Population Needs Assessment

May 2026

Contents

I. Population Needs Assessment Overview

Partnership HealthPlan of California is a not-for-profit Medi-Cal managed care plan (MCP) serving 24 counties in Northern California. As of December 2025, the plan has approximately 893,608 members.[1] Partnership is one of six County Organized Health System (COHS) managed care plans in California, endorsed by its counties' Boards of Supervisors.

Most Medi-Cal beneficiaries, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and those in skilled nursing facilities are automatically assigned to Partnership. In addition, effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. In addition, other dual-eligible Medicare-Medicaid members, who are not Partnership Advantage Members, will be assigned to Partnership as a secondary line of coverage. In 2025, Partnership provided primary and specialty health services through a contracted network of community providers, medical groups, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Centers, local hospitals (acute and other), skilled nursing facilities, pharmacies, and ancillary providers.[2]

Each year, Partnership conducts an overall assessment of the health environment, community needs, and the factors that influence the well-being of the member population. This assessment is required by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). The results of this assessment are used to develop this PNA report, which informs Partnership's Population Health Management Strategy and the corresponding Population Health Management workplan; this assessment may also inform the Cultural & Linguistics (C&L) Program description and its C&L work plan as needed. To develop the 2026 PNA, Partnership integrates and analyzes various data sources, including:

- Partnership Member Enrollment data

[1] Partnership Membership Dashboard, 2025
[2] Partnership Quality and Performance Improvement Program Description, 2025

- Local Community Needs Assessments
- County Health Rankings and Roadmaps
- Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau data
- Published articles and reports from the CDC and other reputable sources
- Partnership Integrated Claims and Encounter data
- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data
- HEDIS Disparities Analysis Summary Dashboard
- Timely Access data
- Partnership Grievance and Appeals data
- Internal Human Resources reports
- Other sources as relevant

Member enrollment data is further segmented by age, gender, race/ethnicity, primary language, geographic distribution, and other factors, to identify gaps in services and health disparities.

Population Health staff completed the analysis and made the decisions included in the report, with cross-departmental input and approval as needed. The writing staff consists of the positions listed in the table below:

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

A. Summary of Key Findings

Partnership's membership remained relatively stable in 2025. At the close of 2025, Partnership served approximately 893,608 members throughout 24 counties. The 2026 Population Needs Assessment draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

1. 2025 Summary of Findings

Local community needs assessments identified a variety of priority areas of need that can be grouped by Healthy People 2030 domains of Social Determinants of Health (SDoH),[3] including:

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

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

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

[3] Social Determinants of Health, Healthy People 2030

Transportation challenges further complicate access to care, especially in remote areas where long distances must be traveled to access healthcare services. Many individuals lack reliable transportation options and geographical isolation exacerbates the difficulty in attending provider visits. Housing issues also remain a constant challenge, with a lack of affordable and quality housing preventing many individuals from securing stable living situations. This issue has remained persistent during 2025, contributing to a continued homelessness crisis across many counties.

In 2025, there were 148 wildfires in Partnership's regions, likely contributing to loss of available housing, and possible adverse pulmonary and cardiovascular effects. Compounding these environmental factors are lifestyle choices like smoking. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties, and some smokers start as early as elementary school.

Partnership utilizes claims and encounter data to approximate disease prevalence among its members. In 2025, hypertension, anxiety, depression, tobacco use, obesity and substance use were the 6 most prevalent conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety, trauma/stress, depression, obesity, asthma, and substance use. Telehealth utilization in general has increased for 2025. Partnership's southern region had the highest number of members accessing specialty mental health services. Breast cancer screening rates and cervical cancer rates in the northern counties also continue to underperform.

To determine if there are health disparities within the overall population served, Partnership reviewed the HEDIS Disparity Analysis Dashboard for Controlling Blood Pressure (CBP). The analysis found that the multiracial group had the poorest rates of blood pressure control for HbA1c in diabetes. Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American populations had significantly higher rates of poor control, performing below the MPL 50th percentile. In contrast, the Asian population had the lowest rate of poor control, performing above the 90th percentile, indicating better control of diabetes. For prenatal care visits, the Asian population had the highest rates of completion, while the Native Hawaiian and Other Pacific Islander population had the lowest. Native Hawaiian and Other Pacific Islanders had the highest rates of postpartum care (100%), while the American Indian and Alaska Native population had the lowest (69.44%). These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others.

2. 2025 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, as well as Member Benefits/Services Education, Health Education, and Culture and Linguistics.

In the realm of organizational structure, in 2025, Partnership has continued to provide teams who work to build relationships with community partners and other stakeholders, including the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). These teams, alongside other population health staff, connect members to local resources and follow up to ensure their needs are met. They also represent Partnership at various community collaborative meetings and events to learn about the ongoing needs of communities.

The position of Director of Health Equity oversees internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. In 2025, the department continued to grow. Additional staff were hired, including 1 Cultural and Linguistic Liaison, a Supervisor of Health Equity Training, and a Manager of Cultural Community. A second position for a Cultural and Linguistic Liaison was also created.

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

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

One of the ways Partnership continues to provide support for members living in fire-prone areas is through a Fire and Disaster Reporting email inbox for member- and provider-facing departments within Partnership. Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area throughout early 2025. The inbox is used as a tool to share information within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. Partnership also posted member materials to Partnership's website comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card.

In the realm of member health and wellness, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer asthma control. In alignment with CalAIM BPHM requirements, Partnership continued the new Asthma Emergency Department (ED) Visit Outreach Program Campaign to better support members with asthma in 2025. The Asthma Management campaign offers additional support to members who were recently seen in the ED for their asthma. To help manage other member chronic diseases, and in alignment with DHCS' Population Health Management requirements, Partnership will continue to support and refine its Basic Population Health Management programs centered on hypertension, diabetes, and depression.

Partnership continued conducting health education sessions around tobacco prevention in counties with high tobacco usage in 2025. Partnership also implemented an ADHD program to help address mental health conditions in children. Furthermore, as part of Partnerships' efforts to improve poor behavioral health outcomes and increase access among K-12 students, Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. Partnership also continues to contract with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and to health centers that do not have ready access to mammography services. With 72 mobile mammography days in 19 different Partnership counties and modest improvements in screening outcomes, Partnership intends to continue this collaboration in 2025. Other organizational efforts in the realm of member health and wellness include efforts to increase cervical cancer screenings and colon cancer screenings.

Finally, Partnership will continue to make significant investments into expanding services for maternal and child health. Partnership performs outreach to all members

with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teen visits for vaccinations and wellness visits. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders which has resulted in plans to conduct school-based clinics, and other strategies to promote childhood wellness care. Partnership will continue to evaluate the impact of these activities through appropriate reports, monitoring efforts, and multi-disciplinary committees.

Efforts to improve access include Partnership's development of a multi-pronged approach to recruit and retain providers. For example, Partnership continued the Provider Recruitment Program in 2025, which focused on helping the contracted network recruit and retain high-quality health professions in Partnership counties; this program provided incentives, including sign-on bonuses. Partnership also has a Provider Retention Initiative (PRI) to recognize primary care clinicians, providers of perinatal services, and/or obstetrics/gynecology, and psychiatrists who are deeply invested in the safety net population, while helping to incentivize additional years of service. These Partnership efforts focus on strengthening recruitment of PCPs, behavioral health providers, mid-levels, and specialists in the areas where access is impacted most, as indicated by high HPSA scores or the "frontier" geographic designation.

Partnership is committed to inclusion and equality of opportunity for staff and members. Partnership hosts Health Equity Week for staff in April with emails, videos, and interactive activities to elevate diversity awareness. Partnership also offered staff training around cultural diversity, linguistics, and gender inclusion, which are all required on a regular basis. In 2026 and beyond, DEI trainings for Partnership will align with new DHCS regulatory requirements.

Partnership is committed to enhancing the member experience by actively reviewing and offering trainings and tools to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2025, Partnership's Cultural and Linguistic and Health Education Team reviewed and updated the comprehensive Cultural and Linguistic toolkit for providers. We also began offering providers regular DEI training to align with NCQA and DHCS quality standards. This training is supported by key staff in the Health Equity Department and will continue in 2026.

American Indian/Alaska Native populations face many health disparities. To help remedy known health disparities, Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area, to decrease known health disparities between American Indian and non-American Indian members. Partnership has been an active participant in several such efforts. Partnership is also heavily involved in other activities geared towards addressing health disparities among other populations and are later described in this report.

To help support health education/culture and linguistics, Partnership shares member-facing videos on relevant topics to help educate members. In 2025, videos were created about colorectal cancer screenings and instructions on how to use the ColoGuard test. Each of Partnership's counties has a dedicated county resource page and the support of Partnership's Population Health Department in accessing those resources. These resources are continuously updated and improved upon, and Population Health staff monitor and follow up on resource needs of members. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services. Furthermore, Partnership Member Services staff are conducting in-person presentations called Member (or Community) Informative Sessions." Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff also provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Finally, Partnership will continue to offer members an opportunity to submit grievances and appeals and will further its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings.

II. Data Sources

A. Overview of Procedures, Resources, and Methodologies

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

- Member demographics such as age, language (including limited English proficiency), race/ethnicity, and geographic location
- Local community needs assessments
- Social Determinants of Health (SDoH), drawn from County Health Rankings

- Service utilization, based on integrated claims and encounter data
- Health conditions and health-related behaviors, based on Partnership's HEDIS data
- Timely Access Data
- Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities, and members with serious mental illness or serious emotional disturbance (SMI/SED), and or both, based on member demographics, and integrated claims and encounter data
- Member satisfaction or lack thereof, based on CAHPS data and member grievance data
- Partnership's Reducing Health Disparities Dashboard (i.e. 2025 Health Disparities data)

1. 2025 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2025. This data includes the total number of individuals enrolled in Medi-Cal and assigned to Partnership by eligibility group. Through daily and monthly releases, DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans based on their contracted service areas. This data includes member-level characteristics such as race/ethnicity, date of birth, gender, language, alternate format selection and eligibility indicators for seniors and persons with disabilities, and membership data for review for enrollment in the California Children's Services Program.

2. Local Community Needs Assessments

The Community Needs Assessment section was compiled using the most recent versions of publicly available Community Health Assessment (CHA), Community Health Improvement Plans (CHIPs), or Local Community Health Needs Assessment (CHNA) reports from each of Partnership's 24-county service area. The reports were published in different years ranging from 2022-2029. Some of Partnership's counties have CHA reports in progress, set to be released in the near future. The reports used to summarize needs in each county are based on the most recent reports available.

3. 2025 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.[4] The 2025 Annual County Health Rankings uses the most currently available data to measure a range of vital health factors, including but not limited to air pollution, adult smoking, severe housing problems, physical inactivity, and food environment index (access to healthy foods). County Health Rankings also typically includes measures such as high school graduation rates, obesity, unemployment, income inequality, teen births, and more. The rankings are modeled after a view of population health that highlights the many factors that influence one's health. If these factors improve, communities thrive and reduce health disparities for subpopulations. The rankings are determined by:

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

4. 2025 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 2025 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services. The data set documents both the diagnosed clinical conditions, and the services and items received by beneficiaries to treat these diagnosed conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. Partnership's paid claims, laboratory results, and encounter data are integrated with state-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims, and claims from our delegated managed behavioral healthcare organization (Carelon Behavioral Health).

5. 2025 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a measurement tool maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used to evaluate clinical quality in a standardized way. The California Department of Healthcare Services (DHCS) and NCQA selects a subset

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

of measures for Medi-Cal plans to report on annually as required for State and NCQA Accreditation reporting. NCQA and DHCS use annual HEDIS performance reporting to evaluate the delivery of quality care and services to its members. For Measurement Year 2025 (MY2025) Partnership will be required to report the HEDIS measures at the plan-wide level to include all (24) counties. The DHCS required reporting measures is referred to as the Managed Care Accountability Set (MCAS); the methodology for each HEDIS measure is described in the annual NCQA HEDIS Technical Specifications corresponding to the measurement year.

Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile based on the National Medicaid benchmarks and varies by each measure.

In addition to the DHCS required reporting, Partnership is also required to report the HEDIS performance for Health Plan Accreditation (HPA). Rate performance and scoring is based on the NCQA Health Plan Rating Methodology. The MY2025 Annual Summary of Performance Report for both the DHCS and HPA was posted on the Partnership HealthPlan website in August 2025. Partnership uses annual HEDIS results to evaluate clinical quality outcomes in a standardized way, and to evaluate health inequities for our members by race, ethnicity, language, and geographic region.

6. 2025 Timely Access Data

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

7. 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

The CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys ask adult members and parents or guardians of child members to provide feedback on a range of categories, such as:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Coordination of Care
- Ease of Filling Out Forms
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan
- Effectiveness of Care Measures

This needs assessment report will focus on the composite scores for the following performance measures concerning adults and children: Rating of Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist.

The CAHPS survey for Measurement Year (MY) 2025 and Reporting Year (RY) 2026 will cover the period from July 1, 2025, to December 31, 2025.

8. 2025 Health Disparities Dashboard

The 2025 health disparities data is taken from Partnership's HEDIS Disparity Analysis Tableau dashboard, in the MCAS County Oversampling Data section. In 2025, Partnership used the assessment methodology developed by the multidisciplinary team to assess health disparities in our newly expanded member population. Both years' analyses are available to all Partnership employees via a Tableau dashboard. This analysis stratifies HEDIS measures by race and ethnicity, language, gender, and housing status. A separate analysis was conducted to assess Partnership's effort to provide culturally and linguistically appropriate services (CLAS). Partnership utilized the measurement year 2024 (MY2024) Managed Care Accountability Set (MCAS) County Oversample data file to evaluate 13 clinical HEDIS measures for this analysis. The rates for each measure are comprised of the members included in each measure's audit for Partnership's DHCS/MCAS required reporting summary of performance report. Partnership's HEDIS vendor, Inovalon, provided the random member sample generated for each measure, along with member race/ethnicity demographic information. Inovalon is classified as a direct data source. This report provides data on health disparities specific to Partnership members.

B. Other Data Sources

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

Partnership regularly reviews published research in areas impacting our population. Partnership leaders and clinicians subscribe to journals that describe evidence-based care, and promising practices to implement among members with complex needs and those with behavioral health or substance use disorders. These journals may include research that addresses SDoH, health equity, and population health management strategies. Partnership also reviews national data sources, such as the CDC and the US Preventive Services Task Force to track national trends and align ourselves with emerging care protocols. For specific demographic information in our various regions, we reference United States Census Bureau reports, which includes the SAIPE State and County Estimates for 2024.

C. Population Segmentation

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

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

III. Key Findings

A. Member Demographics

1. Membership/Group Profile

While member demographic information can fluctuate month to month, at the close of 2025, Partnership served approximately 893,608 Medi-Cal beneficiaries in 24 counties in Northern California. With the passing of H.R. 1 in mid-2025, membership will continue to fluctuate in 2026. Partnership primarily serves children and adults under the age of 65. In 2025, Partnership served approximately 465,144 members between the ages of 21-64, 324,088 members between ages 0-20, and 104,376 members aged 65+. The needs of this population vary and are further described under the Local Community Needs Assessment and throughout this document.

2. Geographic Distribution

Partnership's 6 regional offices are centrally located in Fairfield, Redding, Santa Rosa, Eureka, Auburn and Chico (see Figure 1 below).

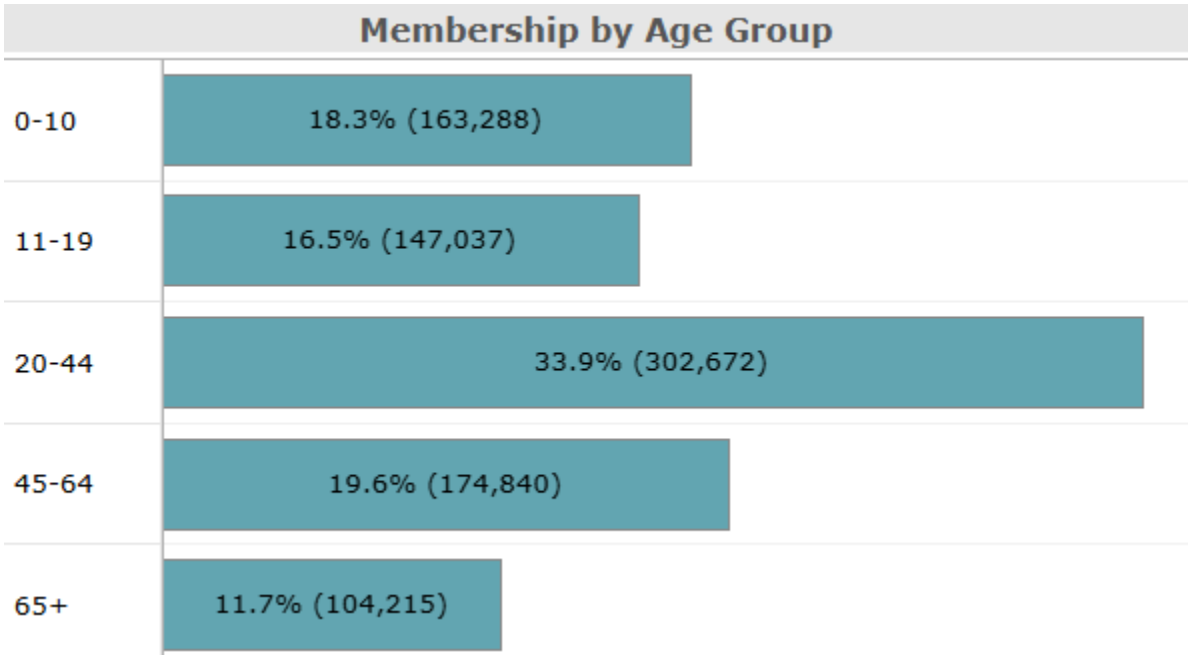
Figure 1: Map of Partnership Counties as of January 2025

Partnership, 2025

3. Age and Gender

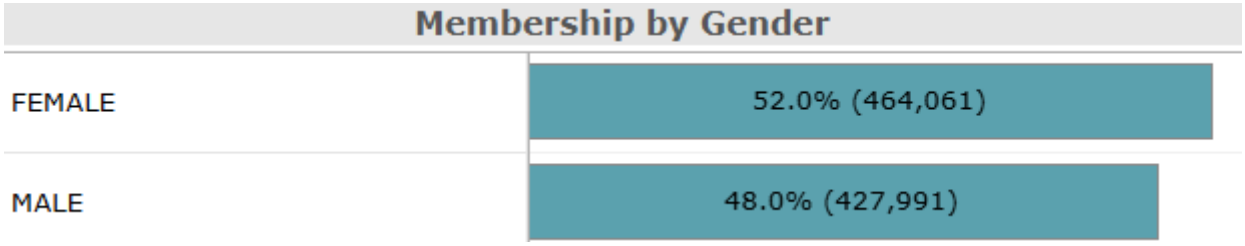
DHCS' definition of children and adolescents is 0-20.[5] According to December 2025 Partnership enrollment data, 18.3% of members are ages 0-10, 16.5% of members are ages 11-19, 33.9% of members are ages 20-44, 19.6% are ages 45-64. Additionally, 52% of members are female while 48% are male (see Figures 2 and 3). There were 11,078 babies born to Partnership members during 2025.

Figure 2: 2025 Partnership Membership by Age Group



Source: December 2025 Member Enrollment Data, Partnership

Figure 3: 2025 Partnership Membership Gender



Source: December 2025 Member Enrollment Data, Partnership

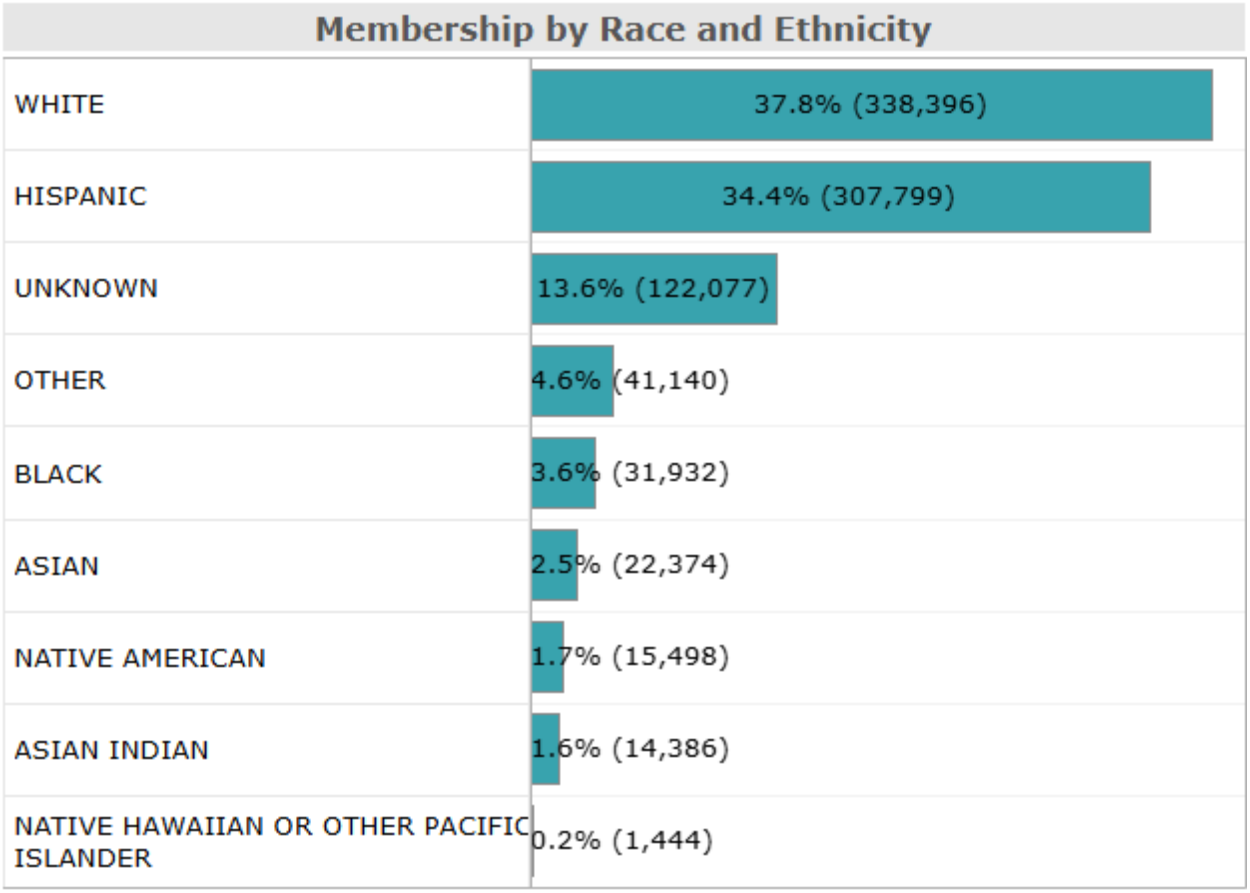
4. Race/Ethnicity

The largest ethnic groups across all 24 counties are White (38%) and Hispanic (34.3%). Figure 4 illustrates the racial and ethnic composition of Partnership's members as of

[5] DHCS Member Information, 2026

December 2025. One limitation with the race/ethnicity category is Hispanic as a category tends to outweigh other races, and multi-racial categories tend not to be reported at all. Furthermore, there are different rates of multiethnic reporting by members when signing up for Medical when compared to the census. This limits the accuracy of interpretation or racial disparities, such that small differences may not need to be intervened upon.

Figure 4: 2025 Partnership Membership by Race and Ethnicity



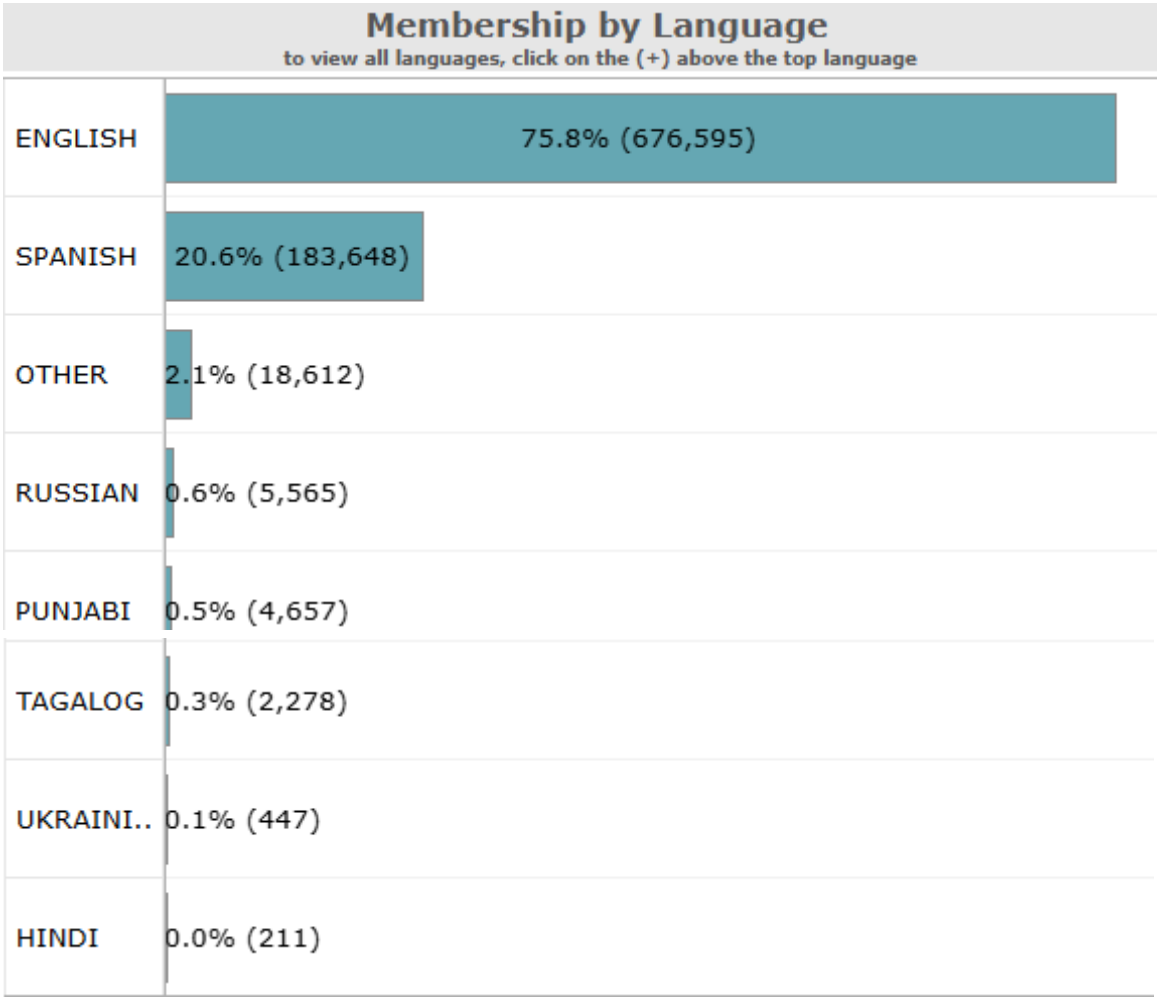
Source: December 2025 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2025 enrollment data, 75.8% of members identify as English speaking and 24% identify as limited English proficiency (LEP). Historically, Partnership had 3 threshold languages – Spanish, Russian, and Tagalog. However, new threshold languages are added as needed. As such, in 2025, Punjabi was added as a threshold language. Members identifying as Spanish speaking total 20.6%. Russian, Tagalog, and Punjabi speakers account for 1.4% of LEP members, while 2.2% of the population speaks a language other than the 4 threshold languages. This data

demonstrates a need to ensure LEP members can access care in their own language to stay healthy.

Figure 5: 2025 Partnership Membership by Primary Language



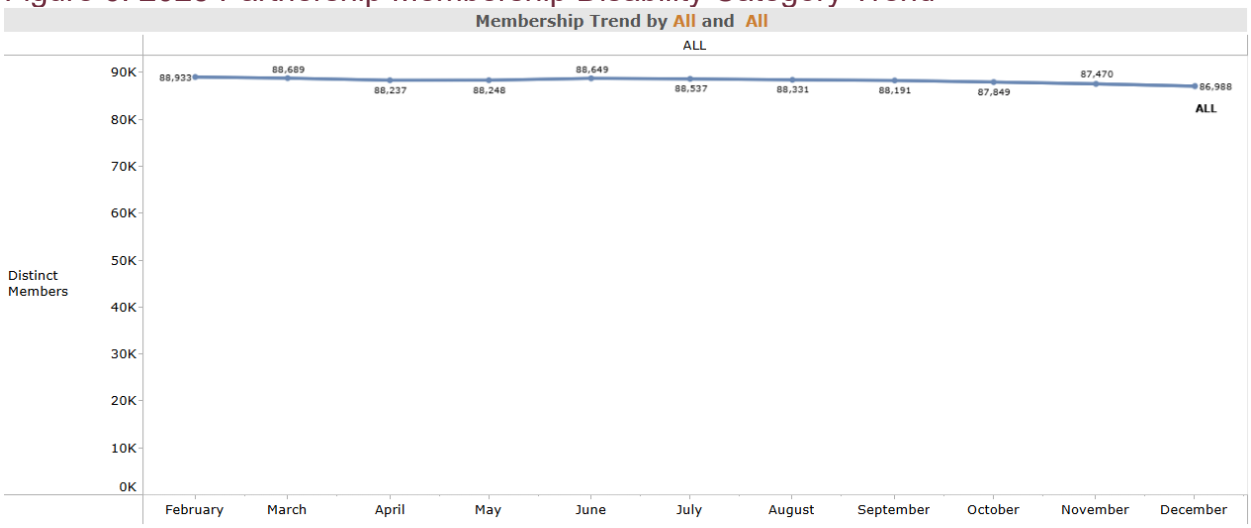
Source: Partnership's December 2025 Member Enrollment Data

6. Disability

Based on December 2025 Partnership enrollment data, approximately 97,609 members are disabled as shown in Figure 6. Furthermore, 9,466 of all disabled members are ages 0-20; 68,612 are ages 21-64; and 22,856 are ages 65 and older. Finally, 49,989 of all disabled members are males, while 47,620 are females.

Furthermore, California Children's Services (CCS) supports children with complex physical health needs. As of December 2025, this program had 10,124 member enrollees. Together this data demonstrates there is a significant number of members with disabilities that may require additional care and resources to remain healthy.

Figure 6: 2025 Partnership Membership Disability Category Trend



Source: Partnership's 2025 Member Enrollment Data

IV. Local Community Needs Assessment

A. Summary of Local Community Needs Assessments

Since January 2024, Partnership's service area has covered 24 counties, each with a diverse demographic makeup.

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

The Local Community Health Assessment section of this report was compiled using the most recent publicly available CHA, CHIP, and/or CHNA reports from the 24 counties, published primarily between 2022 and 2025 by LHJs and/or non-profit hospitals. Although the 24-county service area is geographically expansive and ethnically diverse, there were common priority needs mentioned across each county, many of which could be categorized as SDoH.

The most prevalent SDoH issues across all 24 counties can be grouped into the Healthy People 2030 categories: economic stability; healthcare access and quality; neighborhood and built environment; education access and quality; and social and

community context. Recognizing the prominent themes of the assessments collectively and their alignment within these categories helps to provide clarity on the SDoH impacts to the health of our members.

Economic Stability

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

Healthcare Access and Quality

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

Neighborhood and Built Environment

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

Education Access and Quality

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

Social and Community Context

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

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

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

Despite these challenges, counties have identified opportunities to improve health outcomes through collaboration and leveraging community strengths. Resilience, close-knit communities, successful partnerships, resourcefulness, and existing support programs offer a foundation for positive change which can be leveraged to improve health outcomes through targeted interventions and collective action.

1. Butte County

In 2024, Butte County published its Community Health Improvement Plan (CHIP),[6] focusing on three priority areas: Access to Care, Behavioral Health, and Food Security. These priorities were identified based on the six health needs outlined in the 2023

[6] Butte County Community Health Improvement Plan 2024-2027

Community Health Assessment (CHA).[7] While ongoing efforts are required to address these critical areas, the county has valuable assets at its disposal, including public, nonprofit, and tribal healthcare providers, as well as Community Health Workers. Existing programs, such as the Boys and Girls Club, the Butte County Department of Behavioral Health, culturally tailored support groups, and numerous organizations and collaboratives dedicated to combating food insecurity, will play an integral role. The CHIP aims to harness these resources, focusing on strengthening and improving the county's overall health outcomes in these areas.

2. Colusa County

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

3. Del Norte County

Del Norte County recently completed their 2024 CHA,[9] which identified multiple health needs. These health needs include high rates of substance abuse and mental health challenges, chronic diseases, insufficient oral and healthcare access, poor maternal and child health outcomes, and environmental health risks. Del Norte's CHA revealed multiple strengths which include a resilient community, abundant outdoor resources like trails and beaches, and supportive programs such as CalFresh and WIC that foster collaboration and well-being. These efforts aim to address disparities while leveraging the community's strengths.

4. Glenn County

Glenn County published its CHIP[10] in November 2025, serving as a blueprint for addressing local health needs. It is based on the 2024 CHA,[11] which identified seven priorities: access to resources, medical provider shortage, behavioral health systems, transportation, ACEs, income, and safety. The CHIP focuses on four top priorities:

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[7] Butte County Community Health Assessment Report 2023
[8] Colusa County Community Health Assessment Report 2024
[9] Del Norte County 2024 Community Health Assessment
[10] Glenn County Community Health Improvement Plan Report 2025
[11] Glenn County Community Health Assessment Report 2024

improving access to resources, addressing the medical provider shortage, strengthening behavioral health systems, and enhancing transportation. Despite its small size, Glenn benefits from key assets such as a senior center, substance use disorder programs, and transportation options. Additional strengths include strong interagency partnerships, local non-profit support networks, school-based programs, food distribution services, and community organizations that offer outreach, education, and social support. Leveraging these established networks ensures a coordinated, community-driven approach to enhance health outcomes and equity across the county.

5. Humboldt County

Humboldt County's last CHA was completed in 2018.[12] The CHA showed a range of community health concerns such as access to primary, specialty care and mental health services. New data was revealed during the Community Health Improvement Planning cycle, and Humboldt released an Enhanced Community Health Assessment in 2022, focusing on the Oral Health Assessment and the Youth Report on Substance use in Humboldt County.[13] The 2022 Enhanced Community Health Assessment is the most recently available report, however, Humboldt is actively engaged in a new CHA, initiated in 2025, and Partnership continues to meaningfully engage with this work. The Oral Health Assessment discussed individuals who had complex health or behavioral health conditions, and housing and transportation concerns which impact accessing needed care. This report also identified a lack of access to routine dental care among the population surveyed, with over 90% of respondents stating they had challenges with accessing dental services. The oral health report shared that many of the barriers are due to financial constraints, travel challenges, and lack of providers which has led to a higher number of visits to the emergency room among adults. The Youth Report on Substance Use in Humboldt County is based on a survey called "Your Thoughts on Substance Use in Humboldt." The survey showed responders in Humboldt were largely concerned with the uptake of alcohol and drug use as a means to cope with ACEs. Respondents also expressed the need for community to better support against substance use, and the need for additional substance use prevention.

The 2024 Community Health Needs Assessment (CHNA) by the Southern Humboldt Community Healthcare District focuses on its 775-square-mile service area in northwestern California.[14] The findings align with public health concerns identified in the 2018 Humboldt CHA and the 2022 Enhanced Assessment, but they also highlight emerging challenges within the service area. These include the growing risks posed by wildfires and drought to community health and safety, as well as the limited availability

[12] 2018 Humboldt County Community Health Assessment
[13] 2022 Enhanced Humboldt County Community Health Assessment
[14] Southern Humboldt Community Healthcare District 2024

of affordable housing and unreliable high-speed internet, which are obstacles to economic growth and the recruitment of skilled workers.

6. Lake County

Lake County's most recent CHNA was completed in 2025. The highest priority needs identified were disparities in access to education, housing availability and affordability, and social and economic context (including economic vitality, social inclusion, civic engagement, and place attachment), while lower priority needs included healthcare access, community safety, mental health, climate and natural environment, and financial stability. The CHNA also identified community strengths, including cross-sector CHNA Steering Committee and robust community engagement.

7. Lassen County

As of December 2025, Lassen County has not yet finalized their CHA. However, work is nearly complete. This process began in December 2023 and has been ongoing throughout 2024 and 2025. This is Lassen County's first CHA, and they have faced challenging staffing conditions, which have made it difficult to finalize.

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

8. Marin County

Marin County's 2025 CHA revealed six priority health needs: housing and homelessness, access to care, mental and behavioral health, climate and environment, chronic disease and disability, and income and employment. Housing costs are extreme (median home $1.4M), homelessness disproportionately affects Black residents, and mental health concerns—including a suicide rate of 14.4 per 100k—are rising. Climate risks such as wildfires (291% higher than state average) and flooding compound vulnerabilities. Despite overall affluence, income inequality (Gini 0.47) and racial health gaps persist.[16]

[15] 2022 Banner Health Community Health Needs Assessment
[16] 2025 Marin County Community Health Assessment

9. Mendocino County

The 2024 CHNA for Mendocino County identifies five priority health issues: mental health, community safety, healthcare access, diabetes, and chronic conditions. Mental health needs remain substantial, influenced by limited behavioral health providers, geographic isolation, and high rates of substance use. Community safety concerns including injuries, violence, and substance-related harms continue to affect adolescents and adults, particularly in rural and under-resourced areas. Healthcare access is hindered by ongoing shortages of primary and specialty providers, long travel distances, and transportation barriers, which delay care and worsen health outcomes. Diabetes remains a major concern, with rising prevalence linked to socioeconomic barriers, food insecurity, and limited access to preventive services. Chronic conditions including tobacco use, oral health needs, and other preventable health issues continue to contribute to avoidable illness and early mortality. These challenges are intensified by social determinants of health such as poverty, unstable housing, food insecurity, transportation limitations, and historical trauma in tribal communities, all of which deepen disparities for Indigenous and geographically isolated populations.

10. Modoc County

Modoc County released their last CHNA in January 2024.[17] Modoc's CHNA identifies significant health and socio-economic challenges, particularly in its classification as a rural frontier county. Modoc faces high poverty, unemployment, low educational attainment, and limited access to healthcare. It has higher rates of chronic disease, risk behaviors, and poor physical and mental health when compared to California. These factors are contributing to increased disability and earlier mortality. However, Modoc benefits from less pollution, including cleaner air and water, than most other counties in the state. The community has identified mental health, substance use, chronic disease, and domestic violence as notable concerns. Barriers to health include poverty, inadequate job opportunities, limited healthcare access, and insufficient public transportation. Prenatal care rates are also a concern with less births receiving early care at significantly lower rates than California's average. While Modoc has significantly higher rates of homeownership, the median household income is low with nearly 30% of all children living in poverty. Key recommendations include economic and workforce development, improving transportation, offering more community activities and recruiting additional healthcare providers to address healthcare service gaps and improve health outcomes.

[17] 2024 Modoc County Community Health Needs Assessment

11. Napa County

Napa County completed its recent CHIP in November 2024, identifying five key health priorities: housing, behavioral health, access to health services, racial equity and LGBTQIA+ inclusion, and economic stability.[18]

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

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

12. Nevada County

Nevada County's 2025-2027 CHIP identified the following health areas of focus:

1. Increase access to comprehensive healthcare, prevention, and social services by meeting people where they are.
2. Expand access to affordable early learning and care (ELC) experiences in quality, developmentally appropriate, supportive settings through advocacy and promotion.
3. Increase vaccination rates for children.[19]

Healthcare access included lack of specialty providers, siloed healthcare delivery system, and gaps in care coordination. Issues were identified within the county's ELC provider network, such as limited geographic access to affordable care programs and transportation barriers for families with low socioeconomic status. Nevada County is in the bottom 25% of CA Counties in terms of reported immunizations. The county's assets include a strong network of community-based organizations, dedicated

[18] 2024 Napa County Community Health Improvement Plan
[19] 2025 Nevada County Community Health Improvement Plan

healthcare providers, and active partnerships among local agencies. These resources contribute to ongoing efforts to improve health outcomes and address gaps in service delivery.

13. Placer County

Placer County's 2024-2029 CHIP report highlighted the following health priorities: lifestyle and preventative health concerns, aging and older adults, and the built environment.[20] Lifestyle and preventive health concerns highlighted the need for improved access to nutrition, physical activity, and chronic disease management, with a focus on reducing health disparities. Aging populations face challenges related to healthcare access, service availability, and aging in place, especially in rural areas. The built environment priority aims to improve infrastructure to support healthy living, such as safer housing, better transportation, and more accessible public spaces. Placer's assets include a robust network of healthcare providers, community organizations, and strong partnerships that support these initiatives and work to reduce health inequities and enhance the well-being of all residents.

14. Plumas County

Plumas County's 2023-2028 CHIP identified three priorities selected by the community.[21] The three priority health issues were: Drug and Alcohol Abuse and Overdose, Limited Access to Preventive Services, and Suicide. Other areas of focus included priority gaps, such as resource knowledge, coordination, and navigation, family support, harm reduction, and sustainability.

15. Shasta County

Mercy Medical Center Redding released their most recent CHNA in June of 2025, which covers all of Shasta County and parts of Tehama County.[22] This CHNA prioritized five health needs for the community: access to primary and dental care; access to behavioral health care; affordable and supportive housing; basic needs such as transportation and food security; and community belonging and freedom from violence. When compared with Shasta County's Community Health Assessment from 2023,[23] it is clear that many health concerns in the county continue to persist. With almost every area of the county identified as medically underserved, high rates of cancer, mortality, and substance abuse are likely contributable to poor access to care. Although Shasta County has a high school graduation rate much higher than the State overall and a

[20] Placer County 2024-2029 Community Health Improvement Plan
[21] Plumas County Community Health Improvement Plan 2023-2028
[22] 2025 Community Health Needs Assessment, Mercy Medical Center Redding
[23] 2023 Shasta County Community Health Assessment

poverty rate on par with the State, it still experiences challenging economic disparities across many of its census tracts, with multiple tracts having 20% or more of residents living in poverty for 30 years or longer. These economic challenges are compounded by rising housing costs and a lack of affordable childcare, which affects many low-income families. Additionally, the county has a notably high rate of children entering foster care, particularly infants, and struggles with high levels of emotional abuse and maltreatment.

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

16. Sierra County

Sierra County's 2023 CHA findings, based on both data analysis and community feedback, highlighted the following priority health needs: teen alcohol use, teen tobacco and vaping, adult tobacco use, teen physical fitness, teen mental health, adult obesity, excessive drinking, access to healthy foods, mental health, and commute alone.[24] While Sierra's CHIP report is soon to be published, the 2023 CHA report is the most recently available county health assessment. The county's assets include abundant natural resources, outdoor recreational activities, strong community support, and community-driven health initiatives.

17. Siskiyou County

Siskiyou County published their CHNA in June of 2025, which identified multiple high priority health needs including: vital unmet conditions related to transportation, education, food, and economic stability; income opportunity and humane, supportive housing; access to healthcare including specialty and dental care; access to mental/behavioral health and substance use; and injury and disease prevention management.[25] Geographic distance and barriers contribute significantly to food deserts, limited access to healthcare, public transportation, limited broadband access and fewer economic opportunities. Communities that are 1.5hr+ from the I-5 Highway are ranked in the bottom 99% of healthy communities. Other themes that arose were strengthening community relationships and improved workforce infrastructure. Siskiyou was able to identify 139 resources with potential to help meet the needs of the county service area.

[24] Sierra County Health Assessment 2023
[25] 2025 Siskiyou County Community Health Needs Assessment

18. Solano County

Solano County released their CHA in June 2020. The current CHA covers the period from 2020 to 2025, identified eight priority health areas, which include: socioeconomic challenges, lack of access to safe and secure housing, barriers to accessing healthcare, poorer educational outcomes compared to the state average, higher rates of domestic violence hospitalizations, injury deaths (both intentional and unintentional), and violent crimes, as well as elevated rates of opioid use and suicide ideation.26 The CHA also identified barriers to healthy eating and active living, and poor maternal and infant health outcomes. Following the CHA, Solano released its CHIP in January 2023.27 The current CHIP covers the 2023–2028 implementation period, with the next review cycle scheduled to begin in 2027 to ensure readiness for a 2028 planning cycle. The CHIP outlines several strategic priorities to address the top health needs identified in the CHA: workforce development, community and youth engagement, equity-driven investments, harm reduction, alongside enhanced access to healthcare services.

19. Sonoma County

Sonoma County released their joint Community Health Assessment and Improvement Plan in 2023. Sonoma assessed 12 priority health needs on the subjects of climate change, healthy food access, economic security and housing, education, structural racism, access to clinically and culturally responsive care, coordinated systems of care, chronic disease prevention, communicable disease prevention, youth mental health, adult mental health, and substance use. The 2023 Improvement Plan outlines 4 priority areas for action: to address structural and institutional racism, improve community members' connection to resources, improve system of care coordination, and strengthen capacity of mental health and substance use services.[28] In addition, the four hospital systems that serve Sonoma released their own CHNAs and CHIPs for their service areas in Petaluma and Santa Rosa for 2025. These assessments identified similar priorities to those in the county's Improvement Plan—specifically, access to care, behavioral health, chronic disease management, and member equity.[29]

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[26] 2020 Solano County Community Health Assessment
[27] 2023 Solano County Community Health Improvement Plan
[28] 2023 Sonoma County Community Health Assessment and Improvement Plan
[29] 2025 Kaiser Permanente, Santa Rosa Community Health Needs Assessment
2024–2026 Providence St. Joseph Health, Community Health Improvement Plan: Petaluma Valley Hospital (Providence, 2024)
2024–2026 Providence St. Joseph Health, Community Health Improvement Plan: Santa Rosa Memorial Hospital (Providence, 2024)
2024 Sutter Santa Rosa Regional Hospital, Community Benefit Plan (Sutter Health, 2024)

20. Sutter County

Sutter County published its 2023-2028 CHIP in 2023, outlining three health priorities for the next 3-5 years: combating homelessness, building resilient communities (with a focus on adverse childhood experiences, behavioral health, and nutrition/food access), and reducing STIs.[30] In its 2022 CHA, Sutter County highlighted numerous community resources that promote health and well-being, including parks, bike paths, and senior activities.[31] The Sutter-Yuba Homeless Consortium addresses homelessness, while programs such as Family S.O.U.P. and the Yuba/Sutter Resiliency Connection support families and foster resilience. Cultural groups celebrate diversity, and agriculture is showcased through farmers' markets. The Sutter County Public Health Branch works to ensure equitable access to these resources and will leverage them to address the three health priorities.

21. Tehama County

St. Elizabeth Community Hospital, which serves and is located in Tehama County, adopted and released their most recent CHNA[32] in June of 2025. This CHNA prioritized five health needs for the community: access to primary, specialty, and dental care; access to behavioral health care; basic needs such as education, transportation, and food security; navigation of care; and community belonging and freedom from violence. These interconnected issues significantly impact health, leading to premature death and reduced life expectancy among the population. The insights gained from this assessment, combined with those of the 2023 CHA[33] from Tehama County Public Health (updated February 2025) helped to develop Tehama's CHIP,[34] which was published in July of 2025. This plan covers the period of 2025-2028 and utilizes the MAPP framework to organize collaborative workgroups focused on objectives related to healthcare access, behavioral health services, and food access.

22. Trinity County

Trinity County most recently released a Community Health Equity Assessment in 2023, highlighting the many needs of the county.[35] Main drivers of health inequity identified were poverty, isolation, limited economic opportunity, and lack of affordable housing. Other significant health disparities include inadequate access to a supermarket; high risk of living in a wildfire-prone area; highest rates of childcare cost burden compared to the rest of California; twice the rate of premature death when compared to the state,

[30] Sutter County Community Health Improvement Plan 2023
[31] Sutter County Community Health Assessment 2022
[32] 2025 Community Health Needs Assessment – St. Elizabeth Community Hospital
[33] 2023 Community Health Assessment Tehama County
[34] Tehama County Community Health Improvement Plan 2025-2028
[35] 2023 Trinity County Health Equity Assessment

including the highest rates of suicide in the state, and higher rates of deaths related to unintentional injuries. Trinity also found educational disparities; lower rates of internet access compared to California; higher rates of violent crime higher rates of suicide, and higher rates of death from unintentional injuries, motor vehicle collisions and overdose. Approximately 1 in 5 Trinity residents had one or more disabilities with higher rates among American Indian/Alaska Native residents. Challenges also include higher rates of risk-adjusted hospitalizations due to chronic conditions; transportation limitations; technology limitations, and inadequate and unequal insurance coverage. Over half of Trinity community members also identified economic instability and the physical environment as a root cause of inequity, with many families experiencing hardship but not qualifying for social service assistance.

Trinity's CHIP was published in 2024 and covers the 2024-2028 period.[36] This plan identified two key focus areas: mobilizing healthcare to underserved regions, and expanding substance use disorder resources through collaboration with local partners.

23. Yolo County

Yolo County's most recent CHA was completed in 2023 and covers the 2023 – 2025 period.[37] Eleven significant health need were identified, including: access to resources that ensure basic stability, such as housing, jobs and food; behavioral health and substance use care; prevention for injury and disease; access to healthy eating and exercise; primary, specialty, extended care, and dental care; healthcare system navigation; social connection; safe places to live, and transportation.[38] Other areas of concern are around homelessness, poverty, housing costs, disparities in education, and life expectancy. Following the CHA, Yolo released its latest CHIP in 2026.[39] The plan emphasizes health equity and prevention-focused strategies to address the county's most significant needs. Together, these priorities provide a roadmap for improving community health over the next three years.

Yolo County has a variety of assets. It maintains some of the highest vaccination rates in their area due to strong community connection. The county also offers several resources to support physical health needs such as farmer's markets, neighborhoods, and local trails. In addition, Yolo benefits from a variety of trusted leaders and institutions, and ample employment opportunities.

[36] Community Health Improvement Plan 2024-2028 Trinity County Public Health Branch
[37] 2023-2025 Yolo County Community Health Assessment
[38] 2023-2025 Yolo County Community Health Assessment
[39] 2026 Yolo County Community Health Improvement Plan

24. Yuba County

Yuba County's CHIP for 2023-2028 outlined key priorities aimed at enhancing the well-being of the community.[40] These priorities included healthcare access, mental health services, and the creation of safe neighborhoods and built environments. The community's strengths, identified in the 2022 CHA, such as a lower cost of living compared to urban centers, access to natural areas like mountains and the ocean, and strong local resources such as public transportation and available services in areas like nutrition and legal support provide a solid foundation for the county's efforts to foster a healthier and more vibrant community.[41]

B. Social Determinants of Health (SDoH)

Social Determinants of Health, also known as, "social influencers of health," as defined by the World Health Organization (WHO), are "the conditions in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These conditions are in turn shaped by a wider set of forces: economics, social policies and politics."[42] Healthy People 2030 offers several examples of SDoH including income, polluted air, access to healthy foods and physical activity, and safe housing.[43]

A standardized collection of individual member SDoH is not available. There is no validated means of using diagnosis codes or claims data reliably to indicate 1 or more social determinant of health, and the data is quite incomplete; therefore, it is not useful for meaningful analysis. Instead, Partnership uses the Small Area Income and Poverty Estimates (SAIPE) State and County Estimates for 2024, County Health Rankings & Roadmaps data, and local, publicly available Community Health Assessment reports to understand the drivers that influence the health of our population. We use this data, along with data provided by our county public health agencies, provider partners, and community-based organizations, to gain insight into the needs of our members and the communities where they live. This helps foster collaborative efforts with local agencies in order to improve the social supports that help meet the needs of our members.

[40] 2023 Yuba County Community Health Improvement Plan
[41] 2022 Yuba County Community Health Assessment
[42] World Health Organization. "Social Determinants of Health." *Health Topics*.2025
[43] Healthy People 2030, Social Determinants of Health

1. Income

Income plays a major role in SDoH, specifically as it relates to health outcomes. More income often leads to better health outcomes, and vice versa. Below is a table detailing the median household income among Partnership's different counties.[44]

Table 1: SAIPE State and County Median Income Estimates 2024

Partnership Northern Region	Median Household Income
California	**$100,130**
Del Norte	$58,773
Humboldt	$58,960
Lassen	$68,185
Modoc	$57,390
Shasta	$70,620
Siskiyou	$60,432
Tehama	$62,822
Trinity	$50,481

Partnership Southern Region	Median Household Income
California	**$100,130**
Lake	$55,489
Marin	$145,395
Mendocino	$67,303
Napa	$116,139
Solano	$94,968
Sonoma	$105,956
Yolo	$87,386

Partnership Eastern Region	Median Household Income
California	**$100,130**
Butte	$65,143
Colusa	$69,149
Glenn	$66,061
Nevada	$98,873
Sutter	$74,183
Yuba	$74,273
Placer	$115,845
Plumas	$72,068
Sierra	$69,104

Source: United States Census Bureau 2025

Poverty also plays a major role in SDoH, specifically as it relates to health outcomes. More poverty often leads to poorer health outcomes, and vice versa. Below is a table detailing the percentage estimates for poverty among Partnership's different counties.[45]

Table 2: SAIPE State and County Poverty Estimates 2024

Partnership Northern Region	Percent in Poverty
California	***11.8%***
Del Norte	19.9%
Humboldt	18.0%
Lassen	17.2%
Modoc	17.1%
Shasta	14.6%
Siskiyou	17.3%
Tehama	18.2%
Trinity	23.0%

Partnership Southern Region	Percent in Poverty
California	***11.8%***
Lake	19.7%
Marin	9.9%
Mendocino	13.4%
Napa	7.8%
Solano	10.1%
Sonoma	8.4%
Yolo	17.4%

Partnership Eastern Region	Percent in Poverty
California	***11.8%***
Butte	18.7%
Colusa	13.6%
Glenn	15.5%
Nevada	9.6%
Sutter	12.6%
Yuba	13.5%
Placer	6.8%
Plumas	13.0%
Sierra	13.5%

[44] SAIPE Data, U.S. Census Bureau, 2025
[45] SAIPE Data, U.S. Census Bureau, 2025

Source: United States Census Bureau 2025

2. Air Pollution and Wildfires

In 2025, 148 wildfires in Partnership's regions burned more than 77,814 acres. With the increasing rate of wildfires in California, there is an increased possibility of impacts on Partnership's covered counties' health. Although 2025 was a significantly less destructive fire year for Partnership's regions overall, fires do increase the possibility of adverse pulmonary effects such as chronic bronchitis, asthma, and decreased lung function.[46] Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

County Health Rankings and Roadmaps measures air pollution as the average daily density of fine particulate matter in micrograms per cubic meter. Across the state of California, this measure was 12.6 in Reporting Year 2025 (MY2020).[47] The Partnership County with the highest rates of air pollution is Plumas at 21.1.

Table 3: Air Pollution – Particulate Matter by Partnership County in 2025

Partnership Northern Region	Air Pollution-Particulate Matter
California	***12.6***
Del Norte	10.3
Humboldt	8.8
Lassen	12.4
Modoc	10.4
Shasta	9.8
Siskiyou	10.9
Tehama	13.3
Trinity	10.2

Partnership Southern Region	Air Pollution - Particulate Matter
California	***12.6***
Lake	9.6
Marin	8.6
Mendocino	12.4
Napa	10.3
Solano	12.4
Sonoma	8.3
Yolo	15.9

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***12.6***
Butte	16.1
Colusa	12.8
Glenn	17
Nevada	12.4
Sutter	16.7
Yuba	16.3
Placer	13.1
Plumas	21.1
Sierra	10.8

Source: 2025 County Health Rankings & Roadmaps

The following table shows how many fires occurred and the amount of acreage burned in each county in 2025. Siskiyou and Shasta County were the counties with the most acreage burned in 2025 at 40,390 and 21,215 acres, respectively.

[46] Environmental Protection Agency (EPA), 2025
[47] County Health Rankings, Air Pollution: Particulate Matter, 2025

Table 4: Number of Wildfires and Acreage Burned per Partnership County in 2025

Partnership County	Number of Fires in 2025	Acres Burned in 2025
Butte	9	272
Colusa	1	14
Del Norte	2	47
Glenn	1	20
Humboldt	2	415
Lake	8	190
Lassen	16	1,540
Marin	0	0
Mendocino	3	302
Modoc	13	4,228
Napa	3	6,892
Nevada	3	57
Placer	8	515
Plumas	2	30
Shasta	18	21,215
Sierra	0	0
Siskiyou	22	40,390
Solano	12	550
Sonoma	0	0
Sutter	0	0
Tehama	11	394
Trinity	5	324
Yolo	2	164
Yuba	7	255
Total	**148**	**77,814**

Source: 2025 Fire Season Incident Archive | CAL FIRE

3. Adult Smoking

According to the CDC, cigarette smoking continues to be a main cause of preventable conditions such as disease, disability, and death among the U.S. population. The California Department of Public Health stated in their "2024 Results of the 2023 California Youth Tobacco Survey" that 6.4% of California high school respondents used tobacco in the last 30 days since completing the survey.[48] Vaping also continues to be a concern. Reponses showed that 26.5% of California high school respondents report being exposed to secondhand vapor in a car or room in the last 2 weeks, and about two thirds (64.3%) shared that they were exposed to secondhand vapor outdoors.

[48] 2025 California Department of Public Health Results of the 2024 California Youth Tobacco Survey

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.[49] With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate young people and parents on the harmful effects of tobacco use.

County Health Rankings and Roadmaps say that on average, 10% of adults in Reporting Year 2025 (MY2022) were current smokers in California. Adult smoking rates were higher than the state average in all of Partnership's counties, except for Marin; rates of smoking in Partnership counties ranged from as low as 8% to as high as 19%.

Table 5: 2025 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate
California	***10%***
Del Norte	19%
Humboldt	17%
Lassen	17%
Modoc	14%
Shasta	14%
Siskiyou	16%
Tehama	17%
Modoc	14%

Partnership Southern Region	Adult Smoking Rate
California	***10%***
Lake	14%
Marin	8%
Mendocino	15%
Napa	13%
Solano	13%
Sonoma	11%
Yolo	13%

Partnership Eastern Region	Adult Smoking Rate
California	***10%***
Butte	14%
Colusa	15%
Glenn	16%
Nevada	16%
Sutter	16%
Yuba	16%
Placer	12%
Plumas	13%
Sierra	15%

Source: 2025 County Health Rankings & Roadmaps. Red indicates higher than California average adult smoking rate.

4. Physical Inactivity

Low physical activity relates to several diseases such as diabetes, cancer, hypertension, cardiovascular disease, and premature mortality. Physical activity can improve sleep, cognitive ability, bone and musculoskeletal health. Physical activity not only affects individuals, but also communities.[50]

The 2025 County Roadmaps and Rankings measure physical inactivity as the percentage of adults aged 18 and over reporting no leisure-time physical activity, with higher values indicating less physical activity. In Reporting Year 2025 (MY2022), the

[49] Center for Disease Control and Prevention. Secondhand Smoke
[50] Center for Disease Control and Prevention. Physical Inactivity

California state average was 22%. Among counties covered by Partnership HealthPlan, the Northern Region had physical inactivity rates equal to or higher than the state average, with the exception of Shasta (19%). In contrast, the Southern Region and Eastern Region matched the state average but also displayed variations with some counties showing higher rates than state levels. Sonoma (17%), Marin (13%), Nevada (21%), Placer (17%), Plumas (19%), Shasta (19%), and Sierra (21%) had rates of physical inactivity that were better than the state average.

Table 6: 2025 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity
California	***22%***
Del Norte	27%
Humboldt	22%
Lassen	24%
Modoc	22%
Shasta	19%
Siskiyou	22%
Trinity	23%
Tehama	25%

Partnership Southern Region	Physical Inactivity
California	***22%***
Lake	22%
Marin	13%
Mendocino	22%
Napa	23%
Solano	22%
Sonoma	17%
Yolo	25%

Partnership Eastern Region	Physical Inactivity
California	***22%***
Butte	23%
Colusa	27%
Glenn	27%
Nevada	21%
Sutter	27%
Yuba	25%
Placer	17%
Plumas	19%
Sierra	21%

Source: 2025 County Health Rankings & Roadmaps. Red indicates higher than California average.

5. Severe Housing Problems

As of November 2024, the most recently publicly available data, there are approximately 187,084 unhoused people in California.[51] Additionally, 26% of California's households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.[52] Severe housing problems remain a significant issue in California. In Reporting Year 2025, many of Partnership's service area members continued to experience severe housing problems, especially in counties such as Humboldt (24%), Yolo (24%), Mendocino (23%), Napa (23%), Glenn (22%), Marin (22%), Nevada (22%), Sonoma (22%), and Tehama (22%). The 2025 reporting year reflects data from 2017-2021, see the following table.[53] Partnership's Southern Region experiences higher levels of severe housing problems, likely due to its proximity to the San Francisco Bay Area and Sacramento, while the Eastern Region

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

[52] County Health Rankings, Severe Housing Problems, 2025

shows notable challenges in counties such as Glenn and Nevada. This data demonstrates there is a need for stable housing in Partnership's service area.

Table 7: 2025 Rate of Severe Housing Problems by Partnership County

Partnership Northern Region	Severe Housing Problem
California	**26%**
Del Norte	17%
Humboldt	24%
Lassen	14%
Modoc	12%
Shasta	20%
Siskiyou	18%
Trinity	19%
Tehama	22%

Partnership Southern Region	Severe Housing problem
California	**26%**
Lake	21%
Marin	22%
Mendocino	23%
Napa	23%
Solano	21%
Sonoma	22%
Yolo	24%
Napa	23%

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

Source: 2025 County Health Rankings & Roadmaps

6. Food Environment Index

The Food Environment Index (FEI) accounts for access to healthy foods and food insecurity. Food insecurity is defined "as a household-level economic and social condition of limited or uncertain access to adequate foods."[54] Many areas across Partnership's 24 counties are designated as food deserts—areas where healthy and fresh foods are not readily available for people to access. In these regions, processed foods high in sugar, sodium, fat, and additives often dominate what is available. Additionally, some communities lack food pantries or other supplemental food resources, further restricting access to healthy foods.

The FEI considers three factors: the distance someone lives from a grocery store or supermarket, the availability of locations to purchase healthy foods within communities, and financial barriers to accessing healthy foods. According to the County Health Rankings and Roadmaps Reporting Year 2025 (MY2022), California scored a high 8.7 on a scale from 0 (worst) to 10 (best).

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

- Northern Region: FEI ranges from 6.4 in Modoc County to 7.7 in Shasta County.

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

- Southern Region: FEI is highest in Marin County (9.5) and lowest in Lake County (7.9).
- Eastern Region: FEI is highest in Placer County (9.0) and lowest in Colusa County (6.8).

Counties with the highest scores include Marin (9.5), Napa (9.0), Placer (9.0), Solano (8.9), and Sonoma (8.9), indicating better access to healthy foods. In contrast, rural counties such as Modoc (6.4), Sierra (6.2), Colusa (6.8), Del Norte (6.8), and Siskiyou (6.9) face significant challenges. This data suggests that rural counties generally encounter more difficulties accessing healthy foods, underscoring the need for targeted interventions to address food insecurity in these areas.

Table 8: 2025 Food Environment Index (FEI) in Partnership Counties

Partnership Northern Region	FEI
California	***8.7***
Del Norte	6.8
Humboldt	7.6
Lassen	7.5
Modoc	6.4
Shasta	7.7
Siskiyou	6.9
Trinity	7.2
Tehama	7.1

Partnership Southern Region	FEI
California	***8.7***
Lake	7.9
Marin	9.5
Mendocino	7.6
Napa	9.0
Solano	8.9
Sonoma	8.9
Yolo	8.5

Partnership Eastern Region	FEI
California	***8.7***
Butte	7.6
Colusa	6.8
Glenn	7.5
Sutter	7.5
Nevada	8.2
Yuba	7.2
Placer	9.0
Plumas	8.5
Sierra	6.2

Source: 2025 County Health Rankings & Roadmaps

C. Disease Prevalence

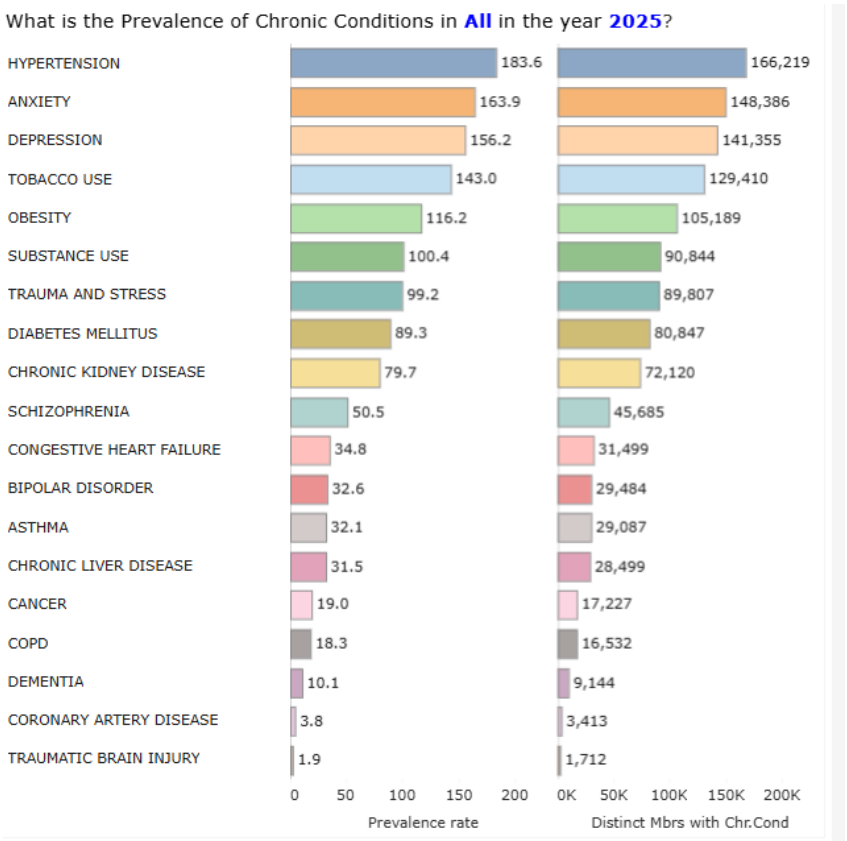
1. Chronic Disease

The 2025 Partnership Integrated Claims and Encounter data highlighted many chronic diseases that are prevalent in adults and children. Chronic diseases can be defined as conditions that last 1 year or more and either require continuing medical attention, limit day-to-day living, or both. Partnership bases estimates of chronic disease prevalence on claims and encounter data, while recognizing the limitations of this data to represent the true prevalence of disease. Furthermore, the true prevalence of chronic disease is likely higher than what claims data reflects.

Figure 7 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (183.6 per 1000 adult

members), Anxiety (163.9 per 1000 adult members), Depression (156.2 per 1000 adult members) Tobacco Use (143.0 per 1000 adult members), Obesity (116.2 per 1000 adult members), and Substance Use (100.4 per 1000 adult members). The top three (3) chronic diseases identified in the table below among the adult population has potential to impact daily living if left untreated. As such, this data demonstrates a significant need to address these top conditions.

Figure 7: 2025 Adults Chronic Conditions Prevalence Data Per 1000 Members

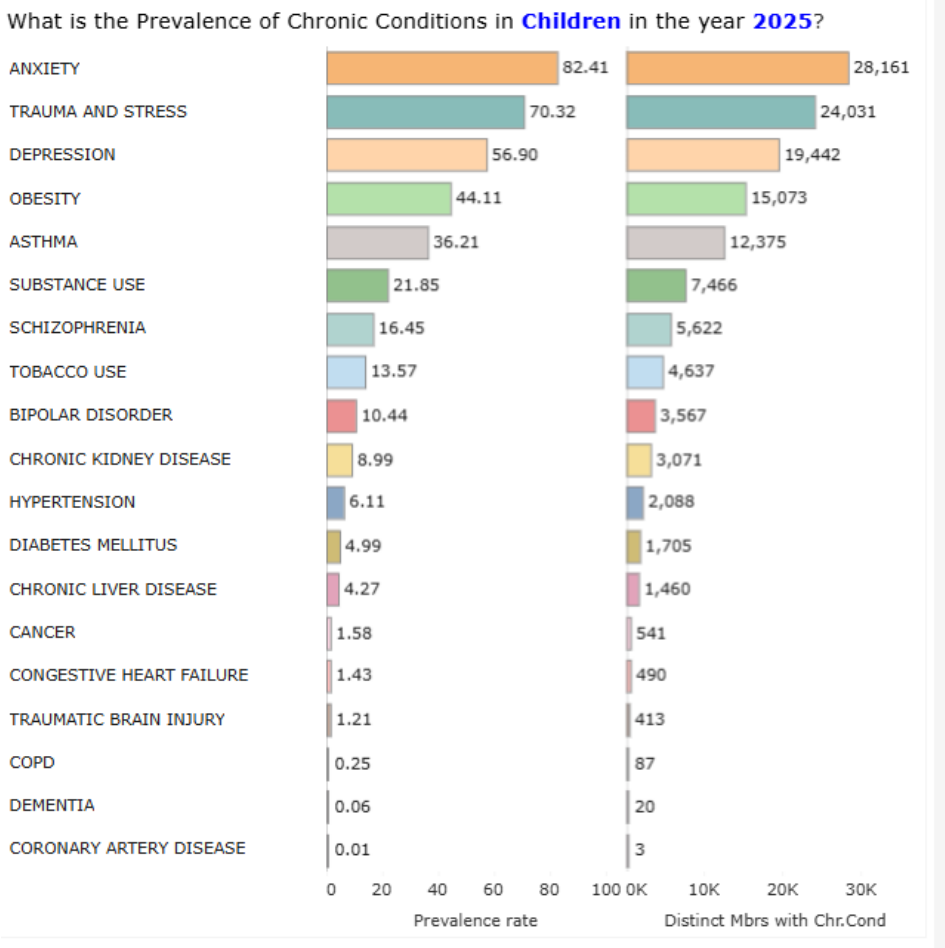


Source: 2025 Partnership Integrated Claims and Encounter Data, Partnership

Figure 8 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (82.41 per 1000 members), Trauma and Stress (70.32 per 1000 members), Depression (56.90 per 1000 members), Obesity (44.11 per 1000 members), Asthma (36.21 per 1000 members) and Substance Use (21.85 per 1000 members). The top three chronic diseases identified in the pediatric population are related to mental health. Poor mental health can impact daily functions.[55] As such, this data demonstrates a significant need to address anxiety, trauma/stress, and depression among the pediatric population.

[55] OASH, HHS.gov

Figure 8: 2025 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2025 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 (see appendix A). The DHCS Minimum Performance Level (MPL) is set at the 50th percentile and the High-Performance Level (HPL) is set at the 90th percentile amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for Reporting Year 2025 (MY2024). In MY2023 Partnership was responsible for reporting its HEDIS measure performance in 4 regional reporting units: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake).

In 2024, Partnership added 10 new counties (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba). Starting in MY2024, Partnership reported plan-

wide performance for all 24 counties, which included drilldowns of plan-wide performance at the following regional levels: NorthBay (Marin, Napa, Solano, Sonoma, Yolo), Rural Upper Central (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba), and Rural Upper North (Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity).

a. Controlling High Blood Pressure

Hypertension affects almost one-half the U.S. adult population and is an important risk factor for cardiovascular disease.[56] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 64.48% for the 2025 Reporting Year (MY2024).[57] Partnership's plan-wide performance was 69.59%. In the 2025 reporting year, Partnership's NorthBay regional performance for this indicator went above the MPL with a performance of 67.20%. In contrast, both Rural Upper Central and Rural Upper Northern region went below the MPL with a performance of 63.26% and 61.13%, respectively.

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 33.33% for the 2025 Reporting Year (MY2024). 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 achieved a plan-wide performance of 32.60%. Partnership's NorthBay and Rural Upper Central region for this indicator went below the MPL with a performance of 34.34% and 39.48%. By contrast, the Rural Upper regional performance was 32.02%.

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[58] yet, it is estimated that only 5.3% of adults 35 years and older in the United States get all recommended preventive care services.[59] 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 preventive care in a timely manner to stay healthy and reduce

[56] Center for Disease Control and Prevention (CDC), 2024
[57] Partnership Health Plan of California HEDIS Measures, 2025
[58] Health.gov Healthy People 2030 Literature Summary, n.d.
[59] Healthy People 2030

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

(1) Adult Cancer Screening

Timely cancer screenings are a major component of preventive care for adult members. Partnership annually monitors and assesses 3 cancer metrics. Breast cancer and cervical cancer screenings are metrics that are a part of both the DHCS MCAS and NCQA health plan accreditation measure sets in MY2024. Colorectal cancer screening is a HEDIS measure that was included in the NCQA health plan accreditation measure set starting in MY2024. Partnership has included a colorectal cancer screening measure as part of the Primary Care Provider Quality Improvement Program (PCP QIP), Partnership's largest pay-for-performance program; it is also part of initiatives to encourage appropriate testing for early detection of colon cancer.

The DHCS-specified MPL for Breast Cancer Screening ECDS (BCS – E) was set at the 50th percentile benchmark of 52.68% for the 2025 Reporting Year (MY2024). Partnership's plan wide performance of 56.29% was slightly above the DHCS 50th percentile benchmark. The Rural Upper Central and Rural Upper North went below the MPL standing at 31.15% and 52.28%, respectively. However, the NorthBay region went above the MPL at 59.08%.

Cervical Cancer Screening showed similar trends. The MPL for this measure set at the 50th percentile of 57.18% for the 2025 Reporting Year (MY2024). The plan wide performance for this indicator was just above the MPL, with a result of 59.12%. The Rural Upper Central and Rural Upper North went below the MPL standing at 45.39% and 57%. In contrast, the NorthBay regional performance went above the MPL at 61.97%.

Partnership's plan wide colorectal cancer screening rate for MY2024 was 32.99% which is just under 33rd percentile benchmark of 34.30%, part of the National Medicaid Benchmarks published by NCQA. DHCS made colorectal cancer screening an accountable measure in their MY2026 Managed Care Accountability Set (MCAS) and a DHCS-specified MPL for this measure is forthcoming. Only 3 of our 14 legacy counties performed above the 33rd percentile for colorectal cancer screenings. Partnership is active liaising with vendors and providers to connect members to easier at-home testing options when clinically appropriate.

(2) Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. They are also metrics DHCS continued to heavily focus on for 2025. 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.[60] A recent study identified common barriers to getting to well-child visits, including difficulty in requesting time off from work, childcare, and other stressors.[61] Addressing social determinants of health plays an important role for improving attendance of well-child visits. The DHCS 50th percentile benchmark for child and adolescent well-care visits (WCV) was set at 51.81%. Additional metrics had the following benchmarks: well-child visits within the first 30 months of life (W30+2) at 69.43% and well-child visits within the first 15 months of life (W30+6) at 60.38%. Partnership's data for WCV, W30+2, and W30+6 is organized into three regions: North Bay (Yolo, Solano, Napa, Sonoma, Marin), Rural Upper Central (Tehama, Plumas, Butte, Glenn, Colusa, Sutter, Yuba, Sierra, Nevada, Placer), and Rural Upper North (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Mendocino, Lake). Partnership's plan-wide performance for WCV went below the MPL at 48.83%. All regions performed below the MPL for the WCV metric: North Bay (51.74%), Rural Upper Central (47.15%), and Rural Upper North (47.13%). However, for W30+2, North Bay and Rural Upper North regions performed above the MPL at 72.69% and 71.68%, while Rural Upper Central region remained below at 61.54%. This trend remained consistent for W30+6, North Bay and Rural Upper North regions performed above the MPL at 66.25% and 68.21%, while Rural Upper Central region remained below at 50%. Performance remains strong in both North Bay and Rural Upper North regions for W30+2 and W30+6. However, persistent gaps in performance in the Rural Upper Central region indicates a clear need to implement targeted interventions to improve W30+2 and W30+6 as well as WCV rates across all regions.

The MPL for Childhood Immunizations Status (CIS-Combo 10) was set at the 50th percentile of 27.49% for the 2025 Reporting Year (MY2024). For children ages 0-2 who received all the recommended immunizations by the time they turned 2 years old, plan wide performance slightly surpassed the MPL at 28.22% (see appendix A). The North Bay region went above the MPL at 34.67%, while Rural Upper Central and Rural Upper North performed below the MPL at 21.79% and 18.22%, respectively.

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 34.30%. The plan wide performance for adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was above the MPL, at 40.39%. Both Rural Upper Central and Rural Upper North performed below the MPL at 29.97% and 29.54%. In contrast, the North Bay region performed above the MPL at

[60] Center for Disease Control and prevention (CDC), 2024
[61] Wolf et. al., 2020

48.53%. This data demonstrates a need to address vaccination rates among the pediatric population in our Central and Northern service areas.

3. Serious Mental Illness/Serious Emotional Disturbances (SMI/SED)

Partnership provides mild to moderate mental and behavioral health services for its members through Carelon Behavioral Health. Partnership does not provide services to members who have severe mental and behavioral health needs, otherwise known as members with serious mental illness/serious emotional disturbance (SMI/SED), and/or members who have both. NCQA defines SMI as "someone over 18 years of age having (within the past year) a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities." NCQA defines SED as "a diagnosable mental, behavioral or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities." Partnership does support coordination of care for members with SMI/SED and/or both and helps connect them to the appropriate level of care.

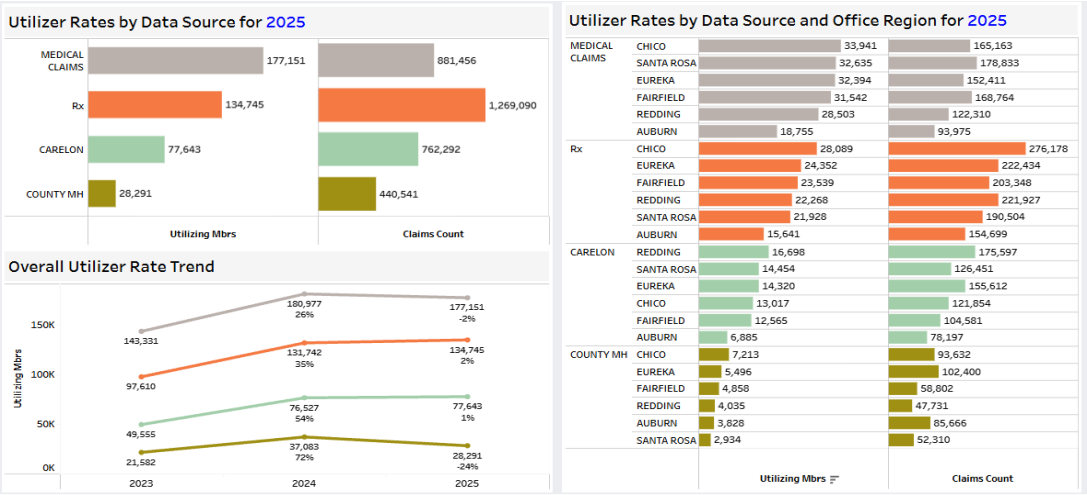
When a Partnership member has a higher level of impairment beyond mild to moderate, and needs specialty mental health services (SMHS), the member's PCP or mental health provider can refer the member to the county mental health plan. Partnership will help coordinate a member's first appointment with a county mental health plan provider to help them choose the right care for them. These include SMHS for Medi-Cal members who meet services rules for SMHS. These services may include outpatient, residential, and inpatient services.[62]

Partnership's regulatory body, the Department of Health Care Services, has two definitions of members who qualify for SMHS,[63] otherwise known as members with SMI/SED and/or both. These definitions are differentiated by age. Recipients 21 years and over must have a significant impairment that is due to a suspected or diagnosed mental health disorder. Recipients under 21 years of age must meet at least 1 of 2 criteria. Criteria 1 is: the member has a significant impairment, a probable reason to believe there is deterioration or lack of developmental progress in key life functions, or there is a need for SMHS. Criteria 2 is: the member's condition listed in criteria 1 is due to a suspected or diagnosed mental health disorder, or a significant trauma that could result in future mental health concerns.

[62] Partnership HealthPlan of California Medi-Cal Member Handbook, 2025
[63] Department of Health Care Services, Non-Specialty Mental Health Services, 2022

Due to limited data availability, the number of members accessing SMHS through county mental health serves as a proxy for the number of Partnership members with SMI/SED and/or both. Figure 9 shows that in 2025, there were 28,291 unique members that accessed specialty mental health services through county mental health and received at least one service. The same figure shows this number further broken down by region. The number of members who access SMHS through county mental health, and therefore the estimated number of members with SPMI, are as follows: 7,213 members in Chico region, 5,496 members in Eureka region, 4,858 members in Fairfield region, 4,035 members in Redding region, 3,828 in Auburn region, and 2,934 in Santa Rosa region. Due to difficulty in data collection, Partnership is unable to provide data on how many members have been referred to SMHS. Nonetheless, this data shows there is a significant number of members with SMI/SED and/or both who need coordination of care and resources from the county to get the care they need.

Figure 9: Partnership Mental Health Utilization Overview - Utilizer Rates by Data Source, 2025



Source: Partnership Data, 2025

D. Access to Care

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

1. Provider Availability

Lack of PCP availability is the most common barrier for Partnership members wanting to attend annual checkups and get routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the population to primary care providers in Reporting Year 2025 (MY2022).[64]

For California as a whole, the ratio of individuals to providers described in Reporting Year 2025 (MY2022) was 1,200:1. For this current reporting year, nearly half of the counties Partnership serves has a worse patient to provider ratio compared to the last reporting period. Of the remaining counties, nine improved, two counties remained the same, and one county had no reporting data compared to the previous year's data. Marin and Placer had some of the best ratios of individuals to providers at 680:1 and 820:1, respectively, while Glenn and Trinity had two of the highest ratios at 7,080:1 and 7,890:1, respectively. Sierra county did not have any data to compare for this reporting year and last year. Despite these countywide numbers, Partnership contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

Table 9: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,200:1	
County	**Ratio**
Marin	680:1
Placer	820:1
Yolo	840:1
Sonoma	990:1
Napa	1,010:1
Solano	1,140:1
Mendocino	1,250:1
Sutter	1,310:1
Shasta	1,370:1
Plumas	1,380:1
Nevada	1,400:1
Modoc	1,420:1
Siskiyou	1,460:1
Del Norte	1,590:1
Humboldt	1,630:1
Butte	1,790:1

[64] County Health Rankings, Primary Care Physicians, 2025

Tehama	1,810:1
Lake	2,440:1
Colusa	3,650:1
Lassen	3,740:1
Yuba	4,220:1
Glenn	7,080:1
Trinity	7,890:1
Sierra	-

Source: County Health Rankings & Roadmaps, 2025. Primary Care Physicians. Green indicates that compared to the previous year's data, provider availability improved (i.e., there were less patients per provider). Red indicates that compared to the previous year's data, provider availability worsened (i.e., there were more patients per provider).

Partnership's most recent Grand Analysis Network Adequacy Report showed a rise in access to care grievances due to an increase in membership of 33.5% from 2023 to 2024. The report revealed that between January 1, 2024, and December 31, 2024, 42% of standard member grievances and 34% of appeals and second level grievances were related to provider access. Access issues mainly consisted of long wait times for providers, and transportation issues such as the driver arriving late and missed rides. Partnership did not meet the 2.47 grievances per 1,000 member threshold but did meet the access Appeals and Second Level Grievances threshold for 2024. This same report also revealed that between January 2024 to December 2024, Partnership met its goal of less than 20 referrals per 1,000 members for out-of-network requests.[65]

Physical access at provider facilities can be a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing a facility's physical accessibility is through a Physical Accessibility Review Survey (PARS), which tracks any changes in a facility's physical accessibility. Physical access is categorized as either "Basic" or "Limited." A facility categorized as "Basic" has met all 29 critical elements used to identify a site's capability of accommodating members who are seniors and/or persons with disabilities. Elements, or domains, include parking, the exterior and interiors of the building, the restroom(s), and the exam room(s). If a facility is categorized as "Limited," it is missing any critical elements. For reviews done in 2025, 174 out of 289 inspected facilities were categorized as Limited; and 115 inspected facilities were categorized as Basic.[66]

[65] Partnership HealthPlan of California Grand Analysis: Network Adequacy Report: Assessment of Network Adequacy, 2025
[66] Partnership HealthPlan of California PARS report, 2025

2. 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey gives members an opportunity to give feedback about their ability to access care and their satisfaction with the care received. The CAHPS survey measure year or period is 2024 (July 1, 2024 – December 31, 2024) and the reporting year is 2025. The CAHPS adult composite scores for reporting year 2025 showed that the ratings increased in most areas, including rating of all health care, getting needed care, getting care quickly, coordination of care, and rating of specialist (see the following table). However, rates decreased for how well doctors communicate and rating of personal doctor, from 92.6% in 2024 to 90.6% in 2025 and 70% in 2024 to 65.7% in 2025, respectively.

The collective increases in performance measures suggest that compared to 2024, adult members are overall more happy with their care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[67] a positive patient experience likely indicates a higher level of trust. Thus, favorable member experience scores could indicate members may be more likely to trust their doctor and are at lower risk of adverse health outcomes. Partnership's Provider Relations department works closely with local providers to improve access to care for our members.

Table 10: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Care (% 9 or 10)	46.3%	55.8%
Getting Needed Care (% Always or Usually)	73.9%	74.5%
Getting Care Quickly (% Always or Usually)	68.0%	74.0%
How Well Doctors Communicate (% Always or Usually)	92.6%	90.6%
Coordination of Care (% Always or Usually)	78.8%	81.3%
Rating of Personal Doctor (% 9 or 10)	70.0%	65.7%
Rating of Specialist (% 9 or 10)	69.5%	70.3%

Source: 2024 CAHPS Medicaid Adult 5.1H Survey, 2025, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

[67] Lerch, S.P., Hänggi, R., Bussmann, Y. et al., 2024

Compared to 2024, the CAHPS child composite scores for reporting year 2025 increased in all areas: 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 (see next table). These increases suggest that compared to 2024, pediatric members are happier overall with their health care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[68] a positive patient experience likely indicates a higher level of trust. Positive member experience scores indicate that members may be more likely to trust their doctor, which can lead to better health outcomes. This data seems to demonstrate that the pediatric population is overall happier with their health care.

Table 11: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Care (% 9, or 10)	58.9%	72.9%
Getting Needed Care (% Always or Usually)	77.1%	77.9%
Getting Care Quickly (% Always or Usually)	78.9%	80.0%
How Well Doctors Communicate (% Always or Usually)	93.0%	93.3%
Coordination of Care (% Always or Usually)	80.4%	84.7%
Rating of Personal Doctor (% 9, or 10)	75.4%	78.6%
Rating of Specialist (% 9, or 10)	63.8%	73.8%

Source: 2024 CAHPS Medicaid Child 5.1H Survey, 2025, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

3. Third Next Available Appointment

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

PCPs are held to performance expectations with 2 specific standards of interest. Standard 1 is defined as "the percentage of providers who have a 3rd next available

[68] Lerch, S.P., Hänggi, R., Bussmann, Y. et al., 2024

primary care adult and/or pediatric primary care appointment in less than or equal to 10 business days." Standard 2 is defined as "the percentage of providers who have a 3rd next available newborn and/or urgent primary care appointment in less than or equal to 48 hours."

The results of the 3NA survey show the percentage of clinics meeting PCP standards in each of the Partnership regions. The results of this survey are displayed in the following table. On the high end for adult primary care, 89% of the clinics in the Redding region met Standard 1, while on the low end, 75% of clinics in the Eureka region met Standard 1 for the same measurement. For primary care pediatrics, the Redding region was the highest performing region at 93% of clinics meeting Standard 1 while 83% of the clinics met Standard 1 in the Auburn and Eureka regions, making it the lowest performing regions. For primary care newborn appointments, 97% of clinics in the Chico region met Stand 2, making it the highest performing region, while 82% of the clinics in the Eureka region met the standard for this same measurement, making it the lowest performing region. For primary care urgent care, 97% of the clinics in Chico met Standard 2, making it the highest performing region, while 83% of the clinics in the Auburn region met the standard, making it the lowest performing region. As shown in the following table, this data seems to demonstrate that for all appointment types in each region, most clinics are meeting the standard and are able to provide members, including pediatric members, with the care they need.

Table 12: 2025 Partnership Third Next Appointment Availability (Percentage of Clinics Meeting PCP Standards)

Third Next Available (3NA) Survey Findings 2025							
Provider Type	Standard	Percentage of Clinics Meeting PCP Standards					
		Auburn	Chico	Eureka	Fairfield	Redding	Santa Rosa
Primary Care Adult	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	77%	86%	75%	76%	89%	77%
Primary Care Pediatrics	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	83%	91%	83%	71%	93%	88%
Primary Care Newborn Appointments	3NA Newborn appointments within 48 hours of discharge **Standard 2**	92%	97%	82%	85%	85%	85%
Primary Care Urgent Care	3NA Urgent Care appointments within 48 hours of request **Standard 2**	83%	97%	94%	94%	94%	90%

Source: 2025 Partnership Third Next Available Survey, 2025 Summary

The results of the 3NA survey (see following table) show the median days for an established PCP appointment for primary care adults, pediatrics, newborn, and urgent care. All regions met standard 1 for Primary Care Adult with Chico performing the best at 2.2 median business days for an appointment. All regions met standard 1 for Primary Care Pediatrics with Auburn performing the best at 2.2 median days for an appointment. All regions met standard 2 for Primary Care Newborn appointments with Auburn performing the best at .75 day wait for an appointment. All regions met standard 2 for Primary Care Urgent Care appointments with Auburn, Chico, and Eureka performing the best at zero wait for an appointment from request time. Meeting standard 1 and 2 for median days of a requested PCP appointment improves patient satisfaction, fosters better health outcomes through timely care, and increases treatment compliance.

Table 13: 2025 Partnership Third Next Appointment Availability (Median Days)

Third Next Available (3NA) Survey Findings 2025							
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment					
		Auburn	Chico	Eureka	Fairfield	Redding	Santa Rosa
Primary Care Adult	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	2.25	2.2	4.75	6.67	5.33	4
Primary Care Pediatrics	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	2	2.2	4.25	3.67	4.67	2.5
Primary Care Newborn Appointments	3NA Newborn appointments within 48 hours of discharge **Standard 2**	.75	.8	1.25	1	1.17	1
Primary Care Urgent Care	3NA Urgent Care appointments within 48 hours of request **Standard 2**	0	0	0	.3	.67	1

Source: 2025 Partnership Third Next Available Survey, 2025 Summary

When looking at 3NA primary care appointment access by county, 19 of the 24 counties did not meet all of the standards for appointment accessibility. For those sites that do not meet the standards, they are surveyed again and are provided with a corrective action plan, as needed.

4. Telemedicine

a. Telehealth Utilization Report

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

In 2025, adult telemedicine utilization had 41,574 visits scheduled with 26,681 completing their visit for a 64.2% completion rate through Partnership-contracted specialty telemedicine providers (see the following table). While the data shows an increase in both scheduled and completed telemedicine visits for 2025 when compared to 2024, the overall completed visit rate was slightly lower.

Table 14: Adult Telemedicine Appointment Details as of December 2025

Adult Telemedicine Appointment Details as of December 2025					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
41,574	26,681	64.2%	10.1%	9.8%	23

Source: Adult Telemedicine Appointment Details Report, 2025, Partnership

For 2025, the number of scheduled pediatric telemedicine appointments was 7,638 and the number of completed pediatric telemedicine appointments was 4,796, with a 62.8% completion rate (see following table). The number of completed pediatric telemedicine appointments ranged from approximately 378-477 visits per month. The high of 477 occurred in October 2025 followed by 472 in April 2025. Since access to care is an important part of staying healthy, this data demonstrates that there is opportunity to increase the rates of access to care for the pediatric population through telemedicine.

Table 15: Pediatric Telemedicine Appointment Details as of December 2025

Pediatric Telemedicine Appointment Details as of December 2025					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
7,638	4,796	62.8%	17.1%	0%	36.2

Source: Pediatric Telemedicine Appointment Details Report for 2025, 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 2025, there were 1,011 adult eConsults completed. Of those, 55.1% were closed because the patient's needs were addressed by eConsult, while 41.1% were referred to face-to-face consultation.

Table 16: Adult eConsult Utilization Report, 2025 Partnership

Adult eConsult Utilization Report as of December 2025				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,020	1,011	55.1%	2.3	41.1%

Source: Safety Net Connect Utilization Report, 2025 Partnership

As of December 2025, there were 50 completed pediatric eConsults. Of those, 68.0%. were closed because the patient's needs were addressed through eConsult, while 26.0% of consults were referred for face-to-face consultation.

Table 17: Pediatric eConsult Utilization Report, As of December 2025 Partnership

Pediatric eConsult Utilization Report as of December 2025				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
50	50	68.0%	.7	26.0%

Source: Safety Net Connect Utilization Report, 2025 Partnership

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

E. Member Experience of Care

1. Satisfaction with Health Plan

Partnership contracted with Press Ganey (PG) to perform the 2025 CAHPS survey. The report is based on data as of July 2025. PG reached out to 3,318 adult members and the guardians of 4,969 pediatric members to participate in the survey. There were 511 adult responses (15.4% of those surveyed) and 783 pediatric responses (15.8% of those surveyed).

The CAHPS results discovered that 86.5% of adult respondents answered "Always" or "Usually" when asked if they received helpful information or were treated with courtesy and respect. This measure is collectively referred to as Customer Service, which changed from 87.0% in 2024 to 86.5% in 2025. This slight change from 2024 to 2025

indicates that Partnership still has room to improve. The following table denotes changes in various measure between 2024 and 2025.

Other categories showed improved responses from the year prior. Adult members were more satisfied with the Rating of Health Plan (increase from 54.5% to 55.8%), Getting Needed Care (increase from 74.0% to 74.5%), and the Ease of Filling Out Forms (increase from 92.7% to 93.7%). The increase in these measures suggests that compared to 2024, adult members are more satisfied with Partnership. Thus, members may be more likely to trust their health plan and may experience better health outcomes.

Table 18: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Adult CAHPS Summary Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	54.5%	55.8%
Getting Needed Care (% Always or Usually)	74.0	74.5%
Customer Service (% Always or Usually)	87.0%	86.5%
Ease of Filling Out Forms (% Always or Usually)	92.7%	93.7%

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Adult 5.1 H, 2025, Press Ganey (p. 10). Red indicates a decrease in score from the previous reporting year. *Green indicates an increase in score from the previous reporting year.*

The Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS survey results revealed that 72.9% of respondents completing forms on behalf of pediatric members rated their child's Health Plan as good or excellent (scores of 9 or 10), compared to 68.1% in 2024. This marks a notable increase. Another improvement was observed in Getting Needed Care, which increased from 77.1% in 2024 to 77.9% in 2025. However, the percentage of respondents reporting on Customer Service as "Always or Usually" decreased slightly from 91.2% in 2024 to 90.5% in 2025. A decrease was also observed with Ease of Filling Out Forms which decreased from 94.2% in 2024 to 93.1% in 2025. These results, as outlined in the following table, suggest that while pediatric members' interactions with Partnership improved, challenges remain in filling out forms and customer service. These factors may influence members' trust in their health plan and their likelihood of seeking care for health concerns as needed. This data seems to demonstrate that the pediatric population is overall happier with their health plan.

Table 19: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	68.1%	72.9%
Getting Needed Care (% Always or Usually)	77.1%	77.9%
Customer Service (% Always or Usually)	91.2%	90.5%
Ease of Filling Out Forms (% Always or Usually)	94.2%	93.1%

Source: MY2024 CAHPS® MEDICAID CHILD 5.1H SURVEY 2024, Press Ganey (p. 12). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

2. Doctor Communication

Partnership uses the Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS survey data to evaluate how satisfied members are with the interactions they have with their doctors. The score is a composite, comprised of indicators measuring how well a member's doctor explained things, if they listened carefully, showed respect, and if the doctor spent enough time with them.

The percentage of adult members who felt their doctor communicated well with them always or usually decreased on aggregate from 92.6% in 2024 to 90.6% in 2025 as compared to the Quality Compass (QC) score shown in the following Figure 10. Aside from showed respect, Partnership scored slightly below Press Ganey's 2025 Benchmark in all aspects of how well doctors communicate with Partnership adult members. Having good communication with one's doctor can help build a relationship and fosters trust between the member and the provider,[69] which can be a proxy measure for health outcomes. Therefore, having good communication with one's doctor is important to ensure Partnership members have the best possible health outcomes.

Figure 10: 2025 Adult Composite CAHPS Survey Result

	2025 Valid n	**2023**	**2024**	**2025**
How Well Doctors Communicate (% Usually or Always)	282	92.9%	92.6%	**90.6%**
Dr. explained things	283	92.5%	93.3%	**90.5%**
Dr. listened carefully	282	93.0%	92.9%	**90.4%**
Dr. showed respect	282	94.9%	91.7%	**94.3%**
Dr. spend enough time	281	91.2%	92.4%	**87.2%**

[69] BMC Primary Care, 2024

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Adult 5.1H Survey, Partnership, 2025

The results of the Child CAHPS Survey show that members rated their care experience with children's providers higher than providers for adults. The percentage of child members who felt their doctor communicated well with them with a response of always or usually increased on aggregate from 93.0% in 2024 to 93.3% in 2025 as shown in Figure 11. This improvement was due to the metric of How Well Doctors Explained Things; this measure showed an increase from 93.6% in 2024 to 95.8% in 2025. On the contrary, Partnership showed a slight decrease in How Well Doctors Listened, How Well Providers Showed Respect, and If Doctors Spent Enough Time with Member. Having good communication with one's doctor is important to ensure Partnership pediatric members trust their doctors and will have the best possible health outcomes. This data demonstrates that the care givers of the pediatric population are generally happy with their providers.

Figure 11: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child Composite CAHPS Survey Result

	2025 Valid n	2023	2024	2025
How Well Doctors Communicate (% Usually or Always)	452	92.7%	93.0%	**93.3%**
Dr. explained things	454	93.8%	93.6%	**95.8%**
Dr. listened carefully	454	92.9%	94.7%	**94.1%**
Dr. showed respect	456	95.6%	96.3%	**96.1%**
Dr. spend enough time	447	88.4%	87.7%	**87.2%**

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Child 5.1 Survey, Partnership, 2025

F. Health Disparities

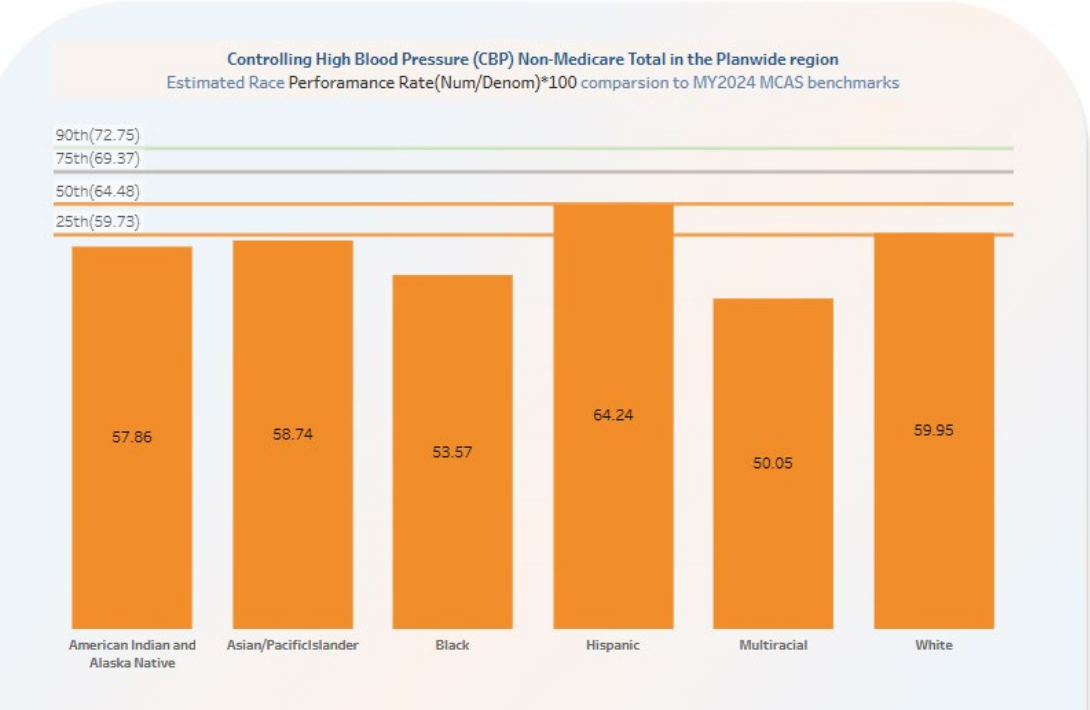
The 2025 health disparities data is taken from Partnership's Disparity Analysis tableau dashboard called the HEDIS Disparity Analysis Dashboard - MCAS County Oversampling Data. The following results are from the MY2024 Managed Care Accountability Set (MCAS) benchmarks.

1. Controlling High Blood Pressure (CPB)

The HEDIS Disparity Analysis dashboard found that performance across the majority of the racial and ethnic groups performed below the 50th percentile MPL of 64.48: the American Indian and Alaska Native came in at 57.86%, the Asian/Pacific Islander population came in at 58.74%, the Black population came in at 53.57%, the Multiracial came in at 50.05%, and the White population came in at 59.95%. The Hispanic group narrowly missed-the 50th percentile at 64.24%. Controlling high blood pressure is an important part of staying healthy. As such, this data demonstrates there is a need to

better address controlling high blood pressure amongst all racial and ethnic groups, but particularly among the multiracial population as they performed the lowest. See Figure 12 below.

Figure 12: 2025 Controlling High Blood Pressure

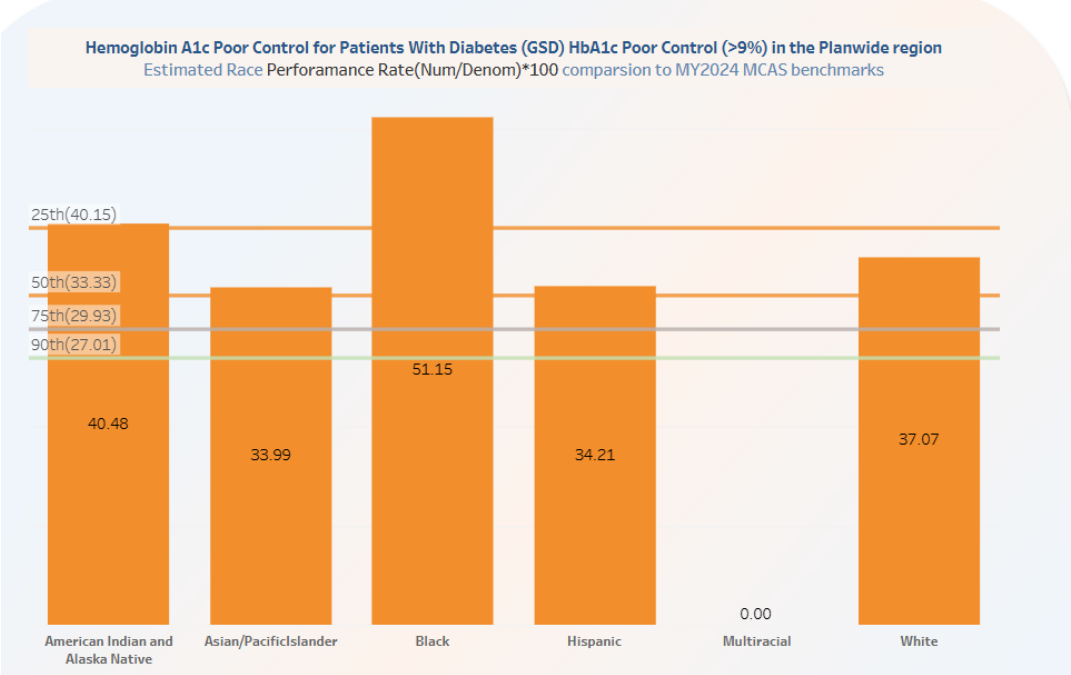


Source: *2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data*

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

The HEDIS Disparity Analysis dashboard found that when comparing the MCAS county oversampling data for each race/ethnicity group to the MCAS benchmarks, the disparity analysis shows that no race/ethnicity group met the minimum performance level. For this measure, the MPL was set at 33.33%, with observed performance rates of 40.48% (American Indian/Alaska Native), 33.99% (Asian/Pacific Islander), 51.15% (Black), 34.21% (Hispanic), and 37.07% (White). Therefore, the data in Figure 13 demonstrates there is a need to better address hemoglobin A1c control amongst all groups, but particularly among the African American/Black, adult population as they performed the worst.

Figure 13: Hemoglobin A1c Control for Diabetes – Poor Control



Source: [2025 *Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data*]

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

The HEDIS Disparity Analysis dashboard report on Well Care Visits (WCV) found that the majority of racial/ethnic groups did not meet the MPL 50th percentile of 51.81%, and no group performed above the 75th percentile of 58.07%. Specifically, the American Indian and Alaska Native population came in at 45.76%, the Asian/Pacific Islander population came in at 51.04%, and the White population came in at 43.12%. The Black or African American population came in at 40.48%, and the Other/Unknown (21.45%) populations performed the lowest, falling below the MPL 50th percentile. In contrast, the Multiracial (53.13%) population performed slightly above the 50th percentile. The Hispanic population performed the best (53.79%) and performed above the MPL 50th percentile. Well-child visits are an important part of staying healthy. As such, the data in Figure 14 demonstrates a clear need to address the low rates of well-child visits amongst most groups, and in particular, increase access to or utilization of well-care visits for the Black and Other/Unknown pediatric populations.

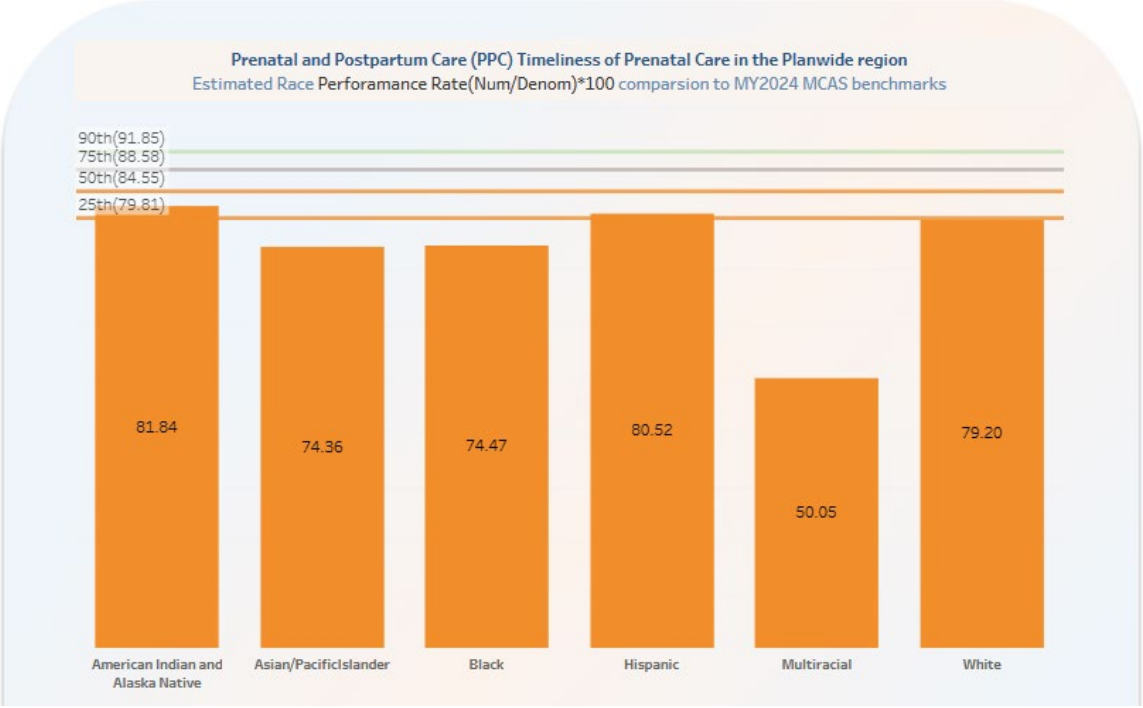
Figure 14: Child and Adolescent Well Care Visits

Source: 2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data

4. Prenatal and Postpartum Care (PPC):

The HEDIS Disparity Analysis dashboard report on the timeliness of Prenatal Care Visits (PPC) found that all groups had lower rates of completion, performing below the MPL 50th percentile of 84.55%: American Indian and Alaska Native came in at 81.84%, the Asian/Pacific Islander population came in at 74.36%, the Black or African American population came in at 74.47%, the Hispanic population came in at 80.52%, and the White population came in at 79.20%. The Multiracial population had the lowest rate of completion at 50.05%, as shown in Figure 15. Prenatal care is an important part of staying healthy. As such, the data in the figure demonstrates there is a need to address prenatal care access amongst all groups, but particularly among the Asian/Pacific Islander and multiracial pregnant population as they performed the lowest.

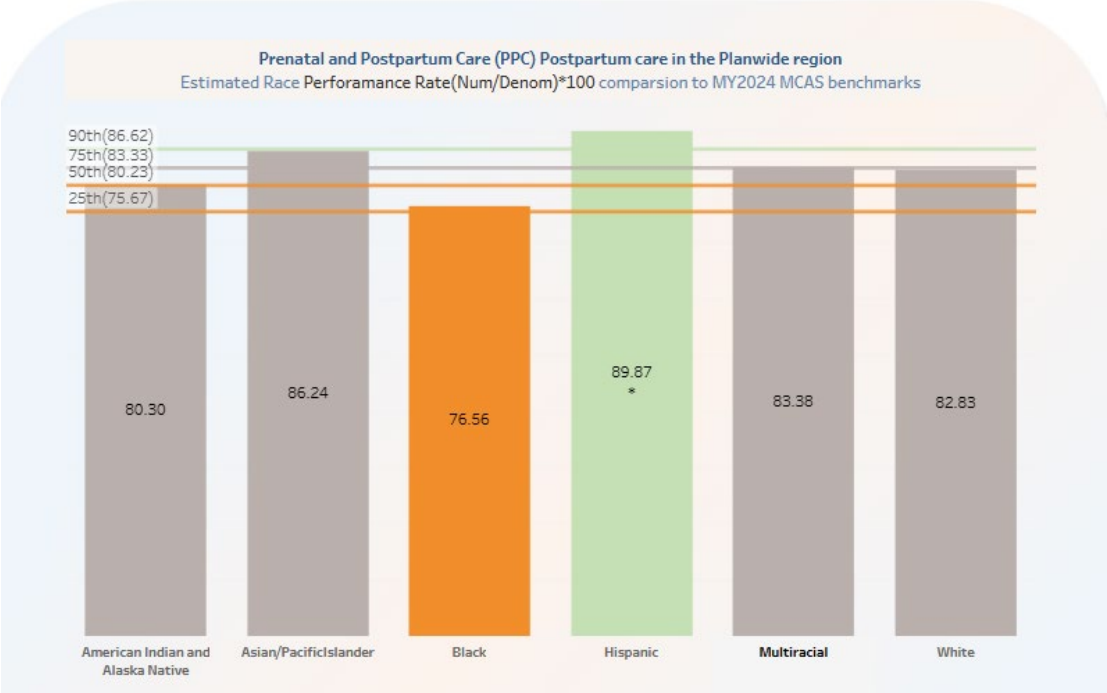
Figure 15: Prenatal and Postpartum Care (PPC - Pre)



Source: *2025* Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data

For Postpartum Care, the Black population (76.56%) was the only group with a completion rate below the MPL 50th percentile of 80.23%. In comparison, the American Indian and Alaska Native (80.30%), Asian/Pacific Islander (86.24%), Multiracial (83.38%), and White (82.83%) groups all had higher rates of completion, performing above the 50th percentile, as shown in Figure 16. The Hispanic population was the only group who performed above the 90th percentile (86.62%). Postpartum care is an important part of staying healthy. As such, there is clear need to address access to postpartum care among the Black group who are of childbearing age, as they performed the lowest.

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



Source: *2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data*

G. Health Education, Cultural & Linguistic Gap Analysis

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

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

Printed copies of materials are available to both members and providers. Educational and informing materials created by Health Education are reviewed and updated no less than every 5 years and are translated into all Partnership threshold languages of Spanish, Russian, Tagalog, and Punjabi; other languages are available upon member

request. Health Education 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.

Health Education has historically been responsible for aspects of the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination (which can include discrimination based on language), and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities; please note in 2025, review of discrimination-based grievance cases was transferred to the Health Equity department. Health Education also historically reviewed and recommended staff and provider training to promote awareness of diversity, equity, and inclusion to serve our members better as requested. However, this activity was also fully transferred over to the Health Equity Department in 2025 as a result of APL 24-016.[70]

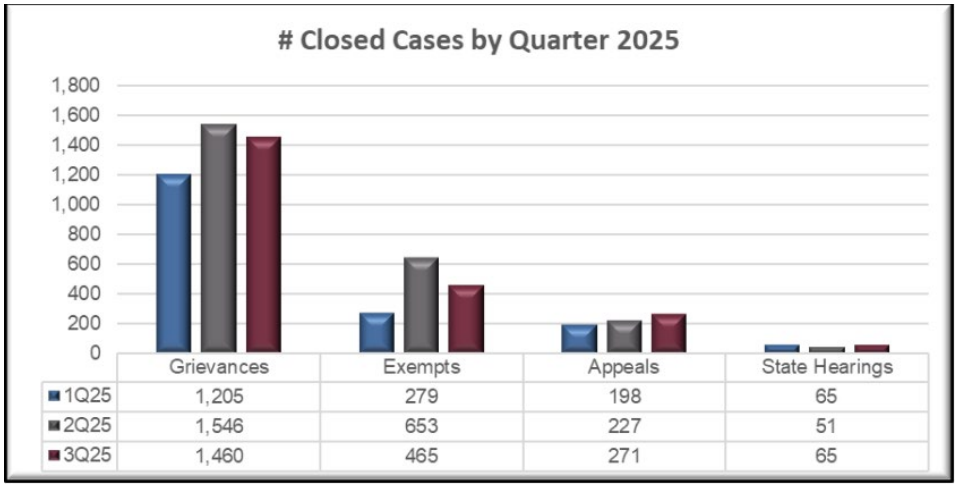
1. Grievance and Appeals

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

By the end of the third quarter in 2025, the G&A team closed 4,211 cases (see Figure 17), representing a slight decrease from the 4,248 cases closed for member reported grievances in 2024. English speakers and the White population continue to be the groups that file the majority of grievances and appeals.

[70] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements

Figure 17: Number of Closed Cases by Quarter 2025



Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2025 were White (56.8%), Other/Unknown (16.0%), Hispanic (15.2) Black (7.3%) and Asian (2.9%), as seen in Figure 18 below.

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

3Q25 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.8%	37.9%
Other/Unknown	16.0%	19.8%
Hispanic	15.2%	34.3%
Black	7.3%	3.6%
Asian	2.9%	2.5%
Native American	1.7%	1.7%
Hawaiian/Pacific Islander	0.1%	0.2%
Grand Total	100.0%	100.0%

Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

In 2025, Partnership continues to identify a disparity in grievances reported by member race/ethnicity and by language. The grievances reported continue to not be proportionate to the percentage of different races/ethnicities and languages within Partnership's membership. Between 2024 and 2025, the proportion of grievances shifted further away from alignment with the demographics of Partnership members. This may indicate a lack of member trust in Partnership to take their concerns seriously, which can lead to less health seeking behaviors (e.g. attending primary care visits) and thus poorer health outcomes for the member population.

Grievances reported by White members increased from 56.0% in 2024 to 56.8% in 2025, which coincides with the percentage of White members increasing from 37.0% to 38.9% in the same period. Grievances reported by Hispanic members increased from 11.8% in 2024 to 19.6% in 2025, which coincides with the percentage of Hispanic members increasing from 32.2% to 34.3% in the same period.

Grievance reporting decrease most significantly between 2024 and 2025 by Native American members, where grievance reporting decreased from 19.6% in 2024 to 1.7% in 2025, although there was an overall decrease in the percentage of Native American members from 1.8% to 1.7%. The decrease in grievances among our Native American members may be attributed to a heightened focus on this population and the provision of dedicated staff support to improve their health outcomes through Partnership health plan benefits. See the table below.

Table 20: Grievances by Race/Ethnicity over Time

Member Race/Ethnicity	2024 % of Cases	2024 % of Membership	2025 % of Cases	2025 % of Membership
White	56.0%	38.9%	56.8%	37.9%
Other/Unknown	5.2%	17.9%	16%	19.8%
Hispanic	19.6%	33.6%	15.2%	34.3%
Black (African American)	0.4%	3.5%	7.3%	3.6%
Asian	15.8%	2.5%	2.9%	2.5%
Native American	19.6%	1.8%	1.7%	1.7%
Native Hawaiian or Pacific Islander	0.1%	0.2%	0.1%	0.2%

Source: 4Q2024 & 4Q2025 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

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

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

3Q25 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	92.5%	75.7%
Spanish	5.6%	20.8%
Other	1.3%	2.1%
Russian	0.3%	0.6%
Tagalog	0.2%	0.3%
Punjabi	0.0%	0.5%
Grand Total	100.0%	100.0%

Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

The percentage of English-speaking members who reported grievances increased from 90.6% in 2024 to 92.5% in 2025. Grievances in Partnership's other languages were low in 2025, however, compared to 2024, grievances in Other, Russian, and Tagalog increased slightly. Spanish, and Punjabi decreased from 2024 to 2025. A lack of grievance can be a sign of lack of trust in an organization. Since trust is important for certain health outcomes,[71] this data suggests there is a disproportionate number of English members reporting their grievances compared to LEP members and therefore a need to be addressed.

Table 21: Grievances by Language over Time

Language	*2024 % of Cases*	*2024 % of Membership*	*2025 % of Cases*	*2025 % of Membership*
English	90.6%	76.2%	92.5%	75.7%
Spanish	8.0%	20.5%	5.6%	20.8%
Other	1.1%	2.0%	1.3%	2.1%
Tagalog	0.1%	0.3%	0.3%	0.6%
Russian	0.0%	0.6%	0.2%	0.3%
Punjabi	0.1%	0.5%	0.0%	0.5%

Source: 4Q2024 & 4Q2025 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

[71] BMC Primary Care, 2024

2. Diversity, Equity, and Inclusion Training

a. Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusion is through an annual Health Equity Week for staff. A project team typically designs emails, videos, and interactive activities to raise staff awareness of the diversity of Partnership's employees and members, and how to respectfully interact with others. Health Equity Week will continue to take place in April. Below are the results of Health Equity Week 2025.

Table 22: LMS Completion Report for Health Equity Week 2025 Activities

LMS Activity	Approximate Completions
Health Equity Week 2025: Vince, a Member's Story	259
Health Equity Week 2025: Tale of Two Zip Codes	11

Source: LMS Training Report; Partnership Human Resource Department, 2025

Table 23: Vimeo and Townhall Completion Report for Health Equity Week 2025 Activities

Vimeo and Townhall	Approximate Completions
Health Equity Week 2025: Q&A Video with Population Health Director Dr. Delorean, Staff member Bethany Hannah	263
Health Disparities and Equity Town Hall Featuring Health Equity Discussion with Dr. Jalloh	1,109

Source: Vimeo 2025; Partnership Human Resource Department, 2025

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There are several mandatory educational sessions per year for various types of Partnership staff. As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of December 31, 2025, there were 1,696 Partnership employees. In 2025 Partnership employees completed the following trainings:

Table 24: Training Sessions for Partnership Staff

Partnership Training Sessions	Staff Assignment	Approximate Completions
Diversity Basics: Foundations	Assigned to all staff in April 2025 and all new hires, temps, & contractors	1,696
Cultural & Linguistics Program Overview and Staff Training	Assigned to new hires, new temps, and new contract employees only	376
Affordable Care Act – Section 1557	Assigned to new hires, new temps, and new contract employees only	374
TGI Training	Assigned to Partnership staff, temps, and contractors of Member Facing departments (pushed every 2 years)	704

Source: Partnership Human Resources, 2025

To promote awareness and understanding of diversity, equity, and inclusion, and to align with the requirements of APL 24-016[72], Partnership will continue to identify and mandate high-quality staff training(s) on an annual basis. Some staff may seek further training opportunities to gain better insight into their peers and Partnership's population. In 2026 and beyond, DEI trainings for Partnership will align with new DHCS regulatory requirements.

Provider Training

Partnership is committed to enhancing the member experience by actively reviewing and offering trainings to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2025, Partnership's Cultural and Linguistic and Health Education Team reviewed and updated the comprehensive Cultural and Linguistic toolkit designed to help providers document patient language needs in medical records, utilize interpreter services, and refer patients to culturally and linguistically appropriate community programs. In addition, Partnership's Director of Health Equity developed a training program in 2024 to align with DHCS's APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements.[73] In 2025 Partnership

[72] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements
[73] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements

began offering providers regular DEI training to align with NCQA and DHCS quality standards. This training, called the Community, Access, Respect, Engagement and Service (CARES) Training, educates providers on the cultural diversity of our members, raises awareness of Partnership's cultural and linguistic policies, and provides guidance on available resources for supporting diverse populations. This training is provided to all existing contracted practitioners with Partnership and its completion is required during their recredentialing period every three years. This activity will continue to be supported by key staff in the Health Equity Department.

V. Review of Activities, Resources, and Opportunities

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 2026 PNA demonstrates how Partnership addresses member needs through various activities. To best support both health and overall wellbeing, Partnership works closely with provider and community resources to ensure members have access to a wide range of services. However, this PNA also revealed opportunities to address needs in the areas of organizational structure; social and environmental needs; member health and wellness; access to care; health disparities; and health education and culture and linguistics.

Over the years, Partnership has cultivated strong relationships with the provider community, public health, and community-based organizations on behalf of its members. As of January 2024, Partnership established 6 regional offices to maintain a community presence and ensure members have local access to someone who can address their concerns.

A. Organizational Structure

Partnership's new claims system was scheduled to go live in mid-2024 but has since been postponed to a later date in 2026. 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. In 2025, Medi-Cal Connect, DHCS' Population Health Management Service platform, went live. As part of a larger initiative, this platform gives health plans and providers improved data access to inform

and guide care coordination, close gaps in care, and improve the health of our members.[74] Medi-Cal Connect and the new claims system will be sufficient for Partnership's future needs; the claims system will provide a framework on which Partnership may build additional IT structures to meet the needs of the organization and our members.

The position of Director of Health Equity was filled in January 2023, overseeing health equity activities and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department hired several staff in 2024. In 2025, the department continued to grow. Additional staff were hired, including one Cultural and Linguistic Liaison, a Supervisor of Health Equity Training, a Manager of Cultural Community, and a Project Coordinator. A second position for a Cultural and Linguistic Liaison was also created.

Within Partnership's Population Health department, there are teams who work to build relationships with community partners and other stakeholders; this work includes the mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). The needs identified in the most recent versions of these reports are summarized earlier in this needs assessment. These teams represent Partnership at various county and community collaborative meetings and learn about the ongoing needs of communities. This is one way that Partnership remains informed about the needs of the counties and communities it serves. Through relationships established in these meetings, organizations work together to identify, conceptualize, and implement interventions for health concerns or disparities in the local communities. In addition to these community partner-facing teams within Population Health, Partnership's medical directors regularly meet with clinic medical directors to discuss the clinical needs of patients, and they work together to make connections and find solutions for the providers and the members. Finally, other Partnership teams attend community events and conduct qualitative, community-based research, often hearing firsthand of various needs of Partnership's members.

There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website (see Appendix D for a list of current Community Resources resources). Additionally, internal staff may use these community resources to augment Partnership's program offerings through closed-loop referrals (which differs in definition from DHCS' closed-loop referrals definition). Partnership members have the option to contact Partnership's

[74] Medi-Cal Connect, Frequently Asked Questions

Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow-up calls to ensure the resource(s) met the needs of the members. Partnership has identified many community resources that are integrated into member care and offers them as member needs arise. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge or change.

DHCS' California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to expand community resources to meet member needs and encourages multi-sector collaboration to overcome social and environmental barriers to health. Partnership continues to look to community agencies and other organizations to implement community health workers, doulas, enhanced care management and community supports services to provide services to members in their communities and to support basic needs. The infrastructure to provide these services to members continues to evolve, but agencies may continue to develop training programs to meet the need for several of 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

California has a shortage of affordable housing. The most current 2024 data shows that California's homeless population grew by 3% since 2023, to over 187,000 people experiencing homelessness.[75] Partnership's service area in particular has a significant homeless member population and likely has an even larger percentage of members who struggle to maintain housing. The local Community Health Assessments and the County Health Rankings data also continue to highlight a lack of stable housing as a pressing issue. Housing and homelessness are chronic concerns for managed care plans; however, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. State funds and initiatives like the CalAIM Incentive Payment Program provide the means for managed care plans to offer grant funding to address housing concerns. As of January 1, 2026, Partnership is also required to cover up to six months of rental assistance for Medi-Cal Members who meet key eligibility requirements and are either homeless or are at risk of becoming homeless.[76] Lastly, as part of DHCS's

[75] The 2024 Annual Homelessness Assessment Report to Congress
[76] DHCS Transitional Rent, 2025

Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

2. Economic Instability (Low Income and Unemployment)

Partnership members experience more social and structural barriers to health and well-being than many in the state of California. Twenty of Partnership's counties have household incomes below California's state average.[77] The Community Health Assessments revealed that many of Partnership's counties face challenges around having sufficient employment and income. Unemployment can make it difficult for Partnership members to access basic needs like housing and food for themselves and their families. There are often insufficient resources in communities to provide living-wage jobs for residents. In collaboration with community partners, Partnership is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes.

Partnership also contracts with organizations that serve as Supervising CHW providers. These organizations provide CHW services to Partnership members. Some of these efforts included exploring how to expand the CHW network in collaboration with interested local public health departments as part of the mandated CHA/CHIP work. Finally, Partnership continues to offer a Member Scholarship Program aimed at helping our members secure funding towards education with a focus on health care, social services, or public service; the recipients of the 2026 scholarships will be announced in summer 2026 (see Appendix C). These local efforts have potential to create new jobs in Partnership's service area, which can ultimately help improve economic stability of the communities we serve.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires can lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. In early 2025, Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area. The inbox is used as a tool to share information with other member- and provider-facing departments within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the

[77] US Census Bureau, 2024

community. In Q1 of 2025, during instances of a natural disaster, Partnership staff sent out informational emails from the Fire and Disaster Reporting inbox to keep leaders within the organization apprised of the situation(s). This allowed for seamless and centralized internal communication and enabled member- and provider-facing departments to be prepared to support members in their time of need. However, for the remainder of 2025 and into 2026, the use of the inbox was discontinued.

Another way Partnership supported member engagement with this topic in 2025 was through materials posted to Partnership's website. These materials are comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card. The booklet included information on creating an action plan, preparing an emergency kit, and listed common emergency resources available throughout the state. It also included a QR code that links members to Partnership's community resource pages if they want more information. The pocket card is a small checklist of items to pack in an emergency kit and go-bag in the event of an emergency. The pocket card can be printed out and easily stored in an emergency bag or in an easy-to-access space within the home for use. The resources allocated to these efforts are sufficient for Partnership member needs.

C. Member Health and Wellness

1. Chronic Disease

HEDIS performance measure reporting provides some insight into the overall health and wellbeing of health plan members. DHCS continues to roll out various programs under CalAIM, including under the ever-evolving Population Health Management (PHM) Policy Guide.[78] The PHM Policy Guide includes a variety of ongoing mandates, including a mandate for Managed Care Plans to include chronic disease basic population health management (BPHM) programs that address hypertension, diabetes, asthma, and depression. In 2025, Partnership continued to administer the BPHM programs, several of which target key populations. In mid-2025, a BPHM texting campaign was also rolled out to target members who do not qualify for the formal BPHM program but may still benefit from additional support; this campaign provides education and resources to members who have diabetes and/or hypertension. These programs continue to align with PNA findings showing that hypertension, tobacco use, and depression are some of the top most common chronic diseases in our adult population in 2025.

[78] Department of Health Care Services DHCS, 2026

For the last few years, Partnership has been required to offer BPHM programs. In 2024, as a result of identified disparities, Partnership modified its hypertension intervention to focus primarily on African American, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander members as part of Partnerships Populations of Focus. The core components of the modified intervention generally remained the same. Partnership continued to offer this program in 2025 and will continue to offer it in 2026. There are sufficient resources to continue performing this program.

Almost all the Partnership counties have adult smoking rates that are higher than the state average. As a result, Partnership's Population Health Department continues to ask questions about smoking behavior to our members during outbound call campaign scripts for all campaigns. In 2025, Partnership also conducted health education sessions on the health impacts of vaping and positive coping strategies for mental well-being across 3 schools in 3 counties. Efforts centered on reaching students from 5th through 12th grade. Each session included an interactive activity designed to reinforce key concepts from the lessons. Activities were incentivized to increase participation and engagement.

Partnership members in all regions face health challenges, though there are regional variations in health. For example, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this has potential to contribute to poorer asthma control. There may be other contributing factors as well. As such, in 2022, Partnership's Pharmacy department created an asthma management program for adults with asthma emergency department visits. However, to better align with CalAIM BPHM and due to Pharmacy staff capacity, the Asthma management project was modified over time and is now run by Population Health. The modified Asthma Emergency Department (ED) Visit Outreach Program Campaign was first rolled out at the end of 2024. In 2025, the Population Health department continued to run the Asthma Post ED Visit Outreach campaign which offers support to members who were recently seen in the ED for their asthma. As part of the program, members receive an asthma education handbook and those who may want additional help can speak with a pharmacist who can provide education on effective self-management of their asthma and use of medications. Members with repeat ED visits due to asthma exacerbation will be referred for additional support. There are sufficient resources to perform this new program.

The top 3 chronic diseases found among Partnership children in 2024 were mental health concerns (anxiety, trauma/stress, and depression). The CDC states that children

with ADHD often have other coexisting conditions (including anxiety disorder).[79] As such, one way Partnership addressed mental health conditions in children was through weekly ADHD new start reports. These reports helped identify Partnership pediatric members that had filled a new ADHD medication. The Pharmacy team then sent fax notifications to providers when one of their patients recently filled a new ADHD medication. The goal is for providers to encourage timely ADHD follow-up visits. This program has shown improved rates of follow ups and will continue into 2026. There are sufficient resources to perform this new program.

Partnership's local community needs assessments also showed that behavioral health concerns, such as poor mental health and substance use, are pressing concerns in Partnership's communities. One way Partnership worked to improve poor behavioral health outcomes in 2025 included continuing to actively participate in and support our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types.

Partnership also supported members with mental health concerns in 2025 through conducting outreach efforts to members with low utilization of non-specialty mental health services, demonstrating that some populations are not effectively utilizing these services; this outreach effort also aligns with a DHCS mandates.[80] As this is an annual DHCS requirement, this will take place again in 2026.

Furthermore, Partnership has rolled out several new programs to support members with a substance abuse diagnosis (SUD) including:

- A program to encourage follow up after an Emergency Department (ED) visit for members with a substance use diagnosis; this includes appointment assistance for members who have sought care through the ED to help address their needs through available SUD services, by county. Similar efforts are occurring for mental health.
- Looking at medication for addiction treatment programs to address prescribing gaps within our primary care service areas.
- Engaging with Regional Model counties to promote peer support services for members with a SUD diagnosis as part of a multi- year Performance Improvement Plan.

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

There are sufficient resources to perform these new programs.

Depression was the third most common chronic condition among Partnership members in 2025. As such, in addition to the efforts listed above, Partnership has also continued to refine its BPHM program which offers to help members who recently suffered a stroke or a myocardial infarction to prevent depression symptoms. This program meets DHCS requirements for a depression intervention program and tests the benefits of having non-clinical staff provide lifestyle coaching for depression. It is possible that members who recently suffered a stroke or MI may develop depression symptoms. Therefore, this BPHM program has potential to decrease the number of Partnership members diagnosed with depression in the future. Currently, Partnership has staff dedicated to this program, although more staff resources are budgeted should current staffing prove insufficient.

2. Health Screening

Some Partnership regions continue to perform below the MPL for breast cancer screenings. To address the need for breast cancer screenings, Partnership continues to collaborate with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and health centers lacking access to mammography sites. Mammograms are a proactive screening that detects breast cancer, and providers have the opportunity to follow up with anyone who has findings on their imaging. Throughout 2025, there were 75 mobile mammography days conducted in 17 Partnership counties (which include the following counties: Butte, Del Norte, Humboldt, Lake, Marin, Mendecino, Modoc, Napa, Nevada, Placer, Shasta, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo). In 2025, there was an improvement in the number of breast cancer screenings completed in comparison to the previous measurement year. This modest improvement helps demonstrate the success of this collaboration and will continue in 2026 to reach more members.

To help increase cervical cancer screenings in low performing regions, Partnership's Women's Health and Perinatal Workgroup conducted a 6-month Cervical Cancer Screening for high-risk human papillomavirus (hrHPV) Self-Swab pilot project in early 2024. In 2025, and into 2026, Partnership's Women's Health and Perinatal Workgroup will continue to provide support and education to our provider network to promote the hrHPV Self-Collect option for patients in clinic. Partnership has also conducted 1 on 1 provider trainings for 111 total sites. Other activities around this work include:

- Updating Cervical Cancer Screening (CCS) Measure Best Practices to include hrHPV Self Collect

- Integrating hrHPV Self-Collect into Improvement Academy materials (a quality improvement program for providers)
- Developing hrHPV Self-Collect instructions in multiple languages
- Reviewing available Health Education materials on this topic
- Identifying providers performing low in cervical cancer screenings and offering 1 on 1 education
- Developing a tracker with cervical cancer screening site performance to monitor Year-over-Year improvements

To address concerns around low colorectal screenings, Partnership also started a colorectal cancer screening pilot project in 2022 along with Exact Sciences to increase the number of colorectal cancer testing. In 2025 and into 2026, Partnership continues to support our providers using the bulk ordering option for colorectal cancer screening with Exact Sciences. The goal is to increase the number of colorectal cancer testing among the 45 years of age and older population.

3. Wellness Care

Partnership continues to make significant investments into expanding services for maternal and child health to improve gaps in care, which was partially highlighted in the disparities data. Partnership performs outreach to all members with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teens to educate about the transition from pediatric visits to adult visits, as well as to inform of the importance of HPV vaccines. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders in the exploration and planning of school-based clinics, and other strategies to promote childhood wellness care. The resources allocated are sufficient for these efforts.

D. Access to Care

Partnership operates in a broad service area encompassing urban, suburban, rural, and frontier settings. Local community needs assessments findings continue to identify access to care as an ongoing issue. Partnership's provider network continues to be challenged by a shortage of providers, and an aging provider community. Because of this, Partnership continues to sponsor a workforce development program called the Provider Recruitment Program (PRP) (see Appendix E). The PRP offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and/or if they come from a county outside of the ones that Partnership serves. Partnership also continues to support a Provider Retention Initiative (PRI) program (Appendix F). The PRI is intended to recognize primary care clinicians, providers of perinatal services,

and/or obstetrics/gynecology, and psychiatrists who are deeply invested in the safety net population, while helping to incentivize additional years of service. Although this work is already in place, a long-term strategy is essential to address the provider shortage in Partnership's service area.

With oversight from Partnership's Board of Commissioners, and in collaboration with state and national initiatives, Partnership continuously works to make the provider recruitment program effectively support expanding access to primary care. In particular, Partnership is expanding efforts to strengthen recruitment of PCPs, behavioral health providers, mid-levels, and targeted specialists in the areas where access is impacted most.

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

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

E. Health Disparities

The PNA revealed notable care gaps among specific racial/ethnic groups. In particular, the HEDIS Disparity Analysis Dashboard for Controlling High Blood Pressure (CPB) demonstrated that performance across the majority of the racial and ethnic groups performed below the 50th percentile MPL of 64.48%: the American Indian and Alaska Native population came in at 57.86%, the Asian/Pacific Islander population came in at 58.74%, the Black population came in at 53.57%, the Multiracial population came in at 50.05%, and the White population came in at 59.95%. The Hispanic group narrowly missed the 50th percentile at 64.24%.

In Hemoglobin A1c Control for Patients with Diabetes (HBD), no race/ethnicity group met the minimum performance level. For this measure, the MPL was set at 33.33%, with observed performance rates of 40.48% (American Indian/Alaska Native), 33.99% (Asian/Pacific Islander), 51.15% (Black), 34.21% (Hispanic), and 37.07% (White).

For Child and Adolescent Well Care Visit completions, the majority of racial/ethnic groups did not meet the MPL 50th percentile of 51.81%. The American Indian and Alaska Native population came in at 45.76%, the Asian/Pacific Islander population came in at 51.04%, and the White population came in at 43.12%. The Black or African American (40.48%) population and the Other/Unknown (21.45%) populations performed the lowest, falling below the MPL 50th percentile. In contrast, the Multiracial (53.13%) population performed slightly above the 50th percentile. The Hispanic population performed the best (53.79%) and performed above the MPL 50th percentile.

For prenatal care, all groups had lower rates of completion, performing below the MPL 50th percentile of 84.55%: the American Indian and Alaska Native population came in at 81.84%, the Asian/Pacific Islander population came in at 74.36%, the Black or African American population came in at (74.47%), the Hispanic population came in at (80.52%), and the White population came in at 79.20%. The Multiracial population had the lowest rate of completion at 50.05%. Finally, for postpartum care the Black population (76.56%) was the only group with a completion rate below the MPL 50th percentile of 80.23%. In comparison, the American Indian and Alaska Native (80.30%), Asian/Pacific Islander (86.24%), Multiracial (83.38%), and White (82.83%) groups all had higher rates of completion, performing above the 50th percentile. The Hispanic population was the only group who performed above the 90th percentile (86.62%). These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others among these four measures.

To address some of these disparities for prenatal and postpartum care, Partnership will continue to perform outbound call campaigns that encourage the perinatal population to attend their pre and postpartum appointments and encourages families to attend well-child visits with their children. In addition to these efforts, and to address key disparities, Partnership hosted multiple photoshoots in 2025 aimed at increasing prenatal and postpartum care and well child visit rates among African American/Black, Alaska Native/American, and Hispanic pregnant members, though all pregnant members are welcome to attend. This intervention aimed to: increase supportive community interactions between fellow pregnant Partnership members and their families, offer social support, as well as raise awareness and promote the use of available Partnership benefits such as doula services, and Partnership's perinatal programs which encourage vaccines typically received during pregnancy, as well as PCP visits before and after pregnancy. These photoshoot events have shown promising results and will continue into 2026. Partnership will also continue to participate in efforts that support members recently diagnosed with diabetes, with special emphasis on the African American, Native American/Alaska Native, and Pacific Islanders populations.

Furthermore, multiple ethnicities/races face many health disparities, with recent data demonstrating lower completion rates of prenatal care visits among the American Indian/Alaskan Native population. As such, Partnership will continue its strategy to strengthen relationships and collaborative efforts with perinatal health providers within its service area to decrease known health disparities amongst this population. Partnership has also been an active participant in Tribal perinatal efforts. One effort is creating homegrown collaboratives to identify needs and work towards interventions. For example, in Siskiyou County, these efforts aim to streamline collaboration among clinical and community initiatives to support perinatal care and education, expand cultural awareness across the health system and build provider skillsets for addressing pregnancy related urgencies. There are also Tribal driven efforts focused on providing community support to access, and education for pregnant individuals and families in which Partnership plays a supporting role. Furthermore, Partnership continues to grow its Tribal Liaison position to provide a more formal point of contact and advocate for Tribal community needs in alignment with new DHCS mandates. While there are sufficient resources currently allocated to strengthen existing relationships, Partnership will continue to explore modifying our programs as additional health needs are identified.

Lastly, 2026 plans for community-based research include a tentative focus group, centered on four priority disparities, several of which were noted in this assessment: Postpartum Care Visits, Well-Care Visits, Childhood Immunizations, and Colorectal Cancer Screening. Focus group locations were selected based on where priority member populations are most represented—for example, sessions in Eureka will focus on Tribal members.

F. Member Benefits/Services Education, Health Education, and Culture & Linguistics

Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them, which may lead to care gaps. While managed care plans have several departments dedicated to member support, Partnership continues to recognize an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, text messaging campaigns, and the distribution of educational materials at community outreach efforts in various threshold languages as appropriate.

One example is heavily promoting the Growing Together Program to Partnership’s providers and community partners; this program promotes well-child visits and perinatal care with (see Appendix B for the update flyer). Another example is Partnership’s

Member Services staff conducting in-person presentations. These presentations are referred to as “Member (or Community) Informative Sessions” and provide an educational and collaborative forum for new members and county partners while also building upon our organizational branding campaign centered around “Your Partner in Health”. At these sessions, Member Services staff provide an overview of Partnership’s services and the resources that are available to members. While onsite, Member Services staff provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Sessions may also be conducted in other languages and are available on request. The overall goal with these sessions is to ensure Partnership members and community partners gain knowledge about Partnership’s benefits and services, and to leave a positive and lasting impression that Partnership is responsive and here to support all the communities we serve. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members about available benefits like vision, mental health services, and preventative care services.

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

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

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings. The goal of these trainings are to engage staff and providers in topics relating to equity (e.g., race, ethnicity, gender, and more) and the barriers members experience that prevent them from being healthy. Partnership also hosts an annual Health Equity Week to educate on and promote health equity for its members and staff. Activities from Health Equity week 2025 included a staff town hall highlighting a health equity discussion, inter-staff interviews, member stories, and more. Finally, Partnership's Director of Health Equity developed and implemented a mandatory Diversity, Equity, and Inclusion training for all Partnership network providers and other relevant stakeholders in 2025; a pilot rollout went live mid-year and will continue into 2026. This offering is sufficient and will continue to be offered to key stakeholders.

VI. Stakeholder Engagement

Partnership solicits stakeholder engagement on the PNA through multiple pathways. The Population Health department uses reports from pertinent departments to draft the report. The Quality Improvement and Health Equity Committee (QIHEC) and Population Needs Assessment Committees review and provide feedback as needed on the draft of the PNA, along with any proposed interventions. Population Health staff also gather member feedback through Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with any proposed recommendations, and their feedback is incorporated in the final report as appropriate. Partnership also solicits stakeholder engagement on the PNA through several other committees as well.

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), and as part of DHCS regulatory requirements.

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

current activities and/or design new interventions to address the identified needs as necessary.

VII. Works Cited

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VIII. Appendix A: HEDIS® MCAS Regional Performance Report Year 2025; Measurement Year 2024

Select Report Year
Report Year 2025; Measurement Year 2024

HEDIS Plan Wide Performance
Report Year 2025; Measurement Year 2024
Performance Relative to Quality Compass® Medicaid Benchmarks

PARTNERSHIP HEALTHPLAN of CALIFORNIA

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

	Plan Wide Performance	National Medicaid Benchmarks			
Measures	**Plan Wide**	**25TH**	**50TH**	**75TH**	**90TH**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	29.65%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

* Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population.
** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD).
*** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method.
^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024.
# The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median.

1

IX. Appendix B: Growing Together Program Flyer

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

The Growing Together Program

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

The Growing Together Program features:

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

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

You will also get:

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

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

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

You will also get:

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

PartnershipHP.org (800) 863-4155 HealthEd175_102324

ACCREDITED NCQA HEALTH PLAN

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

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

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

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

You will also get:

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

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

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

X. Appendix C: Member Scholarship Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

MEMBER SCHOLARSHIPS 2026

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

Partnership HealthPlan of California is now accepting applications for the **2026 Partnership Member Scholarship Program!** This program provides one $10,000 scholarship and four $5,000 scholarships. Scholarships are awarded on the basis of: the quality of responses to essay questions; the strength of the applicant's expression of interest in a career in health care, social service, or public service; and a letter of recommendation.

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

How to enter: Entrants must complete the application form, including essay questions; obtain one letter of recommendation; and sign a waiver of confidentiality and release, as well as an accuracy statement. **Applications can be submitted from January 21 through March 18, 2026.**

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

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

Scholarship winners: Partnership will review all entries and determine recipients. Scholarship winners will be announced in Summer 2026.

For more information, visit our Member Scholarship Program webpage.

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

XI. Appendix D: Community Resource Page

XII. Appendix E: Provider Recruitment Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Recruitment Program

2025 – 2026

The Provider Recruitment Program (PRP) has been extended through our 2025 – 2026 fiscal year (FY). This program continues to support our contracted network in recruiting and retaining high-quality health professionals across our 24-county service area, ultimately enhancing Partnership members' access to care.

Important Updates:

- The FY 2024 – 2025 PRP cycle has concluded.
- To participate in the 2025–2026 PRP and be eligible for grant funding beginning July 1, 2025, organizations must have a fully executed FY 2025–2026 PRP agreement.
- A new Provider Retention Initiative (PRI) agreement is currently in development. Once the 2025 PRP agreement is fully executed, the PRI agreement may be made available to interested organizations.

Program Incentives Available (payable over five years):

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

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

Behavioral Health Professionals Program Highlights / Incentives Available:

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

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

Key Eligibility Criteria for PRP Support:

- For candidates actively practicing at the time of application, they must be from outside of Partnership's 24 counties.
- Providers in training or residency programs within Partnership's 24 counties are eligible for support.
- A reasonable effort must be made to request program support prior to making employment offers.

Questions:

Please contact the Workforce Development team at WFD@partnershiphp.org or visit our PRP webpage.

PartnershipHP.org (707) 863-4100

ACCREDITED NCQA HEALTH PLAN

XIII. Appendix F: Provider Retention Initiative

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Provider Retention Initiative

2025 – 2026

The Provider Retention Initiative (PRI) is now open for applications until June 30, 2026. The PRI is designed to recognize and retain primary care clinicians, providers of perinatal services (including labor and delivery) and/or obstetrics / gynecology, and psychiatrists who have devoted their careers to serving Northern California's safety net population. By incentivizing additional years of service, this Partnership initiative aims to preserve institutional knowledge, strengthen clinical leadership, and foster mentorship opportunities for emerging providers across our network.

Provider Eligibility:

The PRI is open to clinicians who deliver services to Partnership members through Partnership's contracted providers in our 24-county region.

PRI Incentives:

Three-year commitment required; awards are payable over three years.

- $45,000 for doctor of medicine (MD) / doctor of osteopathic medicine (DO)
- $30,000 for nurse practitioner (NP) / physician assistant (PA) / certified nurse midwife (CNM)

Payment Cycle:

Award	FY 25/26	FY 26/27	FY 27/28	FY 28/29
$45,000 MD/DO	$7,500	$7,500	$15,000	$15,000
$30,000 NP/PA/CNM	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA/CNM) has served organization and/or Partnership members for 15 years or more and is committed to at least three more years of service.
- Provider eligibility is limited to family medicine, internal medicine, obstetrics, pediatrics, and psychiatry.
- Provider must serve in a leadership or mentorship capacity within organization.
- Provider organization must submit a competitive grant application due to funding limitation.
- Provider organization must have a signed Provider Recruitment Program agreement with Partnership.

Questions:

Please contact the Workforce Development team: WFD@partnershiphp.org

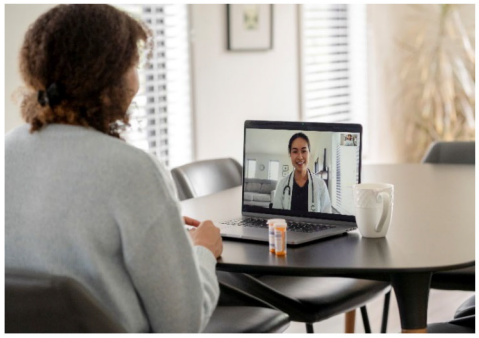
PartnershipHP.org (707) 863-4100

ACCREDITED NCQA HEALTH PLAN

XIV. Appendix G: At-Home Telehealth Specialty Visits

At-Home Telehealth Specialty Visits

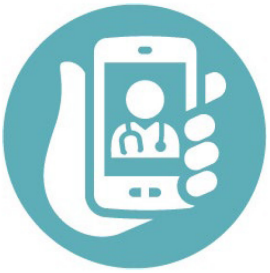
Did you know you could have a telehealth specialty visit from your home?



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

Here is how it works:

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



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

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

Read the questions and answers below to find out more.