive patient experience likely indicates a higher level of trust. Positive member experience scores indicate members may be more likely to trust their doctor, which can lead to improved health outcomes.

[42] Partnership HealthPlan of California PARS report, 2023
[43] BMJ Open, 2020

Table 8: 2023 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2022*** (Previous Reporting YR)	***2023*** (Current Reporting YR)
Rating of Health Care (% 9 or 10)	51.5%	55.7%
Getting Needed Care (% Always or Usually)	76.0%	76.4%
Getting Care Quickly (% Always or Usually)	72.9%	69.5%
How Well Doctors Communicate (% Always or Usually)	88.5%	92.9%
Coordination of Care (% Always or Usually)	81.3%	86.6%
Rating of Personal Doctor (% 9, or 10)	61.8%	66.9%
Rating of Specialist (% 9, or 10)	66.7%	64.4%

Source: 2022 Medicaid Adult CAHPS 5.1 H, 2023, Press Ganey (p. 10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

The CAHPS child composite scores for reporting year 2023 showed that the ratings decreased in all areas, including rating of health care, getting needed care, getting care quickly, how well the doctor communicates, coordination of care, rating of personal doctor, and rating of specialist (see table 9). While not listed in the table below, the exception to these decreasing rates are the scores for rating of health plan and customer service, which increased from 66.9% in 2022 to 68.0% in 2023 and 89.4% in 2022 to 89.9% in 2023, respectively ((shown later in table 16). The collective decreases in measures in table 9 suggest that compared to 2022, pediatric members are overall less happy with their care. Since trust between a patient and provider is a key element to positive health outcomes,[44] a negative patient experience likely indicates a lower level of trust. Thus, negative member experience scores likely indicates members may be less likely to trust their doctor and at risk of worse health outcomes. Partnership's Provider Relations department does work closely with local providers to improve access to care for our members.

[44] BMJ Open, 2020

Table 9: 2023 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2022*** (Previous Reporting YR)	***2023*** (Current Reporting YR)
Rating of Health Care (% 9, or 10)	65.6%	64.2%
Getting Needed Care (% Always or Usually)	79.6%	76.7%
Getting Care Quickly (% Always or Usually)	84.1%	76.3%
How Well Doctors Communicate (% Always or Usually)	94.7%	92.7%
Coordination of Care (% Always or Usually)	85.3%	81.1%
Rating of Personal Doctor (% 9, or 10)	74.6%	74.4%
Rating of Specialist (% 9, or 10)	70.4%	69.5%

Source: At-A-Glance Report, 2023 Medicaid Child CAHPS 5.0 H, 2023, Press Ganey (p. 12). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

3. Third Next Available Appointment

Partnership's Provider Relations department conducts an annual Third Next Available (3NA) survey. This point-in-time survey assesses the availability of members' access to non-urgent primary care appointments for adult, pediatric, and newborn appointments, as well as urgent care appointments. The 3NA survey also assesses overall telephone accessibility during business hours using the number of rings before the phone is answered, minutes on hold, average wait time before seeing a provider, and if a return-call is received within 30 minutes.

PCPs are held to performance expectations with 2 specific standards of interest. Standard 1 is defined as "the percentage of providers who have a 3rd next available primary care adult and/or pediatric primary care appointment in less than or equal to 10 business days." Standard 2 is defined as "the percentage of providers who have a 3rd next available newborn and/or urgent primary care appointment in less than or equal to 48 hours."

The results of the 3NA survey show that 91.7% of the providers in the Southern region and 94.0% of providers in the Northern region met Standard 1 for adult primary care appointments. For all pediatric primary care appointments, the survey results showed that 90.4% of the providers in the Southern region and 94.4% of providers in the Northern region met Standard 1. Furthermore, the survey results showed that 100% of the providers in the Southern region and 96.9% of providers in the Northern region met

Standard 2 for newborn primary care appointments. Finally, 96.9% of the providers in the Southern region and 95.3% of providers in the Northern region met Standard 2 for urgent primary care appointments. Results of this survey are displayed in table 10.

Table 10: 2023 Partnership Third Next Appointment Availability

Third Next Available (3NA) Survey Findings 2023							
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment			Percentage of Clinics Meeting PCP Standards		
		North	South	Plan	North	South	Plan
Primary Care Adult	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	3	3	94.0%	91.7%	92.6%
Primary Care Pediatrics	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	3	3	94.4%	90.4%	92.2%
Primary Care Newborn Appointments	3rd Next Available Newborn appointments within 48 hours of discharge	1	1	1	96.9%	100%	98.7%
Primary Care Urgent Care	3rd Next Available Urgent Care appointments within 48 hours of request	0	0	0	95.3%	96.9%	96.3%

Source: 2023 Partnership Third Next Available Survey, 2023 Summary

When looking at 3NA primary care appointment access by county, some provider sites in Trinity, Marin and Napa counties did not meet all of the standards for appointment accessibility. Sites that do not meet the standards are surveyed again and are provided with a corrective action plan, as needed.

4. Telemedicine

a. Telehealth Utilization Report

Telemedicine and telephone visit opportunities can help ensure access to needed health care. Partnership uses 2 sources of telehealth data for specialty care: The Telehealth Utilization Report and the eConsult Utilization Report. The Telehealth

Utilization Report details video data and shows all video visits completed between a patient, provider, and specialist.

In 2023, telemedicine utilization shows 9,169 visits scheduled and 5,970 (65.1%) completed visits through Partnership-contracted specialty telemedicine providers (see table 11). This data represents an increase in both scheduled and completed telemedicine visits in 2023 when compared to 2022.

Table 11: Adult Telemedicine Appointment Details as of December 2023

Adult Telemedicine Appointment Details as of December 2023					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
9,169	5,970	65.1%	11.2%	10.4%	25.1

Source: Adult Telemedicine Appointment Details Report, 2023, Partnership

As of December 2023, the number of scheduled pediatric telemedicine appointments was 2,702 and the number of completed pediatric telemedicine appointments was 1,775. From December 2022 to December 2023, the number of completed pediatric telemedicine appointments ranged from approximately 125-190 visits per month, with a high of approximately 190 per month in March 2023.

Table 12: Pediatric Telemedicine Appointment Details as of December 2023

Pediatric Telemedicine Appointment Details as of December 2023					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
2,702	1,775	65.7%	18.3%	16.0%	36.3

Source: Pediatric Telemedicine Appointment Details Report for 2023, Partnership

b. eConsult Utilization Report

The second source of telehealth data for specialty care is Partnership's eConsult Utilization Report. This report shows the utilization data of the online eConsult platform. This platform is where providers can directly message specialists regarding patient

care; by using this method, the needs of the patients can be met without requiring a face-to-face visit.

As of December 2023, there were 1,756 adult eConsults completed. Of those, 71.1% were closed because the patient's needs were addressed remotely, while 25.9% were referred to face-to-face services.

Table 13: Adult eConsult Utilization Report, 2023 Partnership

Adult eConsult Utilization Report as of December 2023				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,756	1,739	71.1%	2.4	25.9%

Source: Adult eConsult Utilization Report, 2023 Partnership

As of December 2023, there were 86 completed pediatric eConsults. Of those, 74.4%. were closed because the patient's needs were addressed through the eConsult, while 14.0% of consults were referred for face-to-face services.

Table 14: Pediatric eConsult Utilization Report, As of December 2023 Partnership

Pediatric eConsult Utilization Report as of December 2023				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
87	86	74.4%	4.7	14.0%

Source: Pediatric eConsult Utilization Report, 2023 Partnership

Although telehealth has the ability to improve access to care, Partnership members living in rural and remote areas with limited broadband access may still struggle to receive the care they need. Rural members often require in-person visits to meet their medical needs. In addition, many Partnership members lack the equipment or knowledge needed to connect to a telemedicine appointment.

E. Member Experience of Care

1. Satisfaction with Health Plan

Partnership contracted with Press Ganey (PG) to perform the 2023 CAHPS survey. The report is based on data as of July 2023. PG reached out to 2,700 adult members and the guardians of 4,125 pediatric members to participate in the survey. There were 380

adult responses (14.3% of those surveyed) and 611 pediatric responses (14.9% of those surveyed).

The CAHPS results discovered that 88.6% of adult respondents answered “Always” or “Usually” when asked if they received helpful information or were treated with courtesy and respect. This measure is collectively referred to as Customer Service. This represents a slight increase of 1.4% from the 2022 survey results. Table 15 denotes changes on various measures between 2022 and 2023.

Other categories shown earlier in table 8 showed a decrease in satisfaction. Adult members were less satisfied with Getting Care Quickly (decrease from 72.9% to 69.5%), and the Rating of a Specialist (decrease from 66.7% to 64.4%). The decrease in Getting Care Quickly measure is of particular concern, as this area decreased by 3.4% from 2022 values. The increases in certain measures in table 15 suggest that compared to 2022, adult members are overall happier with Partnership. Thus, members may be more likely to trust their health plan and experience better health outcomes.

Table 15: 2023 Adult CAHPS Summary Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2022*** (Previous Reporting YR)	***2023*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	54.5%	56.8%
Getting Needed Care (% Always or Usually)	76.0%	76.4%
Customer Service (% Always or Usually)	87.2%	88.6%
Ease of Filling Out Forms (% Always or Usually)	91.8%	96.0%

Source: MY 2022 CAHPS Medicaid Adult 5.1 H, 2023, Press Ganey (p. 10).
**Green indicates an increase in score from the previous reporting year; Red indicates a decrease in score from the previous reporting year.*

The 2023 Child CAPHS survey results showed that 68% of those completing forms on behalf of pediatric members rated their child’s Rating of the Health Plan as good or excellent (scores of 9 or 10) compared to 2022 results where 66.9% rated their healthcare as high. This represents an increase of 1.1% from the 2022 report. The other category that showed an increase for pediatric members from 2022 results was Customer Service, which increased from 89.4% to 89.9%. See table 16 for data. The results among the measures in table 16 suggest that compared to 2022, while pediatric members’ interactions with Partnership improved, there were challenges accessing care

and with forms. Thus, members may be more likely or less likely to trust their health plan and seek care for health concerns as needed.

Table 16: Child CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2022*** (Previous Reporting YR)	***2023*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	66.9%	68.0%
Getting Needed Care (% Always or Usually)	79.6%	76.7%
Customer Service (% Always or Usually)	89.4%	89.9%
Ease of Filling Out Forms (% Always or Usually)	95.4%	94.4%

Source: MY 2022 CAHPS® MEDICAID CHILD 5.1H SURVEY 2023, Press Ganey (p. 12). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

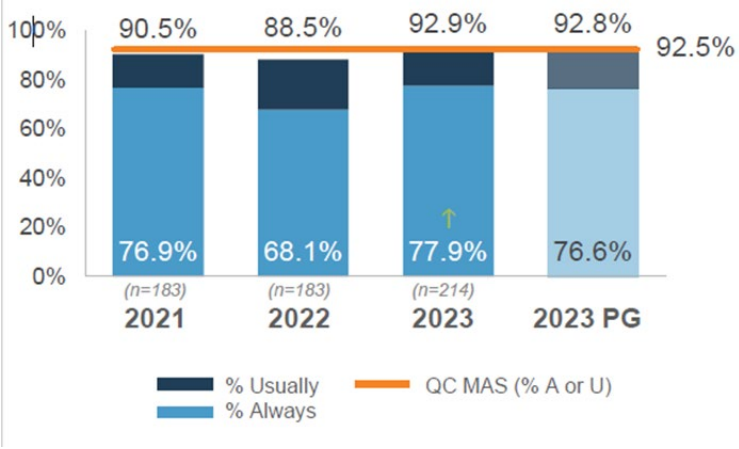
2. Doctor Communication

Partnership uses the 2023 CAHPS survey data to evaluate how satisfied members are with the interactions they have with their doctors. The score is a composite, comprised of indicators measuring how well a member's doctor explained things, if they listened carefully, showed respect, and if the doctor spent enough time with them.

The percentage of adult members who felt their doctor communicated well with them always or usually increased on aggregate from 88.5% in 2022 to 92.9% in 2023 as compared to the Quality Compass (QC) score shown in the tables below. Partnership scored slightly above Press Ganey's 2023 Benchmark in all aspects of how well doctors communicate with Partnership adult members. Having good communication with one's doctor helps build a relationship and fosters trust between the member and the provider,[45] which can be a proxy measure for health outcomes. Therefore having good communication with one's doctor is important to ensure Partnership members have the best possible health outcomes.

[45] BMJ Open, 2020

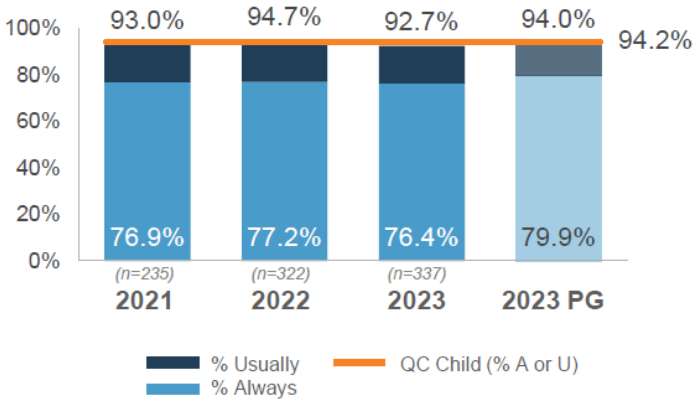
Figure 15: 2023 Adult Composite CAHPS Survey Result



Source: MY 2022 CAHPS Medicaid Adult 5.1H Survey, Partnership, 2023

The results of the Child CAHPS Survey show that members rated their care experience with children's providers higher than providers for adults. The percentage of child members who felt their doctor communicated well with them always or usually decreased on aggregate from 94.7% in 2022 to 92.7% in 2023. This minor decrease means Partnership is slightly below PG's Benchmark score, which stays higher at 94.0%. Having good communication with one's doctor is important to ensure Partnership pediatric members trust their doctors and will have the best possible health outcomes.

Figure 16: 2023 Child Composite CAHPS Survey Result



Source: MY 2022 CAHPS Medicaid Child 5.1 Survey, Partnership, 2023

F. Health Disparities

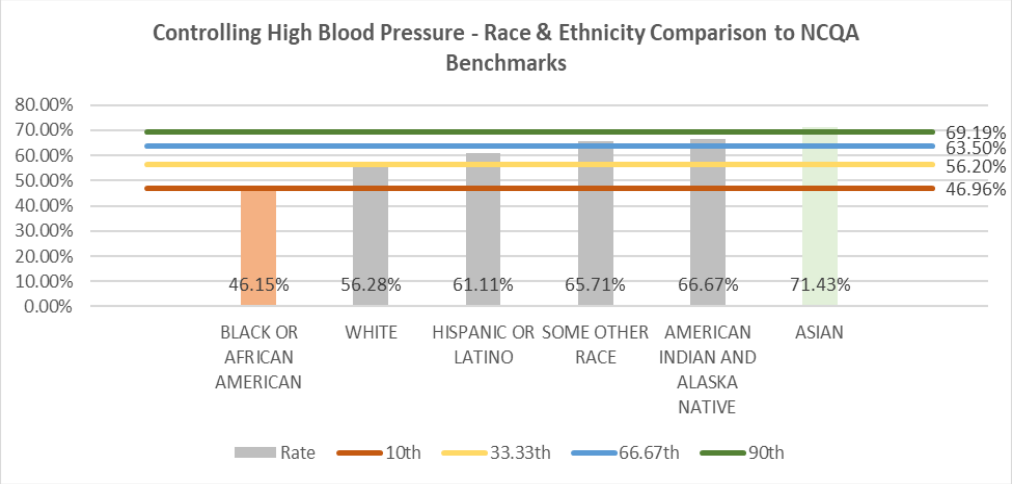
1. Controlling High Blood Pressure (CPB)

The 2023 health disparities data is taken from a grand analysis called the HE 6: Reducing Healthcare Disparities report.[46]

The HE 6: Reducing Healthcare Disparities report found no significant difference when comparing each race/ethnicity group to the White group (Figure 17). However, stratified data (when compared to the National All Lines of Business benchmarks) showed that Black/African American population had lower rates for CBP. The stratified data also showed that they were also the only racial group that scored below the 10th percentile for the measure. Specifically, the Black/African American population had a 10.13% numerically lower rate of CBP when compared to the White population (10.13% Reduction). Most of the other groups achieved at least the 33.33rd percentile (as defined by the National Medicaid benchmarks).

Black/African American population had the lowest rate (46.15%) which is lower than the 50th percentile for Controlling High Blood Pressure (CBP). Although a much smaller sample size compared to the White population, the Asian population had the highest rate (71.43%), while the White population was 56.28%, just slightly higher than the 50th percentile. See figure 17 below.

Figure 17: 2023 Controlling High Blood Pressure



Source: 2023 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

[46] Partnership HealthPlan of California, 2023 HE 6: Reducing Healthcare Disparities report

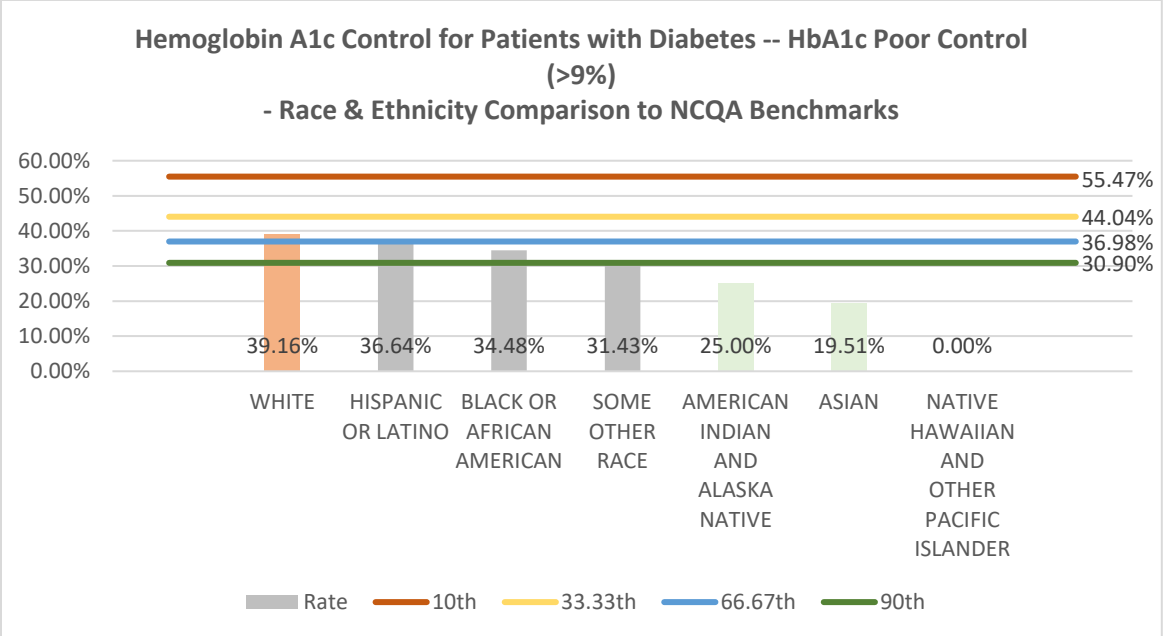
2. Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

The HE 6: Reducing Healthcare Disparities report found that the Asian population showed the lowest, statistically significant rate of HbA1c Poor Control (suggesting high rate of good control) when compared to the White population per the NCQA Health Plan Accreditation associated sample (n=397). The Native Hawaiian/Other Pacific Islander group technically had the lowest rate of HbA1c Poor Control, however the sample size (n=2) was too small for the results to be considered statistically significant.

The report also found that compared to the Asian population, the White population had a significantly higher rate of poor control (20% higher) and was the worst performing group. The Asian, American Indian and Alaska Native and Native Hawaiian or Other Pacific Islander populations all had rates that surpassed the 90th percentile. The Hispanic/Latino, Black/African American and 'Some Other Race' groups performed above the 66.67th percentile.

While not detailed in the figure below, the HE 6: Reducing Healthcare Disparities report further showed that the male population had a statistically significantly higher rate (39.71%) of Hemoglobin A1c Control for Patients with Diabetes (HBD9) HbA1c Poor Control compared to women (29.70%).

Figure 18: Hemoglobin A1c Control for Diabetes – Poor Control



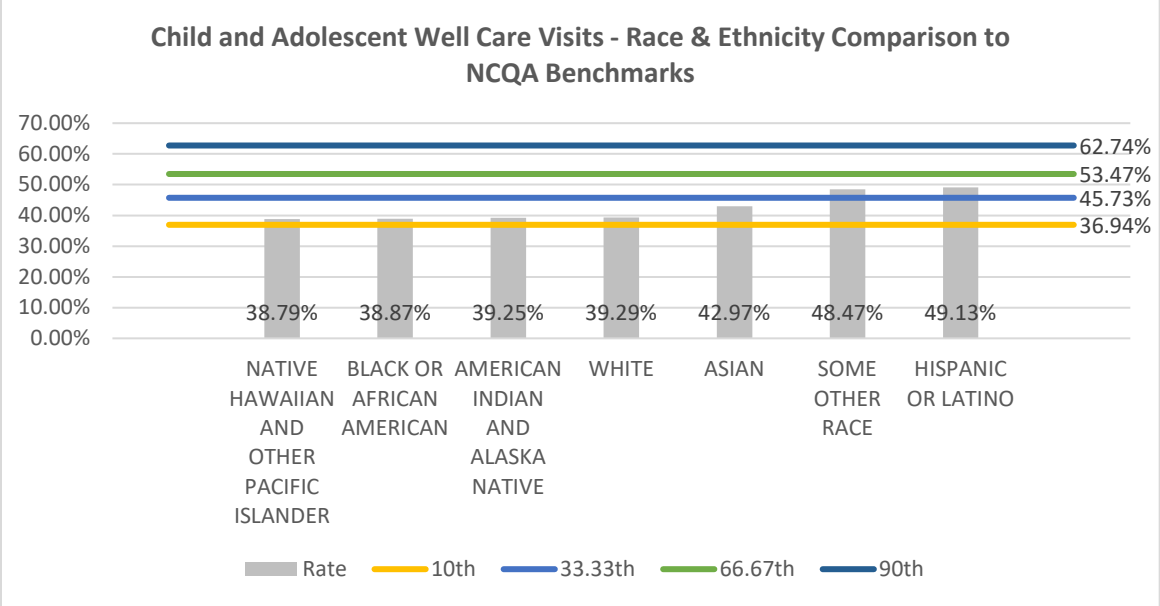
Source: 2023 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

3. Child and Adolescent Well Care Visits (WVC):

The HE 6: Reducing Healthcare Disparities report further showed that compared to the White population (39.29%), the Hispanic/Latino and Asian groups had a significantly higher rate of Child and Adolescent Well Care Visits completions (49.13%). When compared to other groups, the Hispanic/Latino group had the highest rate of completion and achieved the 33.33rd percentile.

In comparison to the other groups and in comparison to the White group, the Black/African American and Native Hawaiian and Other Pacific Islander groups had lower rates of successful completion of child and adolescent well care visits. Of note, no group had a rate that was significantly worse than the White population, and all groups reached at least the 10th percentile of 36.94% (Figure 19).

Figure 19: Child and Adolescent Well Care Visits



Source: 2023 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

The HE 6: Reducing Healthcare Disparities report also found 2 linguistic groups that performed significantly better compared to the English-speaking group (while using the NCQA Health Plan Accreditation denominator for Well-Child Visits). Compared to the English speaking group, the Farsi speaking group (n=165) had a 24% higher rate of completed Well-Child Visits and the Spanish speaking group (n=59,662) had an 8% significantly higher rate of completed Well-Child Visits. This report found no linguistic groups that performed significantly lower than the English group. Lastly, the female

population had a statistically significant higher rate (45.87%) compared to the male population (44.55%) for the same measure.

G. Health Education, Cultural & Linguistic Gap Analysis

Partnership maintains a Health Education unit responsible for creating and providing health education materials at an appropriate reading and comprehension level for members. The Health Education unit creates some materials to meet the needs of various member-outreach activities carried out by the organization. Other health education materials are more readily available on the Member Portal though the Healthy Living Tool. There are additional external health education materials available for both member and provider access on PCH's external website:

- Members: https://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Health-Education---Members.aspx
- Providers: https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/HealthEducationProviders.aspx

Printed copies of materials are available to both members and providers. Educational materials created by the Health Education Team are reviewed and updated no less than every 5 years, and are translated into all Partnership threshold languages (Spanish, Russian, and Tagalog); other language are available upon request. The Health Education unit reviews educational materials on the external website on an annual basis. This established process has been effective in providing materials to members, both directly and through providers.

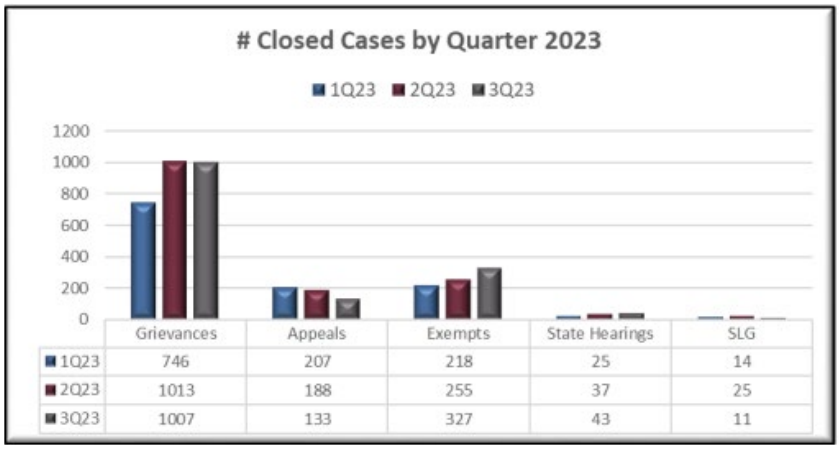
The Health Education team is also responsible for the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination, and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities. They also review and recommend staff and provider training to promote awareness of diversity, equity, and inclusion to serve our members better.

1. Grievance and Appeals

Grievance and Appeals (G&A) data is used to analyze member experience with the health plan and health care services, providing insight into member engagement with the health plan, and capturing reports of discrimination. Each year, Partnership compares the year to date results reported in the Fourth Quarter G&A Pulse report. This Pulse report captures data for the first 3 quarters of each calendar year. Time limitations prevent capture and use of fourth quarter data in this PNA.

As of the close of the third quarter in 2023, the Grievance team investigated 2,766 cases, representing a decrease from the 2,840 cases for member reported grievances in 2022. English speakers and the White population continue to be the groups that file the majority of grievances and appeals.

Figure 20: Number of Closed Cases by Quarter 2023



	Grievances	Appeals	Exempts	State Hearings	SLG
1Q23	746	207	218	25	14
2Q23	1013	188	255	37	25
3Q23	1007	133	327	43	11

Source: 2023 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2023 were White (53.2%), No Response (13.4%), Hispanic (11.8%), Other (11.0%), and Black/African American (7.8%). See figure 19 below.

Figure 21: G&A Pulse Report by Members Ethnicities vs. Partnership Overall Membership by Ethnicity

3Q23 % CASES BY ETHNICITY		
MBR Ethnicity	% Cases	% Membership
White	53.2%	37.0%
No Response	13.4%	11.3%
Hispanic	11.8%	32.2%
Other	11.0%	9.1%
Black (African American)	7.8%	5.2%
Native American	1.8%	2.1%
Asian Indian	0.5%	0.8%
Filipino	0.4%	1.8%
Vietnamese	0.1%	0.5%
Grand Total	100.0%	100.0%

Source: Q4 2023 Partnership G&A Pulse Report, Partnership

In 2023, Partnership identified a disparity in grievances reported by member race/ethnicity and by language. The grievances reported are not proportionate for the percentage of different races/ethnicities and languages within Partnership's

membership. Between 2022 and 2023, the proportion of grievances shifted further away from alignment with the demographics of Partnership members. This may indicate a lack of member trust in Partnership to take their concerns seriously, which can lead to less health seeking behaviors (e.g. attending primary care visits) and thus poorer health outcomes for the member population.

Grievances reported by White members decreased from 56.17% in 2022 to 53.2% in 2023, which coincides with the percentage of White members decreasing from 38.4% to 37.0% in the same period. Grievances reported by Hispanic members decreased from 14.32% in 2022 to 11.8% in 2023, although there was an overall increase in the percentage of Hispanic members from 30.1% to 32.2%.

Grievances from members with an ethnicity categorized as “Other” increased from 10.29% in 2022 to 11.0% in 2023. Grievance reporting increased most significantly between 2022 and 2023 in the “No Response” demographic, where grievance reporting increased from 8.23% in 2022 to 13.4% in 2023. See table 17 below.

Table 17: Grievances by Race/Ethnicity over Time

Member Race/Ethnicity	2022 % of Cases	2022 % of Membership	2023 % of Cases	2023 % of Membership
White	56.17%	38.4%	53.2%	37.0%
Hispanic	14.32%	30.1%	11.8%	32.2%
No Response/Unknown	8.23%	7.8%	13.4%	11.3%
Black/African American	8.06%	5.3%	7.8%	5.2%
Other	10.29%	12.0%	11.0%	9.1%
Native American or American Indian	2.40%	2.2%	1.8%	2.1%
Asian & Pacific Islander	0.52%	2.5%	--	--

Source: 4Q2022 & 4Q2023 Partnership G&A Pulse Report, Partnership HealthPlan of California; December 2022 & 2023 Membership by Ethnicity, Partnership Membership Data

Members who speak English continue to report grievances much more frequently than those who speak other languages or use sign language. See figure 20 below.

Figure 22: G&A Pulse Report by Members Language vs. Partnership Overall Language Profile

3Q23 % CASES BY LANGUAGE		
MBR Language	% Cases	% Membership
English	93.0%	78.0%
Spanish	5.6%	19.4%
Other	0.9%	1.9%
Russian	0.3%	0.3%
Tagalog	0.1%	0.4%
Grand Total	100.0%	100.0%

Source: Q4 2023 Partnership G&A Pulse Report, Partnership

The percentage of English-speaking members who reported grievances increased from 92.02% in 2022 to 93.0% in 2023. Grievances in Partnership's other languages were low in 2023, however, compared to 2022, grievances in Other, Russian and Tagalog all increased from 2022 to 2023.

Table 18: Grievances by Language over Time

Language	*2022 % of Cases*	*2022 % of Membership*	*2023 % of Cases*	*2023 % of Membership*
English	92.02%	77.9%	93.0%	78.0%
Spanish	7.12%	19.3%	5.6%	19.4%
Other	0.86%	2.0%	0.9%	1.9%
Tagalog	0.00%	0.30%	0.1%	0.4%
Russian	0.00%	0.50%	0.3%	0.3%

Source: 2022 & 2023 Partnership Grievance and Appeals Data, Partnership; December 2022 & 2023 Membership by Ethnicity, Partnership Membership Data

2. Diversity, Equity, and Inclusion Training

a. Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusion is through an annual Health Equity Week for staff. Historically in alignment with the Martin Luther King Jr. holiday (the third week of January), a project team designs emails, videos, and interactive activities to raise staff awareness of the diversity of Partnership's employees and members, and how to

respectfully interact with others. Due to competing priorities, Health Equity Week 2024 will take place in April. Below are the results of Health Equity Week 2023.

Table 19: LMS Completion Report for Health Equity Week 2023 Activities

LMS Activity	Total Completions
A Tale of Two Zip Codes	236
Partnership's Health Equity Journey: The Past	168
Partnership's Health Equity Journey: The Present	159
Partnership's Health Equity Journey: The Future	174
What is NCQA Health Equity Accreditation	189

Source: LMS Training Report; Partnership Human Resource Department, 2023

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There is at least 2 mandatory educational sessions per year. As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of December 31, 2023, there were 1,013 Partnership employees.[47] In 2023, Partnership employees completed the following trainings:

Total Completion	Partnership Training Sessions	Staff Assignment
1,110	Diversity, Equity, and Inclusion Training for Employees	Assigned to all staff in January 2023
284	Cultural & Linguistics Program Overview and Staff Training (eCourse)	Assigned to new hires and temps only
283	Affordable Care Act – Section 155	Pushed to new hires and temps only
224	Improving Health Outcomes for People Living in The Crisis of Poverty	Assigned to those who did not complete the live training in Dec 2022
240	Tale of Two Zip Codes	Optional training for all Partnership staff
194	What is NCQA Health Equity Accreditation?	Optional training for all Partnership staff
172	Partnership's Health Equity Journey: The Past	Optional training for all Partnership staff

[47] Partnership Human Resources, 2023

167	Partnership's Health Equity Journey: The Present	Optional training for all Partnership staff
179	Partnership's Health Equity Journey: The Future	Optional training for all Partnership staff

To promote awareness and understanding of diversity, equity, and inclusion, Partnership will continue to identify and mandate high-quality staff training(s) on an annual basis. Some staff may seek further training opportunities to gain better insight into their peers and Partnership's population.

b. Provider Training

Partnership actively reviews and offers training to contracted providers to improve member experience and reduce unintended bias, discrimination, and health disparities. In 2023, Partnership hosted a 3-part training series for providers on Healthy Equity. Session 1 took place on June 13, 2023, and covered Implicit Bias. Session 2 occurred on July 18, and covered the definition of health equity and strategies to improve organizational practices. Session 3 took place on August 15 and presented toolkits to support health equity. The internal work committee agreed that if this work were to continue, the Health Equity officer and staff should have ownership.

Partnership's Director of Health Equity is also tasked with developing a training program in 2024 to align with DHCS's APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements.[48] In 2024, Partnership will identify the training material to offer providers. Partnership will begin offering providers at least 1 training opportunity per year on equity, cultural competency, bias, diversity, and inclusion to align with NCQA and DHCS quality standards by 2026.

V. Review of Activities, Resources, and Opportunities

Over the past 25 years, Partnership has cultivated strong relationships with the provider community, public health, and community-based organizations on behalf of its members. Partnership has established 4 regional offices to maintain a community presence and ensure members have local access to someone who can address their

[48] APL 23-025 Diversity, Equity, And Inclusion Training Program Requirements

concerns. With the addition of 10 new counties, Partnership is also adding 2 additional regional offices in Placer and Butte counties.

Each year Partnership leadership takes the opportunity to review existing programs, resources, and structures to ensure they meet member needs. Department directors collaborate with the executive team to review Partnership's strategic plan and ensure Partnership resources are aligned with its mission and the evolving environment. Departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet Partnership's various initiatives. The 2024 PNA demonstrates how Partnership addresses member needs through various activities. To best support both health and overall wellbeing, Partnership works closely with provider and community resources to ensure members have access to a wide range of services. However, this PNA also revealed opportunities to address needs in the areas of organizational structure; social and environmental needs; member health and wellness; access to care; health disparities; health education; and culture and linguistics.

VI. Organizational Structure

In 2023, Partnership hired a new regional director for the Northeast region overseeing Shasta, Modoc, Siskiyou, Trinity, Lassen, and Tehama. Partnership has also hired an Eastern Regional Director to oversee 9 of the 10 new expansion counties.

Partnership's new claims system is scheduled to go live in mid-2024. Once the new claims system is implemented, there are several other projects planned to help Partnership meet the needs of its population, including a move to a new Grievance platform (scheduled to go live in 2025), and integration of the planned DHCS PHM Service platform. The PHM Service will promote data sharing between managed care plans, providers, the state, and members, and will provide standardized criteria to segment the population into subpopulations for intervention. The new claims system will be sufficient for Partnership's future needs and provide a framework on which Partnership may build additional IT structures to meet the needs of the organization and our members.

The position of Director of Health Equity was filled in January 2023, and serves as Partnership's Chief Health Equity officer overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. Partnership also added an Associate Director of Workforce Development to create a long-term vision and pipeline for health care workers within Partnership's service area.

Within Partnership, there are teams who work to build relationships with community partners and other stakeholders, including the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their community health assessments and action plans. These teams represent Partnership at various community collaborative meetings and learn about the ongoing needs of communities. This is one way that Partnership remains informed about the needs of the counties and communities it serves. Through relationships established in these meetings, organizations work together to conceptualize and implement interventions for health concerns or disparities. In addition to these community partner-facing teams, Partnership's medical directors regularly meet with clinic medical directors to discuss the clinical needs of patients, and they work together to make connections and find solutions for the providers and the members.

There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website (see Appendix B for a full list of Community Resources resources). Additionally, internal staff may use these community resources to augment Partnership's program offerings through closed-loop referrals. Partnership members have the option to contact Partnership's Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow up calls to ensure the resource(s) met the needs of the member. Partnership has identified many community resources that are integrated into member care, and offers them as member needs arise. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge.

DHCS's California Advancing and Innovating Medi-Cal (CalAIM) project aims to expand community resources to meet member needs, and encourages multi-sector collaboration to overcome social and environmental barriers to health. Over the coming years, Partnership will be looking to community agencies and other organizations to implement community health workers and doulas to provide services to members in their communities. The infrastructure to provide these services to members is not fully in place, but many agencies are developing training programs to meet the need for these positions. Partnership is working closely with provider groups and training organizations to develop this pool of workers and incorporate them into program offerings.

A. Social and Environmental Needs

1. Housing Shortage

Partnership's service area has a significant homeless member population and an even larger percentage of members who struggle to maintain housing. California has a shortage of affordable housing. Since the last PNA was published, California's homeless population grew 6%. This growth increased the estimated number of individuals experiencing homelessness to more than 181,000 people, the largest of any state. A 6% growth increase translates to nearly 3 in 10 unhoused people nationwide, according to new federal data.[49] The local Community Health Assessments and the County Health Rankings data also highlight a lack of stable housing as a pressing issue. Housing and homelessness are chronic concerns for managed care plans; however, Partnership has dedicated sufficient staff resources to manage these programs and to collaborate with other community agencies in addressing these challenges. State funds and initiatives like the CalAIM Community Supports service provide the means for managed care plans to offer grant funding to address housing concerns. Recently, Partnership helped in the development of 2 four-story buildings including a mix of studios, 1 bedroom units, and 2 bedroom units called Blue Oak Landing in Vallejo (Solano County) which serves individuals, couples, and families currently experiencing homelessness or who are at risk of experiencing homelessness. Partnership also helped develop Fair Haven Commons, a new housing development in Fairfield (Solano County) which opened in May 2023, which provides housing for very low to low-income households. The Population Health Department at Partnership's Fairfield Office successfully carried out a volunteer backpack stuffing event in the Fall and Winter of 2023. These efforts garnered 5,500+ backpacks for distribution to the homeless population in the counties doing their Homeless Point-in-Time (PIT) count in January 2024. In combination with backpacks from last year, a total of 6,430 backpacks were distributed to 23 of Partnership's 24 counties. The PIT Count is an annual count through HUD that captures sheltered and unsheltered unhoused individuals in all counties for 1 point-in-time snapshot. These counts all take place the last week of January and can last for up to 7 days. In 2023, Partnership also applied for a street medicine grant to support street medicine providers.

2. Economic Instability (Low Income and Unemployment)

Partnership members experience more social and structural barriers to health and well-being than many in the state of California. Ten of Partnership's counties have

[49] Mercury News, 2023

household incomes below California's state average.[50] The Community Health Assessments revealed that all 14 counties face challenges around having sufficient employment and income. Unemployment can make it difficult for Partnership members to access basic needs like housing and food for themselves and their families. There are often insufficient resources in communities to provide living-wage jobs for residents. In collaboration with community partners, Partnership is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes.

In 2023, Partnership offered scholarships to Sacramento City College's Community Health Worker (CHW) Certificate Program to help create employment opportunities for members. There were no applicants, and no scholarships were distributed in 2023. For 2024, the CHW Training Program Scholarship Opportunity is continuing in partnership with Sacramento City College for their fall program cycle. Because CHW services are now a Medi-Cal benefit (APL 22-016), there is heightened interest in opportunities to become certified. Partnership aims to provide $1000 scholarships to 20 applicants for this program in 2024. Many providers and community-based organizations are also exploring means of leveraging CHWs in their service offerings. Partnership is actively looking for ways to increase its CHW network by collaborating with interested providers and community-based organizations to pilot CHW training and certification programs. Some of these efforts include exploring how to build out a CHW training program using pharmacy technicians who are certified as CHWs.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. In preparation for the 2023 fire and flood season, the Population Health Department created a Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area. The inbox is used as a tool to share information with other member- and provider-facing departments within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. In 2023, when there was a sizable fire or natural disaster, the Population Health team sent out informational emails from the Fire and Disaster Reporting inbox to keep leaders within the organization apprised of the situation(s). This allowed for seamless and centralized internal communication and

[50] US Census Bureau, 2023

enabled member- and provider-facing departments to be prepared to support members in their time of need.

Another way Partnership supported member engagement with this topic through mailings to vulnerable members in all 14 counties. Mailings were comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card. The booklet included information on creating an action plan, preparing an emergency kit, and listed common emergency resources available throughout the state. It also included a QR code that links members to Partnership's community resource pages if they want more information. The pocket card is a small laminated checklist of items to pack in an emergency kit and go-bag in the event of an emergency. These materials were mailed out to vulnerable members who use durable medical equipment, have respiratory conditions, or use oxygen concentrators. In total, 10,281 members throughout the 14 county service area were mailed. Of the 10,281 mailers sent, 1,112 were large font, 8 were audio CDs, and 1 was in braille, based on member requests for alternative formats. The resources allocated to these efforts are sufficient for Partnership member needs.

B. Member Health and Wellness

1. Chronic Disease

HEDIS performance measure reporting provides some insight into the overall health and wellbeing of health plan members. DHCS has recently set large efforts into motion on the front of CalAIM, including the creation and evolution of its Population Health Management (PHM) Policy Guide.[51] The PHM Policy Guide includes a variety of new mandates, including a mandate for Managed Care Plans to include chronic disease basic population health management (BPHM) programs that address hypertension, diabetes, asthma, and depression. These programs align with PNA findings showing that hypertension, tobacco use, and depression are the most common chronic diseases in our adult population.

To combat hypertension, Partnership collaborated with providers and other community agencies to provide member education and referrals for recently diagnosed individuals. Partnership developed an outreach campaign to encourage African American/Black members to attend regular doctor appointments, take anti-hypertensive medications as prescribed, and make healthy lifestyle changes. In addition, member-facing teams within Partnership worked with Touro University's Mobile Diabetes Education Center (MOBEC) to reach members with diabetes and hypertension, most recently in

[51] Department of Health Care Services DHCS, 2022

September 2023. At these mobile event days, Partnership staff engaged with the communities in Solano and Napa Counties, connecting members to a PCP and educating them on their Medi-Cal benefits. This partnership helps address the management of some chronic conditions through ongoing BPHM support. However, due to low participation, there are no plans to continue this specific intervention. This year's PNA found hypertension measure disparities among the African American member population. The Native American/Alaska Native population generally tends to have worse health outcomes as well. As a result, Partnership plans to modify its hypertension intervention to focus primarily on African/American, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander members as part of Partnership's Populations of Focus. The core components of the modified intervention will generally remain the same. There are sufficient resources to perform this new program, and Partnership will review its efficacy in 2025.

Many of Partnership's counties have adult smoking rates that are higher than the state average. As a result of this finding, Partnership's Population Health Department has added questions about smoking behavior to the outbound call campaign scripts for all campaigns. Lake County has also expressed significant concerns about the number of adolescent and younger children who are using tobacco products, and requested help from Partnership to mitigate this issue. Based on Lake's need, Partnership piloted a school youth tobacco education and prevention training in 2023 to promote a smoking-free future.

Partnership members in all regions face health challenges, though there are regional variations in health. For example, pediatric members with asthma who live in Partnership's Northern Region have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer asthma control. There may be other contributing factors as well. In order to better understand and support these members, Partnership implemented a one-time Asthma Management campaign done in June of 2022. Partnership staff outreached to the parents of children who had a recent ER visit with an uncontrolled asthma diagnosis code to provide support. Partnership staff provided education on the importance of asthma management, provided education on medication use, addressed any concerns regarding asthma action plan, conducted Asthma Control Tests (ACT), and encouraged members to maintain care/treatment with provider.

While the program was well received by those who participated, very few contacted members opted into it. Using lessons learned, Partnership's Pharmacy department created an alternative asthma management program for adults with asthma Emergency

Department visits, which was piloted from August 2022 to February 2023. The program enrolled 228 intervention and control group members. Partnership pharmacists conducted outreach to members to provide clinical consultation on asthma self-management and medications. Activities included mailing asthma action plans; providing follow-up calls at 1 and 3 months after the emergency department visit if the member agreed; a fax to the member's assigned primary care provider, which notified them of the emergency department visit, asked them to fill out a history, offered the pharmacist's recommendations, and provided them an asthma action plan template. Results of this pilot were collected from August 2023 to January 2024. Partnership is reviewing the efficacy of the pilot in 2024 to consider implementing the program as is, or modifying it. Partnership is also working on building out another evidence-based asthma program for all members with an asthma diagnosis. This program focuses on providing additional support to members with a recent asthma diagnosis by partnering with the member's provider. As this planned asthma program is not operational yet, programmatic effectiveness will be reviewed in 2025. There are sufficient resources to perform this new program.

The top 3 chronic diseases found among Partnership children in 2023 were mental health concerns (anxiety, trauma/stress, and depression). Since as many as a third of children with ADHD have 1 or more coexisting condition (including anxiety disorder),[52] one way Partnership addressed mental health conditions in children was through weekly ADHD new start reports. These helped identify Partnership primary members aged 6-12 years old that had filled a new ADHD medication. The Pharmacy team sent fax notifications to prescribers alerting them that their patient had filled a new ADHD medication, and encouraged the scheduling of a follow-up appointment within 30 days of the medication fill date. Follow-up calls were made after fax was sent to confirm receipt. A total of 332 faxes were sent from March through December 2023. Initial results showed a small improvement in follow-up visit rates among intervention group. Data results from intervention were collected through February 2024. The ADHD program's effectiveness will be reviewed in 2025 to determine if this program will end or continue on either as is, or modified. There are sufficient resources to perform this new program.

Furthermore, as part of efforts to improve poor behavioral health outcomes, which can go hand in hand with substance abuse,[53] one of Partnership's new mandates is to increase behavioral health access among K-12 students enrolled with Partnership. To do so, Partnership is reimbursing wellness coach staff at schools in select counties in its

[52] UpToDate, 2024
[53] NIH, 2023

service area to function as lay mental health workers. There are sufficient resources to perform this new program.

Partnership has also developed a pilot BPHM program offering to help manage depression for members who recently suffered a stroke or a myocardial infarction. This pilot program will meet DHCS requirements for a depression intervention program and test the benefits of having non-clinical staff provide life-style coaching for depression. Depression was the third most common chronic disease found among adult Partnership members in 2023. It is possible that members who had a recent depression diagnosis have also recently suffered a recent stroke or a myocardial infarction. Therefore, this BPHM program has potential to decrease the number of Partnership members diagnosed with depression in the future. Currently, Partnership has staff dedicated to this program, although more staff resources are budgeted should current staffing prove insufficient.

2. Health Screening

To address the need for cancer screening, Partnership collaborated with Alinea Mobile Imaging to bring mobile mammography imaging to rural communities and health centers lacking access to mammography sites. Mammography is a proactive screening that detects breast cancer, and providers had the opportunity to follow up with anyone who had findings on their imaging. Throughout 2023, there were 38 mobile mammography clinics conducted in 11 Partnership counties (Shasta, Del Norte, Trinity, Humboldt, Sonoma, Solano, Yolo, Mendocino, Lake, Lassen, and Marin). This has been a successful partnership, and will be expanded in 2024 to reach more members. There are sufficient resources for this endeavor.

Partnership's Women's Health and Perinatal Workgroup is finalizing logistics to start a 6-month Cervical Cancer Screening Self-Swab pilot project in early 2024. There are 5 Primary Care Provider practices participating, with plans to pilot tests of 200 Partnership members. The objective is to learn what type of instruction and workflow optimizes patient participation, so that when self-swab kits enter mainstream healthcare, Partnership will be poised to assist clinics in implementing and improving cervical cancer screening rates of our members. Partnership also started a colorectal cancer screening pilot project in 2022 along with Exact Sciences to increase numbers of colorectal cancer testing among the 45+ years population. This pilot is still in progress in 2024.

3. Wellness Care

Finally, Partnership is making significant investment into expanding services for maternal and child health. Building off successful programs from prior years,

Partnership now performs outreach to all members with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns are targeting pre-teen visits for vaccinations and wellness visits. Partnership has allocated staff, incentive dollars, and time to collaborate with schools and public health officers, which has resulted in school-based clinics, poster contests, and other marketing strategies to promote childhood wellness care. The resources allocated are sufficient for these efforts, and Partnership will evaluate the impact of these activities through appropriate reports and multi-disciplinary committees.

C. Access to Care

Partnership operates in a broad service area encompassing urban, suburban, rural, and frontier settings. Partnership's provider network is challenged by a national shortage of providers, and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers. Currently, Partnership sponsors a workforce development program that offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and if they come from a county outside of the ones that Partnership serves (see Appendix C). Partnership is also launching a new Provider Retention Initiative (PRI) Pilot. The PRI is intended to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. The hope is to preserve institutional knowledge and clinical leadership in Partnership networks (Appendix D). Although this work is already started and in place, a long-term strategy is essential to address the provider shortage in Partnership's service area.

With oversight from Partnership's Board of Commissioners, and in collaboration with state and national initiatives, Partnership continuously works to make the provider recruitment program effectively support expanded access to primary care. In particular, Partnership is expanding efforts to strengthen recruitment of PCPs, behavioral health providers, mid-levels, and specialists in the areas where access is impacted most, as indicated by high HPSA scores or the "frontier" geographic designation.[54]

Partnership also works to prevent loss of access to care. Recent efforts include a variety of activities, such as:

- Launching a primary care pilot program using a telehealth service called TeleMed2U (see Appendix E)

[54] Partnership 2022-2023 Workforce Needs Assessment

- Launching a mobile mammography program centered around providers located in areas without imaging centers or in proximity to imaging centers with significant access barriers
- A retrospective assessment of specialty providers to better use telehealth during the pandemic
- Provider-specific improvement plans, focusing on providers who have not been successful in Partnership's Quality Incentive Program (QIP) in past years
- Continued support of the QIP program for primary care
- Utilization of Partnership's Transportation Services to allow members to attend provider appointments[55]

Furthermore, Partnership explored means of encouraging provider facilities to improve access for members with disabilities. Partnership formed a workgroup to research available resources to help providers create facilities that are more physically accessible for seniors and members with disabilities. For example, members of the workgroup surveyed possible grants that may help providers upgrade their facilities. Findings from this workgroup were published in a provider newsletter in hopes that knowledge of existing resources would ease the challenges providers face when serving seniors and disabled members.

D. Health Disparities

The PNA revealed notable care gaps between racial/ethnic groups, especially from the HE 6: Reducing Healthcare Disparities.[56] Compared to the White population (56.28%), rates of controlling high blood pressure among Asians (71.43%) were highest, while these rates were the lowest among Black/African Americans (46.15%). The PNA also revealed the White population had a significantly higher rate of HbA1c Poor Control (suggesting low rates of HbA1c control) when compared to the Asian population and was the worst performing group. Males also had a statistically significantly higher rate (39.71%) of Hemoglobin A1c Control for Patients with Diabetes (HBD9) HbA1c Poor Control compared to women (29.70%). Furthermore, the Hispanic/Latino and Asian population had a significantly higher rate of Child and Adolescent Well Care Visit completions (49.13%) when compared to the White population (39.29%). Farsi and Spanish speaking groups also performed better compared to the White population on Child and Adolescent Well Care Visits completions. Lastly, the female population had a statistically significantly higher rate (45.87%), compared to the Male population (44.55%) in regards to Child and Adolescent Well Care Visits. Partnership will continue to perform outbound call campaigns that encourage families to attend well-child visits

[55] Partnership HealthPlan of California Provider Relations, 2022
[56] Partnership HE 6: Reducing Healthcare Disparities report, December 2023

with their children. Partnership will also continue to participate in efforts that support members recently diagnosed with hypertension and diabetes.

In 2024, Partnership will continue strengthening relationships and collaboration with tribal health providers in Humboldt County, in order to decrease identified health disparities between American Indian and non-American Indian members. In October 2023, Partnership held a gathering for Indian Health Services providers. One of the initiatives discussed centered on perinatal supports. The focus of this perinatal support intervention is to improve the birthing outcomes for Native Americans. The entities that want to participate in the perinatal supports program take part in what the tribes call a "consultation," which functions much like an advisory group. This process includes presenting to the tribal organizations and gathering feedback on an idea and corresponding early framework. These efforts kicked off in January 2024. To help move this project forward, Partnership is looking at launching its first cohort in 2024; the second cohort will launch in 2025. Partnership will leverage funding from the Enhanced Care Management program to offer a comprehensive program ensuring optimal outcomes for pregnant Native American woman.

Partnership staff also had the honor of attending a presentation by the Better Birthing Coalition in October 2023. This coalition is a local partnership between K'imaw Medical Center in Hoopa and Providence St. Joseph Hospital in Eureka, which works with local tribes to build relationships and increase trust between the Eureka hospital and the Native communities it serves. The Better Birthing Coalition presented on how they successfully improved the birthing experience for Native women by tailoring birthing practices to ensure cultural sensitivity. The project addresses various opportunities to improve the birthing experience, as identified by the Native population. Some examples of improvements include visual changes in photos depicting Native women and art at the birthing facility to better reflect the community, the use of traditional baby baskets after delivery, and changes to state naming laws, which modified the amount of time given to name a child from 10 days to 21 days, thus preserving the sacred naming ceremonies. The hospital now trains all new staff in cultural sensitivity at St. Joseph's and continues to support Native members in their birth journey. Because of these successful efforts, Partnership has asked the Better Birthing Coalition to share best practices with other tribal health facilities with hopes that they will join the perinatal support intervention.

Partnership has also created a Tribal Liaison position to provide a more formal point of contact and advocate for American Indian needs in alignment with new DHCS mandates. There are sufficient resources currently allocated to strengthen existing relationships.

E. Health Education, Culture & Linguistics

Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them. While managed care plans have several departments dedicated to member support, Partnership recognized an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, and the distribution of educational materials at community outreach efforts. To further promote access, Partnership will continue to collaborate with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services.

Partnership also offers robust Community Resource pages on our external website (see Appendix B). These pages are a collection of local resources that are meant to supplement member needs. Each of Partnership's counties has a dedicated county page. Community Resource pages for Partnership's new expansion counties also went live in December 2023. Partnership members also have the option to contact Partnership's Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow up calls to ensure the resource(s) met the needs of the member. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge.

Member grievance data provides insight into member engagement with the health plan, their experience of culturally and linguistically appropriate care, and reported rates of discrimination. Members who want to report grievances with their care must know how to report a grievance using the appropriate channels, and feel some assurance that their concerns will be taken seriously. Therefore, Partnership uses reported grievances as a proxy for trust in the agencies against whom the grievance is filed. While a general lack of trust in government and institutions may be the root cause for some distrust, Partnership works to overcome this through demonstrating responsiveness to member needs, as reflected in interactions with our members. This effort is ongoing and, while there are sufficient resources allocated, there are likely more opportunities to educate members on their rights and how to exercise them.

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings. The goal of these trainings are to engage staff and providers in topics

relating to equity (e.g., race, ethnicity and gender) and the barriers members experience that prevent them from being healthy. Partnership's Director of Health Equity has also been tasked with developing a mandatory Diversity, Equity, and Inclusion training for all Partnership staff, network providers, and delegates.

VII. Stakeholder Engagement

The Partnership Health Education team solicits stakeholder engagement on the PNA through multiple pathways. The Health Education team uses reports from pertinent departments to draft the report. The Quality Improvement and Health Equity Committee (QIHEC) and Population Needs Assessment Committees review and provide feedback on the final draft of the PNA, along with proposed interventions. The Health Education team gathers member feedback through Partnership's Consumer Advisory Committee (CAC) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with the proposed recommendations, and their feedback is incorporated in the final report.

The PNA then undergoes review by Partnership's Internal Quality Improvement (IQI) Committee, Partnership's Quality/Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Commissioners before submission to the National Committee for Quality Assurance (NCQA) annually, and as part of DHCS regulatory requirements.

Once final, the PNA is made available in a variety of forums for use and strategic planning by contracted health care providers, practitioners, and allied health care personnel. These forums may include, but are not limited to, provider newsletters, Provider Online Services via Partnership's website, HEDIS training, and the Community Report. Furthermore, the PNA is posted on Partnership's internal and external websites. Lastly, Partnership identifies pertinent information related to member needs in the report, and uses that information to update current activities and design new interventions to address the identified needs.

VIII. Works Cited

1. Banner Health 2022 CHNA: Banner Lassen Medical Center. (2022). Retrieved from https://www.bannerhealth.com/-/media/files/project/bh/chna-reports/2022-new/california/banner-lassen-medical-center-susanville.ashx
2. Borsky, A., et. al. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. *Health Affairs.* VOL. 37, NO. 6. https://doi.org/10.1377/hlthaff.2017.1248
3. Cal Fire. (2023). Cal Fire 2023 Incidents. Retrieved from https://www.fire.ca.gov/incidents/2023
4. California Department of Public Health. (2023). Results of the 2022 California Youth Tobacco Survey. Retrieved from https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/CDPH%20Document%20Library/ResearchandEvaluation/FactsandFigures/CYTS2022AnnualReportFinal.pdf
5. Center For Disease Control and Prevention (CDC). (2022). About Chronic Disease. Retrieved from https://www.cdc.gov/chronicdisease/about/index.htm
6. Center for Disease Control and Prevention (CDC). (2023). Catch Up on Well-Child Visits and Recommended Vaccinations. Retrieved from https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html
7. Centers for Disease Control and Prevention. (2022, September 8). Chronic disease fact sheet: Physical inactivity. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/chronicdisease/resources/publications/factsheets/physical-activity.htm
8. Center for Disease Control and Prevention (CDC). (2023). High Blood Pressure. Retrieved from https://www.cdc.gov/bloodpressure/CTA.htm
9. Center for Disease Control and Prevention (CDC). (2023, August). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Retrieved from https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm
10. Center for Disease Control and Prevention (CDC). (2023). Smoking and Tobacco Use Fast Facts and Fact Sheets. Retrieved from CDC Tobacco Tips
11. Center for Disease Control and Prevention (CDC). (2023). Smoking and Tobacco Use Second Hand Smoke. Retrieved from https://www.cdc.gov/tobacco/secondhand-smoke/index.html
12. Center For Disease Control and Prevention (CDC). (2023). Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm
13. Community Health Insights. (2022). 2022 Community Health Needs Assessment, Dignity Health Mercy Medical Center, Redding. Retrieved from

https://www.dignityhealth.org/content/dam/dignity-health/pdfs/chna/2022-chna/mercy-redding-med-center-chna-2022.pdf
14. Community Health Insights. (2022). Siskiyou 2022 Community Health Needs Assessment. Retrieved from https://drive.google.com/file/d/1fHL76rwlZw1jDDdao2_g6R_ck2sg3A4u/view
15. Coren, A., and Miller, J. (April 2023). *2023 Mendocino County Community Health Needs Assessment".* Mendocino County Public Health Department. Retrieved from https://www.mendocinocounty.org/home/showpublisheddocument/61104/638338395370100000
16. County Health Rankings and Roadmaps. (2023). Air Pollution. Retrieved from Air Pollution - Particulate Matter | County Health Rankings & Roadmaps
17. County Health Rankings and Roadmaps. (2023). California. Retrieved from California | County Health Rankings & Roadmaps
18. County Health Rankings & Roadmaps. (2023). *Food environment index*. County Health Rankings & Roadmaps. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/diet-and-exercise/food-environment-index?year=2023
19. County Health Rankings and Roadmaps. (2023). Income Inequality. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors/income/income-inequality?year=2022
20. County Health Rankings and Roadmaps. (2023). Severe Housing Problems. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2023&state=06
21. County Health Rankings and Roadmaps. (2023). Unemployment. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors/income/income-inequality?year=2022
22. Department of Health Care Services. (2023, December 20). APL 23-031 - Medi-Cal Managed Care Plan Implementation Of Primary Care Provider Assignment For The Age 26-49 Adult Expansion Transition. Retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
23. Department of Health Care Services. (May 2023). 2021 Health Disparities Report. Retrieved from dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-Health-Disparities-Report-F3.pdf

24. Department of Health Care Services (DHCS). (2023). Health Disparity Reports. Retrieved from https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfDisp.aspx
25. Department of Health Care Service (DHCS). (2022). Population Health Management (PHM) Strategy and Roadmap. Retrieved from https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf
26. Department of Health Care Services (DHCS). (2023). Medi-Cal Managed Care Quality Improvement Reports. Retrieved from https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx
27. U.S. Department of Housing and Urban Development. (2023, November 20). *HUD 2023 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations.* HUD Exchange. Retrieved from https://files.hudexchange.info/reports/published/CoC_PopSub_State_CA_2023.pdf
28. Diaz, H., Schmedtlein, M., Ainsworth, D., & Van, T. (April 2022). *2022 Community Health Needs Assessment Key Findings Report Summary.* Community Health Insights. Retrieved from https://drive.google.com/file/d/1fHL76rwlZw1jDDdao2_g6R_ck2sg3A4u/view
29. Enviromental Protection Agency (EPA). (2023). Retrieved from https://www.epa.gov/wildfire-smoke-course/health-effects-attributed-wildfire-smoke
30. Freedman, A.E., Garminsa-Calinksy, S., Lua, V., & Nwobilar, N. (June 2019). *County of Del Norte Community Health Assessment.* Resource Development Associates. Retrieved from https://delnortecalfresh.org/wp-content/uploads/Del_Norte_HHS_CHA_Report_20190724_Final.pdf
31. Healthy People 2030. (2020). *Social Determinants of Health*. Social Determinants of Health - Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health
32. Healthy Marin Partnership. (2022). *Marin County 2022 Community Needs Assessment: A Summary of Key Findings*. Retrieved from https://www.healthymarin.org/content/sites/marin/FINAL_2022_CHA-HMP_V.2.pdf
33. Healthy People 2030. (n.d.). Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment
34. Healthy People 2030. (2023). Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care.
35. 2018 Humboldt County Community Health Assessment. (2018). Humboldt County Department of Health & Human Services, Public Health. Retrieved from https://humboldtgov.org/DocumentCenter/View/71701/2018-Community-Health-Assessment-PDF

36. 2022 Humboldt County Enhanced Community Health Assessment. (2022). Humboldt County Department of Health & Human Services, Public Health. Retrieved from https://humboldtgov.org/DocumentCenter/View/110760/CHA-Enhancement-2022-PDF
37. Lake County California: 2022 Community Health Needs Assessment. (2022). County of Lake, Public Health. Retrieved from https://www.lakecountyca.gov/ArchiveCenter/ViewFile/Item/569
38. Modoc County Community Health Needs Assessment. (2024). Modoc County Public Health. Retrieved from https://webgen1files.revize.com/modochealth/Modoc%20County%20Community%20Health%20Needs%20Assessment%20Final%2001-31-24.pdf
39. Napa 2023 Community Health Needs Assessment. (2023). Napa County Health and Human Services Agency, Providence Queen of the Valley Medical Center. Retrieved from https://www.livehealthynapacounty.org/uploads/5/1/4/4/51449431/final_2023_napa_county_cha.pdf
40. Partnership HealthPlan of California Dashboard. (2023). 3rd Next Available Survey, 2023 Summary Dashboard.
41. National Institute of Mental Health (NIH). (March 2024). *Substance Use and Co-Occurring Mental Disorders*. Retrieved from https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health.
42. Partnership HealthPlan of California. (2023). Partnership Integrated Claims and Encounter Data.
43. Partnership HealthPlan of California Telemedicine Team. (2023). Adult Telemedicine Appointment Details Report.
44. Partnership HealthPlan of California. (2023). Adult eConsult Utilization Report.
45. Partnership HealthPlan of California. (2023). Beacon Mental Health Claims and Encounter Data
46. Partnership HealthPlan of California. (2023). Grievance & Appeals Pulse Report, 2023 Fourth Quarter.
47. Partnership HealthPlan of California. (2023). Health Equity Standards – HE 6: Reducing Healthcare Disparities
48. Partnership HealthPlan of California (2023). Human Resources LMS Data for Health Equity.
49. Partnership Health Plan of California HEDIS Measures. (2023). HEDIS Annual Explorer.
50. Partnership HealthPlan of California. (2023). *Mental Health Claims and Encounter Data.*
51. Partnership HealthPlan of California. (2023). PARS Report_3.8.2023.

52. Partnership HealthPlan of California. (2023). Partnership HealthPlan of California Website
53. Partnership HealthPlan of California. (2023). 2023 Partnership Integrated Claims and Encounter Data.
54. Partnership HealthPlan of California. (2023). Partnership Membership Dashboard.
55. Partnership HealthPlan of California. (2023). Partnership Third Next Appointment Availability Data.
56. Partnership HealthPlan of California. (2023). Pediatric eConsult Utilization Report.
57. Partnership HealthPlan of California. (2023). Pediatric Telemedicine Appointment Details Report.
58. Partnership HealthPlan of California. (2023). 2022 MY Health Disparities Data, Department of Healthcare Services
59. Partnership HealthPlan of California. (2023). Quality and Performance Improvement Program description.
60. Partnership HealthPlan of California. (2023). *Substance Use Disorder Data*
61. Partnership HealthPlan of California Provider Relations. Trosky, R. (2023). Grand Analysis: Network Access: Assessment of Network Adequacy
62. Rasiah, Supathiratheavy, et. al. (2020). A study of the nature and level of trust between patients and healthcare providers, its dimensions and determinants: a scoping review protocol. *BMJ Open*. Retrieved from https://bmjopen.bmj.com/content/10/1/e028061
63. Robert Wood Johnson Foundation. (2023). About Us. Retrieved from https://www.countyhealthrankings.org/about-us
64. SAIPE State and County Estimates for 2022 for California. (2022). Retrieved from https://www.census.gov/data/datasets/2022/demo/saipe/2022-state-and-county.html
65. Solano County Department of Public Health. (January 2023). Community Health Improvement Plan. Retrieved from https://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=40374
66. Sonoma County Department of Health Services. (December 2023). Sonoma County Community Health Assessment and Improvement Plan. Retrieved from https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/About%20Us/Public%20Reports/Phase1-Sonoma-CommunityHealthAssessmentImprovePlan-2023.pdf
67. SPH Analytics. (2023). MY 2022 CAHPS Medicaid Adult 5.1 Survey, Partnership HealthPlan of California
68. SPH Analytics. (2023). MY 2022 CAHPS Medicaid Child 5.1 Survey, Partnership HealthPlan of California
69. SPH Analytics. (2023). At-A-Glance Report, 2022 Medicaid Adult CAHPS 5.1 H. 10.
70. SPH Analytics. (2023). At-A-Glance Report, 2022 Medicaid Child CAHPS 5.0 H. 10.

71. Trinity County Department of Public Health. (2023). Equity Assessment. Retrieved from https://www.trinitycounty.org/sites/default/files/Public_Health/Documents/Trinity%20County%20Equity%20Assessment.pdf
72. UpToDate. (2024). *Attention deficit hyperactivity disorder in children and adolescents: Overview of treatment and prognosis*. Retrieved from https://medilib.ir/uptodate/show/623
73. Wolf, E. R., O'Neil, J., Pecsok, J., Etz, R. S., Opel, D. J., Wasserman, R., & Krist, A. H. (2020). Caregiver and Clinician Perspectives on Missed Well-Child Visits. *Annals of family medicine*, *18*(1), 30–34. https://doi.org/10.1370/afm.2466
74. World Health Organization (WHO). (2023). Retrieved from https://www.who.int/news-room/fact-sheets/detail/physical-activity
75. World Health Organization. (2023). Retrieved from https://www.who.int/news-room/questions-and-answers/item/social-determinants-of-health-key-concepts.
76. Yolo County. (2023). Community Health Assessment. Retrieved from https://www.yolocounty.org/home/showpublisheddocument/75735/638096518955230000

IX. Appendix A – HEDIS® MCAS Regional Performance Report Year 2023; Measurement Year 2022

Select Report Year
Report Year 2023; Measurement Year 2022

Select Provider Type
All Providers

HEDIS Regional Performance
Report Year 2023; Measurement Year 2022
Performance Relative to Quality Compass® Medicaid Benchmarks

PARTNERSHIP HEALTHPLAN of CALIFORNIA

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Regional Performance				National Medicaid Benchmarks			
Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Breast Cancer Screening (BCS)*	45.63%	41.44%	58.18%	56.40%	45.23%	50.95%	56.52%	61.27%
Cervical Cancer Screening (CCS)	54.01%	55.04%	65.82%	67.25%	52.39%	57.64%	62.53%	66.88%
Childhood Immunization Status (CIS) - Combo 10	18.49%	23.84%	46.47%	41.61%	28.95%	34.79%	42.09%	49.76%
Chlamydia Screening in Women (CHL) - Total*	49.13%	52.38%	61.27%	58.49%	48.67%	55.32%	62.65%	67.84%
Controlling High Blood Pressure (CBP)	62.89%	62.77%	61.73%	67.27%	54.50%	59.85%	65.10%	69.19%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	26.85%	16.34%	22.43%	28.59%	44.82%	54.51%	63.44%	72.01%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	42.86%	32.16%	34.08%	31.24%	10.72%	21.24%	25.81%	32.38%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	33.75%	33.42%	35.94%	31.19%	46.96%	39.90%	35.52%	30.90%
Immunizations for Adolescents (IMA) - Combo 2	18.73%	24.82%	51.34%	49.64%	30.41%	35.04%	41.12%	48.42%
Lead Screening in Children (LSC)	29.68%	45.74%	50.61%	44.28%	53.28%	63.99%	72.67%	79.57%
Prenatal and Postpartum Care (PPC) - Postpartum care	79.02%	85.67%	88.41%	90.48%	72.87%	77.37%	81.27%	84.18%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	90.49%	86.27%	83.09%	94.56%	81.27%	85.40%	88.86%	91.89%
Well Care Visits (WCV) - Total*	40.73%	43.98%	45.67%	46.99%	43.50%	48.93%	57.44%	62.70%
Well Child 30 (W30) - Well child visits for age15-30 months*	53.22%	61.15%	62.39%	65.71%	60.53%	65.83%	72.24%	78.07%
Well Child 30 (W30) - Well child visits in the first 15 months*	36.18%	43.52%	37.65%	42.96%	49.88%	55.72%	61.19%	67.56%

*- Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.
- In MY2022 the CDC measure was retired and split into 3 stand-alone measures: BPD, EED, and HBD. For MY2022 MCAS required reporting it is now HBD.
- HBD - HbA1c Poor Control is an inverted measure, a lower rate results in a better performance.

2

X. Appendix B – Community Resource Page

XI. Appendix C – Provider Recruitment Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Recruitment Program

January 2024 Update

Partnership is pleased to announce the launch of a new 2024 Provider Recruitment Program (PRP) agreement for partners located in our 24-county region. The PRP's purpose is to help our contracted network recruit and retain high-quality health professionals in our region to improve access to care for Partnership members. This 2024 PRP adds new incentives and provider eligibility, among making other changes. Highlights include:

Program Incentives Available (payable over five years):

- **$100,000** for physicians (providing services in family medicine, internal medicine, pediatrics, obstetrics and psychiatry)
- **$120,000** for medical residents training in Partnership's 24-county region ($20K payable in program year three with a five-year commitment post-graduation)
- **$50,000** for nurse practitioners/physician assistants/certified nurse midwives (NPs/PAs/CNMs)

Newly Eligible Providers:
Obstetric providers (obstetricians, CNMs, family medicine physicians and NPs/PAs, women's health NPs) whose clinical care focuses on perinatal care, including labor and delivery

Behavioral Health Professionals Program Highlights / Incentives Available:

- **$20,000** signing bonus for licensed behavioral health professionals
  - Licensed clinical social workers
  - Licensed marriage and family therapists
  - Licensed professional clinical counselor
  - Licensed clinical psychologists
- **$4,000/$5,000** signing bonus for certified substance use disorder (SUD) and bilingual certified SUD counselors

New Application Process:
We've adopted a grant lifecycle management platform to help improve PRP application efficiency

Key Criteria

- Candidates must not have accepted an offer to practice at a partner site under the previous PRP.
- If the candidate is currently practicing, they must be from outside of Partnership's 24 counties.
- Providers in training or residency programs within Partnership's 24 counties qualify for support.
- A reasonable effort must be made to submit requests for program support before offers are made.
- Please see Partnership's PRP webpage for additional important program criteria.

Questions
Please contact the Workforce Development team with any questions or requests:
wfd@partnershiphp.org | (707) 430-4846

PartnershipHP.org (707) 863-4100 Eureka | Fairfield | Redding | Santa Rosa

ACCREDITED NCQA HEALTH PLAN

XII. Appendix D – Provider Retention Initiative Pilot

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Retention Initiative Pilot

January 2024 Launch

Partnership is launching a new Provider Retention Initiative (PRI) Pilot. The PRI is intended to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while a younger generation of providers can learn from and train with these committed health professionals.

PRI eligibility is limited to practitioners who provide services to Partnership members with Partnership's contracted partners within our 24-county region.

Provider Program Highlights / Incentives Available:

- $45,000 award for Doctor of Medicine (MD) / Doctor of Osteopathic Medicine (DO) – three-year commitment
- $30,000 award for Nurse Practitioner (NP) / Physician Assistant (PA) – three-year commitment

Award Payment Cycle:

Award	FY 23/24	FY 24/25	FY 25/26	FY 26/27
$45,000 MD/DO	$7,500	$7,500	$15,000	$15,000
$30,000 NP/PA	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA) has provided services with organization for 15 years or more and has confirmed commitment for practicing at least three more years.
- Provider eligibility is limited to family medicine, internal medicine, and pediatrics.
- Provider must serve in a leadership or mentorship capacity within organization.
- Given funding limitation, provider organization must complete a competitive grant application.
- Provider organization must have a signed Provider Recruitment Program agreement.

Questions

Please contact the Workforce Development team with any questions or requests:
wfd@partnershiphp.org | (707) 430-4846

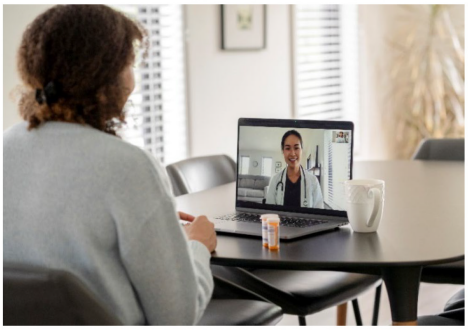
PartnershipHP.org (707) 863-4100 Eureka | Fairfield | Redding | Santa Rosa

ACCREDITED NCQA HEALTH PLAN

XIII. Appendix E – At-Home Telehealth Specialty Visits

At-Home Telehealth Specialty Visits

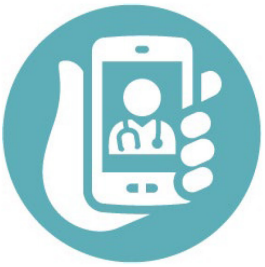
Did you know you could have a telehealth specialty visit from your home?



You may be able to have this visit from your home if your main doctor refers you to see a specialist. This is a telehealth specialty visit. You can use any computer, laptop, tablet, or smart device to have a telehealth specialty visit. The specialty care doctor will help treat your health care needs and will work with you to take care of your issue. Ask your main doctor if a telehealth specialty visit from home is right for you.

Here is how it works:

1. Your main doctor refers you to a specialist
2. TeleMed2U and UC Davis are our telehealth specialty doctors. They will call you to set up your visit
3. The specialist's office will call you to confirm your visit. They will make sure you have what you need for your visit.
4. The specialist will give you a Zoom link. Use the Zoom link to log into the App when it is time to meet with the specialist.
5. If you need medicine, the specialist will send it to the pharmacy you choose.



Call or email the telehealth specialist if you have any trouble or if you need to reschedule your visit:

- Please send an email to referrals@telemed2u.com , or call or text **(855) 446-8628** for adult specialty care.
- Call UC Davis at **(800) 482-3284** for specialty care for kids.

Read the questions and answers below to find out more.