Population Needs Assessment

May 2021

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Population Needs Assessment Overview

Partnership HealthPlan of California (PHC) is a not-for-profit, Medi-Cal Managed Care Plan (MCP), serving fourteen (14) counties in Northern California with a membership size of about 583,727 (as of December 2020). PHC is one of California's six (6) County Organized Health System (COHS) managed care models endorsed by the County Boards of Supervisors that serve exclusively in the assigned counties. PHC contracts with the California Department of Health Care Services (DHCS) to provide health services to members in 14 designated counties. Most Medi-Cal beneficiaries are assigned automatically to PHC, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and beneficiaries in skilled nursing facilities. In addition, dual-eligible Medicare-Medicaid members are assigned to PHC as a secondary line of coverage. PHC provides primary and specialty health services through a contracted network of community providers, medical groups, an integrated HMO (Kaiser Permanente), Federally-Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Centers, local hospitals (acute and other), pharmacies, and ancillary providers.[1]

PHC collects, integrates, and assesses data from its member population to develop and inform the Population Needs Assessment (PNA) and various activities. Data sets used for PHC's 2021 PNA included: Healthcare Effectiveness Data and Information Set (HEDIS®) results; PHC Member Enrollment data; Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data; Health Disparities data; Timely Access data; PHC Integrated Claims and Encounter data; PHC Grievance and Appeals data, County Health Rankings and Roadmaps data, published articles, as well as reports from the Centers for Disease Control and Prevention (CDC) and the American Community Survey from the United States Census BureauThe 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. The key findings identified several ways to improve member experience, involving Quality Improvement, Provider Relations, Member Services, Health Education, and Cultural and Linguistics departments, as well as opportunities to promote understanding of health equity for all PHC staff. The PNA Action Plan for 2021 addresses members' knowledge about use of both PHC Grievance and Appeals as well as Verbal Interpreter Services (VIS); and ongoing improvement of PHC staff knowledge of health equity concepts. Additionally, the PNA identified health disparities among the American Indian/Alaska Native

[1] (Medi-Cal Managed Care Plan, 2020)

population related to Breast Cancer Screening (BCS) and Asthma Medication Ratio (AMR) rates.

The 2021 PNA Action Plan includes:

1. Assess member barriers to using the PHC Grievance and Appeals process by race, ethnicity, and language, by December 31, 2021.
2. Improve member access to verbal interpreter services at provider sites by December 31, 2021.
3. Provide trainings to address health equity knowledge gaps for PHC internal staff by December 31, 2021.
4. Health Disparities: Establish a multi-year strategy to promote health equity that will reduce American Indian health disparities, including those noted above. In 2021, we will engage Indian Health Services providers, as well as Native American tribal leaders and members within PHC's service area, to better understand their needs and priorities for health.

Data Sources

2020 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a comprehensive set of standardized performance measures established by the National Committee of Quality Assurance and designed to allow reliable comparisons of health plan performance. The methodology for each HEDIS measure is described in the annual HEDIS Technical Specifications corresponding to the study year. DHCS selects some of these HEDIS measures to be used as annual performance measures for MCPs, the Managed Care Accountability Sets (MCAS). Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targeted benchmarks for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile of the national NCQA HEDIS performance for Medicaid and varies by each measure. PHC uses annual HEDIS results to determine quality and incentivize improvements, and to evaluate health inequities for our members by race, ethnicity, and language. PHC has four (4) reporting regions for HEDIS measures: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake).

2020 PHC Member Enrollment Data

PHC demographic data is based on the Medi-Cal enrollment data received as of December 2020. This data includes the total number of individuals enrolled in Medi-Cal

and assigned to PHC by eligibility group. DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans monthly based on their service areas. This data reflects the race/ethnicity, age, gender, and language distribution by members, along with indicators for seniors and persons with disabilities, complex pediatric conditions, and those living in long-term care facilities.

2020 PHC Grievance and Appeals Data

PHC's Grievance and Appeals (G&A) team provides quarterly and annual reports that document both the type of concerns raised by members as well as the demographics of the members who file the concerns. Grievances may be related to discrimination, denial of services, complaints about providers, and other issues.

2020 PHC Integrated Claims and Encounter Data

PHC's analytics department maintains an integrated data set, including medical and pharmacy claims data for the services PHC reimburses, as well as services directly reimbursed by the State. The 2020 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services, and documents both the clinical conditions they diagnose as well as the services and items delivered to beneficiaries to treat these conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. PHC's paid claims and encounter data are integrated with State-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims for carved out medications, claims from our delegated managed behavioral healthcare organization, Beacon Health Options (Beacon), and claims from members assigned to Kaiser for medical and mental health services.

2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Agency for Healthcare Research and Quality (AHRQ) develops, implements and administers several different patient experience surveys. These surveys inform health care organizations about patients' or their families' experiences with their health care providers and plans, including hospitals, home health agencies, doctors, and health and drug plans, among other provider types.

Results from the CAHPS survey in 2020 addressed questions related to the timeliness of care, shared decision-making, experiences with personal doctors, and availability of specialists when needed. Below, in Figures 1 and 2, are the summaries of the key PHC CAHPS survey results.

Figure 1: 2020 Adults CAHPS Results

	ADULT CAHPS Composite Score	2019 (Previous Reporting)	2020 (Current Reporting)
Rating Measure	Rating of Health Plan (% 8, 9, 10)	72.5%	70.9%
	Rating of All Health Care (% 8, 9, 10)	73.2%	71.5%
	Rating of Personal Doctor (% 8, 9, 10)	79.8%	81.3%
	Rating of Specialist Seen Most Often (% 8, 9, 10)	82.6%	77.9%
Composite Measure	Getting Needed Care (% Always or Usually)	78.2%	77.2%
	Getting Care Quickly (% Always or Usually)	79.6%	78.4%
	Care Coordination (% Always or Usually)	84.0%	81.9%
	Customer Service (% Always or Usually)	90.8%	88.3%

Source: 2020 CAHPS 5.0 Adult and Child Medicaid Survey, Partnership HealthPlan of California

Figure 2: 2020 Child CAHPS Results

	CHILD CAHPS Composite Score	2019 (Previous Reporting)	2020 (Current Reporting)
Rating Measure	Rating of Health Plan	70.1%	72.1%
	Rating of All Health Care	63.8%	67.8%
	Rating of Personal Doctor	77.2%	77.2%
	Rating of Specialist Seen Most Often (76 responses)	81.6%	74.4%

Composite Measure			
	Getting Needed Care	81.7%	83.2%
	Getting Care Quickly	87.4%	88.8%
	Care Coordination	86.4%	85.9%
	Customer Service	89.2%	91.8%

Source: 2020 CAHPS 5.0 Adult and Child Medicaid Survey, Partnership HealthPlan of California

2020 Timely Access Data

Timely Access data is gathered by an annual survey that assesses the availability of the third next available appointment for adult and pediatric primary care, newborn visits, and urgent care visits. This survey is used to evaluate appointment care access for PHC members.

2020 Health Disparities Data

DHCS contracts with the Health Services Advisory Group (HSAG) to help assess and improve health disparities in California through their annual study. HSAG's sole purpose is to improve healthcare services in order to achieve the best possible patient outcomes. HSAG utilizes Managed Care Accountability Set (MCAS) performance indicators reported by Medi-Cal managed care health plans for reporting year 2020 with data derived from calendar year 2019 to conduct this study. This report provides data on health disparities data specific to PHC.

2020 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.[2] The 2020 annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy food, the quality of air and water, income inequality, and teen births. The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, play, and improve the overall wellbeing of an individual. The rankings are determined by the following factors:

1. Health Outcomes: The overall ranking in health outcomes measures the overall health of county residents. They reflect the physical and mental well-being of

[2] (County Health Rankings and Roadmaps, 2020)

residents within a community through measures representing length of life and quality of life.

2. Health Factors: The overall ranking in health factors represents many things that influence how well 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.

Other Data Sources

In addition to the specific data sources listed above, PHC regularly reviews published research in areas impacting our population. PHC leaders and clinicians subscribe to journals that describe evidence-based care, promising practices in caring for complex members and those with behavioral health or substance use disorders, and address social determinants of health and population health management strategies. We reference United States Census Bureau reports, such as the 2015-2019 American Community Survey (ACS) for demographic information for our various regions. We also review national data sources, such as the Centers for Disease Control and Prevention, to track national trends and align ourselves with emerging care protocols, such as the recommendations for COVID-19 testing, quarantines, and immunizations.

Overview of Procedures, Resources and Methodologies

PHC collects, integrates, and assesses data from its member population to develop and inform the Population Needs Assessment (PNA) and various activities. The integration of data sources may include, but are not limited to, the following:

1. Medical and Behavioral claims and encounters
2. Pharmacy claims
3. Health appraisal results
4. Electronic health records
5. Member satisfaction survey results
6. Health service programs within the organization
7. Advanced data platforms, such as health information exchanges, the California Immunization Registry (CAIR), and the Healthy Places Index (HPI).

PHC uses this data to assess the characteristics and needs of its member population, which may include, but is not limited to, the following:

1. Age
2. Language

3. Race/Ethnicity
4. Geographic location
5. Social Determinants of Health (SDOH) extrapolated from County Health Rankings using member census tract
6. Service utilization
7. Health-related behaviors
8. Health conditions
9. Health disparities
10. Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities and/or with serious and persistent mental illness (SPMI)

Population Segmentation

After reviewing PHC's overall population needs, the population is segmented into subgroups with similar needs and characteristics. This process leverages information gathered from a variety of reports that may include but are not limited to health/risk assessments, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as over and underutilization of care reports. Various factors influence how frequently PHC reviews population segmentation, such as state findings, natural disasters or events such as COVID-19, and standard business practices; however, the overall segmentation is reviewed annually to ensure equity and that all populations are served.

In conjunction with evaluating member needs, PHC assesses and monitors programs and activities no less than annually. The results are used to review and update PHC interventions, as well as to evaluate whether PHC and community resources are sufficient to address member needs.

Key Findings

Membership/Group Profile

PHC currently serves more than 583,000 Medi-Cal beneficiaries in 14 counties in Northern California (per PHC enrollment data as of December 2020). PHC primarily serves children and adults under age 65; in 2020, there were 9,026,052 children living in the State of California, out of which PHC served 2.5% (230,111) of the state's child population.[3]

[3] (Lucille Packard Foundation, 2020)

Geographic Distribution

PHC's service area includes Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo Counties. PHC's four (4) regional offices, as seen in Figure 3, are centrally located in Fairfield, Redding, Santa Rosa and Eureka.

Figure 3: Map of PHC Counties with Location of Regional Offices

Source: Partnership HealthPlan of California Website, 2020

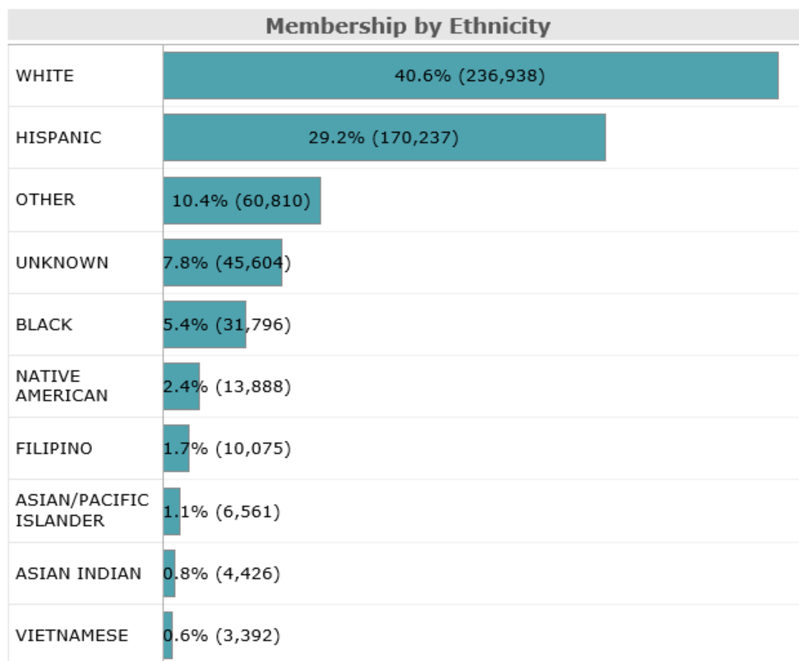
Age and Gender

According to the 2020 PHC member enrollment data, approximately 21% are ages 0-10, 18% are ages 11-19, 32% are ages 20-44, 19% are ages 45-64, and 9% are ages 65 and older. 47% of all members are male while 53% are female. In addition, there were approximately 6,250 babies born to PHC members during CY 2020.

Race/Ethnicity

The largest ethnic categories of our membership are White (40.6%) and Hispanic (29.2%). Figure 4 below illustrates the racial and ethnic composition of PHC members as of December 2020, based on PHC member enrollment data. The Hispanic membership represents the largest non-White ethnic group across all 14 counties.

Figure 4: 2020 PHC Membership by Ethnicity

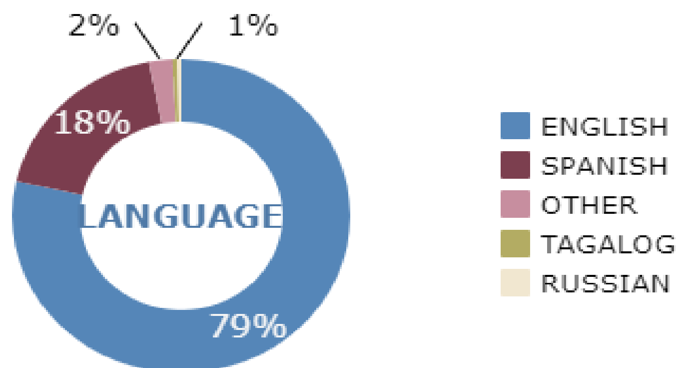


Source: 2020 Member Enrollment Data, Partnership HealthPlan of California

Primary Language

English continues to be the primary language spoken by PHC members according to PHC's 2020 enrollment data. Currently, about 79% of members identify as English speaking and 18% of members identify as Spanish speaking. The other two DHCS threshold languages include Russian and Tagalog (which combine to less than 1% of the population), and 2% of the population speak something other than the four threshold languages.

Figure 5: 2020 PHC Membership by Primary Language



Source: 2020 Member Enrollment Data, Partnership HealthPlan of California

Health Status and Disease Prevalence

SPH Analytics conducted the 2020 CAHPS survey on behalf of PHC in the first quarter of 2020, and before COVID-19 shelter-in-place orders went into effect. SPH reached out to 2,025 adult members and 3,330 pediatric members to perform the surveys. There were 298 adult responses (15%) and 540 (16.5%) pediatric responses. The CAHPS results revealed that 71.5% of adult members who participated in the study rated their overall health care as good or excellent (scores of 8, 9, or 10) compared to 2019 results where 73.2% rated their health care as highly. This represents a drop of 1.7% from the 2019 report.

Figure 6: 2020 Adults CAHPS Results

	SUMMARY RATE		% CHANGE	2020 SPH BENCHMARK		2019 QC BENCHMARK	
	2019	2020		SUMMARY	PERCENTILE	SUMMARY	PERCENTILE
Rating of Health Care *(% 9 or 10)*	49.1%	50.8%	1.7%	58.8%	6th	54.9%	20th
Rating of Health Care *(% 8, 9 or 10)*	73.2%	71.5%	-1.7%	76.9%	11th	75.4%	18th

Source: 2020 CAHPS 5.0 Adult and Child Medicaid Survey, Partnership HealthPlan of California

The children survey results show that 85.1% of those completing forms on behalf of pediatric members rated their child's overall health care as good or excellent (scores of 8, 9, or 10) compared to 2019 results where 83.0% rated their health care as highly. This represents an increase of 2.1% from the 2019 report (Figure 7).

Figure 7: 2020 Child CAHPS Results

	SUMMARY RATE		% CHANGE	2020 SPH BENCHMARK		2019 QC BENCHMARK	
	2019	2020		SUMMARY	PERCENTILE	SUMMARY	PERCENTILE
Rating of Health Care *(% 9 or 10)*	63.8%	67.8%	4.0%	73.0%	15th	70.4%	27th
Rating of Health Care *(% 8, 9 or 10)*	83.0%	85.1%	2.1%	88.7%	11th	87.5%	19th

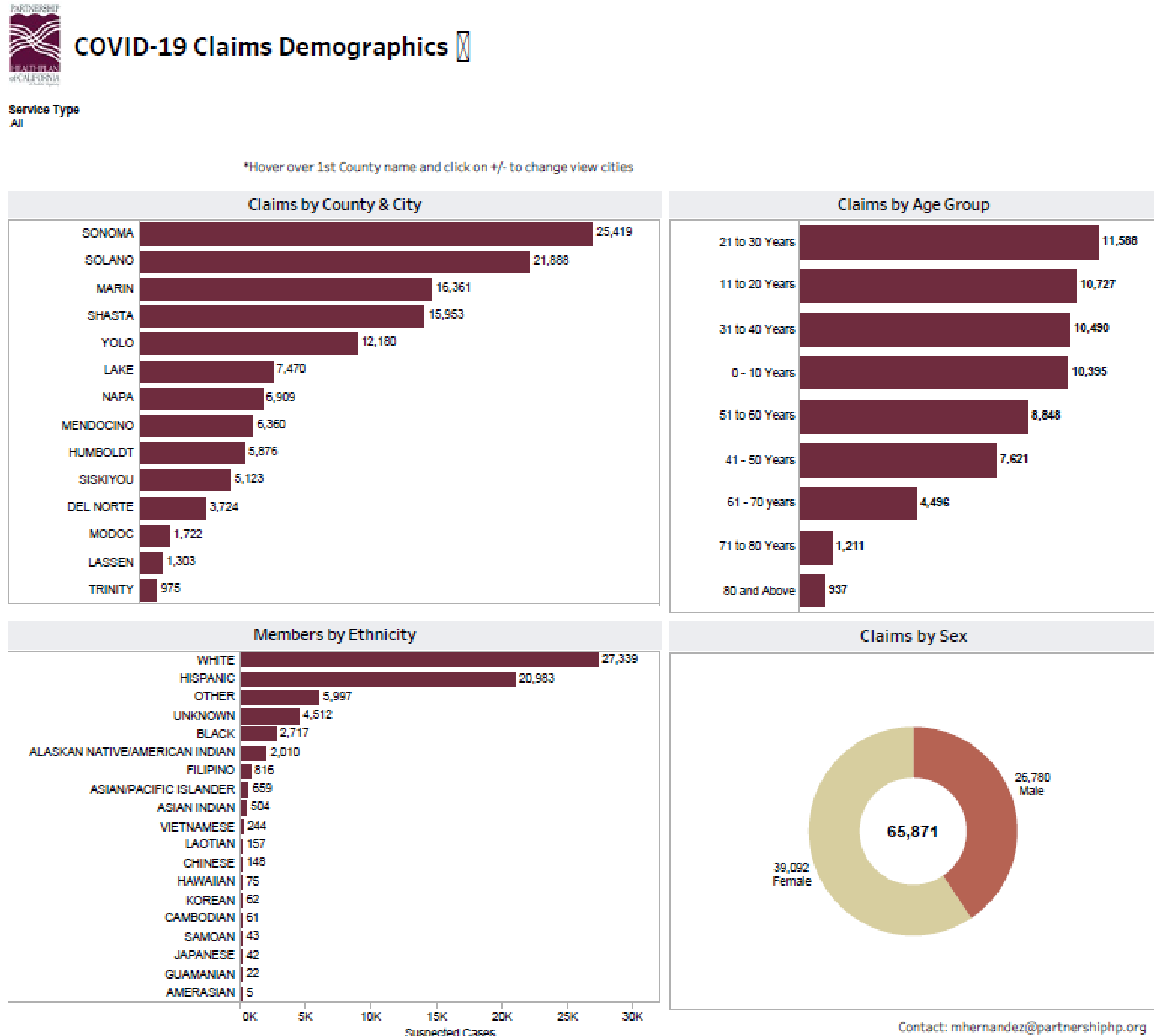
Source: 2020 CAHPS 5.0 Child Medicaid Survey, Partnership HealthPlan of California

COVID-19 Experience and Member Support

COVID-19 has impacted every health plan. As of March 2021, more than 65,000 members have incurred over 123,000 claims related to COVID. These claims are spread across PHC's membership demographics, with White members representing 27,339 of the claims, followed by Hispanic members with 20,983 of the claims. Of interest, members between the ages of 21 – 30 years of age have the most claims at

11,588, followed by members 11 – 20 years of age (10,727) and members 31 – 40 years of age (10,490) (Figure 8).

Figure 8: Partnership HealthPlan COVID-19 Claims Demographics



Source: Partnership HealthPlan 2021 Claims and Encounter Data

When the COVID-19 pandemic swept through the nation, PHC leveraged the newly-formed Population Health department to provide support to members during this unprecedented time. Beginning in April 2020, PHC identified more than 60,000 members who were particularly vulnerable to COVID-19 infection due to age, disability, or chronic conditions. Every PHC department contributed to a 10-week effort to call the 60,000+ members through our “TLC4C19” campaign to offer information about how their providers would be offering services during the season of lock-down and isolation.

As the pandemic continued, PHC identified community-based resources in each of the 14 counties and created COVID resource pages for members looking for help with food, housing, and other social needs. PHC shared this information with Aunt Bertha (a community information exchange platform) to ensure all members of the community had free access to these resources, and updated these resource pages monthly. Regional leaders and staff maintained close contact with communities to identify testing sites and to ensure members knew how and where to go for needed testing.

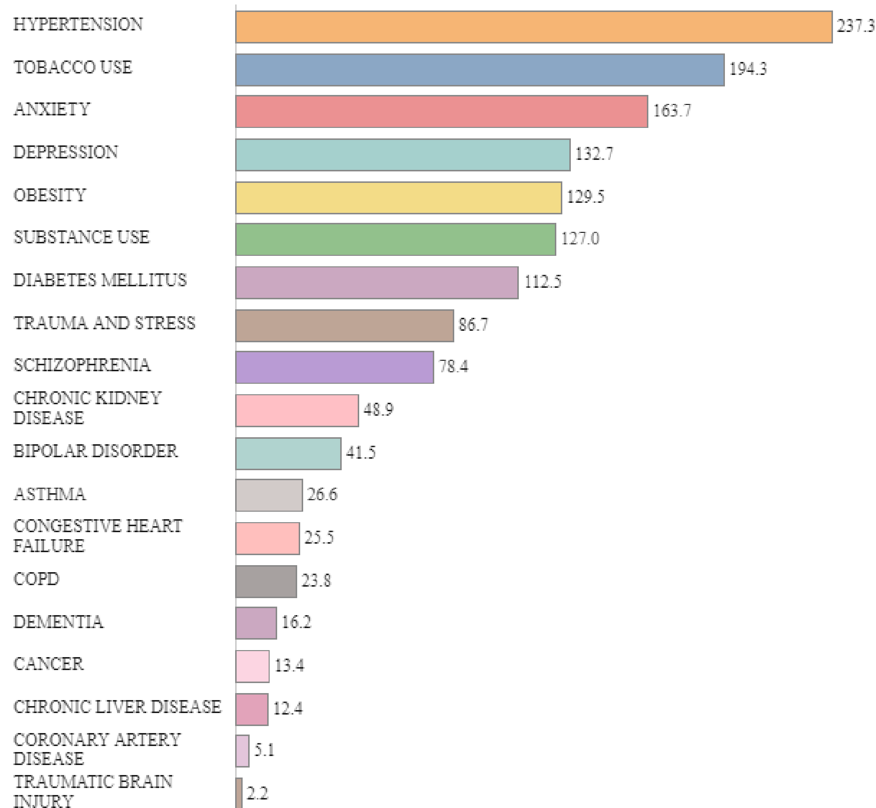
Once immunization efforts began, PHC collaborated with county public health to contact members over 75 years of age who were not well-established with a PCP and having language barriers. We performed outreach to 238 members and were able to set vaccination appointments for 18 of them. Using member language data, we used telephonic interpreter services to ensure that all language groups were notified of vaccination opportunities near them. We also provided counties with lists of members who were over age 65, disabled, and not having had a claim for a PCP visit in the prior two years who we believed may be home-bound, so that counties could provide in-home vaccinations once they were able.

COVID remains the over-riding public health concern in 2021, and it is impossible to predict the long-term effects this disease will have on the population. This pandemic has highlighted the priority of ongoing collaboration between payers, providers, county public health, and other community organizations as essential for meeting this challenge. Many new pathways and forms of communication have developed out of necessity; we have a unique opportunity to capitalize on this pandemic and create enduring partnerships on behalf of our communities.

Disease Prevalence

Per the 2020 PHC Integrated Claims and Encounter data, there were seven (7) chronic diseases prevalent in adults and children. Chronic conditions lead to disability; therefore, mitigating these chronic conditions may improve the functional status of members having these conditions. As shown in Figure 9, the most prevalent chronic conditions for adults were: Hypertension (237.3 per 1000 members), Tobacco Use (194.3 per 1000 members), Anxiety (163.7 per 1000 members), Depression (132.7 per 1000 members), Obesity (129.5 per 1000 members), Substance Use (127 per 1000 members), and Diabetes Mellitus (112.5 per 1000 members).

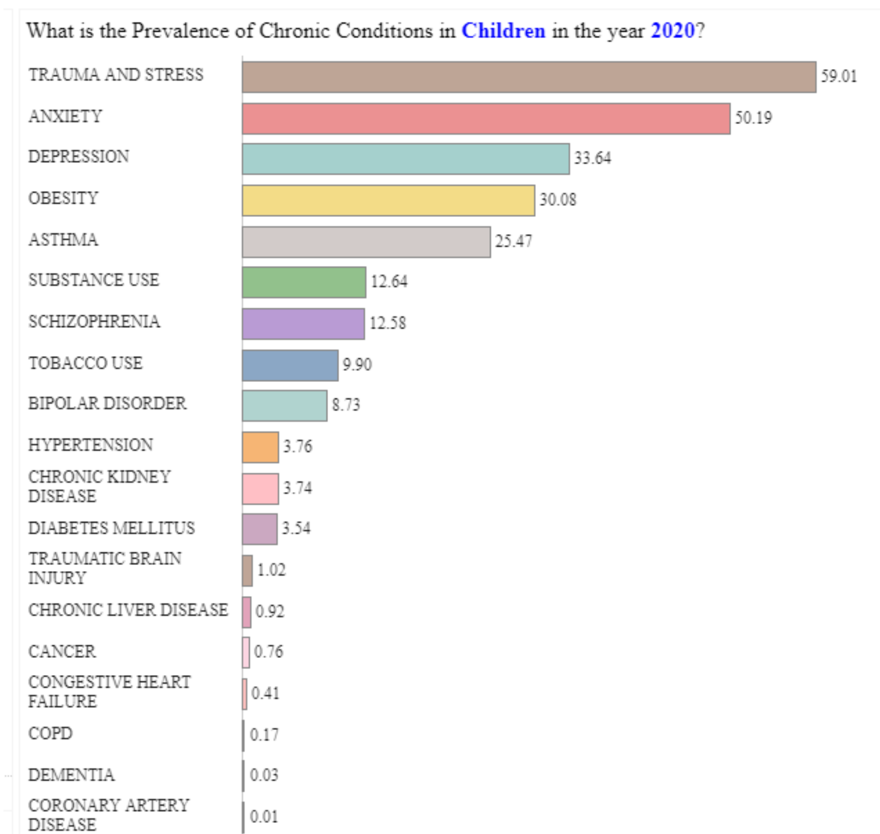
Figure 9: 2020 Adults Chronic Conditions Prevalence Data Per 1000 Members



Source: 2020 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

The seven (7) most prevalent chronic conditions found in children were: Trauma and Stress (59 per 1000), Anxiety (50.1 per 1000), Depression (33.5 per 1000), Obesity (30 per 1000), Asthma (25.4 per 1000), Substance Use (12.6 per 1000), and Schizophrenia (an SPMI) (12.5 per 1000) (Figure 10). Of note, the low rates of prevalence for many conditions suggest that claims data may be incomplete for some of these diagnoses.

Figure 10: 2020 Children Chronic Conditions Prevalence Data



Source: 2020 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

Preventive Care

Adult Cancer Screening

A key component of preventive care is assuring adult members are completing timely cancer screenings. Three cancer metrics are monitored and assessed by PHC on an annual basis. Two measures, breast cancer screening and cervical cancer screening, are assessed as part of the DHCS MCAS and current NCQA HEDIS accreditation measure sets. Colorectal Cancer Screening is a derived HEDIS measure included for assessment as part of the Primary Care Provider Quality Improvement Program (PCP QIP), PHC's largest pay-for-performance program, and initiatives to encourage appropriate testing for early detection of colon cancer.

Women's preventive health is a focus area given lagging rates in some counties. The MPL for Breast Cancer Screening is 58.67% for the 2019 Measurement Year (2020 Reporting Year). The Northeast (55.13%) and Northwest (47.96%) PHC regions performed below the MPL among eligible members 52-74 years of age who had a mammogram as of the last day of the measurement year. In contrast, the Southeast

(64.54%) and Southwest (60.26%) achieved percentile improvement gains over the prior year and reported above-MPL performance. These challenges are being addressed through improvement activities that include exploring mobile mammography options, optimizing referral processes between PCPs and imaging providers, and engaging members in education on the importance of breast cancer screenings.

Similar challenges are also occurring under Cervical Cancer Screening. The MPL for this measure is 60.65% for the 2019 Measurement Year (2020 Reporting Year), reflecting eligible members ages 21-64 years of age who met cervical cancer screening requirements, relative to age dependent screening criteria, during the measurement year. The Northeast (55.96%) and Northwest (50.85%) PHC regions performed well below the MPL, while the Southeast (67.40%) and Southwest (68.37%) performed above the MPL. Member education and engagement on the importance of seeking this screening is a key driver of performance.

Pediatric Well-Care and Immunizations

Pediatric well-child visits and immunization rates remain a growing health concern for children and adolescents throughout California. While child and adolescent immunization rates are showing improvements in some of the counties, they are a major concern in others.

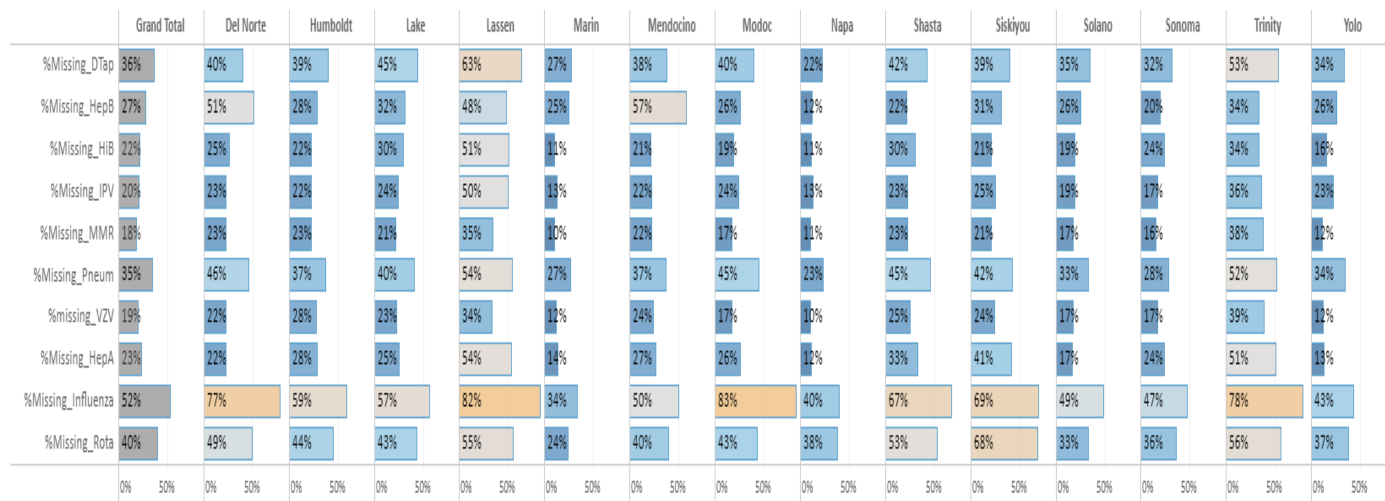
The DHCS-specified Minimum Performance Level (MPL) is set at the 50th percentile of HEDIS performance among health plans nationwide. The MPL for Childhood Immunization Status (CIS-Combo 10) is 34.79% for the 2019 Measurement Year (2020 Reporting Year). For children ages 0-2, who received all recommended immunizations by the time they turned two years old, the Northeast (15.33%) and Northwest (20.19%) PHC regions performed below the MPL, while the Southeast (43.31%) and the Southwest (43.07%) regions performed above the MPL.

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) is 34.43%. The proportion of adolescents receiving the recommended DTaP and meningococcal vaccines by age 13 was below the MPL in the Northeast (18.48%) and Northwest (30.90%) regions. The Southeast (52.31%) and the Southwest (46.47%) regions were above the MPL. For the Northwest, Southwest and Southeast, this represents a 5% or more improvement over the previous year.

There continue to be many reasons parents choose not to vaccinate their children within PHC’s 14 counties. In collaboration with health care providers and county partners, efforts are beginning to show improvements in vaccination rates in most of PHC’s counties. These partnerships help build trusting relationships in the communities and

better educate parents in an effort to overcome concerns about immunizations (Figure 11).

Figure 11: Pediatrics Missed Vaccines in 2020



Source: PHC Integrated Claims and Encounter Data, September 2020.

Chronic Disease – Adults and Children

Chronic conditions such as asthma and hypertension have marked prevalence among the adult PHC patient population.

Hypertension

Hypertension is a precursor to more serious, chronic conditions. There has been worsening control of hypertension nationwide, exemplified by the Surgeon General's Call to Action on Hypertension in October 2020. Additionally, with COVID-19, there is an increased need and urgency to avoid unnecessary provider office visits.

Hypertension is the most prevalent chronic condition among adults at 237.3 per 1000 members. PHC is working to address this in a number of ways, but namely via supporting hypertensive members in achieving control of their blood pressure. The HEDIS MPL for Controlling High Blood Pressure is 61.04% for the 2019 Measurement Year (2020 Reporting Year). All four of PHC's reporting regions achieved at least the MPL in performance reported over 2019. With the onset of the pandemic in early 2020, PHC has invested resources in providing blood pressure monitoring devices directly to hypertensive members, upon request of providers.

Asthma

The annual DHCS HEDIS MCAS performance report identified opportunities to improve the prescription of controller vs. rescue medications. NCQA HEDIS measures evaluate health plan performance via a broadly defined asthma care measure that includes eligible members from 5 to 64 years of age diagnosed with persistent asthma and the ratio of use of controller medication to total asthma medications. This performance data is stratified to better assess member level performance by age groups, but reported as a total performance result by PHC region. The MPL for Asthma Medication Ratio (AMR) is 63.58% for the 2019 Measurement Year (2020 Reporting Year). The Northeast (52.23%) and Northwest (51.85%) performed below the MPL, while the Southeast (71.26%) and Southwest (63.86%) performed above the MPL.

PHC has multiple improvement initiatives under asthma care. One promising intervention pairs PHC clinicians with primary care providers to share evidence-based prescribing practices, leveraging the PHC formulary. PHC calls this process "academic detailing." The process involves peer-to-peer discussions that encourage improved prescribing activities, based on performance analysis specific to the providers' assigned member population. The PCP QIP program reinforces evidenced-based care by incentivizing performance that meets targeted standards.

Behavioral Health Concerns

PHC's overall strategy to address the comprehensive needs of our members requires effectively addressing the behavioral health needs of our members, including both mental health and substance use disorders. In general, the prevalence of behavioral health disorders is higher among low-income people, including those in the Medi-Cal program. About twice as many adult Medi-Cal beneficiaries and 1% as many youth on Medi-Cal experience serious and persistent mental illness (SPMI).[4] Similarly, while about 8% of the general population are diagnosed with substance use disorders, about 12% of the Medicaid (Medi-Cal in California) population are diagnosed with a Substance Use Disorder (SUD).[5]

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[4] In 2015, 1 in 25 adults in the general population were diagnosed with serious mental illness; 1 in 11 in below the federal poverty level had such a diagnosis, with the rates even higher among persons of color. Similarly, one in 13 youth in the general population had serious emotional disturbances, while 1 in 10 of those under the federal poverty line had these disturbances. *California Budget and Policy Center, "Mental Health in California; Understanding Prevalence, Service Connections and Funding, March 2020,* Adriana Ramos-Yamamoto and Scott Graves

[5] Medicaid.gov; https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorders/index.html#:~:text=Substance%20Use%20Disorders%20(SUD)%20impact,effectively%20serve%20individuals%20with%20SUDs.

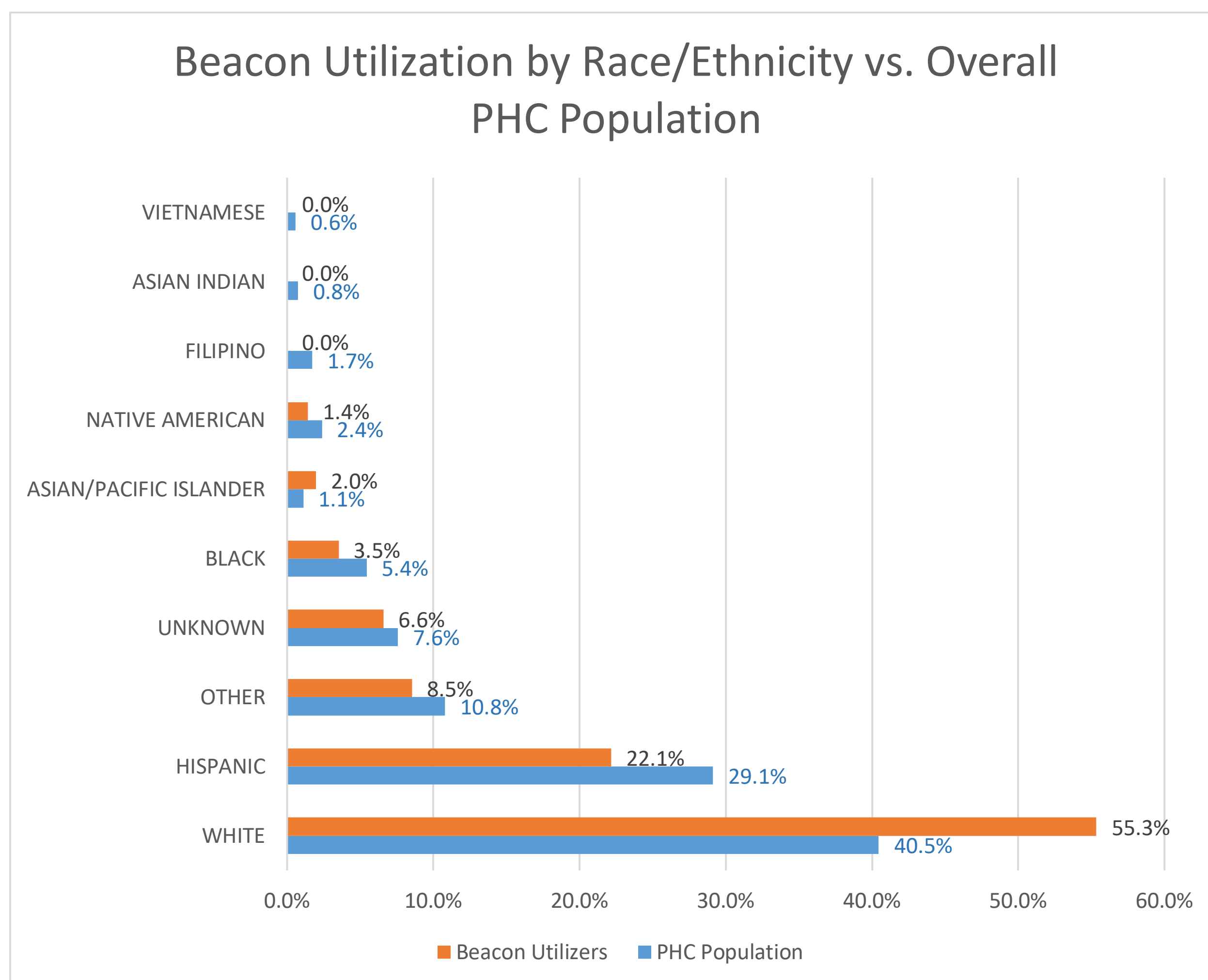
In addition, communities across the United States face intensified behavioral health challenges related to the COVID-19 pandemic. As of late June 2020, the CDC reports that 40% of adults struggled with mental health, SPMI, or substance use issues, and these difficulties are more prevalent among non-White individuals. More than 10% of those surveyed reported suicidal thoughts in the last 30 days, with the percentage an alarming 25.5% among 18 to 24 year olds.[6] These trends were expected to intensify as the pandemic continued to spread.

Mental Health Illness and SPMI

In 2020, 8.3% of PHC members received mental health services from PHC's delegated managed behavioral healthcare organization, Beacon Health Options (Beacon) or from Kaiser's mental health services. According to Beacon's 2020 claims data, 42,481 members had claims for mild to moderate mental health needs. Of those, approximately 71% were adults and 29% were children. While female members comprise approximately 53% of PHCs population, they were higher users of Beacon services, representing 65% of the utilization compared to approximately 35% male utilization. As shown in Figure 12, access to Beacon services by race/ethnicity is not proportionate to PHC's demographics. White members represented over 55% of Beacon's service population while only making up 40% of PHCs total population. The other ethnicity with higher proportional utilization of Beacon services were the Asian/Pacific Islanders, who made up 2.0% of mental health services users while only representing 1.1% of the total PHC population. In contrast, no claims for Beaon services were made in 2020 by PHC's Vietnamese, Asian Indians, and Filipinos, who represent roughly 3.1% of PHC's population.

[6] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

Figure 12: 2020 Beacon Utilization by Race/Ethnicity vs. Overall PHC Population

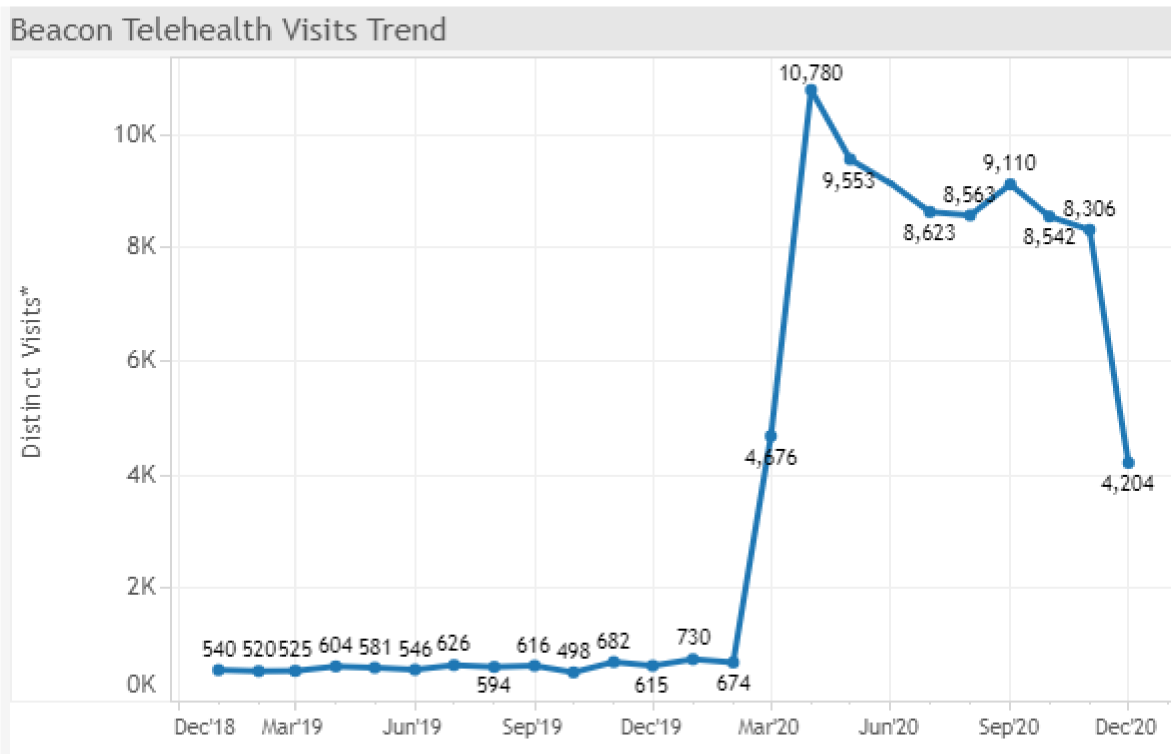


Source: 2020 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California; December 2020 Membership by Ethnicity, PHC Membership Data

Kaiser provided a total of 15,429 service visits to 4,202 members in the same period. Additionally, approximately 10 percent of PHC members received some mental services through their PCP during the same period. Finally, many of PHC's adult members with SPMI and children with serious emotional disturbance (SED) received mental health care from County Mental Health Plans outside of the PHC network. These services are carved out of PHC's benefits and billed directly to the State.

Beacon Telehealth services utilization increased significantly during 2020, as telehealth services became the main mechanism for providing care during COVID-19. A total of 82,818 telehealth services were provided across PHC's counties in 2020, with the highest volume taking place in April 2020 (10,780 visits). Comparatively, there were only 660 visits in January 2020 and 4,204 visits during December 2020. The Beacon Telehealth Visit Trends are seen in Figure 13 below.

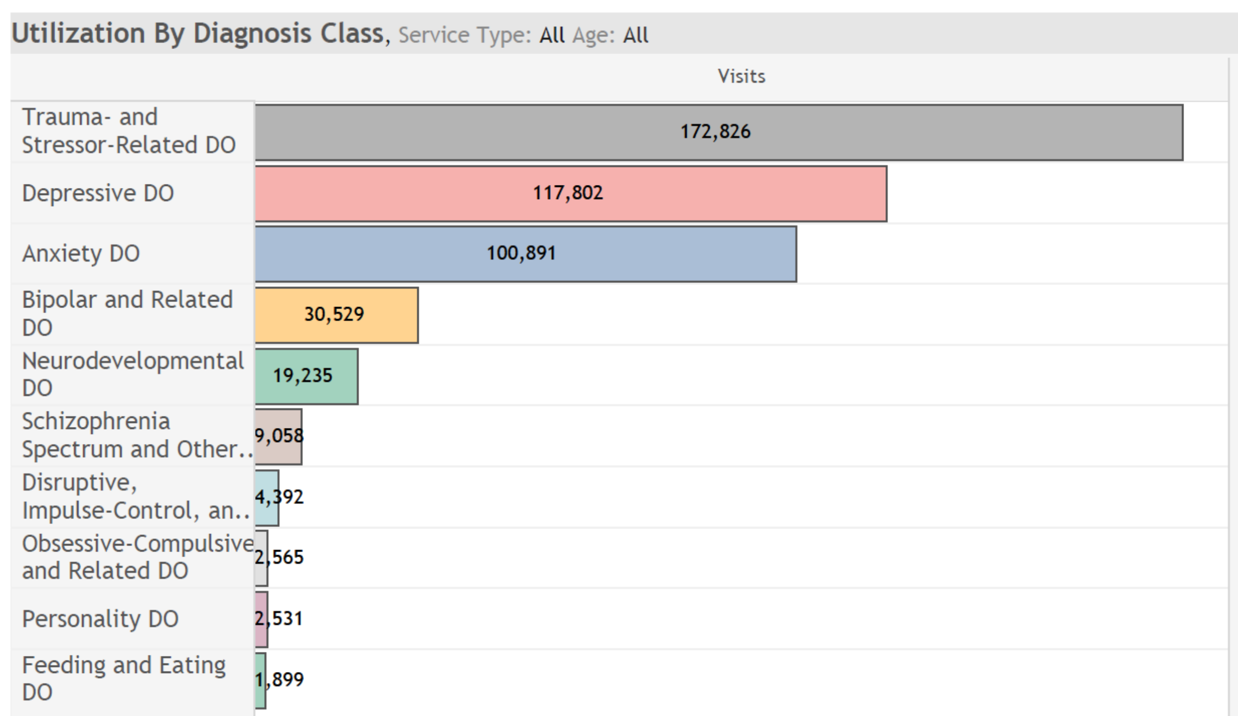
Figure 13: 2020 Beacon Telehealth Visit Trend



Source: 2020 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California

All PHC members are eligible for mental health services as long as their treatment needs can be addressed in a mild-to-moderate fashion, and there are no diagnosis exclusions, not even SPMI. However, individuals whose treatment needs are greater – for instance, those that require hospitalization or more intensive services – are referred to the County Mental Health Plans for care. The diagnoses treated in 2020 are shown in Figure 14 below:

Figure 14: 2020 Beacon Services Utilization by Diagnosis Class (Including SPMI)



Source: 2020 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California

Traumatic Events

Traumatic events can have lasting impact on both behavioral and physical health of individuals. The recognition of these needs is expected to increase as health care providers continue to recognize the importance of Adverse Childhood Experiences (ACES). Beginning in January 2020, the California "ACEs Aware" initiative began offering Medi-Cal providers training, clinical protocols and payment for screening children and adults for ACEs. Unfortunately, initial uptake of using specified codes for screening has been lower than expected state-wide, due to the complexity of the billing requirements. It will also be easier, and more accurate, to gather this information when members are able to see practitioners in person rather than via telephonic visits. As PHC gathers more information on the members who have experienced four or more traumatic events, more detailed interventions may be designed and implemented. This will support the California Surgeon General's vision of reducing the impact of toxic trauma by 50% in the next generation.

PHC has drawn upon its array of services and relationships with community providers to help members cope with traumatic events. As stated previously, during the COVID-19 pandemic PHC staff identified resources in the community to share with members to provide food, housing, and vaccination testing. Likewise, when wildfires and other natural disasters occur in PHC-covered counties, PHC collaborates with local county

public health performing outreach to help members navigate available resources during those types of emergencies. We also contact our disabled and vulnerable members directly to address their most immediate health needs during loss of power or access to essential services such as dialysis.

Substance Use Disorder (SUD)

With the exception of the Wellness and Recovery Program discussed elsewhere in this report, PHC provides limited care options for treating members diagnosed with SUD. Despite that, more than 42,000 members were treated for conditions related to substance abuse in 2020, according to PHC integrated claims and encounter data. Of those, more than 35,000 had a diagnosed SUD. The substances most frequently used by these members were alcohol, opioids and stimulants. Men were slightly over-represented with this diagnosis; 53% of members with SUD were male, compared to PHC's general adult membership of 47% male and 53% female. Almost 49% (17,025) of the members diagnosed with SUD were White, which is higher than the 40.9% of PHC's total White adult membership. About 9.6% were Hispanic compared to 29.1% for the general PHC population; 9.7% Black compared to 5.6% of the general PHC adult population. Similarly, 3.3% of those with SUD were compared to 2.5% in the general population; 1.4% Asian/Pacific Islander with about 1.3% in the general PHC population (Figure 15).

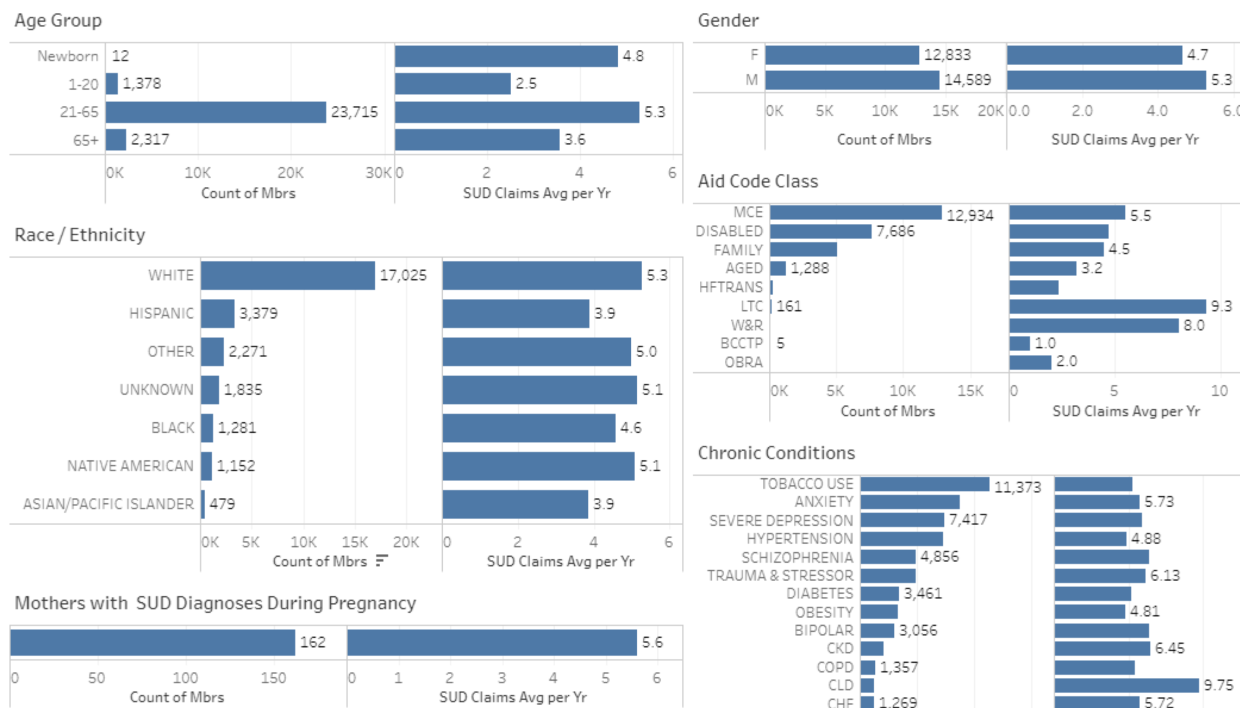
Figure 15: 2020 PHC Members with Substance Use Disorder Diagnosis

Demographics & Disease Status of Members Diagnosed with Substance Use Disorder

This view describes the demographic characteristics of PHC members who had claims with any substance use disorder diagnosis or procedure, the prevalence of major chronic conditions, diagnosis occurrence during pregnancy, and homelessness status at the time of service for those members.

Click on any demographics bar to filter on

Year: 2020 | Choose Location Level: All | Choose Location: Plan-wide | Homelessness: (All) | Risk Class: (All)



Source: 2020 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

Substance use does not exist in a vacuum. As stress levels go up, such as with the ongoing COVID-19 pandemic, there is an increase in the misuse of substances and potential for remission.[7]

Access to Care

Health care status depends on a wide range of factors ranging from personal choices, genetics, the environment and socio-economic-cultural factors affecting the individual member and their community, and, of course, the ability to access care. Access to care also depends on a number of factors including health care coverage, consistency in health care providers, and the ability to navigate an often complicated system. In 2020, COVID-19 added to existing barriers like delayed access to appointments and reluctance to attend primary care appointments, as well as conflicting treatment priorities for providers.

[7] (Center for Disease Control, 2021)

CAHPS surveys provide health plan members an opportunity to tell us about their experiences accessing care. The 2020 CAHPS adult composite scores declined in the areas of: health plan rating, all health care rating, specialist seen most often rating, as well as the ratings for getting needed care and getting care quickly. The 2020 child composite scores saw some improvements from the 2019 scores in the rating areas of health plan, all health care, getting needed care, and getting care quickly. Analysis of CAHPS survey results identified areas for improving member access to appropriate care. The 2020 CAHPS results were impacted by clinician access challenges caused by the impact of the COVID-19 shelter-in-place orders.

Due to COVID-19, PHC engaged with the provider community to increase access to telehealth visits for both primary care and specialty care visits. The advantages of telemedicine include greater access to care, fewer appointment no-shows, and increased utilization of health services. On the other hand, there are ongoing challenges with telehealth, including members having poor access to broadband or computers, privacy concerns when discussing sensitive subjects in shared environments, and the inability to do a complete physical assessment or intervention during the visit. The Health Education Team, in collaboration with other departments, developed materials to help members better understand the process of making and attending telehealth visits. Additionally, PHC sought to help our members manage their health status at home by providing health-monitoring equipment and step-by-step educational materials to make sure members knew how to use the equipment appropriately. This service was of particular benefit to members who were homebound or disabled. Members had to connect with their providers both to receive the equipment, as well as to report results. While we will need to assess provider and member views on these efforts to increase access to care, there is great potential for increasing care outside of traditional office visits. In the coming year, a cross-departmental workgroup will investigate additional intervention options and, in conjunction with input from members, develop a cohesive plan to address member experience in the future.

As a further measure of member access to care, PHC conducts a Third Next Available survey annually to assess availability of routine care appointments. The survey assesses availability of adult and pediatric primary care appointments, newborn appointments, and urgent care appointments. PHC met the 2020 goal for all appointment types (Figure 16).

Figure 16: 2020 PHC Third Next Appointment Availability

Third Next Available (3NA) Survey Findings									
Provider Type	**Standard**	**Median Days for Established PCP Appt.**			**Percentage of Clinics Meeting PCP Standards**			**Goal**	**2020 Goal Met?**
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	2.0	2.0	2.0	98.84%	99.32%	99.14%	≥ 90%	**Met**
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	2.0	2.0	2.0	98.63%	100%	99.45%	≥ 90%	**Met**
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	97.10%	100%	98.88%	≥ 90%	**Met**
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	100%	99.42%	99.62%	≥ 90%	**Met**

Source: 2020 Timely Access data, Partnership HealthPlan of California

Access to Primary Care

Access to PCPs increases the likelihood that community members can schedule routine checkups and screenings. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. Community members who regularly attend primary care appointments are more likely to know where to go for treatment in acute situations and may be less likely to seek urgent or emergency care unnecessarily. Several PHC counties have a shortage of providers relative to the needs of the population, including Trinity, Lassen, Lake, Humboldt, Del Norte, and Shasta. On the other hand, Modoc, Solano and Siskiyou Counties are close to the state average with a ratio of 1,270 patients per provider.[8] In communities that lack a sufficient number of primary care providers, community members may delay necessary care, resulting in more severe and complicated conditions. Workgroups within PHC perform detailed analyses of the access challenges for PHC members, and the workgroups report their findings, opportunities, and planned interventions to regulating bodies.

[8] (County Health Rankings and Roadmaps, 2020)

Preventable Hospital Days

Members unfamiliar with primary care or disenfranchised from the health care system often seek care through a hospital despite inconvenience, long wait times, and the relatively high costs to the plan and the providers. Healthcare systems use preventable hospital days as a surrogate indicator for limited access to outpatient care, assuming that members access hospitals as a source of primary care. In 2020, Lassen County had more preventable hospital days than the state average of 3,598 (per 100,000 Medicare enrollees).[9] Lake, Modoc, Shasta, Solano and Siskiyou Counties are approaching the state average. PHC uses a variety of outreach methods to encourage members to connect to primary care providers, including call campaigns in collaboration with primary care sites.

Health Disparities

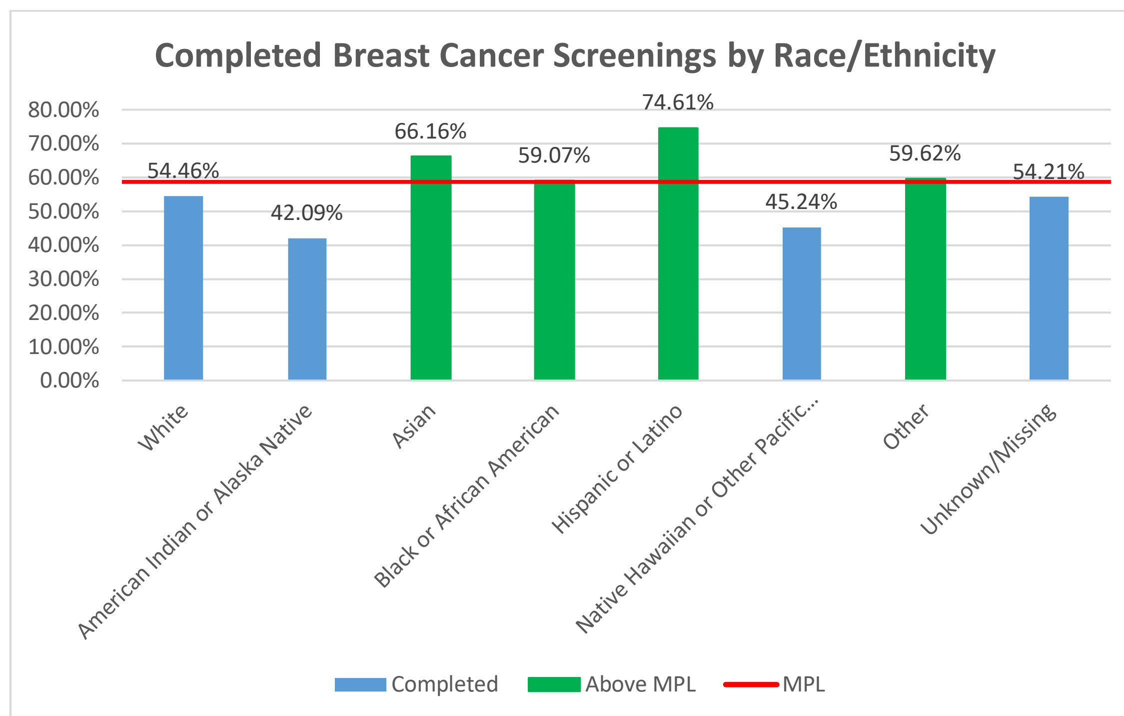
PHC uses DHCS's plan-specific 2019 Health Disparities Report data for the 2020 reporting year to assess disparities within the membership. This report identified differences among race/ethnicity groups in two HEDIS measures: Breast Cancer Screening (BCS) and Asthma Medication Ratio (AMR) rate.

Breast Cancer Screening

Of members eligible for BCS, only 42.0% of American Indian or Alaskan Native and 45.2% of Native Hawaiian or Other Pacific Islanders completed breast-cancer screenings, which is significantly below the MPL of 58.68% (Figure 17).

[9] (County Health Rankings and Roadmaps, 2020)

Figure 17: 2020 PHC Completed Breast Cancer Screenings by Race/Ethnicity



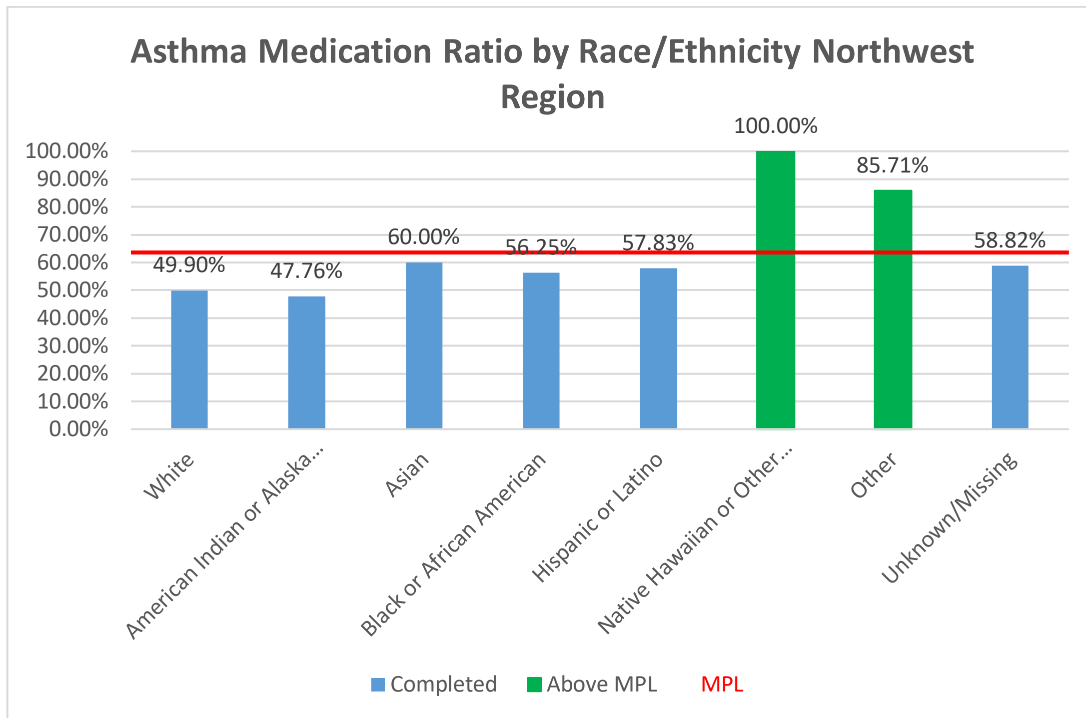
Source: 2020 Health Disparities Data, Department of Health Care Services

Regional screening rates give more insight into the screening disparities: the screening rate for American Indian/Alaska Natives is 41.7% in PHC's Northeast region, 38.9% in the Northwest, and 40.3% in the Southwest. The Native Hawaiian or Other Pacific Islander completion rate was 45.8% in PHC's Southeast region.

Asthma Medication Ratio

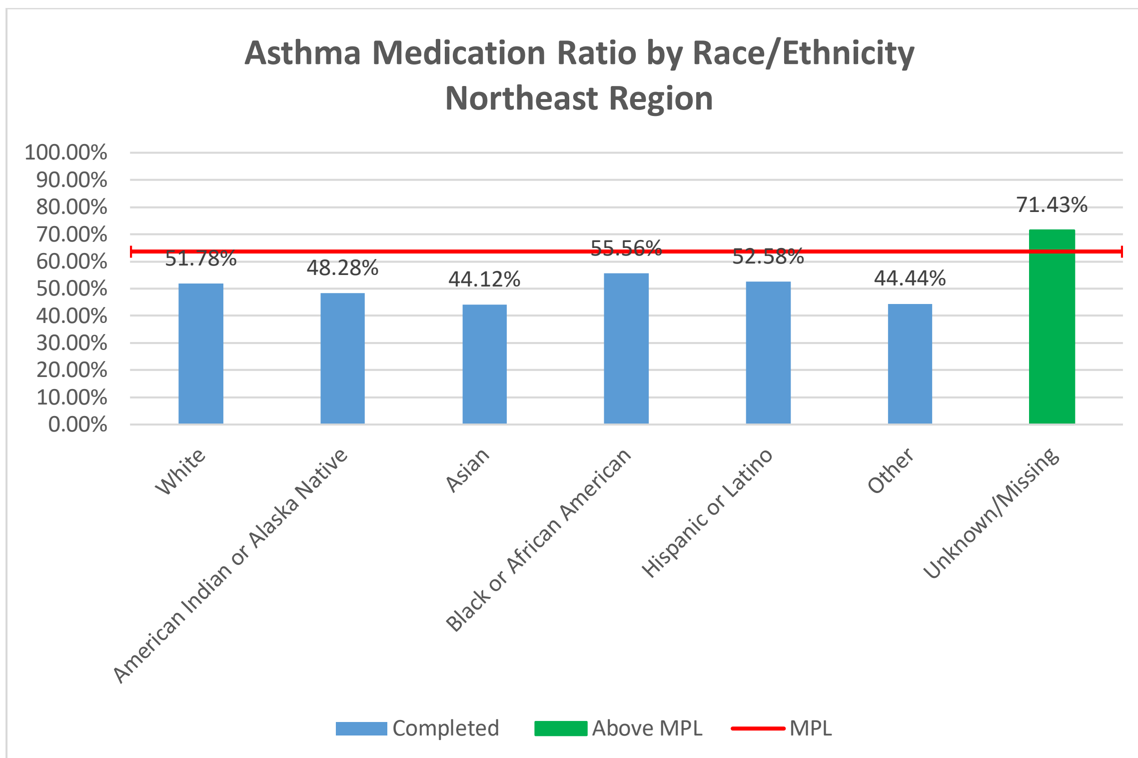
Similar differences were found among race/ethnicity groups of members eligible for AMR. Per the 2020 Health Disparities Data provided, PHC's aggregate score for this measure is 63.47% of members using asthma controller medications as recommended, which is very close to the MPL of 63.58%. However, if the data is analyzed by race and region, we see low performance among the American Indian/Alaska Natives in the Northwest region and the Asian Population in the Northeast region with rates of 47.7% and 44.1% respectively (see Figures 18 & 19).

Figure 18: 2020 Asthma Medication Ratio by Race/Ethnicity – Northwest Region



Source: 2020 Health Disparities Data, Department of Health Care Services

Figure 19: 2020 Asthma Medication Ratio by Race/Ethnicity – Northeast Region



Source: 2020 Health Disparities Data, Department of Health Care Services

Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH), also known as, "social influencers of health," are defined by the World Health Organization (WHO) as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics."

With the pending implementation of California's Advancing and Innovating Medi-Cal (CalAIM) initiative, a primary goal is to "identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health." PHC uses the County Health Rankings as a means to estimate the concerns 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 better understand the needs of our members in the communities where they live. This gives us a framework by which we can build collaborative efforts with local agencies to improve the social support needs of our population.

Poverty

People living in poverty experience limited access to quality health care, healthy foods, safe neighborhoods, stable housing, opportunities for physical activity, and education beyond high school. Poverty acts as a predictor of poorer health outcomes.

According to the 2015-2019 American Community Survey 5-year estimates, California has a poverty rate of 9.6%.[10] Of the 14 PHC covered counties, nine counties have poverty rates above the California average. The counties include Del Norte (14.7%), Humboldt (10.5%), Lake (14.1%), Lassen (10.0%), Mendocino (13.0%), Modoc (10.9%), Shasta (11.0%), Siskiyou (12.5%) and Trinity (12.2%) (Table 1).

[10] (U.S. Census Bureau, 2020)

Table 1: PHC Counties by Poverty Rates

PHC Northern Region	Poverty rate (%)
California	***9.6***
Del Norte	14.7
Humboldt	10.5
Lassen	10.0
Modoc	10.9
Shasta	11.0
Siskiyou	12.5
Trinity	12.2

PHC Southern Region	Poverty rate (%)
California	***9.6***
Lake	14.1
Marin	3.8
Mendocino	13.0
Napa	5.1
Solano	7.2
Sonoma	5.3
Yolo	9.0

Source: 2015-2019 American Community Survey (ACS), 5-year estimates

Children Living in Poverty

Measuring the number of children living in poverty allows the assessment of current and future health risks. The impact poverty has on health is pervasive in all ages, but children in poverty may experience especially persistent effects. Children in low-income households are more susceptible to asthma, obesity, diabetes, ADHD, behavior disorders, anxiety, and dental concerns.

On average, 17% of Californians under 18 live in poverty.[11] Among PHC counties, the lowest rates of children in poverty are Marin (6%), Napa (9%) and Solano (10%), well below the state average. However, there are some PHC regions where the levels of children in poverty are much greater than the California average. Trinity (31%), and Del Norte and Modoc (27% each) reflect the persistent need for effective strategies to bolster the economy in these regions in order to pay living wages to these vulnerable communities.

High School Graduation

Education level acts as a predictor of health outcomes, both individually and as a community. Adults with more education tend to earn more money and be more consistently employed than their less educated peers. People with lower levels of education are more likely to be unemployed, leading to poorer health outcomes and more limited access to care. The COVID-19 pandemic has drastically impacted education access; it remains to be seen what the long-term effects will be from interrupted or delayed schooling at all levels of study.

[11] (County Health Rankings and Roadmaps, 2020)

In California the average high school graduation rate is 83%.[12] Marin, Shasta and Yolo counties each have a high school graduation rate of 87%, the highest among PHC's fourteen counties. The high school graduation rate falls below the state average in Del Norte, Lake, Siskiyou, Solano, Sonoma and Trinity counties.

Unemployment

Employment status plays an important role in the health status of individuals and their communities. The unemployed population is at risk for unhealthy behaviors such as alcohol and tobacco consumption, poor diet, and less exercise. There is also a link between employment status and other social factors such as lack of economic security, low quality housing access, and limited access to health coverage.

Unemployment is measured as the percentage of the population ages 16 and older who are unemployed but seeking work. In the state of California, the pre-COVID unemployment rate was 4.2%, and was estimated to be 9% by the end of 2020.[13] The pre-COVID reported rates of unemployment in PHC's covered counties were higher than the California pre-COVID average in Del Norte (5.5%), Lake (5.2%), Modoc (7.5%), Siskiyou (6.7%), and Trinity (5.7%). Conversely, Marin (2.4%), Napa (2.9%) and Sonoma (2.7%) counties each had pre-COVID unemployment rates below 3%.

Income

The median household income provides information about the financial resources of a community. Areas with higher household income levels correspond to greater access to employment opportunities, education, and ultimately, to health outcomes.

According to the 2015-2019 American Community Survey (ACS) 5-year estimates data, the median household income for California residents is $75,235 (Table 2).[14] Ten of PHC's covered counties have median household incomes below California state average. Trinity, Del Norte and Modoc have the lowest median household incomes.

Income inequality does not just impact county-wide opportunities, but also adversely impacts individual and community health statuses. Individuals with lower socio-economic status often feel a lack of trust, belonging, and support in relation to those with higher economic status. The County Health and Rankings Roadmaps report measures income inequality as a ratio between those households with incomes at the 80th percentile and those with incomes at the 20th percentile. Overall, California has an income inequality ratio of 5.3. Lake, Marin, and Yolo counties each have income

[12] (County Health Rankings and Roadmaps, 2020)
[13] (County Health Rankings and Roadmaps, 2020)
[14] (U.S. Census Bureau, 2020)

inequality ratios greater than the state average. It is important to note that while these three PHC covered counties do not have median income levels below the state average, income inequality can still impact the health outcomes of individual residents or community groups.

Table 2: Median Household Income by PHC County

PHC Northern Region	Median Household Income (dollars)
California	***75,235***
Del Norte County	45,283
Humboldt County	48,041
Lassen County	56,352
Modoc County	45,507
Shasta County	54,667
Siskiyou County	45,241
Trinity County	40,846

PHC Southern Region	Median Household Income (dollars)
California	***75,235***
Lake County	47,040
Marin County	115,246
Mendocino County	51,416
Napa County	88,596
Solano County	81,472
Sonoma County	81,018
Yolo County	70,228

Source: 2015-2019 American Community Survey (ACS), 5-year estimates

Access to Food

Access to quality, affordable foods is directly related to the health of both individuals and communities. The 2020 County Health Rankings calculated an index of factors that contribute to a healthy food environment. A food environment takes into consideration proximity to healthy food options and income levels. There is evidence that where there are fewer opportunities for healthy food, whether due to distance or unaffordable prices, there are poorer health outcomes. Without consistent access to quality foods, people, especially children, may face related negative health outcomes such as asthma, activity limitations, and weight gain.

In California, the Food Environment Index sits at 8.9 on a scale from 0 (worst) to 10 (best). None of PHC's covered counties exceed the California Food Environment Index ranking. The lowest ranked PHC counties are Del Norte (6.4), Modoc (6.8), Shasta (6.9) and Siskiyou (6.6).

Violent Crime

High levels of violent crime impact not only the physical safety of a community, but also on its socio-emotional well-being. Violent crimes are defined as face-to-face confrontations including homicide, sexual assault, robbery, or aggregated assaults. Violent crimes have an impact on the physical safety of places; people are less likely to pursue outdoor activities where crime rates are higher. Additionally, exposure to high crime rates has been shown to increase stress. Chronic stress can lead to an increased prevalence of certain diseases, such as upper respiratory illness and asthma.

County Health Rankings and Roadmaps measures violent crimes reported per 100,000 people;[15] in 2020, California's state average was 421. Marin, Napa, Siskiyou, Sonoma, Trinity and Yolo counties all have rates of violent crimes lower than the state of California, with the lowest in Marin at 178 violent crimes per 100,000. Mendocino County has the highest violent crime rate at 640 per 100,000.

Injury Deaths

According to the CDC, in 2020 most of the leading causes of death in the United States were due to diseases such as heart disease, cancer, diabetes, etc.[16] However, both unintentional injuries (accidents) and intentional injuries (homicide/suicide) contribute to high death rates. Unintentional injuries are the third leading cause of death in the U.S., and intentional injuries are the 10th. County Health Rankings and Roadmaps measures the number of deaths due to injury per 100,000 individuals, and has ranked California's state average of 50 deaths per 100,000.[17] Across PHC's counties, the only county with a rate below California's is Yolo County, with 48 deaths due to injury per 100,000 people. All the other thirteen PHC counties have rates higher than the state average, with Lake County the highest at 154 deaths per 100,000 lives.

Air Pollution

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 is 9.5. The PHC counties that have higher rates of air pollution are Marin, Napa, Siskiyou, Solano, Sonoma and Yolo.

With the increasingly devastating forest fires in many areas across Northern California, there is an increased possibility of impacts on the community's health. In particular, the increase in the possibility of adverse pulmonary effects such as chronic bronchitis, asthma and decreased lung function. Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

Adult Smoking

Cigarette smoking is a leading cause of preventable death in the United States. Smoking impacts nearly every organ and can cause cancer in various parts of the body. Compared to nonsmokers, smokers are more likely to develop heart disease, stroke,

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[15] (County Health Rankings and Roadmaps, 2020)
[16] (Center for Disease Control, 2020)
[17] (County Health Rankings and Roadmaps, 2020)

and lung cancer. According to the CDC, cigarette smoking is higher among people with low annual household incomes.[18]

On average, 11% of adults are current smokers in the state of California. Adult smoking rates are higher than the state average in many of PHC's counties: Del Norte (15%), Humboldt (14%), Lake (14%), Lassen (14%), Mendocino (13%), Modoc (14%), Shasta (14%), Siskiyou (14%), Solano (12%), and Trinity (15%).[19]

Physical Inactivity

Low physical activity is associated with several diseases, such as diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. Physical activity can improve sleep, cognitive ability, and bone and musculoskeletal health. Physical activity impacts individuals as well as a community since physical inactivity often correlates a community's lack of recreational activities and infrastructure, and to higher community prevalence of poverty. Additionally, members with disabilities are often less active, which further compounds their disabilities.

The 2020 County Health Rankings measures physical inactivity as the percentage of adults age 20 and over reporting no leisure time physical activity. The pre-COVID state average is 18%, with Humboldt (17%), Marin (13%), Sonoma (16%) and Yolo (14%) counties all below that average, meaning they are more physically active than the state as a whole. On the other hand, several PHC counties report much higher levels of physical inactivity than the state average. In the Northern Region, Del Norte (25%), Lassen (37%), Modoc (25%), Shasta (20%), Siskiyou (23%), and Trinity (24%) counties have high to very-high levels of physical inactivity. In the Southern Region, Napa and Mendocino counties were just above the state average at 19% each; Lake and Solano counties reported inactivity rates of 23% each. COVID has adversely impacted state and national activity levels, and we anticipate further decline in activity across all PHC regions.

Member Experience of Care

Doctor Communication

PHC uses the 2020 PHC CAHPS survey data to evaluate how satisfied our members are with their interactions with their doctors. The proportion of adult members pleased with how well their doctors communicate with them decreased on aggregate from 91.0% in 2019 to 90.6% in 2020. This score is comprised of indicators measuring how well the

[18] (Center for Disease Control, 2020)
[19] (County Health Rankings and Roadmaps, 2020)

doctor explained things, listened carefully, showed respect, and if they spent enough time with the member. PHC scored below the 2020 SPH Analytics Benchmark in all aspects of doctor communication in the 2020 Survey (Figures 20 & 21).

Figure 20: 2020 Adult CAHPS Survey Result

	2020 Responses	2018	2019	2020	2020 SPH BENCHMARK	2019 QC BENCHMARK
How Well Doctors Communicate (% Always or Usually)	**149**	**NA**	**91.0%**	**90.6%**	**93.2%**	**92.0%**
Q12. Personal doctors explained things	149	NA	91.2%	91.9%	93.5%	92.2%
Q13. Personal doctors listened carefully	149	NA	91.2%	92.6%	93.5%	92.3%
Q14. Personal doctors showed respect	147	NA	92.8%	90.5%	94.6%	93.6%
Q15. Personal doctors spent enough time	149	NA	88.8%	87.2%	91.5%	89.9%

Source: 2020 CAHPS 5.0 Adult Medicaid Survey, Partnership HealthPlan of California

Members rated their care experience higher in the child CAHPS survey, with 92.8% of members indicating they were happy with how well their doctor communicated with them, on aggregate. There were no significant changes seen in the child results for doctor communication between 2019 and 2020 CAHPS report. Nevertheless, the scores are below the 2020 SPH Analytics benchmark in all areas.

Figure 21: 2020 Child CAHPS Survey Result

	2020 Responses	2018	2019	2020	2020 SPH BENCHMARK	2019 QC BENCHMARK
How Well Doctors Communicate (% Always or Usually)	**294**	**NA**	**92.8%**	**92.8%**	**95.1%**	**94.0%**
Q12. Personal doctors explained things	295	NA	93.2%	93.6%	95.4%	94.5%
Q13. Personal doctors listened carefully	295	NA	95.0%	94.2%	96.2%	95.3%
Q14. Personal doctors showed respect	295	NA	96.4%	96.6%	97.1%	96.3%
Q17. Personal doctors spent enough time	290	NA	86.6%	86.9%	91.7%	89.7%

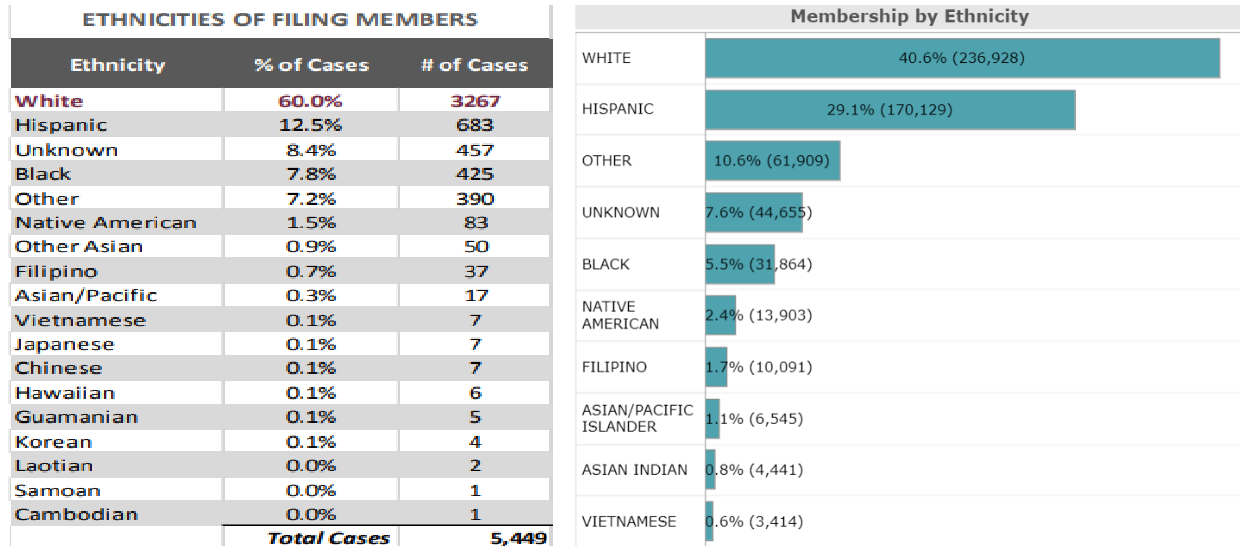
Source: 2020 CAHPS 5.0 Child Medicaid Survey, Partnership HealthPlan of California

Grievance and Appeals

PHC also utilizes the Grievance and Appeals (G&A) data to analyze member experiences with the services offered; the Cultural & Linguistic unit evaluates whether these grievances are related to discrimination. In 2020, PHC investigated 5,449 Grievance and Appeals cases. Members reporting these cases represented sixteen (16) ethnicities and spoke thirteen (13) different languages. Fifty percent of cases filed were

from members residing in Solano, Sonoma and Shasta counties. However, 60% of the cases filed were by the White population, with Hispanic 12.5%, Black 7.8% and Native American 1.5% respectively. Of interest is that the grievances reported are not proportionate for the percentage of different races and languages within PHC's membership (Figures 22 & 23).

Figure 22: Grievance and Appeals Report by Members Ethnicities vs. PHC Overall Membership by Ethnicity

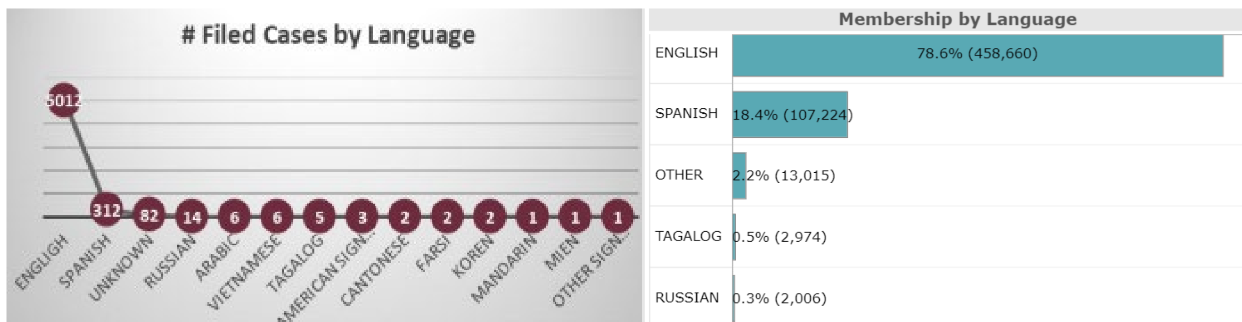


ETHNICITIES OF FILING MEMBERS

Ethnicity	% of Cases	# of Cases
White	60.0%	3267
Hispanic	12.5%	683
Unknown	8.4%	457
Black	7.8%	425
Other	7.2%	390
Native American	1.5%	83
Other Asian	0.9%	50
Filipino	0.7%	37
Asian/Pacific	0.3%	17
Vietnamese	0.1%	7
Japanese	0.1%	7
Chinese	0.1%	7
Hawaiian	0.1%	6
Guamanian	0.1%	5
Korean	0.1%	4
Laotian	0.0%	2
Samoan	0.0%	1
Cambodian	0.0%	1
	Total Cases	5,449

Source: 2020 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2020 Membership by Ethnicity, PHC Membership Data

Figure 23: Grievance and Appeals Report by Members Language vs. PHC Overall Language Profile



Source: 2020 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2020 Membership by Ethnicity, PHC Membership Data

Review of Activities and Resources

Each year, PHC undertakes a strategic review of existing programs, resources, and structures for meeting member needs. Department directors collaborate with the executive team to review PHC's strategic plan and ensure PHC resources are aligned

with its mission and the changing environment. During that same time, departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet PHC's various initiatives.

In 2020, PHC recognized the national shift towards population health as both a payment model and a service-delivery model, and created a Population Health department to focus on translating policy into action. In addition to leadership positions and administrative support, the department includes Health Educators, Community Outreach Representatives, Healthy Living Coaches, and Wellness Guides.

The Wellness Guides perform outreach calls to subpopulations, encouraging wellness behaviors such as preventive care visits and vaccinations, as well as offering resources in emergencies and disasters. The Healthy Living Coaches engage members individually or in group settings (like health fairs) to identify member barriers to care and promote healthy lifestyles, including managing chronic conditions like asthma or diabetes. Community Outreach Representatives work closely within their assigned communities to identify resources that can be integrated into PHC's program offerings and shared with members, and to enhance community-based organizations' understandings of PHC's member benefits. The Community Outreach Representatives also maintain Community Resource pages that support member needs in each of PHC's counties. During 2020, Community Outreach Representatives identified resources in 22 different categories for each of PHC's 14 counties. Resource categories include crisis services, food, housing, mental health, public assistance, and others. Resource postings are reviewed every six months to ensure they are still active; Community Outreach Representatives continually evaluate the offered resources, and there are no gaps or additional needs for community services at this time. In addition to writing the PNA, the Health Educators ensure member materials are written at the appropriate reading and comprehension levels, and translated into PHC's threshold languages. They also review member grievances when there are concerns of discrimination or bias against the member. These newly-assigned resources have been sufficient to meet PHC's needs during 2020's unusual challenges, and are poised to adapt to 2021's changing environment.

Besides staffing a new department, PHC also allocated IT and Health Analytics to support and meet Population Health requirements. Multi-disciplinary workgroups from both teams helped develop member campaign tracking and reporting tools, implemented a new "Population Health" module that interacts with PHC's existing Case Management/Utilization Management system, and designed a Population Health Dashboard to track the success of department initiatives. Future plans include a Member 360 database that will support segmentation of members by social and

demographic factors, which can be integrated with claims data for enhanced insight into member needs. Member 360 implementation is planned for the next 12 – 24 months; however, there are competing initiatives during this time period. The organization is reviewing the sufficiency of available resources, and the possible need for additional staff hires to support this effort.

Health Education, Cultural & Linguistic, and Equity Gap Analysis

Based on the data evaluated above, the following gaps in member experience were identified for Partnership members. PHC 2020 Grievance and Appeals (G&A) reports low reporting rates for non-English speaking population and non-White ethnicities when compared to their representation with PHC’s population. To minimize these gaps, the Health Education, Cultural and Linguistics (HEC&L) team will work with Member Services, Provider Relations, and G&A to gather information from the diverse language/race/ethnicity groups we serve to understand their barriers for low reporting. Once the barriers are known and understood, HEC&L will work with the G&A team to develop a written strategy with targeted interventions for language/race/ethnicity groups to ensure PHC better captures challenges to the experience of care for our non-White or non-English speaking members.

Another gap was discovered: current interpreter services offered onsite at provider offices require several days to schedule the appointment, confirm with the provider, and ensure that both the member and interpreter show up at the same date, place, and time. In 2020, non-English speaking members filed grievances about poor interpreter service availability in provider offices. Member Services has initiated a pilot for on-demand interpreter services at four provider sites to determine the feasibility of virtual interpreting services. The pilot testers included Spanish, Tagalog, and ASL languages, and both providers and members indicated they would like to move forward with this program. This new option, or a similar solution, is under review for widespread implementation. The HEC&L team will work together with Member Services and Provider Relations to broadly implement a more accessible means of interpreter services. Health Education and Provider Relations teams will focus on educating providers to ensure that they understand PHC interpreter service policies and procedures through Provider Network Education (PNEs) and Provider Staff Education and Training (PSET) programs.

PHC is concerned about the health equity knowledge gaps among PHC staff. During the annual Health Equity week in January 2021, PHC surveyed staff to assess their knowledge of health equity and to understand their level of confidence in discussing

issues around health equity and other social determinants of health. The aim of this survey was to help the organization further promote health equity goals among the staff and subsequently its member population. The HEC&L team will focus on reviewing the 2021 Employee Survey on health equity and researching opportunities for improvement. Findings from the survey and resources to improve the knowledge gap will be shared with staff. PHC will also continue its culture of hosting regular employee forums to further engage staff in topics relating to equity (e.g., race, ethnicity and gender).

Finally, the HEC&L team identified ongoing health disparities for the American Indian/Alaska Native member population showing lower HEDIS rates in both BCS and AMR measures. BCS was an area of focus in the 2020 PNA Action Plan (see below) and warrants ongoing engagement to improve these rates. In 2021, PHC will focus on strengthening relationships with PHC Indian Health Services providers to engage and build a stronger and sustainable PHC presence within the American Indian/Alaska Native communities. In addition, the HEC&L team will assess PHC staff knowledge and availability of internal resources to help reduce disparities for the American Indian/Alaska Native population, and to better understand the needs of this community. Identified staff will help build meaningful and sustainable relationships with members and tribal health leaders of the American Indian/Alaska Native communities. The HEC&L team will also work to identify culturally appropriate ways to share information and collaborate with Indian Health Services providers to help improve the HEDIS rates and reduce health disparities.

Annual Action Plan and Action Plan Updates

2021 Action Plan

Objective 1: Increase the proportion Non-English speaking/Non-White members reporting Grievances from 40% to 42.5% by March 1, 2022. Data Source: 2020 PHC Grievance and Appeals Report , Partnership HealthPlan of California
Strategies
1. Assess member barriers to using the PHC Grievance and Appeals process by race, ethnicity, and language.
2. Gather information from race/ethnicity groups with low grievance reporting rates to ascertain barriers and causes for low reporting rates (e.g., focus groups, key informant interviews, etc.).
3. Develop a written strategy with targeted interventions for race/ethnicity groups with very low grievance reporting rates, based on information gathered from the effort described above.

4. Obtain organizational agreement for written strategy.

Objective 2: Promote member's usage of video remote interpreter services (VRI) at provider sites from 0% to at least 10% of total in-office interpreter services by December 31, 2021. Data Source: 2020 PHC Grievance and Appeals Report , Partnership HealthPlan of California
Strategies
1. Assess the existing PHC interpreter services materials for our Provider network and update as needed.
2. Roll out new PHC video remote interpreter (VRI) services service for our members.
3. Develop and publish member-facing materials for Provider sites that clarify PHC interpreter services procedures.
4. Review member grievances related to interpreter services to evaluate efficacy of VRI in addressing member concerns.

Objective 3: Provide two (2) trainings to address health equity knowledge gaps for PHC internal staff by December 31, 2021. Data Source: 2021 Health Equity Workforce Survey, Partnership HealthPlan of California
Strategies
1. Review the 2021 Employee Survey on Health Equity and research opportunities for improvement.
2. Report findings from the 2021 Employee Survey to staff and share resources to increase staff understanding of health equity concerns.
3. Facilitate two Employee Engagement Forums or Training Events to engage staff in topics relating to equity (e.g., poverty, race, ethnicity, gender, etc.).

Health Disparities Objective 4: Increase Breast Cancer Screening participation rate among all PHC regions' American Indians/Alaskan Native members from 42.0% to 48.0% by March 1, 2022. Data Source: 2020 DHCS Health Disparity Data

Strategies
1. Perform internal survey of PHC staff knowledge and resources to learn more about the American Indian/Alaska Native populations we serve.
2. Identify staff who can help build sustainable relationships with the American Indian/Alaska Native populations and Tribal health leaders.
3. Engage Indian Health Services providers, as well as Native American tribal leaders and members within PHC's service area, to better understand their needs and priorities for health.
4. Identify culturally appropriate ways to share information and collaborate with Indian Health Services providers on interventions to reduce health disparities as observed in BCS and AMR HEDIS scores.
5. Establish a multi-year strategy to promote health equity that will reduce the American Indian health disparities

Health Disparities (Continued from 2020) Objective 5: Improve the Asthma Medication Ratio (AMR) as defined by the HEDIS AMR metric for pediatric members in the Northern Region (Del Norte, Humboldt, Siskiyou, Lassen, Shasta, Trinity, and Modoc) from the 62.66% baseline to 65% by March 1, 2022. Data source: (PHC HEDIS Rolling Year Data, February 2021)
Strategies
1. By November 1, 2021, train Health Educators and Healthy Living Coaches on asthma management and home visiting services through the Asthma Management Academy.
2. By December 1, 2021, use the Health Educators and Healthy Living Coaches to conduct two courses (in-person or virtually) in order to build the capacity of community based programs to conduct asthma home visiting services, in partnership with regional provider and pharmacy efforts.
3. By March 1, 2022, engage at least 10 Northern Region PHC parents or guardians to build and establish a care plan for their child/children with asthma, utilizing the Healthy Living Tool (HLT) embedded in the PHC Member Portal.

Health Disparities (Continued from 2020) Objective 6: Improve Hispanic/Latino participation in well-care visits for children ages 3-5 years of age from 66.67% baseline to 70% in PHC's Northern Region (Del Norte, Humboldt, Siskiyou, Lassen, Shasta, Trinity, and Modoc), by December 30, 2021. Data source: (PHC Health Disparities Data, December 31, 2019)

Strategies
1. By December 31, 2021, Research best practices with proven evidence of changing members' behaviors, which might drive their participation in healthcare.

2020 Action Plan Review and Update

Objective 1 Continue in 2021: Improve Hispanic/Latino participation in well-care visits for children ages 2 to 5 years of age from 66.67% baseline in PHC's Northern Region (Del Norte, Humboldt, Siskiyou, Lassen, Shasta, Trinity, and Modoc), as reported in the PHC Health Disparities Data for 2021. Data source: (PHC Health Disparities Data, March 2020)	Progress Measure: Well Child Visit for Hispanic/Latino children 2 to 5 years old improved from a baseline of 66.67% to 71.30%. Data source: Well Child Visit for Hispanic/Latino children 2 to 5 years old improved from a baseline of 66.67% to 71.30%. Data source: PHC Enterprise Data Warehouse. PHC Health Disparities Data for 2021 did not include W34
	Progress Toward Objective: While significant efforts were applied toward improving well-child visits in 2020, the COVID-19 pandemic interrupted most well-care activities. Members were hesitant to leave their homes to attend visits, and virtual visits did not allow for physicians to complete certain parts of well-child visits.
Strategies	
1. By December 31, 2020, Research best practices with proven evidence of changing members' behaviors, which might drive their participation in healthcare. Continue in 2021	Progress Discussion: Well-child visits are described as the foundation for current and future well-being. While COVID-19 Pandemic has negatively impacted well-child visits and vaccinations for all children, Hispanic/Latino children's access to well-child visits is compounded by continuing barriers to care including language, getting time off from work for the parents, and attending to other family members in the home. PHC is working to provide information in Spanish about the long term health benefits of well-child visits and options to access well care, including supports to address major barriers to care, such as telehealth and transportation.
2. By January 31, 2021, conduct in-depth focus group discussions or at least 10 member interviews with Hispanic/Latino members	Progress Discussion: 100% Completed. Outreach calls were conducted with 208 Hispanic/Latino members in the Northern region who were non-complaint to well-child visits in 2020. Of the 208 members called, we had a response rate of 10.6% (22 members). The major barriers for parents not

to understand their perspectives on attending well-child visits. Obtain feedback on research into best practices (see above) to inform implementation strategy. Do not continue in 2021	taking their child for well-child visits were the closure of primary care facilities due to COVID and the limited appointment times that were available.
3. By March 15, 2021, Develop health education materials, resources, and a suggested plan for implementation of best practices identified above to promote the importance of well-child visits for Hispanic/Latino members. Do not continue in 2021	Progress Discussion: Health Education materials were created and shared with providers, members and via the Health Education page on PHC website. We also made a series of calls to members in adherence with DHCS mandated outreach calls to improve preventive health care in children. The link to the materials can be found here: The link to the materials can be found here: Well Child Visits.

Objective 2: Do not continue in 2021. Maintain or improve upon American Indian/Alaskan Native member participation in breast cancer screening for those members who qualify for HEDIS BCS criteria from the baseline of 34.41% in PHC's Northwestern Region (Del Norte and Humboldt), as reported in the PHC Health Disparities Data of 2021. Data source: (PHC Health Disparities Data, March 2020)	Progress Measure: Rate increased from 34.14% to 46.15% Data source: RY 2020 CA DHCS Disparities Partnership Rate Sheet
	Progress Toward Objective: PHC partnered with United Indian Health Services (UHIS) Clinics in Humboldt and Del Norte and the K'ima:w Health Center in Humboldt to assess perceptions and barriers to breast cancer screening. UHIS was going to use their Community Health Workers to conduct the assessments. K'ima:w was holding a mobile mammography screening and they were to going to do the assessments as part of their outcall campaign to schedule appointments, particularly with women who were hesitant to schedule appointments. Due to COVID-19, these activities were cancelled and PHC staff conducted the assessments.
Strategies	

1. By December 31, 2020, conduct an in-depth focus group discussion or member interviews with American Indian/Alaskan Native members to understand their perspectives on receiving Breast Cancer Screenings (BCS). Do not continue in 2021.	Progress Discussion: 100% Completed. An outreach call was conducted with American Indian/Alaska Native members in Humboldt and Del Norte counties who were non-complaint to Breast Cancer Screening in 2020. Of the 62 members called, we had a response rate of 9.7% (6 members). The major barriers for women not attending a Breast Cancer Screening were the closure of primary care facilities due to COVID and lack of information on when to get screened.
2. By December 31, 2020, Research best practices with proven evidence of changing members' behaviors that might drive their participation in healthcare. Do not continue in 2021.	Progress Discussion: Research focusing on American Indian/Alaska Native women found that the women did not have the necessary information about breast cancer screening and potential outcomes in simple, straightforward language. Women also expressed many competing priorities that prevented them for getting mammograms, such as family obligations, traveling long distances, and lack of transportation. Providing easy to understand educational materials to providers who serve American Indian/Alaska Native members can address the need for information in straightforward language. In 2021, we created a new measure measure to engage Indian Health Services Providers, Native American tribal leaders, and members within PHC's service area to better understand their needs and priorities for health.
3. By March 15, 2021, Develop health education materials, resources, and a suggested plan for implementation of these best practices to promote the importance of breast cancer screening, focused on the American Indian/Alaskan Native members.	Progress Discussion: Updated current breast cancer screening materials with pictures and captions that reflect American Indian/Alaska Native women and communities. Existing materials describing PHC benefits, including transportation, were made more widely available to American Indian/Alaska Native members to help overcome some of the barriers to getting breast cancer screenings. In 2021, we have expanded our implementation plan by initiating discussions with Indian Health Services providers, Native American tribal leaders, and

Do not continue in 2021.	members within PHC's service area to better understand their needs and priorities for health. The expansion of this work is reflected in the 2021 Action Plan Health Disparities Objective 4, which will focus on a multi-year strategy to promote health equity.

Objective 3 Continue in 2021: By February 2021, maintain or improve the Asthma Medication Ratio (AMR) as defined by the HEDIS AMR metric for pediatric members in the Northern Region (Del Norte, Humboldt, Siskiyou, Lassen, Shasta, Trinity, and Modoc) from the 62.66% baseline, as of February 2020 HEDIS Rolling Year Data. Data source: (PHC HEDIS Rolling Year Data, February 2020)	Progress Measure: Increased from 62.66% to 65.45% by December of 2020. Data source: PHC HEDIS Rolling Year Data, December 2020 The largest barriers to this objective were the competing priorities of COVID-19 on both CDPH and PHC. Since PHC staff went to remote working and California Department of Public Health (CDPH) had to rework their program for virtual settings, there was a large delay in organizing a training. This delay in training pushed us behind on our other strategies. We plan to send our Health Educators, Community Outreach Representatives and Healthy Living Coaches to the training in Spring or Summer of 2021 and proceeding with our strategies moving forward. We are continuing conversations with CDPH in preparation for both training and implementation of an Asthma program within PHC's Population Health department.
Strategies	
1. By December 31, 2020, train Health Educators and Healthy Living Coaches on asthma management and home visiting services through the Asthma Management Academy. Continue in 2021.	Progress Discussion: Delayed based on other high priorities from the CDHP. Training will be rescheduled in Spring or Summer of 2021.

2. By February 28, 2021, use the Health Educators and Healthy Living Coaches to conduct two courses (in-person or virtually) in order to build the capacity of community based programs to conduct asthma home visiting services, in partnership with regional provider and pharmacy efforts. Continue in 2021.	Progress Discussion: The training from Strategy 1 was delayed based on other high priorities relating to COVID-19 from the CDHP and PHC. The training will be rescheduled for Spring or Summer 2021. The training delay also delayed this strategy.
3. By March 31, 2021, engage at least 10 Northern Region PHC parents or guardians to build and establish a care plan for their child/children with asthma, utilizing the Healthy Living Tool (HLT) embedded in the PHC Member Portal. Continue in 2021.	Progress Discussion: Given that the training from Strategy 1 was delayed, based on other high priorities relating to COVID-19 from the CDHP and PHC, and the delay in Strategy 2, we were unable to execute Strategy 3. Our new deadline will be November 1, 2021.

Objective 4 Do not continue in 2021: By February 2021, maintain access to timely prenatal care at least 90% of the time (first visit in the first trimester) for members across all PHC regions. Data source: (PHC HEDIS Exploratory Data, February 2020)	Progress Measure: HEDIS 90% first prenatal visit in the first trimester met for all PHC regions Data source: PHC HEDIS Exploratory Data, March 2021
	Progress Toward Objective: Significant organizational effort has gone into meeting this objective. The perinatal packet has been completed, translated into all four threshold languages, and is being distributed to members as they access prenatal care. Resources are now available on PHC's website as well.

Strategies	
1. Develop, obtain member feedback, and prepare for member distribution of at least five documents supporting health education, resources, and tools on prenatal and postpartum support services that enhance member knowledge on the availability of support services. Do not continue in 2021.	Progress Discussion: 100% Completed. A perinatal packet was developed with information covering prenatal to postpartum and healthy babies care. Members can request a copy of the perinatal packet by emailing CLHE@partnershiphp.org
2. By December 31, 2020, launch revised Growing Together program to engage pregnant members (utilizing mailing services) and make resources and tools on self-care available for pregnant/delivered members and babies. Publish all resources and tools to PHC external website and member portal with an option to be emailed. Do not continue in 2021.	Progress Discussion: The revised Growing Together program was launched in September 2020, targeting pregnant and post-partum members to seek access to care. This program includes an incentive for each milestone completed, as well as a packet describing best practices of care for pregnant and post-partum members, as well as care for infants through three years of age. Members can request a copy of the project charter by emailing CLHE@partnershiphp.org. Packets are mailed out to all members participating in the PHC Growing Together Program at 33-weeks' gestation or after delivery. Members can request a copy of the packet by emailing CLHE@partnershiphp.org. HEC&L is working with Communications to post these resources to both the PCH external website and to the member portal.

Objective 5 Do not continue in 2021: Increase the gender sensitivity awareness of PHC staff from 48% to 80%, thereby creating	Progress Measure: Increased gender sensitivity awareness in PHC staff from 48% in 2020 to 49%, based on the Internal Health Equity Survey in 2021. Data source: PHC Internal Health Equity Survey Data, 2020 and 2021.

an environment that is supportive of their culture, ethnicity, sexual orientation, and gender identity, as evidenced by responses to equivalent questions to be presented on the 2021 Health Equity Survey, specifically targeting gender identity and sexual orientation, assessed independently. Data source: (PHC Internal Health Equity Survey Data, 2020)	Progress Toward Objective: The Gender Inclusivity Training PHC offered through Reimagine Gender was an incredible opportunity for staff. While the increase in gender sensitivity seems minimal in the Health Equity Survey results, it is worth noting that our survey results show that 0% of the staff who participated in the 2021 Survey responded "Strongly Disagree" to the question asking if the environment is supportive of their culture, ethnicity, sexual orientation or gender identity. This is an improvement from 2020 results where 5% of PHC strongly disagreed with the same question. Through the Health Equity Team Goal, PHC is also continuing to explore areas of training and safe spaces that promote diversity, inclusivity and equity.
Strategies	
1. By February 1, 2021, develop and hold a required annual training on gender sensitivity awareness for all PHC staff via LMS. Do not continue in 2021.	Progress Discussion: 100% completed. Starting November 2020 to March 2021, PHC hosted a total of 10 mandated training sessions on Gender Inclusivity for all of PHC staff. Originally, the trainings were scheduled to run from November to January, however, additional trainings were offered in March as make-up sessions, to ensure all PHC staff attended. The training was led by facilitator Lisa Kenney from Reimagine Gender, a vendor contracted to conduct the training.
2. By March 31, 2021, work with PHC's Human Resources and leadership to create a policy proposal to include gender sensitive pronouns in the organization signature line. Do not continue in 2021.	Progress Discussion: After both the trainings and discussions with the facilitator from Reimagine Gender, PHC's Human Resources leaders and Legal team decided against a mandate to include pronouns in the organization signature lines. Instead, PHC's departments, including HR, Legal Services, and Communications, will develop a style guide or supplemental information for staff. Implementation is planned for Summer 2021.
3. By March 31, 2021, work with PHC's Human Resources and leadership to create policy	Progress Discussion: PHC already has strong policies relating to anti-discrimination and inclusivity. We will continue using our Health Equity Team Goal to create safe spaces for staff to engage in topics

recommendations for safe spaces to enable staff to express their culture, ethnicity, sexual orientation, and gender identity freely while keeping with the organizational regulations. Do not continue in 2021.	such as culture, ethnicity, gender, and sexual orientation identities. In addition, the HEC&L team will revise the annual mandatory PHC-wide Cultural and Linguistic training. With this redraft, we will include information promoting equity and safe spaces for all staff, regardless of culture, ethnicity, gender, and sexual orientation identities.

Stakeholder Engagement

Stakeholder engagement of the PNA is conducted through multiple modalities. The Health Education team utilizes reports from pertinent departments, and the final draft of the PNA and proposed action plan are shared with stakeholders during the Population Health Management (PHM) Steering Committee meeting. The PNA also undergoes review by PHC's Internal Quality Improvement (IQI) Committee, PHC's Quality/ Utilization Advisory Committee (Q/UAC), PHC's Physician Advisory Committee (PAC), and by PHC's Board of Commissioners before submission to California's Department of Health Care Services (DHCS), per regulatory requirements.

The Health Education team also conducts stakeholder engagement through PHC's Consumers Advisory Committee (CAC) and Family Advisory Committee (FAC). The CAC usually convenes on a quarterly basis, and stakeholders will be engaged to provide input into the PNA when appropriate. PNA findings, action plans and process towards PNA goals will also be presented to the CAC for review. PNA findings are to be presented to the CAC committee in mid-June of 2021 for input and feedback.

The Senior Health Educator will educate contracted health care providers, practitioners and allied health care personnel regarding pertinent information related to the PNA findings and member needs through various platforms, which may include but are not limited to provider newsletters, the provider portal via PHC website, HEDIS training, and the Community Report. The PNA report will also be posted on the PHC external website. PHC also identifies pertinent information related to member needs in the report, and determines the most appropriate platform to utilize and share information.

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