Population Health Management Strategy & Program Description

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Table of Contents

Program Purpose 4
Introduction 4
Data Analysis and Strategy 4
Quality Improvement and Health Equity Committee (QIHEC) 8
Population Needs and Community Needs Assessments 8
Social Drivers of Health and Community Needs 10
Population Risk Stratification & Segmentation 11
Partnership's Risk Stratification Process 11
Future Risk Stratification and Segmentation and Risk Tiering 15
Programs and Services 15
Basic Population Health Management 16
Wellness and Prevention Programs 17
Organizational Support for PHM 18
Health Education 23
Material Development 25
Member Incentives 26
Point of Service Education 27
Practitioner Education and Training 28
Health Education Interventions 29
Other Activities – Interventions that Indirectly Affect Members 29
Informing Members About Available PHM Programs 31
Community Engagement and Coordination of PHM Programs 31
Informing Members on Interactive Content 34
Program Evaluation 34
Identifying Opportunities for Improvement 35
Delivery-System Supports for Population Health Management 35
Value-Based Payment Programs 36
Incentivizing Patient-Centered Medical Home (PCMH) Recognition 36
Sharing Data 37

eReports 37
Partnership Quality Dashboard (PQD) 38
Transformation Technical Assistance 38
Population Health and Health Education Delegation Oversight and Monitoring 39
Population Health Department Structure 39
Team Roles and Responsibilities 40
References 43
Population Health Management Strategy & Program Description Approval 44
Appendix A 45
Appendix B 46

Program Purpose

To identify the strategy and organizational structure Partnership HealthPlan of California (Partnership) utilizes to assess, segment, and act in order to meet the needs of its member population and subpopulations within the context of the various communities in which Partnership's members live.

Introduction

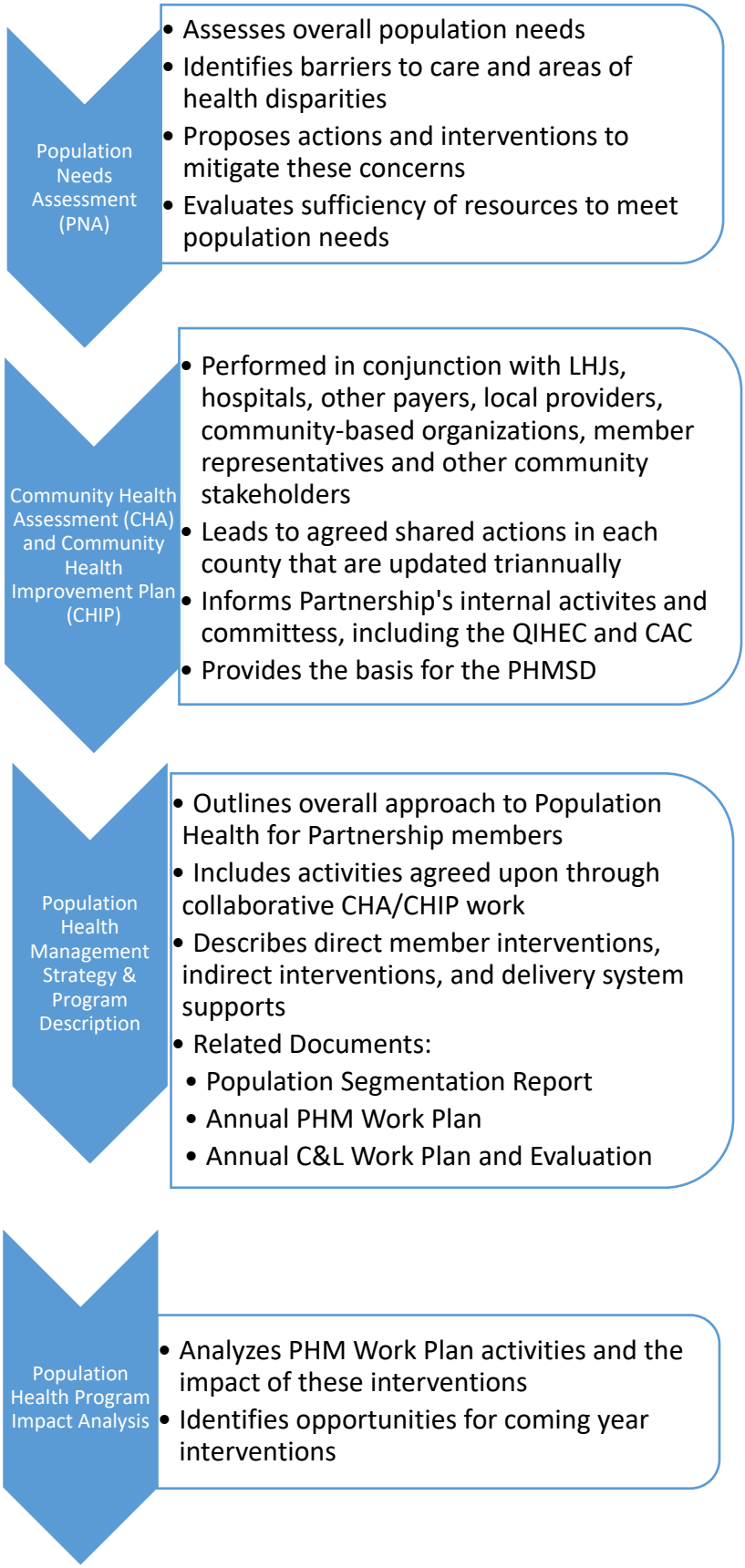
Partnership's Population Health Management (PHM) Strategy & Program Description outlines a cohesive plan of action for addressing Partnership's member needs across the continuum of care engaging not only the Population Health department, but also multiple departments within the organization. The unique characteristics and needs of Partnership's member population determine the programs and services designed to help individual members and subpopulation groups, in alignment with California's Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) requirements. This document also highlights Partnership-sponsored delivery system supports designed to enhance population health management within our provider network, describes the process for annual assessment of member needs, and the effectiveness of our population health strategy in meeting those needs. As part of Partnership's Population Health strategy, Partnership is committed to identifying root causes of health disparities for its members and collaborating across the organization, with providers, and with other community agencies to reduce inequities for the members we serve and to address Social Drivers of Health.

As part of NCQA requirements, Partnership performs an annual Population Needs Assessment (PNA), which identifies factors leading to health disparities for Partnership subpopulations, and outlines a plan for addressing and mitigating these disparities. In addition, as part of DCHS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), and Public Hospitals as appropriate, on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

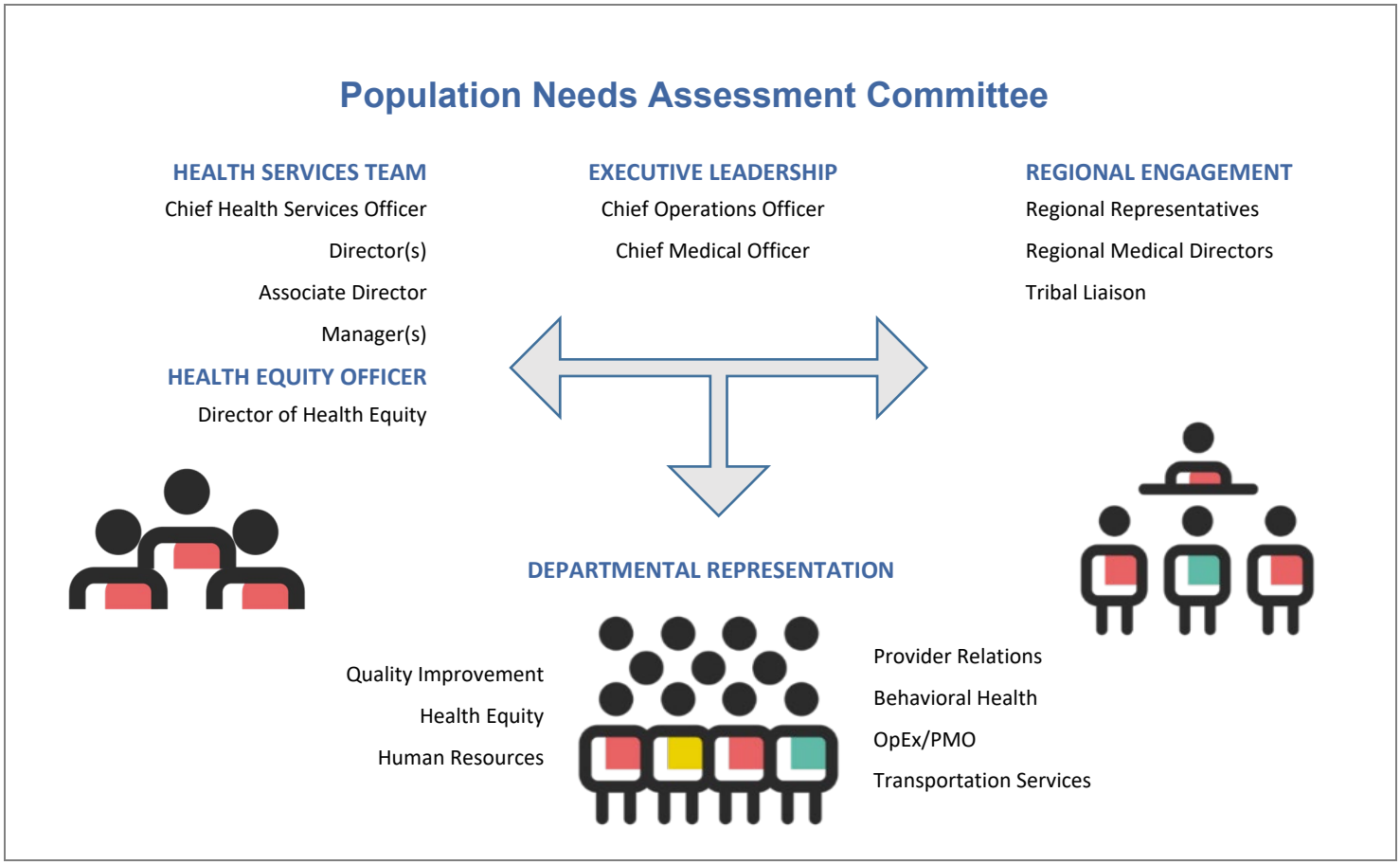
Data Analysis and Strategy

Partnership uses several methods to identify member needs, and to strategize the means best to meet them. Both the annual PNA and county CHAs/CHIPs describe the overall health, social, health education, and cultural and linguistic needs of Partnership's membership, including members who are less than 21 years of age, by analyzing service utilization patterns, disease burden, and gaps in care for our members, taking

into account their risk level, geographic location, and age groups and recommends interventions to address barriers and disparities. The PNA identifies community resources to integrate in program offerings (including Partnership's Community Resource pages), and describes Partnership's collaboration with network providers, LHJs, and community leaders in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies and are electronically submitted to the appropriate governing bodies per their respective reporting timelines. Key stakeholders within Partnership review the PNA and CHA/CHIP findings and from there, develop the annual PHM Work Plan, DHCS PHM Strategy Deliverable (PHMSD), Segmentation Report, Cultural & Linguistics (C&L) Work Plan, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description as appropriate. These work plans outline specific interventions to mitigate health disparities both on a member and system level. The PHM Strategy & Program Description (MCND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The PHM Work Plan provides details on specific member-facing interventions, staff who will perform the interventions, method of contact, and outcome measures Partnership will implement during the year. Similarly, the C&L Work Plan identifies specific health equity concerns and provides a strategy for how Partnership will address them through annual activities. The PHM Impact Analysis report evaluates Partnership's programs and services to determine if the benefits offered are adequate to meet our member needs and identifies opportunities for further intervention. The PHM Segmentation Report categorizes Partnership's subpopulations into the appropriate categories on the continuum of risk as defined by DHCS and NCQA and as described under "Organizational Support for PHM". The following diagram shows the relationship of these activities:


Population Needs Assessment (PNA)
• Assesses overall population needs
• Identifies barriers to care and areas of health disparities
• Proposes actions and interventions to mitigate these concerns
• Evaluates sufficiency of resources to meet population needs
Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)
• Performed in conjunction with LHJs, hospitals, other payers, local providers, community-based organizations, member representatives and other community stakeholders
• Leads to agreed shared actions in each county that are updated triannually
• Informs Partnership's internal activites and committess, including the QIHEC and CAC
• Provides the basis for the PHMSD
Population Health Management Strategy & Program Description
• Outlines overall approach to Population Health for Partnership members
• Includes activities agreed upon through collaborative CHA/CHIP work
• Describes direct member interventions, indirect interventions, and delivery system supports
• Related Documents:
• Population Segmentation Report
• Annual PHM Work Plan
• Annual C&L Work Plan and Evaluation
Population Health Program Impact Analysis
• Analyzes PHM Work Plan activities and the impact of these interventions
• Identifies opportunities for coming year interventions

In late 2023, Partnership replaced the Population Health Management and Health Equity Committee with the internal Population Needs Assessment (PNA) Committee. The PNA Committee is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PNA Committee Meetings occur on a quarterly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the implementation of the shared SMART goals between Partnership and each of the LHJs in Partnerships service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Quality Improvement and Health Equity Committee (QIHEC), Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.



Quality Improvement and Health Equity Committee (QIHEC)

Following each PNA committee meeting, the proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are forwarded to Partnership's QIHEC for deliberation and approval. The QIHEC consists of a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership members. The committee identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. It is also responsible for reviewing the PNA, CHA/CHIP updates, and other reports and data that represent Partnership's activity to promote the quality and equity of program offerings. For more information, see Policy MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

Population Needs and Community Needs Assessments

Partnership routinely collects data regarding cultural, ethnic, racial, linguistic, health education and environmental needs of its members, and conducts a quantitative and qualitative evaluation to determine unmet needs and areas of health disparities. Data sources may include, but are not limited to, US census and enrollment data, member surveys, member grievances, and other published health statistics, as well as data provided by Health Plan sponsors or other sources such as local community needs assessments. Partnership's Health Analytics and Health Education teams analyze the data collected no less than annually with the goal of ensuring Partnership and its providers deliver services that equitably meet the needs of our culturally and linguistically diverse member population.

Population Health staff prepare an annual Population Needs Assessment (PNA) for NCQA that describes our membership and region, including Partnership's demographics, community-identified needs and resources, health education, and cultural and linguistic needs, health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified disparities and promote health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, traditional health beliefs, and beliefs about health and health care utilization.

The Manager of Population Health provides a summary report of the NCQA PNA findings for discussion with the Consumer Advisory Committee (CAC) session and the Family Advisory Committees (FAC). Members of both committees are given an opportunity to provide input and advice on selecting Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs. The

NCQA PNA and its proposed actions also undergo review by Partnership's PNA Committee, the QIHEC, Internal Quality Improvement Committee, Quality/Utilization Advisory Committee, Physician Advisory Committee, and by the Board of Directors before submission to NCQA and DHCS per regulatory requirements. PNA findings are also sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide[1] and 2024 Contract, Partnership works collaboratively with LHJs, hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP report. This collaborative work has replaced DHCS's historically mandated PNA. The county CHAs/CHIPs represent the overall community needs and priorities, and provide an opportunity for health plans to work with LHJs, local hospitals, and other community stakeholders to prioritize local needs and agree upon a shared plan of action. The PNA committee, CAC, FAC, and QIHEC receive regular updates on the CHA/CHIP collaborative work and are provided an opportunity to give feedback. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

Each county has its own schedule for CHA/CHIP work, and Partnership will align its reporting with each county as needed until timelines are standardized in 2028. The shared action plans and findings from county collaborations lead to development of Partnership's annual PHM Strategy Deliverable (PHMSD) that demonstrates commitment to the implementation of prioritized actions and responses to community needs. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document and the annual NCQA-approved PNA. Findings from these collaboratives are also used to guide the following efforts:

- Targeted health education materials for members, and the creation of member-facing outreach materials for any identified gaps in services and resources, including but not limited to, Non-Specialty Mental Health Services;
- Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
- Wellness and prevention programs

[1] 2024 PHM Policy Guide

Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of Partnership's collaboration on the report.

Similar to the PNA review described above, the annual PHMSD will be shared with members (through CAC and FAC sessions as well as through key informant interviews), with the PNA Committee, the Quality Improvement Health Equity Committee (QIHEC), Partnership's Internal Quality Improvement Committee (IQI), Partnership's Quality Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Directors. These documents will be posted on Partnership's external website as they are updated, and provider newsletters will prompt providers when new versions are available.

Social Drivers of Health and Community Needs

Partnership's Health Analytics department estimates the impact of Social Drivers of Health (SDOH) for the region and membership through proxy data sources. One such source is the California Healthy Places Index (HPI) data produced by the Public Health Alliance of Southern California (healthyplacesindex.org). This freely available data set ranks California census tracts on a composite score of health disadvantage by incorporating data on 25 individual indicators organized in eight domains: economy, education, healthcare access, housing, neighborhoods, clean environment, transportation, and social environment. In every census tract, each indicator is shown on standardized scales (Z-scores) of increasing disadvantage, and averaged for each domain. The overall score is calculated as the weighted sum of domain scores. The HPI data set also includes the percentiles of each domain and individual indicator, as well as the overall composite values ranking each census tract.

Using the residential addresses of members found in the Membership data files received from DHCS, Partnership's Health Analytics team determines the geographic coordinate of each member's valid address and finds the corresponding census tract. The calculated census tract for each member is then joined with the HPI scores (https://healthyplacesindex.org/about/). These HPI scores are used in combination with the rest of the SDOH data to estimate the SDOH risks for each of Partnership's members.

Member-specific sources for SDOH data include location, distance from providers, and non-medical transportation claims that demonstrate member needs for services; demographic attributes found in membership data; specific social risk factors identified from diagnosis codes; and homelessness data derived from members' addresses and diagnosis coding. Members who are new to Partnership and having either a Senior or

Person with Disability (SPD) aid code, or identified as California Children's Services (CCS) beneficiaries complete a detailed assessment of their social supports, barriers to care, food security, and financial resources, as well as their medical history and current care needs.

Members who have serious mental illness or serious emotional disturbance (SMI/SED) receive care for those conditions through county-administered Mental Health Managed Care, which is carved out of Partnership's benefit package and assigned to the county in which the member lives (see All Plan Letter 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services).

In July 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. Partnership works together with our providers and partners in seven Partnership counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) to provide integrated physical health and SUD services for the Medi-Cal population.

In addition, Partnership's disease registry flags members with SMI/SED conditions, such as schizophrenia or major depression. Partnership uses prescription data for anti-psychotic and specific anti-manic medications as a means of identifying members who may have any SMI/SED, and leverages this data to ensure members with SMI/SED receive care for comorbid medical conditions.

Population Risk Stratification & Segmentation

Currently, Partnership analyzes and segments the entire population by need and appropriate intervention(s), as described in the Population Segmentation Report. Once DHCS has launched the PHM Service and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data points and methods to further stratify populations for intervention. Partnership's RSS and Risk Tiering approach is available upon DHCS request.

Partnership has developed a proprietary method currently in use for assigning members to a risk level, which will be used until DHCS launches the PHM Service's Risk Stratification and Segmentation and Risk Tiering Tool (RSST).

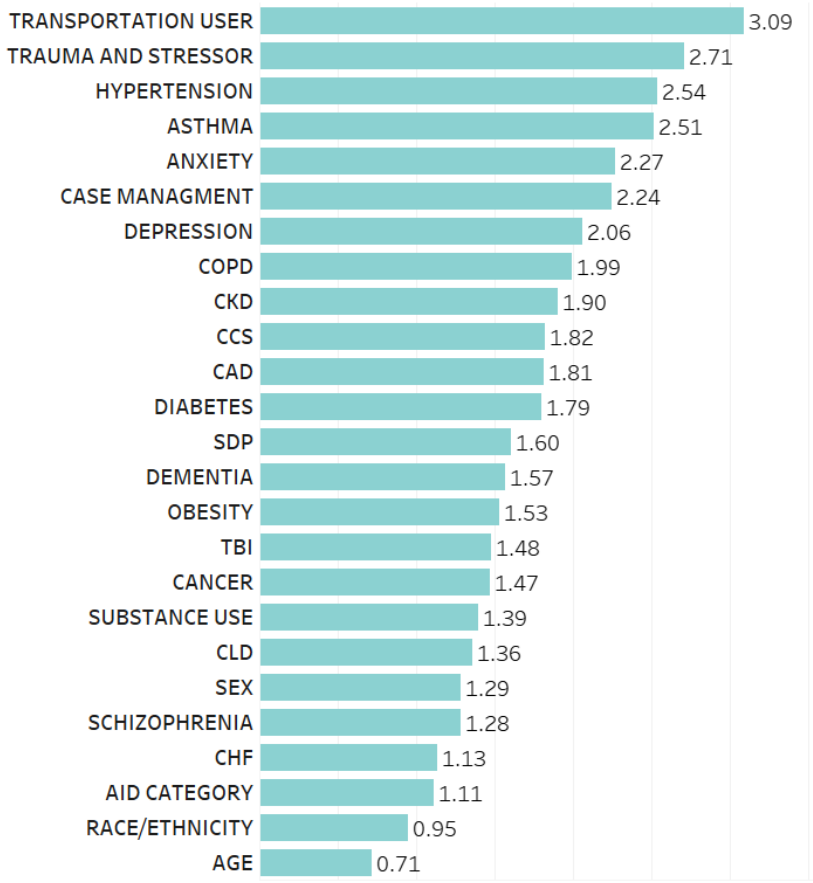
Partnership's Risk Stratification Process

Partnership's Health Analytics team has developed a risk score model that predicts member's risk for becoming a high-utilizer at individual level by applying the following data sources: member demographic data, claims (behavioral, medical, and pharmacy),

case management enrollment, and external data (California's health index and census tract). This risk score model forecasts the likelihood of a member becoming a high utilizer within the next six months. A member will be classified as a high utilizer if they meet any of these four criteria within a six-month period: (a) five or more ED visits, (b) one or more acute hospital admission, (c) fifteen or more distinct drug prescriptions, or (d) total paid claims of more than $50,000 for medical cost (hospital and pharmacy). During the development of the risk score model, the health utilization of the entire Partnership population was included in the study to avoid any sampling bias and also ensured no bias from other factors like race and ethnicity. The risk score model adjusts for social determinants, demographics, member's aid category, chronic disease conditions (up to 19 chronic conditions as defined through HEDIS or CMS protocols), as well as the member's eligibility criteria under the CCS program or SPD aid codes. In the realm of social determinants, the risk score adjust for homelessness, non-emergency transportation usage, and the Healthy Places Index. Similarly, in the demographic category, the adjustments include gender, age, and race/ethnicity.

The relative significance of these factors on the member's overall risk score is estimated using the odds ratio. The higher the odds ratio, the higher the contribution of that factor to the risk score. The bar chart below shows the odds ratios of all the factors that have a statistical significant contribution to the risk score. For example, members who use non-medical transportation benefit are 3.09 times more likely to become high utilizers compared to those who do not use this benefit, holding all other conditions constant. Similarly, considering the race and ethnicity factor, the white population (with an odd ratio of 0.95) is slightly less likely to experience the risk comparing to other race and ethnicity groups.

The influence of isolated factors on a member becoming a high utilizer



The risk score generated from this model has values ranging between zero and one, going up to 5 decimal places. In addition, the entire Partnership membership is segmented into four risk tiers by defining risk score ranges that delineate homogenous risk groups.

Accordingly, the risk tiers are assigned as follows:

No Risk:	Risk score is less than 0.02004
Low Risk:	Risk score is between 0.02004 and 0.0742
Medium Risk:	Risk score is between 0.0742 and 0.20038
High Risk:	Risk score is above 0.20038

Within every risk tier, we evaluated the distribution of race and ethnicity and ensured that there were no significant biases due to the risk segmentation.

Risk scores prove valuable in assigning members to risk-tiered programs for individuals whose health and well-being require the support of intensive interventions.

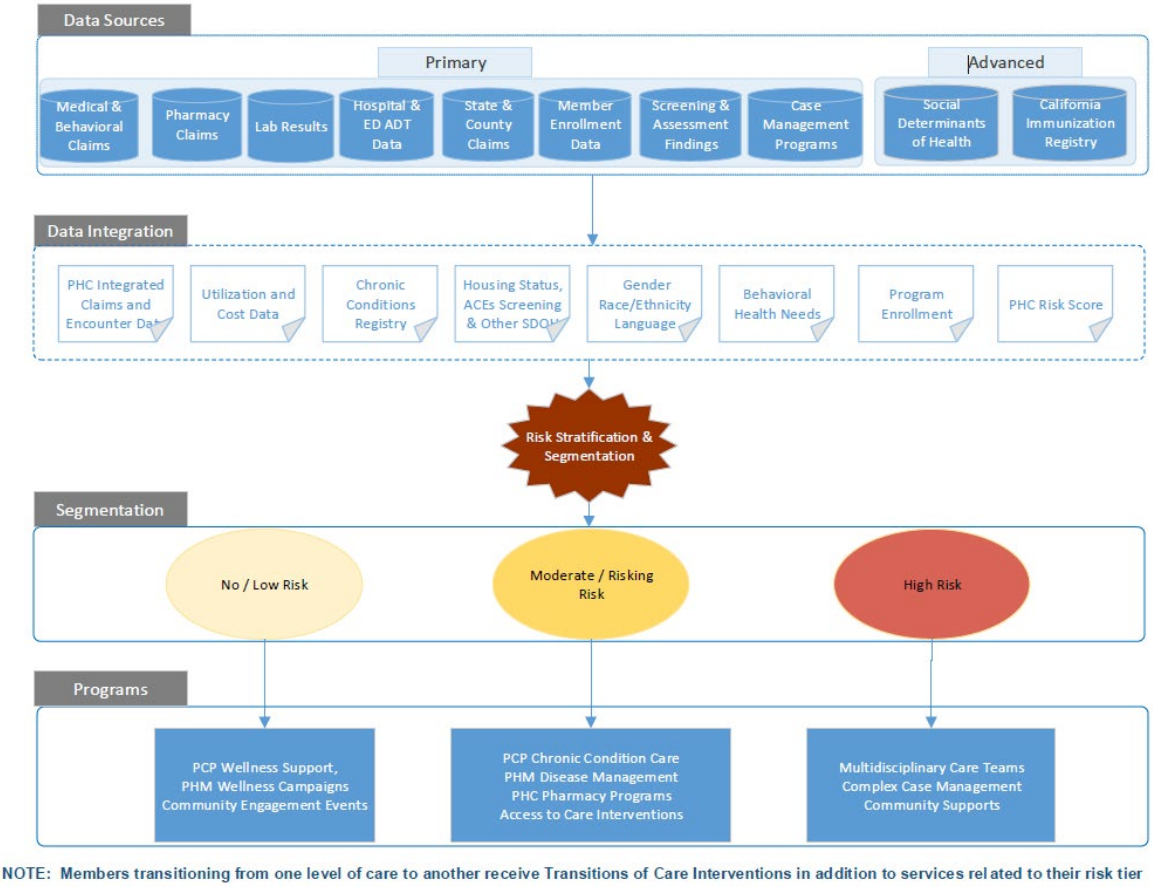
Partnership's Health Analytics team runs the risk stratification report every month so that members who have a significant change in health status are captured and offered appropriate interventions to support their health and wellbeing. In addition, Partnership's Quality team uses HEDIS data to evaluate Population Health interventions. Partnership analyzes HEDIS performance by race/ethnicity and language to identify statistically significant disparities that drive development of interventions to promote health equity within its membership.

HEDIS measures provide insight on members having gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. Partnership's Population Health team uses monthly care gap reports to perform outreach to members, explaining their benefits and connecting them with providers.

The PNA describes how Partnership analyzes HEDIS Measure results in aggregate, by race/ethnicity, and by language, and examines individual measures for evidence of subpopulations experiencing disparities that warrant intervention. Census, Healthy Places Index, and County Health Rankings data provide insight into the challenges faced by communities and racial groups that lead to health disparities, such as food insecurity, housing problems, tobacco use, and other concerns. Data provided by our providers and community partners also helps identify opportunities and interventions for members with low risk scores, insufficient data to assign a risk score, or members who may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the impact of racial bias that could result from risk stratification based solely on utilization patterns by evaluating the entire population through multiple lenses (including race, language, housing status, and other social factors) for enrollment into a wide variety of programs that meet subpopulation needs according to shared identifiers. Partnership will continuously reassess the effectiveness of the RSS methodologies and tools.

Partnership works in collaboration with local providers and community resources to analyze, develop, and implement interventions that support the health and well-being of the entire population (see diagram).

Partnership's Risk Stratification and Segmentation Process



NOTE: Members transitioning from one level of care to another receive Transitions of Care Interventions in addition to services related to their risk tier

Future Risk Stratification and Segmentation and Risk Tiering

After the release of the DHCS PHM Service's RSST methodologies, Partnership will assign member risk first based on the DHCS methodology, and will ensure members who are identified as high-risk are assessed for appropriate intervention, including care management programs, BPHM, and Transitional Care Services. Partnership will also evaluate members through its proprietary methodology to cull members not identified through the DHCS RSST methodology, who may benefit from Partnership interventions, programs, and services. Partnership will perform the RSST process no less than annually and/or upon each member's enrollment, a significant change in health status/level of care, and upon an occurrence of events or when new information arises that potentially changes a member's needs.

Programs and Services

Partnership leverages committees and multidisciplinary workgroups to design and implement programs and services. Using the risk stratification and segmentation

method described above, the Population Health department maintains a PHM Work Plan that describes the interventions offered to members along the continuum of risk. These interventions represent Partnership's basic population health management and case management service offerings to improve the health of our members and to promote health equity within the communities we serve. Beyond the interventions described in the PHM Work Plan, Partnership collaborates with providers, specialty groups, community based organizations (CBOs), public health agencies, local education agencies, justice programs, and other agencies to support the health and well-being of the members and communities we serve.

Basic Population Health Management

Partnership's BPHM is for all members. BPHM includes services such as having an ongoing source of care, Care Coordination, and sharing resources and education to improve the health of members.

Each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs. Partnership also works to ensure members are engaged with their assigned PCP, and receive all needed preventive services. Member utilization reports are reviewed to identify members not using primary care. At minimum, reports are stratified by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services. Strategies are then developed to address differences in utilization to promote health equity for all members.

Partnership works to ensure the member's PCP plays a key role in the member's care coordination. Members receiving care from out-of-network providers will maintain efficient care coordination and continuity of care. Members have access to needed services including:

- Care coordination
- Navigation and referrals to services that address a members' developmental, physical, mental health, substance use disorder, dementia, long-term services and supports, palliative care, and oral health needs
- Help with making appointments
- Help with arranging transportation
- Health education on the importance of Primary Care when disengaged with their Primary Care Provider, especially among members less than 21 years of age

To address members' needs, health and social services are coordinated between settings of care, across other Medi-Cal MCPs, delivery systems, and programs (e.g.,

Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services. Referrals are coordinated to ensure Care Coordination with public benefits programs. Members, and members' parents, family members, legal guardians, authorized representatives (ARs), caregivers, or authorized support persons can receive assistance with navigating the health delivery systems in order to access care and services that may benefit the member. All care coordination provided to a member is communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons as appropriate. Partnership maintains processes to ensure there is no duplication of services.

Members are further provided with resources and education about how to access the various programs and services offered by organizations Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed MOU. Members are also provided with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that promotes health equity for all members.

Providers serving Partnership members must maintain and share, as appropriate, the members' Medical Records, and any necessary member information, in accordance with professional standards and State and federal privacy laws and regulations.

Wellness and Prevention Programs

Partnership provides wellness and prevention programs that strive to align with NCQA PHM standards and DHCS requirements, including access to evidence-based self-management tools through our member portal. All members also have access to culturally and linguistically appropriate health education materials.

Partnership provides wellness and prevention programs to improve the health outcomes of all members. Eligible members have access to evidence-based disease management and improvement programs that incorporate health education interventions, target Members for engagement, and/or seek to close care gaps for participating members that include, but are not limited to:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

- Improving access to preventative health visits, developmental screenings, and services for members less than 21 years of age
- Improving pregnancy outcomes for women, including through 12 months post-partum
- Ensuring adults have access to Preventive Care
- Programs aimed at helping Members set and achieve wellness goals.

Partnership works to ensure there is a process for monitoring the provision of wellness and preventive services by PCPs as part of its contractor's site review process. Partnership also submits its wellness and prevention programs to DHCS for review and approval as appropriate, and strives to align its wellness and prevention programs with the DHCS Comprehensive Quality Strategy.

On an annual basis, Partnership's DHCS PHMSD reports how community-specific information and stakeholder input from the CHA/CHIP collaborations are used to design and implement evidence-based wellness and prevention strategies. Findings from the NCQA Population Needs Assessment are also incorporated into the design and implementation process of wellness and prevention strategies.

Organizational Support for PHM

As an organization, Partnership is engaged in promoting the health and well-being of members. Various departments address particular segments of the population, per NCQA's four area of focus and DHCS's three levels of risk. For example, Member Services, Quality Improvement, the Population Health department with the Health Education Unit, all provide outreach to members with no identified risk or low risk to Keep Members Healthy, offer BPHM interventions, and promote health equity where there are barriers to health. Population Health and its Health Education Unit, Quality Improvement, Pharmacy, and Care Coordination collaborate to identify and support Members with Emerging Risk, including racial or language groups with health disparities. Care Coordination collaborates with Utilization Review and Member Services to assist members with their Outcomes Across Settings and to bolster provider communication along the continuum of care. Care Coordination's clinical and social work teams provide highly skilled support to assist members who are Managing Multiple Chronic Conditions.

Members may move up and down the acuity continuum as their needs change, and services are matched to the member's evolving level of need. A member may have few identified risks, but might have difficulty navigating the healthcare system and require an intensive level of intervention through Partnership's Complex Case Management (CCM), or through other member benefits such as Community Health Worker (CHW)

support or Enhanced Case Management (ECM). Conversely, a member with multiple chronic conditions may have well-established support systems and not require assistance from the Care Coordination team in order to access care. The information in the following table outlines Partnership's approach to population health management. The PHM Work Plan and supporting desktop procedures provide details about each service and the associated goals for member segments.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
No/Low Risk: Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	*Keeping Members Healthy*	*Member Needs:* To understand benefits and how to access them; identify and access providers for primary care; help with prescriptions or DME; access to non-Partnership services (Denti-Cal, In Home Support Services, etc.). *Population Health Interventions:* Member outreach campaigns to promote well-child visits or other wellness care. Collaborate with local agencies to identify community events for underserved communities (immigrant populations, homeless members, rural and frontier communities, etc.) to promote Partnership services and benefits. *Health Education Interventions*: Develop and distribute member newsletters and benefits information. Create educational materials on various health topics in threshold language groups and racial groups that have outcome data revealing inequities. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers. *Quality Interventions:* Provide HEDIS-based gap reports to providers, showing

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		which members are missing well care visits, timely immunizations, and cancer prevention screenings; evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and the quality of care members receive.
Moderate / Rising Risk Pregnant members, or members that that have risk of disease/ disease exacerbation, or a newly diagnosed chronic illness. Racial groups with inequitable access to health care, e.g., American Indian access to mammograms.	*Managing Emerging Risk*	*Member Needs:* Access to specialty care and/or behavioral health providers to manage emerging or stable chronic conditions; resources/education supporting lifestyle management to maximize health and wellness, and mitigating effects of chronic disease; education on managing new diagnoses. *Population Health Interventions*: Offer BPHM services to engage members to understand barriers to care; provide member coaching on how to manage chronic illnesses. Outreach to members who are homebound or vulnerable to poor air quality to encourage them to prepare for disasters and wildfires. Schedule mobile mammography clinic days in conjunction with Tribal Health clinics. *Care Coordination Interventions:* Outreach to CCS members who have not had an annual well-child visit to encourage them to maintain program eligibility; coordinate care for members who identify (or whose provider identified) a care gap or equipment gap,

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		who need basic case management support. *Grievance Interventions:* Streamlined grievance process and produced educational videos in multiple languages to educate non-English speaking or LEP members on how to report dissatisfaction. Conduct ongoing grievance process improvement efforts. *Health Education Interventions:* Develop and distribute educational member materials on staying healthy, common conditions, and their management, aligning with member age, sex, education, culture, and at a 6th-grade reading level. *Quality Interventions:* Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. Member Services uses these reports to remind members of these care gaps during member calls. Evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and member-level outcomes
Transitions of Care: Members going through	*Outcomes Across Settings*	*Member Needs:* Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
transitions in their care.		*Member Services Interventions:* Support members discharged after hospitalization who may need to establish care with a PCP. *Utilization Management Interventions:* Collaborate with facility discharge planners to approve post-acute care needs. *Care Coordination Interventions:* Review and implement of hospital discharge plan; coordinate services; assess member's need for ongoing case management; help schedule follow-up appointments; ensure transportation is available to attend appointments; collaborate with the PCP office to ensure a full transition of care.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
High Risk: Members with multiple chronic conditions, unmanaged conditions like asthma or diabetes, medically fragile, frequent visits to emergency department and/or inpatient admissions; may also have poor social supports or other psychosocial issues.	*Managing Members with Multiple Chronic Conditions*	*Member Needs:* Coordination of medically complex care needs. Members may have multiple chronic conditions or unmanaged chronic conditions or may be complex due to other factors such as disorganized care delivery, cognitive or developmental impairment, behavioral health challenges, or lack a wellness support structure. *Care Coordination Interventions:* Complex case management support; personalized assessments; individualized care plans; motivational interviewing; medication reconciliation; education/support for disease(s); coordination of services; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts; may include face-to-face interactions.

Health Education

The Health Education team is integrated into the Population Health department and works closely with all Partnership departments to assess member needs, to evaluate and improve established programs/activities, and to develop and implement new programs/activities/materials to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver evidence-based health education programs, services, and education materials directly to members (including members under age 21), and through members' health care providers according to members' health education and cultural and linguistic needs and preferences.

The Health Education team uses general health education, health promotion, and patient education methods to help Partnership's members prevent sickness and

disease; improve their health; manage their illnesses; effectively use health care services; and ensure that members who have not had a recent visit with their assigned medical home or PCP receive health education on the importance of primary care (including members under age 21). Partnership also provides health education opportunities to members directly through resources offered on the Partnership Member Portal and via select subcontracted providers who are skilled in delivering health education services and whose performance is monitored. Select written Health Education materials are available on Partnership's website for members, providers, and the community at large. Partnership members can also call in or email Population Health to request additional health education materials or resources. Finally, Partnership promotes health education information and Population Health programs through the member newsletter, the provider newsletter, the Partnership website and social media, and through targeted outreach.

Partnership's Health Education system promotes member health through 3 categories of educational interventions:

- Effective use of managed health care services: Partnership provides written information (at a 6th grade reading level) to help members effectively use the services of their managed care plan. This includes accessing preventive and primary health care services, obstetrical care, appropriate use of complementary and alternative care, dental and vision care, and health education services.
- Evidence-based Risk-Reduction as well as Wellness & Prevention programs: Partnership connects members to educational interventions designed to modify health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes. Programs can include: smoking and tobacco cessation; managing stress; injury prevention; prevention of sexually transmitted diseases and; nutrition/healthy eating, weight maintenance, physical activity; avoiding risky drinking; and identifying depressive symptoms. These interventions are available on Partnership's Member Portal as Healthy Living Tools.
- Evidence-based Healthy Lifestyle, Self-Care, and Management of Health Conditions: Partnership provides or connects members to health educational interventions that can help members learn about and follow self-care management for existing chronic diseases or health conditions like obesity, pregnancy, depression, asthma, diabetes, and hypertension.

This collection of health education strategies forms the health education system. The health education system is maintained and monitored to ensure equal access to all Partnership programs for all members, including accessibility for Limited English

Proficient (LEP) members; to ensure appropriate allocation of health education resources; and to conduct appropriate levels of program evaluation. All programs and materials are available to members at no charge. Programs will not discriminate against Partnership members for any reason.

The Senior Health Educator participates in Partnership's internal committees, addressing quality and compliance with Partnership's programs. The Senior Health Educator ensures that all health education programs and materials are appropriate for members of varying demographics, including but not limited to: language, age, race, ethnicity, national origin, disability, sex and gender per Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557).

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other departments, the Health Education team develops targeted health education materials to help members modify health behaviors, achieve healthy lifestyles, and promote health equity (See Appendix A). Data from the PNA, CHA/CHIP collaboratives, other resources, and regulatory requirements also guide decisions regarding the availability of health educational materials and resources for specific member populations. Furthermore, the health education team assesses member health care needs and barriers to care by consulting regularly with the Consumer Advisory Committee (CAC), the Family Advisory Committee (FAC), community organizations, Partnership's Chief Medical Officer, and also through community outreach such as through CHA CHIP efforts, use of Healthy Living Tools, and analysis of Partnership's data. Materials are available to members through direct mail, their network provider's office, community events, on the Partnership website and Member Portal, and via email by request.

The Senior Health Educator assesses written, member facing materials for readability and suitability according to state and national guidelines, which ensures that member facing materials are written at the sixth grade reading level using a readability formula that is most appropriate and reliable for the type of materials and target audience. The Senior Health Educator also ensures that health education materials are culturally and linguistically appropriate for the intended audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up-to-date. Health education materials are made available in Partnership's threshold languages, large font, and in any of California's top 18 non-English languages upon the request of the member. Partnership's qualified Health Educator(s) can approve written member health education materials as long as the following conditions are met:

- Materials purchased to distribute for member health education are from a DHCS approved company. The Health Education team will maintain a list of approved companies as these are updated by DHCS throughout each year.
- Materials are field-tested to ensure written health education materials are understood by the target audience. The qualified Senior Health Educator will provide oversight of the field-testing of all materials. Field-testing is designed to garner feedback from the targeted audience for the materials and may include community focus groups, key informant interviews, simple review and surveys by community member, and/or review during Consumer Advisory Committee and Family Advisory Committee meetings. The health education team will review the results and adapt materials as needed and as appropriate.
- Health Education materials are assessed using the Readability and Suitability Checklist (per DHCS website requirements). They are approved when:
    - A majority of the Readability and Suitability Checklist provisions are met.
    - When some of the Readability and Suitability Checklist provisions are somewhat met and/or not met, so long as the qualified Health Educator provides justification, and keeps the justification on file with the Suitability Checklist.
- The signed/approved Readability and Suitability Checklist, along with the approved health education material, must be kept (electronic file or hard copy) by the health plan and made available to DHCS for auditing/monitoring purpose upon request.
- The assessment and approval process must be conducted by a qualified health educator/health education specialist with the equivalent training and background required by DHCS per APL 18-016.

Health education staff who do not meet the definition of a “qualified health educator” as listed above will not approve health education materials for Partnership. If Partnership does not have a qualified health educator on staff to assess and approve health education materials, Partnership will submit health education materials to the Managed Care Quality and Monitoring Division (MCQMD) of DHCS for review and prior approval, along with a completed Readability and Suitability Checklist.

Member Incentives

Non-monetary member incentives (MI) may be used in conjunction with, or as a component of, Partnership education programs and Basic Population Health Management programs to motivate members to adopt heathy behaviors, enhance health education activities, including participation in focus groups, or to gain feedback on member experiences. Member incentives must meet DHCS guidelines and follow

Partnership's approval process for Member, Survey and Focus Groups (see Appendix B). MI program components include, but are not limited to:

- Increasing member participation, learning, and motivation to effectively use health care services including preventive and primary care services.
- Appropriate health care utilization that includes, but is not limited to:
    - Timely prenatal and post-partum care
    - Timely immunizations
    - Timely well child visits
    - Timely screenings (i.e., mammograms, colorectal screening)
    - Regular monitoring tests for chronic diseases
- Non-monetary member incentives that may range in value depending on the components and complexity of the health education program.
- A Member Incentive Request, Focus Group Request, or Survey Request form (per APL 16-005) that includes:
    - Completion of the MI request form by a qualified Health Educator
    - Review by Partnership's Regulatory Affairs and Compliance Coordinator
    - Submission to DHCS Health Education Consultants for final review and approval at least two weeks prior to implementing new MI programs or focus groups.
- Annual Member Incentive, Focus Group, and Survey Incentive Evaluation forms are required to be submitted to the DHCS Health Education Consultant thirteen (13) months after the planned program start date, covering the prior 12 months. If the program has ended, a Member Incentive Evaluation form must be submitted to the DHCS Health Education Consultant within 45 days from the date the program ended. Focus group and survey incentive program evaluation forms are due 60 days after the due date for completed surveys.

Point of Service Education

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 90 days of a member's assignment to a PCP (whichever is most recent). Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process. The IHA must include the member's physical and behavioral health history, identification of risks, an identification process of any needs for preventive screens or services, referrals to health education where appropriate, physical examination, and if applicable, the diagnosis and treatment plan for any diseases.

Primary Care Providers (PCPs) are responsible for the screening and identification of members with specific health educational needs. PCPs are also responsible for

providing appropriate health education information or referring the member and/or the caregiver to Partnership's Population Health department for assessment of appropriate health education activities or materials, and for following up on referrals (including providing anticipatory guidance).

Members can also identify their own needs for health education. Partnership makes educational materials, resource information, and other tools (such as training, and programs) available to help network providers provide health education services. Select Health Education materials are available on Partnership's website or upon request.

Partnership Health Education materials and resource topics are also available on Partnership's Member Portal and include, but are not limited to:

- Age-Specific Anticipatory Guidance
- Alcohol and drug use
- Asthma
- COPD
- Chronic Disease Management
- Diabetes Management
- Family Planning (contraception)
- Heart Disease & Prevention
- HIV/STD Prevention
- Immunizations
- Injury Prevention
- Living Well with a Disability
- Medication Management
- Nutrition
- Parenting
- Perinatal/Breastfeeding
- Physical Activity
- Preventive Screening
- Senior Services
- Stress Management
- Tobacco Prevention & Cessation
- Weight Management & Exercise

Practitioner Education and Training

Partnership's Health Education team supports network providers through trainings on the unique cultural needs of Partnership's member populations. The PNA and CHA/CHIP collaborative serves as guidance for provider trainings highlighting Partnership members' beliefs about illness and health, their cultural health behaviors, and their preferences for interacting with providers and the health care system. The trainings are designed to support network providers and their staff in providing effective health education in a manner that respects the cultural and linguistic diversity of patients and promotes health equity.

Starting in 2025, Partnership will offer trainings to providers in its network on topics of health equity, including cultural competency, bias, diversity or inclusion training. Some of the trainings will include information about relevant health inequities and identified cultural groups in the Partnership's service area. Topics may include, but are not limited to: seniors and persons with disabilities awareness and sensitivity, preventive health

care for children, alcohol misuse screening and counseling, and other concerns as appropriate for the population. Other trainings may also include PHM program requirements, including referrals, health education resources, and provider and member incentive programs. Trainings may be delivered in person, virtually, and made available on the external website.

Health Education Interventions

The CHA/CHIP efforts, PNA, and other regulatory requirements serve as vehicles for setting the Health Education Program goals, which are documented in the Quality Improvement and Health Equity Transformation Program (QIHETP)/Cultural & Linguistic (C&L) Work Plan as appropriate. The annual QIHETP/C&L Work Plan and C&L Evaluation report describes the methodology for evaluating intervention outcomes to ensure Partnership is effective in delivering high-quality health education and culturally and linguistically appropriate interventions for our members to promote health equity and reduce disparities. The PNA and conclusions drawn from CHA/CHIP efforts evaluate and make recommendations for appropriate allocation of health education resources based on needs assessment findings, provider training results, Partnership staff training results, intervention evaluation results, and other data. The departments responsible for each specific intervention monitor their outcomes to ensure program objectives are being met. Performance improvement plans are implemented as necessary to improve Partnership and provider performance in delivering programs and services to our members.

Other Activities – Interventions that Indirectly Affect Members

There are many opportunities to collaborate through joint action with providers, county initiatives, and local care management programs to meet the needs of individual members. The following table describes the strategies used to promote population wellness through partnerships with community resources and organizations.

Initiative Type	Definition
Partnership Provider Population Reports	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. Supports providers in conducting direct outreach to close gaps in preventive care.
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.

Initiative Type	Definition
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services.
Poster Campaign, School Engagement	Educational events where students create art projects that amplify a health topic (e.g., immunizations, tobacco prevention); engagements with screening sessions at school clinics.
Provider Newsletters	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations department (Provider Newsletter) with dedicated space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
Provider Education	Coaching, consultation, measure review, and in-depth guidance for providers on HEDIS/Quality Improvement Program (QIP) measures as part of the Partnership value-based payment program, improving communication between providers, and promoting appropriate specialty referrals. Annual training on health equity.
Provider Fax Blast (email or fax)	Communication to all network providers for important updates (e.g., a fax blast on new standards for using combined long acting beta agonist/corticosteroid combinations in treating asthma).
Partnership Website	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
Point of Service Interaction	Inform pharmacies of important clinical issues (such as drug class duplication) through point of service notices.
Media Campaign	Social media campaign(s) and county-level websites focused on improving member education and influencing member decision-making in preventive services/screenings. Websites include Public Service Announcements from local providers and community-based organizations.

Informing Members About Available PHM Programs

Partnership shares information on programs and services available to the communities it serves in multiple ways, including Partnership's website (PartnershipHP.org), the Partnership Member Portal, member newsletters, program introductory letters, and telephonically through Partnership's Care Coordination, Population Health, and Member Services departments. When a member requires a referral to a Population Health or Care Coordination program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

Community Engagement and Coordination of PHM Programs

Partnership has committed to being an active partner in each of the communities it serves, through local presence, local knowledge, and consciously building productive and strong working relationships. The new emphasis on Population Health is an exciting opportunity to expand community engagement activities and build on the strong partnerships developed over many years, and in some cases, decades.

Partnership is divided into five distinct geographic areas, with regional offices strategically located in each area. Regional offices and the regional staff are responsible for working closely with local providers of health care to Partnership members, county health and social services departments, local health improvement coalitions and a variety of community-based organizations addressing the social, economic and health needs of Plan members. Regional staff live and work in these communities and share their knowledge of the managed care program with the community, and just as importantly, share their knowledge of the community with Partnership.

Regional staff meet regularly with county health and social service leaders to share information and collaborate on projects with aligned goals, such as childhood immunization campaigns, local disaster response management or planning, CHA/CHIP activities, and more. These staff attend a variety of community organization meetings and collaboratives, and they participate in local initiatives aimed at improving health and quality of life for Partnership members and others in the community. All communities (including Partnership) came together to respond to the devastating wildfires in Northern California, forming strong working relationships. Regional staff were able to build on these working relationships as the COVID pandemic emerged to share information, communicate consistently, and build cohesive strategies in each community. Partnership seeks to continue this type of collaboration for years to come.

Partnership has many different member programs/initiatives concurrently planned and executed. In order to prevent duplication of effort, any department planning or

implementing programs affecting our members has read-only access to Essette, Partnership's case-management software system. A move to a new system is planned after mid-2024. Member-facing campaigns are logged in a Campaign Tracker and shared with the entire organization, ensuring staff are aware of current interventions. Monthly check-in meetings include all member-facing departments, and provide updates on new initiatives and outreach campaigns. Population Health department staff communicate with providers, multidisciplinary health agencies, community resources, community-based organizations, and workgroups to share and gather information about member-facing programs. This process facilitates identification, planning, and support of healthy initiatives in the community, and identifies community programs and resources that can improve member health and wellness.

Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may be of benefit to Partnership's members and share these resources with the organization to promote integration into program offerings and meet member needs. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms, along with the cloud-based Collective Medical Platform to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCCP2032). This allows members of Care Coordination or other member-facing teams to collaborate with community partners and external case management leads without duplicating services. In addition, Partnership has appropriate agreements in place with each lead entity to ensure HIPAA mandates are followed and member data is not shared inappropriately.

Per DHCS's California Advancing and Innovating Medi-Cal (CalAIM) effective January 1, 2022, members with exceptional clinical and non-clinical needs have access to a community-based benefit called Enhanced Case Management (ECM). ECM provides

coordination of services and comprehensive care management through an interdisciplinary, high-touch, person-centered care plan. Members who qualify for ECM services are tracked through a shared data platform to promote communication between providers and reduce duplication of effort.

Partnership also executes Memorandums of Understanding (MOUs) with the following Third Party Entities to ensure the delivery of services to Partnership members:

- County In-Home Supportive Services to coordinate between county and managed care plan (MCP) for members who may be eligible for and/or are receiving IHSS
- Regional Centers for the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center, including Intermediate Care Facilities for Developmentally Disabled Services
- Mental Health Plans (MHPs) to coordinate between MCP and MHP for Non-specialty and specialty Mental Health Services
- Substance Use Disorder Treatment Services to coordinate covered substance abuse services between DMC-ODS and MCPs
- Local Health Jurisdictions/Local Health Departments to coordinate between LHJ/LHD and MCP for the delivery of care and services for Members who reside in LHJ's jurisdiction and may be eligible for one or more services provided, made available, or arranged for by LHJ including:
    - California Children's Services (CCS);
    - Maternal and Child and Adolescent Health; and
    - Tuberculosis Direct Observed Therapy;
- County Social Services for Child Welfare to coordinate between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services
- Women, Infant, and Children (WIC) to coordinate services between WIC Agencies and MCP to ensure provision and delivery of MCP's Covered Services and WIC Services to Members
- Local Government Agency (LGA) County-Based Targeted Case Management (TCM) Program to coordinate services between LGA TCM Programs and the MCP to ensure the delivery of care and services for eligible Members.
- County Behavioral Health Departments to coordinate services around Substance Use Disorder Treatment Services in Drug Medi-Cal State Plan Counties

Other MOUs with the following organizations will be effective on January 1, 2025:

- HCBS Waiver Agencies and Programs
- LGA/Jails, Juvenile Facilities and Probation Departments
- Continuum of Care
- First 5 Programs
- Area Agencies on Aging
- California Caregiver Resource Centers
- Local Education Agencies (LEAs)
- Indian Health Services/Tribal Entities

By January 1, 2025, Partnership must also have a process to implement DHCS guidance regarding Closed Loop Referrals to applicable Community Supports, ECM benefits, and/or community-based resources. Partnership must also work to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner.

Informing Members on Interactive Content

Many of Partnership's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances, members have the ability to opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction – this preference is documented for each campaign or intervention. The PHM Work Plan details the interactive services offered, how members qualify for programs, and how to opt out of programs.

Program Evaluation

The Population Health department analyzes the impact of PHM programs annually through clinical, utilization, and member experience measures, in accordance with the PHM efforts of the year. Partnership's Health Analytics department takes the lead in performing quantitative analyses to monitor the cost of services and programs, utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis includes advanced data sets described previously, as well as annual medical/behavioral and pharmacy claims data, transportation claims data, health appraisal results, HEDIS data, and data specific to internal programs such as case management, pilot programs, and/or provider performance improvement activities, as appropriate. The QIHEC reviews reports of PHM activities for potential areas of concern, opportunities for improvement, and evaluates the impact of existing programs. This allows Partnership's leadership to review and update PHM activities to meet the needs of the members, as

well as identify staffing, education, system, and infrastructure changes/requirements needed to support the delivery of those services. Partnership's Quality Improvement and Performance Improvement programs use HEDIS monthly and annual reporting and analysis to monitor the impact of the programs and select opportunities for future interventions. The PHM Work Plan tracks the progress of interventions according to the measures identified at the beginning of the year, while the Population Health Management Impact Analysis reports on select clinical and utilization measures, as well as member experiences with the population health interventions.

In addition, Partnership hosts quarterly committees to encourage members to engage directly with Partnership. One such committee is the Consumer Advisory Committee (CAC), made up of member representatives from each of the regions in which Partnership operates. This committee meets to review Partnership's programs and provide feedback on how Partnership is meeting the needs of its members and of its communities. A separate Family Advisory Committee (FAC) is comprised of members whose children have special needs. The Pediatric Quality Committee consists of public and private sector physicians who care for Partnership members; the committee provides insight into challenges members may have in getting the care they need from a provider perspective.

The Grievances & Appeals department gathers and analyzes trends in member-reported complaints to identify areas for program improvement in the coming year. Partnership also has a process for identifying and intervening where there may be Potential Quality Issues (PQIs) related to a provider or provider organization. Finally, Partnership participates in two NCQA-approved Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; one assesses factors under Health Plan influence, the other focuses on factors managed by Primary Care sites.

Identifying Opportunities for Improvement

No less than annually, the QIHEC evaluates the impact of PHM's programs, identifies opportunities for improvement, and selects at least one improvement opportunity to address in the coming year.

Delivery-System Supports for Population Health Management

Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description

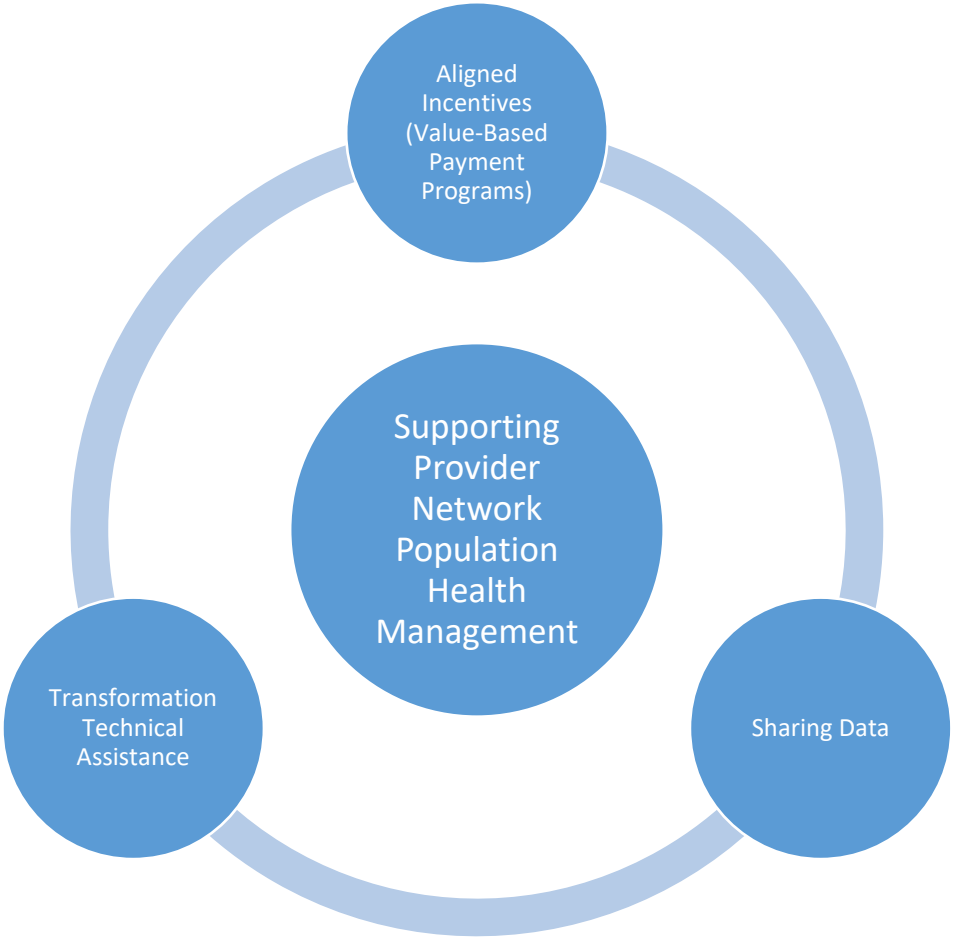
(See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.

Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial bonus for quality-related performance. There are separate incentive programs for primary care providers, hospitals, pharmacies, perinatal providers, behavioral health, palliative care, and other specialty providers. Partnership's Primary Care Provider Quality Improvement Program (PCP-QIP) is Partnership's value-based payment program for primary care providers. The PCP-QIP is largely focused on improving the quality of care members receive through a measure set reflecting Partnership's HEDIS measure score improvement priorities.

Incentivizing Patient-Centered Medical Home (PCMH) Recognition

Through our PCP-QIP, Partnership incentivizes contracted primary care practices to achieve and maintain Patient-Centered Medical Home recognition. This program is designed as an annual incentive, intended to encourage and recognize those provider practices that achieve excellent levels of service, care integration, and panel management, as recognized by established quality organizations.



Sharing Data

Partnership shares a variety of member data with our provider network in an effort to facilitate coordination of care and population health management. The two main systems for data sharing are eReports and the Partnership Quality Dashboard (PQD). Partnership also shares an annual data report with County Public Health Departments in alignment with DHCS' PHM requirements.[2]

eReports

eReports is a web-based platform that supports measurement and reporting for the clinical care domain of the Core Measurement set in Partnership's PCP-QIP. These preventive care and chronic disease management measures reflect DHCS's priority quality measures and are developed in-house by Partnership. The Core Measurement set is reviewed, modified, and approved annually by Partnership's Physician Advisory

[2] DHCS Population Health Management Policy Guide, 2024

Committee (PAC) after considerable input from an internal technical workgroup, an external provider advisory group, and an open comment period involving all participating providers. eReports gives providers member-level data showing member eligibility and compliance for each clinical measure leveraging claims, lab, pharmacy, and immunization registry data. Providers may also upload medical record data to substantiate member compliance where representative administrative data is unavailable. eReports data are refreshed twice per week, giving providers nearly real-time visibility to their measure-specific performance relative to performance targets. It also offers the ability to drill down into member lists by measure and view measure performance by site or organizational level (i.e. if multi-site provider).

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

Measure-Specific Data	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
Trended Data	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
Comparative Data	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Note: While the most currently available data for QIP Clinical measures is available on eReports, PQD serves as a visualization tool. PQD does not allow for any data entry. Instead, all clinical rates are calculated in eReports, and PQD takes the output of eReports, presenting the data longitudinally and comparatively. While eReports displays performance at a given point in time, PQD shows performance data trending. In addition, the eReports interface compares performance against pre-defined thresholds, whereas PQD has multiple means of comparison including averages at regional, sub-regional, and county levels. PQD also includes data for non-clinical measures (e.g., readmissions, PCP Office Visits).

Transformation Technical Assistance

In addition to aligned incentives and data sharing, Partnership supports quality improvement and care delivery transformation in our network via the Partnership

Improvement Academy and its component offerings. These opportunities are designed to prepare providers to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. The Academy offerings include the ABCs of QI (QI basic methodology for the model for improvement) and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership delegates activities for both Population Health, Health Education, and Cultural and Linguistics functions. A formal agreement is maintained and inclusive of all delegated functions. Partnership conducts an audit of all delegated entities no less than annually to ensure the appropriate policies and procedures are in place. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval, as needed.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy, identifying the health disparities and wellness needs of Partnership's members, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, promote collaboration of effort, and reduce duplication of services.

Team Roles and Responsibilities

Chief Health Services Officer:

Provides overall direction to the Heath Services (HS) Care Coordination/Population Health/Utilization Management Leadership Team. This position has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location.

Director of Health Equity (Health Equity Officer)

In collaboration with other Partnership leaders, develops and drives forward the key strategies helping Partnership be a diverse, equitable, and inclusive organization. Works to raise awareness of health inequities within Partnership's staff, providers, and membership, and creates concrete plans for addressing them. Works closely with the Senior Director of Health Services, Quality, Human Resources, Provider Relations and Population Health departments toward shared goals, and with other internal and external Partnership stakeholders to ensure high standards of equitability.

Director of Population Health

Provides oversight of the Population Health strategy, programs and services to improve the health of Partnership members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables.

Manager of Population Health

The Manager of Population Health gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, CHA/CHIP activities, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisors,

manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit.

Supervisor of Population Health

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Community Health Needs Liaison

Supports the coordination and implementation of Partnership's Population Needs Assessment (CHA/CHIP) activities through active and meaningful engagement in identified community workgroup and initiatives. On behalf of the health plan, identifies and supports key strategic activities and interventions that support alignment of collective agency efforts that promote and support efforts to encourage member health outcomes. Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate as needed. Makes these resources available on Partnership's external website.

Senior Health Educator

A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. Supports the creation of trainings for contracted providers and internal Partnership staff to promote cultural competency, health equity, and member wellness. Assists with preparation and implementation of the PNA. Monitors and provides administrative oversight of all regulatory requirements related to Health Education and the Cultural & Linguistics programs. Provides assistance with regulatory requirements as needed.

Health Educator

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on assigned member education projects, monitors health education materials, performs literacy reviews to ensure appropriate readability and suitability levels, and evaluates member discrimination grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials.

Healthy Living Coach

Engages Partnership members to identify barriers to care, member concerns, and resources needed. Leads member wellness campaigns and supports members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learning with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

Wellness Guide

Performs outbound call campaigns to members based on identified member needs (e.g., pregnant members, members impacted by natural disasters, etc.) using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved database/tracking system, per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved health education materials.

Project Manager

Responsible for managing timelines and deliverables in department projects. Develops agendas and leads meetings to advance departmental objectives. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables.

Project Coordinator

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

Coordinator

Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

References

DHCS APL 18-016 Readability and Suitability of Written Health Education Materials (10/05/2018)

Document A (APL 18-016): Review and Approval Guidance for Written Health Education and Member Information Materials

Document B (APL 18-016): Readability and Suitability Checklist for Written Health Education materials

DHCS APL 16-005 *Revised* Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys (11/23/2016)

DHCS 2024 Contract

DHCS Population Health Management Policy Guide, 2024

NCQA. (2018). *Population Health Management / Resource Guide.* www.ncqa.org.

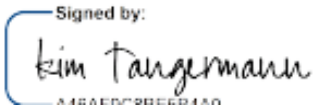
Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557)

Snyder, A. M., Willey, C., McKenna, M., Foley, P., & Coleman, R. (2005). Development of a Risk Assessment Tool for Predicting Pediatric Health Services Utilization. *Journal of Clinical Outcomes Management*, 451-458.

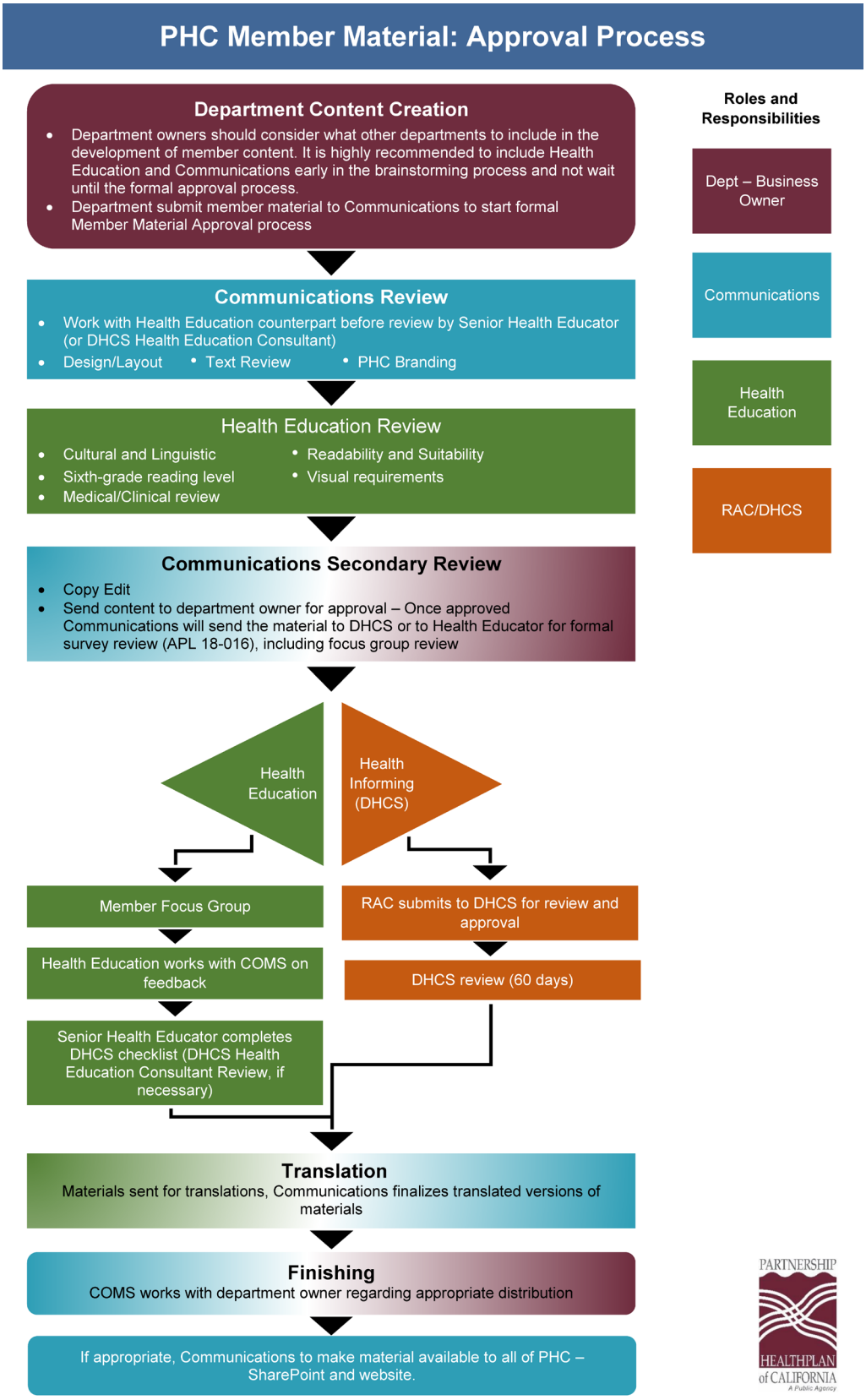
Population Health Management Strategy & Program Description Approval

	06/19/24
Robert Moore, MD, MPH, MBA *Quality/Utilization Advisory Committee Chairperson*	*Date Approved*

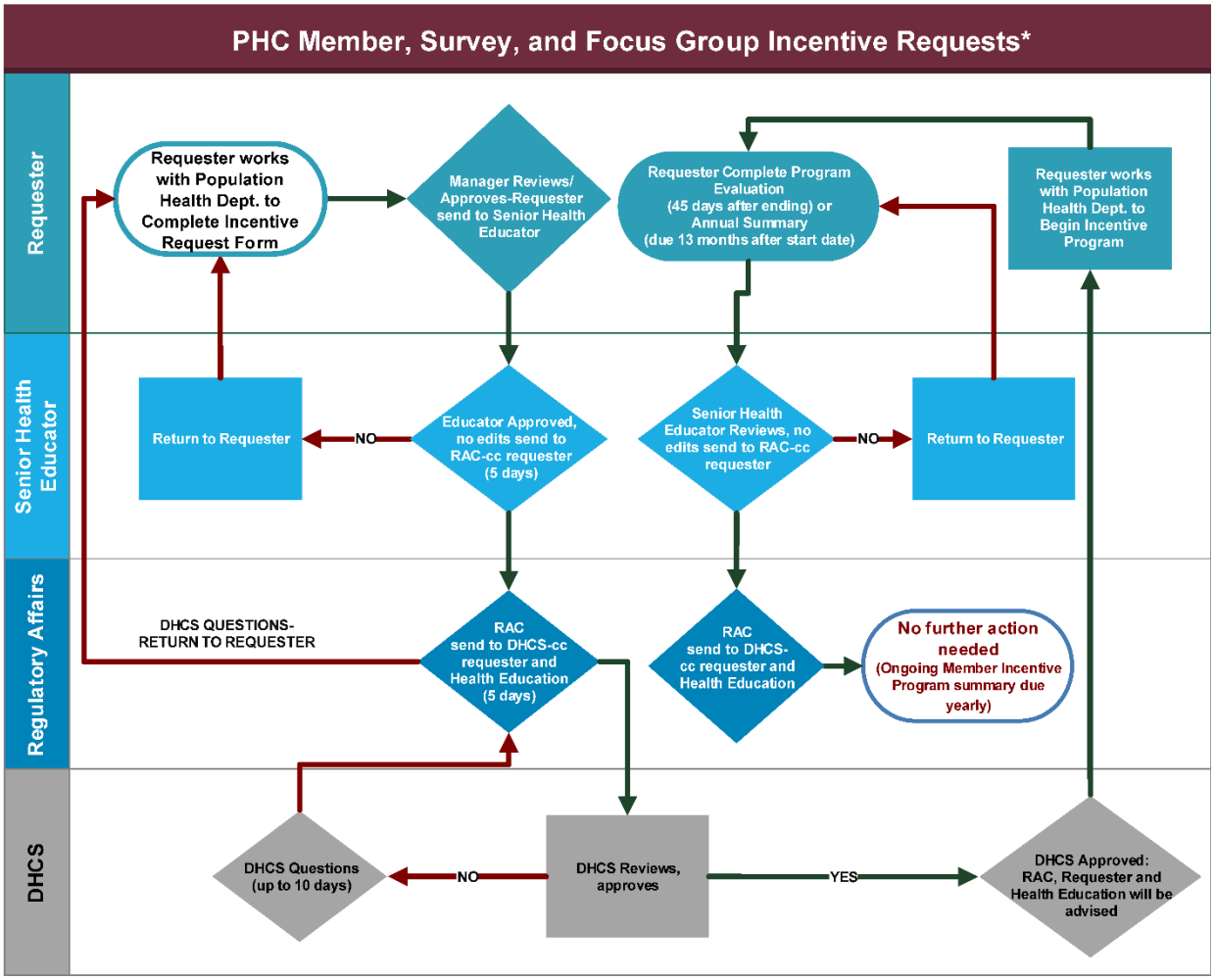
	08/14/24
Steve Gwiazdowski, M.D. *Physician Advisory Committee Chairperson*	*Date Approved*

	08/28/24
Kim Tangermann *Board of Commissioners Chairperson*	*Date Approved*

Appendix A


PHC Member Material: Approval Process
Department Content Creation
Department owners should consider what other departments to include in the development of member content. It is highly recommended to include Health Education and Communications early in the brainstorming process and not wait until the formal approval process.
Department submit member material to Communications to start formal Member Material Approval process
Communications Review
Work with Health Education counterpart before review by Senior Health Educator (or DHCS Health Education Consultant)
Design/Layout
Text Review
PHC Branding
Health Education Review
Cultural and Linguistic
Sixth-grade reading level
Medical/Clinical review
Readability and Suitability
Visual requirements
Communications Secondary Review
Copy Edit
Send content to department owner for approval – Once approved Communications will send the material to DHCS or to Health Educator for formal survey review (APL 18-016), including focus group review
Health Education
Health Informing (DHCS)
Member Focus Group
Health Education works with COMS on feedback
Senior Health Educator completes DHCS checklist (DHCS Health Education Consultant Review, if necessary)
RAC submits to DHCS for review and approval
DHCS review (60 days)
Translation
Materials sent for translations, Communications finalizes translated versions of materials
Finishing
COMS works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of PHC – SharePoint and website.
Roles and Responsibilities
Dept – Business Owner
Communications
Health Education
RAC/DHCS

Appendix B



Email incentive requests to the Senior Health Educator at CLHE@partnershiphp.org

*As referenced by MMCD All Plan Letter (APL) 16-005 Revised