Population Needs Assessment

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Contents

I. Population Needs Assessment Overview 5
A. Summary of Key Findings 6
1. Summary of Findings 6
2. Summary of Planned Actions 7
II. Data Sources 9
A. Overview of Procedures, Resources, and Methodologies 9
1. 2022 Partnership Member Enrollment Data 9
2. Local Community Needs Assessments 9
3. 2022 County Health Rankings and Roadmaps 10
4. 2022 Partnership Integrated Claims and Encounter Data 10
5. 2022 Healthcare Effectiveness Data and Information Set (HEDIS®) 11
6. 2022 Timely Access Data 11
7. 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 11
8. 2022 Health Disparities Data 12
B. Other Data Sources 12
C. Population Segmentation 13
III. Key Findings 13
A. Member Demographics 13
1. Membership/Group Profile 13
2. Geographic Distribution 13
3. Age and Gender 14
4. Race/Ethnicity 14
5. Primary Language 15
6. Disability 16
B. Local Community Needs Assessment 17
1. Clinical Care 18
2. Health Behaviors 18
3. Social and Economic Factors 19

4. Physical Needs 20
C. Social Determinants of Health (SDOH) 21
1. Poverty 21
2. Income 22
3. Income Inequality 22
4. High School Completion 25
5. Air Pollution and Wildfires 26
6. Adult Smoking 27
7. Physical Inactivity 28
D. Disease Prevalence 29
1. Chronic Disease 29
2. HEDIS® Scores 31
3. Behavioral Health 33
4. Substance Use Disorder 37
E. Access to Care 39
1. Provider Availability 39
2. CAHPS Health Care Performance 41
3. Third Next Available Appointment 42
4. Telemedicine 44
F. Member Experience of Care 46
1. Satisfaction with Health Plan 46
2. Doctor Communication 48
G. Health Disparities 49
1. Breast Cancer Screening 49
2. Controlling High Blood Pressure 50
3. Immunizations for Adolescents 51
H. Health Education, Cultural & Linguistic Gap Analysis 51
1. Grievance and Appeals 52
2. Diversity, Equity, and Inclusion Training 55
IV. Review of Activities, Resources, and Opportunities 56

A. Organizational Structure 57
B. Social and Environmental Needs 58
1. Housing Shortage 58
2. Low Income and Unemployment 59
3. Air Quality and Wildfires 59
4. Tobacco Use 60
C. Member Health and Wellness 60
1. Chronic Disease 60
2. Health Screening 61
3. Wellness Care 61
D. Access to Care 62
E. Health Disparities 63
F. Health Education, Culture & Linguistics 63
V. Stakeholder Engagement 64
VI. Works Cited 65
A. Appendix Source: HEDIS® MCAS Regional Performance Report Year 2022; Measurement Year 2021 69
B. Appendix Top Priority Needs Per County, Identified Through Community Health Needs Assessment 70
1. CHNA Reference List 72
C. Appendix - Flyer for Equity in Health Care Training Series 76

I. Population Needs Assessment Overview

Partnership HealthPlan of California (Partnership) is a not-for-profit, Medi-Cal Managed Care Plan (MCP), serving 14 counties in Northern California with a membership size of about 675,673 as of December 2022.[1] Partnership is one of California's 6 County Organized Health System (COHS) managed care models endorsed by the County Boards of Supervisors that serve exclusively in the assigned counties. Most Medi-Cal beneficiaries are assigned automatically to Partnership, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and beneficiaries in skilled nursing facilities. In addition, dual-eligible Medicare-Medi-Cal members are assigned to Partnership as a secondary line of coverage. Partnership 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.[2]

Each year, Partnership reviews and analyzes the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population per the requirements of both the California Department of Health Care Services (DHCS) as well as the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). Partnership collects, integrates, and assesses data from its member population to develop and inform the PNA, which then drives Partnership's Population Health Management Strategy along with the Cultural & Linguistics Program Strategy and their associated work plans. Data sets used for Partnership's 2023 PNA include Partnership Member Enrollment data, Local Community Needs Assessments, County Health Rankings and Roadmaps data, Small Area Income and Poverty Estimates (SAIPE) data, U.S. Census Bureau data, published articles, reports from the Centers for Disease Control and Prevention (CDC), Partnership Integrated Claims and Encounter data, Healthcare Effectiveness Data and Information Set (HEDIS®) results, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data, Health Disparities data, Timely Access data, and Partnership Grievance and Appeals data. 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.

[1] Partnership Membership Dashboard, 2022
[2] Partnership Quality and Performance Improvement Program Description, 2022

A. Summary of Key Findings

Partnership's membership has increased during the COVID Public Health emergency, with 675,673 members throughout 14 counties at the close of 2022. The 2023 Population Needs Assessment (PNA) draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

1. Summary of Findings

Local community needs assessments identified 5 priority areas of need: access to healthcare services, mental health services, substance use services, transportation, and housing. Other data sources confirm that while all of Partnership's counties have concerns about the number of available providers (including primary care, dental care, specialty care, mental/behavioral health, and substance use care), concerns are heightened in the rural and frontier regions. There is an acute need for obstetric providers, and patients tend to experience long wait times for first-trimester appointments.

Many members require help with transportation to and from provider visits, a need that grows more prevalent in remote areas where provider offices may be far from members' homes. Transportation issues include having to travel long distances (including to other counties) for care, and not having a vehicle, friend, or taxi service available for transportation. Almost all counties have a lack of affordable and quality housing, and many individuals who qualify for housing assistance cannot find a place to rent. Homelessness remains constant since 2022's PNA throughout all counties, though each county has worked to house people.

In 2022, there were 40 wildfires in Partnership's regions, contributing to loss of available housing and possible adverse pulmonary and cardiovascular effects. Compounding these environmental factors are lifestyle choices like smoking. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties; and some counties expressed concern that their children are starting to smoke as young as elementary school age.

Partnership uses claims and encounter data to approximate disease prevalence among its members. In 2022, hypertension and tobacco use were the 2 most common conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety and trauma/stress. Telehealth utilization for behavioral health has increased since 2019, allowing more members to access this important service.

To determine if there are health disparities within the overall population served, Partnership reviews HEDIS results by race and ethnicity. In measurement year 2021 (reporting year 2022), American Indians/Alaskan Natives completed significantly fewer breast cancer screenings than the white population, while Hispanic or Latinos had the highest breast cancer screening rates. Similarly, American Indians and Alaskan Natives had the fewest members controlling their high blood pressure. Whites and American Indian/Alaskan Native populations had the lowest rates of adolescent immunizations.

2. Summary of Planned Actions

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

Partnership has added 2 key roles within the organization to address pervasive concerns. A Director of Health Equity was hired in January 2023 to oversee internal staff equity, equity of contracted providers and other contractors, member equity, and interventions designed to mitigate health disparities. Partnership also added an Associate Director of Workforce Development, tasked with creating a long-term vision and pipeline for health care workers within Partnership's service area. In addition, Partnership is working closely with provider groups and training organizations to develop a pool of community health workers (CHWs) and doulas, and to incorporate them into program offerings.

To address social and environmental concerns, Partnership is leveraging state funds. Initiatives like the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports service and Homeless and Housing Incentive Program (HHIP), which provides means for managed care plans to offer grant funding to address housing concerns. This is in addition to workforce development efforts to provide living-wage job training for members.

One of the ways Partnership has provided support for members living in fire-prone areas is by performing member outreach, encouraging members to prepare for disaster by leveraging tools provided by local utility companies and public health departments. In another planned intervention, Partnership is exploring a pilot to engage school youth with tobacco education training and prevention to promote a smoke-free future.

Partnership is exploring multiple approaches to address chronic conditions and disparities among subpopulations. Partnership collaborated with providers and other

community agencies to provide member education and referrals for individuals recently diagnosed with hypertension. Partnership contracted with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and to health centers that do not have ready access to mammography services, such as remote areas and where our American Indian/Alaskan Native population live. In 2023, Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers in Humboldt County (the Partnership county with the largest tribal population), to decrease known health disparities between American Indian and non-American Indian members.

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

Partnership has developed a multi-pronged approach to recruit and retain providers, with oversight from the Board of Governors, and in collaboration with state and national initiatives. For example, Partnership is expanding efforts to strengthen recruitment of primary care providers (PCPs), behavioral health providers, mid-levels, and specialists in the areas where access is impacted most, as indicated by high Health Professional Shortage Areas (HPSA) scores or the “frontier” geographic designation. Partnership is forming a work group to research resources that will help providers operate facilities that are more physically accessible for seniors and members with disabilities. To further promote access, Partnership will collaborate with community groups to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services.

II. Data Sources

A. Overview of Procedures, Resources, and Methodologies

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

- Member demographics such as age, language (including limited English proficiency), race/ethnicity, and geographic location
- Local community needs assessments
- Social Determinants of Health (SDOH), drawn from County Health Rankings
- Service utilization, based on integrated claims and encounter data
- Health conditions and health-related behaviors, based on Partnership's HEDIS data
- 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), based on member demographics, and integrated claims and encounter data
- Member satisfaction or lack thereof, based on CAHPS data and member grievance data
- Health disparities, based on Health Services Advisory Group (HSAG) reported HEDIS measure disparity data

1. 2022 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2022. This data includes the total number of individuals enrolled in Medi-Cal and assigned to Partnership by eligibility group. Each month DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans based on their service areas. This data includes member-level characteristics such as race/ethnicity, age, gender, language, and eligibility indicators for seniors and persons with disabilities, complex pediatric conditions, and those living in long-term care facilities.

2. Local Community Needs Assessments

The Community Needs Assessment was compiled using publically available Community Health Needs Assessment (CHNA) reports from 12 counties and Local Oral Health

Program Assessments from 2 counties that did not have CHNA reports. The reports were published in 2019, using community and stakeholder input from 2018.

3. 2022 County Health Rankings and Roadmaps

The County Health Ranking and Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The 2022 annual County Health Rankings measures a range of vital health factors, such as high school graduation rates, obesity, smoking, unemployment, access to healthy food, the quality of air and water, income inequality, teen births, and more. The rankings are modeled after a view of population health that highlights the many factors that impact one's health. If these factors improve, communities thrive and reduce health disparities for subpopulations. The rankings are determined by:

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

4. 2022 Partnership Integrated Claims and Encounter Data

Partnership's Health Analytics team manages an integrated data set, including medical, behavioral, laboratory results, and services directly reimbursed by the state (e.g., pharmacy claims). The 2022 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services. The data set documents both the diagnosed clinical conditions, and the services and items received by beneficiaries to treat these diagnosed conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. Partnership's paid claims, laboratory results, and encounter data are integrated with state-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims, claims from our delegated managed behavioral healthcare organization, Carelon Behavioral Health (formerly Beacon Health Options), and claims from members assigned to Kaiser for medical and mental health services.

5. 2022 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a comprehensive set of standardized performance measures. These measures were established by the National Committee for Quality Assurance (NCQA) and are designed to allow reliable comparisons of health plan performance. The methodology for each HEDIS measure is described in the annual HEDIS Technical Specifications corresponding to the measurement year. DHCS selects some of these HEDIS measures to be used as annual performance measures for Managed Care Plans; these are referred to as the Managed Care Accountability Set (MCAS). See Appendix A for the HEDIS Regional Performance Report Year 2022, Measurement Year 2021. DHCS has designated four (4) HEDIS performance reporting regions for PHC: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake). Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile of the national NCQA HEDIS performance for Medicaid and varies by each measure. In addition to the MCAS measures, Partnership collects data plan-wide for NCQA HEDIS measures required for NCQA Accredited Medicaid Managed Care Plans. Partnership uses annual HEDIS results to evaluate clinical quality in a standardized way, and to evaluate health inequities for our members by race, ethnicity, language, and geographic region.

6. 2022 Timely Access Data

Partnership's Provider Relations department gathers Timely Access data through an annual survey. This survey identifies 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 Partnership members.

7. 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In alignment with the National Committee for Quality Assurance (NCQA), Partnership has selected Press Ganey, formerly known as SPH Analytics, to perform member surveys to capture information about member experiences with the health plan and their respective health care. These surveys inform health care organizations about patients' or their families' experiences with their health care providers and plans, including hospitals, home health agencies, doctors, health and drug plans, and other provider types. The CAHPS surveys ask adult and child members to provide feedback in multiple categories, such as: Getting Needed Care; Getting Care Quickly; How Well Doctors Communicate; Customer Service; Coordination of Care; Ease of Filling Out Forms; Rating of Health Care; Rating of Personal Doctor; Rating of Specialist; Rating of Health

plan; and Effectiveness of Care Measures. This report will focus on the composite scores for Rating of Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist measures for both adults and children. The CAHPS survey measurement year (MY) or period is for 2021 (July 1, 2021 – December 31, 2021) and the reporting year is 2022.[3]

8. 2022 Health Disparities Data

DHCS contracts with HSAG to help assess and improve health disparities in California through their annual study.[4] HSAG used MCAS performance indicators reported by Medi-Cal managed care health plans for reporting year 2022 (measurement year 2021) to conduct this study.[5] This report provides data on health disparities data specific to Partnership.

B. Other Data Sources

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

Partnership regularly reviews published research in areas impacting our population. Partnership leaders and clinicians subscribe to journals that describe evidence-based care, and promising practices to implement among members with complex needs and those with behavioral health or substance use disorders. These journals include research that addresses social determinants of health, health equity, and population health management strategies. Partnership also reviews national data sources, such as the CDC and the US Preventive Services Task Force to track national trends and align ourselves with emerging care protocols, like recommendations for COVID-19 testing, quarantines, and immunizations. For demographic information in our various regions, we reference United States Census Bureau reports and the SAIPE State and County Estimates for 2021.

[3] SHP Analytics, 2022
[4] Department of Health Care Services, 2020; Department of Health Care Services, 2022; Department of Health Care Services, 2023
[5] Department of Health Care Services, 2022

C. Population Segmentation

After reviewing Partnership'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 pulls information from a variety of reports that may include but are not limited to member demographics, health/risk assessments, laboratory results, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as reports and analyses of over and under-utilization of care. Partnership reviews population segmentation on an annual basis to evaluate for disparities, potential inequities, and to ensure that all populations are served. However, a number of factors may influence Partnership to conduct additional reviews of population segmentation, such as state findings, natural disasters or events such as COVID-19, and standard business practices.

In addition to evaluating member needs, Partnership also analyzes programs and activities no less than annually. Partnership uses the results to inform and refine its interventions, including those activities and resources to address health care disparities, and evaluate whether Partnership and community resources are sufficient to address member needs.

III. Key Findings

A. Member Demographics

1. Membership/Group Profile

As of December 2022, Partnership served 675,673 Medi-Cal beneficiaries in 14 counties in Northern California. Partnership primarily serves children and adults under the age of 65. In 2022, Partnership served 417,141 adults and 258,532 children.[6]

2. Geographic Distribution

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

[6] Partnership Membership Dashboard, 2022

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

2022, Partnership's Website

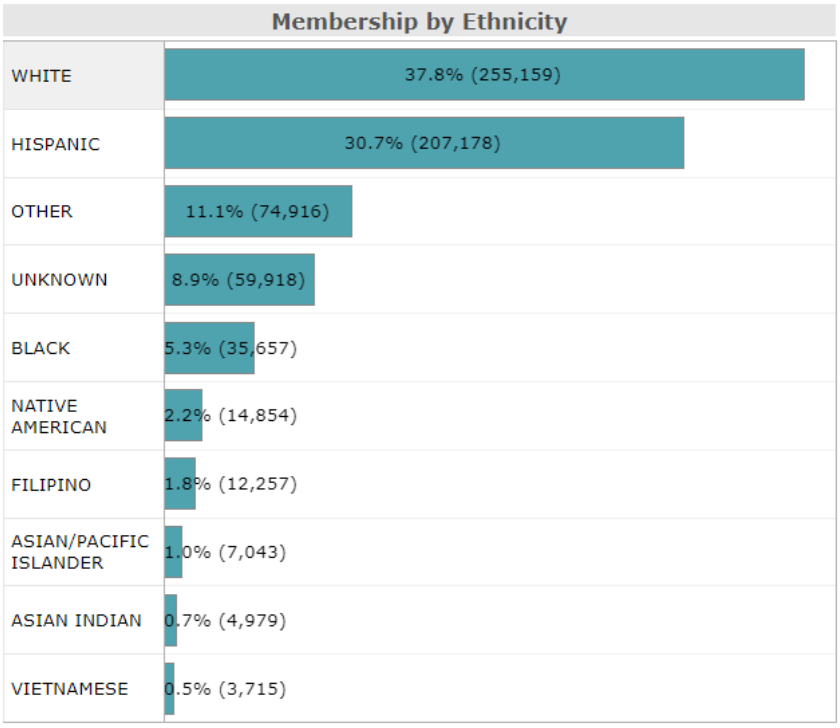
3. Age and Gender

According to the 2022 Partnership enrollment data, 19.2% of members are ages 0-10, 17.3% are 11-19, 34.4% are 20-44, 19.5% are 45-65, and 9.5% are ages 65 and older. In addition, 52.5% of all members are female while 47.5% are male. There were 6,553 babies born to Partnership members during 2022.

4. Race/Ethnicity

The largest ethnic categories of our membership are White (37.8%) and Hispanic (30.7%). Figure 2 illustrates the racial and ethnic composition of Partnership members as of December 2022. Whites and Hispanics represent the largest ethnic groups across all 14 counties.

Figure 2 : 2022 Partnership Membership by Race/Ethnicity

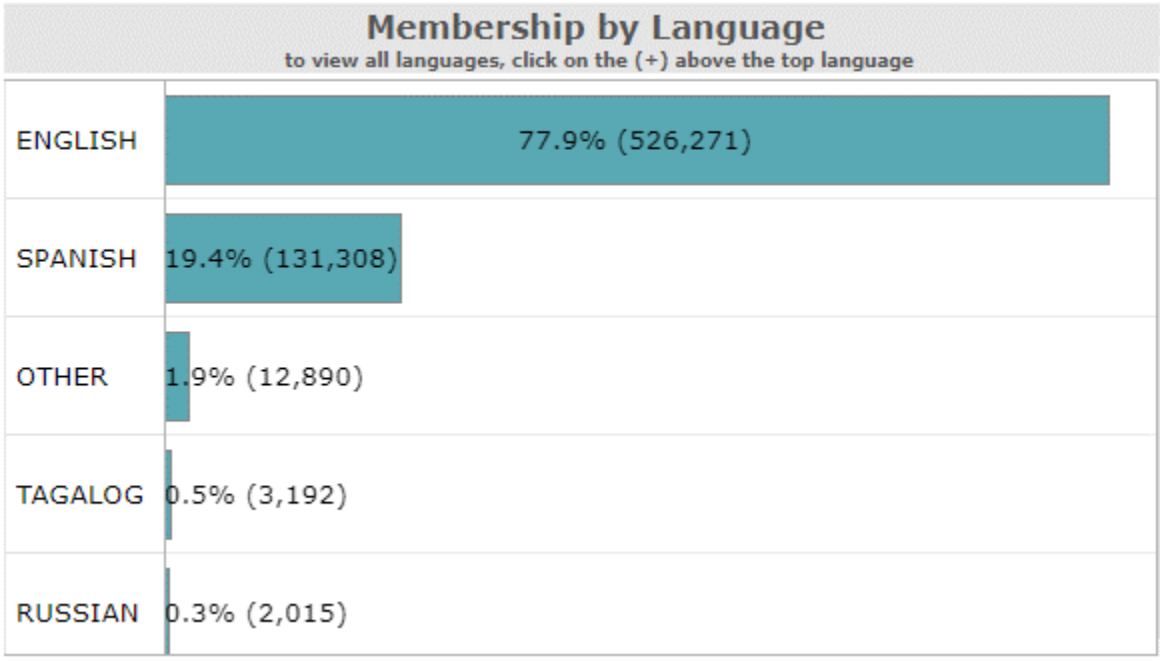


Source: 2022 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's 2022 enrollment data, 77.9% of members identify as English speaking and 20.2% identify as limited English proficiency (LEP). Furthermore, 19.4% of LEP members identify as Spanish speaking. The other 2 Partnership threshold languages include Russian and Tagalog which combine to less than 1% of LEP members, and 1.9% of the population speaks a language other than the 3 threshold languages.

Figure 3: 2022 Partnership Membership by Primary Language

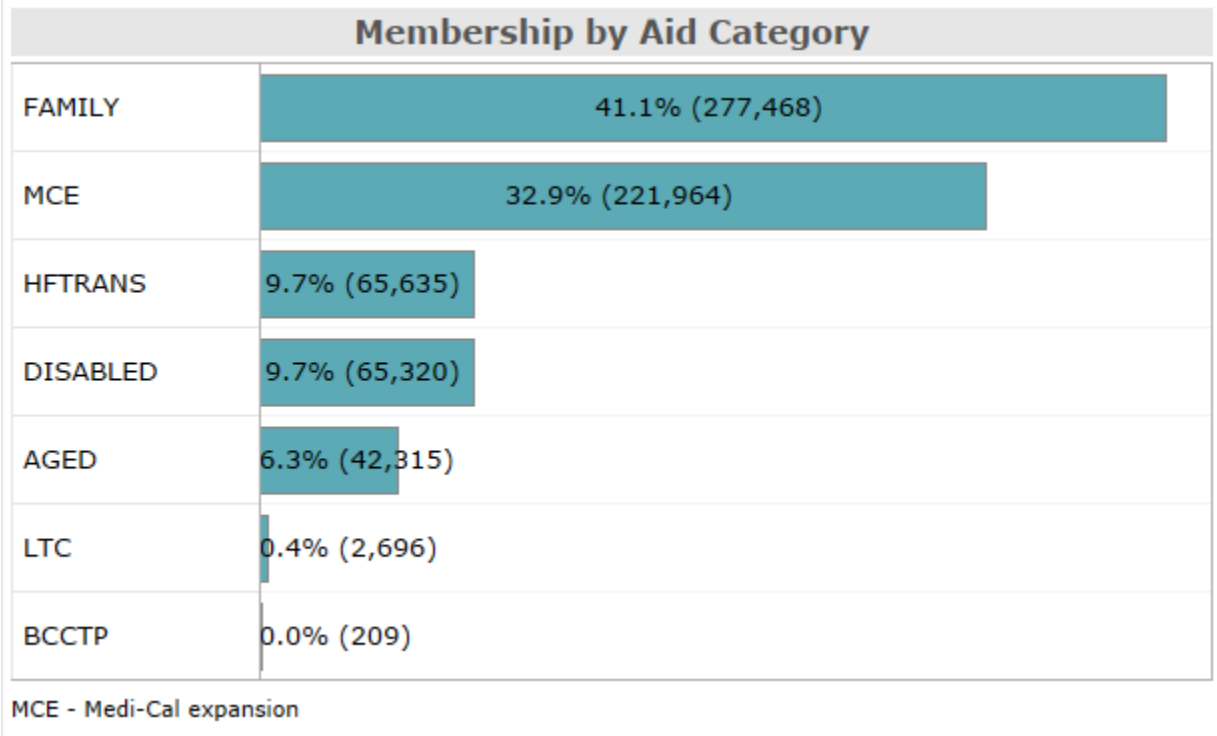


Source: Partnership's December 2022 Member Enrollment Data

6. Disability

Based on the 2022 Partnership enrollment data, 65,262 of members are disabled. Furthermore, 5,995 of all disabled member are ages 0-20; 46,671 are ages 21-64; and 12,382 are ages 65 and older. Finally, 33,136 of all disabled members are males while 31,912 are females.

Figure 4: 2022 Partnership Membership Aid Category and Disability Status



Source: Partnership's December 2022 Member Enrollment Data

B. Local Community Needs Assessment

Partnership has a 14 county service area where the demographic makeup of the residents is diverse, and there are numerous priority needs identified by the counties. Here the focus is on the top priority need areas of each county, the gaps in services or care they identified, and a review of Partnership's current activities for alignment with county priorities. The Local Community Needs Assessment was compiled using publically available Community Health Needs Assessment (CHNA) reports from 12 counties and available Local Oral Health Program Assessments from 2 counties that did not have CHNA reports. The reports were published in 2019, using community and stakeholder input from 2018.

Although the 14 county service area is geographically expansive and ethnically diverse, there were common priority needs mentioned across all 14, including access to Healthcare Services, Mental Health and Substance Use Services, Transportation, and Housing. After reviewing all needs, broader categories were identified for simplification. The priority area categories are as follows: Clinical Care, Health Behaviors, Social and Economic Factors, and Physical Needs. Appendix B summarizes these broader categories for each individual county.

1. Clinical Care

Within the clinical care category are the priority needs of access to quality primary care, dental care, specialty and extended care, mental health/behavioral health, and substance use services. Throughout the counties, there is a need for more recruitment and retention of healthcare providers. Often, there are long wait times for patients to get into their provider's office, so many people don't use their primary care benefits. Because they do not regularly see a healthcare provider, patients often use local emergency rooms for medical services. For many of Partnership's members in rural counties, distance impedes access to specialty services. Specialty services are often in the nearest large city, which can be across county lines. This is the same situation for dental providers; there are a very limited number of dental providers in Partnership's northern rural counties that accept Medi-Cal Dental, and a shortage of dentists who see children. Other services reported by counties as inaccessible were substance use and mental health services. Overall findings indicated limited services available, not enough mental health professionals, and an inadequate amount of substance use programs and treatment facilities. Though there are treatment facilities and providers throughout the 14 counties, there are not enough to meet the needs of the community.

Four counties identified injury and disease prevention and management as a priority area for attention. These counties needed more fall prevention services for their elderly residents and education on injury prevention for the labor workforce. Counties view CHWs or promotoras as support for chronic disease prevention and education, as diabetes and obesity are common throughout various counties. There is a need for more overall support of chronic disease management, including in-person sessions for residents to learn how to manage their conditions better and how to work with their provider to better control their conditions.

Maternal and child health was a significant concern for a few counties. The assessment reports outlined a need for better access to prenatal care and education on pregnancy and postpartum care. In rural counties, prenatal care is lacking; there tend to be long wait times to be seen for first-trimester appointments. Often, when people face barriers while scheduling care, they choose to forgo the care and not be seen. Dental care during pregnancy is essential, but there is a lack of education about how dental health affects a person's physical health. Furthermore, there are few dentists accepting Medi-Cal Dental who see pregnant patients.

2. Health Behaviors

Use of substances, specifically tobacco, alcohol and other drugs, are common throughout all 14 counties, though most prevalent in the rural areas. There is

widespread concern about youth using these substances, since drug abuse often runs in families; when youth observe this behavior, they are likely to see it as normal and mirror the same behaviors as they grow up. There are notable disparities among ethnic groups when it comes to substance use; Native American populations have a higher proportion of substance use rates when compared to their white counterparts.

Many counties report that physical activity and exercise are a priority area, as many kids and young people do not have the opportunity to exercise daily, or choose not to do so. The evolution of technology has created barriers to exercise, with many youth choosing to use their devices instead of going outside; this habit creates a sedentary lifestyle, which contributes to poor health outcomes later in life. Some areas are not suitable for recreational outdoor activity, which also contributes to physical activity and exercise barriers.

Throughout numerous counties, nutrition education was called out as a priority. Many areas across Partnership's 14 counties are designated as food deserts, which are areas where healthy and fresh foods are not readily available for people to access. In these places, processed foods high in sugar, sodium, fat, and chemical additives make up most of what is available. Some communities lack food pantries or other food supplement options. Counties state that nutrition education would enable individuals and families the opportunity to learn more about what kinds of nutritious meals can be made with the items they have at their local market or corner store. There is currently a lack of knowledge about how to utilize fresh foods to create a well-balanced meal. Diets made up of mostly high sugar, sodium, and fat can contribute to dental cavities, obesity, and type 2 diabetes.

3. Social and Economic Factors

Among the counties that Partnership serves, there are numerous social and economic needs identified. The most commonly mentioned social and economic issues mentioned throughout all county needs assessments were homelessness and the need for affordable housing. Access to affordable housing is a constant barrier for many people. Often, there are not enough housing units available for people to rent, even when people qualify for housing vouchers through local housing authorities. There is a lack of affordable and quality housing in almost all counties. Homelessness seems to be holding steady throughout all counties, though there has been work in each county to combat homelessness.

Jobs and employment were a concern for some communities; there are limited opportunities for employment in some areas. Many people work multiple jobs to support themselves and their families' basic needs. A high percentage of Partnership's

members live below the federal poverty level, and it is difficult to transition out of poverty.

Many people have lost a sense of connection with their communities. Some counties are receiving an influx of people moving into the area due to rising housing costs in neighboring counties. Other areas are concerned with issues of discrimination and the perception that residents are not open to and welcoming of other cultures. Some minority communities report feeling fearful when it comes to using public services and resources. In Partnership's northern rural counties, there are concerns about social isolation and transportation requirements to access basic services. Additionally, winter weather further isolates people when there are power outages or road closures, preventing people from connecting with anyone nearby.

Education is another social factor identified as a priority need for a couple of counties. In some areas, there are disparities in educational attainment and a lack of early childhood education and development services. There may be a correlation between these factors, because minority children are less likely to be prepared for kindergarten than their white counterparts, and more likely to not graduate from high school.

Childhood trauma and adverse childhood experiences affect many residents throughout the 14 counties. Throughout the various needs assessments, there was mention of children exposed to parental domestic violence, or being abused themselves. Children who experience multiple Adverse Childhood Experiences (ACEs) are more likely to have poorer physical health outcomes when they are adults, when compared to people who have not had the same adverse experiences.

4. Physical Needs

Access to transportation was one of the top 3 priority needs throughout all 14 counties. The majority of Partnership's counties are rural and have geographical barriers, like winding, narrow roads, and mountains. Transportation issues range from having to travel long distances, or even out of county for care, to not having a vehicle, friend, or taxi service available for transportation. Roads get harder to pass during the winter for multiple counties, and public transportation during this time becomes limited. There are limited options for ride-share services in rural areas, which adds to transportation challenges. Some counties note a need for more transportation options for the disabled and mobility impaired.

Livable communities are a top priority for some counties wanting to create more livable spaces, including recreational outdoor areas, parks, and adding more safe sidewalks for

pedestrians. Creating a livable community also encompasses better functioning transportation systems and the creation of additional affordable housing units.

C. Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH), also known as, "social influencers of health," as defined by the World Health Organization (WHO), are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics."[7]

Standardized collection of individual member SDOH is not available. There is no validated means of using diagnosis codes or claims data reliably to indicate one or more social determinants of health, and the data is quite incomplete; therefore, it is not useful for meaningful analysis. Instead, Partnership uses the Small Area Income and Poverty Estimates (SAIPE) State and County Estimates for 2021 and County Health Rankings & Roadmaps data to understand the drivers that influence the health of our population. We use this data, along with data provided by our county public health agencies, provider partners, and community-based organizations, to gain insight into the needs of our members and the communities where they live. This helps foster collaborative efforts with local agencies in order to improve the social supports that help meet the needs of our members.

1. Poverty

People living in poverty have limited access to quality health care, healthy foods, safe neighborhoods, stable housing, and fewer opportunities for physical activity and higher education.

According to most recent data available from the 2021 SAIPE, California has a state poverty rate of 12.3%. Of Partnership's 14 counties, 10 have poverty rates above the California average. The counties include Del Norte (21.4%), Humboldt (19.4%), Lake (16.5%), Lassen (18.8%), Mendocino (16.1%), Yolo (14.8%), Modoc (19.9%), Shasta (14.0%), Siskiyou (16.8%) and Trinity (19.1%). The SAIPE data reveals that all 7 of Partnership's Northern Region counties' poverty rates are higher than California's average. Of note, compared to the SAIPE 2020 report, poverty rates in all of Partnership's 14 counties increased according to the data in the SAIPE 2021 report.

[7] World Health Organization, 2013

Table 1: 2021 Partnership Counties by Poverty Rates

Partnership Northern Region	Poverty Rate (%)	Partnership Southern Region	Poverty Rate (%)
California	***12.3***	***California***	***12.3***
Del Norte	21.4	Lake	16.5
Humboldt	19.4	Marin	7.8
Lassen	18.8	Mendocino	16.1
Modoc	19.9	Napa	9.0
Shasta	14.0	Solano	10.0
Siskiyou	16.8	Sonoma	9.1
Trinity	19.1	Yolo	14.8

Source: 2021 Small Area Income and Poverty Estimates (SAIPE). Red indicates higher than California average.

2. Income

According to the 2021 SAIPE, the median household income in California is $84,831 (SAIPE California, 2021). Ten of Partnership'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: 2021 Median Household Income by Partnership County

Partnership Northern Region	Median Household Income	Partnership Southern Region	Median Household Income
California	***$84,831***	***California***	***$84,831***
Del Norte	$48,108	Lake	$55,801
Humboldt	$53,924	Marin	$118,472
Lassen	$56,923	Mendocino	$57,516
Modoc	$49,273	Napa	$94,127
Shasta	$60,187	Solano	$87,348
Siskiyou	$50,069	Sonoma	$92,999
Trinity	$45,508	Yolo	$45,508

Source: 2021 Small Area Income and Poverty Estimates (SAIPE). Red indicates lower than California median income.

3. Income Inequality

Another way to view this data is through the lens of income inequality. Income inequality is related to health and wellbeing, regardless of the income for individual households.

Communities with significant disparities in income can result in more extreme differences in social class and status. 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 5.1 in 2022. Of Partnership's covered counties, Del Norte, Humboldt, and Yolo Counties have income inequality ratios higher than the California average, indicating a wider gap in income. Those counties with lower scores show a less drastic contrast among the population in each county.

Table 3: 2022 Median Household Income by Partnership County

Partnership Northern Region	Income Inequality Ratio	Partnership Southern Region	Income Inequality Ratio
California	***5.1***	***California***	***5.1***
Del Norte	5.4	Lake	5.1
Humboldt	5.2	Marin	Data not available
Lassen	4.1	Mendocino	4.8
Modoc	3.8	Napa	4.5
Shasta	4.9	Solano	3.9
Siskiyou	4.6	Sonoma	4.3
Trinity	4.8	Yolo	5.9

Source: 2022 County Health Rankings & Roadmaps. Red indicates a higher than California average income inequality ratio.

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 affected adversely by poverty, children in poverty 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. In 2022 on average, 15% of California children live in poverty. Compared to 2021 County Health Rankings, almost all of the rates of children living in poverty in Partnership's counties have risen. Of Partnership's covered counties, 9 counties have high rates of children experiencing poverty. Del Norte (23%), Humboldt (19%), Lassen (16%), Modoc (28%), Shasta (18%), Siskiyou (20%), Trinity (26%), Lake (22%), and Mendocino (19%) counties demonstrate that there is a continued need to support the health of children significantly impacted by poverty. Five counties have lower rates of children experiencing poverty: Marin (6%), Napa (9%), Sonoma (9%), Solano (11%), and Yolo (11%).

Table 4: Children Living in Poverty by Partnership County in 2022

Partnership Northern Region	Percentage of Children Living in Poverty	Partnership Southern Region	Percentage of Children Living in Poverty
California	***15%***	***California***	***15%***
Del Norte	23%	Lake	22%
Humboldt	19%	Marin	6%
Lassen	16%	Mendocino	19%
Modoc	28%	Napa	9%
Shasta	18%	Solano	11%
Siskiyou	20%	Sonoma	9%
Trinity	26%	Yolo	11%

Source: 2022 County Health Rankings & Roadmaps. Red indicates higher than California average.

Employment status plays an important role in the health status of individuals and their communities. The unemployed population is at risk for unhealthy behaviors connected to alcohol and tobacco consumption, diet, exercise and other habits related to health. There is also a link between employment status and other factors such as lack of economic security, low quality housing access, and limited access to health coverage.[8] Unemployment is measured as a percentage of the population aged 16 and older who are unemployed but seeking work.

In 2021, 8 of Partnerships covered counties had higher unemployment rates compared to the California average (Yolo, Lassen, Shasta, Lake, Trinity, Del Norte, Siskiyou and Modoc); in the same year, 5 of Partnership's covered counties had lower levels of unemployment (Marin, Sonoma, Napa, Humboldt and Solano). In 2022, California's average rate of unemployment was 10.1%. When comparing the unemployment rates in Partnership's counties to the 2022 California average, all counties were below the state average.

[8] Health.gov Healthy People 2030 Literature Summary, n.d.

Table 5: Unemployment Rate by Partnership County in 2022

Partnership Northern Region	Unemployment Rate	Partnership Southern Region	Unemployment Rate
California	***10.1%***	***California***	***10.1%***
Del Norte	9.5%	Lake	9.6%
Humboldt	8.4%	Marin	6.7%
Lassen	7.1%	Mendocino	8.9%
Modoc	8.5%	Napa	8.7%
Shasta	8.7%	Solano	9.5%
Siskiyou	9.7%	Sonoma	7.9%
Trinity	8.0%	Yolo	7.5%

Source: 2022 County Health Rankings & Roadmaps.

4. High School Completion

Educational attainment is positively correlated with improved health outcomes for both quality-of-life and life expectancy. Adults with more education tend to be more consistently employed and earn more money than their less educated peers.

In California, the percent of adults age 25 or over with a high school diploma or equivalent was 84% in 2022. The populations of Del Norte County and Lassen County have lower high school completion than the state average. Partnership's remaining counties are above the state average for high school completion, with Marin, Trinity, Shasta, and Siskiyou at 90% or above.

Table 6: High School Completion Percentages by Partnership County in 2022

Partnership Northern Region	High School Graduation (Completion)	Partnership Southern Region	High School Graduation (Completion)
California	***84%***	***California***	***84%***
Del Norte	80%	Lake	86%
Humboldt	91%	Marin	94%
Lassen	81%	Mendocino	87%
Modoc	85%	Napa	86%
Shasta	91%	Solano	89%
Siskiyou	90%	Sonoma	89%
Trinity	93%	Yolo	87%

Source: 2022 County Health Rankings & Roadmaps. Red indicates lower than California average. Green indicates graduation rates at or above 90%.

5. 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 was 12.9 in 2022. The Partnership County with the highest rates of air pollution is Siskiyou at 20.9.

In 2022, 40 wildfires in Partnership's regions, burned more than 127,000 acres. With the increasing rate of wildfires in California, there is an increased possibility of impacts on Partnership's covered counties health. Fires increase the possibility of adverse pulmonary effects such as chronic bronchitis, asthma and decreased lung function.[9] Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

Table 7: Air Pollution – Particulate Matter by Partnership County in 2022

Partnership Northern Region	Air Pollution - Particulate Matter	Partnership Southern Region	Air Pollution - Particulate Matter
California	***12.9***	***California***	***12.9***
Del Norte	11.6	Lake	9.2
Humboldt	7.8	Marin	11.2
Lassen	9.4	Mendocino	11.4
Modoc	10.0	Napa	13.4
Shasta	14.8	Solano	12.9
Siskiyou	20.9	Sonoma	8.4
Trinity	11.3	Yolo	12.9

Source: 2022 County Health Rankings & Roadmaps

The high rates of air pollution in Siskiyou County may be partially explained by the massive wildfires that occurred in 2022. Table 8 shows how many fires occurred and the amount of acreages burned in each county in 2022.

[9] Environmental Protection Agency (EPA), 2022

Table 8: Number of Wildfires and Acreage Burned by Partnership County in 2022

Partnership County	Number of Fires in 2022	Acres Burned in 2022
Humboldt	3	51
Lake	1	14
Lassen	1	14
Marin	1	113
Mendocino	5	240
Modoc	2	5,843
Napa	1	570
Shasta	4	436
Siskiyou	15	78,170
Solano	3	276
Sonoma	2	84
Trinity	1	41,600
Yolo	1	120
Total	40	127,531

Source: Cal Fire 2022 Incidents

6. Adult Smoking

According to the CDC, cigarette smoking continues to be a main cause of preventable conditions such as disease, disability, and death among the U.S. population. Smoking affects almost every organ of the human body; it can also cause cancer in various parts of the body. Smoking can be a contributing factor to a variety of diseases including: cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Secondhand smoke can also increase the risk for health concerns.[10] 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, 10% of adults in 2022 were current smokers in California. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties; rates of smoking in Partnership counties ranged from as low as 10% to as high as 18%.

[10] Center for Disease Control and Prevention (CDC), 2022

Table 9: 2022 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate	Partnership Southern Region	Adult Smoking Rate
California	***10%***	***California***	***10%***
Del Norte	18%	Lake	17%
Humboldt	15%	Marin	10%
Lassen	17%	Mendocino	15%
Modoc	17%	Napa	11%
Shasta	16%	Solano	12%
Siskiyou	16%	Sonoma	11%
Trinity	17%	Yolo	12%

Source: 2022 County Health Rankings & Roadmaps. Red indicates higher than California average adult smoking rate.

7. Physical Inactivity

Low physical activity relates to several diseases such as diabetes, cancer, hypertension, cardiovascular disease and premature mortality. Physical activity can improve sleep, cognitive ability, and bone and musculoskeletal health. Physical activity not only affects individuals, but also communities.[11]

The 2022 County Health Roadmaps and Rankings measures physical inactivity as the percentage of adults age 18 and over reporting no leisure time physical activity, with higher values indicating less time for physical activity. In 2022, the California state average was 22%. In Partnership covered counties, Del Norte (27%), Lassen (26%), Lake (27%), Modoc (26%), Mendocino (25%), Solano (25%), Siskiyou (24%), Trinity (25%) and Yolo (24%) counties all had physical inactivity rates that were worse the state average. Humboldt (22%) and Shasta (22%) were the same as the state average. Marin (17%), Napa (21%), and Sonoma (19%) counties had rates of physical inactivity better than the state average.

Table 10: 2022 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity	Partnership Southern Region	Physical Inactivity
California	***22%***	***California***	***22%***
Del Norte	27%	Lake	27%
Humboldt	22%	Marin	17%
Lassen	26%	Mendocino	25%
Modoc	26%	Napa	21%

[11] World Health Organization (WHO), 2022

Partnership Northern Region	Physical Inactivity	Partnership Southern Region	Physical Inactivity
California	***22%***	***California***	***22%***
Shasta	22%	Solano	25%
Siskiyou	24%	Sonoma	19%
Trinity	25%	Yolo	24%

Source: 2022 County Health Rankings & Roadmaps. Red indicates higher than California average.

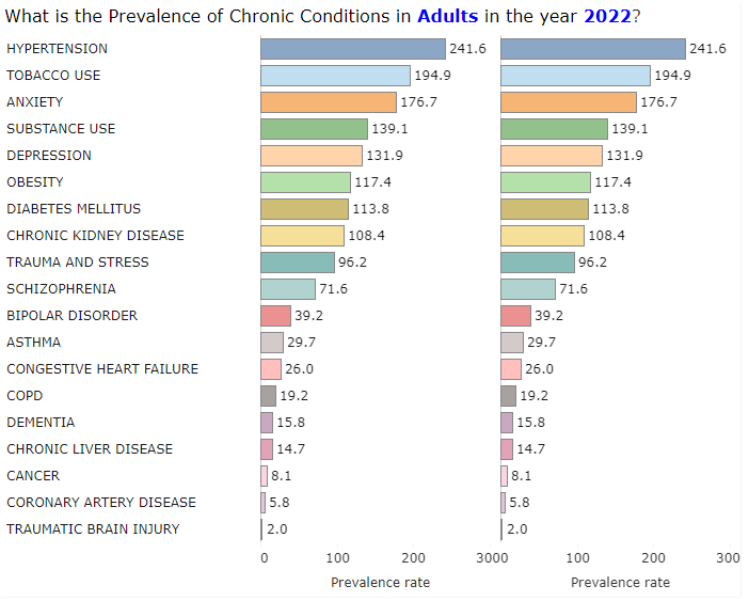
D. Disease Prevalence

1. Chronic Disease

The 2022 Partnership Integrated Claims and Encounter data highlighted many chronic diseases that are prevalent in adults and children. Chronic diseases can be defined as conditions that last one year or more and either require continuing medical attention, limit day-to-day living, or both.[12] Partnership bases estimates of chronic disease prevalence on claims and encounter data, while recognizing the limitations of this data to represent the true prevalence of disease. True prevalence of chronic disease is higher than that which is captured and coded through claims. Figure 5 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (241.6 per 1000 adult members), Tobacco use (194.9 per 1000 adult members), Anxiety (176.7 per 1000 adult members), Substance use (139.1 per 1000 adult members), Depression (131.9 per 1000 adult members), and Obesity (117.4 per 1000 adult members).

[12] Center for Disease Control and Prevention, 2022

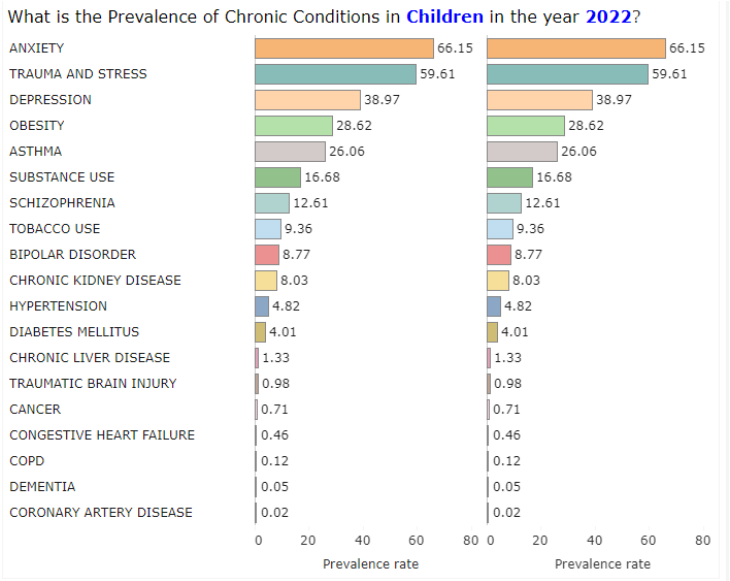
Figure 5: 2022 Adults Chronic Conditions Prevalence Data Per 1000 Members



Source: 2022 Partnership Integrated Claims and Encounter Data, Partnership

Figure 6 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (66.15 per 1000 members), Trauma and Stress (59.61 per 1000 members), Depression (38.97 per 1000 members), Obesity (28.62 per 1000 members), Asthma (26.06 per 1000 members) and Substance Use (16.68 per 1000 members).

Figure 6: 2022 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2022 Partnership Integrated Claims and Encounter Data, Partnership

2. HEDIS® Scores

Partnership uses HEDIS measure performance to assess how well the health plan is providing preventive care and serving members with chronic diseases. The DHCS Minimum Performance Level (MPL) is set at the 50th percentile of HEDIS performance amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for reporting 2022 (measurement year 2021). Partnership has 4 reporting regions for HEDIS measures: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake).

a. Controlling High Blood Pressure

Hypertension is a risk factor for conditions such as heart disease and stroke; these conditions are the first and fifth leading causes of death in the United States, respectively.[13] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 55.35% for the 2022 Reporting Year (2021 Measurement Year).[14] In the 2022 Reporting Year, only Partnership's Northwest regions fell below the MPL for controlling high blood pressure. The other 3 reporting regions were at or above the MPL for controlling high blood pressure.

b. Comprehensive Diabetes Care

The HEDIS MPL around the Comprehensive Diabetes Care measure indicator for poor diabetes control (HbA1c level >9%) was set at the 50th percentile of 43.19% for the 2021 Measurement Year (2022 Reporting Year). This measure is HEDIS's only measure where lower scores are considered better; this is because performance is inversely related to the percentage reported. Partnership's Northern Region Performance for this indicator went below the MPL with a performance of 42.82% and 40.63% in the Northeast and Northwest regions, respectively. Partnership's Southern Region Performance for Comprehensive Diabetes Care also went below the MPL with a performance of 36.50% and 37.23% in the Southeast and Southwest regions, respectively. These scores indicate that all of Partnership's reporting regions performed better than the HEDIS MPL for this indicator.[15]

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[16] yet, it is estimated that only 8% of adults 35 years and older in the United States get all

[13] Center for Disease Control and Prevention (CDC), 2020
[14] Partnership Health Plan of California HEDIS Measures, 2022
[15] Partnership Health Plan of California HEDIS Measures, 2022
[16] Health.gov Healthy People 2030 Literature Summary, n.d.

recommended preventive care services.[17] Getting preventive care helps prevent disease and premature death by using preventive screening tests such as colorectal and breast cancer screening for adults, tracking of child development milestones, and various vaccinations for all ages. It is of utmost importance to help people comprehend the importance of getting preventative care in a timely manner to stay healthy and reduce health inequities. Partnership believes this work is foundational to help our members and our communities stay healthy.

c.i. Adult Cancer Screening

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

While efforts were made to improve breast cancer screening rates, all regions fell short of the DHCS-specified MPL set at the 50th percentile of 53.93% for the 2021 Measurement Year (2022 Reporting Year). The Northeast came in at 46.93%, the Northwest measured at 40.73%; the Southeast was 52.67%, and the Southwest was at 53.14%.[18]

Cervical Cancer Screening showed similar challenges. The MPL for this measure set at the 50th percentile of 59.12% for the 2021 Measurement Year (2022 Reporting Year). The Northeast (48.91%) and Northwest (55.12%) continue to perform below the MPL. In the Southern regions, the Southeast was above the MPL at 61.52% while the Southwest was below the MPL at 57.45%. The Southeast represents a small increase from the previous year's rate of 60.38%.[19]

c.ii. Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. Well-child visits track growth and milestones, opening the door for parents to address any questions or concerns they may have around their child's health. Children who are not protected by vaccines are more likely to contract and pass on certain diseases.[20] A recent study identified common barriers to getting to well-child visits, including difficulty

[17] Borsky A., et. al., 2018
[18] Partnership Health Plan of California HEDIS Measures, 2022
[19] Partnership Health Plan of California HEDIS Measures, 2022
[20] Center for Disease Control and prevention (CDC), 2022

in requesting time off from work, childcare, and other stressors.[21] Addressing the social determinants of health plays an important role for improving attendance of well-child visits.

The MPL for Childhood Immunization Status (CIS-Combo 10) was set at the 50th percentile of 38.20% for the 2021 Measurement Year (2022 Reporting Year). For children ages 0-2 who received all the recommended immunizations by the time they turned 2 years old, the Northeast (18.25%) and Northwest (32.60%) continued to perform below the MPL while the Southeast (40.63%) and the Southwest (41.61%) regions performed at about the MPL. Of note, the performance of the Southeast region in this measurement remained unchanged between 2020 and 2021 measurement years, (2021 and 2022 reporting year) at a rate of 40.63%. Furthermore, the Northwest saw a modest increase from 27.98% to 32.60% when comparing measurement year 2020 and 2021 respectively (reporting year 2021 and 2022 respectively).[22]

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 36.74%. The proportion of adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was below the MPL in the Northeast (19.22%) and Northwest (21.41%) regions. The Southeast (47.20%) and the Southwest (44.53%) regions were above the MPL. In the 2021 measurement year (2022 reporting year), 3 of the 4 regions performed worse compared to 2020 (2021 reporting year). The exception is the Southeast region, which performed better in the 2021 measurement year (2022 reporting year) compared to 2020 (2021 reporting year), at 47.20% compared to 46.83%, respectively.[23]

3. Behavioral Health

Partnership's overall strategy to address the comprehensive needs of our members requires effectively addressing their behavioral health needs, including both mental health and substance abuse disorders. In addition, communities across the United States faced intensified behavioral health challenges related to the COVID-19 pandemic. In June 2020, the CDC reported that 40.9% of adults struggled with mental or behavioral health, serious and persistent mental illness (SPMI), or substance use issues; these difficulties were more prevalent among non-White individuals. The CDC further reported that 10.7% of those surveyed reported suicidal thoughts in the last 30 days, with the percentage at 25.5% among 18 to 24 year olds.[24]

[21] Wolf et. al., 2020
[22] Partnership Health Plan of California HEDIS Measures, 2022
[23] Partnership Health Plan of California HEDIS Measures, 2022
[24] Center for Disease Control and Prevention, 2020

a. Telehealth Utilization for Behavioral Health

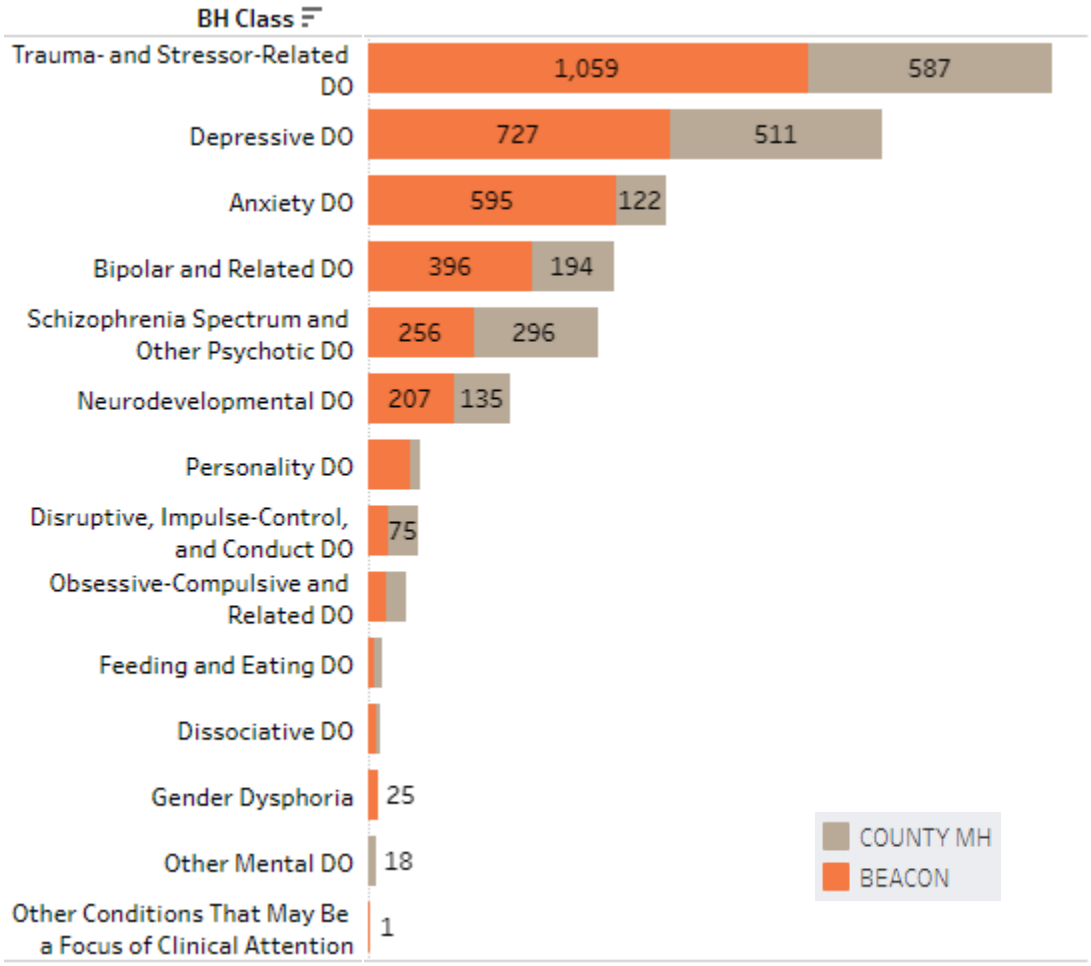
Carelon Behavioral Health (known as Beacon Health Options at time of data capture) telehealth services utilization increased significantly during 2020, as telehealth services became the main mechanism for providing care during COVID-19. A total of 89,835 telehealth services were provided across Partnership's counties in 2022, with the highest volume taking place in March (8,515 visits).

Figure 7: 2022 Carelon/Beacon Telehealth Visits Trend

Source: 2022 Beacon Mental Health Claims and Encounter Data, Partnership

All Partnership members are eligible for mental health services as long as their treatment needs can be addressed in a mild-to-moderate fashion, and there are no diagnosis exclusions. However, individuals with serious and persistent mental illness (SPMI) whose treatment needs require hospitalization or more intensive services are referred to the County Mental Health Plans for care.

Figure 8: 2022 Behavioral Health Diagnoses (Carelon/Beacon and the County)



Source: 2022 Mental Health Claims and Encounter Data, Partnership

b. Mental Health Illness and SPMI

In 2022, 43,350 Partnership members utilized mental health services from Partnership's delegated managed behavioral healthcare organization, Carelon Behavioral Health (formerly known as Beacon Health Options) in 510,256 distinct visits. According to Carelon data, female members had a higher number of Carelon visits, representing 357,330 visits compared to 152,926 by male members. As shown in Figure 9, access to Carelon's services by race/ethnicity is not distributed proportionately among Partnership's demographics. White members represented 58.7% of Carelon visits while only making up 38.1% of Partnership's total population. The Hispanic population made up the second largest utilization group, at 17.9% of Carelon visits while representing 30.6% of the total Partnership's population.

Figure 9: 2022 Beacon Services Utilization by Race and Ethnicity

Source: 2022 Beacon Mental Health Claims and Encounter Data, Partnership

In 2022, Kaiser had a total of 37,082 claims from 7,891 utilizing members for mental health services. Many of Partnership's adult members with SPMI and children with serious emotional disturbance (SED) received mental health care from County Mental Health Plans outside of the Partnership network. These services are carved out of Partnership's benefits and billed directly to the state.

4. Substance Use Disorder

In July 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. DMC ODS is an innovative program administered through Managed Care Plans, providing organized and comprehensive substance use disorder (SUD) care for Medi-Cal enrollees. This effort is referred to as the Partnership Wellness and Recovery Program, or the "Regional Model." Eight Partnership counties opted to participate: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, and Marin. Lake County will join the program in July of 2023. Partnership works with its providers and partners in these 9 counties to provide integrated physical health and SUD services to the Medi-Cal population.

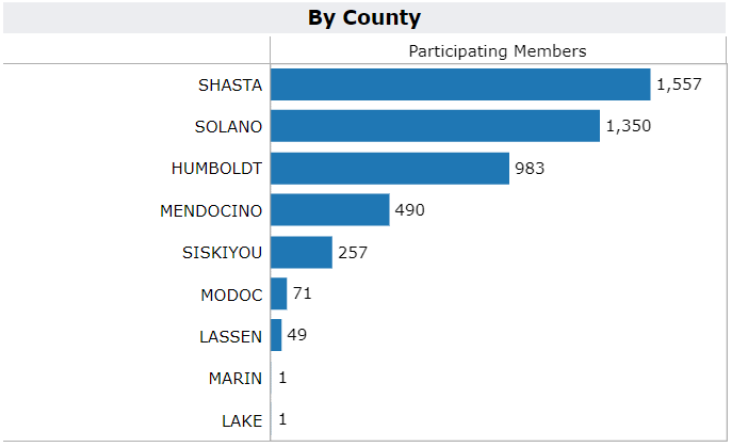
The range of services offered through the Wellness & Recovery Program includes:

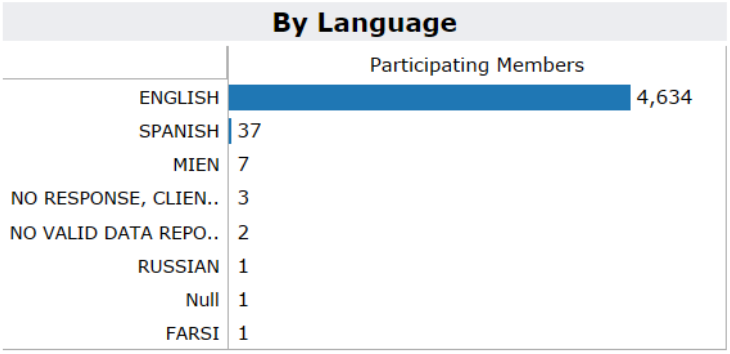
- Outpatient treatment (licensed professional or certified counselor, up to 9 hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 19 hours per week for adults
- Detoxification services (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.

In 2022, there were a total of 7,687 members participating in the Wellness & Recovery program, with the highest numbers in Shasta (1,557) and Solano (1,350) counties. The majority of participating members were English-speaking (4,634), and 3,118 of participants identified as White.

Figure 10: 2022 Participation in Wellness and Recovery Services





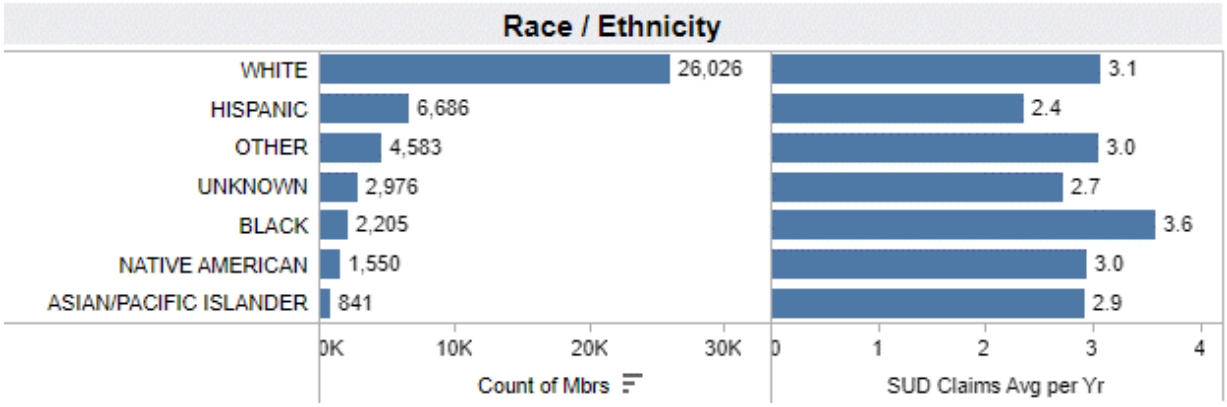
by Ethnicity

Race and Ethnicity group	
ASIAN/PACIFIC ISLANDER	75
BLACK	331
HISPANIC	476
OTHER	912
UNKNOWN	1
WHITE	3,118

Source: 2022 Partnership Integrated Claims and Encounter Data,

With the exception of the Wellness and Recovery Program, Partnership provides limited care options for treating members diagnosed with SUD. In 2022, 33,317 members were treated for conditions related to substance abuse. Of these members, 29,508 had a diagnosed SUD. The substances most frequently used by these members were alcohol, opioids and stimulants. Men were slightly over-represented with this diagnosis; about 52% (15,211) of members with SUD were male, compared to Partnership's general membership of 47.5% male and 52.5% female. The White population had the highest number of SUD, 26,026; 6,686 members were Hispanic; 2,205 were Black; 1,550 were Native American; and 841 were Asian/Pacific Islander.

Figure 11: 2022 SUD by Race and Ethnicity



Source: 2022 Substance Use Disorder Data, Partnership

E. Access to Care

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

1. Provider Availability

Primary Care Provider availability is the most important factor for Partnership members wanting to attend annual checkups and get routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the population to primary care providers to assess provider availability. County Health Rankings describes the ratio as the number of patients per primary care providers.

For California as a whole, the ratio of individuals to providers reported in 2022 is 1,240:1. As of November 2022, in Partnership's Northern Region (indicated with "(N)" in Figure 12 below), all of the counties underperform when compared to the California ratio. Lassen and Trinity counties have the least availability of providers to the population with Lassen at a ratio of 3,400:1 and Trinity at a ratio 3,070:1. In Partnership's Southern region (indicated with "(S)" in Figure 12), multiple counties performed better compared to the California ratio, including Mendocino (1,100:1), Marin (670:1), Solano (1,210:1), Sonoma (980), Napa (1,040:1), and Yolo (810:1). In spite of these county-wide numbers, Partnership contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

Figure 12: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,240:1	
County	**Ratio**
Del Norte (N)	1,740:1
Humboldt (N)	1,590:1
Lake (S)	2,300:1
Lassen (N)	3,400:1
Marin (S)	670:1
Mendocino (S)	1,100:1
Modoc (N)	1,470:1
Napa (S)	1,040:1
Shasta (N)	1,360:1
Siskiyou (N)	1,360:1
Solano (S)	1,210:1
Sonoma (S)	980:1
Trinity (N)	3,070:1
Yolo (S)	810:1

Source: County Health Rankings, 2022: Green indicates that compared to 2021, provider availability improved (i.e. there were less patients per provider). Red indicates that compared to 2021, provider availability worsened (i.e. there were more patients per provider).

Partnership's recent Grand Analysis Report on Network Access also revealed that between January 1, 2021, and December 31, 2021, 34% of standard member grievances and 43% of appeals and second level grievances were related to provider access. This same report also revealed that between March 2021 to February 2022, Partnership met its goal of less than 20 referrals per 1,000 members.[25]

Physical access at provider facilities has been a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing of a facility's physical accessibility is through a Physical Accessibility Review Survey (PARS), which tracks any changes in a facility's physical accessibility. Physical access is categorized as either Basic or Limited. A facility categorized as "Basic" has met all 29 critical elements used to identify a site's capability of accommodating members who are seniors and/or persons with disabilities. Elements, or domains, include parking, the exterior and interiors of the building, the restroom(s), and the exam room(s). If a facility is categorized as "Limited," it is missing one or more of the domains. As of March 2023,

[25] Partnership HealthPlan of California Grand Analysis: Network Access: Assessment of Network Adequacy, 2022

344 out of 497 facilities were categorized as Limited; and 153 were categorized as Basic.[26]

2. CAHPS Health Care Performance

The CAHPS survey gives members an opportunity to give feedback about their ability to access care and their satisfaction with the care received. The CAHPS survey measure year or period is 2021 (July 1, 2021 – December 31, 2021) and the reporting year is 2022. Compared to 2021, the CAHPS Adult Composite Scores for the 2022 reporting year decreased in the areas of rating of health care, getting care quickly, how well doctors communicate, coordination of care, and rating of personal doctor.

The exceptions to these decreasing rates are the scores for rating of specialists, which increased from 81.3% in 2021 to 82.3% in 2022. While not listed in the table below, customer service also showed an increase from 85.6% in 2021 to 87.2% in 2022.

Table 11: 2022 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2021*** (Previous Reporting YR)	***2022*** (Current Reporting YR)
Rating of Health Care (% 8, 9 or 10)	77.9%	70.0%
Getting Needed Care (% Always or Usually)	81.6%	76.0%
Getting Care Quickly (% Always or Usually)	80.3%	72.9%
How Well Doctors Communicate (% Always or Usually)	90.5%	88.5%
Coordination of Care (% Always or Usually)	88.6%	81.3%
Rating of Personal Doctor (% 8, 9, or 10)	84.0%	77.6%
Rating of Specialist (% 8, 9, or 10)	81.3%	82.3%

Source: At-A-Glance Report, 2022 Medicaid Adult CAHPS 5.1 H, 2022, SPH Analytics (p. 10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

The CAHPS child composite scores for reporting year 2022 showed that the ratings increased in the areas of rating of health care, getting care quickly, how well the doctor communicates, coordination of care, rating of personal doctor, and rating of specialist.

[26] Partnership HealthPlan of California PARS report, 2023

The exception to these increasing rates is the score for Getting Needed Care, which decreased from 80.7% in 2021 to 79.6% in 2022.

Table 12: 2022 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2021*** (Previous Reporting YR)	***2022*** (Current Reporting YR)
Rating of Health Care (% 8, 9, or 10)	82.8%	83.7%
Getting Needed Care (% Always or Usually)	80.7%	79.6%
Getting Care Quickly (% Always or Usually)	81.1%	84.1%
How Well Doctors Communicate (% Always or Usually)	93.0%	94.7%
Coordination of Care (% Always or Usually)	84.4%	85.3%
Rating of Personal Doctor (% 8, 9, or 10)	87.2%	89.0%
Rating of Specialist (% 8, 9, or 10)	79.2%	81.6%

Source: At-A-Glance Report, 2022 Medicaid Child CAHPS 5.0 H, 2022, SPH Analytics (p. 10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

3. Third Next Available Appointment

Partnership's Provider Relations department conducts an annual Third Next Available (3NA) survey. This point-in-time survey assesses the availability of members' access to non-urgent primary care appointments for adult, pediatric, and newborn appointments, as well as urgent care appointments. The 3NA survey also assesses overall telephone accessibility after business hours using the number of rings before the phone is answered, minutes on hold, average wait time before seeing a provider, and if a return call is received within 30 minutes. The results of the 3NA survey show that 100% of Partnership providers met the 2022 performance goal for primary care telephone accessibility. PCPs are held to performance expectations with 2 specific standards of interest. Standard 1 is defined as "the percentage of providers who have a 3rd next available adult and/or pediatric primary care appointment in less than or equal to 10 business days". Standard 2 is defined as "the percentage of providers who have a 3rd next available newborn and/or urgent primary care appointment in less than or equal to 48 hours."

The results of the 3NA survey show that 93.6% of the providers in the Southern region and 100% of providers in the Northern region met Standard 1 for adult primary care

appointments. For all pediatric primary care appointments, the survey results showed that 94.2% of the providers in the Southern region and 100% of providers in the Northern region met Standard 1. Furthermore, the survey results showed that 99.0% of the providers in the Southern region and 100% of providers in the Northern region met Standard 2 for newborn primary care appointments. Finally, 100% of the providers in the Southern region and 100% of providers in the Northern region met Standard 2 for urgent primary care appointments.

Table 13: 2022 Partnership Third Next Appointment Availability

Third Next Available (3NA) Survey Findings 2022							
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment			Percentage of Clinics Meeting PCP Standards		
		North	South	Plan	North	South	Plan
Primary Care Adult	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	3	3	100%	93.6%	96.1%
Primary Care Pediatrics	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	2	2	2	100%	94.2%	96.6%
Primary Care Newborn Appointments	3rd Next Available Newborn appointments within 48 hours of discharge	1	1	1	100%	99%	99.4%
Primary Care Urgent Care	3rd Next Available Urgent Care appointments within 48 hours of request	0	0	0	100%	100%	100%

Source: 2022 Partnership Third Next Available Survey, 2022 Summary

When looking at 3NA primary care appointment access by county, some provider sites in Lake, Mendocino, and Napa counties did not meet all of the standards for appointment accessibility. Any site not meeting the standards is surveyed again and provided with a corrective action plan, as needed.

4. Telemedicine

a. Telehealth Utilization Report

Telemedicine and telephone visit opportunities can help ensure access to needed health care. Partnership uses 2 sources of telehealth data for specialty care: The Telehealth Utilization Report and the eConsult Utilization Report. The Telehealth Utilization Report details video data and shows all video visits completed between a patient, provider, and specialist.

In 2021, telemedicine utilization shows 5,159 visits scheduled and 3,698 (71.7%) completed visits. As of December 2022, Partnership's adult members scheduled approximately 5,808 specialty telemedicine visits through Partnership-contracted specialty telemedicine providers and completed approximately 3,797 (65.4%) of those scheduled appointments. This data represents an increase in both scheduled and completed telemedicine visits in 2022.

Table 14: Adult Telemedicine Appointment Details as of December 2022

Adult Telemedicine Appointment Details as of November 2022					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
5,808	3,797	65.4%	11.9%	11.8%.8	22.3

Source: Adult Telemedicine Appointment Details Report, 2022, Partnership

As of November 2022, the number of scheduled pediatric telemedicine appointments was 385 and the number of completed pediatric telemedicine appointments was 262. From November 2021 to October 2022, the number of completed pediatric telemedicine appointments ranged from approximately 12-25 visits per month, with a high of approximately 37 per month in March 2022. In addition to these telemedicine visits, many primary care providers and network specialists began providing substantial numbers of virtual visits, permitted by DHCS and CMS as part of the COVID response.

Table 15: Pediatric Telemedicine Appointment Details as of November 2022

Pediatric Telemedicine Appointment Details as of November 2022					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
385	262	68.1%	23.6%	8.3%	19.4

Source: Pediatric Telemedicine Appointment Details Report for 2022, Partnership

b. eConsult Utilization Report

The second source of telehealth data for specialty care is Partnership's eConsult Utilization Report. This report shows the utilization data of the online eConsult platform. This platform is where providers can directly message specialists regarding patient care; by using this method, the needs of the patients can be met without requiring a face-to-face visit.

As of December 2022, there were 1,917 adult eConsults completed. Of those, 48.8% were closed because the patient's needs were addressed remotely, while 48.0% were referred to face-to-face services.

Table 16: Adult eConsult Utilization Report, 2022 Partnership

Adult eConsult Utilization Report as of November 2022				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,917	1,901	48.8%	2.6	48.0%

Source: Adult eConsult Utilization Report, 2022 Partnership

As of December 2022, there were 102 completed pediatric eConsults (Partnership Telemedicine eConsult Utilization Report, 2022). 68.4% were closed because the patient's needs were addressed through the eConsult, while 25.5% of consults were referred to face-to-face services.

Table 17: Pediatric eConsult Utilization Report, As of December 2022 Partnership

Pediatric eConsult Utilization Report as of November 2022				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
102	98	68.4%	3.5	25.5%

Source: Pediatric eConsult Utilization Report, 2022 Partnership

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

F. Member Experience of Care

1. Satisfaction with Health Plan

Partnership contracted with SPH Analytics to perform the 2022 CAHPS survey. The report is based on data as of July 2022. SPH reached out to 2,700 adult members and the guardians of 4,125 pediatric members to participate in the survey. There were 372 adult responses (14.1% of those surveyed) and 587 pediatric responses (14.5% of those surveyed).

The CAHPS results discovered that 87.2% of adult respondents answered “Always” or “Usually” when asked if they received helpful information or were treated with courtesy and respect. This measure is collectively referred to as Customer Service. In 2021, only 85.6% of adult members rated Customer Service as “Always” or “Usually. This represents a modest increase of 1.6% from the 2021 survey results. This is a positive trend given that between 2020 and 2021, there was a 2% decrease in satisfaction (decrease from 88.3% to 85.6%).

Other categories showed a decrease in satisfaction. Adult members were less satisfied with the Rating of Health Plan (decrease from 74.0% to 69.9%), Getting Needed Care (decrease from 81.6% to 76.0%), and the Ease of Filling Out Forms (decrease from 93.7% to 91.8%). The decrease in Getting Needed Care and the decrease in the Rating of Health Plan measures of particular concern, as these areas each decreased by 5.6% from 2021 values.

Table 18: 2022 Adult CAHPS Summary Composite Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2021*** (Previous Reporting YR)	***2022*** (Current Reporting YR)
Rating of Health Plan (% 8, 9, or 10)	74.0%	69.9%
Getting Needed Care (% Always or Usually)	81.6%	76.0%
Customer Service (% Always or Usually)	85.6%	87.2%
Ease of Filling Out Forms (% Always or Usually)	93.7%	91.8%

*Source: At-A-Glance Report, 2022 Medicaid Adult CAHPS 5.1 H, 2022, SPH Analytics (p. 10). *Green indicates an increase in score from the previous reporting year; Red indicates a decrease in score from the previous reporting year.*

The 2022 Child CAPHS survey results showed that 95.4% of those completing forms on behalf of pediatric members rated their child's Rating of the Health Plan as good or excellent (scores of 8, 9, 10) compared to 2021 results where 96.1% rated their healthcare as high. This represents a decrease of 0.7% from the 2021 report. The remaining survey responses also decreased for pediatric members: Getting Needed Care decreased from 80.7% to 79.6% of members; Customer Service decreased from 88.7% to 80.7%, and Ease of Filling Out Forms decreased from 96.1% to 95.4%.

Table 19: Adult CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2021*** (Previous Reporting YR)	***2022*** (Current Reporting YR)
Rating of Health Plan (% 8, 9, or 10)	84.8%	82.2%
Getting Needed Care (% Always or Usually)	80.7%	79.6%
Customer Service (% Always or Usually)	88.7%	80.7%
Ease of Filling Out Forms (% Always or Usually)	96.1%	95.4%

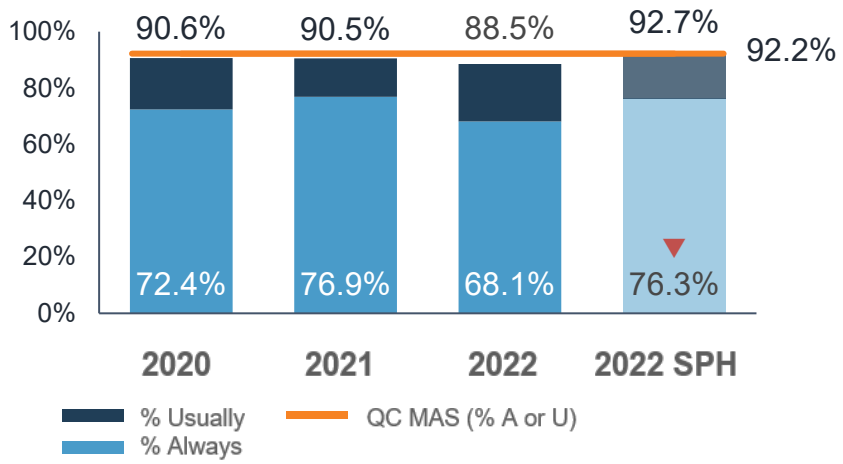
Source: At-A-Glance Report, 2022 Medicaid Child CAHPS 5.0 H, 2022, SPH Analytics (p. 10). Red indicates a decrease in score from the previous reporting year.

2. Doctor Communication

Partnership uses the 2022 CAHPS survey data to evaluate how satisfied members are with the interactions they have with their doctors. The score is a composite, comprised of indicators measuring how well a member's personal doctor explained things, if they listened carefully, showed respect, and if the doctor spent enough time with them.

The percentage of adult members who felt their personal doctor communicated well with them always or usually decreased on aggregate from 90.5% in 2021 to 88.5% in 2022 as compared to the Quality Compass (QC) score shown in the tables below. Partnership scored below the 2022 SPH Analytics Benchmark in all aspects of how well doctors communicate with Partnership adult members.

Figure 13: 2022 Adult Composite CAHPS Survey Result

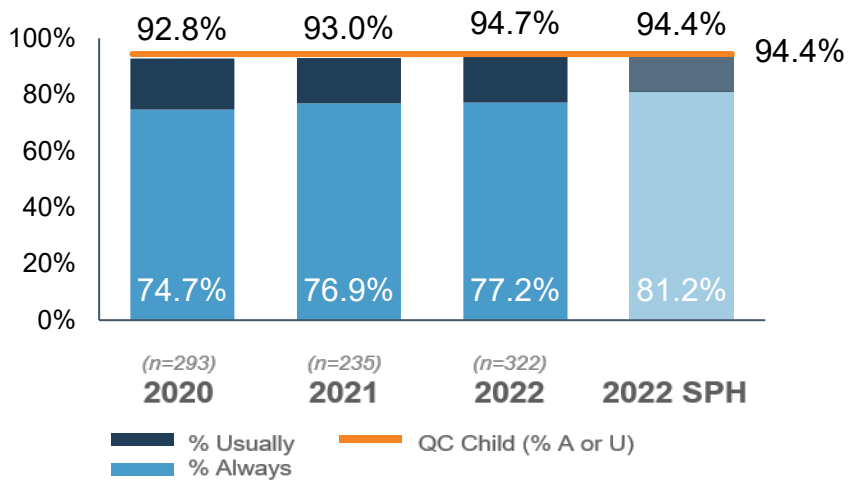


Source: MY 2021 CAHPS Medicaid Adult 5.1 Survey, Partnership, 2022

The results of the Child CAHPS Survey show that members rated their care experience with children's providers higher than providers for adults. The percentage of child members who felt their personal doctor communicated well with them always or usually increased on aggregate from 93.0% in 2021 to 94.7% in 2022. As a result of this minor increase, Partnership's 2022 aggregate score is almost equal to the 2022 SPH Benchmark (94.7% vs. 94.4% respectively) for how well doctors communicate with Partnership child members.[27]

[27] SPH Analytics, 2022

Figure 14: 2022 Child Composite CAHPS Survey Result



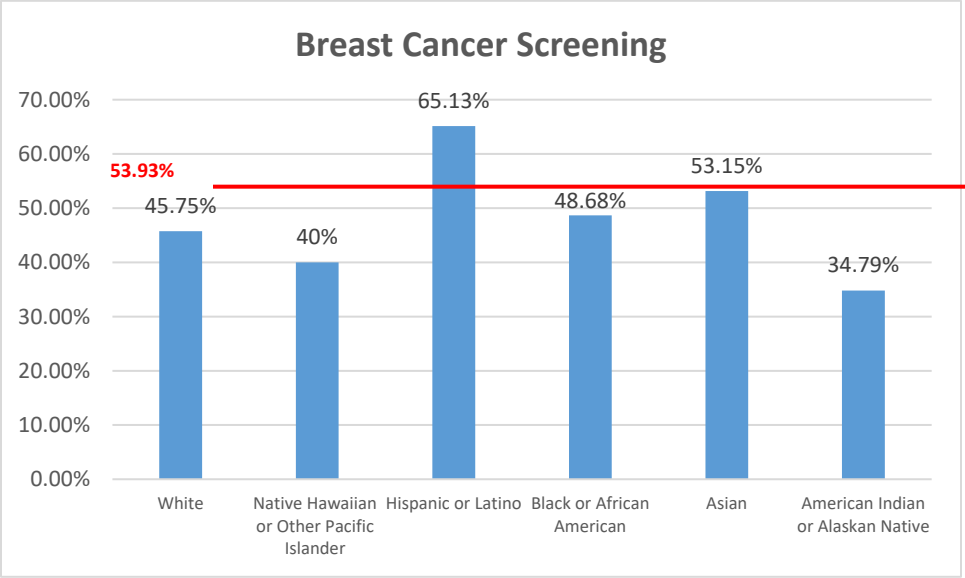
Source: MY 2021 CAHPS Medicaid Child 5.1 Survey, Partnership, 2022

G. Health Disparities

1. Breast Cancer Screening

Within the members eligible for Breast Cancer Screening (BCS) in measure year 2021, only 34.79% of American Indians or Alaskan Natives completed screening, which is below the 53.93% Minimum Performance Level (MPL) and a decrease from the previous year (37.6%). The White population (45.75%) also has care gaps for BCS, and Partnership continues to pursue means to improve this metric. In contrast, the Hispanic or Latino population had the highest Breast Cancer Screening rate (65.13%), and was the only population above the MPL for this measure.

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

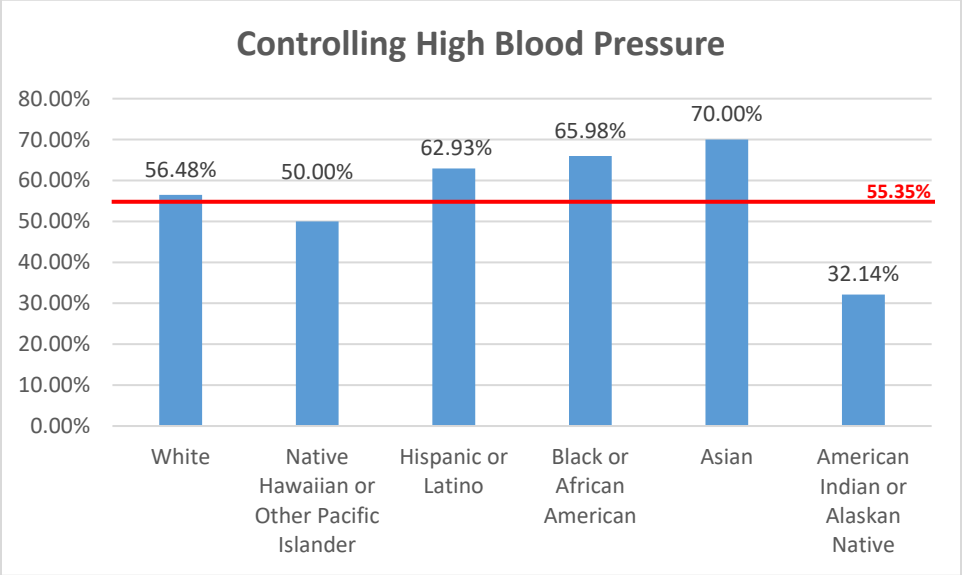


Source: 2021 MY Health Disparities Data, Department of Healthcare Services

2. Controlling High Blood Pressure

Like the previous measure, Americans Indians and Alaskan Natives had the lowest rate (32.14%), significantly below the MPL (55.35%). Although a much smaller sample size compared to the White population, the Asian population had the highest rate (70%), while the White population was 56.48%, just slightly higher than the MPL.

Figure 16: 2021 Controlling High Blood Pressure

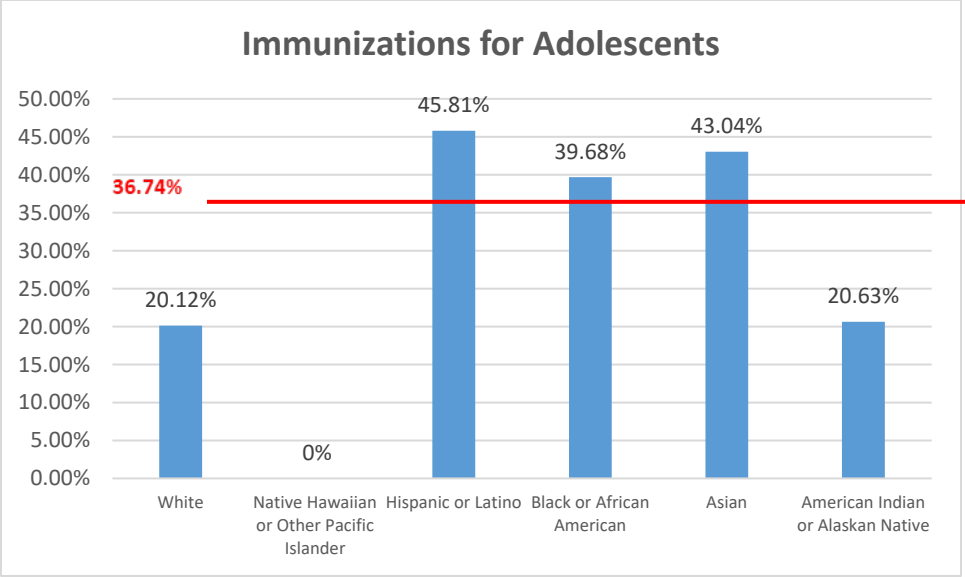


Source: 2021 MY Health Disparities Data, Department of Healthcare Services

3. Immunizations for Adolescents

Of the adolescent members eligible for immunizations, 45.81% of the Hispanic/Latino population received Tdap and meningococcal vaccines by age 13, which is higher than the 36.74% MPL. The White and American Indian or Alaskan Native populations had the lowest rates, at 20.12% and 20.63% respectively, both of which are significantly lower than the MPL.

Figure 17: Immunizations for Adolescents (Tdap and Meningococcal)



Source: 2021 MY Health Disparities Data, Department of Healthcare Services

H. Health Education, Cultural & Linguistic Gap Analysis

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

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

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

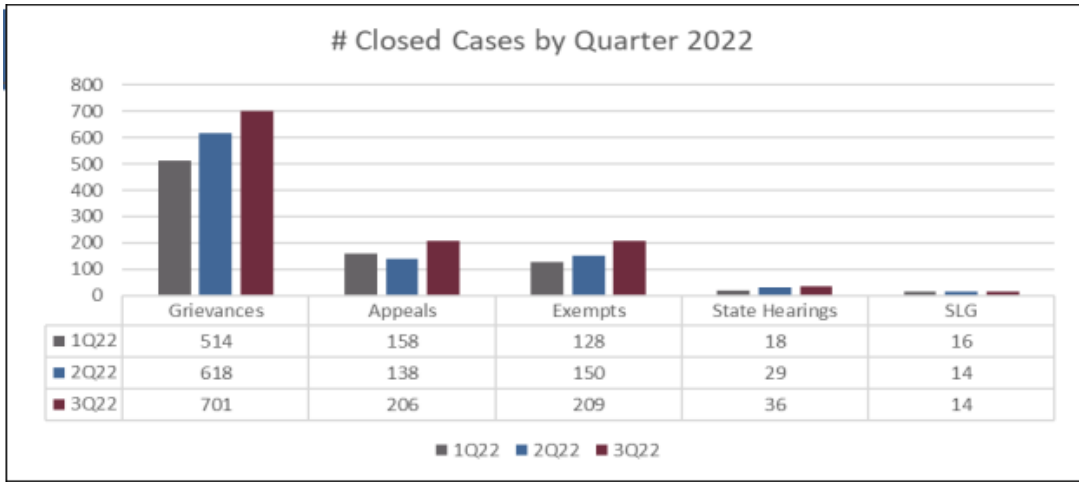
The Health Education team is also responsible for the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination, and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities. They also review and recommend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

1. Grievance and Appeals

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

As of the close of the third quarter in 2022, the Grievance team investigated 2,840 cases, representing a decrease from the 2,949 cases for member reported grievances in 2021.

Figure 18: Number of Closed Cases by Quarter 2022



Source: Q4 2022 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2022 were White (56.17%), Hispanic (14.32%), Other (10.29%), No Response (8.23%), and Black/African American (8.06%).

Figure 19: G&A Pulse Report by Members Ethnicities vs. Partnership Overall Membership by Ethnicity

3Q22 % CASES BY ETHNICITY		
MBR Ethnicity	% Cases	% Membership
White	56.17%	38.40%
Hispanic	14.32%	30.10%
Other	10.29%	12.00%
No Response	8.23%	7.80%
Black (African American)	8.06%	5.30%
Alaskan Native or Amer. Ind	2.40%	2.20%
Filipino	0.43%	1.80%
Asian Indian	0.09%	0.70%
Grand Total	100.00%	98.30%

Source: Q4 2022 Partnership G&A Pulse Report, Partnership

In 2022, Partnership identified a disparity in grievances reported by member race/ethnicity and by language. The grievances reported are not proportionate for the percentage of different races/ethnicities and languages within Partnership's membership. Between 2021 and 2022, the proportion of grievances shifted further away from alignment with the demographics of Partnership members.

Grievances reported by White members increased from 55.75% in 2021 to 56.17% in 2022, despite the overall percentage of White members decreasing from 39.2% to 38.4% in the same period. Grievances reported by Hispanic members decreased from 15.98% in 2021 to 14.32% in 2022, although there was an overall increase in the percentage of Hispanic members from 29.5% to 30.1%. Grievances from members with an ethnicity categorized as "Other" decreased from 18.85% in 2021 to 10.29% in 2022. Grievance reporting increased most significantly between 2021 and 2022 in the Black/African American demographic, where grievance reporting increased from 4.83% in 2021 to 8.06% in 2022. Finally, while Partnership's 2021 data was able to capture the race/ethnicity of all members filing a grievance, the number of "Unknown" race/ethnicities was 8.23% in 2022.

Table 20: Grievances by Race/Ethnicity Over Time

Member Race/Ethnicity	2021 % of Cases	2021 % of Membership	2022 % of Cases	2022 % of Membership
White	55.75%	39.2%	56.17%	38.4%
Hispanic	15.98%	29.5%	14.32%	30.1%
No Response/Unknown	–	8.5%	8.23%	7.8%
Black/African American	4.83%	5.4%	8.06%	5.3%
Other	18.85%	11.7%	10.29%	12.0%
Native American or American Indian	1.95%	2.3%	2.40%	2.2%
Asian & Pacific Islander	2.63%	4.3%	0.52%	2.5%

Source: 4Q2021 & 4Q2022 Partnership G&A Pulse Report, Partnership HealthPlan of California; December 2021 & 2022 Membership by Ethnicity, Partnership Membership Data

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

Figure 20: G&A Pulse Report by Members Language vs. Partnership Overall Language Profile

3Q22 % CASES BY LANGUAGE		
MBR Language	% Cases	% Membership
English	92.02%	77.90%
Spanish	7.12%	19.30%
Other	0.86%	2.00%
Russian	0.00%	0.50%
Tagalog	0.00%	0.30%
Grand Total	100.00%	100.00%

Source: Q4 2022 Partnership G&A Pulse Report, Partnership

The percentage of English-speaking members who reported grievances decreased from 93.68% in 2021 to 92.02% in 2022. Grievances in Partnership's other languages were

low in 2022, however, compared to 2021, grievances in Spanish increased from 5.40% in 2021 to 7.12% in 2022.

Table 21: Grievances by Language Over Time

Language	2021 % of Cases	2021 % of Membership	2022 % of Cases	2022 % of Membership
English	93.68%	79.1%	92.02%	77.9%
Spanish	5.40%	18.2%	7.12%	19.3%
Other	-	1.9%	0.86%	2.0%
Tagalog	0.11%	0.5%	0.00%	0.30%
Russian	-	0.30%	0.00%	0.50%

Source: 2020 & 2021 Partnership Grievance and Appeals Data, Partnership; December 2020 & 2021 Membership by Ethnicity, Partnership Membership Data.

2. Diversity, Equity, and Inclusion Training

a. Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusion is through an annual Health Equity Week for staff. In alignment with the Martin Luther King Jr. holiday (the third week of January), a project team designs emails, videos, and interactive activities to raise staff awareness of the diversity of Partnership's employees and members, and how to respectfully interact with others. Below are the results of Health Equity Week 2022.

Table 22: LMS Completion Report for Health Equity Week 2022 Activities

LMS Activity	Total Completions
Health Equity Workforce Survey	53
Activity 1	73
Partnership's Health Equity Journey: The Past	111
Partnership's Health Equity Journey: The Present	96
Partnership's Health Equity Journey: The Future	88
A Tale of Two Zip Codes	73

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

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There is at least one mandatory educational session per year.

As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of February 2, 2023, there were 896 Partnership employees.[28] In 2022, Partnership employees completed the following trainings:

- 906 Partnership staff completed Cultural & Linguistics Program Overview and Staff Training (eCourse)
- 833 Partnership staff completed Diversity, Inclusion, and Belonging (eCourse)
- 882 Partnership staff completed Diversity, Equity, and Inclusion Training for Employees (eCourse)
- 930 Partnership staff completed Affordable Care Act – Section 1557 (eCourse)
- 857 Partnership staff completed Improving Health Outcomes for People Living in The Crisis of Poverty (687 in-person and 170 online)
- 655 Partnership staff completed Gender Inclusivity (in-person)[29]

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

b. Provider Training

Partnership actively reviews and offers training to contracted providers to improve member experience and reduce unintended bias, discrimination, and health disparities. In 2023, Partnership will host a 3-part training series for providers on Healthy Equity. Session 1 taking place on June 13, 2023, will cover Implicit Bias. Session 2 will occur on July 18, covering the definition of health equity and strategies to improve organizational practices. Session 3 on August 15 will present toolkits to support health equity. See Appendix C for the event flyer.

Partnership will continue to offer providers at least one training opportunity per year on equity, cultural competency, bias, diversity, and inclusion to align with NCQA and DHCS quality standards.

IV. Review of Activities, Resources, and Opportunities

Over the past 25 years, Partnership has cultivated strong relationships with the provider community, public health, and community-based organizations on behalf of its

[28] Partnership Human Resources, 2022
[29] Partnership Human Resources LMS Data for Health Equity, 2023

members. Partnership has established 4 regional offices to maintain a community presence and ensure members have local access to someone who can address their concerns.

Each year Partnership leadership takes the opportunity to review existing programs, resources, and structures to ensure they meet member needs. Department directors collaborate with the executive team to review Partnership's strategic plan and ensure Partnership resources are aligned with its mission and the evolving environment. Departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet Partnership's various initiatives. The 2023 PNA demonstrates how Partnership addresses member needs through various activities. To best support both health and overall wellbeing, Partnership works closely with provider and community resources to ensure members have access to a wide range of services. However, this PNA also revealed opportunities to address needs in the areas of organizational structure; social and environmental needs; member health and wellness; access to care; health disparities; health education; and culture and linguistics.

A. Organizational Structure

Partnership's primary project in 2022 was moving to a new claims system, which is due to go live in June 2023. The IT department devoted several years to identifying and migrating to a new system, which affects other Partnership IT systems. Once the new claims system is implemented, there are several other projects planned to help Partnership meet the needs of its population, including a move to a new Grievance platform, and integration of the planned DHCS PHM Service platform. The PHM Service will promote data sharing between managed care plans, providers, the state, and members, and will provide standardized criteria to segment the population into subpopulations for intervention. The new claims system will be sufficient for Partnership's future needs and provide a framework on which Partnership may build additional IT structures to meet the needs of the organization and our members.

In addition to changes in the information system supports, Partnership identified the need for an organizational leader in health equity. The new position of Director of Health Equity was filled in January 2023, and serves as Partnership's Chief Health Equity officer overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. Partnership also added an Associate Director of Workforce Development, tasked with creating a long-term vision and pipeline for health care workers within Partnership's service area.

Within Partnership, there are teams who work to build relationships with community partners and other stakeholders. These teams represent Partnership at various

community collaborative meetings and learn about the ongoing needs of communities. This is one way that Partnership remains in the know about the needs of the counties and communities it serves. Through relationships established in these meetings, organizations work together to conceptualize and implement interventions for health concerns or disparities. In addition to these community partner-facing teams, Partnership's medical directors regularly meet with clinic medical directors to discuss the clinical needs of patients, and they work together to make connections and find solutions for the providers and the members. There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website. Additionally, internal staff may use these community resources to augment Partnership's program offerings through closed-loop referrals. Partnership has identified many community resources that are integrated into member care; however, there is more to be done.

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

B. Social and Environmental Needs

1. Housing Shortage

As with many communities across the US, Partnership has a significant homeless population and an even larger percentage of members who struggle to maintain housing. California has a shortage of affordable housing. State funds and initiatives like the CalAIM Community Supports service or the Homeless and Housing Incentive Program (HHIP) provide means for managed care plans to offer grant funding to address housing concerns. Recently, Partnership partnered with Yolo County, Sutter Health, the City of Davis, and the Yolo community to open a new innovative 4 story multi-use building that supports the area's unhoused community. The new housing, Paul's Place, offers a day-use resource center and emergency, transitional, and permanent supportive housing.

Housing and homelessness are chronic concerns for managed care plans; however, Partnership has dedicated sufficient staff resources to manage these programs and to collaborate with other community agencies in addressing these challenges.

2. Low Income and Unemployment

Partnership members experience more social and structural barriers to health and wellbeing than many in the state of California. Ten of Partnership's counties have household incomes below California's state average. Unemployment can make it difficult for Partnership members to access basic needs like housing and food for themselves and their families. There are often insufficient resources in communities to provide living-wage jobs for residents. In collaboration with community partners, Partnership is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes. Partnership has a workforce development taskforce dedicated to this challenge.

In 2022, Partnership offered scholarships to Sacramento City College's Community Health Worker (CHW) Certificate Program to help create employment opportunities for members. There was one member interested, but they were unable to continue with the training; there were no other applicants, and no scholarships were distributed in 2022. For 2023, the CHW Training Program Scholarship Opportunity is continuing in partnership with Sacramento City College for their fall program cycle. Because CHW services are now a Medi-Cal benefit (APL 22-016), there is heightened interest in opportunities to become certified. Partnership aims to provide 20 scholarships for this program in 2023. Many providers and community-based organizations are also exploring means of leveraging CHWs in their service offerings.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. One of the ways Partnership has provided support for vulnerable members living in fire-prone areas is by performing member outreach, leveraging tools provided by local utility companies and public health departments. For the purpose of this campaign, vulnerable (or disabled) members are those who are homebound, requiring oxygen support (ventilator, home oxygen, or CPAP), dialysis, or 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 emergencies. The resources allocated to these efforts are sufficient for Partnership member needs.

4. Tobacco Use

Several Partnership counties have adult smoking rates that are higher than the state average. Lake County has expressed significant concerns about the number of adolescent and younger children who are using tobacco products, and requested help from Partnership to mitigate this issue. Partnership is planning a pilot in 2023–24 to engage school youth with tobacco education training and prevention to promote a smoke-free future. In addition, Partnership will maximize support for schools in Lake County through DHCS's Student Behavioral Health Incentive Program (SBHIP), other student behavioral health programs, and through other opportunities for funding and collaboration that address tobacco and SUD prevention efforts.

C. Member Health and Wellness

1. Chronic Disease

HEDIS performance measure reporting provides some insight into the overall health and wellbeing of health plan members. DHCS has recently set large efforts into motion on the front of CalAIM, including the creation of the Population Health Management (PHM) Policy Guide, which DHCS has named "the cornerstone" of CalAIM.[30] The PHM Policy Guide includes a mandate for Managed Care Plans to include chronic disease basic population health management (BPHM) programs that address hypertension, diabetes, asthma, and depression.

These programs align with PNA findings showing that hypertension is the most common chronic disease in our adult population. To combat hypertension, Partnership collaborated with providers and other community agencies to provide member education and referrals for recently diagnosed individuals. Partnership developed an outreach campaign to encourage African American/Black members to attend regular doctor appointments, take anti-hypertensive medications as prescribed, and make healthy lifestyle changes. In addition, member-facing teams within Partnership worked with Touro University's Mobile Diabetes Education Center (MOBEC) to reach members with diabetes and hypertension. At these mobile event days, Partnership staff engaged with the communities in Solano and Napa Counties, connecting members to a PCP and educating them on their Medi-Cal benefits. This partnership helps address the management of some chronic conditions through ongoing BPHM support. If more community partners are identified, these interventions could be expanded to more communities and members.

[30] Department of Health Care Services DHCS, 2022

Partnership members in all regions face health challenges, though there are regional variations in health. For example, pediatric members with asthma who live in Partnership's Northern Region have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer asthma control. There may be other contributing factors, as well. In order to better understand and support these members, Partnership trained staff to coach parents of these members on how to better control asthma without the use of rescue medications in a 2022 pilot program. While the program was well received by those who participated, very few contacted members opted into it. Using lessons learned, Partnership's Pharmacy department crafted an alternative asthma management program, currently being piloted. There are sufficient resources to perform this new program, and Partnership will review its efficacy in 2024.

Partnership has also developed a pilot BPHM program offering to help manage depression for members who recently suffered a stroke or a myocardial infarction. This pilot program will meet DHCS requirements for a depression intervention program and test the benefits of having non-clinical staff provide life-style coaching for depression. Currently, Partnership has staff dedicated to this program, although more staff resources are budgeted should current staffing prove insufficient.

2. Health Screening

To address the need for cancer screening, Partnership partnered with Alinea Mobile Imaging to bring mobile mammography imaging to rural communities and health centers lacking access to mammography sites. Mammography is a proactive screening that detects breast cancer, and providers had the opportunity to follow up with anyone who had findings on their imaging. Throughout 2022, there were 20 mobile mammography clinics conducted in 5 Partnership counties (Humboldt, Sonoma, Solano, Napa, and Marin). This has been a successful partnership, and will be expanded in 2023 to reach more members. There are sufficient resources for this endeavor.

3. Wellness Care

Finally, Partnership is making significant investment into expanding services for birthing persons and children. Building off successful programs from prior years, Partnership now performs outreach to all members from gestation through age 6 offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teen visits for vaccinations and wellness visits. Partnership has allocated staff, incentive dollars, and time to collaborate with schools and public health officers, which has resulted in school-based clinics, poster contests, and other marketing

strategies to promote childhood wellness care. The resources allocated are sufficient for these efforts, and Partnership will evaluate the impact of these activities through appropriate reports and multi-disciplinary committees.

D. Access to Care

Partnership operates in a broad service area encompassing urban, suburban, rural, and frontier settings. Partnership's provider network is challenged by a national shortage of providers, combined with the effects of COVID on health care providers and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers. Currently, Partnership sponsors a workforce development program that offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and if they come from a county outside of the 14 that Partnership serves. Although this work is already started and in place, a long-term strategy is essential to address the provider shortage in Partnership's service area.

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

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

- Launching a primary care pilot program using a telehealth service called TeleMed2U
- A retrospective assessment of specialty providers to better use telehealth during the pandemic
- Provider-specific improvement plans
- Continued support of the QIP program for primary care
- Utilization of the transportation benefit to allow members to attend provider appointments[31]

Furthermore, Partnership is exploring means of encouraging provider facilities to improve access for members with disabilities. Partnership is forming a work group to research resources that will help providers create facilities that are more physically accessible for seniors and members with disabilities. For example, workgroup members will survey possible grants that may help providers upgrade their facilities, and create a

[31] Partnership HealthPlan of California Provider Relations, 2022

list of sources for durable medical equipment (DME) to make it easier for providers to serve seniors and disabled members.

E. Health Disparities

The PNA revealed notable care gaps between racial/ethnic groups. Compared to Whites (45.75%), rates of breast cancer screenings among Hispanic/Latinos (65.13%) were highest, while these rates were the lowest among American Indian/Alaskan Native (34.79%). Controlled high blood pressure was the worst among the American Indian/Alaskan Native population (32.14%) compared to Whites (56.48%) and Asians (70%). Finally, Hispanics had the best rates for adolescent immunizations (45.81%), whereas Whites (20.12%) and American Indian/Alaskan Natives (20.63%) had the lowest rates of adolescent immunizations. In 2023, Partnership has a strategy to continue to strengthen relationships and collaboration with tribal health providers in Humboldt County, in order to decrease identified health disparities between American Indian and non-American Indian members. While there are sufficient resources currently allocated to strengthen existing relationships, Partnership has identified an opportunity to develop a position of Tribal Liaison to provide a more formal point of contact and advocate for American Indian needs.

F. Health Education, Culture & Linguistics

A common concern described in local community needs assessments is how few Medi-Cal members know their benefits and how to use them. While managed care plans have several departments dedicated to member support, Partnership recognized an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, and the distribution of educational materials at community outreach efforts. Partnership will also partner with community groups to offer educational sessions to members, particularly non-English speaking members, about available benefits such as vision, mental health services, and preventative care services.

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

there are sufficient resources allocated, there are likely opportunities to find additional ways to educate members on their rights and how to exercise them.

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by hosting regular employee forums, as well as staff and provider trainings. The goal of these forums and staff trainings are 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.

V. Stakeholder Engagement

The Partnership Health Education team solicits stakeholder engagement on the PNA through multiple pathways. The Health Education team uses reports from pertinent departments to draft the report. The PHM&HE Committee reviews and provides feedback on the final draft of the PNA, along with proposed interventions. The Health Education team gathers member feedback through Partnership's Consumer Advisory Committee (CAC) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with the proposed recommendations, and their feedback is incorporated in the final report.

The PNA then undergoes review by Partnership's Internal Quality Improvement (IQI) Committee, Partnership's Quality/Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Commissioners before submission to the National Committee for Quality Assurance (NCQA) annually, and DHCS every 3 years, per regulatory requirements.

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

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A. Appendix Source: HEDIS® MCAS Regional Performance Report Year 2022; Measurement Year 2021

Select Report Year

Report Year 2022; Measurement Year 2021

Select Provider Type

All Providers

HEDIS Regional Performance
Report Year 2022; Measurement Year 2021
Performance Relative to Quality Compass® Medicaid Benchmarks

- 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)

Measures	Regional Performance				National Medicaid Benchmarks			
	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Breast Cancer Screening (BCS)*	46.93%	40.73%	52.67%	53.14%	48.07%	53.93%	58.70%	63.77%
Cervical Cancer Screening (CCS)	48.91%	55.12%	61.52%	57.45%	51.80%	59.12%	63.66%	67.99%
Childhood Immunization Status (CIS) - Combo 10	18.25%	32.60%	40.63%	41.61%	31.87%	38.20%	45.50%	53.66%
Chlamydia Screening in Women (CHL)*	46.65%	53.47%	62.81%	57.82%	48.29%	54.91%	61.75%	66.15%
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9%)	42.82%	40.63%	36.50%	37.23%	51.90%	43.19%	38.37%	34.06%
Controlling High Blood Pressure (CBP)	62.81%	49.15%	61.22%	62.29%	50.61%	55.35%	62.53%	66.79%
Immunizations for Adolescents (IMA) - Combo 2	19.22%	21.41%	47.20%	44.53%	30.90%	36.74%	43.55%	50.61%
Prenatal and Postpartum Care (PPC) - Postpartum Care	79.44%	83.46%	88.96%	93.24%	71.11%	76.40%	79.56%	83.70%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	76.01%	72.31%	88.41%	91.30%	79.32%	85.89%	89.29%	92.21%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - BMI Percentiles	85.12%	77.78%	76.10%	80.78%	69.19%	76.64%	82.73%	87.18%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - Counseling for Nutrition	68.78%	72.59%	79.51%	79.32%	61.07%	70.11%	76.64%	82.48%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC) - Counseling for Physical Activity	66.83%	70.62%	76.34%	76.16%	55.79%	66.18%	72.81%	79.32%
Well Care Visits (WCV)*	39.92%	41.48%	45.78%	46.89%	39.41%	45.31%	53.83%	61.97%
Well Child 30 (W30) - Well child visits for age15-30 months*	55.47%	56.52%	52.93%	64.05%	66.43%	70.67%	76.12%	82.82%
Well Child 30 (W30) - Well child visits in the first 15 months*	35.38%	36.13%	26.16%	39.88%	44.99%	54.92%	61.25%	68.33%

*- 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.
- CDC-Poor Control is an inverted measure; a lower rate results in a better performance.

2

B. Appendix Top Priority Needs Per County, Identified Through Community Health Needs Assessment

Del Norte County

1. Access to Quality Primary Health Care and Access to Mental Health, Behavioral Health, and/or Substance Use Services
2. Access to Basic Needs (housing, food, jobs)
3. Access and Functional Needs
4. Injury and Disease Prevention and Management
5. Access to Specialty and Extended Care

Humboldt County

1. Early Childhood Education and Development
2. Access to Care
3. Transportation
4. Unintentional Injuries and Violence
5. Nutrition and Education Access

Lake County

1. Access to Health Services
2. Alcoholism
3. Drug Use
4. Housing Stability and Homelessness
5. Mental Health

Lassen County

1. Access to Care
2. Chronic Disease Management
3. Behavioral Health including Substance Use and Depression

Modoc County

1. Access to Care
2. Drug Use and Crime
3. Dental Care
4. Tobacco Use

Marin County

1. Obesity and Diabetes
2. Access to Healthcare
3. Mental Health / Substance Use
4. Economic Security

5. Education

Mendocino County

1. Childhood Obesity and Family Wellness
2. Childhood Trauma
3. Housing
4. Mental Health
5. Poverty

Napa County

1. Food Insecurity
2. Housing
3. Livable Communities
4. Access To and Quality of Healthcare
5. Personal Health Behaviors - Tobacco and Alcohol Use

Shasta County

1. Housing Instability / Affordable Housing
2. Income and Job Stability
3. Mental Health and Wellness
4. Health Wellness
5. Substance Use/Abuse

Siskiyou County

1. Access to Mental/Behavioral Health & Substance Use Services
2. Injury and Disease Prevention and Management
3. Access to Basic Needs
4. Quality Primary Care Health Services
5. Specialty and Extended Care

Solano County

1. Access to Basic Needs (housing, food, jobs)
2. Mental/Behavioral/Substance Use Services
3. Injury and Disease Prevention and Management
4. Quality Primary Care
5. Community Connections

Sonoma County

1. Housing and Homelessness
2. Education
3. Economic Security

4. Access to Care
5. Mental Health and Substance Use/Abuse

Trinity County

1. Access to Dental Care
2. Transportation
3. Community Connectedness / Social Isolation
4. Access to Health Care
5. Maternal and Child Health

Yolo County

1. Access to Mental, Behavioral, and Substance Use Services
2. Injury and Disease Prevention and Management
3. Access to Basic Needs (housing, food, jobs)
4. Active Living and Healthy Eating
5. Access to Primary Quality Care Services

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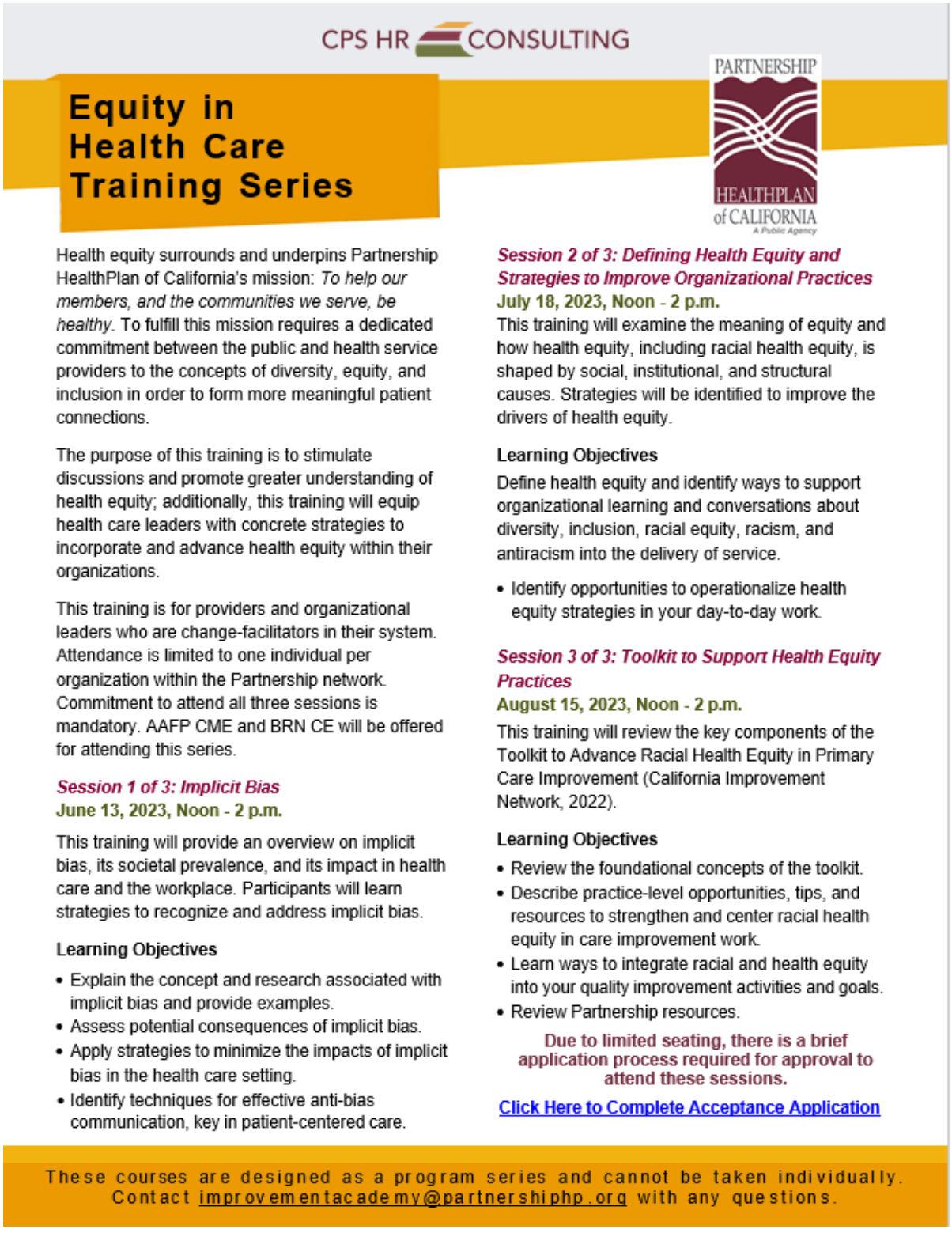
C. Appendix - Flyer for Equity in Health Care Training Series



CPS HR CONSULTING

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Equity in Health Care Training Series

Health equity surrounds and underpins Partnership HealthPlan of California's mission: *To help our members, and the communities we serve, be healthy*. To fulfill this mission requires a dedicated commitment between the public and health service providers to the concepts of diversity, equity, and inclusion in order to form more meaningful patient connections.

The purpose of this training is to stimulate discussions and promote greater understanding of health equity; additionally, this training will equip health care leaders with concrete strategies to incorporate and advance health equity within their organizations.

This training is for providers and organizational leaders who are change-facilitators in their system. Attendance is limited to one individual per organization within the Partnership network. Commitment to attend all three sessions is mandatory. AAFP CME and BRN CE will be offered for attending this series.

Session 1 of 3: Implicit Bias
June 13, 2023, Noon - 2 p.m.

This training will provide an overview on implicit bias, its societal prevalence, and its impact in health care and the workplace. Participants will learn strategies to recognize and address implicit bias.

Learning Objectives

- Explain the concept and research associated with implicit bias and provide examples.
- Assess potential consequences of implicit bias.
- Apply strategies to minimize the impacts of implicit bias in the health care setting.
- Identify techniques for effective anti-bias communication, key in patient-centered care.

Session 2 of 3: Defining Health Equity and Strategies to Improve Organizational Practices
July 18, 2023, Noon - 2 p.m.

This training will examine the meaning of equity and how health equity, including racial health equity, is shaped by social, institutional, and structural causes. Strategies will be identified to improve the drivers of health equity.

Learning Objectives

Define health equity and identify ways to support organizational learning and conversations about diversity, inclusion, racial equity, racism, and antiracism into the delivery of service.

- Identify opportunities to operationalize health equity strategies in your day-to-day work.

Session 3 of 3: Toolkit to Support Health Equity Practices
August 15, 2023, Noon - 2 p.m.

This training will review the key components of the Toolkit to Advance Racial Health Equity in Primary Care Improvement (California Improvement Network, 2022).

Learning Objectives

- Review the foundational concepts of the toolkit.
- Describe practice-level opportunities, tips, and resources to strengthen and center racial health equity in care improvement work.
- Learn ways to integrate racial and health equity into your quality improvement activities and goals.
- Review Partnership resources.

Due to limited seating, there is a brief application process required for approval to attend these sessions.

Click Here to Complete Acceptance Application

These courses are designed as a program series and cannot be taken individually.
Contact improvementacademy@partnershiphp.org with any questions.