

Population Health Management Strategy & Program Description

MPND9001
(previously MCND9001, MCCD2027)

June 2026

Original Date: 11/13/2019
Previously Applied to MCCD2027 11/13/19 to 04/08/20
Revision Dates: MCND9001 04/08/20; 08/11/21; 08/10/22; 08/09/23; 08/14/2024; MPND9001 08/13/2025; 08/12/2026

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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 HealthPlan of California operates a Medicaid (Medi-Cal) line of business. 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 Enrollee Handbook.

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. In addition, as part of DCHS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), and other community stakeholders as appropriate, on their Community Health Assessments (CHAs) and Community

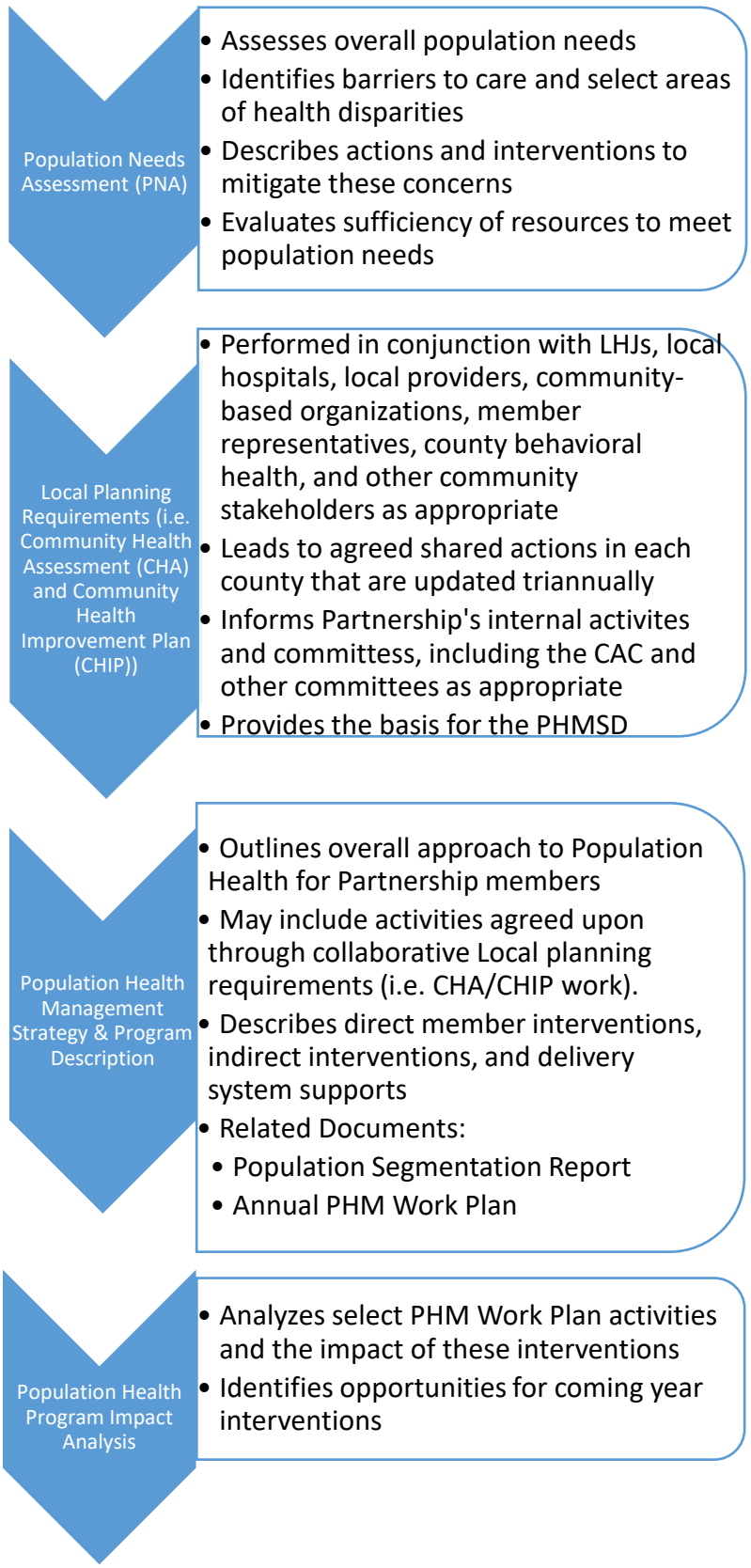
Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

Data Analysis and Strategy

Partnership uses several methods to identify member needs, and to strategize the best means 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, or highlights existing 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, community leaders, and other community partners in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies and activities and are electronically submitted to the appropriate governing bodies by their respective reporting timelines. Key stakeholders within Partnership review the PNA and CHA/CHIP findings, both of which are used to complete the annual DHCS PHM Strategy Deliverable (PHMSD). These findings may also be used to complete the annual PHM Work Plan, Segmentation Report, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description (MPND9001) as appropriate. An impact analysis of the previous year's activities is also drafted based on select programs.

The PHM Strategy & Program Description (MPND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The PHM Work Plan outlines specific interventions to mitigate health disparities both on a member and system level. The PHM Work Plan provides details on specific member-facing interventions, method of contact, outcome measures Partnership will implement during the year, and more (refer to the workplan for full details). The PHM Impact Analysis report evaluates select 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" for targeted interventions.

The following diagram shows the relationship between these activities:


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

Quality Improvement and Health Equity Committee (QIHEC)

The proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are presented to Partnership's QIHEC for review. 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 also reviews the PNA, CHA/CHIP updates as needed, 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 Local Planning Requirements (CHA/CHIP) 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 other sources such as local community needs assessments. Partnership analyzes 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, select health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified care gaps and disparities and promotes health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, and beliefs about health and health care utilization.

A summary report of the NCQA PNA findings is prepared for the Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) session and the Family Advisory Committees (FAC) (see MPND9002 for more information on these committees). Members of both committees are given an opportunity to provide input and advice on Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs as appropriate. The NCQA PNA and its proposed

actions also undergo review by Partnership's Quality Improvement Health Equity Committee (QIHEC), Internal Quality Improvement Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), by the Board of Directors and other committees before submission and approval to appropriate governing bodies and per regulatory requirements. PNA findings are also sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice. Please note the Population Needs Assessment Committee, which has reviewed the PNA since its founding, reviewed it for the last time in March 2026 before the committee was disbanded.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide[1] and the DHCS Contract, Partnership works collaboratively with LHJs, hospitals, community providers, other payers, community-based organizations, member representatives, other local MCPs, and other community stakeholders on each Partnership county's CHA and CHIP process. As of 2025, county behavioral health departments are also required to integrate into their local county CHA/CHIP processes as part of their newly required Integrated Plan. Partnership and its local county behavioral health departments are also tasked with working together to help advance the statewide population behavioral health goals.

This collaborative work on the CHA/CHIP process, referred to as the Local Planning requirements, has replaced DHCS's historically mandated PNA and PNA Action Plan. The county CHAs/CHIPs represent the overall community needs and priorities and provides 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. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice. The PNA committee, CAC, and QIHEC receive updates on the CHA/CHIP collaborative work as needed and are provided with an opportunity to give feedback as appropriate.

Currently, each Partnership county has its own schedule for CHA/CHIP work; Partnership will align with each county's distinct timeline as needed until timelines are standardized in 2028. The shared action plans and findings from these county collaborations on the CHA/CHIP work lead to the 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 also leveraged to report on how Partnership has supported each of its LHJs' CHA/CHIP processes through resource contributions, data sharing, stakeholder

[1] 2026 PHM Policy Guide

engagement, progress towards various DHCS goals/quality measures, and other required elements as specified in the DHCS-provided template. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document (MPND9001) and the annual NCQA-approved PNA.

Findings from these collaboratives may be 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

Per the PHM Policy Guide, Partnership also strives to use input/advice from their Community Advisory Community (CAC) on how to use findings from the CHAs/CHIP collaborative work. Partnership also encourages CAC members to join their local county's CHA/CHIP planning process. The CAC is a committee that acts as a liaison between Partnership and its members (see MPND9002 for more information). As appropriate, feedback may be used to influence:

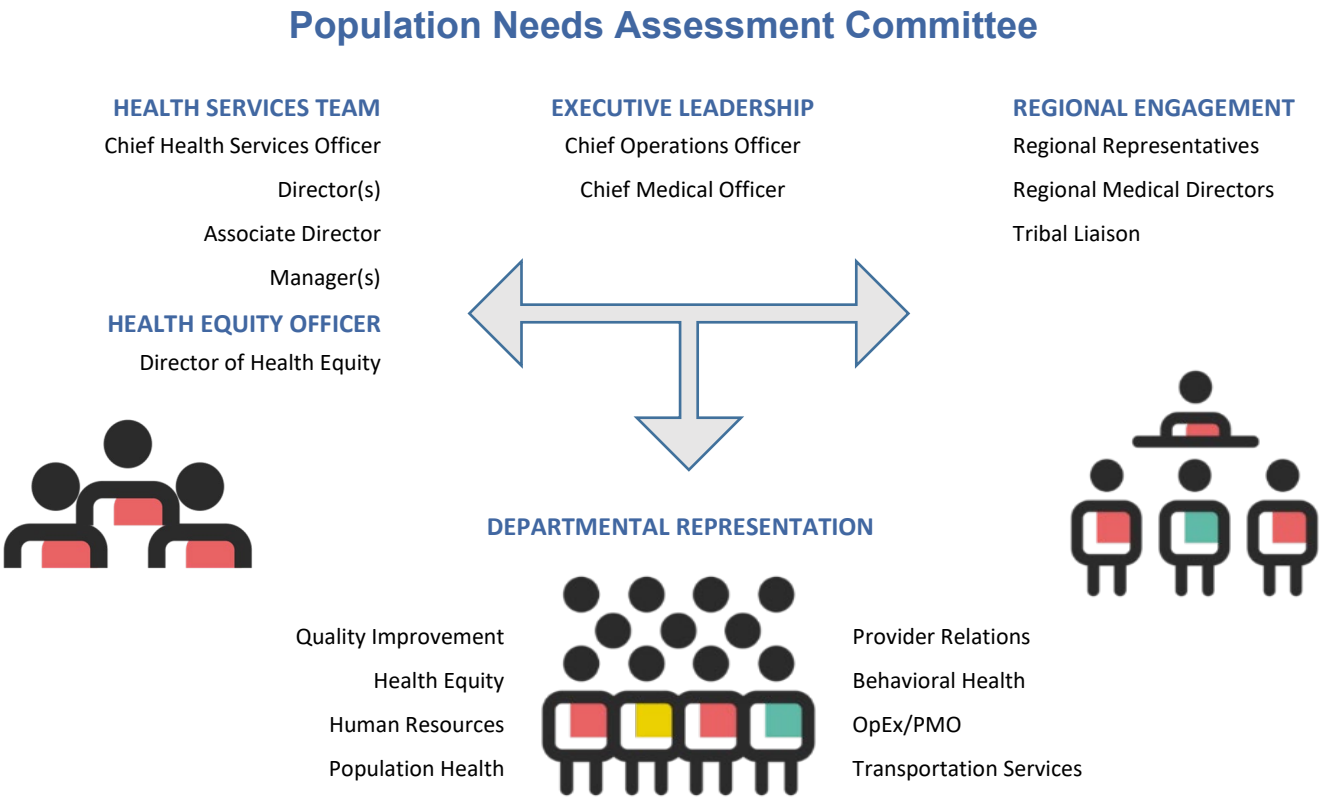
- Partnership's strategies and workstreams related to the Bold Goals defined in the PHM Policy Guide,
- Wellness and prevention strategies
- Health equity needs
- Health education needs, and
- Cultural and linguistic needs

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

Population Needs Assessment (PNA) Committee

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 support 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 bi-monthly 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 goals/SMART objectives between Partnership and each of the LHJs in Partnership's service. On an annual basis, this committee also reviews and makes recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations are shared with the Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), and Physician Advisory Committee (PAC). Please note, the PNA committee was disbanded in early 2026. This was due in part to DHCS retiring the requirement to report out on the shared goal/SMART objectives requirement in the annual PHMSD.



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 matched to the corresponding 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 have 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, a serious emotional disturbance (SMI/SED), or both, receive specialty mental health 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 26-002: Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services[2]).

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

[2] All Plan Letter 26-002: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services

population. By 2026 year-end, Partnership plans to transition the administration of this benefit back to these counties. The following counties have their own county-managed programs: Lake, Marin, Napa, Nevada, Placer, Sonoma and Yolo over which Partnership has no regulatory oversight.

Effective January 1, 2028, Partnership will also cover behavioral health services for Partnership Advantage members. Services include:

- Inpatient psychiatric hospital services as a basic Medicare Part A benefit
- Outpatient behavioral health services under Medicare Part B including diagnostic and therapeutic services, incident-to-physician services, and mental health counselor services. Additionally, the treatment of Opioid Use Disorder is a covered service in Partnership Advantage provided by Opioid Treatment Programs (OTPs).

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

Population Risk Stratification & Segmentation

Currently, Partnership analyzes and segments the population by need and appropriate intervention(s), as demonstrated in the Population Segmentation Report. Partnership currently utilizes a proprietary risk scoring and stratification method to assign members to risk levels. Partnership assesses and reassesses member risk scores on a monthly basis. DHCS recently launched its initial risk stratification, segmentation, and tiering (RSST) methodology, which Partnership is actively evaluating through pilot programs across various risk domains. DHCS plans to fully implement this methodology starting in late 2026. Once the official implementation begins, Partnership will incorporate DHCS's data points and methods to further stratify populations for targeted interventions. Moving forward, both Partnership's and DHCS's methods will be used in tandem. Partnership's Risk stratification and tiering approach remains available upon DHCS's request.

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),

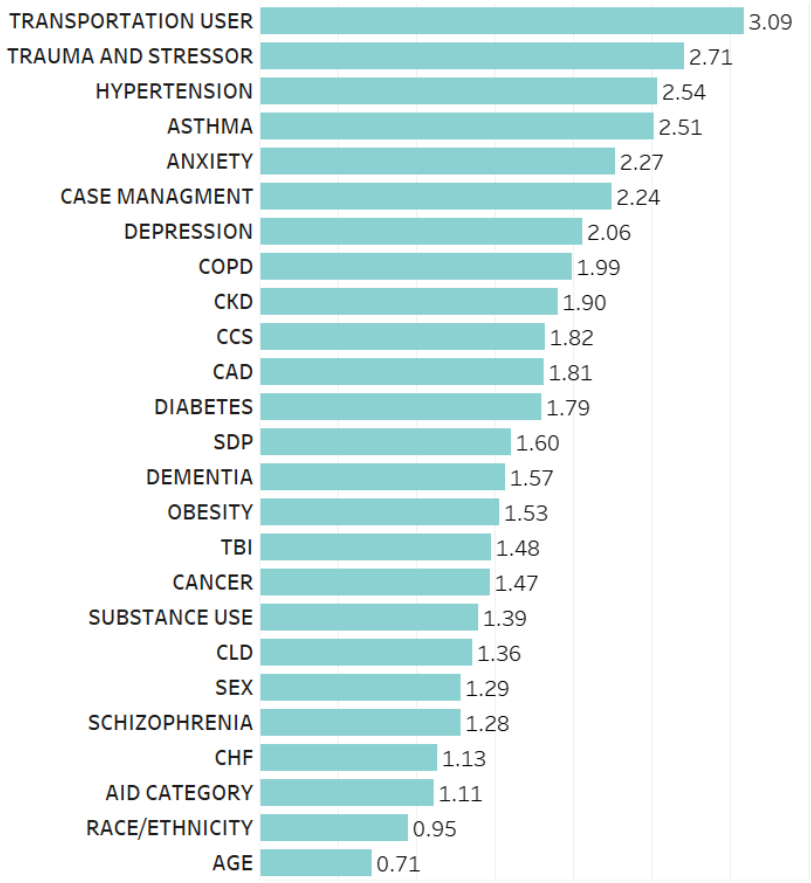
case management enrollment, and external data (California's health index and census tract). This risk score model forecasts the likelihood of a member becoming a high utilizer within the next six months. A member will be classified as a high utilizer if they meet any of these four criteria within a six-month period:

1. Five or more ED visits,
2. One or more acute hospital admission,
3. Fifteen or more distinct drug prescriptions, or
4. Total paid claims of more than $50,000 for medical costs (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 adjusts 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 statistically 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 compared 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.

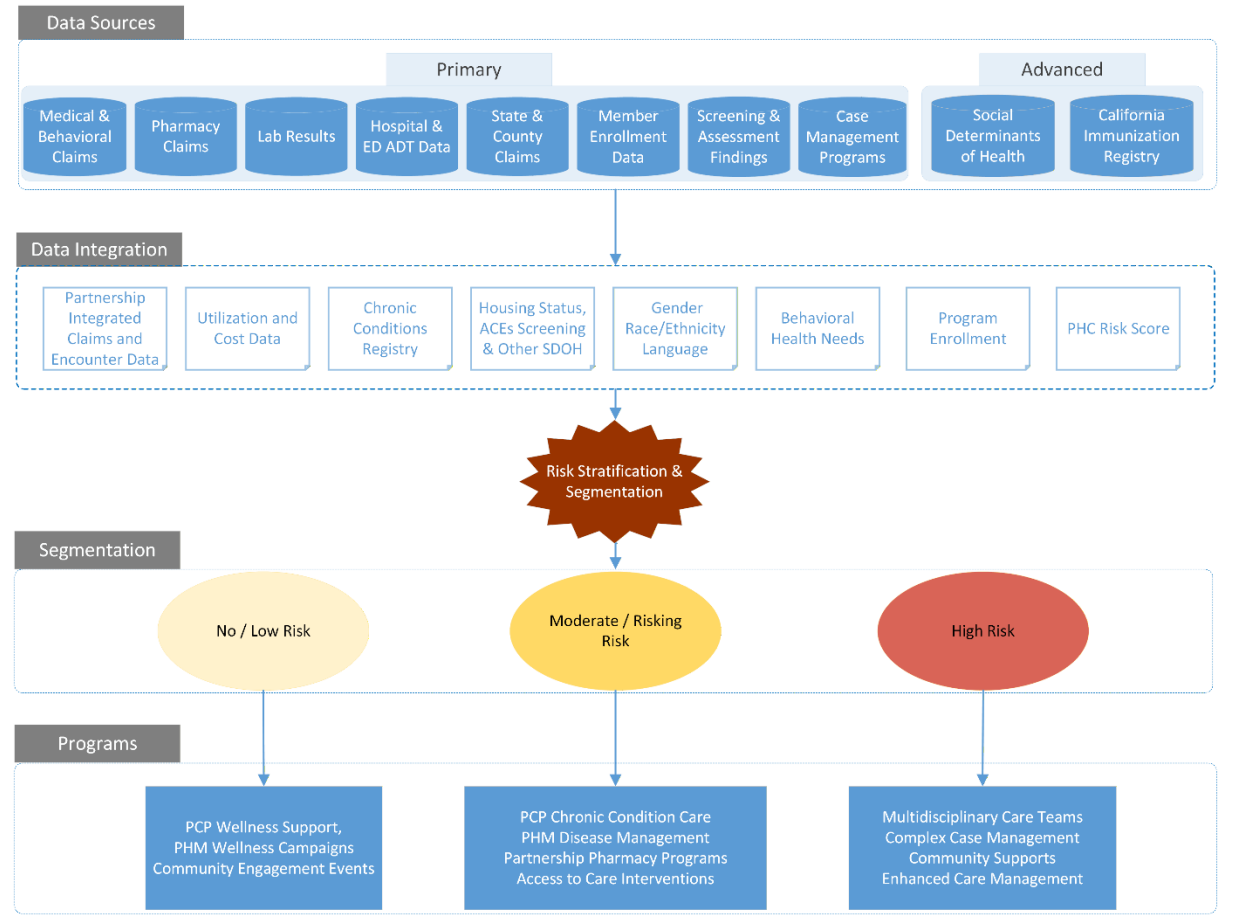
Partnership's Health Analytics team runs the risk stratification report every month so that members who have a significant change in health status are captured and offered appropriate interventions to support their health and wellbeing. In addition, Partnership's Quality team often uses HEDIS data to 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 into members experiencing gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. Partnership's Population Health team has various member-facing campaigns that are designed to positively impact various HEDIS measures. The care gaps report allows the team to be better informed about where focuses for campaigns should be.

Partnership's PNA and the Annual Reducing Health Disparities report describes how Partnership analyzes select 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, Segmentation, and Risk Tiering

Medi-Cal Connect serves as the platform for DHCS's PHM Service RSST methodology. As of 2026, Partnership is piloting DHCS's RSST in operational workflows to inform member identification, outreach, and intervention planning. Medi-Cal Connect was released in the latter half of 2025. Following the implementation of Medi-Cal Connect, 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 find members not identified through the DHCS RSST methodology, who may benefit from Partnership interventions, programs, and services. Partnership uses RSST risk-tiering data to identify members who are newly classified as high risk within each tier. When a member is triggered high risk, Partnership ensures they receive outreach and engagement specific to that tier at least once annually. This approach supports consistent, timely follow-up for all high-risk members while ensuring each tier's

requirements for annual engagement are met whenever a new high-risk designation occurs.

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 outlined in the workplan represent Partnership's key basic population health management and case management service offerings to improve the health of our members and to promote and demonstrate commitment to health equity within the communities we serve. These programs are measured for effectiveness as appropriate. 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 within Partnership's service area. Partnership regularly monitors its own PHM program for areas of improvement.

Basic Population Health Management

In alignment with the DHCS contract and the PHM Policy Guide, Partnership's BPHM is for all members and is further described below. BPHM includes services such as ensuring members have an ongoing source of care, care coordination, navigation and referrals across health and social services, sharing resources, providing education to improve the health of members and to access resources and/or services available to members, Community Health Worker services, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and more, with referral to higher-intensity services when appropriate.[3,4]

Partnership works to ensure 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 who do not use primary care. As part of the Population Health BPHM programs, Member utilization reports are also reviewed to identify members who have not gotten their A1C within 1 year and who have recently been diagnosed with hypertension. Reports can be stratified by race and ethnicity to identify health disparities that result from differences in

[3] 2024 Contract, Exhibit A, Attachment III, section 4.3.8
[4] 2026 PHM Policy Guide

utilization of outpatient and preventive services. Under the BPHM programs, member utilization reports are also reviewed to identify members who have recently had a stroke or myocardial infraction, as they are more vulnerable to depression. Strategies are then developed to address differences in utilization to promote health equity for all members as needed in a culturally and linguistically appropriate manner.

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 the services needed including but not limited to:

- Care coordination
- Navigation and referrals to services that address a member's developmental, physical, mental health, substance use disorder, dementia, long-term services and supports, palliative care, and oral health needs
- Assist with making appointments
- Assist with arranging non-emergency or medically appropriate transportation
- Health education on the importance of Primary Care when disengaged with their PCP, 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 as appropriate, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services). Coordination also occurs with external entities, for services such as CalAIM programs (i.e. Community Supports and Enhanced Care Management), and other community-based resources even if they are not Covered Services. Referrals are managed to ensure alignment with public benefits programs. Members, and when appropriate, 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 activities provided to a member are communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons to members as appropriate. Partnership maintains processes to prevent duplication of services and/or benefits.

Members receive resources and education on how to access the various programs and services offered by organizations that Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed Memorandums of Understanding (MOUs). Members are also supported through resources to address the progression of a disease, condition, or disability, and improve

behavioral (including mental health and substance use disorder), developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that advances 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, Prevention, and Chronic Disease Management Programs

In alignment with the DHCS 2024 contract and 2026 PHM policy guide, Partnership provides wellness and prevention programs that strive to align with NCQA PHM standards and DHCS requirements, including access to NCQA accredited, evidence-based self-management tools through our member portal. All members also have culturally and linguistically appropriate health education materials available to them. Partnership also offers chronic disease management programs. This collection of programs and services aims to improve the health outcomes of all members.

Eligible members have access to evidence-based disease management and improvement programs that may incorporate health education interventions, target Members for engagement, work to improve health equity, and/or seek to close care gaps for participating members that include, but are not limited to:

- Diabetes
- Hypertension
- Cardiovascular disease
- Asthma
- Depression
- Improving access to preventative health visits, developmental screenings, and treatment 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
- Other Evidence-based Risk-Reduction and Wellness & Prevention programs

For more information on these programs, refer to Partnership's program charters for the Growing Together Program and the Basic Population Health Management chronic disease management programs. Please also see the "Health Education" section of this program description (MPND9001 Population Health Strategy and Program Description) to learn more about the Evidence-based Risk-Reduction and Wellness & Prevention programs.

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. Please see the Health Education section for additional programs.

On an annual basis, Partnership also surveys CAC members on how to use community-specific information and stakeholder input from the CHA/CHIP collaborations to inform wellness and prevention strategies and other Partnership programs, as applicable. Findings from Partnership's annual, NCQA-approved Population Needs Assessment may also be incorporated into the design and implementation process of wellness and prevention strategies and other programs as appropriate.

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 areas 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's 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 Management 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 members' 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 Care 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* 1) Healthy Babies Growing Together 2) Healthy Kids Growing Together 3) Health Care Transitions 4) Medi-Cal for Kids and Teens (EPSDT) Awareness campaign 5) Routine Member Newsletters 6) Community Resource Connections 7) Mobile Mammography Clinics 8) School-Based Vaccination Education & Clinics 9) Community Outreach / Engagement Events 10) Health Equity/Disparity Community Outreach Events	*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; host events focused on addressing disparities; promote local community resources on Partnership's external website and refer members to Partnership's Care Coordination team as needed to address additional clinical, social, or care coordination needs identified through outreach activities. *Health Education Interventions*: Develop and distribute member newsletters and benefits information targeting various demographics (including members under 21). Create educational materials on various health topics in threshold language groups and racial groups that have outcome data revealing inequities.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		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 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. Offer incentives to providers to encourage outreach and provide preventative care visits. Support preventive care events (such as for vaccines and mammography screenings). Providers have on-demand access to their care gap data via the eReports online platform, which is updated biweekly. Partnership's secure, online platform Partnership Quality Dashboard (PQD) is updated monthly and contains current year as well as prior year quality care gap data..

DHCS Risk Segment	NCQA Program/Services	Organizational Support
Moderate / Rising Risk/ Moderate – intensity for Pregnancy Pregnant members with risk factors, or members at 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 timely postnatal care, and members identified as moderate risk through Partnership's risk stratification	*Managing Members with Emerging Risk* 1) Perinatal Growing Together – Prenatal 2) Perinatal Growing Together - Post-Partum 3) Disaster Preparedness 4) BPHM - Asthma Control / Improvement Program 5) BPHM - Hypertension Lifestyle Control Program Management 6) BPHM - Diabetes Management Program 7) BPHM Depression Management Program	*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 (such as hypertension, diabetes, depression and asthma). Post emergency preparedness materials online for members to encourage them to prepare for disasters and wildfires. Schedule mobile mammography clinic days in conjunction with Tribal Health and other rural clinics. Refer members to Partnership's Care Coordination team as needed to address additional clinical, social, or care coordination needs identified through outreach activities, including escalation to higher-intensity services when appropriate. *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, who need basic case management support.

DHCS Risk Segment	NCQA Program/Services	Organizational 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. These reports are used to create (ePrompts) in our Call Center System. This allows Member Service Representatives, while speaking to the member, to identify when the caller has specific preventive screenings due; 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. Offer a pay-for-performance program that incentivizes chronic disease management, which can enable purchasing POC devices.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
Transitional Care Services: Members going through transitions in their care, and members identified through Partnership's risk stratification, in alignment with DHCS-defined Transitional Care Service categories based on member risk and pregnancy status.	*Outcomes Across Settings* 1) Transitional Care Services	*Member Needs:* Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home. *Member Services Interventions:* Support members who contact Partnership post hospital discharge who may need to establish care with a PCP. Refers members to Care Coordination to assess the needs of the member and whether a primary care assignment is appropriate. *Utilization Management Interventions:* Collaborate with facility discharge planners to ensure all necessary prior authorizations required for member discharge are completed in timeframes consistent with member's condition and regulatory requirements. *Care Coordination Interventions:* Review and implement 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; and provide medication reconciliation.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
High Risk/High-Intensity Pregnancy: Members with high intensity pregnancies, 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; and members identified as high risk through Partnership's risk stratification.	*Managing Members with Multiple Chronic Conditions* 1) Complex Case Management 2) High Risk (*High Intensity)* Pregnancies	*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 a part of 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 and materials as needed to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver 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; 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); and more. 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 as needed and whose performance is monitored. 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 in the language and format they prefer. Finally, Partnership promotes health education information and Population Health programs through the member newsletter, the provider newsletter, the Partnership website, social media, and through targeted outreach as needed.

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, Medi-Cal benefits, obstetrical care, appropriate use of complementary and alternative care, and dental and vision care.
- 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 based on member needs. Programs can include: smoking and

tobacco cessation; managing stress; injury prevention; 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 NCQA accredited Healthy Living Tools under action plans.

- 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, 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).[5]

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other internal 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 and creation of health educational materials and resources for specific member populations. Furthermore, the health education team may assess member health care needs and barriers to care by consulting with the Community 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, and analysis of

[5] Section 1557, HHS, 2020

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 request.

In alignment with APL 18-016,[6] 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 6th 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. Member facing materials (which includes health education materials) are made available in Partnership's threshold languages, large font, in any of California's top 18 non-English languages upon the request of the member, and in specific languages as requested; alternative formats such as braille, large font, or audio are also available upon request (see MNCD9002 Cultural and Linguistic Program Description for more information on this). 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. A qualified 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 members, and/or review during Community 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 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.

[6] APL 18-016

    - 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

In alignment with APL 16-005,[7] 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 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
    - Other as appropriate
- Non-monetary member incentives 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

[7] APL 16-005 Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, And Member Surveys

    - Review by Partnership's Regulatory Affairs and Compliance Coordinator
    - Submission to DHCS Health Education Consultants for final review and approval at least 2 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.

For more information on incentives, please refer to APL 16-005.

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, past medical history, social history, Review of Systems, identification of risks, an assessment of any needs for preventive screens or services, referrals to health education where appropriate, a member risk assessment, 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). For more information on IHA, please refer to MCQP1021 Initial Health Appointment policy.

Members can also identify their own needs for health education. Partnership makes educational materials, benefits and resource information, and other tools (such as the Healthy Living Tools) available to members and network providers. 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, topics such as:

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

Practitioner Education and Training

Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. This training is referred to as the CARES training. Partnership staff will receive the staff-specific DEI training on an annual basis. For more information on these training courses, please see MPND9002 Cultural and Linguistic Program Description and the forthcoming policy MCEP6004 DEI/Cultural Connection Training Policy which describes requirements for the Diversity, Equity, and Inclusion Training Program for External Practitioners.

Health Education Interventions

The CHA/CHIP efforts, PNA, community needs, and other regulatory requirements serve as the basis of setting the Health Education Program goals and activities. The written PNA findings and conclusions drawn from CHA/CHIP efforts may be used to evaluate and make recommendations for appropriate allocation of health education resources, provider trainings, Partnership staff trainings, and intervention evaluation efforts. The departments responsible for monitoring outcomes for specific interventions 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. County Health Officer Forums are held to disperse annual data and encourage collaboration and alignment.
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services. Incentives may be provided to add operational days / hours to expand access to members.
School Engagement	Peer-to-peer, school-based projects where students receive information and resources on a health topic (e.g. tobacco and vaping prevention, mental health) to engage their peers in incentivized educational activities.
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. Regular training on health equity. Webinars provide reminders on standards and

Initiative Type	Definition
	best practices, including reminders about external policies, APLs and other regulatory/contractual guidance.
Provider Email & Fax Blast	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	I The Provider Relations Education team will collaborate with the Pharmacy and QI departments to ensure educational notices are created and sent to providers when there are changes or updates that impact them.
Media Campaign	Social media campaigns 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 members.

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, event attendance, and its provider network as appropriate, as well as telephonically through Partnership's Care Coordination, Population Health, Member Services departments. Partnership also has the ability to inform providers of various programs through Partnership's website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution. 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, and providers are informed as appropriate to support referrals and coordination of member care.

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 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 six 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) have come together over the years to respond to various natural disasters and outbreaks such as the devastating wildfires in Northern California and the COVID pandemic. Given the success of these joint efforts, 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 efforts, any department planning or implementing programs affecting our members has the ability to log their member-facing campaign in the Population Health Campaign Tracker within Partnership’s internal SharePoint sites. This campaign tracker is a central location for anyone in the organization to ensure staff are aware of current interventions. Quarterly check-in meetings include all member-facing departments and provide updates on new initiatives and outreach campaigns. Member-facing departments also have read-only or edit access to Essette, Partnership’s case-management software system. A move to a new system, JIVA, is planned for 2026. Campaign documentation occurs within the case management platform, and departments with read-only access have the ability to read through outreach that has already been conducted on a mutual member.

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 efforts. 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 Care Management (ECM)
- Community Health Workers
- Doulas
- 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.
- Partnerships with Local Health Jurisdiction
- And more

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms as appropriate. The cloud-based Point Click Care Platform is also used to facilitate real-time data sharing between Partnership and ECM providers of services (see Partnership Policy MCAP7002). 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 Care 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. Certain services may differ for a Medi-Cal Member compared to a members enrolled in a Dual Eligible Special Needs Plan (D-SNP) with Medicare.

In alignment with the most recent DHCS PHM Policy Guide, Partnership also makes a good faith effort to execute 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
- 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 for Specialty Mental Health Services in Medi-Cal Mental Health Plans and SUD Services in Drug Medi-Cal Organized Delivery System (ODS) Counties
- LGA/California Department of Corrections and Rehabilitation, County Jails, and Youth
- First 5 Programs

- Whole Child Model
- Local Education Agencies (LEAs) (effective in 2027)

Partnership also makes a good faith effort to implement DHCS guidance regarding Closed Loop Referrals to applicable services, and in certain MOUs, as needed. Furthermore, Partnership works to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner. Finally, Partnership supports warm handoffs with third party entities as appropriate. For more information on MOU requirements, see MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities.

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 of interactive services, 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 annual 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 utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis may include advanced data sets described previously, as well as member demographics, annual medical/behavioral and pharmacy claims data, immunization data from California Immunization Registry, 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, and member feedback survey results. The QIHEC reviews reports on 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 as needed. 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. Data from Quality Incentive Programs is also used as a proxy while HEDIS data is tabulated. 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 Community 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 meets 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 input on pediatric members that are eligible for CCS services and helps shape policies and access for these members as well as provide input on pediatric concerns.

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 reviews the impact of PHM's programs, identifies opportunities for improvement, and may select at least one improvement opportunity to address in the coming year as appropriate.

Delivery-System Supports for Population Health Management

Through PHM, Partnership supports providers by working intentionally and collaboratively with the provider community to improve population health outcomes. The Quality and Performance Improvement Program Description (Policy MPQD1001) outlines how Partnership identifies population health needs using performance monitoring, disparities analyses, community health assessments, member experience data, and other required evaluations. The annual Work Plan then translates those

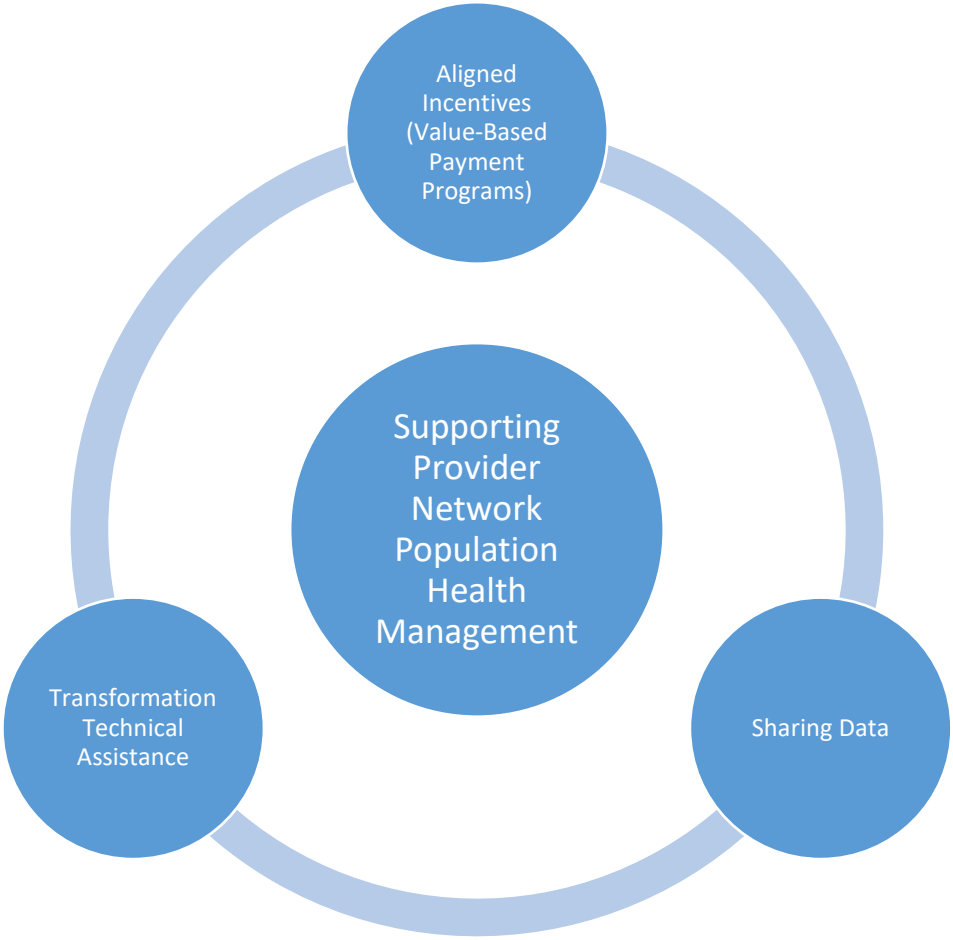
identified needs into targeted strategies and activities, including improvement initiatives, value-based programs, reporting tools, training, and technical assistance.

Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial incentives for quality-related performance. There are separate incentive programs for primary care providers, hospitals, perinatal providers, palliative care, ECM providers, extended care and more. 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 a publicly available, annual data report with County Public Health Departments in alignment with DHCS's PHM requirements.[8]

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

[8] DHCS Population Health Management Policy Guide, 2026

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 is 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). Once an organization is contracted with Partnership, their PCP sites are loaded into the eReports platform and their Quality contact is notified via email by the QIP team with eReports registration and user access instructions.

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 display 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. 7 Day Follow-Up Visits, Avoidable ED Visits). This data, which is inclusive of measures involving follow-up visits after discharge from the emergency department, and

ambulatory care sensitive admissions, are displayed in PQD allowing providers to view the number of members with admissions based on Preventive Quality Indicator diagnosis, date of admission and date of discharge. Other measures display members in a denominator based on number of acute inpatient discharge or observation visits in the measurement year and who received a follow-up visit within seven (7) days of hospital discharge. This data is all displayed at the member level and is available for download into Excel format.

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, including primary care 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 Improvement Academy offerings include the ABCs of Quality Improvement (QI) (QI basic methodology for the model for improvement); the Improving Measure Outcome series that focuses on Partnership's Primary Care and Perinatal Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, and advance health equity; improve clinical outcomes; 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. The QI Project Training program helps providers and community partners to plan and lead quality improvement projects.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership may delegate Population Health, Health Education, and Cultural and Linguistics functions. Prior to assigning delegated responsibility, Partnership ensures the entity's capacity to perform. This is called a pre-delegation evaluation. Once confirmed, the parties enter into a formal agreement inclusive of all delegated responsibilities. Partnership conducts an audit of all delegated entities no less than annually to ensure that the delegate is performing consistent with the delegation agreement, applicable Partnership policies/procedures, and applicable regulatory obligations. 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, partnering with other departments to identify the health disparities and wellness needs of Partnership's members, implement DHCS's local planning requirements (previously known as the PNA requirement), 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, support each local LHJ's CHA/CHIP process, and reduce duplication of services.

Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. Required education includes an MD/DO degree from an accredited program, preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for 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. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least 5 years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.

Associate Director of Population Health

Under the leadership of the Director of Population Health, manages and provides direction to the Population Health team managers and supervisors to ensure key Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of 5 years of relevant experience in health care operations, a minimum of 3 years of management experience with effective problem solving, or equivalent combination of education and experience is required.

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

Supervisor of Population Health

Provides daily oversight, leadership, support, training, and direction of assigned Population Health staff. Supports and assists the Team 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. Bachelor's degree in business, Communication, Healthcare Administration, or a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.

Community Health Needs Liaison

In collaboration with departmental and organizational leadership, supports the coordination and implementation of Partnership's Local Planning process (Population Needs Assessment or CHA/CHIP process) requirements and activities through active and meaningful engagement in identified community workgroups 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 and shares with appropriate stakeholders as needed. Supports the development of the key deliverables for DHCS and NCQA. Required education includes bachelor's degree in public health, Community Health or related field; A minimum of 2 years of experience in public health is preferred.

Senior Health Educator

The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative and regulatory oversight of member facing materials (health education and member informing materials) and supports oversight of select cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. More specifically, plans, implements and evaluates health education activities identified through gaps found in the PNA, CHA/CHIP work, HEDIS measures in conjunction with health promotion and equity programs; and supports cultural and linguistic services as appropriate. The Senior Health Educator also performs supervisor responsibilities for the Health Education team. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of 2 years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

Health Educator

Trained and competent to actively participate in the design and implementation of health education activities, including the creation of health education materials and classes and member informing materials. Leads on assigned member education projects, monitors health education materials, and performs literacy reviews to ensure

appropriate readability and suitability levels. Supports and helps in delegate audits to ensure accuracy, compliance, and alignment with cultural and linguistic standards. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a bachelor's degree in health education, Public Health, Community Health or related field, experience in Public Health Education. A minimum of 2 years of health education experience is preferred.

Healthy Living Coach

Performs outbound call campaigns to members based on identified member needs 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 case management system per prescribed protocols. Engages Partnership members to identify barriers to care, member concerns, and resources needed. Lead member wellness campaigns and support members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learnings with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

Wellness Guide

This position provides support and guidance to Partnership HealthPlan of California (Partnership) members for wellness services and incentive programs in a call-center environment. The Wellness Guide works closely with members and their families to encourage members to engage in healthy activities (including preventative care visits and chronic care management), remind members of available benefits, and connect members to available internal and external resources. Required education includes a high school diploma or equivalent combination of experience and education required; associate's or bachelor's degree is preferred. Two (2) years of experience working in a health care setting recommended, to include experience in health coaching, behavioral change, or any work experience, training or specialized education that would likely provide the ability to perform the essential functions of the position. Preference may be given to individuals certified and/or licensed in a health-related field

Project Manager

This position is responsible for effectively leading assigned projects, utilizing appropriate project management methodologies to drive the planning, implementation, and tracking of projects through all aspects of the project lifecycle. Project Managers are responsible for the planning, procurement, and execution of a project. This role also provides routine

ad hoc reporting for key Population Health activities and initiatives and works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Additional duties include supporting ongoing audit readiness activities by maintaining structures around audit deliverables. Required education includes a bachelor's degree and at least one (1) year of relevant project management experience required. In lieu of a degree, a minimum of three (3) years of relevant project management experience will be considered. Other requirements include experience managing multiple projects with medium to large teams. Experience in a health plan environment is preferred.

Project Coordinator

This role supports the planning, organization, management, and implementation of projects. The Project Coordinator also oversees timelines and deliverables for department projects, provides routine and ad hoc reporting for key Population Health activities and initiatives, and 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. Required education includes a high school diploma or equivalent. A minimum of one (1) year project coordination or relevant experience is also required.

Coordinator

The Coordinator role provides coordination and administrative support to department teams and management. This role performs a variety of general clerical duties, including data entry, report generation, managing and responding to call inquiries, managing internal Helpdesk inquiries, managing and assigning follow up inquiries from other departments, creates and revises desktop protocols, and develops forms and presentations. Other duties include referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc. Required education includes a High School Diploma or equivalent. One (1) year of related experience in the medical/clerical field or equivalent combination of education and experience is also required. Experience in phone-based customer service may be preferred.

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

References

DHCS APL 26-002 Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services (04/08/2022)

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

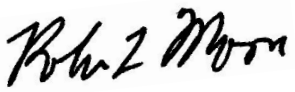
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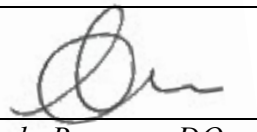
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World Health Organization. (2023, April 3). *Health Equity*. Retrieved from World Health Organization: https://www.who.int/health-topics/health-equity#tab=tab_1

Population Health Management Strategy & Program Description Approval

	06/17/2026

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

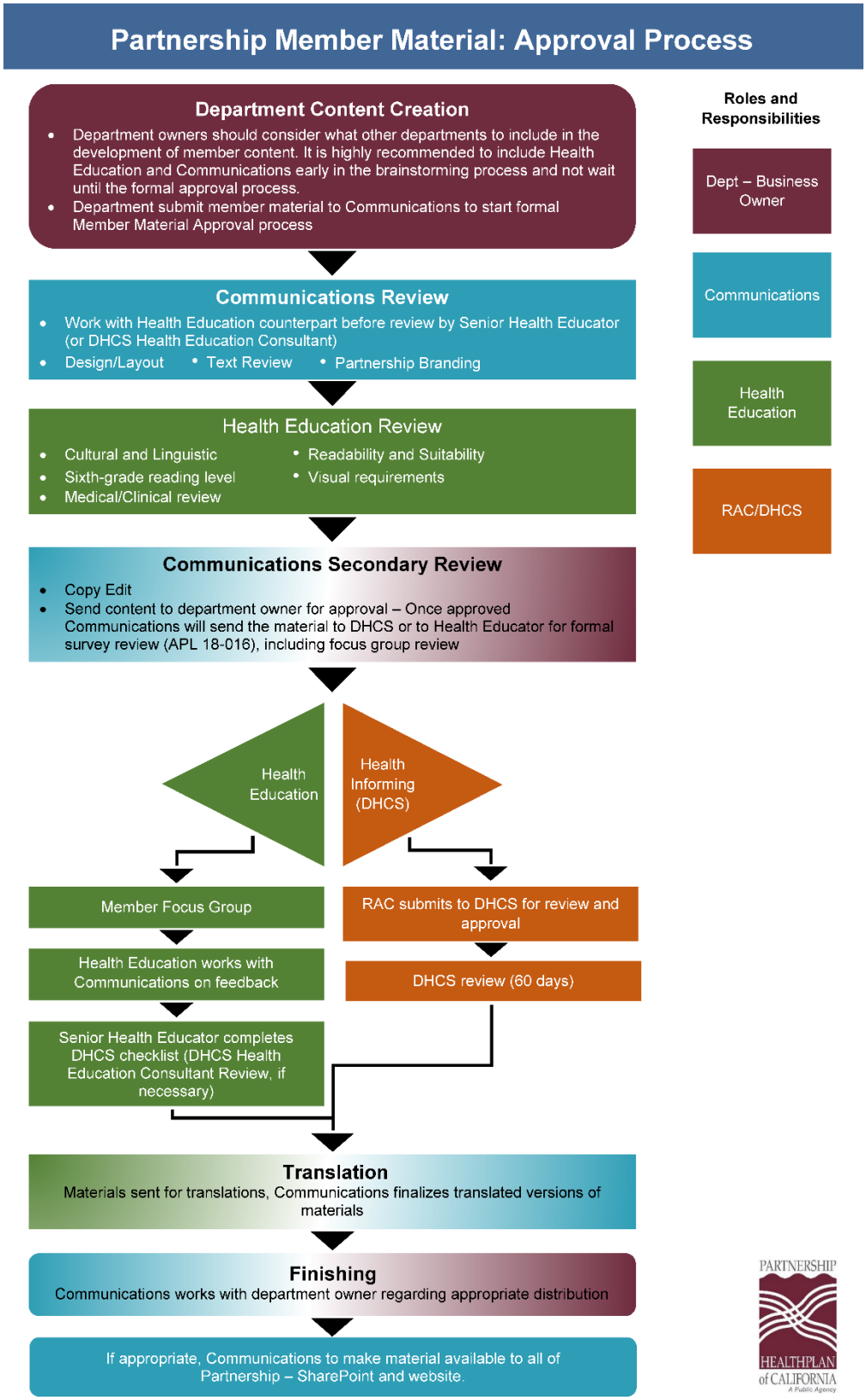
	09/09/2026

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

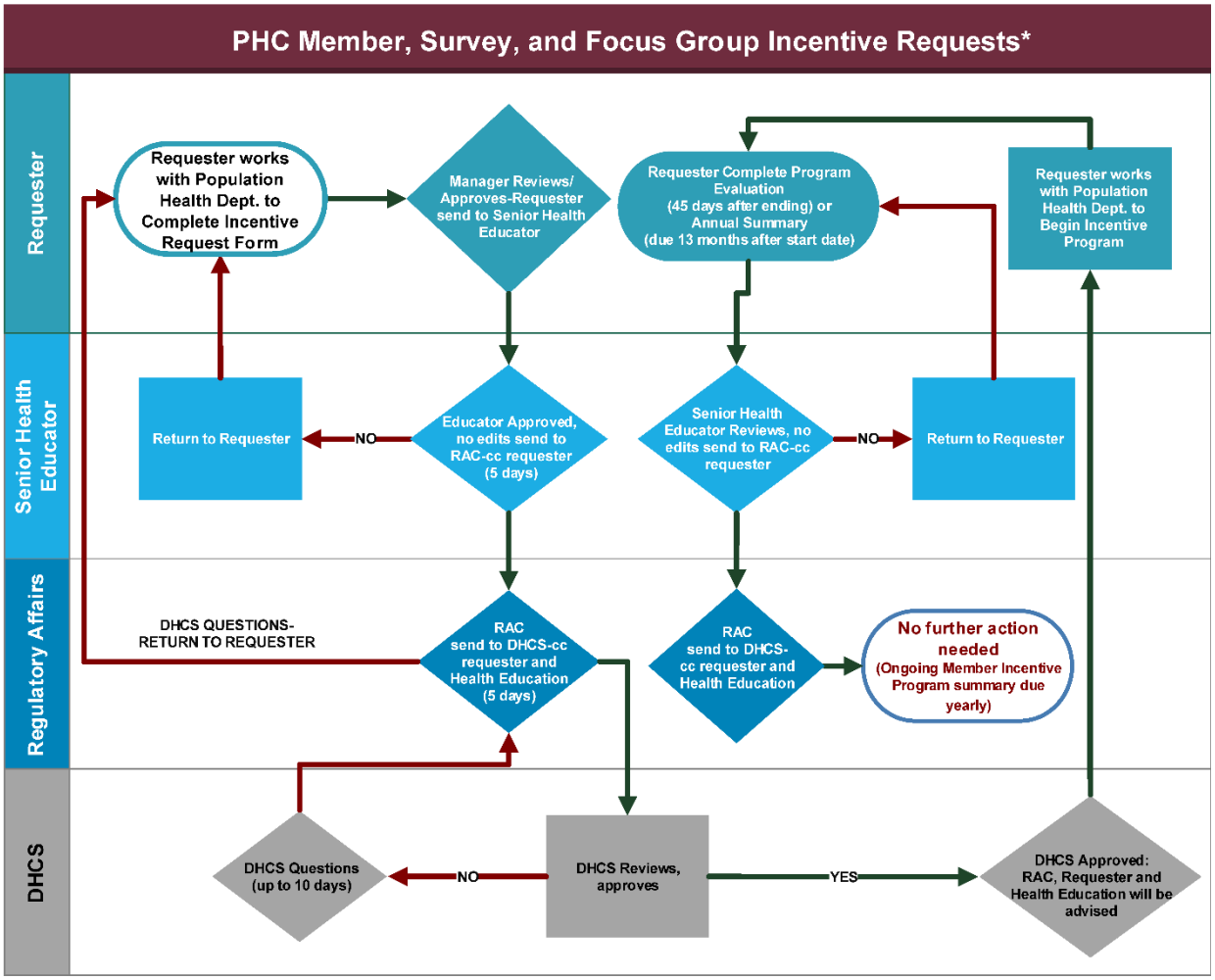
	10/28/2026

Dean Germano *Date Approved*
Board of Commissioners Chairperson

Appendix A


Partnership 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
Partnership 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 Communications 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
Communications works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of Partnership – 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