Population Needs Assessment

May 2025

Contents

I. Population Needs Assessment Overview

Partnership HealthPlan of California is a not-for-profit Medi-Cal managed care plan (MCP) serving 24 counties in Northern California. As of December 2024, the plan has approximately 895,129 members.[1] On January 1, 2024, Partnership expanded its service area by adding 10 new counties. Partnership is 1 of 6 County Organized Health System (COHS) managed care plans in California, endorsed by its counties' Board of Supervisors.

Most Medi-Cal beneficiaries, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and those in skilled nursing facilities are automatically assigned to Partnership. In addition, dual-eligible Medicare-Medicaid members are assigned to Partnership as a secondary line of coverage. In 2024, Partnership provided primary and specialty health services through a contracted network of community providers, medical groups, 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 is no longer contracted with Kaiser Permanente due to the statewide Kaiser Transition to an individual Medi-Cal managed care plan.

Each year, Partnership conducts an overall assessment of the health environment, community needs, and the factors that influence the well-being of the member population. This assessment is required by both the California Department of Health Care Services (DHCS) as part of a larger annual deliverable, and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). The results of this assessment are used to develop the PNA, which informs Partnership's Population Health Management Strategy, as well as the Cultural & Linguistics Program description and their related work plans. To develop the 2025 PNA, Partnership integrates and analyzes various data sources, including:

- Partnership Member Enrollment data
- Local Community Needs Assessments
- County Health Rankings and Roadmaps
- Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau data
- Published articles and reports from the CDC and other reputable sources

[1] Partnership Membership Dashboard, 2024
[2] Partnership Quality and Performance Improvement Program Description, 2024

- Partnership Integrated Claims and Encounter data
- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Consumer Assessment of Healthcare 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
- Internal Human Resources reports
- Other sources as relevant

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

Position Title	Department
Manager	Population Health
Community Health Needs Liaisons	Population Health

A. Summary of Key Findings

Since the January 2024 10-county expansion, Partnership's membership remained relatively stable for the remainder of 2024. At the close of 2024, Partnership served approximately 895,129 members throughout 24 counties. The 2025 Population Needs Assessment draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

a. Summary of Findings

Local community needs assessments identified a variety of priority areas of need that can be grouped by Healthy People 2030 domains of Social Determinants of Health (SDoH), including:

- Economic stability: high poverty rates, economic instability, food insecurity and disparities in access to social services

- Healthcare access and quality: provider shortages, insufficient access to healthcare, mental health, substance use disorder and prenatal care services
- Neighborhood and built environment: geographic isolation, lack of affordable housing, safe neighborhoods, higher rates of violence, unintentional injury, fire threat, and challenges with transportation
- Education access and quality: Low education attainment and limited internet access
- Social and community context: higher rates of adverse childhood experiences (ACEs), need for fostering community connections, trusted leaders and institutions, and healthcare system navigation

A review of the data sources highlights significant concerns related to access to care, behavioral health, and other social determinants of health. Across multiple counties, challenges such as a shortage of healthcare providers, transportation barriers, and economic instability are prevalent. Behavioral health, including mental health and substance use disorders, is consistently identified as a primary concern. Additionally, social determinants like income inequality, housing insecurity, and food deserts disproportionately affect marginalized communities, exacerbating health disparities. These factors contribute to a landscape where members face compounding obstacles to achieving optimal health.

Disparities in health outcomes are particularly pronounced among racial minorities, LGBTQ+ individuals, and Indigenous populations. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further emphasize the need for targeted interventions. The availability of healthcare providers remains a significant concern across all counties, particularly in rural and frontier regions, where the number of available providers in areas like primary care, dental care, and mental/behavioral health is insufficient to meet demand.

Transportation challenges further complicate access to care, especially in remote areas where long distances must be traveled to access healthcare services. Many individuals lack reliable transportation options and geographical isolation exacerbates the difficulty in attending provider visits. Housing issues also remain a constant challenge, with a lack of affordable and quality housing preventing many individuals from securing stable living situations. This issue has remained persistent during 2024, contributing to a continued homelessness crisis across many counties.

In 2024, there were 118 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 utilizes claims and encounter data to approximate disease prevalence among its members. In 2024, hypertension, tobacco use, depression, anxiety, substance use, and obesity were the 6 most prevalent conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety, trauma/stress, depression, asthma, obesity, and substance use. Telehealth utilization in general has increased for 2024. Partnership's southern region had the highest number of members accessing specialty mental health services. Breast cancer screening rates and cervical cancer rates in the northern counties also continue to underperform.

To determine if there are health disparities within the overall population served, Partnership reviewed the HE6: Reducing Healthcare Disparities report, which analyzed samples by race/ethnicity, gender, and language. The analysis found that both the "Some Other Race" and Asian groups had the lowest controlled blood pressure measures when compared to all other racial/ethnic groups. For HbA1c control in diabetes, the Native Hawaiian/Other Pacific Islander, American Indian and Alaska Native, and Black/African American populations all performed below the 50th percentile for poor control, indicating disparities in managing diabetes. In terms of Child and Adolescent Well Care Visits, Native Hawaiian/Other Pacific Islander, Black/African American, White, and American Indian and Alaska Native groups had lower rates of completion, performing below the 50th percentile. For prenatal care visits, Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black/African American populations also performed below the 50th percentile. These findings highlight significant disparities in healthcare access and outcomes for these populations.

b. 2024 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 the realm of organizational structure, in 2024, Partnership hired two new regional directors. One director was hired to fill the role for the new Auburn (Eastern) region,

overseeing Plumas, Nevada, Placer and Sierra Counties. The other director was hired to replace the director in the Santa Rosa (Southwest) region, overseeing Sonoma and Marin counties. Partnership will also be implementing new technological advances to better support its efforts, including a new claims system and the DHCS PHM Service platform. Furthermore, Partnership also added 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 (CHA) and Community Health Improvement Plans (CHIP). These teams, alongside other population health staff, connect members to local resources and follow up to ensure their needs are met. They also represent Partnership at various community collaborative meetings and events to learn about the ongoing needs of communities.

The position of Director of Health Equity was filled in January 2023, overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department has hired several staff in 2024 with plans to continue growing the team in 2025.

To address social and environmental concerns, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. One example is the state funds and initiatives like the CalAIM Incentive Payment Program which provides the means for managed care plans to offer grant funding to address housing concerns. Lastly, as part of DHCS's Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

Many of Partnership's counties have household incomes below the state average, and local Community Health Assessments revealed challenges around sufficient employment and income. In collaboration with community partners, Partnership is working to increase workforce opportunities including providing member scholarships to aid in education with a focus on health care, social work, and other related fields.

One of the ways Partnership provides support for members living in fire-prone areas was by creating a Fire and Disaster Reporting email inbox for member- and provider-facing departments within Partnership in 2023. Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area that happened in 2024. The inbox is used

as a tool to share information within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. Partnership also posted member materials to Partnership's website comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card.

In the realm of member health and wellness, pediatric members with asthma who live in Partnership's Northern Region may 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. In alignment with CalAIM BPHM, requirements Partnership rolled out the new Asthma Emergency Department (ED) Visit Outreach Program Campaign at the end of 2024 to better support members with asthma. The Asthma Management campaign will offer additional support to members who were recently seen in the ED for their asthma and will be reviewed for effectiveness in 2025. To help manage other member chronic diseases, and in alignment with DHCS' Population Health Management requirements, Partnership continues to support and refine its Basic Population Health Management programs centered on hypertension, diabetes, and depression.

In 2024, Partnership explored conducting health education sessions around tobacco prevention in counties with high tobacco usage. Plans are in place to conduct these sessions in 2025. Partnership also implemented an ADHD program to help address mental health conditions in children which will continue into 2025. Furthermore, as part of Partnerships' efforts to improve poor behavioral health outcomes and increase access among K-12 students, Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. 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. With 72 mobile mammography days in 19 different Partnership counties and modest improvements in screening outcomes, Partnership intends to continue this collaboration in 2025. Other organizational efforts in the realm of member health and wellness include efforts to increase cervical cancer screenings and colon cancer screenings.

Finally, Partnership continues to make significant investments into expanding services for maternal and child health. Partnership 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 target pre-teen visits for vaccinations and wellness visits. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary

stakeholders which has resulted in plans to conduct school-based clinics, and other strategies to promote childhood wellness care. Partnership will continue to evaluate the impact of these activities through appropriate reports, monitoring efforts, and multi-disciplinary committees.

Efforts to improve access include Partnership's development of a multi-pronged approach to recruit and retain providers. For example, Partnership started a Provider Recruitment Program in January 2024, which focused on helping the contracted network recruit and retain high-quality health professions in Partnership counties; this program provided incentives, including sign-on bonuses. Partnership also has a Provider Retention Initiative (PRI) to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service in effort to preserve institutional knowledge and clinical leadership in Partnership networks. These Partnership efforts focus on strengthening 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.

American Indian/Alaska Native populations face many health disparities. To help remedy known 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. Partnership is also heavily involved in other activities geared towards addressing health disparities among other populations and are later described in this report.

To help support health education/culture and linguistics, Partnership created member-facing videos on several topics to help educate members in a more interactive way in 2024. Topics included preventive care, vaccines safety and efficacy, and mental health. Each of Partnership's counties has a dedicated county resource page and the support of Partnership's Population Health Department in accessing those resources. These resources are continuously updated and improved upon, and Population Health staff monitor and follow up on resource needs of members. Partnership will also 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. Furthermore, Partnership Member Services staff are conducting in-person presentations called Member (or Community) Informative Sessions". Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff also provide in-the-moment support, helping members navigate their

transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Finally, Partnership will continue to offer members an opportunity to submit grievances and appeals and will further its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings.

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. 2024 Health Disparities data)

1. 2024 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2024. 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, and members enrolled in the California Children's Services Program.

2. Local Community Needs Assessments

The Community Needs Assessment section was compiled using the most recent versions of publicly available Community Health Assessment (CHA), Community Health Improvement Plans (CHIPs), or Local Community Health Needs Assessment (CHNA) reports from each of Partnership's 24-county service area. The reports were published in different years ranging from 2022-2025. Some of Partnership's counties have CHA reports in progress, set to be released in the near future. The reports used to summarize needs in each county are based on the most recent reports available.

3. 2024 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.[3] The 2024 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, and 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. 2024 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.,

[3] Robert Wood Johnson Foundation, About Us, 2024

pharmacy claims). The 2024 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, and claims from our delegated managed behavioral healthcare organization (Carelon Behavioral Health).

5. 2024 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a measurement tool maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used to evaluate clinical quality in a standardized way. The California Department of Healthcare Services (DHCS) and NCQA selects a subset of measures for Medi-Cal plans to report on annually as required for State and NCQA Accreditation reporting. NCQA and DHCS use annual HEDIS performance reporting to evaluate the delivery of quality care and services to its members. For Measurement Year 2024 (MY2024) Partnership will be required to report the HEDIS measures at the plan-wide level to include all (24) counties. The DHCS required reporting measures is referred to as the Managed Care Accountability Set (MCAS); the methodology for each HEDIS measure is described in the annual NCQA HEDIS Technical Specifications corresponding to the measurement year.

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 based on the National Medicaid benchmarks and varies by each measure.

In addition to the DHCS required reporting, Partnership is also required to report the HEDIS performance for HealthPlan Accreditation. Rate performance and scoring is based on the NCQA HealthPlan Rating Methodology. The MY2024 Annual Summary of Performance Report for both the DHCS and HPA will be posted on the Partnership HealthPlan Website in August 2025. 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. 2024 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. 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Partnership has chosen Press Ganey (PG) to conduct member surveys in alignment with the National Committee for Quality Assurance (NCQA). These surveys aim to gather information about members' experiences with their health plan and healthcare providers. The feedback collected helps our plan understand the experiences of covered members/patients and their families across the provider network and health plan delivery.

The CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys ask adult members and parents or guardians of child members to provide feedback on a range of 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
- Effectiveness of Care Measures

This needs assessment report will focus on the composite scores for the following performance measures concerning adults and children: 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.

The CAHPS survey for Measurement Year (MY) 2023 and Reporting Year (RY) 2024 will cover the period from July 1, 2023, to December 31, 2023.

8. 2024 Health Disparities Data Report

In 2024, Partnership convened a multidisciplinary team to assess health disparities in our member population as part of a grand analysis to complete the HE 6: Reducing Healthcare Disparities report which was completed in September 2024. 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 2023 (MY 2023) Health Plan Accreditation final measure samples (n=186 to 167,450 members) to evaluate each of the clinical measures of focus later described in the health disparities 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 specific demographic information in our various regions, we reference United States Census Bureau reports, which includes the SAIPE State and County Estimates for 2023.

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 2024, Partnership served approximately 895,129 Medi-Cal beneficiaries in 24 counties in Northern California. Partnership primarily serves children and adults under the age of 65. In 2024, Partnership served approximately 582,593 adults and 312,216 children. In 2024, Partnership worked 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 recent Department of Health Care Services requirement expanded 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). The needs of this population vary and are further described under the Local Community Needs Assessment and throughout this document.

2. Geographic Distribution

In 2023, Partnership's service area included Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo Counties. In January 2024, Partnership added 10 new counties to our service area: Tehama, Glenn, Colusa, Butte, Sutter, Yuba, Plumas, Sierra, Nevada and Placer. Partnership's 4 regional offices are centrally located in Fairfield, Redding, Santa Rosa, and Eureka. In 2024, Partnership opened two new regional locations in Auburn and Chico 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

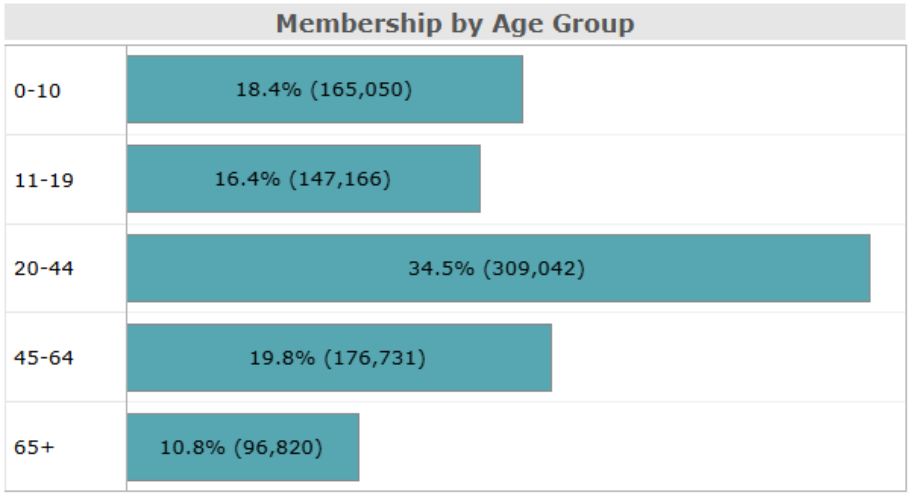
Figure 1: Map of Partnership Counties as of January 2024

Partnership, 2024

3. Age and Gender

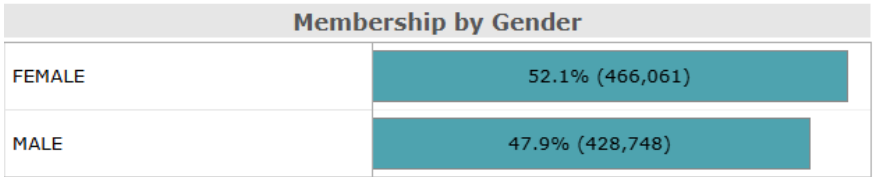
According to December 2024 Partnership enrollment data, 18.4% of members are ages 0-10, 16.4% of members are ages 11-19, 34.5% of members are ages 20-44, 19.8% of members are ages 45-64, and 10.8% of members are ages 65 and older. Additionally, 52.1% of members are female while 47.9% are male (see Figures 2 and 3). There were 11,295 babies born to Partnership members during 2024.

Figure 2: 2024 Partnership Membership by Age Group



December 2024 Member Enrollment Data, Partnership

Figure 3: 2024 Partnership Membership Gender

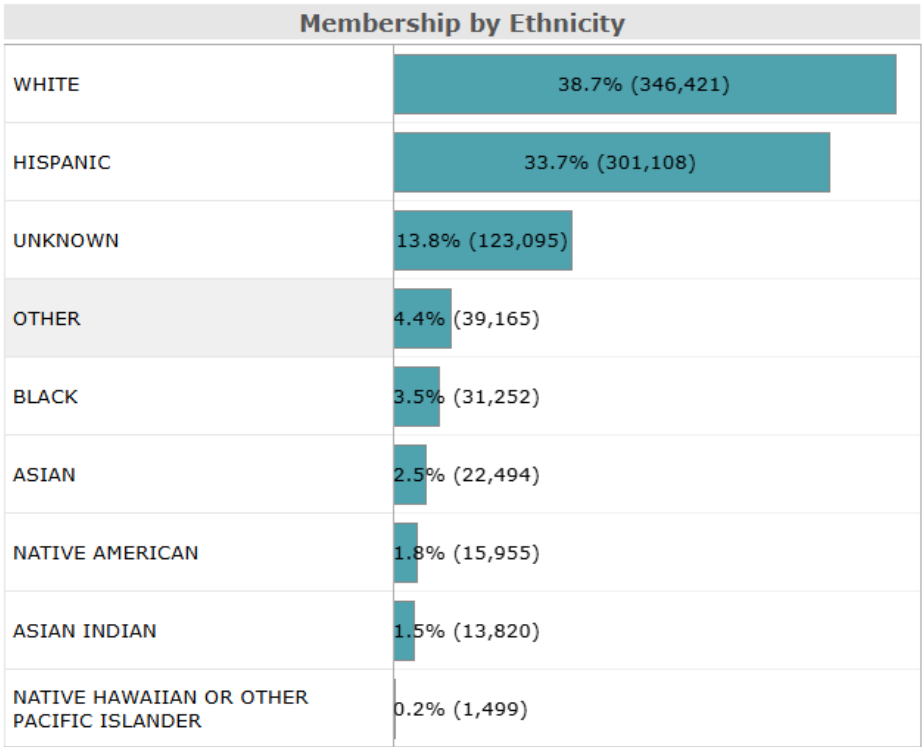


Source: December 2024 Member Enrollment Data, Partnership

4. Race/Ethnicity

The largest ethnic groups across all 24 counties are White (38.7%) and Hispanic (33.7%). Figure 4 illustrates the racial and ethnic composition of Partnership's members as of December 2024. One limitation with the race/ethnicity category is Hispanic as a category tends to outweigh other races, and multi-racial categories tend not to be reported at all. Furthermore, there are different rates of multiethnic reporting by members when signing up for Medical when compared to the census. This limits the accuracy of interpretation or racial disparities, such that small differences may not need to be intervened upon.

Figure 4: 2024 Partnership Membership by Race/Ethnicity

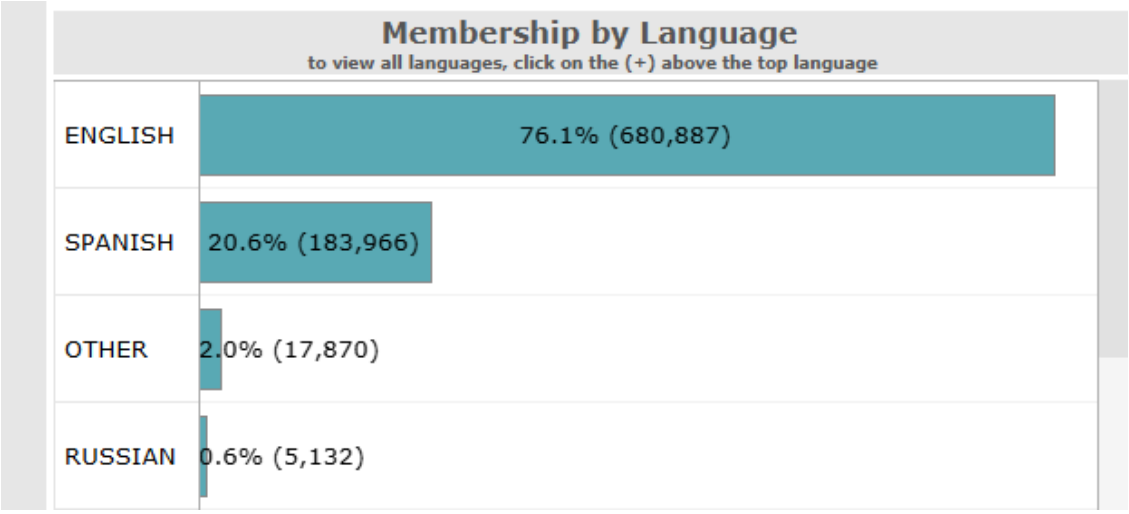


Source: December 2024 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2024 enrollment data, 76.1% of members identify as English speaking and 24% identify as limited English proficiency (LEP). Partnership has 3 threshold languages – Spanish, Russian, and Tagalog. New threshold languages are added as needed. Members identifying as Spanish speaking total 20.6%. Russian and Tagalog speakers account for 0.9% of LEP members, while 2.5% of the population speaks a language other than the 3 threshold languages. This data demonstrates a need to ensure LEP members can access care in their own language to stay healthy.

Figure 5: 2024 Partnership Membership by Primary Language

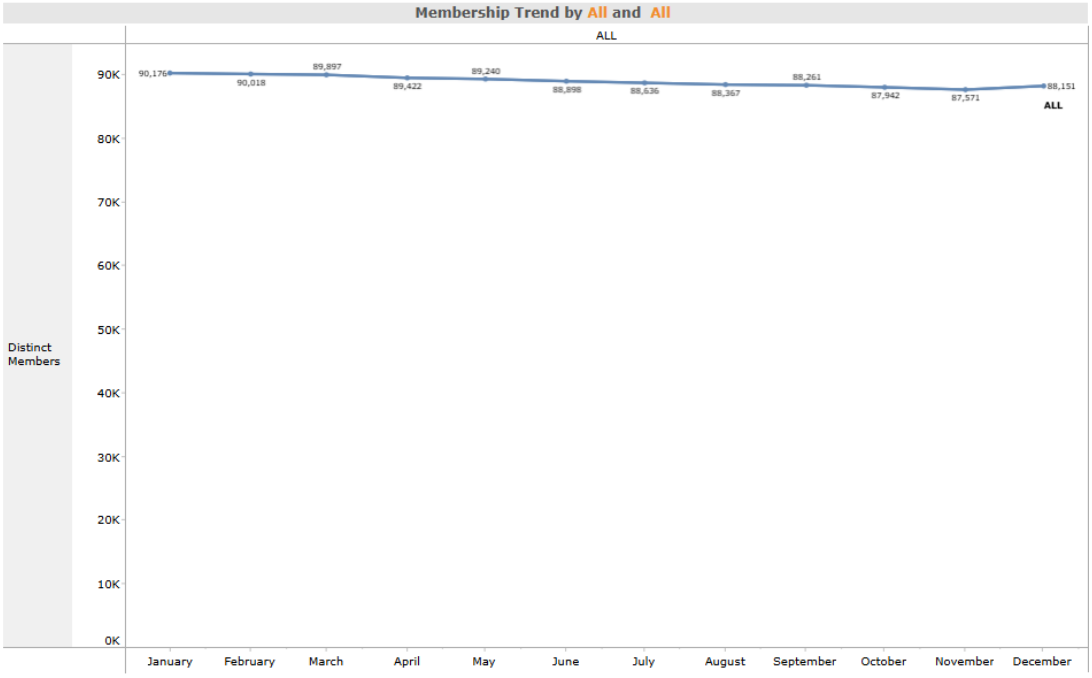


Source: Partnership's December 2024 Member Enrollment Data

6. Disability

Based on December 2024 Partnership enrollment data, approximately 88,151 members are disabled as shown in Figure 6. Furthermore, 9,605 of all disabled members are ages 0-20; 71,396 are ages 21-64; and 23,399 are ages 65 and older. Finally, 51,043 of all disabled members are males while 48,822 are females. Furthermore, California Children's Services (CCS) supports children with complex physical health needs; this program had 11,041 member enrollees as of December 2024. Together this data demonstrates there is a significant number of members with disabilities that may require additional care and resources to remain healthy.

Figure 6: 2024 Partnership Membership Disability Category Trend



Source: Partnership's December 2024 Member Enrollment Data

IV. Local Community Needs Assessment

A. Summary of Local Community Needs Assessments

In January 2024, Partnership expanded its service area to include an additional 10 counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Tehama Sierra, Sutter and Yuba. Since then, Partnership's service area has covered 24 counties, each with a diverse demographic makeup. This 2025 PNA includes assessments of Partnership's existing and newly added counties.

Since late 2023, Partnership has actively collaborated with Local Health Jurisdictions (LHJs) to engage in the assessment and health improvement planning processes led by each LHJ. This collaboration involved participating in and supporting each county's Community Health Assessment (CHA), Community Health Needs Assessment (CHNA), and Community Health Improvement Plan (CHIP). Through this collaboration and a review of the available CHA reports (or similar documents) from the 24 counties, a range of priority need areas and gaps in services or care were revealed. Partnership aims to align its activities with the identified priority needs across its service area.

The Local Community Health Assessment section of this report was compiled using the most recent publicly available Community Health Assessment (CHA), Community

Health Improvement Plan (CHIP), and/or Community Health Needs Assessment (CHNA) reports from the 24 counties, published primarily between 2022 and 2025 by LHJs and non-profit hospitals. Although the 24-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 24 counties can be grouped into the Healthy People 2030 categories: economic stability; healthcare access and quality; neighborhood and built environment; education access and quality; and social and community context.[5] Recognizing the prominent themes of the assessments collectively and their alignment within these categories help to provide clarity on the SDoH impacts to the health of our members.

Economic Stability

- Theme: Economic Instability and Poverty
    - High poverty rates, unemployment, economic instability, and disparities in access to social services.
- Theme: Food Insecurity
    - Rising rates of food insecurity, limited access to supermarkets, and challenges in promoting healthy eating habits.

Healthcare Access and Quality

- Theme: Limited Access to Healthcare
    - Barriers to accessing primary, specialty, and dental care are prevalent, including transportation challenges, and healthcare provider shortages.
- Theme: Behavioral and Mental Health Needs
    - High rates of suicide, substance use disorders, and the need for comprehensive mental/behavioral health services.
- Theme: Chronic Disease and Injury Prevention
    - High rates of chronic illnesses like heart disease, diabetes, and obesity, as well as unintentional injuries including overdose and motor vehicle collisions.

Neighborhood and Built Environment

- Theme: Homelessness and Housing Affordability

[5] Healthy People 2030 Social Determinants of Health

    - Lack of affordable housing, homelessness, and associated stressors impacting health and stability.
- Theme: Transportation and Geographic Isolation
    - Transportation limitations and geographic isolation, especially in rural areas, hinder access to healthcare, resources, and economic opportunities.
- Theme: Environmental and Physical Risks
    - Vulnerability to wildfires, extreme heat, and drought, as well as disparities in access to green spaces and safe neighborhoods.

Education Access and Quality

- Theme: Educational and Technological Disparities
    - Low educational attainment and limited internet access hinder opportunities for economic mobility and access to telehealth services.

Social and Community Context

- Theme: Community and Social Support Needs
    - A strong need for fostering community connections, safe neighborhoods, and guidance through healthcare systems, along with leveraging trusted leaders and institutions.

A scan of the county's health assessments reveals widespread concerns about access to care, behavioral health, and other social determinants of health. Many counties struggle with a lack of healthcare providers, transportation barriers, and economic instability. Behavioral health issues, including mental health challenges and substance use, are consistently identified as major priorities. Social determinants such as income inequality, housing insecurity, and food deserts disproportionately impact marginalized communities, amplifying health disparities.

Disparities in health outcomes are commonly noted, with racial minorities, LGBTQ+ individuals, and Indigenous populations facing unique challenges. For instance, African American residents in Marin County experience lower life expectancy and higher premature death rates, while Indigenous communities in Mendocino and Shasta Counties report historical trauma and exclusion. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further underline the need for targeted interventions to support vulnerable populations.

Despite these challenges, counties have identified opportunities to improve health outcomes through collaboration and leveraging community strengths. Resilience, close-

knit communities, successful partnerships, resourcefulness, and existing support programs offer a foundation for positive change which can be leveraged to improve health outcomes through targeted interventions and collective action.

1. Butte County

In 2024, Butte County published its Community Health Improvement Plan,[6] focusing on three priority areas: Access to Care, Behavioral Health, and Food Security. These priorities were identified based on the six health needs outlined in the 2023 Community Health Assessment.[7] While ongoing efforts are required to address these critical areas, the county has valuable assets at its disposal, including public, nonprofit, and tribal healthcare providers, as well as Community Health Workers. Existing programs, such as the Boys and Girls Club, the Butte County Department of Behavioral Health, culturally tailored support groups, and numerous organizations and collaboratives dedicated to combating food insecurity, will play an integral role. The CHIP aims to harness these resources, focusing on strengthening and improving the county's overall health outcomes in these areas.

2. Colusa County

Colusa County Public Health completed its Community Health Assessment in 2024, identifying seven strategic issues: Access to Medical Healthcare Services, Access to Behavioral Healthcare Services, Access to Existing Services and Resources, Affordable Housing, Lack of Economic Opportunity and Sustainability, ACEs Prevention and Response, and Environmental Health Risks.[8] The assessment also highlighted the county assets, which are strong community engagement and collaboration, abundant resources, and supportive programs like the Mobile Health Clinic, Safe Haven, and the Emergency Domestic Well Program, all of which will support efforts to improve community health.

3. Del Norte County

Del Norte County recently completed their 2024 Community Health Assessment,[9] which identified multiple health needs. These health needs include high rates of substance abuse and mental health challenges, chronic diseases, insufficient oral and healthcare access, poor maternal and child health outcomes, and environmental health risks. Del Norte CHA revealed multiple strengths which include a resilient community, abundant outdoor resources like trails and beaches, and supportive programs such as CalFresh

[6] Butte County Community Health Improvement Plan 2024-2027
[7] Butte County Community Health Assessment Report 2023
[8] Colusa County Community Health Assessment Report 2024
[9] Del Norte County 2024 Community Health Assessment

and WIC that foster collaboration and well-being. These efforts aim to address disparities while leveraging the community's strengths.

4. Glenn County

Glenn County's 2024 Community Health Assessment identified seven health priorities during the assessment process.[10] These priorities were Access to Resources, Medical Provider Shortage, Behavioral Health Systems, Transportation, ACEs (Adverse Childhood Experiences), Income, and Safety. The assessment also highlighted community strengths that supported efforts to address the top four health needs. Despite its small size, the county featured numerous community strengths, including resources such as a senior center and substance use disorder programs. It offered a variety of services, including urgent care, transportation, and specialized healthcare. The community strengths highlight how the community comes together to help one another, ensuring that people have access to the support they need.

5. Humboldt County

Humboldt's last Community Health Assessment (CHA) was completed in 2018.[11] The CHA showed a range of community health concerns such as access to primary, specialty care and mental health services. During the Community Health Improvement Planning cycle, new data was revealed, and 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.[12] 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 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.

The 2024 Community Health Needs Assessment (CHNA) by the Southern Humboldt Community Healthcare District focuses on its 775-square-mile service area in

[10] Glenn County Community Health Assessment Report 2024
[11] 2018 Humboldt County Community Health Assessment
[12] 2022 Enhanced Humboldt County Community Health Assessment

northwestern California.[13] The findings align with public health concerns identified in the 2018 Humboldt CHA and the 2022 enhanced assessment, but they also highlight emerging challenges within the service area. These include the growing risks posed by wildfires and drought to community health and safety, as well as the limited availability of affordable housing and unreliable high-speed internet, which are obstacles to economic growth and the recruitment of skilled workers.

6. Lake County

Lake County's most recent CHA was completed in 2022.[14] Their priority areas are insufficient access to care, health risk behaviors, and mental health. Concerns with 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.

7. Lassen County

As of December 2024, Lassen County has not yet finalized their CHA. However, work is underway, with a contractor engaged to manage the coordination among partners including Partnership. This process began in December 2023 and is ongoing throughout 2024 and into early 2025.

Other local health assessments have been completed. According to Banner Health's 2022 CHNA by Banner Lassen Medical Center, Lassen County's priority needs include: access to care, chronic disease management, and behavioral health.[15] The same assessment also identifies areas of strength for Lassen County, such as health behaviors (lower rates of physical inactivity and sexually transmitted diseases), clinical care (uninsured and dentists), and social and economic factors (unemployment and income inequality). In these areas, when compared to the state, Lassen has health data that is stronger.

[13] Southern Humboldt Community Healthcare District 2024
[14] 2022 Lake County Community Health Assessment
[15] 2022 Banner Health Community Health Needs Assessment

8. Marin County

Marin County completed their last CHA in 2022.[16] 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.

9. 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.[17] 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).

10. Modoc County

Modoc County released their last Community Health Needs Assessment (CHNA) in January 2024.[18] Modoc's CHNA identifies significant health and socio-economic challenges, particularly in its classification as a rural frontier county. Modoc County faces high poverty, unemployment, low educational attainment, and limited access to healthcare. It has higher rates of chronic disease, risk behaviors, and poor physical and mental health when compared to California. These factors are contributing to increased disability and earlier mortality. However, Modoc County benefits from less pollution,

[16] 2022 Marin County Community Health Assessment
[17] 2023 Mendocino County Community Health Improvement Plan
[18] 2024 Modoc County Community Health Needs Assessment

including cleaner air and water, than most other counties in the state. The community has identified that mental health, substance use, chronic disease, and domestic violence are notable concerns. Barriers to health include poverty, inadequate job opportunities, limited healthcare access, and insufficient public transportation. Prenatal care rates are also a concern with less births receiving early care at significantly lower rates than California's average. While Modoc County has significantly higher rates of homeownership, the median household income is low with nearly 30% of all children living in poverty. Key recommendations include economic and workforce development, improving transportation, offering more community activities and recruiting additional healthcare providers to address healthcare service gaps and improve health outcomes.

11. Napa County

Napa County completed its recent Community Health Improvement Plan (CHIP) in November 2024, identifying five key health priorities: housing, behavioral health, access to health services, racial equity and LGBTQIA+ inclusion, and economic stability.[19]

Key challenges were identified in the housing sector, including the rising cost of living, low wages, and limited availability of affordable housing options. In the area of mental health, systemic and cultural challenges persist, such as a shortage of mental health professionals, clinician burnout, increased patient caseloads, and the stigma surrounding access to care. County residents reported significant difficulty accessing healthcare services due to several factors: long wait times, reliance on emergency departments (ED) as a first point of care, a complex healthcare system, and barriers to accessing transgender healthcare services. Racism was also cited as a major barrier for residents of color, with limited representation in leadership positions, and challenges in interactions with law enforcement. Many families highlighted the need for higher wages and greater employment opportunities to meet the high cost of living.

Despite these persistent challenges, Napa County has notable strengths, including strong system cohesion, efficient emergency response capabilities, access to green spaces, and a high-quality public service sector. These assets, alongside community stakeholder engagement, will be instrumental in supporting ongoing action planning and improving the health priority areas identified in the CHIP.

12. Nevada County

The 2025 Nevada County Community Health Improvement Plan identified the following health areas of focus: comprehensive healthcare and social services, affordable early learning and care (ELC) programs, and vaccination rates for children.[20] Healthcare

[19] 2024 Napa County Community Health Improvement Plan
[20] 2025 Nevada County Community Health Improvement Plan

access included lack of providers, siloed healthcare delivery system, and gaps in care coordination. Issues were identified within the county's ELC provider network, such as limited geographic access to affordable care programs and transportation barriers for families with low socioeconomic status. Local data indicated that 82% of kindergarten students were fully up to date with required vaccines, which is lower than the state's average. The county's assets include a strong network of community-based organizations, dedicated healthcare providers, and active partnerships among local agencies. These resources contribute to ongoing efforts to improve health outcomes and address gaps in service delivery.

13. Placer County

The 2024 Placer County Community Health Improvement Plan highlighted the following health priorities: lifestyle and preventative health concerns, aging and older adults, and the built environment.[21] Lifestyle and preventive health concerns highlighted the need for improved access to nutrition, physical activity, and chronic disease management, with a focus on reducing health disparities. Aging populations face challenges related to healthcare access, service availability, and aging in place, especially in rural areas. The built environment priority aims to improve infrastructure to support healthy living, such as safer housing, better transportation, and more accessible public spaces. Placer County's assets include a robust network of healthcare providers, community organizations, and strong partnerships that support these initiatives and work to reduce health inequities and enhance the well-being of all residents.

14. Plumas County

Plumas County published its Community Health Improvement Plan in 2023, identifying the top three priorities selected by the community.[22] The three priority health issues were: Drug and Alcohol Abuse and Overdose, Limited Access to Preventive Services, and Suicide. Other areas of focus included priority gaps, such as resource knowledge, coordination, and navigation, family support, harm reduction, and sustainability. These gaps were to be addressed through interventions targeting priority health issues.

15. Shasta County

The 2023 Shasta County Community Health Assessment (CHA) identified nine key health needs: access to basic needs such as housing, jobs, and food; a safe, violence-free environment; access to mental and behavioral health and substance-use services; increased community connections; access to quality primary care; access to specialty and extended care; system navigation; injury and disease prevention and management;

[21] 2024 Placer County Community Health Improvement Plan
[22] Plumas County Community Health Improvement Plan 2023-2028

and access to functional needs.[23] When compared to the previous CHA, it is clear that several health concerns persist, including issues related to housing, medical providers, mental health resources, substance abuse, employment, and rural transportation. Unintentional injuries, including drug-related deaths, are a leading cause of death in the county, with rates surpassing state averages. Shasta County also ranks high in cancer-related deaths. These ongoing challenges highlight the need for sustained investment in community infrastructure to address complex problems effectively. Shasta County also faces significant economic disparities. These economic challenges are compounded by rising housing costs and a lack of affordable childcare, which affects many low-income families. Additionally, the county has a notably high rate of children entering foster care, particularly infants, and struggles with high levels of emotional abuse and maltreatment.

The Indigenous community in Shasta County also faces unique challenges, including a lack of inclusion, barriers to maintaining cultural practices, and inadequate mental health resources. There is an emphasized need for more programs supporting Indigenous welfare, cultural preservation, and services for youth. Despite these challenges, the community's strengths lie in its cultural traditions, elders, and practices, which could play a central role in fostering community well-being.

16. Sierra County

The 2023 Sierra County Community Health Assessment findings, based on both data analysis and community feedback, highlighted the following priority health needs: teen electronic cigarette use, teen mental health, adult mental health, adult cigarette smoking, adult drinking, access to healthy foods, recreational activity, services, communication, and community.[24] The county's assets within the community, including the area's natural beauty, outdoor recreational activities, strong community support, local health initiatives, and outreach efforts.

17. Siskiyou County

Siskiyou County is currently developing an updated CHNA for 2025. Although this CHNA is in progress, the previously released CHNA in 2022identified 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, 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.[25] Geographic distance and barriers contribute

[23] 2023 Shasta County Community Health Assessment
[24] Sierra County Health Assessment 2023
[25] 2022 Siskiyou County Community Health Needs Assessment

significantly to food deserts, limited access to healthcare, public transportation, limited broadband access and fewer economic opportunities. Communities that are 1.5hr+ from the I5 corridor are ranked in the bottom 99% of healthy communities. Other themes that arose were strengthening community relationships and improved workforce infrastructure. Siskiyou was able to identify 139 resources with potential to help meet the needs of the county service area.

18. Solano County

Solano County is planning for an updated Community Health Assessment (CHA) in 2025. The current CHA, covering the period from 2020 to 2025, identified eight priority health areas, which include: socioeconomic challenges, lack of access to safe and secure housing, barriers to accessing healthcare, poorer educational outcomes compared to the state average, higher rates of domestic violence hospitalizations, injury deaths (both intentional and unintentional), and violent crimes, as well as elevated rates of opioid use and suicide ideation.[26] The CHA also identified barriers to healthy eating and active living, and poor maternal and infant health outcomes. Following the CHA, Solano County released its CHIP in January 2023.[27] The CHIP outlines several strategic priorities to address the top health needs identified in the CHA: workforce development, community and youth engagement, equity-driven investments, harm reduction, alongside enhanced access to healthcare services.

19. 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.[28]

20. Sutter County

Sutter County published its Community Health Improvement Plan in 2023, outlining three health priorities for the next 3-5 years: combating homelessness, building resilient communities (with a focus on adverse childhood experiences, behavioral health, and

[26] 2020 Solano County Community Health Assessment
[27] 2023 Solano County Community Health Improvement Plan
[28] 2023 Sonoma County Community Health Assessment and Improvement Plan

nutrition/food access), and reducing STIs.[29] In its 2022 Community Health Assessment, Sutter County highlighted numerous community resources that promote health and well-being, including parks, bike paths, and senior activities.[30] The Sutter-Yuba Homeless Consortium addresses homelessness, while programs such as Family S.O.U.P. and the Yuba/Sutter Resiliency Connection support families and foster resilience. Cultural groups celebrate diversity, and agriculture is showcased through farmers' markets. The Sutter County Public Health Branch works to ensure equitable access to these resources and will leverage them to address the three health priorities.

21. Tehama County

Tehama County's 2023 Community Health Assessment reveals many challenges that its residents confront, including high poverty and unemployment rates, low educational attainment, and restricted access to healthcare.[31] Tehama has the sixth lowest per capita income in the state and inequities exist geographically within the county, with rates of poverty varying greatly among communities. Tehama also ranks in the zero percentile for park access. While Tehama has better air and water quality, the area experiences significant risks for wildfire due to extreme heat and drought.

These interconnected issues significantly impact health, leading to premature death and reduced life expectancy among the population. The insights gained from this assessment are crucial for the development of Tehama's CHIP, currently in progress as of December 2024. By pinpointing critical areas for strategic, collective action, efforts can be mobilized to enhance health outcomes and foster a healthier future for all Tehama residents.

22. Trinity County

Trinity County released a Community Health Equity Assessment in 2023, that highlights many needs of the county.[32] Main drivers of health inequity identified were poverty, isolation, limited economic opportunity, and lack of affordable housing. Other significant health disparities include 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, including the highest rates of suicide in the state, and higher rates of deaths related to unintentional injuries. Educational disparities; lower rates of internet access compared to California; higher rates of violent crime higher rates of suicide, higher rates of death from unintentional injuries, motor vehicle collisions and overdose. Approximately 1 in 5 Trinity

[29] Sutter County Community Health Improvement Plan 2023
[30] Sutter County Community Health Assessment 2022
[31] 2023 Tehama County Community Health Assessment
[32] 2023 Trinity County Health Equity Assessment

County residents had one or more disabilities with higher rates among American Indian/Alaska Native residents. Challenges also include higher rates of risk-adjusted hospitalizations due to chronic conditions; transportation limitations; technology limitations, and inadequate and unequal insurance coverage. Over half of Trinity County community members also identified economic instability and the physical environment as a root cause of inequity, with many families experiencing hardship but not qualifying for social service assistance.

Despite these challenges Trinity County has several assets, including successful interventions that foster partnerships across sectors, mobile services, trust-building programs. Potential interventions to improve health equity include “meeting people where they are”, accessible services, robust communication with micro-communities, health education on disease prevention, incentives for providers, and securing funding for community efforts. Trinity also boasts strengths such as pride, personal responsibility, resourcefulness, and a close-knit community.

23. Yolo County

Yolo County’s most recent CHA was completed in 2023.[33] 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.[34] 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.

24. Yuba County

Yuba County’s Community Health Improvement Plan for 2023-2028 outlined key priorities aimed at enhancing the well-being of the community.[35] These priorities included healthcare access, mental health services, and the creation of safe neighborhoods and built environments. The community’s strengths, identified in the 2022 Community Health Assessment, such as a lower cost of living compared to urban

[33] 2023-2025 Yolo County Community Health Assessment
[34] 2023-2025 Yolo County Community Health Assessment
[35] 2023 Yuba County Community Health Improvement Plan

centers, access to natural areas like mountains and the ocean, and strong local resources such as public transportation and available services in areas like nutrition and legal support provide a solid foundation for the county's efforts to foster a healthier and more vibrant community.[36]

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 conditions in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These conditions are in turn shaped by a wider set of forces: economics, social policies and politics."[37] Healthy People 2030 offers several examples of SDoH including income, polluted air, access to healthy foods and physical activity, and safe housing.[38]

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 2023, County Health Rankings & Roadmaps data, and local, publicly 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.[39]

[36] 2022 Yuba County Community Health Assessment
[37] World Health Organization. "Social Determinants of Health." *Health Topics*.2025
[38] Healthy People 2030, Social Determinants of Health
[39] SAIPE Data, U.S. Census Bureau, 2024

Table 1: SAIPE State and County Estimates 2023

Partnership Northern Region	Median Household Income
California	**$95,473**
Del Norte	$70,231
Humboldt	$61,307
Lassen	$77,743
Modoc	$51,996
Shasta	$71,935
Siskiyou	$58,975
Tehama	$77,719
Trinity	$52,079

Partnership Southern Region	Median Household Income
California	**$95,473**
Lake	$51,848
Marin	$135,960
Mendocino	$63,621
Napa	$98,580
Solano	$92,711
Sonoma	$96,312
Yolo	$82,359

Partnership Eastern Region	Median Household Income
California	**$95,473**
Butte	$65,000
Colusa	$60,000
Glenn	$58,000
Nevada	$87,142
Sutter	$70,000
Yuba	$62,000
Placer	$110,020
Plumas	$64,121
Sierra	$67,675

Source: United States Census Bureau 2024

2. Air Pollution and Wildfires

In 2024, 118 wildfires in Partnership's regions burned more than acres 853,412. 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.[40] 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 2024 (Measurement Year 2019).[41] The Partnership County with the highest rates of air pollution is Plumas at 12.2.

Table 2: Air Pollution – Particulate Matter by Partnership County in 2024

Partnership Northern Region	Air Pollution- Particulate Matter
California	***7.1***
Del Norte	6.1
Humboldt	6.8
Lassen	6.0
Modoc	5.8

Partnership Southern Region	Air Pollution - Particulate Matter
California	***7.1***
Lake	3.1
Marin	6.4
Mendocino	6.0
Napa	5.9

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***7.1***
Butte	7.1
Colusa	7.0
Glenn	7.8
Nevada	6.3

[40] Environmental Protection Agency (EPA), 2024
[41] County Health Rankings, Air Pollution: Particulate Matter, 2024

Partnership Northern Region	Air Pollution-Particulate Matter
California	***7.1***
Shasta	6.6
Siskiyou	5.8
Tehama	5.4
Trinity	6.8

Partnership Southern Region	Air Pollution - Particulate Matter
California	***7.1***
Solano	9.0
Sonoma	5.7
Yolo	7.7

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***7.1***
Sutter	8.5
Yuba	8.7
Placer	7.2
Plumas	12.2
Sierra	5.1

Source: 2024 County Health Rankings & Roadmaps

Table 3 below shows how many fires occurred and the amount of acreage burned in each county in 2024. Butte and Tehama County were the counties with the most acreage burned in 2024 at 382,642 and 376,537 acres, respectively.

Table 3: Number of Wildfires and Acreage Burned by Partnership County in 2024

Partnership County	Number of Fires in 2024	Acres Burned in 2024
Butte	16	382,642
Colusa	3	21,961
Del Norte	0	0
Glenn	2	79
Humboldt	8	20,376
Lake	5	3,473
Lassen	8	1,025
Marin	1	18
Mendocino	5	144
Modoc	7	6,892
Napa	0	0
Nevada	1	28
Placer	10	1839
Plumas	1	3,007
Shasta	9	5,561
Sierra	2	3,723
Siskiyou	9	16,240
Solano	7	1,093
Sonoma	8	1,381
Sutter	0	0
Tehama	8	376,537
Trinity	3	7,290
Yolo	0	0
Yuba	5	103

Partnership County	Number of Fires in 2024	Acres Burned in 2024
Total	**118**	**853,412**

Source: [2024 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 "2024 Results of the 2023 California Youth Tobacco Survey" that 7.3% of California high school respondents used tobacco in the last 30 days since completing the survey.[42] Vaping also continues to be a concern. Reponses showed that 29% of California high school respondents report being exposed to secondhand vapor in a car or room in the last 2 weeks, and about a third (42.1%) 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.[43] With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate young people and parents on the harmful effects of tobacco use.

County Health Rankings and Roadmaps say that on average, 9% of adults in Reporting Year 2024 (Measurement Year 2021) 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 19%.

Table 4: 2024 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate
California	***9%***
Del Norte	17%
Humboldt	17%
Lassen	19%
Modoc	17%
Shasta	15%

Partnership Southern Region	Adult Smoking Rate
California	*9%*
Lake	16%
Marin	9%
Mendocino	15%
Napa	11%
Solano	12%

Partnership Eastern Region	Adult Smoking Rate
California	***9%***
Butte	15%
Colusa	14%
Glenn	16%
Nevada	12%
Sutter	14%

[42] 2024 California Department of Public Health Results of the 2023 California Youth Tobacco Survey
[43] Center for Disease Control and Prevention. Secondhand Smoke.

Partnership Northern Region	Adult Smoking Rate
California	***9%***
Siskiyou	16%
Tehama	16%
Modoc	17%
Shasta	15%

Partnership Southern Region	Adult Smoking Rate
California	*9%*
Sonoma	11%
Yolo	11%

Partnership Eastern Region	Adult Smoking Rate
California	***9%***
Yuba	15%
Placer	14%
Plumas	10%
Sierra	13%

Source: 2024 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.[44]

The 2024 County Roadmaps and Rankings measure physical inactivity as the percentage of adults aged 18 and over reporting no leisure-time physical activity, with higher values indicating less physical activity. In Reporting Year 2024 (Measurement Year 2021), the California state average was 20%. Among counties covered by Partnership HealthPlan, the Northern Region had physical inactivity rates equal to or higher than the state average. In contrast, the Southern Region and Eastern Region matched the state average but also displayed variations with some counties showing higher rates than state levels. Napa (18%), Sonoma (18%), Marin (13%), Nevada (15%), Placer (15%), Plumas (18%), and Sierra (18%) had rates of physical inactivity that were better than the state average.

Table 5: 2024 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity
California	***20%***
Del Norte	23%
Humboldt	20%
Lassen	22%
Modoc	22%
Shasta	20%
Siskiyou	21%
Trinity	22%

Partnership Southern Region	Physical Inactivity
California	***20%***
Lake	24%
Marin	13%
Mendocino	21%
Napa	18%
Solano	21%
Sonoma	17%
Yolo	20%

Partnership Eastern Region	Physical Inactivity
California	***20%***
Butte	20%
Colusa	26%
Glenn	25%
Nevada	15%
Sutter	24%
Yuba	23%
Placer	15%

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

Partnership Northern Region	Physical Inactivity
California	***20%***
Tehama	23%

Partnership Southern Region	Physical Inactivity
California	***20%***

Partnership Eastern Region	Physical Inactivity
California	***20%***
Plumas	18%
Sierra	18%

Source: 2024 County Health Rankings & Roadmaps. Red indicates higher than California average.

5. Severe Housing Problems

As of November 2024, there are approximately 187,084 unhoused people in California.[45] Additionally, 27% 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. Severe housing problems remain a significant issue in California. In Reporting Year 2024 (Measurement Year 2020), many of Partnership's service area members continued to experience severe housing problems, especially in counties such as Humboldt (25%), Mendocino (24%), Yolo (23%), Shasta (21%), Marin (22%), Napa (22%), Sonoma (22%), Glenn (22%), and Nevada (20%). See Table 6.[46] Partnership's Southern Region experiences higher levels of severe housing problems, likely due to its proximity to the San Francisco Bay Area and Sacramento, while the Eastern Region shows notable challenges in counties such as Glenn and Nevada.

Table 6: 2024 Rate of Severe Housing Problems by Partnership County

Partnership Northern Region	Severe Housing Problem
California	**26%**
Del Norte	19%
Humboldt	25%
Lassen	15%
Modoc	12%
Shasta	21%
Siskiyou	17%
Trinity	21%
Tehama	22%

Partnership Southern Region	Severe Housing problem
California	**26%**
Lake	20%
Marin	22%
Mendocino	24%
Napa	22%
Solano	20%
Sonoma	22%
Yolo	23%
Napa	22%

Partnership Eastern Region	Severe Housing Problem
California	***26%***
Butte	21%
Colusa	17%
Glenn	22%
Nevada	20%
Sutter	19%
Yuba	19%
Placer	16%
Plumas	15%
Sierra	20%

Source: 2024 County Health Rankings & Roadmaps

[45] HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations

[46] County Health Rankings, Severe Housing Shortage, 2024

6. Food Environment Index

The Food Environment Index (FEI) accounts for 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." Many areas across Partnership's 24 counties are designated as food deserts—areas where healthy and fresh foods are not readily available for people to access. In these regions, processed foods high in sugar, sodium, fat, and additives often dominate what is available. Additionally, some communities lack food pantries or other supplemental food resources, further restricting access to healthy foods.

The FEI considers three factors: the distance someone lives from a grocery store or supermarket, the availability of locations to purchase healthy foods within communities, and financial barriers to accessing healthy foods. According to the County Health Rankings and Roadmaps Reporting Year 2024 (Measurement Year 2020), California scored a high 8.6 on a scale from 0 (worst) to 10 (best).[47]

Partnership's regions show a range of scores reflecting regional disparities:

- Northern Region: FEI ranges from 6.2 in Modoc County to 7.7 in Lassen County.
- Southern Region: FEI is highest in Marin County (9.3) and lowest in Lake County (7.8).
- Eastern Region: FEI is highest in Placer County (8.9) and lowest in Colusa County (6.9).

Counties with the highest scores include Marin (9.3), Placer (8.9), and Sonoma (8.8), indicating better access to healthy foods. In contrast, rural counties such as Modoc (6.2), Sierra (6.4), and Del Norte (6.5) face significant challenges. This data suggests that rural counties generally encounter more difficulties accessing healthy foods, underscoring the need for targeted interventions to address food insecurity in these areas.

Table 7: 2024 Food Environment Index (FEI) in Partnership Counties

Partnership Northern Region	FEI
California	***8.6***
Del Norte	6.5
Humboldt	7.4
Lassen	7.7

Partnership Southern Region	FEI
California	***8.6***
Lake	7.8
Marin	9.3
Mendocino	7.5

Partnership Eastern Region	FEI
California	***8.6***
Butte	7.5
Colusa	6.9
Glenn	7.6

[47] County Health Rankings, Food Environment Index, 2024

Partnership Northern Region	FEI
California	***8.6***
Modoc	6.2
Shasta	7.5
Siskiyou	6.8
Trinity	6.9
Tehama	7.0

Partnership Southern Region	FEI
California	***8.6***
Napa	8.9
Solano	8.7
Sonoma	8.8
Yolo	8.5

Partnership Eastern Region	FEI
California	***8.6***
Sutter	7.5
Nevada	8.0
Yuba	7.1
Placer	8.9
Plumas	8.2
Sierra	6.4

Source: 2024 County Health Rankings & Roadmaps

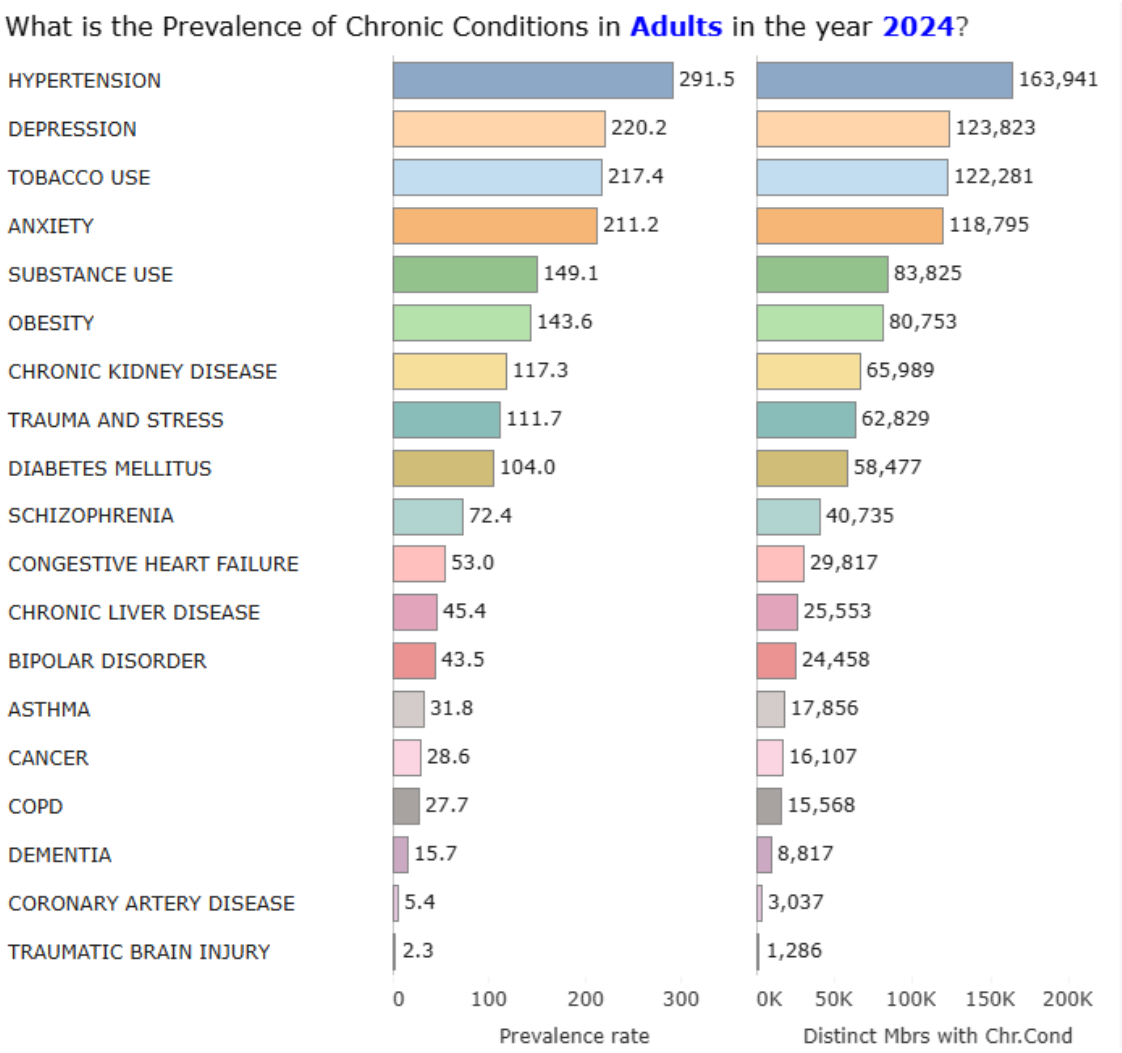
C. Disease Prevalence

1. Chronic Disease

The 2024 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. Due to delays in claim processing, full 2024 data will not be available until March 2025. Furthermore, the true prevalence of chronic disease is likely higher than what claims data reflects.

Figure 7 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (291.5 per 1000 adult members), Depression (220.2 per 1000 adult members), Tobacco use (217.4 per 1000 adult members), Anxiety (211.2 per 1000 adult members), Substance Use (149.1 per 1000 adult members), and Obesity (143.6 per 1000 adult members).

Figure 7: 2024 Adults Chronic Conditions Prevalence Data Per 1000 Members

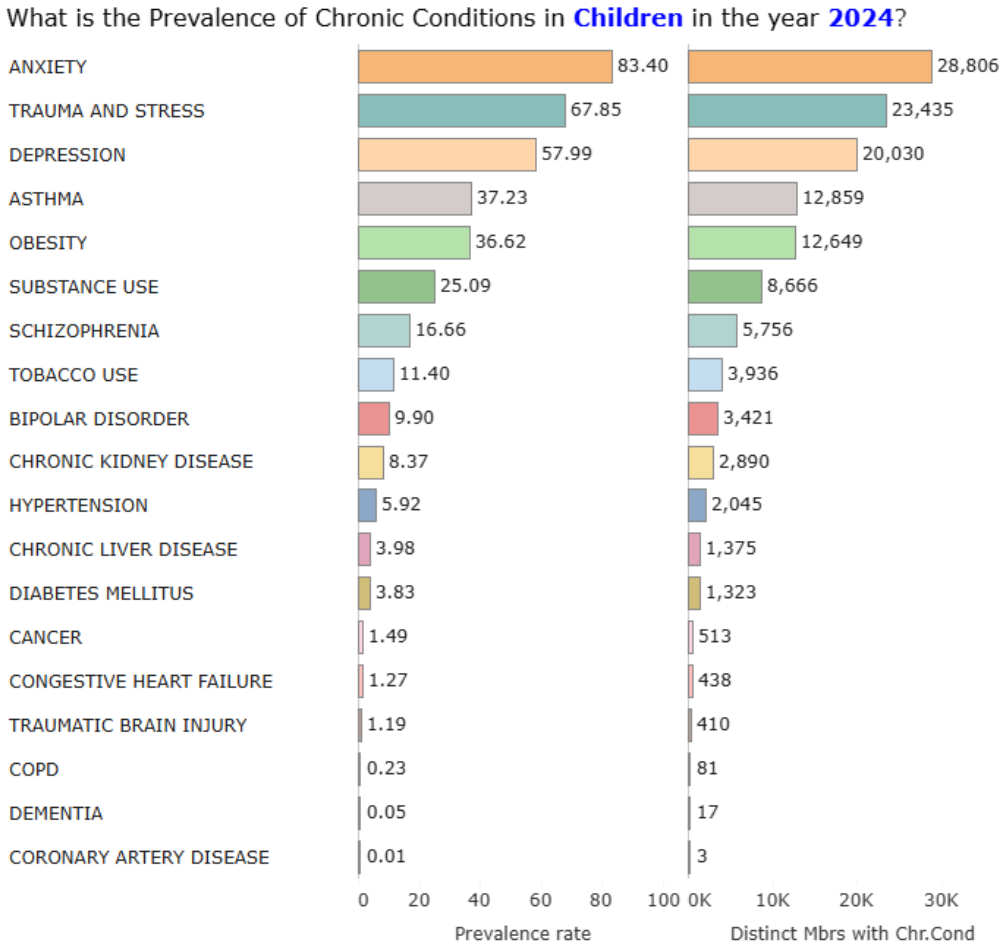


Source: 2024 Partnership Integrated Claims and Encounter Data, Partnership

Figure 8 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (83.4 per 1000 members), Trauma and Stress (67.85 per 1000 members), Depression (57.99 per 1000 members), Asthma (37.23 per 1000 members) Obesity (36.62 per 1000 members), and Substance Use (25.09 per 1000 members). The top three chronic diseases identified in the pediatric population are related to mental health. Poor mental health can impact daily functions.[48] As such, this data demonstrates a significant need to address anxiety, trauma/stress, and depression among the pediatric population.

[48] OASH, HHS.gov

Figure 8: 2024 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2024 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 and the High-Performance Level (HPL) is set at the 90th percentile amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for Reporting Year 2024 (Measurement Year 2023). In MY 2023, Partnership was responsible for reporting its HEDIS measure performance in 4 regional reporting units: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake). In 2024, Partnership added 10 new counties (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba). Starting in MY2024, Partnership will report plan-wide performance for its entire service region, including its new expansion

counties. This reporting will also include drilldowns of plan-wide performance down to the county-level.

a. Controlling High Blood Pressure

Hypertension affects almost one-half the U.S. adult population and is an important risk factor for cardiovascular disease.[49] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 61.31% for the 2024 Reporting Year (2023 Measurement Year).[50] In the 2024 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 37.96% for the 2024 Reporting Year (2023 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 Northeast Region Performance for this indicator went below the MPL with a performance of 38.81%. In contrast, the Northwest regional performance was 33.15%. Partnership's Southern Region Performance for Comprehensive Diabetes Care also went below the MPL with a performance of 31.32% and 33.06% in the Southeast and Southwest regions, respectively. These scores indicate that majority of Partnership's reporting regions performed better than the HEDIS MPL for this indicator, demonstrating strong performance across most areas.[51]

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[52] yet, it is estimated that only 8% of adults 35 years and older in the United States get all recommended preventive care services.[53] 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

[49] Center for Disease Control and Prevention (CDC), 2024
[50] Partnership Health Plan of California HEDIS Measures, 2024
[51] Partnership Health Plan of California HEDIS Measures, 2024
[52] Health.gov Healthy People 2030 Literature Summary, n.d.
[53] Borsky A., et. al., 2018

reduce health inequities. Partnership believes this work is foundational to help our members and our communities stay healthy.

(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 in MY2023. Colorectal cancer screening is a HEDIS measure that will be included in the NCQA health plan accreditation measure set starting in MY2024. In preparation, Partnership has included a colorectal cancer screening measure 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 52.60% for the 2024 Reporting Year (2023 Measurement Year). The Northeast and Northwest were still below the MPL standing at 50% and 45.64%, respectively. However, the Southeast and Southwest were above the MPL standing at 59.95% and 57.06%, respectively.[54]

Cervical Cancer Screening showed similar changes. The MPL for this measure set at the 50th percentile of 57.11% for the 2024 Reporting Year (2023 Measurement Year). The Northeast Region's performance for this indicator fell below the MPL, with a result of 45.97%. In contrast, the Northwest Region's performance went above the MPL, reaching 58.72%, compared to last year's performance. In the Southern regions, the Southeast and Southwest were above the MPL at 59.84% and 61.75%, respectively.[55]

(2) Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. They are also metrics DHCS was heavily focused on for 2024. 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.[56] A recent study identified common barriers to getting to well-child visits, including difficulty in requesting time off

[54] Partnership Health Plan of California HEDIS Measures, 2024
[55] Partnership Health Plan of California HEDIS Measures, 2024
[56] Center for Disease Control and prevention (CDC), 2024

from work, childcare, and other stressors.[57] 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 30.90% for the 2024 Reporting Year (2023 Measurement Year). For children ages 0-2 who received all the recommended immunizations by the time they turned 2 years old, the Northeast (8.03%) and Northwest (18.98%) continued to perform below the MPL while the Southeast (44.53%) and the Southwest (37.47%) regions performed above the MPL (see appendix A).

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 34.31%. The proportion of adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was below the MPL in the Northeast and Northwest regions, 20.19% and 31.87% respectively. The Southeast exceeded the HPL at 51.82% and Southwest region went above the MPL at 47.93%. This data demonstrates a need to address vaccination rates among the pediatric population in certain regions.

3. Serious and Persistent Mental Illness (SPMI)

Partnership provides mild to moderate mental and behavioral health services for its members through Carelon Behavioral Health. Partnership does not provide services to members who have severe mental and behavioral health needs, otherwise known as serious and persistent mental illness (SPMI) members. NCQA defines SPMI as “a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits one or more major activities.” Partnership does support coordination of care for members with SPMI and helps connect them to the appropriate level of care.

When a Partnership member has a higher level of impairment beyond mild to moderate, and needs specialty mental health services (SMHS), the member’s PCP or mental health provider can refer the member to the county mental health plan. Partnership will help coordinate a member’s first appointment with a county mental health plan provider to help them choose the right care for them. These include SMHS for Medi-Cal members who meet services rules for SMHS. These services may include outpatient, residential, and inpatient services.[58]

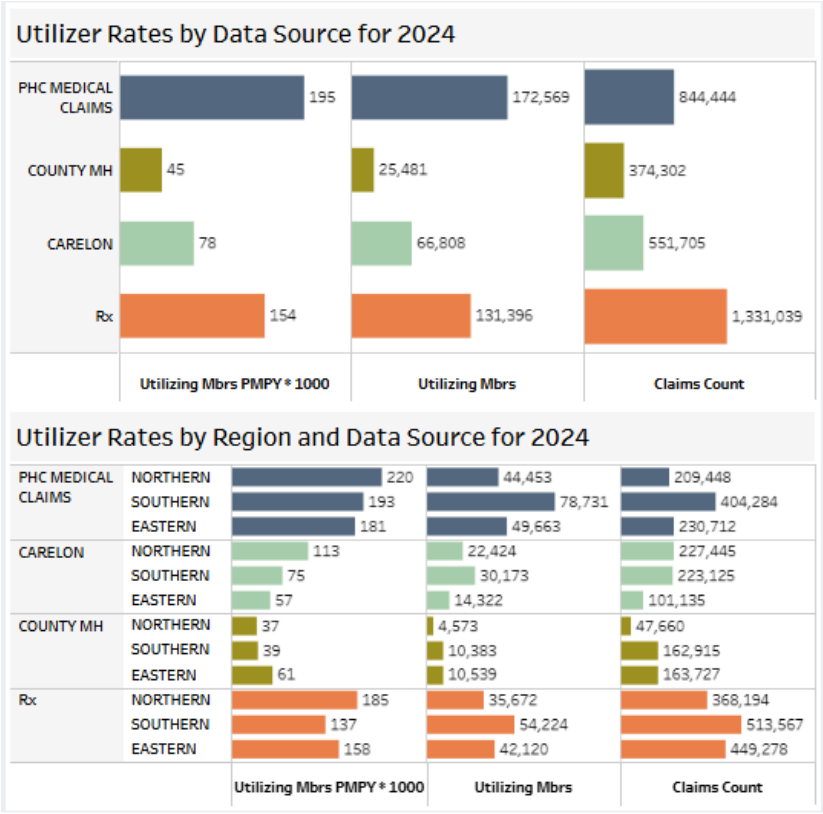
[57] Wolf et. al., 2020
[58] Partnership HealthPlan of California Medi-Cal Member Handbook, 2025

Partnership's regulatory body, the Department of Health Care Services, has two definitions of members who qualify for SMHS,[59] otherwise known as members with SPMI. These definitions are differentiated by age. Recipients 21 years and over must have a significant impairment that is due to a suspected or diagnosed mental health disorder. Recipients under 21 years of age must meet at least 1 of 2 criteria. Criteria 1 is: the member has a significant impairment, a probable reason to believe there is deterioration or lack of developmental progress in key life functions, or there is a need for SMHS. Criteria 2 is: the member's condition listed in criteria 1 is due to a suspected or diagnosed mental health disorder, or a significant trauma that could result in future mental health concerns.

Due to limited data availability, the number of members accessing SMHS through county mental health serves as a proxy for the number of Partnership members with SPMI. Figure 9 shows that in 2024, there were 25,481 unique members that accessed specialty mental health services through county mental health and received at least one service. The same figure shows this number further broken down by region. The number of members who access SMHS through county mental health, and therefore the estimated number of members with SPMI, are as follows: 4,573 in the Northern region, 10,383 members in the Southern Region, and 10,539 members in the Eastern region. Due to difficulty in data collection, Partnership is unable to provide data on how many members have been referred to SMHS. Nonetheless, this data shows there is a significant number of members with SPMI who need coordination of care and resources from the county to get the care they need.

[59] Department of Health Care Services, Non-Specialty Mental Health Services, 2022

Figure 9: Partnership Mental Health Utilization Overview - Utilizer Rates by Data Source, 2024



Source: Partnership Data 2024

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 2024 (Measurement Year 2021).[60]

For California as a whole, the ratio of individuals to providers reported in Reporting Year 2024 (Measurement Year 2021) is 1,230:1. As of December 2024, in Partnership's Northern Region comprised of the Eureka Region (indicated with "NW" in Table 8) and the Redding Region (indicated with "NE" in Table 8), all the counties underperformed when compared to the California ratio. Lake, Del Norte, Lassen and Trinity counties have the least availability of providers to the population with Lake at a ratio of 2,370:1, Del Norte at a ratio of 1,650:1, Lassen at a ratio of 3,680:1 and Trinity at a ratio of 5,350:1. In Partnership's Eastern Region comprised of both the Chico Region and Auburn Region (indicated with "E" in Table 8 below), all the counties within the Chico Region underperformed when compared to the California ratio. Yuba and Glenn counties have the least availability of providers to the population with Yuba at a ratio of 4,910:1 and Glenn at a ratio 5,760:1. In Partnership's Sothern Region comprised of the Santa Rosa Region (indicated with "SW" in Table 8) and the Fairfield Region (indicated with "SE" in Table 8) multiple counties performed better compared to the California ratio, including Marin (670:1), Sonoma (980:1), Solano (1,190:1), Napa (1,020:1), and Yolo (810:1). Despite 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.

Table 8: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,230:1	
County	**Ratio**
Sierra (E)	-
Marin (SW)	670:1
Yolo (SE)	810:1
Placer (E)	820:1
Sonoma (SW)	980:1
Napa (SE)	1,020:1
Solano (SE)	1,190:1
Shasta (NE)	1,280:1
Mendocino (NW)	1,290:1
Sutter (E)	1,320:1
Plumas (E)	1330:1
Siskiyou (NE)	1,340:1

[60] County Health Rankings, Primary Care Physicians, 2024

Nevada (E)	1,380:1
Humboldt (NW)	1,640:1
Del Norte (NW)	1,650:1
Butte (E)	1,710:1
Tehama (NE)	1,870:1
Modoc (NE)	2,170:1
Lake (NW)	2,370:1
Colusa (E)	3,650:1
Lassen (NE)	3,680:1
Yuba (E)	4,910:1
Trinity (NE)	5,350:1
Glenn (E)	5,760:1

Source: County Health Rankings & Roadmaps, 2024. Primary Care Physicians. Green indicates that compared to the previous year's data, provider availability improved (i.e. there were less patients per provider). Red indicates that compared to the previous year's data, provider availability worsened (i.e. there were more patients per provider).

Partnership's recent Grand Analysis Report on Network Adequacy also revealed that between January 1, 2023, and December 31, 2023, 43% of standard member grievances and 50.1% of appeals and second level grievances were related to provider access. This same report also revealed that between January 2023 to December 2023, Partnership met its goal of less than 20 referrals per 1,000 members for out-of-network requests.[61]

Physical access at provider facilities can be a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing 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 is categorized as "Limited," it is missing 1 or more of the domains. As of December 2024, 96 out of 179 inspected facilities were categorized as Limited; and 83 inspected facilities were categorized as Basic.[62]

[61] Partnership HealthPlan of California Grand Analysis: Network Adequacy Report: Assessment of Network Adequacy, 2024
[62] Partnership HealthPlan of California PARS report, 2024

2. 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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 2023 (July 1, 2023 – December 31, 2023) and the reporting year is 2024. The CAHPS adult composite scores for reporting year 2024 showed that the ratings decreased in most areas, including rating of all health care, getting needed care, getting care quickly, how well doctors communicate, and coordination of care (see Table 9). The exception to these decreasing rates is the scores for rating of personal doctor and rating of specialist seen most often, which increased from 66.9% in 2023 to 70% in 2024 and 64.4% in 2023 to 69.5% in 2024, respectively (see Table 9).

The collective decreases in measures in Table 9 suggest that compared to 2023, adult members are overall less happy with their care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[63] a negative patient experience likely indicates a lower level of trust. Thus, negative member experience scores could indicate members may be less likely to trust their doctor and are 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.

Table 9: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Care (% 9 or 10)	55.7%	46.3%
Getting Needed Care (% Always or Usually)	76.4%	73.9%
Getting Care Quickly (% Always or Usually)	69.5%	68.0%
How Well Doctors Communicate (% Always or Usually)	92.9%	92.6%
Coordination of Care (% Always or Usually)	86.6%	78.8%
Rating of Personal Doctor (% 9 or 10)	66.9%	70.0%
Rating of Specialist (% 9 or 10)	64.4%	69.5%

Source: 2023 CAHPS Medicaid Adult 5.1H Survey, 2024, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

Compared to 2023, the CAHPS child composite scores for reporting year 2024 increased in most areas such as getting needed care, getting care quickly, how well

[63] BMC Primary Care, 2024

doctors communicate, and rating of personal doctor (see Table 10). The exceptions to these increasing rates are the scores for areas of rating of health care, rating of specialist, and Coordination of care which decreased from 64.3% in 2023 to 58.9% in 2024, from 69.5% in 2023 to 63.9% in 2024, and from 81.1% in 2023 to 80.4% in 2024, respectively.

The increases in certain measures in Table 10 suggest that compared to 2023, pediatric members are happier overall with their health care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[64] 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 better health outcomes. This data seems to demonstrate that the pediatric population is overall happier with their health care.

Table 10: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Care (% 9, or 10)	64.3%	58.9%
Getting Needed Care (% Always or Usually)	76.7%	77.1%
Getting Care Quickly (% Always or Usually)	76.3%	78.9%
How Well Doctors Communicate (% Always or Usually)	92.7%	93.0%
Coordination of Care (% Always or Usually)	81.1%	80.4%
Rating of Personal Doctor (% 9, or 10)	74.4%	75.5%
Rating of Specialist (% 9, or 10)	69.5%	63.9%

Source: 2023 CAHPS Medicaid Child 5.1H Survey, 2024, Press Ganey (p. 9-10). 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 the 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

[64] BMC Primary Care, 2024

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 91.4% of providers in the Northern region, 91.3% of providers in the Eastern region and 78.7% of providers in the Southern region met Standard 1 for adult primary care appointments. For all pediatric primary care appointments, the survey results showed that 93.6% of providers in the Northern region, 96.4% of providers in the Eastern region and 85.1% of providers in the Southern region met Standard 1. Furthermore, the survey results showed that 100% of the providers in the Northern region, 99.0% of providers in the Southern region and 93.2% of providers in the Eastern region met Standard 2 for newborn primary care appointments. Finally, 97.9% of providers in the Northern region, 97.4% of providers in the Southern region, and 95.4% of providers in the Eastern region met Standard 2 for urgent primary care appointments. The results of this survey are displayed in Table 11. This data seems to demonstrate that for all appointment types in each region, most clinics are meeting the standard and are able to provide members, including pediatric members, with the care they need.

Table 11: 2024 Partnership Third Next Appointment Availability

Third Next Available (3NA) Survey Findings 2024									
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment				Percentage of Clinics Meeting PCP Standards			
		North	South	East	Plan	North	South	East	Plan
Primary Care Adult	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	5	2.5	3	91.4%	78.7%	91.3%	86.2%
Primary Care Pediatrics	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	4	2	3	93.6%	85.1%	96.4%	91.3%
Primary Care Newborn Appointments	3rd Next Available Newborn appointments within 48 hours of discharge	1	1	1	1	100%	99.0%	93.2%	97.4%
Primary Care Urgent Care	3rd Next Available Urgent Care appointments within 48 hours of request	1	1	0	0	97.9%	97.4%	95.4%	96.9%

Source: 2024 Partnership Third Next Available Survey, 2024 Summary

When looking at 3NA primary care appointment access by county, some provider sites in Butte, Humboldt, Lassen, Marin, Mendocino, Napa, Siskiyou, Solano, Sutter, Trinity, Yolo, and Yuba 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 2024, telemedicine utilization shows 25,089 visits scheduled and 16,748 (66.8%) completed visits through Partnership-contracted specialty telemedicine providers (see Table 12). This data represents an increase in both scheduled and completed telemedicine visits in 2024 when compared to 2023.

Table 12: Adult Telemedicine Appointment Details as of December 2024

Adult Telemedicine Appointment Details as of December 2024					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
25,089	16,748	66.8%	9.3%	8.7%	25.3

Source: Adult Telemedicine Appointment Details Report, 2024, Partnership

As of December 2024, the number of scheduled pediatric telemedicine appointments was 6,268 and the number of completed pediatric telemedicine appointments was 3,964. From December 2023 to December 2024, the number of completed pediatric telemedicine appointments ranged from approximately 164-406 visits per month, with a high of approximately 406 per month in May 2024. Since access to care is an important part of staying healthy, this data demonstrates that there is opportunity to increase the rates of access to care for the pediatric population through telemedicine.

Table 13: Pediatric Telemedicine Appointment Details as of December 2024

Pediatric Telemedicine Appointment Details as of December 2024					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
6,268	3,964	63.2%	17.2%	19.6%	37.9

Source: Pediatric Telemedicine Appointment Details Report for 2024, 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 2024, there were 1,281 adult eConsults completed. Of those, 69.0% were closed because the patient's needs were addressed eConsult, while 27.9% were referred to face-to-face services.

Table 14: Adult eConsult Utilization Report, 2024 Partnership

Adult eConsult Utilization Report as of December 2024				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,295	1,281	69.0%	2.6	27.9%

Source: Adult eConsult Utilization Report, 2024 Partnership

As of December 2024, there were 103 completed pediatric eConsults. Of those, 75.7%. were closed because the patient's needs were addressed through eConsult, while 17.5% of consults were referred for face-to-face services.

Table 15: Pediatric eConsult Utilization Report, As of December 2023 Partnership

Pediatric eConsult Utilization Report as of December 2024				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
103	103	75.7%	2.5	17.5%

Source: Pediatric eConsult Utilization Report, 2024 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 2024 CAHPS survey. The report is based on data as of July 2024. PG reached out to 3,375 adult members and the guardians of 4,125 pediatric members to participate in the survey. There were 510 adult responses (15.3% of those surveyed) and 659 pediatric responses (16.1% of those surveyed).

The CAHPS results discovered that 87.0% 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 which changed from 56.8% in 2023 to 54.5% in 2024. This represents a slight decrease from

the 2023 survey results. Table 16 denotes changes in various measures between 2023 and 2024.

Other categories also showed mixed responses. Adult members were less satisfied with the Rating of Health Plan (decrease from 56.8% to 54.5%), Getting Needed Care (decrease from 76.5% to 74.0%), but were more satisfied with the Ease of Filling Out Forms (decrease from 96.0% to 97.7%). The decrease in certain measures in Table 16 suggests that compared to 2023, adult members are less happy with Partnership. Thus, members may be less likely to trust their health plan and may experience worse health outcomes.

Table 16: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Adult CAHPS Summary Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	56.8%	54.5%
Getting Needed Care (% Always or Usually)	76.4%	74.0%
Customer Service (% Always or Usually)	88.6%	87.00%
Ease of Filling Out Forms (% Always or Usually)	96.0%	97.7%

Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Adult 5.1 H, 2024, Press Ganey (p. 10). Red indicates a decrease in score from the previous reporting year. *Green indicates an increase in score from the previous reporting year.*

The Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS survey results revealed that 68.1% of respondents completing forms on behalf of pediatric members rated their child's Health Plan as good or excellent (scores of 9 or 10), compared to 68.0% in 2023. This marks a slight increase. Another notable improvement was observed in Customer Service, which increased from 89.9% in 2023 to 91.2% in 2024. However, the percentage of respondents reporting the ease of filling out forms as "Always or Usually" decreased slightly from 95.4% in 2023 to 94.2% in 2024. Despite these mixed trends, the percentage of respondents reporting success in "Getting Needed Care" rose modestly from 76.7% to 77.0%. These results, as outlined in Table 17, suggest that while pediatric members' interactions with Partnership improved, challenges remain in filling out forms. These factors may influence members' trust in their health plan and their likelihood of seeking care for health concerns as needed. This

data seems to demonstrate that the pediatric population is overall happier with their health plan.

Table 17: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	68%	68.1%
Getting Needed Care (% Always or Usually)	76.7%	77.0%
Customer Service (% Always or Usually)	89.9%	91.2%
Ease of Filling Out Forms (% Always or Usually)	95.4%	94.2%

Source: MY 2023 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.

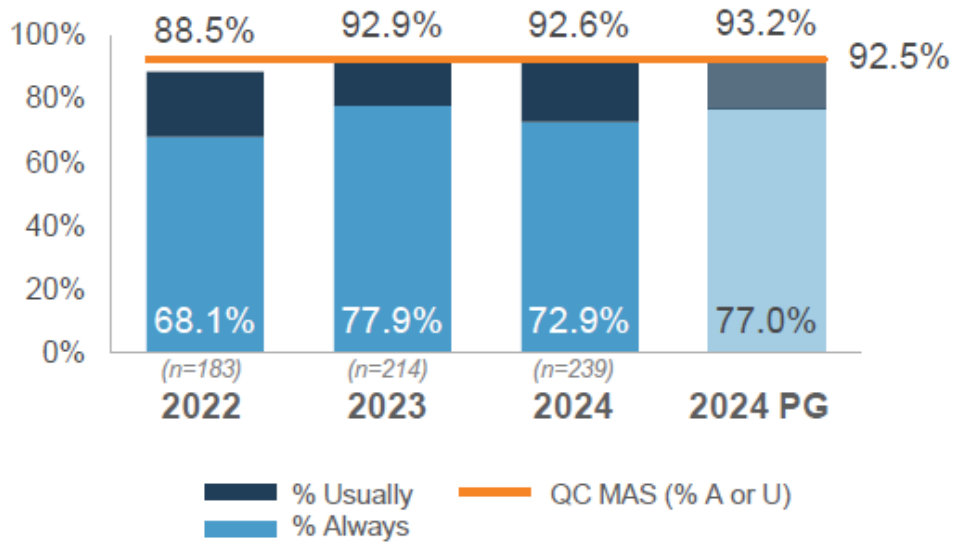
2. Doctor Communication

Partnership uses the Measure Year (MY) 2023 and Reporting Year (RY) 2024 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 decreased on aggregate from 92.9% in 2023 to 92.6% in 2024 as compared to the Quality Compass (QC) score shown in the following figures. Partnership scored slightly above Press Ganey's 2024 Benchmark in all aspects of how well doctors communicate with Partnership adult members. Having good communication with one's doctor can help build a relationship and fosters trust between the member and the provider,[65] 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.

[65] BMC Primary Care, 2024

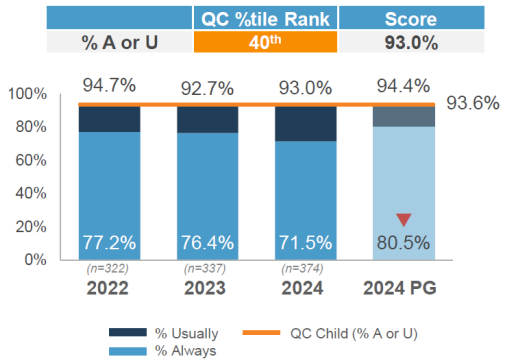
Figure 10: 2024 Adult Composite CAHPS Survey Result



Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Adult 5.1H Survey, Partnership, 2024

The results of the Child CAHPS Survey show that members rated their care experience with children's providers slightly 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 92.7% in 2023 to 93.0% in 2024. This minor decrease means Partnership is slightly below PG's Benchmark score, which stays higher at 94.4%. 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. This data demonstrates that the population is generally happy with their providers.

Figure 11: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child Composite CAHPS Survey Result



Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Child 5.1 Survey, Partnership, 2024

F. Health Disparities

The 2024 health disparities data is taken from a grand analysis called the HE 6: Reducing Healthcare Disparities report.[66]

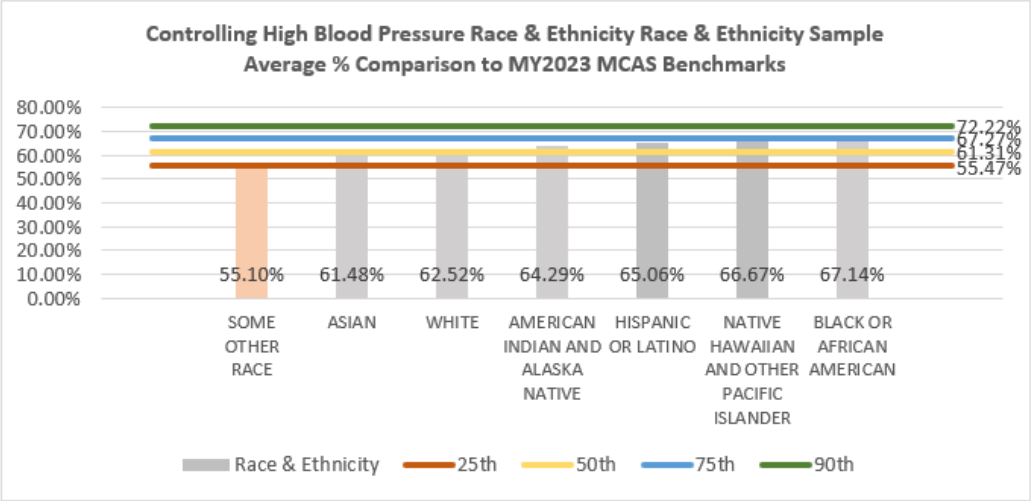
The key measures for the 2024 Health Equity Report are: controlling high blood pressure (CPB), Hemoglobin A1c Control for Patients with Diabetes (HBD), Prenatal and Postpartum Care (PPC), and Child and Adolescent Well Care Visits (WCV). Due to low sample sizes (n=186 to 368) for the hybrid measures in the Health Plan Accreditation data (MY23), and the absence of statistically significant inequities identified for all measures, no substantial disparities were found. In response, Partnership evaluated the MY 2023 Managed Care Accountability Set (MCAS) final rate samples (n=812 to 167,450 members) to provide a meaningful analysis of the key measures. Please refer to Appendix H for the NCQA Health Plan Accreditation generated sample results. The following results are from the MY 2023 Managed Care Accountability Set (MCAS) final rate samples:

1. Controlling High Blood Pressure (CPB)

HE 6: Reducing Healthcare Disparities report found that the 'Some Other Race' group performed below the MPL at 55.10%, compared to higher-performing populations. In contrast, the Asian population performed at 61.48%, the White population at 62.52%, the American Indian and Alaska Native group at 64.29%, the Hispanic or Latino group at 65.06%, and the Native Hawaiian and other Pacific Islander group at 66.67%, with the Black/African-American population performing at 67.14%. While all groups except the 'Some Other Race' group hit at least the 50th percentile, no group exceeded the 90th percentile threshold. Controlling high blood pressure is an important part of staying healthy. As such, this data demonstrates there is a need to better address controlling high blood pressure among the 'Some Other Race' group.

[66] Partnership HealthPlan of California, 2024 HE 6: Reducing Healthcare Disparities report

Figure 12: 2024 Controlling High Blood Pressure

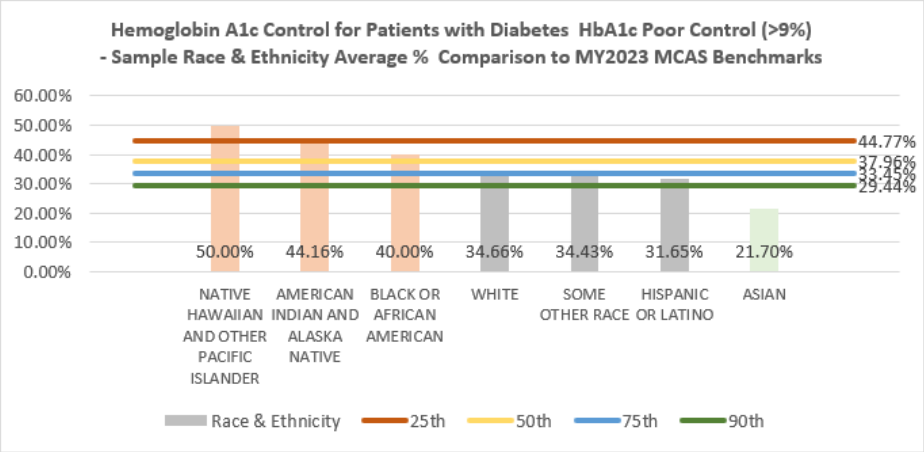


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

2. Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c 3. Poor Control (>9.0%):

The HE 6: Reducing Healthcare Disparities report found that when comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (44.16%), and Black or African American (40%) groups all performed below the MPL – 50th. In contrast, the Asian population had the lowest rate of poor control at 21.70%, performing above the 90th percentile. Controlling Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c is an important part of staying healthy. Therefore, the data in Figure 13 demonstrates there is a need to better address hemoglobin A1c control among the Native Hawaiian and Other Pacific Islander group, American Indian and Alaska Native, and Black or African American groups.

Figure 13: Hemoglobin A1c Control for Diabetes – Poor Control

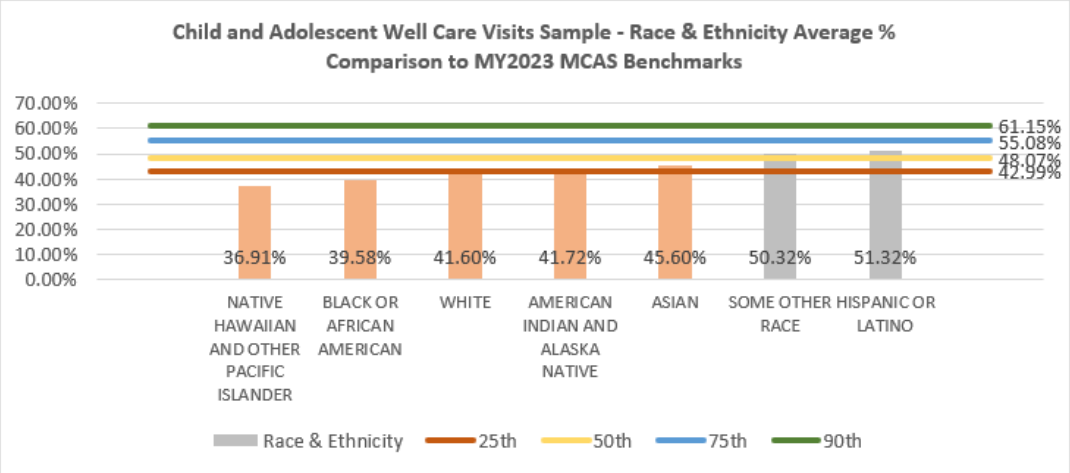


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

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

The HE 6: Reducing Healthcare Disparities report on Child and Adolescent Well Care Visits (WCV) found that the majority of racial/ethnic groups did not meet the MPL – 50th percentile, and no group performed above the 90th percentile. Specifically, the Native Hawaiian and Other Pacific Islander (36.91%), and Black or African American (39.58%), White (41.60%) populations, and American Indian and Alaska Native (41.72%) populations performed the lowest, falling below the MPL – 50th percentile. In contrast, the Asian population (45.60%) performed slightly better, though still below the 50th percentile, indicating overall limited access to or utilization of well-care visits compared to the benchmark. The Hispanic population performed the best (51.32) and performed above the MPL 50th percentile. Well child visits are an important part of staying healthy. As such, while the data in Figure 14 demonstrates a need to address the low rates of well child visits among all groups (except for the “Some Other Race” category and the Hispanic/Latino Population), the Native Hawaiian and other Pacific Islander pediatric sub-population are of particular interest. While this population only makes up 0.2% of the total Partnership member population (as noted in previously in Figure 4), the data demonstrates the Native Hawaiian and other Pacific Islander pediatric population performed the lowest on this clinical measure and shows a clear need for this population to have better access to child and adolescent well care visits.

Figure 14: Child and Adolescent Well Care Visits

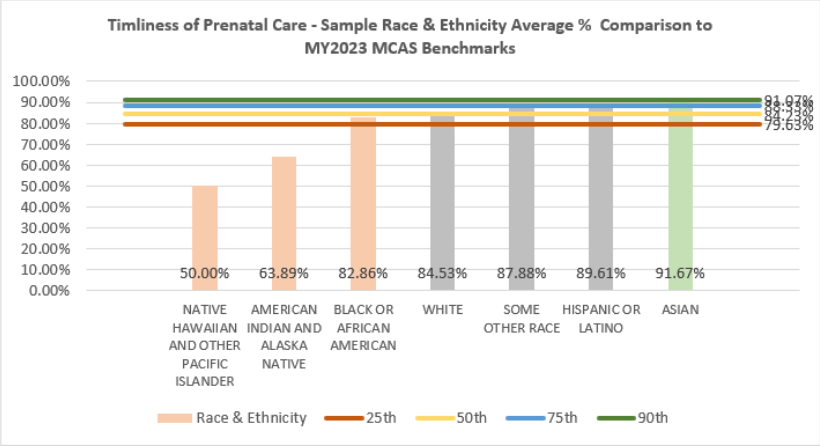


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

5. Prenatal and Postpartum Care (PPC):

The HE 6: Reducing Healthcare Disparities report on Prenatal Care Visits (PPC) found that the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (63.89%), and Black or African American (82.86%) groups all had lower rates of completion, performing below the MPL – 50th percentile. In contrast, the Asian group had a higher rate of completion at 91.67%, performing above the 90th percentile, as shown in Figure 15. Prenatal care is an important part of staying healthy. As such, the data in the figure demonstrates there is need to address prenatal care access among the Native Hawaiian and Other Pacific Islander group, American Indian and Alaska Native, and Black or African American groups.

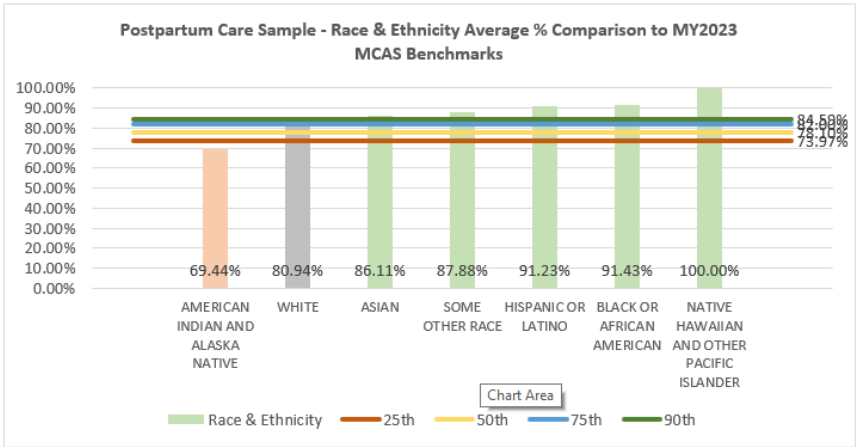
Figure 15: Prenatal and Postpartum Care (PPC - Pre)



Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

For Postpartum Care, the American Indian and Alaska Native group (69.44%) was the only group with a completion rate below the MPL – 50th percentile. In comparison, the Asian (86.11%), 'Some Other Race' (87.88%), Hispanic or Latino (91.23%), Black or African American (91.43%), and Native Hawaiian and Other Pacific Islander (100%) groups all had higher rates of completion, performing above the 90th percentile, as shown in Figure 16. The White population (80.94%) performed just below the 75th percentile. Postpartum care is an important part of staying healthy. As such, while the American Indian and Alaska Native population only makes up 1.8% of the total Partnership member population (as noted in previously in Figure 4), the data in Figure 16 demonstrates this sub-population performed the lowest on this clinical measure. As such, there is clear need to address access to postpartum care among the American Indian and Alaska Native group who are of childbearing age.

Figure 16: Prenatal and Postpartum Care (PPC - Post)



Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

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 through the Healthy Living Tool. There are additional external health education materials available for both member and provider access on PCH's external website:

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

Printed copies of materials are available to both members and providers. Educational and informing 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, Tagalog; Punjabi will likely become part of this list in 2025); other languages are available upon member 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 (which includes discrimination based on language), 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 as requested. The evaluation of member grievances for issues arising from discrimination will transition to the Health Equity department in 2025.

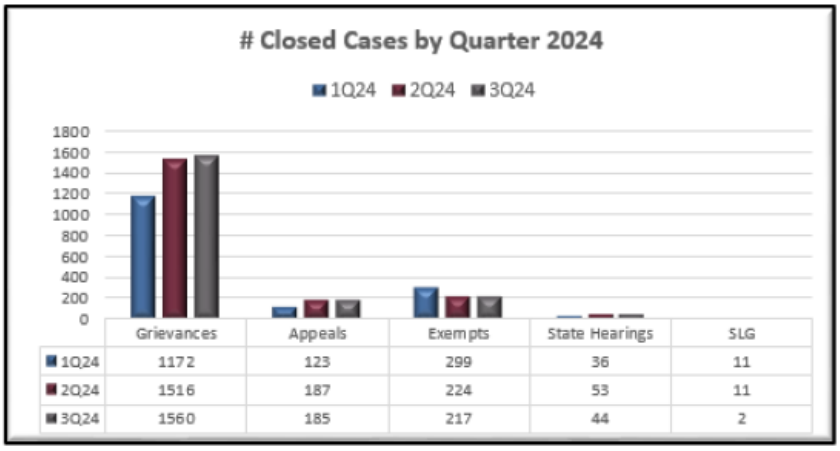
1. Grievance and Appeals

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.

By the end of the third quarter in 2024, the G&A team closed 4,248 cases, representing an increase from the 2,766 cases closed for member reported grievances in 2023. English speakers and the White population continue to be the groups that file the majority of grievances and appeals.

Figure 17: Number of Closed Cases by Quarter 2024



	Grievances	Appeals	Exempts	State Hearings	SLG
1Q24	1172	123	299	36	11
2Q24	1516	187	224	53	11
3Q24	1560	185	217	44	2

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2024 were White (56.0%), Hispanic (19.6%), Native American (19.6%), Asian (15.8%), and Other/Unknown (5.2%). See Figure 18 below.

Figure 18: G&A Pulse Report by Members Ethnicities vs. Partnership Overall Membership by Ethnicity

3Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.0%	38.9%
Hispanic	19.6%	33.6%
Other/Unknown	5.2%	17.9%
Black (African Amer	0.4%	3.5%
Asian	15.8%	2.5%
Native American	19.6%	1.8%
Asian Indian	0.7%	1.6%
Native Hawaiian or	0.1%	0.2%
Grand Total	100.0%	100.0%

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

In 2024, Partnership identified a disparity in grievances reported by member race/ethnicity and by language. The grievances reported continue to not be proportionate to the percentage of different races/ethnicities and languages within Partnership's membership. Between 2023 and 2024, 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 increased from 53.2% in 2023 to 56.0% in 2024, which coincides with the percentage of White members increasing from 37.0% to 38.9% in the same period. Grievances reported by Hispanic members increased from 11.8% in 2023 to 19.6% in 2024, which coincides with the percentage of Hispanic members increasing from 32.2% to 33.6% in the same period.

Grievance reporting increased most significantly between 2023 and 2024 by Native American members, where grievance reporting increased from 1.8% in 2023 to 19.6% in 2024, although there was an overall decrease in the percentage of Native American members from 2.1% to 1.8%. See Table 18 below.

Table 18: Grievances by Race/Ethnicity over Time

Member Race/Ethnicity	2023 % of Cases	2023 % of Membership	2024 % of Cases	2024 % of Membership
White	53.2%	37.0%	56.0%	38.9%
Hispanic	11.8%	32.2%	19.6%	33.6%
Other/Unknown	11.0%	9.1%	5.2%	17.9%
Black (African American)	7.8%	5.2%	0.4%	3.5%
Asian	-	-	15.8%	2.5%
Native American	1.8%	2.1%	19.6%	1.8%
Asian Indian	0.5%	0.8%	0.7%	1.6%
Native Hawaiian or Pacific Islander	-	-	0.1%	0.2%

Source: 4Q2023 & 4Q2024 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

Members who speak English continue to report grievances much more frequently than those who speak other languages or use sign language. See Figure 19 below.

Figure 19: G&A Pulse Report by Members Language vs. Partnership Overall Language Profile

3Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	90.6%	76.2%
Spanish	8.0%	20.5%
Other	1.1%	2.0%
Russian	0.0%	0.6%
Punjabi	0.1%	0.5%
Tagalog	0.1%	0.3%
Grand Total	100.0%	100.0%

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

The percentage of English-speaking members who reported grievances decreased from 93.0% in 2023 to 90.6% in 2024. Grievances in Partnership's other languages were low in 2024, however, compared to 2023, grievances in Spanish and Other increased from

2023 to 2024. A lack of grievances can be a sign of lack of trust in an organization. Since trust is important for certain health outcomes,[67] this data suggests there is a disproportionate number of English members reporting their grievances compared to LEP members and therefore a need to be addressed.

Table 19: Grievances by Language over Time

Language	2023 % of Cases	2023 % of Membership	2024 % of Cases	2024 % of Membership
English	93.0%	78.0%	90.6%	76.2%
Spanish	5.6%	19.4%	8.0%	20.5%
Other	0.9%	1.9%	1.1%	2.0%
Tagalog	0.1%	0.4%	0.1%	0.3%
Russian	0.3%	0.3%	0.0%	0.6%
Punjabi	-	-	0.1%	0.5%

Source: 4Q2023 & 4Q2024 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

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. 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. Health Equity Week 2025 will continue to take place in April. Below are the results of Health Equity Week 2024.

Table 20: LMS Completion Report for Health Equity Week 2023 Activities

LMS Activity	Total Completions
Health Equity Week 2024: A Conversation with Partnership's Dr. Mohamed Jalloh & Hannah O'Leary	236
Health Equity Week 2024: Gena, a Member's Story	266

[67] BMC Primary Care, 2024

Health Equity Week 2024: Madeline, a Member's Story	280

Source: LMS Training Report; Partnership Human Resource Department, 2024

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 are 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, 2024, there were 1,307 Partnership employees.[68] In 2024, Partnership employees completed the following trainings:

Table 21: Training Sessions for Partnership Staff

Total Completion	Partnership Training Sessions	Staff Assignment
1421	Diversity Basics: Foundations	Assigned to all staff in April 2024 and all new hires, temps, & contractors
445	Cultural & Linguistics Program Overview and Staff Training	Assigned to new hires and temps only
443	Affordable Care Act – Section 155	Assigned to new hires and temps only
280	Health Equity Week 2024: Madeline, a Member's Story	Optional training for all Partnership staff
266	Health Equity Week 2024: Gena, a Member's Story	Optional training for all Partnership staff
236	Health Equity Week 2024: A Conversation with Partnership's Dr. Mohamed Jalloh & Hannah O'Leary	Optional training for all Partnership staff
20	Improving Health Outcomes for People Living in The Crisis of Poverty	Optional training for all Partnership staff
24	Tale of Two Zip Codes	Optional training for all Partnership staff
1	Partnership's Health Equity Journey: The Present	Optional training for all Partnership staff

[68] Partnership Human Resources, 2024

Source: Partnership Human Resources, 2024

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. In 2025 and beyond, DEI trainings for Partnership will evolve to align with new DHCS regulatory requirements.

b. Provider Training

Partnership is committed to enhancing the member experience by actively reviewing and offering training to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2024, Partnership's Cultural and Linguistic/Health Education Team reviewed and updated the comprehensive toolkit designed to help providers document patient language needs in medical records, utilize interpreter services, and refer patients to culturally and linguistically appropriate community programs. Additionally, Partnership offers an on-demand Cultural and Linguistic training webinar for providers and their staff, ensuring they receive the necessary tools to improve cultural competency and communication with patients. Furthermore, Partnership provides cultural awareness and sensitivity training for all contracted providers and their employees who interact with members of the Seniors and People with Disabilities population, supporting a more inclusive and effective healthcare experience.

Partnership's Director of Health Equity developed a training program in 2024 to align with DHCS's APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements.[69] In 2025 and beyond, Partnership will begin offering providers regular DEI training to align with NCQA and DHCS quality standards.

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. As of January 2024, Partnership has established 6 regional offices to maintain a community presence and ensure members have local access to someone who can address their concerns.

[69] APL 24-016 Diversity, Equity, And Inclusion Training Program Requirements

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 2025 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; and health education and culture and linguistics.

A. Organizational Structure

In 2024, Partnership hired two new regional directors. One director was hired to fill the role for the new Auburn (Eastern) region, overseeing Plumas, Nevada, Placer and Sierra Counties. The other director was hired to replace the director in the Santa Rosa (Southwest) region, overseeing Sonoma and Marin counties.

Partnership's new claims system was scheduled to go live in mid-2024 but has since been postponed to a later date. 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 called Medi-Cal Connect. Medi-Cal Connect provides key stakeholders with the full story of an individual's benefits as well as health and population-level insights.[70] Medi-Cal Connect also grants Medi-Cal health plans, providers, and other key partners with access to data, tools, and assessments to improve health outcomes and drive equity throughout California. 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, overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department has hired several staff in 2024 with plans to continue growing the team in 2025.

[70] Medi-Cal Frequently Asked Questions, 2024

In 2024, Partnership hired a new Director of Population Health to oversee and implement a variety of initiatives. Within Partnership's Population Health department, there are teams who work to build relationships with community partners and other stakeholders; this work includes the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). These teams represent Partnership at various county and 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 identify, conceptualize, and implement interventions for health concerns or disparities in the local communities. In addition to these community partner-facing teams within Population Health, 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. Finally, other Partnership teams attend community events, often hearing firsthand of various needs of Partnership's member.

There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website (see Appendix D 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. Partnership continues to look to community agencies and other organizations to implement community health workers, doulas, enhanced care management and community supports services to provide services to members in their communities and to support basic needs. The infrastructure to provide these services to members remains in progress, 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.

B. 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. In 2024, California's homeless population grew by 3% to over 187,000 people experiencing homelessness.[71] 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 staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. State funds and initiatives like the CalAIM Incentive Payment Program provide the means for managed care plans to offer grant funding to address housing concerns. Lastly, as part of DHCS's Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

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. Twenty of Partnership's counties have household incomes below California's state average.[72] The Community Health Assessments revealed that many of Partnership's 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 2024, Partnership offered scholarships to Sacramento City College's Community Health Worker (CHW) Certificate Program to help create employment opportunities for

[71] The 2024 Annual Homelessness Assessment Report to Congress
[72] US Census Bureau, 2023

members. In 2024 there were two awardees. Partnership also contracts with organizations that serve as Supervising CHW providers. These organizations provide CHW services to Partnership members. Some of these efforts included working to build out a CHW training program using pharmacy technicians who are certified as CHWs and exploring how to expand the CHW network in collaboration with interested local public health departments as part of the newly mandated CHA/CHIP work. Finally, Partnership is offering a Member Scholarship Program aimed at helping our members secure funding towards education with a focus on health care, social work, or public service (see Appendix C). These local efforts have potential to create new jobs in Partnership's service area, which can ultimately help improve economic stability of the communities we serve.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires can lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. Created in 2023, Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area that happened in 2024. 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 2024, during instances of a sizable fire or natural disaster, Partnership staff 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 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 was through posting materials to Partnership's website. These materials are 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 checklist of items to pack in an emergency kit and go-bag in the event of an emergency. The pocket card can be printed out and easily stored in an emergency bag or in an easy-to-access space within the home for use. The resources allocated to these efforts are sufficient for Partnership member needs.

C. 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 continues to rollout various programs under CalAIM, including the ever-evolving Population Health Management (PHM) Policy Guide.[73] The PHM Policy Guide includes a variety of ongoing 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. In 2024, Partnership worked to refine these programs, including setting eligibility criteria focused on specific populations. These programs continue to align with PNA findings showing that hypertension, depression, and tobacco use are the most common chronic diseases in our adult population in 2024.

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 members to attend regular doctor appointments, take anti-hypertensive medications as prescribed, and make healthy lifestyle changes. In 2024, as a result of identified disparities, Partnership modified its hypertension intervention to focus primarily on African American, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander members as part of Partnerships 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 Partnership counties have adult smoking rates that are higher than the state average. As a result of this finding, Partnership's Population Health Department continues to ask questions about smoking behavior to our members during outbound call campaign scripts for all campaigns. In 2024, Partnership also explored conducting health education sessions around tobacco prevention in certain counties with high tobacco usage. Partnership plans to conduct these sessions in 2025; efficacy of these sessions will be reviewed.

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 may 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

[73] Department of Health Care Services DHCS, 2024

asthma control. There may be other contributing factors as well. In order to better support members with asthma, Partnership's Pharmacy department created an asthma management program for adults with asthma emergency department visits. This program was piloted from August 2022 to February 2023. The results of the pilot showed improvement in several of the outcomes that were tracked, including the number of members who reached the AMR target of 0.5 compared to a control group. However, a major limitation to continuing the project in its original form was pharmacist time.

Due to programmatic challenges, and to align with CalAIM BPHM, the project was modified and is now run by Population Health. The new Asthma Emergency Department (ED) Visit Outreach Program Campaign was rolled out at the end of 2024. The Asthma Management campaign will offer additional support to members who were recently seen in the ED for their asthma. Members will receive an asthma education handbook and those who may want additional help can speak with a pharmacist who can provide education on effective self-management of their asthma and use of medications. Effectiveness of this program will be assessed in the future. There are sufficient resources to perform this new program.

The top 3 chronic diseases found among Partnership children in 2024 were mental health concerns (anxiety, trauma/stress, and depression). The CDC states that children with ADHD often have other coexisting conditions (including anxiety disorder).[74] As such, 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. The results from the intervention conducted March through December 2023 showed an improvement in follow-up care rate when compared to the baseline rate from MY2022. Data results from the intervention were collected through February 2024. The project is slated to continue in 2025 with some modifications. There are sufficient resources to perform this new program.

Partnership's local community needs assessment showed that substance use is a pressing concern in Partnerships communities. Furthermore, in alignment with DHCS mandates,[75] Partnership recently conducted outreach to members with low utilization of

[74] CDC, 2024
[75] APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements

non-specialty mental health services, demonstrating that some populations are not effectively utilizing these services. As part of efforts to improve poor behavioral health outcomes, which can go hand in hand with substance abuse,[76] Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. There are sufficient resources to perform this new program.

Depression was the second most common chronic condition among Partnership members in 2024. As such, Partnership has also continued to refine its BPHM program which offers to help manage depression for members who recently suffered a stroke or a myocardial infarction. This program will meet DHCS requirements for a depression intervention program and test the benefits of having non-clinical staff provide lifestyle coaching for depression. 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 screenings, Partnership continues to collaborate with Alinea Medical 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 have the opportunity to follow up with anyone who had findings on their imaging. Throughout 2024, there were 72 mobile mammography days conducted in 19 Partnership counties (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Marin, Mendocino, Modoc, Nevada, Shasta, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, Yuba). In 2024, there was some improvement in breast cancer screenings in comparison to the previous measurement year. This modest improvement helps demonstrate the success of this collaboration and will continue in 2025 to reach more members. There are sufficient resources for this endeavor.

Partnership's Women's Health and Perinatal Workgroup conducted a 6-month Cervical Cancer Screening Self-Swab pilot project in early 2024. There were 5 Primary Care Provider practices participating, with plans to pilot tests of 200 Partnership members. This workgroup closed out the Cervical Cancer Screening self-swab pilot project in September 2024. Eighty-nine of the 200 self-swab kits were used by the close of the

[76] NIH, 2023

project. Due in large part to technical and logistical issues with the self-swab kit vendor, only 3 of the 5 initial providers were able to participate in the program. In July of 2024, the FDA approved self-swab as a sample collection methodology in a health care setting. The pilot has given Partnership great insight into how we can best support providers to adopt this method into their workflow and improve our members' access to valuable cancer screening.

Partnership also started a colorectal cancer screening pilot project in 2022 along with Exact Sciences to increase the number of colorectal cancer testing. Partnership continues to support our providers using the bulk ordering option for colorectal cancer screening with Exact Sciences. The goal is to increase the number of colorectal cancer testing among the 45 years of age and older population.

3. Wellness Care

Partnership continues to make significant investments into expanding services for maternal and child health. Partnership 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. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders in the exploration and planning of school-based clinics, and other 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, monitoring efforts, and multi-disciplinary committees as appropriate.

D. 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 continues to sponsor a workforce development program called the Provider Recruitment Program (PRP). The PRP offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and/or if they come from a county outside of the ones that Partnership serves (see Appendix E). Partnership also continues to support a Provider Retention Initiative (PRI) program. 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 F). Although this work is already 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 targeted specialists in the areas where access is impacted most.

Finally, Partnership works to prevent loss of access to care. Efforts include a variety of activities, such as:

- Continuing to support a primary care program using a telehealth service called TeleMed2U (see Appendix G)
- Continuing to support the mobile mammography program centered around providers located in areas without imaging centers or in proximity to imaging centers with significant access barriers
- Supporting a modified Quality Improvement program (QIP) that focuses on providers that are the lowest performing in the Primary Care Provider (PCP) QIP
- Continued support of the QIP program for primary care
- Utilization of Partnership's Transportation Services to allow members to attend provider appointments

E. Health Disparities

The PNA revealed notable care gaps between racial/ethnic groups, particularly from the HE 6: Reducing Healthcare Disparities report. For Controlling High Blood Pressure (CPB), the 'Some Other Race' group had the lowest rates of control (55.10%), while the Black/African American population had the highest rates (67.14%); all racial categories hit the 25th percentile MCAS benchmark for this measure. In Hemoglobin A1c Control for Patients with Diabetes (HBD), the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (44.16%), and Black or African American (40%) populations had significantly higher rates of poor control, performing below the MPL – 50th percentile. In contrast, the Asian population had the lowest rate of poor control (21.7%), performing above the 90th percentile, indicating better control of diabetes. For Child and Adolescent Well Care Visit completions, the Hispanic/Latino (51.32%), and "Some Other Race" category (50.32%) had higher rates compared to other groups, both of which hit the 50th percentile MCAS benchmark for this measure. The Native Hawaiian and Other Pacific Islander population had the lowest rate of completion (36.91%), suggesting disparities in access to well-care visits. Regarding timely prenatal care, the

Asian population had the highest rates of completion (91.67%), while the Native Hawaiian and Other Pacific Islander population had the lowest (50%), and was 1 of 3 racial groups to not hit the 50th percentile MCAS benchmark for this measure. Finally, for postpartum care, Native Hawaiian and Other Pacific Islanders had the highest rates of postpartum care (100%), while the American Indian and Alaska Native population had the lowest (69.44%) and was the only racial category that did not hit the 50th percentile MCAS benchmark for this measure. These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others.

Partnership will continue to perform outbound call campaigns that encourage the perinatal population to attend their pre and postpartum appointments and encourages families to attend well-child visits with their children. In addition to these efforts, Partnership also recently hosted a photoshoot aimed at increasing prenatal and postpartum care and well child visit rates among African American/Black, Alaska Native/American, and Hispanic pregnant members. This short-term intervention aimed to increase supportive community interactions and social support, raise awareness and promote the use of available benefits, and connect members with doula services and Partnership's outbound call campaign programs. Partnership plans to expand this intervention in 2025 into three events with different focuses. Events are intended to focus on efforts to connect pregnant members to perinatal resources, offer a no-cost setting for professional development, and encourage vaccines typically received during pregnancy. These efforts will be evaluated in 2026. Partnership will also continue to participate in efforts that support members recently diagnosed with hypertension and diabetes, with special emphasis on the African American, Native American/Alaska Native, and Pacific Islanders populations.

Lastly, American Indian/Alaska Native populations face many health disparities, with recent health disparities data demonstrating lower completion rates of postnatal care visits among this population. Due to historic lack of trust in government and other challenges, traditional QI approaches have had limited success. As such Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area to decrease known health disparities among American Indian/Alaska Native (AI/AN) members. Many of these strategies are described in Partnership's Tribal Health Engagement Strategic and Tactical Plan.

Partnership has also been an active participant in tribal perinatal efforts. One effort is creating homegrown collaboratives to identify needs and work towards interventions. For example, in Siskiyou County, these efforts aim to streamline collaboration among clinical and community initiatives to support perinatal care and education, expand

cultural awareness across the health system and build provider skillsets for addressing pregnancy related urgencies. There are also Native American driven efforts focused on providing community support to access and education for pregnant individuals and families in which Partnership plays a supporting role.

Lastly, Partnership continues to grow its Tribal Liaison position to provide a more formal point of contact and advocate for AIAN needs in alignment with new DHCS mandates. While there are sufficient resources currently allocated to strengthen existing relationships, Partnership will continue to explore modifying our programs as additional health needs are identified.

F. 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 in various threshold languages as appropriate. One example is heavily promoting the Growing Together Program to Partnership's providers and community partners; this program promotes well-child visits and perinatal care with (see Appendix B for the update flyer).

Another example is Partnership's Member Services staff conducting in-person presentations. These presentations are referred to as "Member (or Community) Informative Sessions" and provide an educational and collaborative forum for new members and county partners while also building upon our organizational branding campaign centered around "Your Partner in Health". At these sessions, Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Sessions may also be conducted in other languages and are available on request. The overall goal with these sessions is to ensure Partnership members and community partners gain knowledge about Partnership's benefits and services, and to leave a positive and lasting impression that Partnership is responsive and here to support all the communities we serve. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members 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 D). 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. 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 grievances 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, gender, and more) and the barriers members experience that prevent them from being healthy. Partnership also hosts an annual Health Equity Week to educate on and promote health equity for its members and staff. Activities from Health Equity week 2024 included a staff town hall highlighting health equity efforts, staff interviews, member stories, and more. Finally, Partnership's Director of Health Equity has also been tasked with developing a mandatory Diversity, Equity, and Inclusion training for all Partnership network providers and other relevant stakeholders; a pilot rollout will go live mid-2025.

VI. Stakeholder Engagement

Partnership solicits stakeholder engagement on the PNA through multiple pathways. The Population Health department 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 as needed on the final draft of the PNA, along with any proposed interventions. Population Health staff gather member feedback through Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with any proposed recommendations, and their feedback is incorporated in the final report as appropriate.

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 as necessary.

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VIII. Appendix A: HEDIS® MCAS Regional Performance Report Year 2024; Measurement Year 2023

Select Report Year
Report Year 2024; Measurement Year 2023

Select Provider Type
All Providers

HEDIS Regional Performance
Report Year 2024; Measurement Year 2023
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
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	49.92%	58.54%	69.61%	66.50%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	50.00%	45.64%	59.95%	57.06%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	45.97%	58.72%	59.84%	61.75%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	8.03%	18.98%	44.53%	37.47%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	49.23%	51.78%	59.02%	57.40%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	61.34%	63.14%	64.29%	64.75%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	30.34%	31.60%	27.35%	34.81%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	38.85%	32.46%	29.85%	30.00%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	38.81%	33.15%	31.32%	33.06%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	20.19%	31.87%	51.82%	47.93%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	51.09%	64.96%	61.07%	59.37%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	81.36%	82.19%	87.50%	93.71%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	85.30%	79.00%	88.75%	93.71%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	41.64%	48.03%	47.79%	49.45%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	56.09%	65.44%	65.20%	67.47%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	39.25%	45.26%	36.83%	46.28%	52.84%	58.38%	63.34%	68.09%

**- 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.*
****BCS-E In historical measurement years was named BCS. New data collections ECDS*
– HBD - HbA1c Poor Control is an inverted measure; a lower rate results in a better performance.
Note: AMR is a new measure held to MPL for MY2023

2

IX. Appendix B: Growing Together Program Flyer

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

The Growing Together Program

Our Growing Together Program supports members during and after pregnancy, and children from birth up to age 3. This program is offered to Partnership members at no cost. Learn how the Growing Together Program can help you.

The Growing Together Program features:

The Prenatal Program – earn up to $50 in gift cards!

This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

You will also get:

- A welcome call upon referral
- Up to 3 check-in phone calls throughout the program
- Information about doula benefits
- Support for prenatal visits
- Referrals to care coordination
- Health education

The Postpartum Program – earn up to $100 in gift cards!

This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

You will also get:

- A welcome call upon having your new baby
- Up to 2 check-in calls throughout the program
- Help to enroll your baby into Medi-Cal
- Support for postpartum and well-baby visits
- Referrals to care coordination
- Health education

PartnershipHP.org (800) 863-4155 HealthEd175_102324

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The Healthy Baby Program – earn up to $200 dollars in gift cards!

This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits:

- 2 well-child visits before 3 months
- 2 well-child visits before 9 months
- 2 well-child visits between 9-15 months
- 2 well-child visits between 15-30 months

Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age. A vaccine record must be submitted to Partnership's Population Health Department. Call us to enroll your baby as soon as they get Partnership.

You will also get:

- A welcome call
- Referrals to care coordination
- Check-in calls at 3, 7, 14, 22, 26, and 30 months
- Support for well-baby visits and the recommended screenings and vaccines

To learn more or sign up for the Growing Together Program, call us at **(855) 798-8764**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**. You can also email us at PopHealthOutreach@partnershiphp.org.

This notice does not change your Partnership benefits or keep you from getting the care you need.

X. Appendix C: Member Scholarship Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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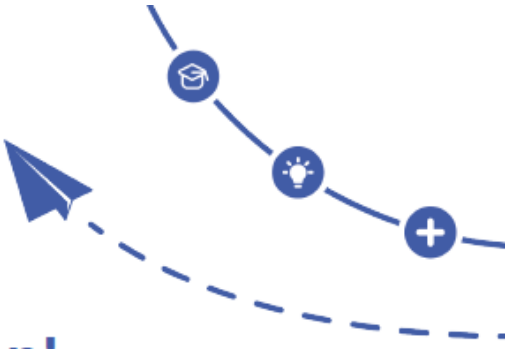

MEMBER SCHOLARSHIPS 2025

Apply for up to $10,000 Towards higher education!

Partnership HealthPlan of California is introducing our first-ever scholarship program for our members! **The Partnership Member Scholarship Program** provides one $10,000 scholarship and four $5,000 scholarships. Scholarships are awarded on the basis of: the quality of responses to essay questions; the strength of the applicant's expression of interest in a career in health care, social service, or public service; and a letter of recommendation.

Who can enter: Current Partnership members, those who were Partnership members within the past 12 months, or foster care youth who were Partnership members within the past three years. The entrant must show they intend to pursue a career in health care, social service, or public service and must be enrolled at or applying to a higher education institution and enrolled within one year of the application due date.

How to enter: Entrants must complete the application form including essay questions; obtain one letter of recommendation; and sign a waiver of confidentiality and release, as well as an accuracy statement. **Applications can be submitted from January 6 through February 28, 2025.**

Essay questions: (See application for details and word limits.)

1. How will your studies further your plans for a career in health care and/or human/public/social services fields? What are your career goals?
2. How has Partnership HealthPlan of California been a partner in your health/life? (This can be medical care, services, and/or supports that Partnership has helped provide.)
3. Optional: Is there anything else you want to share that makes you a good candidate to receive this award?

Scholarship winners: Partnership will review all entries and determine recipients. Scholarship winners will be announced in May 2025.

For more information, visit our Member Scholarship Program webpage.

If you have additional questions, email Communications@partnershiphp.org

XI. Appendix D: Community Resource Page

XII. Appendix E: Provider Recruitment Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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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

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XIII. Appendix F: Provider Retention Initiative

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Retention Initiative

January 2025

Partnership has updated the Provider Retention Initiative (PRI), which is now available and open for applications until June 30, 2025. The PRI is intended to recognize primary care clinicians, as well as those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, 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 in 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) / certified nurse midwife (CNM) – three-year commitment

Award Payment Cycle:

Award	FY 24/25	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/CNM	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA/CNM) 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, obstetrics, 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

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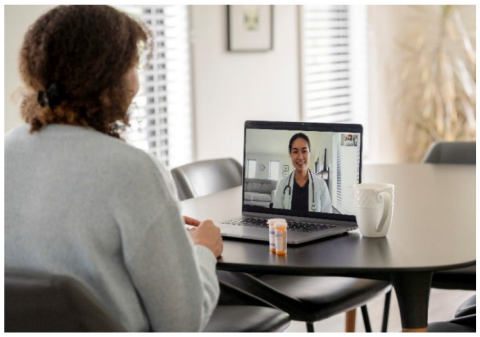
XIV. Appendix G: At-Home Telehealth Specialty Visits

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.

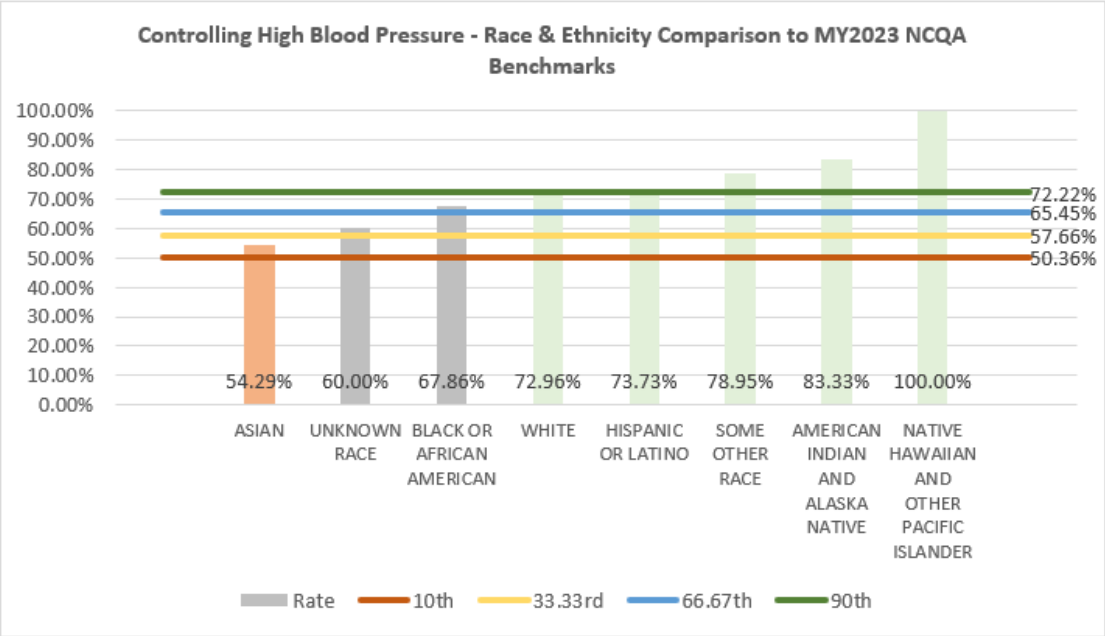
Call or email the telehealth specialist if you have any trouble or if you need to reschedule your visit:

- 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.

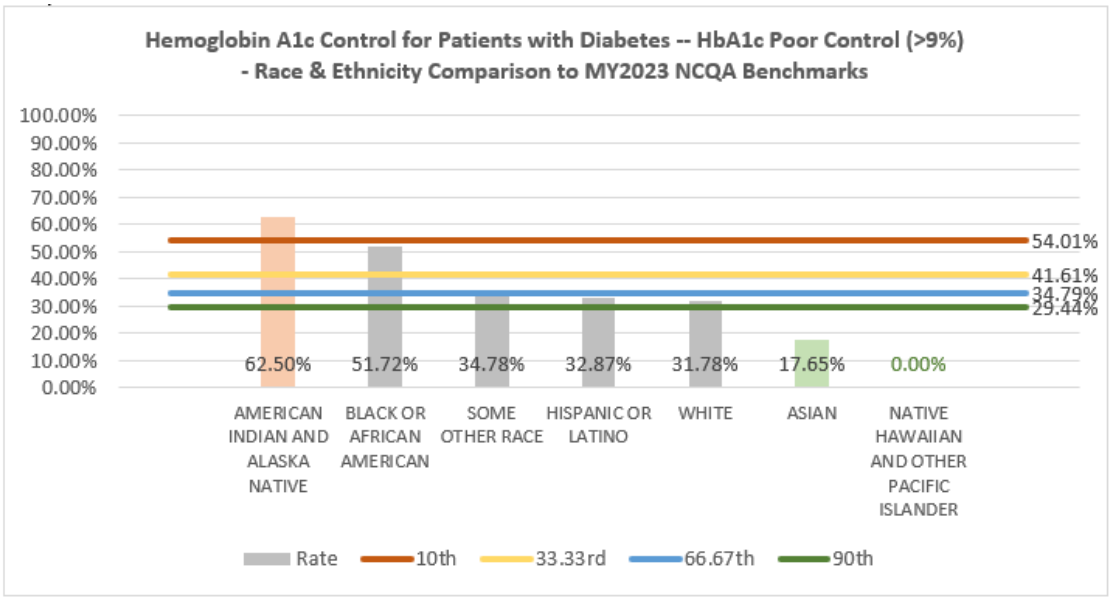
Read the questions and answers below to find out more.

XV. Appendix H – NCQA Benchmarks

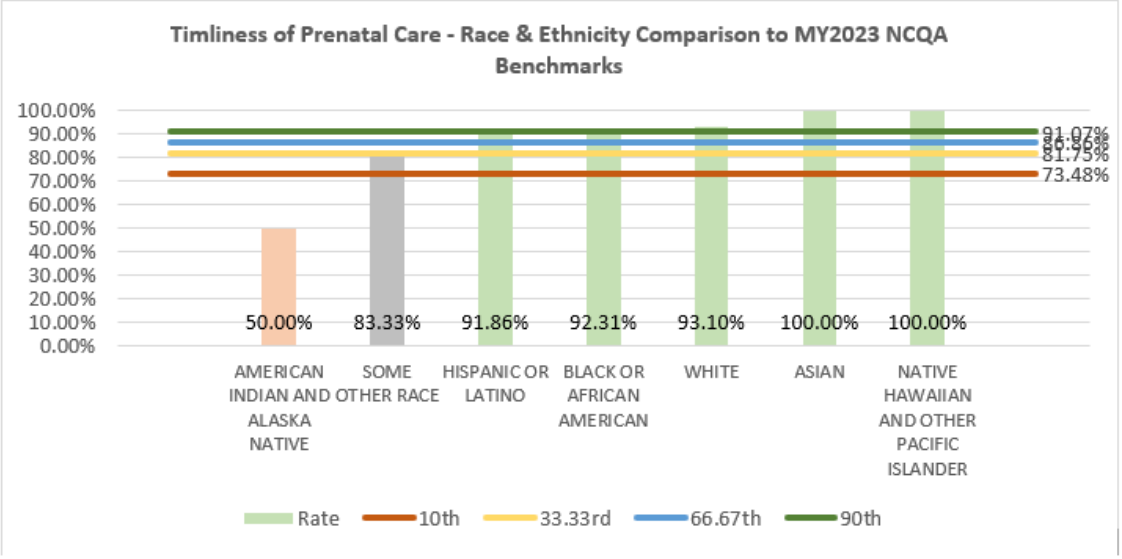
Graph I: Controlling High Blood Pressure - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



Graph 2: Hemoglobin A1c Control for Patients with Diabetes -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

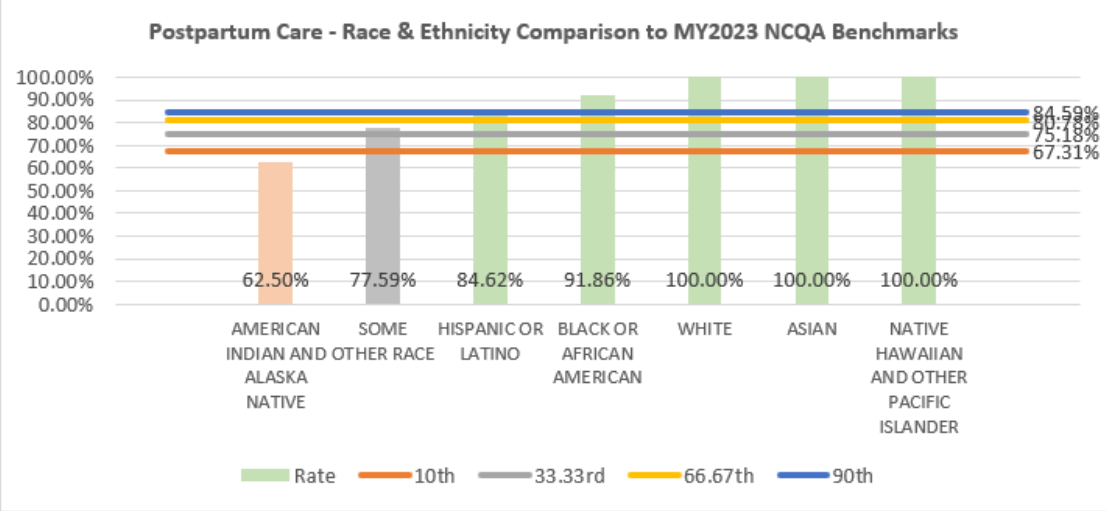


Graph 3: Timeliness of Prenatal Care - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Graph 4: Postpartum Care (PPC – Post) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



Graph 5: Child & Adolescent Well Care Visits (WCV) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks