Population Needs Assessment

May 2022

DHCS Submission Date: June 29, 2022

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I. 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 627,799 (as of December 2021). 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]

Each year, PHC analyzes the environment, community needs, and assigned member population per the requirements of both DHCS for an annual Population Needs Assessment (PNA), as well as the National Committee for Quality Assurance (NCQA) Population Health Standard 2, Elements A, B, & C. 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 2022 PNA included: PHC Member Enrollment data; Healthcare Effectiveness Data and Information Set (HEDIS®) results; 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 Bureau. The 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.

A. Summary of Key Findings

There are many factors that impact the health of PHC members, including social and environmental constructs, geographical influences, and clinical disparities resulting in

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

inequitable health outcomes. PHC also reviews internal measures that reveal opportunities for improving our services to our members.

Any population covered through Medi-Cal or Medicaid plans faces common social barriers to care, such as poverty, difficulty accessing quality and affordable foods, crime, pollution, limited access to safe physical activity, and others. However, there are social and environmental barriers to health that are more pronounced for PHC members than for other parts of California. Much of PHC's region is burdened with poor economic opportunity: in ten of PHC's 14 counties, the average household income is below the state average, and unemployment rates in eight PHC counties are higher than the state average. An environmental factor that disproportionately impacts the health of PHC members is the prevalence of wildfires in the region.

In addition to social and environmental factors, PHC uses annual HEDIS results to evaluate clinical quality in a standardized way, and to evaluate health inequities for our members by geographic region and also by race, ethnicity, and language. Supplemental data collected from primary care providers provides additional detail for HEDIS hybrid measures. The 2022 PNA identifies concerns with pediatric asthma control in in the Northern Region, breast cancer screening for American Indian/Alaskan Natives, and blood pressure control for African American/Black members. Addressing these disparities remains a priority for PHC.

PHC also explores other data sources for insights into member experiences and disparities. Member grievance reports serve as a proxy measure for member trust and engagement with the health plan. PHC seeks to balance the proportion of reported grievances to reflect the race/ethnicity and language of PHC's membership.

Finally, in alignment with DHCS and NCQA objectives, PHC will continue to promote staff awareness through education on diversity, equity, and inclusion. Each of the objectives identified align with PHC's mission to help our members, and the communities we serve, be healthy.

The objectives for the 2022 PNA Action Plan are:

- Improve opportunities for sustainable employment for our members by launching a Community Health Worker (CHW) Scholarship program that engages representatives from traditionally under-represented groups.
- Improve vulnerable member preparedness for disaster through a targeted outreach campaign.

- Improve the Asthma Medication Ratio (AMR) for pediatric members in PHC's Northern Region.
- Increase Breast Cancer Screening participation rate among all PHC regions' American Indians/Alaskan Native members.
- Improve Black/African American management of controlling high blood pressure in adults in PHC's Southern Region.
- Increase the proportion Non-English speaking/Non-White members reporting grievances.
- Promote awareness and understanding of health equity by providing at least one training opportunity for PHC employees on diversity, equity, and inclusion.

II. Data Sources

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

- Member demographics including age, language, including limited English proficiency, race/ethnicity, and geographic location
- Social Determinants of Health (SDOH) extrapolated from Healthy Places Index and County Health Rankings
- Service utilization
- Health conditions and health-related behaviors
- Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities, and members with serious and persistent mental illness (SPMI)
- Member satisfaction
- Health disparities

B. 2021 PHC Member Enrollment Data

PHC demographic data is based on the Medi-Cal enrollment data received as of December 2021. 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.

C. 2021 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 2021 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, improve the overall wellbeing of an individual and reduce health disparities for subpopulations. The rankings are determined by the following factors:

- Health Outcomes: The overall ranking in health outcomes measures the overall health of county residents. They reflect the physical and mental well-being of residents within a community through measures representing length of life and quality of life.
- Health Factors: The overall ranking in health factors represents many things that influence 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.

D. 2021 PHC Integrated Claims and Encounter Data

PHC's analytics department maintains an integrated data set, including medical, behavioral, and pharmacy claims data for the services PHC reimburses, laboratory results, as well as services directly reimbursed by the State. (Note, in January 2022, the pharmacy benefit has transitioned from managed care plans to California oversight; future pharmacy data will be based upon data provided by the state). The 2021 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, laboratory results, and encounter data are integrated with State-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims for

[2] (Robert Wood Johnson Foundation, 2021)

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.

E. 2021 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a comprehensive set of standardized performance measures established by the National Committee for 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 measurement year. DHCS selects some of these HEDIS measures to be used as annual performance measures for MCPs, the Managed Care Accountability Set (MCAS). Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile of the national NCQA HEDIS performance for Medicaid and varies by each measure. In addition to the MCAS measures, PHC has begun collecting data on NCQA HEDIS measures required for NCQA Accredited Medicaid Managed Care Plans. PHC uses annual HEDIS results to evaluate clinical quality in a standardized way, and to evaluate health inequities for our members by race, ethnicity, and language, as well as by geographic region. 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).

F. 2021 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.

G. 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In alignment with the National Committee for Quality Assurance (NCQA), PHC has selected SPH Analytics (SPH) to perform member surveys to capture information about member experiences with the health plan and health care. These surveys inform health care organizations about patients' or their families' experiences with their health care providers and plans, including hospitals, home health agencies, doctors, and health and drug plans, among other provider types. The CAHPS surveys ask members to provide

feedback on the timeliness of care, shared decision-making, experiences with personal doctors, availability of specialists when needed, along with over-all experience with the health plan.

H. 2021 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 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 2021 with data derived from measurement year 2020 to conduct this study. This report provides data on health disparities data specific to PHC.

I. Other Data Sources

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

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, health equity, and population health management strategies. We reference United States Census Bureau reports, such as the 2015-2019 American Community Survey (ACS) and the SAIPE State and County Estimates for 2020, 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.

J. Population Segmentation

After reviewing PHC's overall population needs, the population is segmented into subpopulations with similar needs and characteristics. Each of these subpopulations are further assessed to identify any additional needs and disparities. This process leverages information gathered from a variety of reports that may include but are not limited to

member demographics, health/risk assessments, laboratory results, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as reports and analyses of over- and under-utilization of care. 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 evaluate for disparities and potential inequities, and to ensure 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.

III. Key Findings

A. Membership/Group Profile

According to PHC enrollment data as of December 2021, PHC currently serves more than 627,799 Medi-Cal beneficiaries in 14 counties in Northern California, representing approximately 5% of Medi-Cal beneficiaries in California. PHC primarily serves children and adults under age 65. In 2021, there were 8,828,513 children living in the State of California, of which 2.7% (239,071)[3] were assigned to PHC.

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 1, are centrally located in Fairfield, Redding, Santa Rosa and Eureka.

[3] (United States Census Bureau)

Figure 1: Map of PHC Counties with Location of Regional Offices

Source: Partnership HealthPlan of California Website, 2021

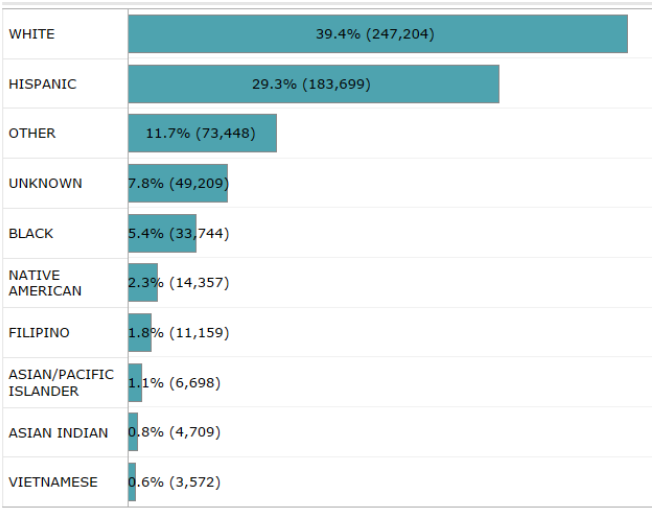
Age and Gender

According to the December 2021 PHC member enrollment data, approximately 20% of members are ages 0-10, 18% are ages 11-19, 34% 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 6,440 babies born to PHC members during calendar year 2021.

Race/Ethnicity

PHC members self-identify their race/ethnicity when enrolling in Medi-Cal, using the federal Office of Management and Budget (OMB) combined format. Of note, members may only select one race/ethnicity on the current enrollment form. The largest ethnic categories of our membership are White (40%) and Hispanic (29%). Figure 2 below illustrates the racial and ethnic composition of PHC members as of December 2021, based on PHC member enrollment data. The Hispanic membership represents the largest non-White ethnic group across all 14 counties.

Figure 2: 2021 PHC Membership by Race/Ethnicity

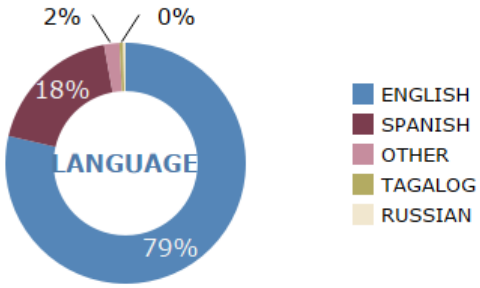


Source: 2021 Member Enrollment Data, Partnership HealthPlan of California

Primary Language

Primary language data also comes from the members' self-declaration of preferred language when enrolling in MediCal. English continues to be the primary language spoken by PHC members according to PHC's 2021 enrollment data. Currently, about 79% of members identify as English speaking and 18% of members identify as Spanish speaking. The other DHCS threshold languages, Russian and Tagalog, account for less than 1% of the population; and 2% of the population speak something other than the three threshold languages. (Figure 3).

Figure 3: 2021 PHC Membership by Primary Language



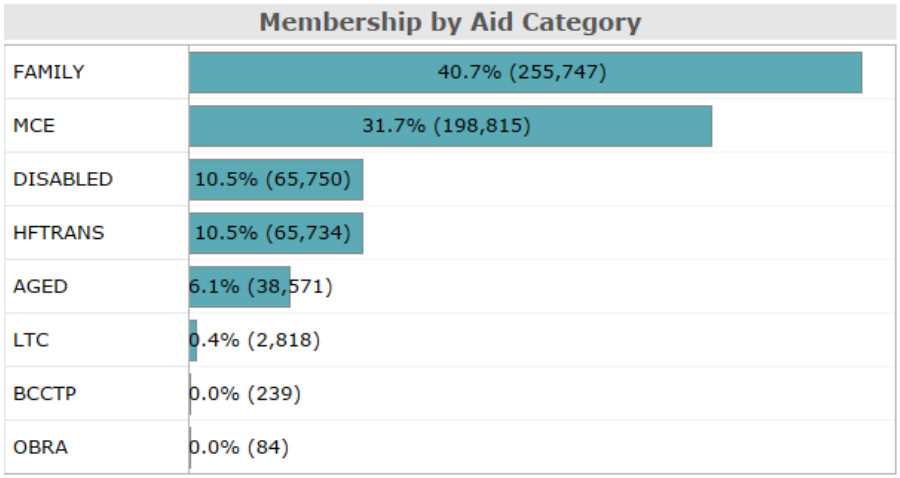
Source: 2021 Member Enrollment Data, Partnership HealthPlan of California

Disability

Medi-Cal beneficiaries qualify for coverage based upon many factors reflected in their Medi-Cal Eligibility Aid Category. These categories are determined during the Medi-Cal

enrollment process. While many members qualify for Medi-Cal based upon income thresholds (Family, Managed Care Expansion (MCE), and Healthy Families Transition (HFTrans), there are some members who qualify based on having a disability. In 2021, 10.5% of enrolled members (65,750) qualified for PHC membership because of disabling conditions (Figure 4). PHC provides a directory of community resources for each county, including a section dedicated to services for members with disabilities (See Appendix C for an example).

Figure 4: 2021 PHC Membership Aid Category and Disability Status



Source: 2021 Member Enrollment Data, Partnership HealthPlan of California

B. Social Determinants of Health (SDOH)

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

Standardized collection of individual member social determinants of health is not available. Claims data containing diagnosis codes indicating one or more social determinants of health is not validated and is quite incomplete, and so is not useful for meaningful analysis. Instead, PHC uses the SAIPE State and County Estimates for 2020 along with County Health Rankings & Roadmaps data, 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 of the needs of our population.

Poverty

People living in poverty experience limited access to quality health care, healthy foods, safe neighborhoods, stable housing, and opportunities for physical activity, and higher education. As a Medi-Cal Managed Care Plan, PHC enrollees include most of the people experiencing poverty who live in PHC's region.

According to most recent data available from the 2020 Small Area Income and Poverty Estimates (SAIPE), California has a state poverty rate of 11.5%. Of PHC's 14 counties, ten counties have poverty rates above the California average. The counties include Del Norte (18.5%), Humboldt (15.8%), Lake (15.9%), Lassen (15.5%), Mendocino (14.3%), Yolo (14.8%), Modoc (17.9%), Shasta (13.9%), Siskiyou (14.3%) and Trinity (18%). The SAIPE data reveal that all seven of PHC's Northern Region counties are above the poverty rate of California.

Table 1: PHC Counties by Poverty Rates

PHC Northern Region	Poverty Rate (%)	PHC Southern Region	Poverty Rate (%)
California	***11.5***	***California***	***11.5***
Del Norte	18.5	Lake	15.9
Humboldt	15.8	Marin	6.0
Lassen	15.5	Mendocino	14.3
Modoc	17.9	Napa	7.9
Shasta	13.9	Solano	9.3
Siskiyou	14.3	Sonoma	7.8
Trinity	18.0	Yolo	14.8

Source: 2020 Small Area Income and Poverty Estimates (SAIPE)

Income

According to the 2020 Small Area Income and Poverty Estimates (SAIPE), the median household income in California is $83,001. Ten of PHC's covered counties have median household incomes below California's state average. These counties are the same as the counties exceeding the poverty rate, as previously noted (Del Norte, Humboldt, Lake, Lassen, Mendocino, Yolo, Modoc, Shasta, Siskiyou and Trinity).

Table 2: Median Household Income by PHC County

PHC Northern Region	Median Household Income	PHC Southern Region	Median Household Income
California	***$ 83,001***	***California***	***$ 83,001***
Del Norte	$ 47,442	Lake	$ 52,345

PHC Northern Region	Median Household Income	PHC Southern Region	Median Household Income
California	***$ 83,001***	***California***	***$ 83,001***
Humboldt	$ 56,071	Marin	$127,601
Lassen	$ 63,803	Mendocino	$ 53,176
Modoc	$ 46,838	Napa	$ 92,149
Shasta	$ 59,108	Solano	$ 83,678
Siskiyou	$ 49,441	Sonoma	$ 87,336
Trinity	$ 45,113	Yolo	$ 80,668

Source: 2020 Small Area Income and Poverty Estimates (SAIPE)

Income inequality is another way to view these data. Income inequality is connected to health as well, regardless of income of individual households. Living in a community with high income inequality can heighten differences in social class and status (County Health Rankings and Roadmaps, 2021). According to County Health Rankings and Roadmaps, income inequality is a ratio between households with incomes at the 80th percentile and those with incomes at the 20th percentile. Overall, California has an income inequality ratio of 5.2. Of PHC's covered counties, Marin and Yolo counties have income inequality ratios higher than the California average, indicating a wider gap in income. Those counties with lower scores show more incomes within the counties.

Table 3: Median Household Income by PHC County

PHC Northern Region	Income Inequality Ratio	PHC Southern Region	Income Inequality Ratio
California	***5.2***	***California***	***5.2***
Del Norte	5.0	Lake	4.9
Humboldt	5.0	Marin	5.8
Lassen	4.3	Mendocino	4.8
Modoc	4.1	Napa	4.4
Shasta	4.9	Solano	4.1
Siskiyou	4.6	Sonoma	4.3
Trinity	4.5	Yolo	5.9

Source: 2021 County Health Rankings & Roadmaps

Children Living in Poverty

One measure of present and future health risk of a population is the percentage of children living in poverty within a county. While people of all ages are impacted by poverty, children are especially susceptible to more frequent and severe chronic conditions such as asthma, obesity, diabetes, ADHD, behavior disorders, anxiety, and dental concerns.

The County Health Rankings and Roadmaps report measures Children in Poverty as the percentage of people under the age of 18 living in poverty. On average, 16% of Californian children live in poverty (County Health Rankings and Roadmaps, 2021). Of PHC's covered counties, six counties have lower rates of children experiencing poverty: Marin (7%), Napa (8%), Sonoma (8%), Solano (11%), Yolo (13%) and Lassen (15%). PHC also has counties with children in poverty rates that exceed the California average. Modoc (31%), Del Norte and Siskiyou (26% each) counties demonstrate that there is a continued need to support the health of children significantly impacted by poverty.

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 a limited access to health coverage.

Unemployment is measured as a percentage of the population aged 16 and older who are unemployed but seeking work. In California, the unemployment average is 4%. The unemployment rates of eight of PHCs covered counties were higher than the state average (Yolo, Lassen, Shasta, Lake, Trinity, Del Norte, Siskiyou and Modoc). Mendocino County finds itself at the same unemployment rate as California. On the other hand, Marin, Sonoma, Napa, Humboldt and Solano counties have fewer individuals unemployed than the California average.

High School Graduation

Educational attainment is positively correlated with improved health outcomes for both quality-of-life and life expectancy. Adults with more education, on average, tend to be more consistently employed and earn more money than their less educated peers. Given the persistent impact of COVID-19 on educational access, it remains to be seen what long-term effects will be for all school-aged people.

In California, the average high school graduation rate is 83% (County Health Rankings and Roadmaps, 2021). Lassen County's high school graduation rate is at the state average, while Del Norte County's high school graduation rate is below the state average. PHC's remaining 12 counties have high school graduation rates above the state average, with Marin, Trinity and Shasta as the highest (93%, 92%, 91%, respectively). PHC continues to support access to higher education through programs such as the Association for Community Affiliated Plans (ACAP) scholarship award and grants supporting education of Community Health Workers.

Air Pollution and Wildfires

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 8.1. The PHC counties that have the highest rates of air pollution are Napa (8.6) and Solano (9.0).

In 2021, there were 13 wildfires in PHC's region that burned over 1,000 acres, and there were 18 fires burning 1,000 acres or more in 2020. With the increasing rate of wild fires in California, there is an increased possibility of impacts on PHC's covered counties health. In particular, fires increase 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

According to the CDC, cigarette smoking remains a leading cause of preventable disease, disability and death in the United States[4]. Smoking impacts nearly every organ of the body and can cause cancer in various parts of the body. Compared to nonsmokers, smokers are more likely to develop heart disease, stroke and lung cancer. Secondhand smoke can also increase the risk for health concerns. With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate youth and parents on the harmful effects of tobacco use.

County Health Rankings and Roadmaps data say that on average, 11% of adults are current smokers in California. Adult smoking rates are higher than the state average in many of PHC's counties, with the only exception being Marin (10%). PHC's pharmacy department is launching a pilot to encourage members who smoke to sign up with state smoking cessation programs.

Table 4: Adult Smoking Rates by PHC County

PHC Northern Region	Adult Smoking Rate	PHC Southern Region	Adult Smoking Rate
California	***11%***	***California***	***11%***
Del Norte	19%	Lake	18%
Humboldt	17%	Marin	10%
Lassen	18%	Mendocino	17%
Modoc	19%	Napa	12%
Shasta	17%	Solano	14%
Siskiyou	18%	Sonoma	13%

[4] (CDC, 2021)

PHC Northern Region	Adult Smoking Rate	PHC Southern Region	Adult Smoking Rate
California	***11%***	***California***	***11%***
Trinity	19%	Yolo	14%

Source: 2021 County Health Rankings & Roadmaps

Physical Inactivity

Low physical activity relates to 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 due to the connection

The 2021 County Health Roadmaps and Rankings measures physical inactivity as the percentage of adults age 20 and over reporting no leisure time physical activity, with higher values indicating less time for physical activity. The California state average was 18%. In PHC covered counties, Del Norte (33%), Lassen (34%), Lake (23%), Modoc (24%), Solano (22%), Siskiyou (25%) and Trinity (22%) counties all had physical inactivity rates that were worse the state average. In Marin (13%), Mendocino (16%), Sonoma (16%), Yolo (15%), Humboldt (16%) and Shasta (17%) counties, they had rates of physical inactivity better than the state average.

Summary of Social Factors

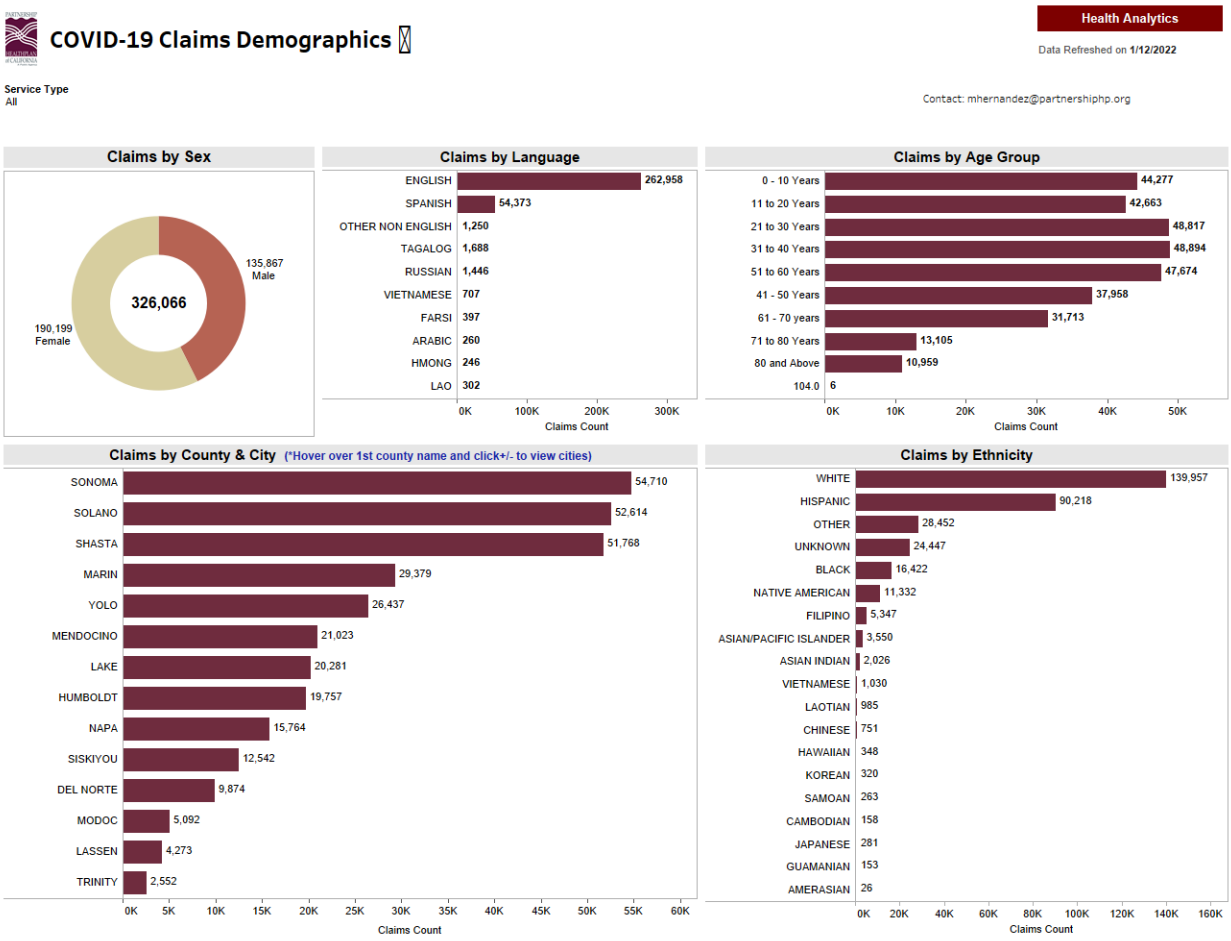
The structural and environmental conditions within PHC's region are daunting. There is limited opportunity for meaningful employment throughout many of PHC counties. The environmental challenge of persistent wildfires and power outages contributes to poor air quality, and also to loss of housing and behavioral health sequelae such as depression, substance use, reduced physical activity, and others. As social and economic factors deteriorate, it becomes harder for individuals to overcome barriers to health. In collaboration with community partners, PHC is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes. Additionally, PHC is working with public health and utility companies to mitigate the impact of wildfires with the most vulnerable members – those who are dependent on oxygen, dialysis, or medications requiring refrigeration for their daily health.

C. Disease Prevalence

COVID-19 Experience and Member Support

COVID-19 remained a prominent concern in PHC's covered counties during 2021, and into 2022. As of January 13, 2022, over 130,000 PHC members incurred over 300,000 claims related to COVID-19. The spread of COVID-19 related claims included members across PHC's 14 counties, demographics and ages. The largest proportion of claims geographically have come from Sonoma, Solano and Shasta counties, which the counties with the largest PHC membership. Members ages 31-40 accrued the most claims, at 48,291, with members ages 21-30 at 48,175 claims and members 51-60 years at 47,205 claims. A majority of PHC's COVID Claims data were from our female identifying members, measured at 58% of the claims. (Figure 5.)

Figure 5: Partnership HealthPlan All COVID-19 Claims Demographics



Source: Partnership HealthPlan 2021 Claims and Encounter Data

In August of 2021, DHCS launched an initiative for Managed Care Plans to offer incentives for Medi-Cal members to get their vaccines. PHC chose to participate in the

DHCS Medi-Cal COVID-10 Vaccination Incentive Program and began planning implementation in August 2021. APL 21-010 identified several populations of focus for health plans from which PHC identified the following four populations for targeted intervention:

- Homebound members
- Native American members
- Black members
- Members 12-29 years of age (teen and young adult members)

Prior to the Vaccination Incentive Program, PHC had established relationships with public health departments and local community based organizations. Once the program started, PHC leveraged those relationships to identify:

- Current vaccination activities
- Regional highest priorities
- Trusted and effective CBOs (Community-Based Organizations)
- Best practices for increasing vaccination
- Lessons learned/practices that have not been as effective

PHC's regional managers and Population Health departments supported these discussions. These ongoing conversations helped inform the trusted messages PHC helped promote to our members related to vaccination.

Member Focused Efforts

PHC elected to distribute incentive gift cards as part of a Vaccination Incentive Program to PHC members through two vaccination channels. Members who were vaccinated at a participating provider site received an incentive when the provider sent PHC documentation of the vaccination. There were 52 provider sites who participated in this vaccination program, which resulted in over 2000 incentives distributed.

In addition, members vaccinated at a local vaccination 'pop-up' events also received an incentive. Between August 1, 2021 and February 28, 2022, PHC's Population Health Department attended 132 COVID vaccination events across the 14 counties. PHC distributed $25 gift cards per dose to members who were vaccinated with Pfizer or Moderna vaccines and $50 value to members who were vaccinated with Johnson & Johnson on or after September 1, 2021. In PHC's Southeast Region, our Population Health team partnered with Touro University School of Osteopathic Medicine (Touro) and Solano County to promote vaccines. This strengthened relationship with Touro

proved promising in partnering with local medical institutions toward shared population health goals. PHC partnered with local public health offices in other counties to identify, promote, and participate in other vaccination clinics, as well.

PHC hosted two drive-thru vaccine clinics in partnership with Shasta County Public Health. PHC's Communications team provided Facebook posts, press releases and flyers in the Redding area. The success of the first clinic in November led to another held a month later, in December 2021.

Aside from face-to-face member engagement, PHC leveraged the success of the 2020 call campaigns to continue engaging members on COVID-19 information and vaccination information. Call campaigns focused on reaching homebound members, and members to offer help in scheduling vaccinations. PHC also promoted the Vaccine Incentive Program through messages played for members are on hold with selected member-facing departments.

COVID-19 continues to burden the healthcare system with the rise of new variants. As of January 2022, 53.7% of PHC eligible members were fully vaccinated. The largest share of vaccinations among an eligible age group was among the 65 and up aged population with 75% of the population vaccinated; 16% of the age group 5-11 years were vaccinated.

PHC will continue to collaborate with trusted community-based organizations and providers to help our members and the communities we serve, navigate these difficult times. PHC remains committed to assisting our members receive vaccines and boosters when appropriate.

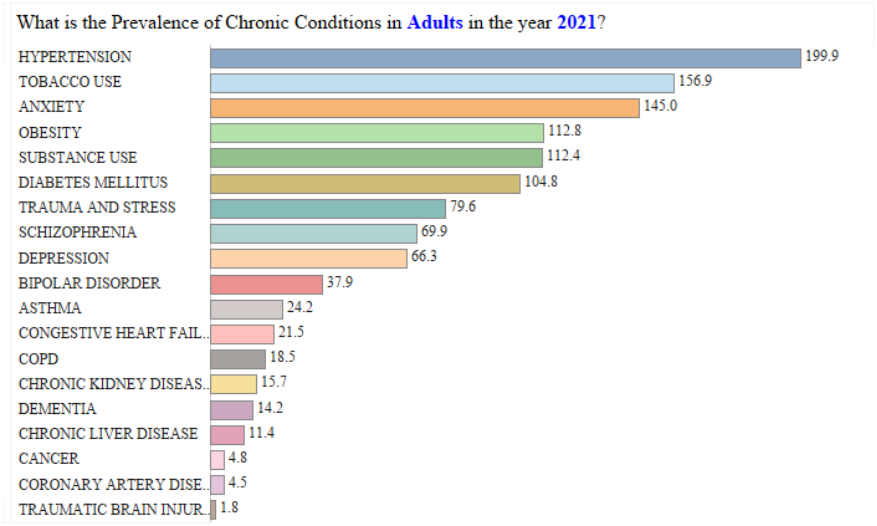
Chronic Disease

The 2021 PHC Integrated Claims and Encounter data highlighted eight (8) chronic diseases prevalent in adults and children. Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both[5]. Chronic condition prevalence is based on claims data which inherently does not record all conditions each member has; thus, the true prevalence of disease is higher. Figure 5 shows the most prevalent chronic condition claims for adults were: Hypertension (199.9 per 1000 adult members), Tobacco Use (156.9 per 1000 adult members), Anxiety (145.0 per 1000 adult members), Obesity

[5] (CDC, 2021)

(112.8 per 1000 adult members), Substance Use (112.4 per 1000 adult members), and Diabetes Mellitus (104.8 per 1000 adult members).

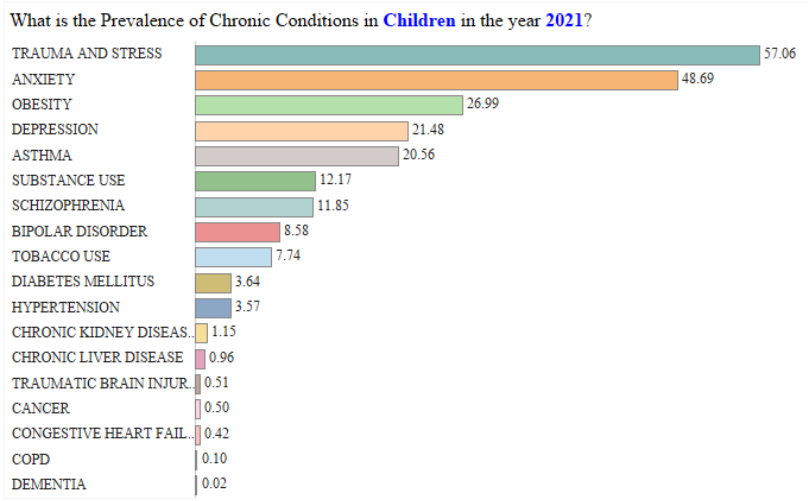
Figure 6: 2021 Adults Chronic Conditions Prevalence Data Per 1000 Members



Source: 2021 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

The eight (8) most prevalent chronic conditions found in pediatric claims were: Trauma and Stress (57.06 per 1000 pediatric members), Anxiety (48.69 per 1000 pediatric members), Obesity (26.99 per 1000 pediatric members), Depression (21.48 per 1000 pediatric members), and Asthma (20.56 per 1000 members).

Figure 7: 2021 Children Chronic Conditions Prevalence Data



Source: 2021 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

HEDIS Scores

PHC uses HEDIS measure performance to assess how well the health plan is providing preventive care as well as serving members with chronic diseases. Appendix A shows the HEDIS scores for all tracked performance measures for reporting 2021 (measurement year 2020). 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).

Hypertension

Hypertension is a major preventable risk factor for heart disease and stroke, which are the first and fifth leading causes of death in the United States, respectively (Ritchey MD, 2018). In 2021, Hypertension was the most prevalent chronic condition among PHC's adult members with the diagnosis showing for 199.9 per 1000 adult members (2021 PHC Integrated Claims and Encounter Data), and this number only reflects those members with claims submitted for care. The HEDIS Minimum Performance Level (MPL) for Controlling High Blood Pressure was 61.80% for the 2020 Measurement Year (2021 Reporting Year). In the 2021 Reporting Year, each of PHC's four regions fell below the MPL for controlling high blood pressure.

In 2021, PHC built upon a pilot to expand distribution of home blood pressure monitoring devices to PHC members. With the equipment, members were provided educational materials on the use of the monitors and tracking blood pressure numbers. In conjunction with member-focused efforts, PHC's Quality Improvement Department and PHC Medical Directors conducted provider webinars on the importance and best practices of home blood pressure monitoring. Given DHCS 2022 proposed equity metrics includes controlling high blood pressure, working towards helping members control high blood pressure will continue to be an organization-wide effort at PHC.

Asthma

The HEDIS MPL for Asthma Medication Ratio (AMR) was 62.43% for the 2020 Measurement Year (2021 Reporting Year). PHC's Northeast Region Performance for AMR fell below the MPL with a rate of 56.28%, and the Northwest Region was slightly lower with a rate of 56.04%. PHC's Southeast Region performed above the high performance level (73.38%) with a rate of 73.50%. The Southwest Region performed between the 75th and 90th percentiles, with a rate of 68.74%.

One of PHC's Quality Improvement organization-wide goals for 2020-2021 included a focus area of the AMR MCAS measure. In that year, the QI department completed 14 asthma academic detailing sessions. In 2021, PHC's Population Health staff members

completed CDPH's Asthma Management Academy to learn how to properly educate members with asthma. Taking these learnings and applying them to our Action Plan 2022 is an integral intervention this year.

Diabetes

Diabetes remains a serious health condition and a major risk factor for heart disease and stroke. Uncontrolled diabetes can lead to significant disability, including blindness, amputations and kidney failure[6]. In 2021, Diabetes accounted for one of the most prevalent chronic conditions found in both adult and children. The prevalence of Diabetes was measured at 104.8 per 1000 members in the adult population and 3.64 per 1000 members in the children population.

The HEDIS MPL for Comprehensive Diabetes Care measure indicator for poor diabetes control (HbA1c level >9%) was 37.47% for the 2020 Measurement Year (2021 Reporting Year). Of note, this measure is HEDIS's only measure where performance is inversely related to the percentage reported, meaning lower scores are better. PHC's Northern Region Performance for CDC went above the MPL with low performance of 38.93% and 39.90% in the northeast and northwest regions, respectively. PHC's Southeast Region also show similar difference with a score of 37.96%. The Southwest Region performed below the MPL with score of 36.50% which indicates that members in this region had good diabetes control.

Preventive Care

The Goal of Healthy People 2030 is to increase preventive care for people of all ages. Getting preventive care helps prevent disease and death through the use of preventive screening tests such as colorectal and breast cancer screening for adults, tracking of child development and vaccinations for all ages. It is estimated that millions of people in the United States do not get recommended preventive care services.[7] Helping people understand the importance of getting timely preventive care services is vital to improving the health for people and the communities they live in as well as reducing inequities in long-term health. PHC believes this is foundational to the work we do to help our members and the communities we serve be healthy.

Adult Cancer Screening

Timely cancer screenings are a key component of the preventive care for adult members. On an annual basis, PHC monitors and assesses three (3) cancer metrics. Breast cancer and cervical cancer screenings are assessed as part of the DHCS MCAS

[6] (California Department of Public Health, 2020)
[7] (Health Affairs, 2018)

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. Colorectal cancer screening will be a Medicaid HEDIS measure starting in 2022.

Despite efforts to improve breast cancer screening rates among eligible members 52-74 years of age, performance in all regions fell short of the DHCS- specified Minimum Performance Level (MPL) of 58.82% for the 2020 Measurement Year (2021 Reporting Year): Northeast (50.09%), Northwest (42.42%), Southeast (56.64%), and Southwest (52.8%). The effect of COVID-19 certainly played a role in the declining rates, with members hesitant to seek preventive care and hospitals reducing elective diagnostic services to accommodate surges of COVID-related admissions. PHC will continue with improvement activities such as educating members about the importance of breast cancer screening and collaboration with mobile mammography providers. We will also explore the hesitancy many populations have about mammograms in order to improve our outreach and messaging about getting mammograms.

Similar challenges are occurring with the Cervical Cancer Screening. The MPL for this measure is 61.31% for the 2020 Measurement Year (2021 Reporting Year). The Northeast (51.35%) and Northwest (53.53%) continued to perform well below the MPL. It should be noted that the Northwest had a small improvement in the measure from 2019 to 2020. In the Southern regions, the Southeast below the MPL to 60.38% while the Southwest met the MPL at 65.28%. While the Southwest met the MPL, is should be noted that the current score represents a decrease from the previous year's rate of 68.37%. To increase member's knowledge on the importance of cancer screening, the Health Education team developed series of health education collateral (flyer, postcard, brochure, and poster) targeting breast and cervical cancer screenings.

Pediatric Well-Care and Immunizations

A recent study on missed well-child visits revealed that caregivers and clinicians recognized that well-child visit, immunizations, detection of disease, and monitoring of growth and development are important for child wellbeing[8]. Similar barriers to getting well-child care were also identified by both groups including: transportation barriers, getting time off from work, difficulty with child care, and other social stressors. Addressing the social determinants of health play a role for improving attendance of well-child visits.

[8] (PMC, 2020)

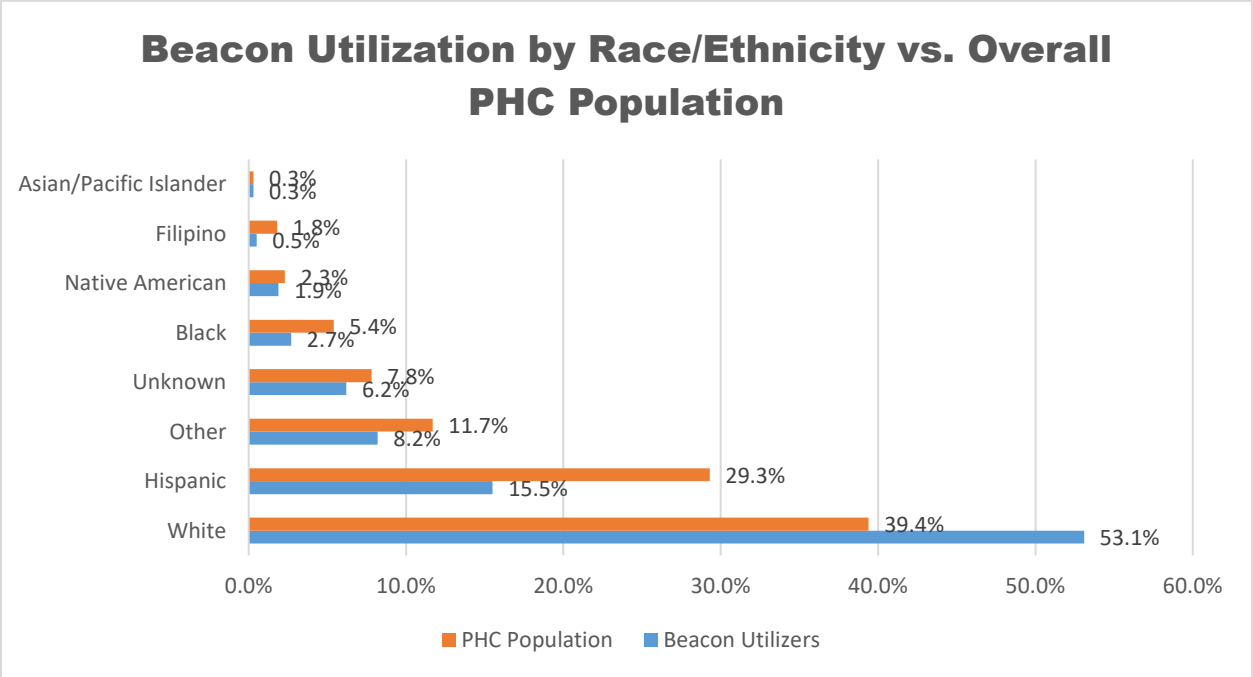
The DHCS Minimum Performance Level (MPL) is set at the 50th percentile of HEDIS performance among health plans nationwide. The MPL for Childhood Immunization Status (CIS-Combo 10) is 34.47% for the 2020 Measurement Year (2021 Reporting Year). For children ages 0-2 who received all the recommend immunization by the time they turned two years old, the Northeast (19.22%) and Northwest (27.98%) continued to perform well below the MPL while the Southeast (40.63%) and the Southwest (43.55%) regions performed about the MPL. While the Southeast performed above the 2020 MPL, the rate represented a decrease from the 2019 rate of 43.31%.

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) is 36.86%. The proportion of adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was below the MPL in the Northeast (21.17%) and Northwest (27.74%) regions. The Southeast (46.83%) and the Southwest (46.23%) regions were above the MPL. While Southeast performed above the 2020 MPL, the rate represented a decrease from the 2019 rate of 52.31%.

Behavioral Health

Throughout 2021, over 40,000 distinct members used PHC's delegated managed behavioral healthcare organization, Beacon Health Options (Beacon). Another 2,000 distinct members used Indian Health Mental Health services, based on PHC's claims data. Of these behavioral health utilizers, approximately 66% were female and 34% male members. A larger share of the members were adults, at 72% of utilizing members and 28% at youth under the age of 21. According to the Beacon Utilization by Race/Ethnicity vs. Overall PHC Population (Figure 7), there is a disproportionate share of white members seeking behavioral health services compared to other racial/ethnic groups. The trend of utilizers does follow that of the PHC's demographic breakdown; however, White members made up the highest utilizers of behavioral health services, at a rate of 53.1 per 1000 members.

Figure 8: 2021 Beacon Utilization by Race/Ethnicity vs. Overall PHC Population

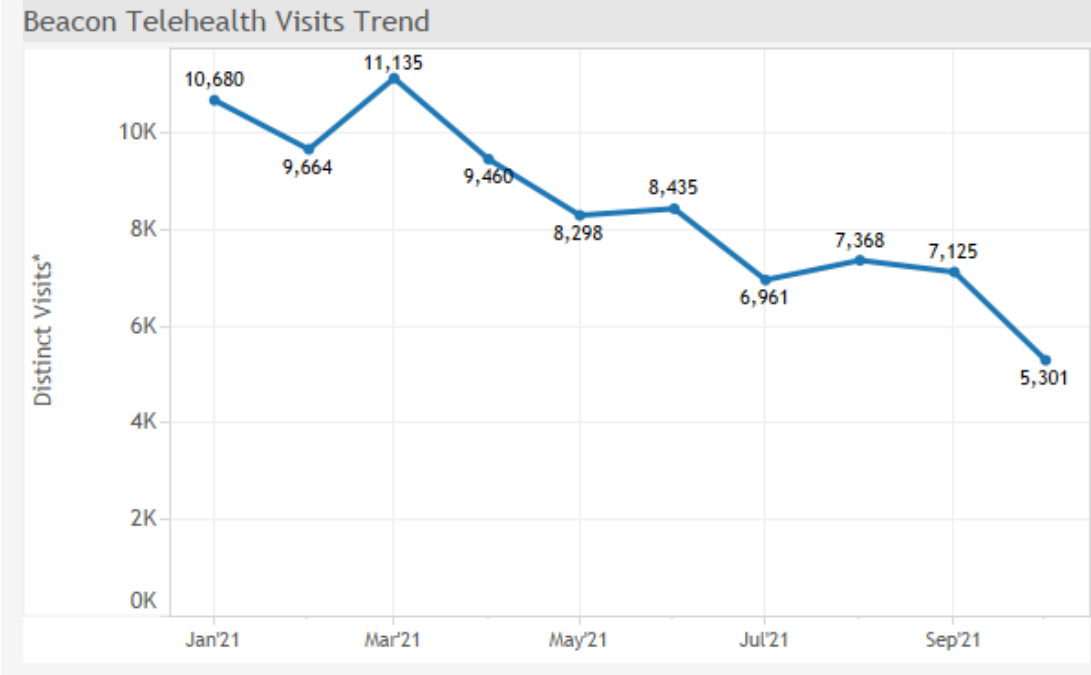


Source: 2021 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California; December 2021 Membership by Ethnicity, PHC Membership Data

Telehealth Utilization for Behavioral Health

Beacon Telehealth services declined slightly during 2021 (Figure 8). The highest volume of telehealth visits occurred in March of 2021, at 11,132 visits. As of November 2021, there were 84,427 Beacon Telehealth visits in the year. It is worth noting that while the year 2021 saw an overall decline in Beacon telehealth visits, Beacon's telehealth services were far greater in 2020 and 2021 compared to previous years. In the years 2018 and 2019, telehealth visits fell below 1,000 per month. As the COVID-19 pandemic continues to stay relevant, we anticipate telehealth services to remain at a similar rate and possibly continue moving forward.

Figure 9: 2021 Beacon Telehealth Visit Trend

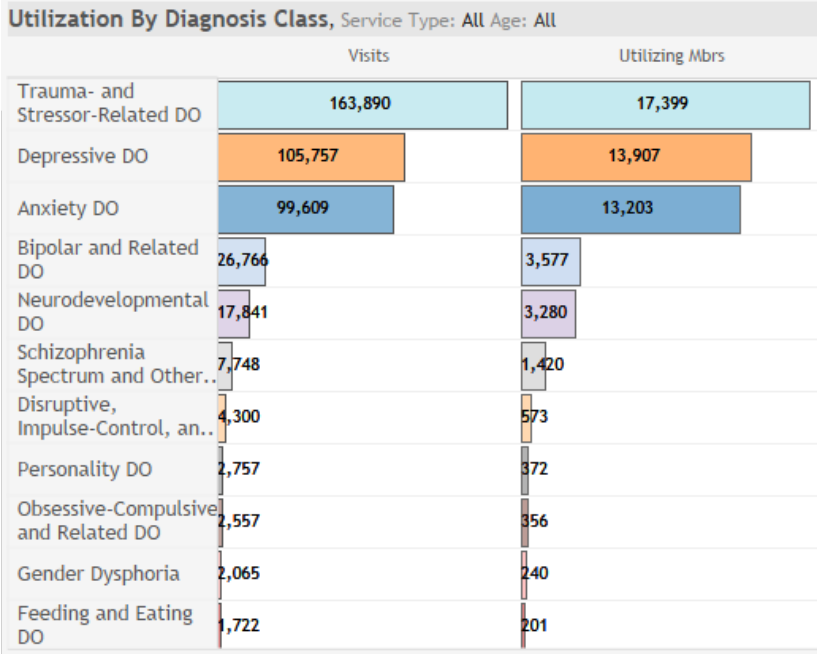


Source: 2021 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California

Mental Health Illness and SPMI

All of PHC's members are eligible for mental health services through Beacon so long as their diagnosis is mild-to-moderate. If an adult member needs treatment for serious or persistent mental illness (SPMI) or a pediatric member has serious emotional disturbance (SED), they are referred to the County Mental Health Plans for care. Beacon's covered diagnoses for 2021 are displayed in Figure 9. It is worth noting that Gender Dysphoria was among the top 10 Beacon Services in 2021. It was not nearly as prominent as Trauma and Stressor related diagnosis, Depression or Anxiety, but its increased prevalence supports the importance of training providers and staff on gender sensitivity when appropriate.

Figure 10: 2021 Beacon Services Utilization by Diagnosis Class (Including SPMI)



Source: 2021 Beacon Mental Health Claims and Encounter Data, Partnership HealthPlan of California

Substance Use Disorder (SUD)

In July 2020, DHCS On July 1, 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. DMC ODS is an innovated program designed to provide organized and comprehensive SUD care for Medi-Cal enrollees, and is administered through Managed Care Plans. This effort is referred to as the PHC Wellness and Recovery Program, or the 'Regional Model.' PHC, along with our providers and partners in these seven counties, work together for integrated physical health and SUD services for the Medi-Cal population. Seven PHC counties opted to participate: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

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

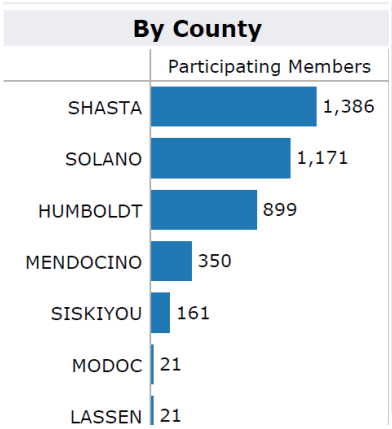
- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, nine-19 hours per week for adults
- Detoxification services (withdrawal management)
- Residential treatment

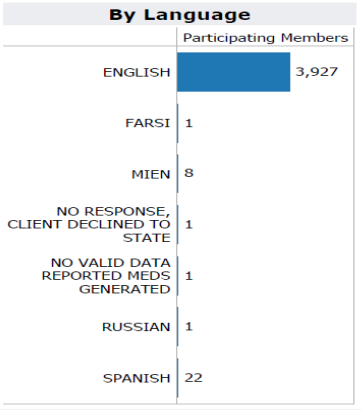
- Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)

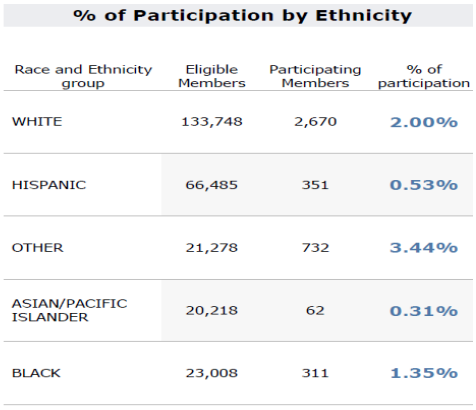
Services are accessible through contracted Drug Medi-Cal providers and are available to Medi-Cal recipients who meet the medical necessity criteria as determined by the American Society of Addiction Management (ASAM) scale.

Expanded SUD services are available in Napa, Marin, and Yolo counties, and are administered by the counties. A more limited benefit is administered by the remaining four counties, Del Norte, Lake, Sonoma, and Trinity. In 2021, there were a total of 4, 009 members participating in the Wellness & Recovery program, with the highest numbers in Shasta (1,386) and Solano (1,171) counties. Nearly all the participating members were English-speaking (3,927), and 67% of participants identified as White.

Figure 11: 2021 Participation in Wellness & Recovery Services







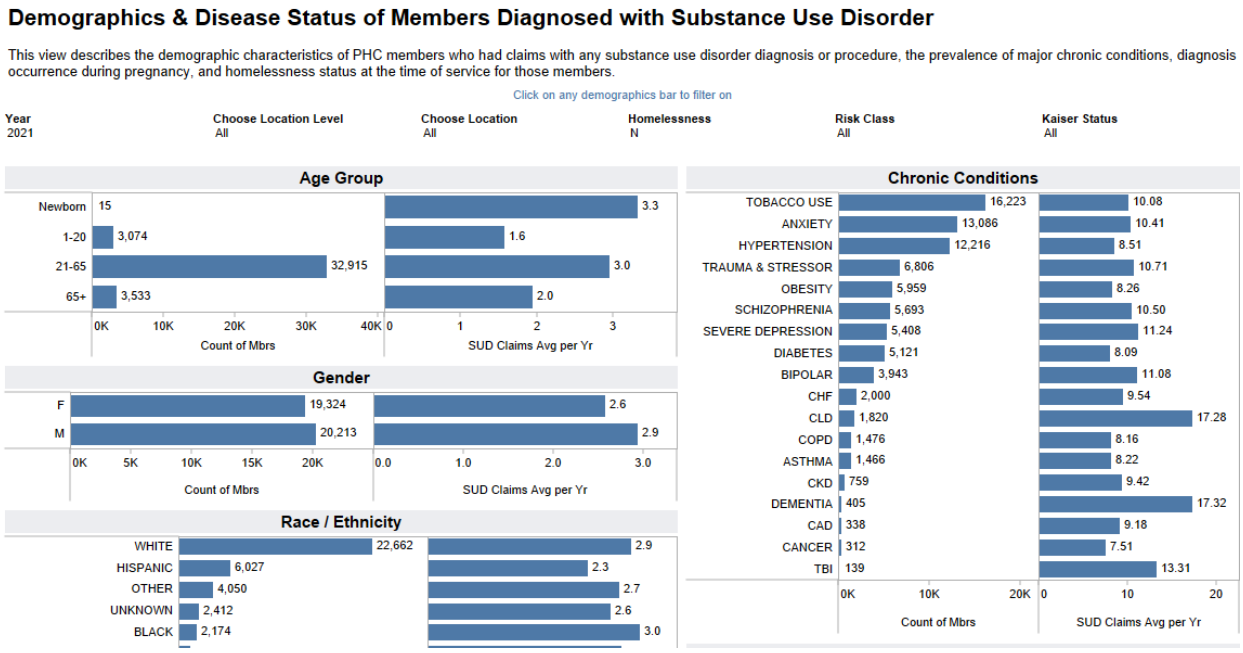
Race and Ethnicity group	Eligible Members	Participating Members	% of participation
WHITE	133,748	2,670	2.00%
HISPANIC	66,485	351	0.53%
OTHER	21,278	732	3.44%
ASIAN/PACIFIC ISLANDER	20,218	62	0.31%
BLACK	23,008	311	1.35%

2021 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

In counties not offering the Wellness & Recovery Program, PHC offers limited care options for directly treating members diagnosed with SUD. In total, PHC paid claims for approximately 45,000 members diagnosed with SUD in 2021. The substances most frequently used were alcohol, opioids and stimulants. Compared to mental health data from Beacon, there was a slightly larger share of male members with an average of 2.9 SUD claims per year compared to female members averaging at 2.6 SUD claims per year. The SUD claims show that roughly 57% of members diagnosed with SUD were White in 2021. This is greater than the share of White members across PHC, about 40% of our membership. Hispanic members had 15% of the share of SUD claims compared to the 47% share they have of PHC. Members diagnosed with SUD

frequently have co-existing conditions, such as tobacco use, anxiety, hypertension, and others as outlined in the figure below.

Figure 12: 2021 PHC Members with Substance Use Disorder Diagnosis



Source: 2021 PHC Integrated Claims and Encounter Data, Partnership HealthPlan of California

In January 2022, the first phase of DHCS's CalAIM benefits launched. The Enhanced Care Management (ECM) benefit offers adults with serious persistent mental illness (SPMI) and/or SUD in Marin, Mendocino, Napa, Shasta and Sonoma counties intensive, community-based case management services to support medical, behavioral, dental, long-term support and/or community support needs. In July 2022, the second phase of DHCS's CalAIM ECM benefit will roll out and provide the same type of services for members in Del Norte, Humboldt, Lake, Lassen, Modoc, Siskiyou, Solano, Trinity, and Yolo counties. Future PNAs will describe the impact of this benefit for PHC members.

D. Access to Care

As defined by the National Academies of Sciences, Engineering, and Medicine, access to health care encompasses "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[9] Many barriers to accessing health care exist within the general population but can be exacerbated by barriers that affect low income

(National Academy Press, 1996)

and rural populations. These barriers include access to fewer health care providers, cultural and linguistic challenges and transportation challenges to name a few. Health literacy challenges also contribute to a person's ability to access and use health care services. As occurred in 2020, COVID-19 continues to create barriers to accessing care that include delayed access to appointments as well as reluctance to attend appointments.

Provider Availability

Provider availability is the primary factor influencing our members' ability to attend annual checkups, routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the population to primary care providers to assess provider availability. The ratio is the number of individuals served by one primary care provider. For California as a whole, the ratio of individuals to providers is 1,250:1. In PHC's Northern Region, none of the counties approach the California ratio. Lassen and Trinity counties have the least availability of providers to the population with Lassen at a ratio of 3,420:1 and Trinity at a ratio 4,180:1. In PHC's Southern region several counties outperformed the California ratio including Mendocino (1,140:1), Marin (690:1), Solano (1,180:1), Sonoma (970), Napa (1,060:1), and Yolo (820:1). Lake County stands at a ratio of 2,300:1. In spite of these county-wide numbers, PHC contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

While PHC strives to connect members to providers in our network, there are circumstances that necessitate an out of the network referral. According to the Out of Network Referrals Report, PHC met our goal of less than 20 per 1,000 member referrals. When looking at referrals by county, Del Norte, Lassen, Modoc and Siskiyou had higher rates of out of network referrals, all of which are border counties with large medical centers in the adjacent state, which are most convenient for certain types of specialty care.

While not unique to PHC, rural counties across many states and regions have a hard time attracting and maintaining specialists. About 20 percent of Americans live in rural areas, while one-tenth of physicians practice in rural areas[10]. The federal government projects a shortage of over 20,000 primary care physicians in rural areas by 2025[11].

[10] (BMC Health, 2019)
[11] (NCBI, 2017)

CAHPS Health Care Performance

The CAHPS survey provides members an opportunity to tell us about their ability to access care and their satisfaction with the care received. Compared to 2020, the 2021 CAHPS adult composite scores increased in the areas of: rating of plan, rating of health care, getting care quickly, rating of personal doctor, and rating of specialist.

Table 5: 2021 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2020*** (Previous Reporting YR)	***2021*** (Current Reporting YR)
Rating of Health Care (% 8, 9, 10)	71.5%	77.9%
Getting Care Quickly (% Always or Usually)	78.4%	80.3%
How Well Doctors Communicate (% Always or Usually)	90.6%	90.5%
Coordination of Care (% Always or Usually)	81.9%	88.6%
Rating of Personal Doctor (% 8, 9, or 10)	81.3%	84.0%
Rating of Specialist (%8, 9, or 10)	77.9%	81.3%

Source: MY 2020 CAHPS Medicaid Adult 5.1 Final Report, SPH Analytics

For the 2021 CAHPS child composite scores, the rating of health care increased; however, a number of scores showed decreases including: getting care quickly, rating of personal doctor (significant decrease from 2020), and rating of specialist. Of note: SPH Analytics commented that the response rate was low compared to previous years and recommended using caution when interpreting the results.

Table 6: 2021 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2020*** (Previous Reporting YR)	***2021*** (Current Reporting YR)
Rating of Health Care (% 8, 9, 10)	85.1%	82.8%
Getting Care Quickly (% Always or Usually)	88.8%	81.1%
How Well Doctors Communicate (% Always or Usually)	92.8%	93.0%
Coordination of Care (% Always or Usually)	85.9%	84.4%
Rating of Personal Doctor (% 8, 9, or 10)	90.6%	87.2%
Rating of Specialist (%8, 9, or 10)	88.4%	79.2%

Source: MY 2020 CAHPS Medicaid Child 5.1 Final Report, SPH Analytics

Third Next Available Appointment

PHC's Provider Relations department conducts an annual Third Next Available (3NA) survey to assess the availability of members' access to non-urgent primary care appointments for adults, pediatric, and newborn appointments, as well as primary care urgent care appointments. The results of the 3NA survey show that PHC met the 2021 performance goal of 90% for all primary care appointments. Telephone accessibility after business hours is also measured by assessing the number of rings before the phone is answered, minutes on hold, average wait time before seeing a provided, and a return call within 30 minutes. The results of the 3NA survey show that PHC met the 2021 performance goal for primary care telephone accessibility. When looking at 3NA primary care appointment access by county, some provider sites in Lake and Lassen counties did not meet the standards for appointment accessibility. All of the sites that did not meet the standards are resurveyed and provided with a corrective action plan as needed.

Table 7: 2021 PHC Third Next Appointment Availability

Third Next Available (3NA) Survey Findings 2021									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2021 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	98.9%	96.5%	97.4%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	2.0	2.0	2.0	98.6%	96.3%	97.2%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	100%	100%	100%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	100%	100%	100%	≥ 90%	Met

Source: 2021 Timely Access Data, Partnership HealthPlan of California

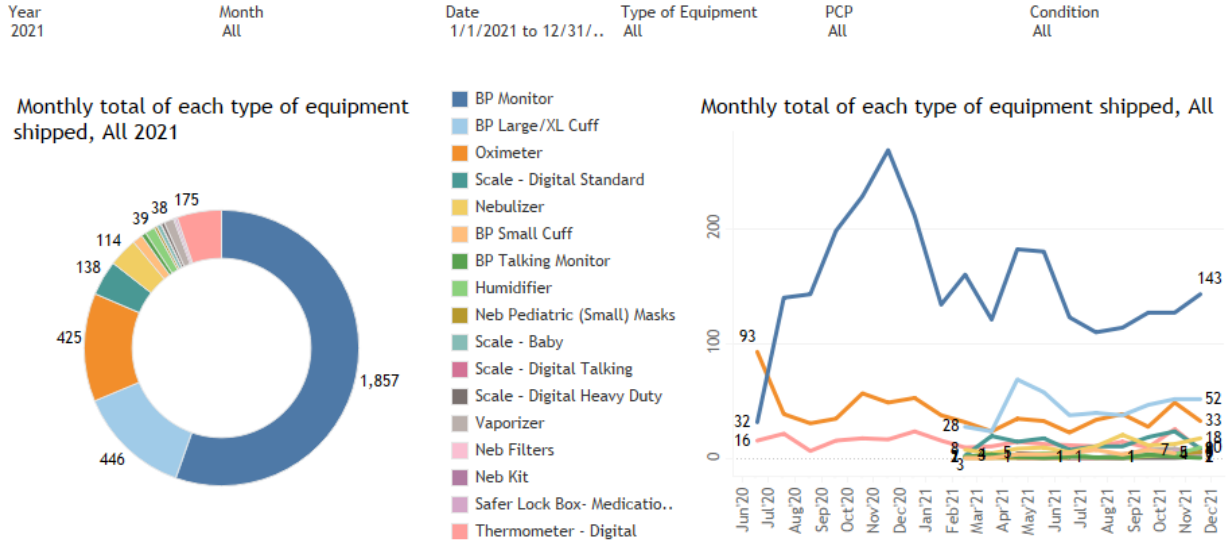
Telemedicine

In 2021, PHC encouraged providers to continue leveraging telemedicine and telephone visit opportunities to ensure access to needed health care. In 2020, PHC adult members scheduled 4,275 specialty telemedicine visits through the PHC contracted specialty telemedicine provider and completed 3,043 (71.2%) of these scheduled appointments. In 2021, utilization of these telemedicine visits increased to 5,159 scheduled and 3,698 (71.7%) completed visits, an increase of 655 completed visits. In addition to these telemedicine visits, many primary care providers and network specialists began providing substantial numbers of virtual visits, as permitted by DHCS and CMS as part of the COVID response.

While telemedicine can increase access to both primary and specialist appointments, PHC members living in rural and remote areas with limited broadband access require in-person visits to meet their medical needs. In addition, many PHC members lack the equipment, or knowledge needed, to connect to a telemedicine appointment.

To complement telemedicine and telephone visits, PHC provides members with health monitoring equipment. These tools promote member engagement in monitoring their health conditions and enables them to share their results with their providers. PHC staff developed easy-to-read instructions for each device to ensure members are able to correctly use the equipment and get valid results to share with their providers. In 2021, PHC distributed 1,857 monitoring devices to members to help manage their various health conditions. (Figure 11).

Figure 12: 2021 Monitoring Equipment Distribution Report



Source: 2021 Monitoring Distribution Report, Partnership HealthPlan of California

E. Member Experience of Care

Satisfaction with Health Plan

The 2021 CAHPS survey was conducted by SPH Analytics on behalf of Partnership in the first quarter of 2021. Based on the analysis, SPH reached out to 1,999 adult members and 3,247 pediatric members to participate in the survey. There were 319 adult responses (16%) and 565 (17.4%) pediatric responses. The CAHPS results discovered that 74.0% 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 2020 results where 70.9% rated their health care as high. This represents an increase of 3.1% from the 2020 report. Adult survey responses were also improved for Getting Needed Care (increase from 77.2% to 81.6%). However, adult members were less satisfied with Customer Service (decrease from 88.3% to 85.6%) and Ease of Filling Out Forms (95.3% to 93.7%). Table 6.

Table 8: 2021 Adults CAHPS Health Plan Performance Results

ADULT CAHPS Health Plan Performance	***2020*** (Previous Reporting YR)	***2021*** (Current Reporting YR)
Rating of Health Plan (% 8, 9, 10)	70.9%	74.0%
Getting Needed Care (% Always or Usually)	77.2%	81.6%
Customer Service (% Always or Usually)	88.3%	85.6%
Ease of Filling Out Forms (% Always or Usually)	95.3%	93.7%

Source: MY 2020 CAHPS Medicaid Adult 5.1 Final Report, SPH Analytics

The children survey results show that 84.8% of those completing forms on behalf of pediatric members rated their child's experience with the health plan care as good or excellent (scores 8, 9, 10) compared to 2020 results where 85.4% rated their healthcare as highly. This represents a decrease of 0.6% from the 2020 report (Figure 5). The remaining survey responses were also decreased for pediatric members: Getting Needed Care decreased from 83.2% to 80.7%; Customer Service decreased from 91.8% to 88.7%, and Ease of Filling Out Forms decreased from 96.8% to 96.1%.

Table 9: 2021 Child CAHPS Health Plan Performance Results

CHILD CAHPS Summary Scores	***2020*** (Previous Reporting YR)	***2021*** (Current Reporting YR)
Rating of Health Plan (% 8, 9, 10)	85.4%	84.8%
Getting Needed Care (% Always or Usually)	83.2%	80.7%
Customer Service (% Always or Usually)	91.8%	88.7%
Ease of Filling Out Forms (% Always or Usually)	96.8%	96.1%

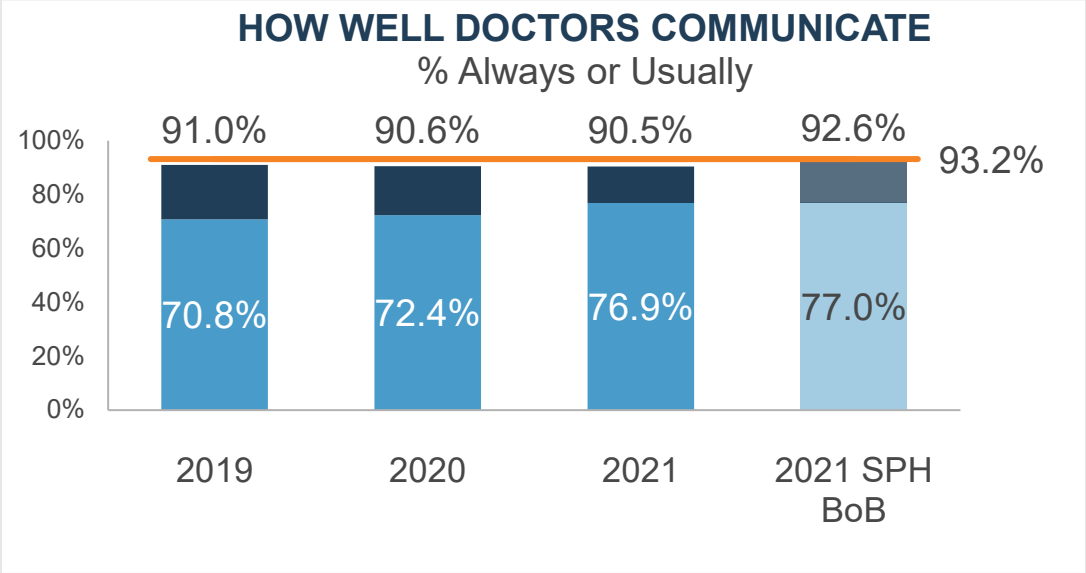
Source: MY 2020 CAHPS Medicaid Child 5.1 Final Report, SPH Analytics

Doctor Communication

PHC uses the 2021 PHC CAHPS survey data to evaluate how satisfied they are with the interactions they have with their doctors. The score is comprised of indicators measuring how well a member's personal doctor explained things, listened carefully, showed respect, and if doctor spent enough time with them. The proportion of adult members who felt their personal doctor communicated well with them always or usually decreased on aggregate from 90.6% in 2020 to 90.5% in 2021. PHC scored below the

2021 SPH Analytics Benchmark in all aspects of how well doctors communicate with PHC adult members (Figures 12 and 13).

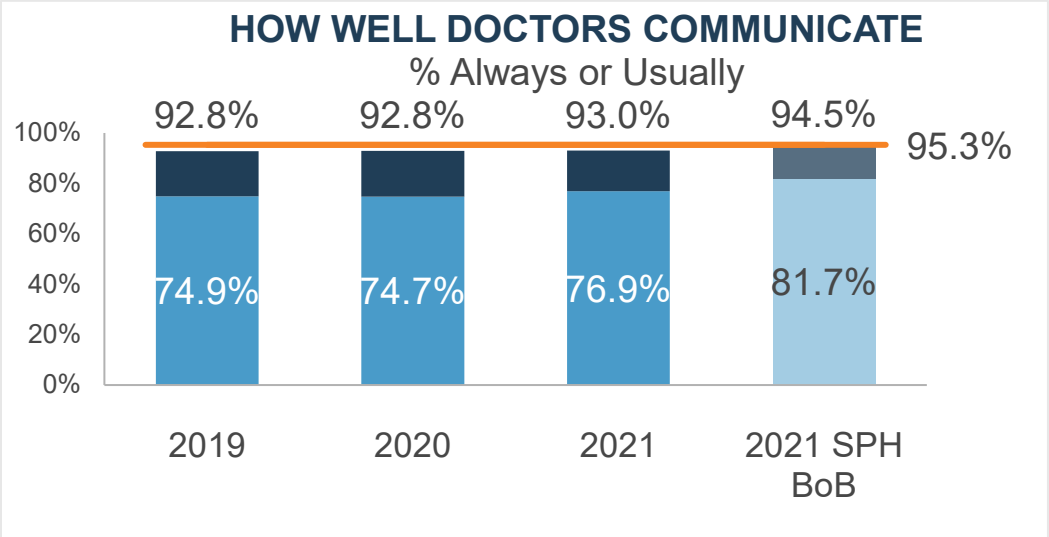
Figure 13: 2021 Adult CAHPS Survey Result



Source: 2021 CAHPS 5.1 Adult Medicaid Survey, Partnership HealthPlan of California

The results of the Child CAHPS Survey show that members rated their care experience with the child's provider higher than the care experience with the adult's provider care. The proportion of child members who felt their personal doctor communicated well with them always or usually increased on aggregate from 92.8% in 2020 to 93.0% in 2021. Nevertheless, the scores are below the 2020 SPH Benchmark of 94.5% in all aspects of how well doctors communicate with PHC child members.

Figure 14: 2021 Child CAHPS Survey Result



Source: 2021 CAHPS 5.1 Adult Medicaid Survey, Partnership HealthPlan of California

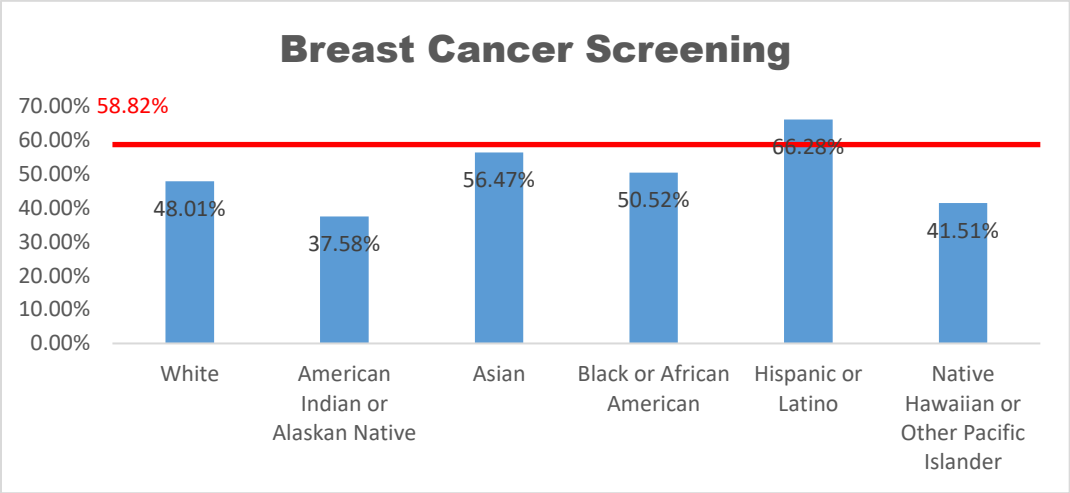
F. Health Disparities

PHC uses DHCS plan-specific Measurement Year (MY) 2020 Health Disparities report data (2021 reporting year) to assess disparities for chronic disease measures within the membership. This report identified race/ethnicities that have statistically significant health disparities in four (4) HEDIS measures: Breast Cancer Screening (BCS), Asthma Medication Ratio (AMR), Controlling High Blood Pressure (CBP) and Comprehensive Diabetes Care (CDC).

Breast Cancer Screening

Over the last three (3) PNA cycles, the American Indian or Alaskan Native members have had persistent disparities in BCS. In 2021, of members eligible for Breast Cancer screening, only 37.6% of American Indian or Alaskan Native completed screening, which is significantly below the MPL of 58.82% (Figure 18). Native Hawaiian or Other Pacific Islanders also lag, but have a low sample size. The White population (48.01%) and Black or African American population (50.52%) also have care gaps for BCS, and PHC continues to pursue means to improve this important metric.

Figure 15: 2021 PHC Completed Breast Cancer Screenings by Race/Ethnicity

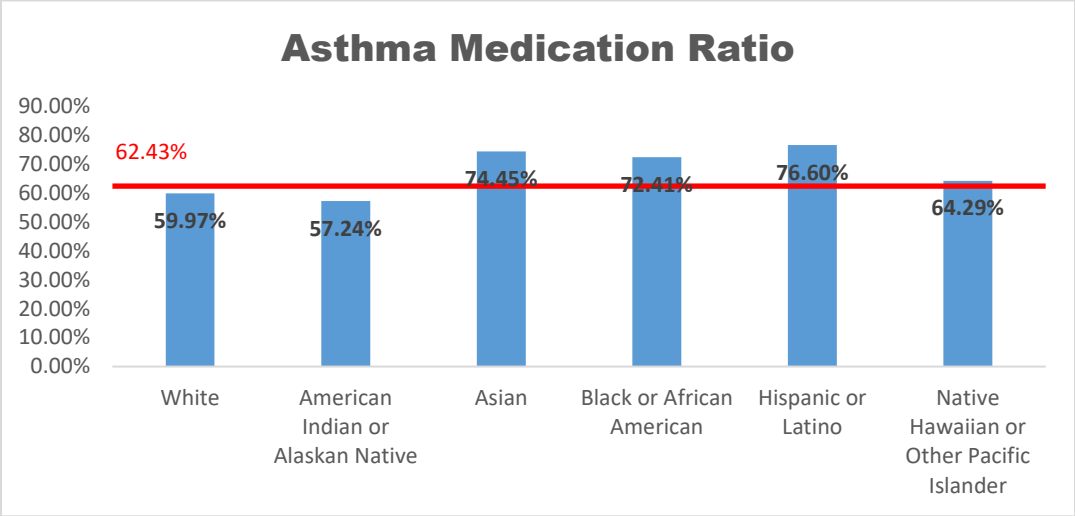


Source: MY 2020 Health Disparities Data, Department of Health Care Services

Asthma Medication Ratio

The AMR measure has improved within the last year. However, differences were found among race/ethnicity groups of members eligible for the AMR measure population with White and American Indian or Alaskan Native as the lowest performing groups. These ethnicities had AMR rates of 59.97% and 57.42%, respectively, while the other racial/ethnic groups performed better than the MPL.

Figure 16: 2021 PHC Completed Asthma Medication Ratio by Race/Ethnicity

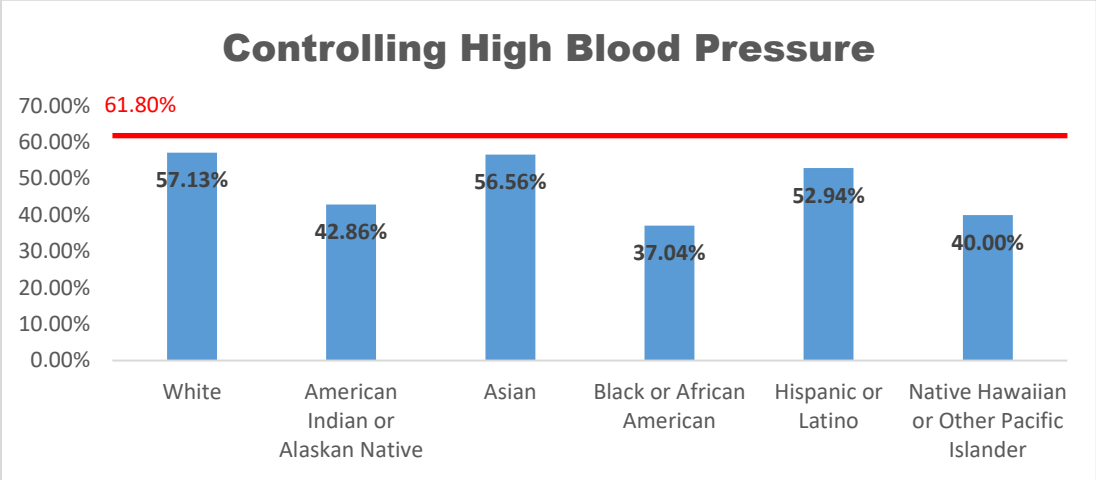


Source: MY 2020 Health Disparities Data, Department of Health Care Services

Controlling High Blood Pressure

As with the other measures, CBP results varied by race/ethnicity. None of the ethnic groups met the MPL of 61.8%, although the White were the race/ethnicity category with the highest control rate of 57.1%. The Black/African American group experienced the lowest control rate of 37.0%, falling significantly lower than the MPL. Native Hawaiian or Other Pacific Islanders and American Indian or Alaskan Native members are also challenged with CBP control values of 40.0% and 42.86% respectively.

Figure 17: 2021 PHC Controlling High Blood Pressure Data by Race/Ethnicity

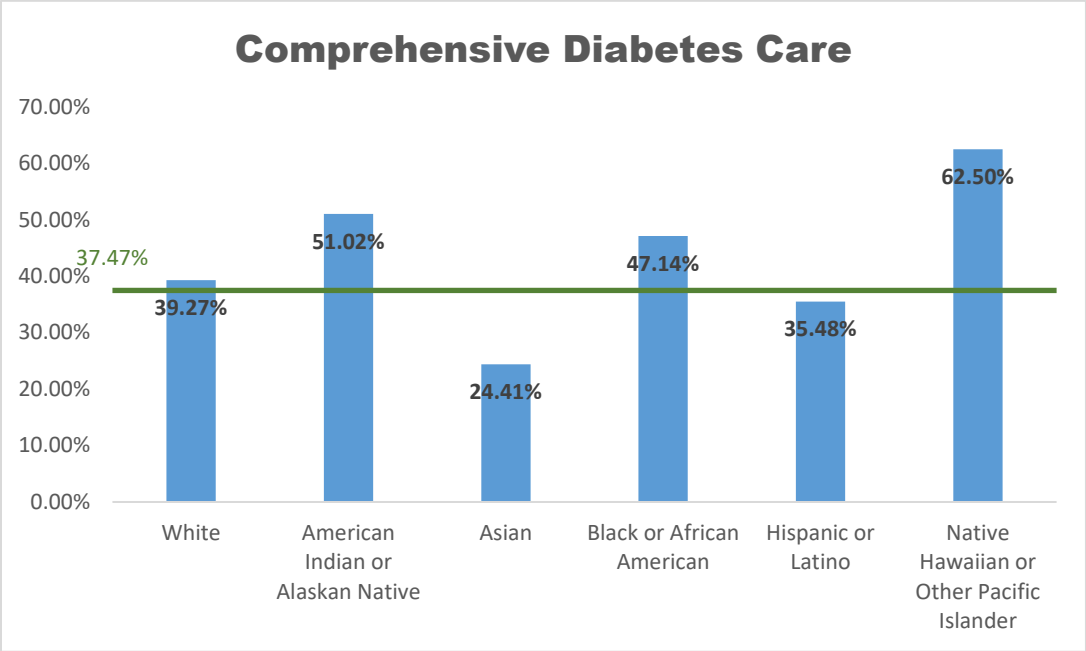


Source: MY 2020 Health Disparities Data, Department of Health Care Services

Comprehensive Diabetes Care

The CDC Poor Control indicator is an inverse measure, meaning that lower number shows improved diabetic control of blood glucose levels. The Native Hawaiian or Other Pacific Islanders population have the most extreme disparity of 62.5%; however, the sample size for this group is not statistically significant. The Asian population shows statistically strong performance with a CDC-H9 rate of 24.4% which is lower than the MPL of 37.4%. The differences among the racial/ethnic groups for these measures indicate opportunities for improvement, specifically for the American Indian or Alaskan Native (51.02%) and the Black or African American (47.14%) populations.

Figure 18: 2021 PHC Comprehensive Diabetes Care Data by Race/Ethnicity



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

G. Health Education, Cultural & Linguistic Gap Analysis

PHC maintains a Health Education unit responsible for providing health education materials at an appropriate reading and comprehension level for members. These materials are available on the PHC external website (linked here: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Health-Education---Members.aspx) and printed copies are available to both members and providers. Educational materials are reviewed and updated no less than every five years, and are translated into all PHC threshold languages. This established process has been effective in providing materials to members both directly and through providers.

In addition, the Health Education team bears responsibility for the Cultural & Linguistic program including evaluating member grievances for issues arising from discrimination. They also review and recommend staff and provider training to promote awareness of diversity, equity, and inclusion to better serve the population.

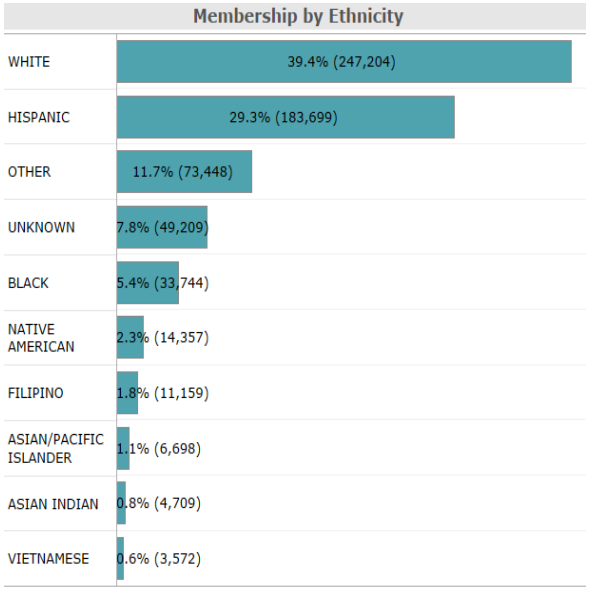
Grievance and Appeals

Grievance and Appeals (G&A) data is used to analyze member experience with health plan and health care services, provides insight into member engagement with the health plan, and captures reports of discrimination.

In 2021, the Grievance team investigated a total of 4099 cases, which represents 7.5% decrease in member reported grievances from 2020. The top 5 ethnicities of people filing grievances are White (60%), Hispanic (12%), African American (5.5%), Native American (2%) and Filipino (1%).

Figure 19: Grievance and Appeals Report by Members Ethnicities vs. PHC Overall Membership by Ethnicity

3Q21 % CASES BY ETHNICITY	
MBR Ethnicity	% Cases
White	55.75%
Other	18.85%
Hispanic	15.98%
Black (African American)	4.83%
Alaskan Native or American Ind	1.95%
Asian Indian	0.92%
Filipino	0.46%
Other Asian	0.46%
Hawaiian	0.23%
Korean	0.23%
Vietnamese	0.11%
Laotian	0.11%
Chinese	0.11%
Grand Total	100.00%



Source: 2021 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2021 Membership by Ethnicity, PHC Membership Data

In 2020, PHC identified a disparity in how grievances are reported by race/ethnicity and by language. The grievances reported are not proportionate for the percentage of different races/ethnicities and languages within PHC's membership. Between 2020 and 2021, the proportion of grievances shifted to more closely represent the demographics of PHC members. Grievances reported by White members decreased from 60.0% in 2020 to 55.75% in 2021, while grievances reported by Hispanic members increased from 12.5% in 2020 to 15.98% in 2021. Members with an ethnicity categorized as "Other" increased from 7.2% in 2020 to 18.85% in 2021. Significantly, PHC was able to capture the race/ethnicity of all members filing a grievance, so the number of "Unknown" race/ethnicities dropped from 8.4% to 0% between 2020 and 2021.

Table 10: Grievances by Race/Ethnicity Over Time

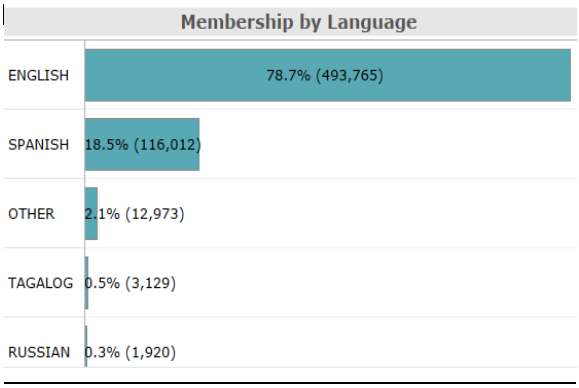
Member Race/Ethnicity	*2020 % of Cases*	*2020 % of Membership*	*2021 % of Cases*	*2021 % of Membership*
White	60.0%	40.6%	55.75%	39.4%
Hispanic	12.5%	29.1%	15.98%	29.3%
Unknown	8.4%	7.6%	–	7.8%
Black	7.8%	5.5%	4.83%	5.4%
Other	7.2%	10.6%	18.85%	11.7%
Native American	1.5%	2.4%	1.95%	2.3%
Asian & Pacific Islander	2.5%	4.2%	2.63%	4.1%

Source: 2020 & 2021 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2020 & 2021 Membership by Ethnicity, PHC Membership Data

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

Figure 20: Grievance and Appeals Report by Members Language vs. PHC Overall Language Profile

3Q21 % CASES BY LANGUAGE	
MBR Language	% Cases
English	93.68%
Spanish	5.40%
Unknown	0.46%
Korean	0.11%
Tagalog	0.11%
Farsi	0.11%
Vietnamese	0.11%
Grand Total	100.00%



Source: 2021 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2021 Membership by Ethnicity, PHC Membership Data

The percentage of English-speaking members who reported grievances increased from 91.98% in 2020 to 93.68% in 2021, while grievances in PHC's other threshold languages decreased.

Table 11: Grievances by Language Over Time

Member Race/Ethnicity	2020 % of Cases	2020 % of Membership	2021 % of Cases	2021 % of Membership
English	91.98%	78.6%	93.68%	78.7%
Spanish	5.72%	18.4%	5.40%	18.5%
Other	1.96%	2.2%	0.81%	2.1%
Tagalog	0.09%	0.5%	0.11%	0.5%
Russian	0.25%	0.3%	0.00%	0.3%

Source: 2020 & 2021 PHC Grievance and Appeals Data, Partnership HealthPlan of California; December 2020 & 2021 Membership by Ethnicity, PHC Membership Data

Diversity, Equity, and Inclusion Training

PHC Staff Training

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

PHC also offers virtual and recorded training sessions for all staff to both remind them of the legal rights of our diverse team and to educate them on how to best include others in office activities. There is at least one mandatory educational session per year, and, as additional training opportunities are identified, they are made available to staff for access based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of January 1, 2022, there were 859 PHC staff members. Per LMS, between December 2021 and March 2022, 826 PHC staff members (96%) completed the mandatory *Diversity, Equity and Inclusion Training* modules assigned. In addition, 301 staff members (35%) completed the *Office Hours with Dr. DeVido* raising awareness of mental health and the stigma associated with identifying as a person with mental health concerns. Nine staff members completed a four-hour training called *Tipping the Scale: Deconstructing Race and Racism with Dr. Sharon Washington*.

PHC will continue to identify and mandate yearly high-quality training for staff to promote awareness and understanding of diversity, equity, and inclusion concerns. In

addition to the mandated training for all staff, some staff may also seek further training opportunities to gain greater insight into their peers and PHC's population.

Provider Training

In addition to staff training, PHC offers training to contracted providers to continuously improve member experience and reduce unintended bias, discrimination, and health disparities. On June 22, 2021, PHC hosted a Hospital Quality Symposium, which included a sesson titled "Deconstructing the Origins of Racial/Ethnic Health Disparities: Reflections on Quality and Equality." Fifty-one provider staff from twenty-three hospitals that provide services to PHC members attended this event. (See Appendix D for the event flyer.)

In alignment with NCQA and DHCS quality standards, PHC will offer providers at least one training opportunity per year on equity, cultural competency, bias, diversity, and inclusion.

IV. Review of Activities, Resources, and Opportunities

PHC is a non-profit community-based health care organization dedicated to ensuring Medi-Cal recipients have access to high-quality, comprehensive, cost-effective health care. In over twenty-five years of operations, PHC has developed strong relationships with the provider community, public health, and community-based organizations on behalf of its members. PHC has established four regional offices to maintain a community-presence and ensure members have local access to someone who can address their concerns.

Annually, PHC leadership undertakes a strategic review of existing programs, resources, and structures to meet our members' needs. Department directors collaborate with the executive team to review PHC's strategic plan and ensure PHC resources are aligned with our mission and the changing environment. Departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet PHC's various initiatives.

The Population Health team was formed in 2020; in 2021 the teams were deployed in member-engagement activities. Wellness Guides (WGs) outreached telephonically to members throughout PHC's 14 counties to inform and encourage members to engage in annual well care visits, immunizations, cancer screenings, well baby visits, and prenatal and postnatal care. Healthy Living Coaches (HLCs) engaged with members to help them identify barriers to care, promote healthy lifestyles, and manage chronic health conditions. A Population Health Dashboard was developed to track campaigns in

progress and the success of the campaigns. Community Outreach Representatives (CORs) continued to work closely with community organizations in their assigned counties. The efforts of the CORs helped organizations understand what PHC is as well as the benefits offered to PHC members. The CORs maintain and continue to expand the Community Resource pages, which can be found on the PHC website. HEs developed a number of health education materials promoting wellness visits, health screenings and managing chronic conditions. HEs partnered with other PHC departments to develop member facing materials. This role is to ensure that materials meet DHCS readability and suitability requirements for member facing materials, but also to ensure the cultural appropriateness of materials. HEs continue to support the Grievance and Appeals department in reviewing grievances identified with potential discrimination or bias. This new department has met PHC's need to engage members of low and rising risk in wellness behaviors, and PHC continues to allocate resources to ensure the department is able to undertake sufficient activities to meet member needs.

In 2021, COVID-19 was the focus of most PHC activity. PHC engaged providers, community partners, vendors, and staff to educate members on COVID and to facilitate vaccinations. PHC shared messages on its website, on-hold messages, outcall campaigns, text campaigns, and even media purchases to educate members on how to safely attend medical appointments along with reminders to attend well care visits, stay current with all immunizations, and continue with preventative care screenings. PHC staff also participated in COVID-19 vaccination events sponsored by community partners and even sponsored vaccination events. PHC staff reached out to members identified as being homebound to help schedule appointments to receive COVID-19 vaccinations at home. While promoting COVID safety will remain a priority in 2022, PHC recognizes activities and resources should now be reallocated toward other health concerns that have lagged during the public health emergency, such as well child visits, preventive care screenings, and monitoring chronic conditions.

PHC's primary project in 2022 is moving to a new claims system. The IT department has devoted several years to identify and migrate to a new system, and this system will impact all the other PHC IT systems. Once the new claims system is implemented, there are several other projects planned to help PHC meet the needs of its population including a move to a new Grievance platform, and implementation of 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.

In addition to changes in the information system supports, PHC has dedicated several departments to implement the DHCS CalAIM Enhanced Case Management Benefit and create structures for data sharing and cross-organizational communication for case

management efforts. Another department is devoted to support the needs of members with behavioral health concerns; this effort requires considerable collaboration with county-based mental health care, public schools, public health, and other stakeholders in the community. PHC continually reviews the sufficiency of available resources, the possible need for additional staff hires to support these efforts, and how to best allocate resources for the good of the communities we serve.

The 2022 PNA demonstrates PHC has activities in place to address the member needs. PHC collaborates with provider and community resources to ensure members have access to a broad range of services supporting both health and overall wellbeing. However, this PNA also revealed opportunities for action by addressing social and environmental factors, member health and wellness, health disparities, as well as health education, culture and linguistic needs.

A. Social and Environmental Factors

Of all the Social and Environmental influencers of health, PHC believes the issues of greatest concern to its members are concerns related to income/employment, and the impact of wildfires on vulnerable members.

Low Income & Unemployment

PHC members experience more social and structural barriers to health and wellbeing than much of the state of California. Ten of PHC's covered counties have household incomes below California's state average, and unemployment rates in eight PHC counties are higher than the state average. These combined factors make it difficult for PHC members to provide for the basic needs of themselves and their families. To address widespread concerns of employment opportunities at a living wage with PHC's Northern Region, the organization has created a multi-disciplinary workgroup focused on Workforce Development. This workgroup adopted a strategy through which PHC is collaborating with Sacramento City College and local providers to create scholarships for Community Health Workers and employment opportunities once members are certified in this field (See Appendix B). Up to 20 scholarships will be offered in 2022. Action Plan Objective 1 describes the planned intervention in more detail.

Air Quality and Wildfires

In addition to financial concerns, many PHC members live under the persistent threat of wild fire. Wildfires lead to poor air quality, loss of housing, stress and anxiety, and the long-term sequelae of these factors. PHC has created an outreach campaign for vulnerable members leveraging tools provided by local utility companies and public health departments. For the purpose of this campaign, vulnerable members are those

who require oxygen support (ventilator, home oxygen, or CPAP), dialysis, or require shift nursing. These calls encourage members to prepare proactively for disasters in their areas and to ensure they have a list of needed tools and resources in the event of wildfire or other emergency. Objective 2 of the Action Plan further delineates the scope of this project.

B. Health and Wellness

PHC members in all regions face health challenges; however, there are regional variations in health, as well. For example, pediatric members with asthma who live in PHC's Northern Region have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in PHC's Northern Region than in the Southern Region, and this may contribute to the poor asthma control. There may be other contributing factors, as well. In order to better understand and support these members, PHC has trained staff to coach parents of these members how to better control asthma without use of rescue medications and will implement this intervention during 2022. This intervention is outlined in more detail in Objective 3 of the Action Plan.

C. Health Disparities

In addition to regional care disparities, there are also notable care gaps between racial/ethnic groups. As in the 2021 PNA, the American Indian/Alaskan Native Breast Cancer Screening rates remain much lower than the rates for other racial/ethnic groups. Similarly, African Americans have greater challenges with blood pressure than the other racial/ethnic groups. Addressing these disparities remains a priority for PHC as described in Action Plan Objectives 4 & 5.

D. Health Education, Culture & Linguistics

Member grievance data provides insight into member engagement with the health plan, their experience of culturally and linguistically appropriate care, and reports of discrimination. Members who report grievances in their care must know how to access the grievance system and have some confidence that their concerns will be taken seriously. As such, reported grievances are a barometer of trust in the agencies with whom the grievance is filed. While a general lack of trust in government and institutions may be underlying this, PHC works to overcome this distrust though an organizational value of responsiveness to the needs of our members, as reflected in interactions with our members. One reflection of the success of this approach will be a better balance the proportion of grievances with the racial/ethnic and language profile of its members, as outlined in Objective 6 of the Action Plan.

Finally, in alignment with DHCS and NCQA objectives, PHC will continue its own organizational culture of diversity, equity and inclusion by hosting regular employee forums and staff training to engage staff in topics relating to equity (e.g., race, ethnicity and gender) and the barriers members experience that prevent them from being healthy. This is captured in Objective 7 of the Action Plan.

V. Annual Action Plan and Action Plan Updates

A. 2022 Action Plan

Objective 1: By December 31, 2022, Improve opportunities for sustainable employment for our members by launching a Community Health Worker (CHW) Scholarship program that engages representatives from traditionally under-represented groups in PHC's Northern Region and enrolling at least PHC 10 members into the program. Data source: (County Health Rankings 2021)
Strategies
1. Secure externships with partner organizations for CHW program.
2. Work with Sacramento City College to secure workforce funding.
3. Launch CHW scholarship with Sacramento City College
4. Market CHW program to community partners, members and providers

Objective 2: Improve vulnerable member preparedness for disaster through targeted outreach campaign enrolling at least 25% of members identified as potential beneficiaries of the campaign by December 31, 2022. Data source: (2021 PHC Integrated Claims and Encounter Data)
Strategies
1. Identify vulnerable members through organizationally approved methodology
2. Research available resources and tools to share with members
3. Develop outreach call script and supporting materials
4. Contact members per outreach campaign guidelines and enroll those in agreement with the campaign
5. Review results of campaign including contact attempts, members enrolled, and member satisfaction with outreach

Objective 3 (Health Disparities – Continued from 2021): 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 65.62% baseline to 68.5% by December 31, 2022. Data source: (PHC HEDIS Rolling Year Data, December 2021)
Strategies
1. By October 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, using tools shared by CDPH and PHC's Healthy Living Tools.
2. Evaluate impact of intervention by measuring target group's use of rescue medications, use of urgent care/emergency department, and overall satisfaction with the intervention via survey.
3. Make recommendations regarding future of this intervention: adopt / adapt / abandon

Objective 4 (Health Disparities – Continued from 2021): Increase Breast Cancer Screening participation rate among all PHC regions' American Indians/Alaskan Native members from 37.58% to 41.0% by March 1, 2023. Data Source: 2021 DHCS Health Disparity Data
Strategies
1. Engage with PHC's contracted 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.
2. 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 other HEDIS scores.
3. Establish a multi-year strategy to promote health equity that will reduce the American Indian health disparities

Objective 5 (Health Disparities): Improve Black/African American management of controlling high blood pressure in Adults ages 18-85 years from 37.04% baseline to 40.0% in PHC's Southern Region (Solano, Yolo, Sonoma, Lake, Mendocino, Napa and Marin) by December 31, 2022. Data source: 2021 DHCS Health Disparities Data
Strategies
1. Identify at least one community partner for collaboration promoting blood pressure control for adult African Americans in PHC's Southern Region
2. Identify at least one provider in PHC's Southern Region with whom to collaborate to promote visits with PCP to track BP and begin medication therapy
3. Develop a communication plan and educational materials on blood pressure risks that are appropriate and relevant for the African American subpopulation.
4. In collaboration with provider and community partners, introduce self-management of BP to members using blood pressure monitoring tools

Objective 6 (Continued from 2021): Increase the proportion Non-English speaking/Non-White members reporting Grievances from 44.25% to 47.5% by March 1, 2023. Data Source: 2021 PHC Grievance and Appeals Report. Partnership HealthPlan of California
Strategies
1. Create a series of brief videos helping members understand their benefits and how to report a grievance a. Translate into all threshold languages b. Test with members of threshold language groups 2. Publish on PHC website, social media, and share with providers
3. 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.).
4. 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.
5. Obtain organizational agreement for written strategy.

Objective 7 (Continued from 2021): Provide at least one (1) training for PHC employees to promote awareness and understanding of health equity for PHC internal staff by March 1, 2023. Data Source: 2022 PHC LMS Training Report
Strategies
1. Leverage PHC's multidisciplinary Health Equity Team Goal Workgroup to identify training needs for staff to promote awareness and understanding of health equity across the organization.
2. Identify training modalities best suited to communicate the information (video training, in person training, book club, etc.)
3. Schedule and hold training event(s)
4. Evaluate impact of trainings through post-activity surveys and annual overall Health Equity awareness survey

B. Prior Year Action Plan Review and Update

Below is a summary of the actions undertaking in 2021 to meet the identified needs of the 2021 PNA. Each objective is reviewed for progress toward the overall goal and movement toward the goal.

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) ***2021 Objective Achieved – Continue with new objective in 2022***	**Progress Measure:** As of November 2021, the percentage of Non-English speaking/Non-White members reporting grievances increased from 39.9% in 2020 to 44.25%. Data source: (2021 PHC Grievance and Appeals Report. Partnership HealthPlan of California)
	Progress Toward Objective: 2021 Goal Met. Continue progress to expanded objective in 2022. PHC's Grievance and Appeals team revised the grievance form in 2021. The simplified form reduced barriers to filing grievances as evidenced by the increased proportion of non-English speaking/Non-White members reporting grievances.

Strategies	
1. Assess member barriers to using the PHC Grievance and Appeals process by race, ethnicity, and language	**Progress Discussion:** In Progress. The Health Education team held series of meetings with the Grievance and Appeals team and other member facing departments to understand some of the barriers to members using the PHC grievance process. The current Call Center data fields only capture limited member demographics. A new member call center data base will be deployed in 2022, and the member demographic information (such as preferred communication format) will be enhanced in this new system.
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.).	**Progress Discussion:** This activity was put on hold to first fix the organization gaps before conducting a deep dive to understand the barriers from member's perspectives.
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.	**Progress Discussion:** This process will be updated in the 2022 Action Plan.
4. Obtain organizational agreement for written strategy.	Updated strategies to be included in the 2022 Action Plan

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.	**Progress Measure:** In 2021, PHC transitioned to a new interpreter service provider – AMN. Between January 1 and December 31, 2021, there were a total of 5380 member encounters that used interpreter services. Of those, 1,781 (33%) were performed using VRI services, and 3,599 (67%) encounters used audio technology. There were no in-person or face-to-face interpretation services used.

Data Source: PHC Translation Services Utilization Report ***2021 Objective Achieved – No further action at this time.***	Data Source: PHC Translation Services Utilization Report **Progress Toward Objective:** Goal Met. In November 2021, PHC partnered with AMN healthcare to offer video remote interpreter (VRI) services to members. The launch of VRI services provided an option for our members to have access to an interpreter through telephonic or video connection.
Strategies	
1. Assess the existing PHC interpreter services materials for our Provider network and update as needed.	**Progress Discussion:** 100% Completed. With the roll out of VRI services, PHC updated all Provider and Member Services materials to share information on the addition of the new service. These materials were posted on the website, in the Member newsletter, and share with the Provider network during Providers Network Education (PNE) Meetings.
2. Roll out new PHC video remote interpreter (VRI) services service for our members.	**Progress Discussion:** 100% Completed. PHC launched VRI services to its provider network on October 1, 2021.
3. Develop and publish member-facing materials for Provider sites that clarify PHC interpreter services procedures.	**Progress Discussion:** 100% Completed. The Provider Relations team has provided interpreter services procedural updates which can be found here.
4. Review member grievances related to interpreter services to evaluate efficacy of VRI in addressing member concerns.	**Progress Discussion:** 100% Complete. As of January 1, 2021, PHC provided 1,781 VRI services to members through their Provider Network. There have been no member grievance cases relating to VRI services since its rollout. The Grievance and Appeals team will provide regular updates of any grievances related to VRI services.

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 ***2021 Objective Achieved – Continue with new objective in 2022***	**Progress Measure:** There were 3 training opportunities provided for all PHC staff between January 1, 2021 and March 1, 2022, in addition to activities offered through PHC's Health Equity Week. There were 826 staff who completed the mandatory training, and 310 staff who completed optional trainings. Participation in Health Equity Week was not tracked. Data Source: 2022 PHC LMS Training Report **Progress Toward Objective: Goal Met** PHC staff have engaged in both mandatory and optional trainings that address health equity knowledge gaps. PHC will continue building staff knowledge of health equity, diversity, and inclusion through annual training opportunities.
Strategies	
1. Review the 2021 Employee Survey on Health Equity and research opportunities for improvement	**Progress Discussion:** 100% Completed. The results from the 2021 Employee Survey on Health Equity was reviewed with Department leads and representatives at the organization wide Team Goal meeting focused on Health Equity. Opportunities for improvement and implementation priorities were also decided at these meetings.
2. Report findings from the 2021 Employee Survey to staff and share resources to increase staff understanding of health equity concerns.	**Progress Discussion:** 100% Completed. The results from the 2021 Employee Survey on Health Equity were shared with both the PHC organization wide Team Goal focused on Health Equity as well as other Departments. With the impending NCQA Health Equity requirements, these conversations will continue to expand and collaborate closely with the Provider Relations team as we prioritize provider's education and awareness of Health Equity.
3. Facilitate two Employee Engagement Forums or Training Events to engage staff in topics relating to equity (e.g. poverty, race, ethnicity, gender, etc.)	**Progress Discussion:** 100% Completed. In January 2022, a mandatory DEI (Diversity, Equity, and Inclusivity) Training was launched on PHC's training module. In addition, PHC created a series of videos in which PHC leaders described the past, present and future of health equity at PHC. These videos

	were shared with the organization in the 2022 Health Equity week held the third week of January.

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 Disparities Data ***2021 Objective In Progress– Continue in 2022***	**Progress Measure:** In Progress The Breast Cancer Screening participation rate actually decreased to 37.58% in 2021. This measure will continue in 2022. **Progress Toward Objective:** In Progress Due to the ongoing public health emergency of COVID, neither providers nor PHC staff were able to devote attention to this measure. We will resume efforts in 2022. Data source: (2021 DHCS Health Disparities Data)
Strategies	
1. Perform internal survey of PHC staff knowledge and resources to learn more about the American Indian/Alaska Native populations we serve.	**Progress Discussion:** In progress. PHC is seeking to establish staff affinity groups by race and ethnicity, to provide insight into various subpopulations. However, there were concerns about how this topic would best be approached. The Health Education team met with the Human Resources department to solicit advice on the best way to conduct this activity without staff feeling targeted based on their race/ethnicity. This strategy will be revisited in the future.
2. Identify staff who can help build sustainable relationships with the American Indian/Alaska Native populations and Tribal health leaders.	**Progress Discussion:** In Progress. The Health Education team met with the Human Resources department to solicit advice on the best way to conduct this activity without staff feeling targeted based on their race/ethnicity. This process will continue in 2022
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.	**Progress Discussion:** In Progress. PHC held series of meetings with California Rural Indian Health Board (CRIHB) to establish processes for collaboration and coordination between the both organizations. The major highlight from this meeting was the possibility of data sharing. There were some identified data gaps with the information being received by PHC. These conversations are going to continue in order to

	establish a relationship with the American Indian/Alaskan Native population to actively engage in healthcare services.
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 other HEDIS scores.	**Progress Discussion:** In Progress. The Population Health Department developed workgroups to focus on sub-populations of interest to better understand the needs of the community for COVID-19 vaccination. These workgroups consist of regional leaders, medical directors and staff in the region. One of the sub populations was the American Indian/Alaskan Native population. The workgroups have shifted focus from COVID-19 to cultivating long term relationship building and understanding how to culturally engage these targeted populations. These workgroups will continue and expand in 2022.
5. Establish a multi-year strategy to promote health equity that will reduce the American Indian health disparities.	**Progress Discussion:** In Progress. This activity will continue in 2022 as PHC develops a comprehensive strategy to promote health equity within its membership.

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) ***2021 Objective In Progress – Continue in 2022***	**Progress Measure:** In Progress. The baseline data from 2021 was inaccurate – the correct baseline as of January 2021 for pediatric members (ages 2 – 18 living in the Northern Region) was 67.23%. As of December 2021, those results decreased to 65.62%. This measure will be continued in 2022. Data source: (PHC HEDIS Rolling Year Data, December 2021)
	Progress Toward Objective: In Progress Due to the ongoing public health emergency of COVID, neither providers nor PHC staff were able to devote attention to this measure. We will resume efforts in 2022.

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	**Progress Discussion:** 100% Completed. As of July 29, 2021, PHC Health Educators (3), Healthy Living Coaches (5), and Community Outreach Representatives (4) were trained by CDPH's 3-day, virtual Asthma Management Academy. Since the training, PHC has retained eight (8) of the twelve (12) staff members trained.
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.	**Progress Discussion:** Given the competing priorities due to COVID-19, Strategy 2 was not able to be completed. This activity will be updated in 2022.
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.	**Progress Discussion:** Given the competing priorities due to COVID-19, Strategy 3 will continue in 2022.

Objective 6 Health Disparities (Continued from 2020) Improve Hispanic/Latino participation in well-care visits	**Progress Toward Objective:** Target data no longer available. In 2021, the Health Disparities was updated and now provides aggregated data on all well child visits from age 3-21. The 2021 results show that 37.33% of Hispanic/Latino children in the new age range for the

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: 2020 DHCS Health Disparities Data ***2021 Objective – Unable to Assess. Alternate measures selected for 2022.***	Northern Region attended well-child visits, which is better than the performance all other races/ethnicities in all PHC regions during the measurement period. PHC will be addressing aggregate Well Child Visits concerns through several organizational initiatives reported through other forums. Data source: 2021 DHCS Health Disparities Data
1. By December 31, 2021, Research best practices with proven evidence of changing members' behaviors, which might drive their participation in healthcare.	**Progress Discussion:** 100% complete. Due the ongoing public health emergency of COVID, providers had several priorities that competed with well-child examinations during the measurement period. PHC began this effort by surveying members about their barriers to participation in well-child visits. In May, 2021, PHC conducted outreach calls to members who had not had recent office visits in the Northern Region for key-informant interviews. Key barriers highlighted were their fear for COVID and difficulty getting doctor appointments. Based on member's feedback, the Health Education team researched best-practices from eight sources including university research, published articles, and on-line collaboratives to identify ways to encourage member participation in wellness visits. The team then created materials to inform members of the safety practices at Providers offices and encourage the use of telehealth appointments. PHC also held discussion with Provider networks to open up more appointment times and encourage members to call our Member Services or Care Coordination team if they needed help with booking appointments. Materials created can be found here.

VI. 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 were presented to the CAC committee in mid-March of 2022 for input and feedback.

The Health Educator team 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 report will also be share with PHC delegates within thirty (30) days after the report has been approved by DHCS as per regulatory requirements. The PNA report will also be posted on the PHC external website. PHC will also identifies pertinent information related to member needs in the report, and determines the most appropriate platform to utilize and share information.

Appendix A - HEDIS Regional Performance Report Year 2021; Measurement Year 2020

Select Report Year
Report Year 2021; Measurement Year 2020

Select Provider Type
All Providers

HEDIS Regional Performance
Report Year 2021; Measurement Year 2020
Performance Relative to Quality Compass® Medicaid Benchmarks

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Note: Percentile rankings were established by the NCQA using MY 2019 performance data during a non-pandemic year.

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

	Regional Performance				National Medicaid Benchmarks			
Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment*	62.25%	61.09%	64.53%	58.62%	50.38%	53.57%	58.93%	64.29%
Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment*	44.54%	44.78%	46.15%	40.22%	34.23%	38.18%	43.10%	49.37%
Asthma Medication Ratio (AMR) - Total 5 to 64 Ratios > 50%*	56.28%	56.04%	73.50%	68.74%	57.59%	62.43%	68.13%	73.38%
Breast Cancer Screening (BCS)*	50.09%	42.41%	56.64%	52.88%	52.85%	58.82%	64.06%	69.22%
Cervical Cancer Screening (CCS)	51.35%	53.53%	60.38%	65.28%	55.23%	61.31%	67.40%	72.68%
Childhood Immunization Status (CIS) - Combo 10	19.22%	27.98%	40.63%	43.55%	30.17%	37.47%	44.77%	52.07%
Chlamydia Screening in Women (CHL)*	49.04%	51.87%	63.21%	54.68%	51.34%	58.44%	66.26%	71.42%
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9%)	38.93%	39.90%	37.96%	36.50%	45.96%	37.47%	32.85%	27.98%
Controlling High Blood Pressure (CBP)	59.85%	51.82%	53.28%	55.47%	54.01%	61.80%	67.64%	72.75%
Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antipsychotic Meds (SSD)*	77.34%	78.68%	75.65%	75.71%	78.65%	82.09%	84.78%	87.91%
Immunizations for Adolescents (IMA) - Combo 2	21.17%	27.74%	46.83%	46.23%	31.02%	36.86%	43.06%	50.85%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Total*	30.94%	32.23%	29.87%	45.28%	29.35%	35.43%	44.30%	56.34%
Prenatal and Postpartum Care (PPC) - Postpartum Care	74.21%	87.59%	86.13%	87.59%	71.30%	76.40%	80.89%	84.18%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	81.27%	81.51%	89.05%	86.13%	84.18%	89.05%	92.94%	95.86%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - BMI Percentiles	84.91%	76.16%	70.32%	77.37%	71.29%	80.50%	87.23%	90.77%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - Counseling for Nutrition	60.58%	64.72%	63.02%	67.40%	63.02%	71.55%	80.05%	85.16%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - Counseling for Physical Activity	56.45%	63.99%	60.10%	63.26%	57.42%	66.79%	76.28%	81.02%

**- Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

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Appendix B – Community Health Worker Training Program Scholarship Opportunity

Community Health Worker Training Program Scholarship Opportunity

Partnership HealthPlan of California (PHC) is excited to announce a new scholarship opportunity. Current and former PHC members who apply and are accepted in the upcoming Sacramento City College (SCC) community health worker (CHW) training program may be eligible for up to a $1,000 scholarship to be applied to tuition and direct educational expenses (e.g. application fees and books). Beginning February 15, 2022, SCC will be accepting applications for a cohort of CHW students to begin in August 2022. Interested SCC applicants will need to complete the CHW online application by April 30, 2022. Those interested in applying for PHC's CHW scholarship will also need to complete PHC's application by April 30, 2022.

PHC believes our current or former members who have an excellent understanding of the community in which they live could make an ideal CHW. A CHW can act as a liaison between health, social services, and the community to facilitate access to services and improve the quality, health equity, and cultural competence of service delivery. In 2019, the California Future Health Workforce Commission (report linked here) identified the CHW role as one of the 10 priorities to invest in over a 10-year period to help close California's health care workforce gaps.

Please note, that the SCC CHW training program includes both virtual and an in-person practicum to take place. All interested applicants residing within the counties PHC serves are eligible to participate, however, PHC members residing in Del Norte, Modoc, and Trinity are encouraged to apply for this cohort in order to allow for travel to practicum sites in those counties. Organizations within PHC counties that are interested in learning more about the process to become a practicum site can view a webinar that outlines steps with the SCC's CHW program here.

In addition, applicants may reach out to their local workforce boards to verify whether eligibility for benefits may exist. Del Norte and Trinity county resident applicants interested in reaching out may contact SMART Workforce Center here, and Modoc County resident applicants may contact The Alliance for Workforce Development here.

If you have additional questions on the Sacramento City College CHW opportunity, please visit their CHW webpage by clicking here or emailing the program directly at SCC-Healthoccupations@scc.losrios.edu.

Applicants interested in the PHC scholarship opportunity may reach out with questions by emailing phcscholarships@partnershiphp.org.

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

Appendix C – Community Resources for Members with Disabilities

Note: Some services may have changed due to COVID-19, Please call to confirm hours and services available

ADULT DAY PROGRAM

Collabria Care
Location: 414 S. Jefferson Street
Napa, CA 94559
Contact: (707) 258-9080
Website: https://collabriacare.org/
Last Verified On: 03/24/2021

ADULT PROTECTIVE SERVICES & PREVENTION

Napa County Adult Protective Services
Location: 650 Imperial Way, Ste. 101
Napa, CA 94559
Contact: (707) 253-4398
Website:
https://www.countyofnapa.org/185/Adult-Protective-Services
Last Verified On: 03/24/2021

ASSISTANCE DOGS

Canine Companions for Independence®
"Enhances the lives of people with disabilities by providing highly trained assistance dogs at no charge to the recipient."
Contact: (800) 572-2275
Form: http://www.cci.org/assistance-dogs/is-a-dog-right-for-you.html
Email: info@cci.org
Website: http://www.cci.org/
Last Verified On: 03/24/2021

NON- TRAUMATIC AND TRAUMATIC BRAIN INJURY (TBI) RESOURCES,

American Stroke Association
"The American Stroke Association is dedicated to prevention, diagnosis and treatment to save lives from stroke: …guide healthcare professionals and provide information to enhance the quality of life for stroke survivors."
Stroke Family Warmline: 1 (888) 478-7653
Website:
http://www.strokeassociation.org/STROKEORG/
Last Verified On: 03/24/2021

National and Statewide Brain Injury & Disability Research & resources.
"The following brain injury resources are not listed by county, but are general resources that anyone in California can benefit from. Many of the following resources are professional association related to brain injury, while other simply have useful information."
Website: http://www.abta.org/
Contact: 1 (800) 886-2282
Last Verified On: 03/24/2021

Brain Injury.com
"Brain Injury.com is the largest collection of medical and legal information about brain injury on the web. This website provides a nationwide network of legal services to serve those with cases involving brain injury, and they provide cutting edge information for those in need."
Contact: 1(866) 882-7246
Website: http://www.braininjury.com/
Last Verified On: 03/24/2021

Brain Injury Association of America (BIAA)
"BIAA's mission is to advance awareness, research, treatment, and education and to improve the quality of life for all people affected by brain injury."
Contact: (800) 444-6443
Website: https://www.biausa.org/brain-injury
Last Verified On: 03/24/2021

Brainline
"BrainLine offers information and support to anyone whose life has been affected by brain injury or PTSD: people with brain injuries, their family and friends, and the professionals who work with them. BrainLine also provides military-specific information and resources on traumatic brain injury and post-traumatic stress disorder (PTSD) to veterans, service members, and their families."
Website: http://www.brainline.org/
Last Verified On: 03/24/2021

Brain and Spinal Cord Injury Resource Center
BrainandSpinalCord.org is a resource for brain and spinal cord injury survivors and their families to learn more information about medical conditions, rehabilitation, and legal options."
Contact: Phone: 1(866) 510-5970
Website: http://www.brainandspinalcord.org/
Last Verified On: 03/24/2021

VISUAL IMPAIRMENT RESOURCES

CDSS Department of Social Services Blind Services
"The Office of Services to the Blind (OSB) provides information and referral on services, programs, entitlements, and products of benefit to individuals who are blind or low vision and their families or service providers. OSB staff assists such individuals in understanding the availability of services, their eligibility for services, and the purpose and scope of the various service programs."
Contact: (916)657-3327
Website: https://www.cdss.ca.gov/blind-services
Last Verified On: 03/24/2021

Free Slate and Stylus Program National Federation of the Blind
"The National Federation of the Blind will distribute a plastic, four-line, and twenty-eight cell slate along with a saddle stylus to those that need them. That includes those that are blind and low vision who know Braille or want to learn Braille."
Contact: (410) 659-9314
Website: https://www.nfb.org/programs-services/free-slate-and-stylus-program
Last Verified On: 03/24/2021

Appendix D – Hospital Quality Symposium Flyer

2021 Northern California Hospital Quality Symposium

Date: Tuesday, June 22, 2021

Time: 8:30 a.m. – 1:30 p.m.

Partnership HealthPlan of California invites you to join us for our first **virtual** Hospital Quality Symposium.

REGISTER HERE:
2021 HQS

Target Audience:
All hospital staff interested in improving quality of care

Please note: This is a virtual-only event. Hosted via Webex by Cisco.

Application for CE credit has been filed with the California Board of Registered Nursing, Provider CEP16728 for (hours TBD) contact hours. Determination of credit is pending.

Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Questions: Contact us at HQIP@partnershiphp.org

AGENDA

8:30-9 a.m.	**Opening Remarks**
9-9:50 a.m.	***Deconstructing the Origins of Racial/ Ethnic Health Disparities: Reflections on Quality and Equality***
9:50-9:55 a.m.	Break
9:55-10:45 a.m.	***Improving Outcomes for People Who Use Drugs***
10:45-11:35 a.m.	***Shattering the Wall of Silence – When Words and Actions Matter Most: The Case for CANDOR and BETA HEART***
11:35-11:40 a.m.	Break
11:40 a.m.-12:30 p.m.	***Lessons Learned for Hospitals During COVID-19: Where To From Here?***
12:30-1:20 p.m.	***Don't Panic – Understanding Variations in Data***
1:20-1:30 p.m.	**Closing Remarks**

Our Mission: To help our members, and the communities we serve, be healthy.

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