Medical Directors Forum

Spring 2022

Detailed Notes of Clinical Topics

(Leadership Version)

Primary Care Almanac

Introduction:

Partnership HealthPlan of California's (PHC) mission is:

"To help our members, and the communities we serve, be healthy."

This dual focus – on both the individuals who are members of the health plan and the communities that we all live in – is rooted in our not-for-profit status and our governance structure. Our governing Board of Commissioners includes a diversity of representatives from all 14 counties that we serve in Northern California.

PHC's vision is:

"To be the most highly regarded health plan in California."

We strive to be highly regarded by our members, the provider network comprising our health care delivery system, our community partners, the state legislative and executive branches, other health plans (our peers), and by our employees. This requires engagement and communication with each of these groups. The Medical Directors Forum is one example of this.

Facilitator/Presenter
Robert L. Moore, MD, MPH, MBA
Chief Medical Officer
E-Mail: rmoore@partnershiphp.org

Your Regional Medical Directors:
Marshall Kubota, MD, Regional Medical Director (Marin, Sonoma, Mendocino and Lake Counties)
Colleen Townsend, MD, Regional Medical Director (Napa, Solano and Yolo Counties)
Jeff Ribordy, MD, Regional Medical Director (Humboldt, Del Norte, Trinity, Shasta, Siskiyou, Modoc and Lassen Counties)

PHC website: www.partnershiphp.org

Table of Contents

County Profiles

County Profiles were distributed with the meeting materials. Highlights:

- Enrollment and Ethnicity
- Health Status
- Quality Metrics
  - ACES
  - Developmental Screening
  - Fluoride Dental Varnish
- Utilization Trends
- Member & Provider Satisfaction

PHC Strategic Issues

Geographic Expansion

The boards of supervisors of ten counties north of Sacramento (in red below) voted to submit a letter of Intent (LOI) to DHCS to become a County Organized Health System (COHS) Model as part of PHC, starting in January 2024. The existing PHC counties are indicated in green below.

In February 2022, DHCS announced that these 10 counties would become part of the COHS in January 2024 (they were removed from the option of health plan Reprocurement). There are a few steps left before this is certain, including agreement with the state on rates.

Kaiser Statewide Contract

In early February, 2022, DHCS announced that after secret negotiations with Kaiser Health Plan, they planned to offer Kaiser HealthPlan a state-wide direct contract to cover MediCal beneficiaries. This would seem to violate the principles agreed to by the counties that chose to participate in the formation of County Organized Health Systems, like PHC. Legislative approval is required, and DHCS is seeking the authority to act on the governor's Kaiser plan through a trailer budget bill which is not subject to the usual committee review process, and is typically negotiated without public opportunity for input.

PHC foresees a number of adverse consequences to the proposed Kaiser contract, but is most distressed at the manner in which the agreement was negotiated, the shifting rationale offered by the executive branch, and a lack of transparency into the long-term strategic vision for the MediCal program.

We are asking the boards of supervisors in our counties to preserve the county organized health system model and oppose the bill authorizing that would allow a private, commercial health plan such as Kaiser a direct contract for MediCal in our counties. We are also asking for our state legislators to do the same.

CalAIM Update

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the DHCS to implement overarching policy changes across all Medi-Cal delivery systems with these objectives:

a. Reduce variation and complexity across the delivery system;
b. Identify and manage member risks and needs through population health management strategies
c. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Two components of CalAIM that have begun are Enhanced Care Management (ECM) and Community Supports (CS, formerly known as In Lieu of Services). Services started in January 2021 in counties with Whole Person Care funding (Marin, Sonoma, Napa, Mendocino and Shasta counties) and in July 2021 in other counties: Enhanced care management services designed for a whole-person approach that addresses the clinical and non-clinical needs of complex Medi-Cal

beneficiaries. The old Whole Person Care pilots (including those in the five PHC counties noted above) and the PHC Intensive Outpatient Care Management Program (IOPCM) folded into this new ECM benefit.

Additionally, we began offering CS services, flexible wrap-around services, which are provided as a substitute, or to avoid, other costs and services, such as a hospital or skilled nursing facility admissions or discharge delays.

For documents and presentations related to the ECM and CS programs, see our website:
http://www.partnershiphp.org/Community/Pages/CalAIM.aspx

The current categories proposed for populations covered by ECM and the potential services covered by ILOS are listed here:

ECM target populations:

The following three populations are currently approved:

1. Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
2. Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
3. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

Starting in July 2022, in the original 5 counties, and in January 2023 in the other counties, the additional populations will be added:

4. Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
5. Individuals at risk for institutionalization who are eligible for long-term care services.
6. Nursing facility residents who want to transition to the community.

Six months later, one last population will be added.

7. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Community Support Services covered by PHC include the following:

- Housing Transition Navigation Services
- Housing Deposits

- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Meals/Medically Tailored Meals

As of March 8, PHC had fully executed contracts with 19 ECM providers and 16 CS providers. An additional 20 ECM and 16 CS contracts are in process.

Several supplemental funding streams exist to support development and expansion of ECM and CS services.

1. ECM QIP: A pay for performance program to provide supplemental funding to for achieving reporting and quality outcomes. http://www.partnershiphp.org/Providers/Quality/Pages/ECM-QIP-Enhanced-Care-Management.aspx

2. Capacity Building Grants (State IPP=Incentive Payment Program funding stream)

   The PHC CalAIM Grant Program is one avenue for providers to apply for the funds necessary to support their efforts. The grant program will span three program years with Program Year 1 (January 1, 2022 to December 31, 2022) focusing on three priority areas for funding:

   Priority Area 1: Delivery System Infrastructure

   -To strengthen the data exchange infrastructure of ECM and CS providers

   Priority Area 2: ECM Provider Capacity Building

   -To increase ECM provider capacity and abilities

   Priority Area 3: Community Supports Provider Capacity Building and Take-up

   -To increase Community Supports provider capacity and abilities

   Application Process

   Utilizing the PHC CalAIM Grant Program application, each applicant will select one or more priority areas to invest in over the Program Year 1. The first round of application submission and review timeline is as follows:

Deliverable/Activity	Timeline
Application Submission Period	March 10 through April 7, 2022
Application Evaluation Period	April 8 through May 3, 2022
Grantee Approval Announcement	May 6, 2022

Note: PHC will host a second round of grant awards beginning May 2022 to align with the rollout of CalAIM Phase 2 implementation.

Questions: Contact the CalAIM Grant Program team: grants@partnershiphp.org

3. Housing and Homeless Incentive Program (HHIP), funding to the health plan to work with other funding sources to work towards housing the homeless. Does not include funding for housing, itself. One time funding; details not yet officially released. Each county will have a plan by mid 2022. PHC share potentially over $50 million, over about 1.5 years. **If you have a homeless health care program, we hope you can contribute to this planning process in your county.**
4. Whole person care counties are also eligible for transitional funding, directly from DHCS. (PATH or Providing Access and Transforming Health Supports) If you are working with your county on a WPC program, ask them how they are planning to use this funding.

Future components of CalAIM scheduled for the future include the following. See the DHCS website for details. https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx and https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Go-Live-Schedule.pdf

1. *Population Health Management (projected to start January 2023)* Medi-Cal managed care plans will develop and maintain population health management strategies that include initial and ongoing assessments of risk and need, leverage risk stratification in care planning, consider social determinants of health, ensure smooth transitions of care, and focus on data collection and reporting.
2. *Behavioral Health:* Proposal to steadily integrate behavioral health services with the rest of the health care system.
3. *Services and Supports for Justice*-Involved Adults and Youth, including MediCal coverage prior to discharge to facilitate transition of health and social services after release, starting in January 2023.

4. *NCQA Accreditation* will be required for all Medi-Cal managed care plans as of 2026.
5. *Requirement all Managed Care Plans to implement a MediCare-MediCal* joint health plan product (also known as a Dual-Special Needs Plan or a D-SNP) by 2026, assuming a feasibility study in 2022 shows this can work.

Medi-Cal Rx: Pharmacy Carve-Out

The long awaited state pharmacy carve-out, known as MediCalRx went live on January 2022. It was an inauspicious beginning with call center answer times in the hours and over a week long back-log of TARS to process. In response, DHCS essentially turned off all prior authorization requirements, and allowed pharmacies to override rejections. This did not resolve the underlying programmatic issues that caused the problems in the first place. As a result, when the TAR processing requirements are restarting in May, and the 6 month transition period will end in July, there is a strong probability of these challenges recurring.

We urge all clinicians to become familiar with the Contract drug list and make changes to your patients' prescriptions to synchronize the medications to that list before May.

Use hyperlink https://medi-calrx.dhcs.ca.gov/provider/drug-lookup/ to access the CDL.

In addition, be sure your clinicians have access to the TAR processing system set up by Magellan/DHCS, to allow you to submit TARS more expeditiously. The primary methods for TAR submission is fax, the Magellan Provider Portal, and CoverMyMed (CMM), a commercial online platform for drug prior authorization. Most prescribers and pharmacies are using CMM as the platform for completing TARs. However, pharmacies can only initiate the TAR on CMM and are blocked from submitting the TAR to Medi-Cal. Under Medi-Cal Rx, only the prescriber can submit the TAR to Medi-Cal through CMM. If you receive a notification from CMM or the pharmacy to complete a TAR, please complete the TAR on CMM and submit to Medi-Cal. You can also print out the form and fax the TAR directly to Medi-Cal at 800-869-4325.

Many current claim denials due to Medi-Cal's claim adjudication issues can be overridden with a TAR. A TAR is the most direct and expeditious process to resolve a claim denial and help your patient obtain their prescription at the pharmacy.

Magellan is responsible for fielding calls from both members and providers

for problems they encounter. If you or your patients find this system is not working in individual cases, please contact PHC to assist. Resolution through Magellan should always be pursued first. Here are some options:

1. If you as a prescriber want to have a conversation with Magellan about a TAR deferral to discuss the particulars of the case. Please call Magellan at 800-977-2273. This is especially important for urgent patient needs.

2. If an inappropriate denial of a medication is made, but it is not urgent, the standard process for appealing a denied TAR is to submit an appeal for the TAR adjudication results, clearly identified as appeals to: Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 610. Rancho Cordova, CA 95741-0610. Medi-Cal Rx will acknowledge each submitted TAR appeal within three days of receipt and make a decision within 60 days of receipt.

3. For patients who want to file a grievance related to the process, recommending that they call the Magellan customer support at 800-977-2273.

4. If these options are not yielding results, you can reach out to our PHC pharmacy staff directly at 707-863-4155 to assist with getting Magellan to respond. PHC does not have the ability to overturn Magellan/DHCS denials, but we have one additional escalation pathway we can use if the above are not successful.

Implementation of New Core Claims Processing System

For a Health Plan, the claims processing system is the single most important IT software system in the organization. Tens of millions of claims are processed each year, over $2 billion worth at PHC. All our providers count on that system to be paid accurately and timely.

PHC is scheduled to change from our legacy system, called Amysis, to a new system called Health Rules Payer (HRP) sometime after July of this year. It does require a huge amount of IT resources, as all systems interfacing with the claims system need to have new interfaces mapped, built and tested. If all goes well our providers will not notice any changes resulting from this change.

State Policy Updates

California Budget for 2022-2023: What to watch

The Governor's 2022/2023 Fiscal Year State Budget (Budget) proposal of $286
Billion incuded a surplus of over $45 billion is close to a record high, and there is a 9.1% annual spend increase over last year. Health-related proposals include:

- The Governor has included almost $3 billion for COVID response to cover immediate needs and interventions the rest of the year, including vaccine distribution and administration, testing, hospital and health system surges, and contact tracing.
- Covering the remaining undocumented residents of California with full scope Medi-Cal, between the ages of 26 and 49 years. If that proposal passes, there would be universal coverage in the state, and the first in the nation.
- Funding of the Office of Health Care Affordability, which would be charged with making pricing more transparent and developing cost targets.
- $400 million proposed for one-time provider payments to help address health equity and improve children's preventive care, maternal care, and integrated behavioral health. Partnership is very curious about this proposal, which was not detailed.

Other recent state health policy actions:

- Single-Payor Health Care Coverage (Assembly Bill [AB] 1400) – This proposal was introduced but failed a key procedural step, putting any action on hold for at least a year.
- Medi-Cal Caseload – Overall, it is expected that the Medi-Cal caseload will decrease by about 3% per year. During the public health emergency (scheduled to end after March), redeterminations for eligibility had been suspended. It is anticipated that this will begin again in spring.
- California Advancing and Innovating Medi-Cal (CalAIM) Waiver –The State had its signature 5 year Waiver proposal approved by the Centers for Medicare and Medicaid Services (CMS), which was a portfolio of waivers and amendments for the state. In large part, those were approved at the end of December by CMS. A couple highlights that became immediately apparent is that the State has received permission to provide contingency management services for those who are afflicted with substance use disorder, as well as the creation and reimbursement of a workforce called Peer-Support Specialists to help address behavioral health issues, which could include traditional tribal healers.

California POLST Registry Planned

The dream of a statewide POLST registry in California, took a huge step toward becoming a reality as Governor Gavin Newsom, signed the main 2021-2022 State Budget Trailer Bill, related to health (SB 133). This bill includes a $10 million appropriation for the California Emergency Medical Services Authority (EMSA), to develop a POLST eRegistry in consultation with the Coalition for Compassionate Care of California (CCCC), and other stakeholders.

The eRegistry implementation is planned over the next several years, and includes a requirement that POLSTs be submitted electronically, a fundamental change from the paper-based POLST that is currently allowed. National standards organizations are currently working on a standard format for electronic POLST forms, which will enable vendors of Electronic Health Records (EHRs) to build both the electronic POLST and a connection with the eRegistry into their platforms.

Assembly member Dr. Joaquin Arambula, Emergency Room physician from Fresno, submitted the proposal to the legislature and administration and shepherded it through the budget process. POLST champions and stakeholder organizations including the California Medical Association (CMA), supported the proposal through the budget committees and the finance department of the Newsom administration.

As the operational home of the California POLST program, since its inception in 2008, CCCC has worked collaboratively with other stakeholders to advance POLST in California through education and advocacy. The budget allocations are the culmination of years of effort, spearheaded by CCCC, to support electronic exchange of POLST information whenever, and wherever it is needed to support person-centered care.

EMSA is the State Administrative Authority in charge of the POLST form, and whom will lead the POLST registry project and contracting. This will be the first time the state has invested significant time and resources into the POLST and the CCCC will work closely with EMSA to provide education, and lead quality improvement efforts.

Primary Care Physicians, Hospitals, Skilled Nursing Facilities, and PHC will need to complete many steps in order to prepare for the eRegistry implementation. PHC will be actively supporting these preparatory steps in the years to come, likely including aligned pay-for-performance incentives.

There is much work to come to make this a reality, but we very much celebrate this key milestone!

Federal Policy Update

A few issues to watch in the coming year:

1. Telemedicine flexibilities. While California has extended telephone visit equivalence to in-person visits for all of 2022, the federal flexibility is still tied to the declaration of a public health emergency, which is extended 90 days at a time and currently planned to expire in April 2022. For providers in California, if the federal flexibility ends, it will affect Medicare patients. Several bills are pending in Congress that would extend the audio-only visit flexibility.

2. Health Provisions within the Build Back Better Act, pass in the House of Representatives but which failed to pass in the Senate. Considerations of taking pieces of this bill which have more support to get them passed are under negotiation. Health related provisions with the greatest chance of advancing include: ACA tax credits, prescription drug cost controls, funding for 1000 new GME positions, and building the U.S. public health infrastructure.

PHC COVID-19 Updates

Surplus of Covid-19 Therapeutics Available

During the Omicron wave of Covid, the small amount of Paxlovid and lack of effectiveness of many monoclonal antibodies led to a sense of scarcity: that these options for early treatment of Covid should be reserved for those most likely to become ill, perhaps elderly patients who were unvaccinated. In fact, the CDC still has information on prioritization of treatments on its website.

As Omicron has subsided, the available supply of Paxlovid, sotrovimab, remdesivir, and bebtelovimab, all effective in preventing severe disease in those with Omicron, has grown faster than the demand for its use. Many counties are turning away offers of more sotrovimab and bebtelovimab, as they had run out of room to store doses.

As a result, public health officials are working to reframe physician thinking about these treatments, from scarce resources to be rationed, to a resource to be used for a wider group of patients at risk. Criteria for use has now returned to the original risk categories, including not just chronic heart and lung disease, but also obesity, those with chronic mental health issues, and anyone over the age of 65, regardless of vaccination status. The CDC has a full list of conditions on its website.

We recommend consulting with your local health department and larger health centers on the locations with these treatments in stock. The standard of care is now shifting to much more widespread treatment. Spread the word to your providers, and set up systems to screen those who call into the office for potential treatment, in addition to the usual recommendation to isolate at home.

The CDC recommends prioritization of treatments in this order (most preferred to least preferred), for those with early Covid and a risk factor:

1. Paxlovid
2. Soltrovimab
3. Remdesivir
4. Bebtelovimab
5. Molnupiravir

A proposal by the federal government to make these treatments available in pharmacies without physician prescription (test and treat) is stalled, as clinician groups point out the complex drug-drug interactions and other reasons they believe a clinician who can access the patient's medical history should be involved in the decision to treat.

Covid Home Test Kits Covered for Medi-Cal Beneficiaries

The California Department of Health Care Services (DHCS) announced that they will cover rapid antigen tests for Covid, through pharmacies, paid by Medi-CalRx, the new state pharmacy carve out, starting on February 1, 2022. Patients may receive up to four test kits per month (each with two tests) with a prescription from a prescribing clinician or the pharmacist.

Coverage does not guarantee availability, however with all commercial insurers covering home tests and the government purchasing test kits in bulk for direct distribution, it can be hard to find a pharmacy who has these Covid tests in stock.

Medi-Cal beneficiaries can request retroactive reimbursement for home Covid tests purchased between March 11, 2021 to January 31, 2021. Instructions are available on the MediCal Website.

PHC COVID-19 Flexibilities:

During the Covid pandemic, CMS, DHCS and PHC have instituted a number of flexibilities in previous rules and standards of care, to balance the dangers of Covid with the need to provide health care as safely and responsibly as we can.

Phone visits and video visits are permitted in lieu of office visits or home visits through the end of 2022, while a state workgroup investigates options for the future.

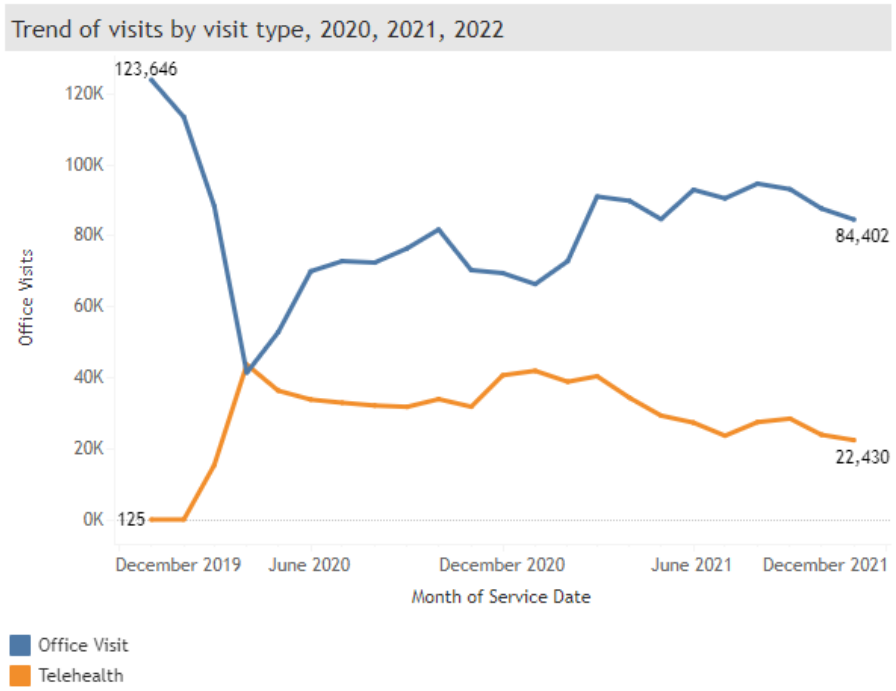
Of note, now that Covid levels have dropped, we expect that pediatric preventive visits will be done in person, in whole or in part. This is the standard promulgated by AAP and DHCS. The public health rationale for balancing the risk of in-person visits during Covid will no longer be considered a justification for performing pediatric preventive visits entirely virtually. Note that the well child visit HEDIS measure is now an administrative measure, so billing codes for preventive visits do count toward HEDIS and QIP measure, regardless of the modifier.

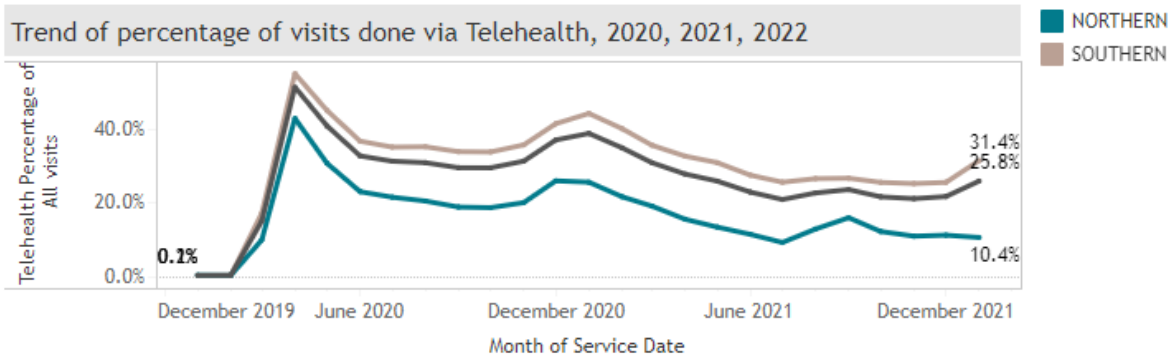
PHC is focusing our medical record audits on visits completed by telemedicine, including preventive health visits. While most of these visits were conducted appropriately, we have encountered a number of examples where the clinical circumstances clearly indicated an examination was needed.

One common example is the ordering of advanced imaging requests after a virtual visit, without performing a physical exam, first. A second example is patients without Covid symptoms but with some sort of potential exposure who were excluded from coming in for an appointment, regardless of the complaint. (Remember the parking lot visit?) A third example is an appointment for a complaint that clearly could never be done virtually but was scheduled that way nonetheless, because the criteria given the schedulers was insufficient.

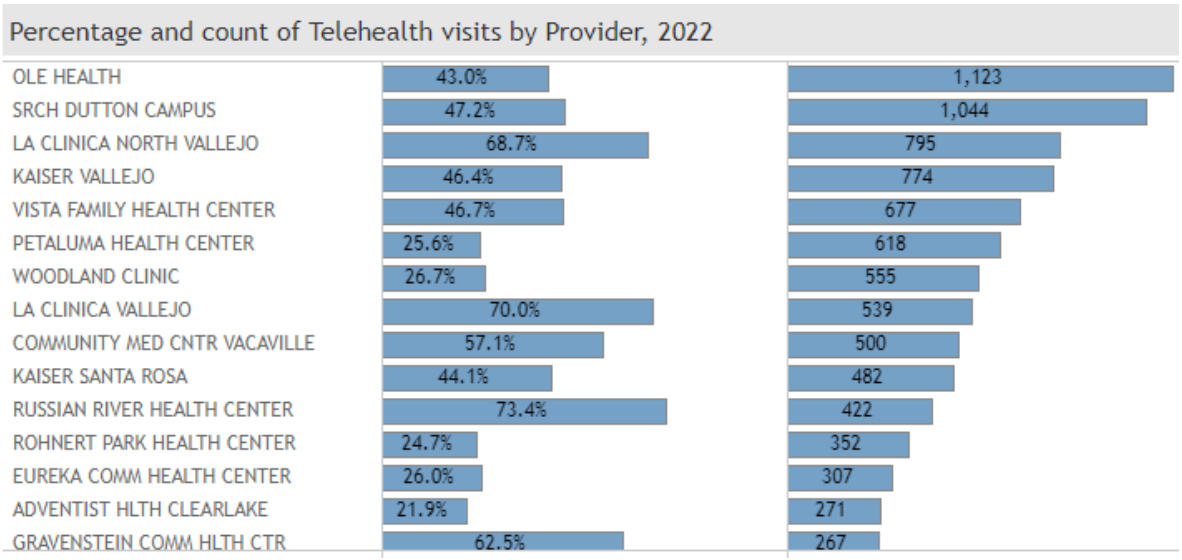
Please review the process you use to decide which visits are okay to be virtual and which ones are not. Ensuring that virtual visits are appropriate is important if we want regulators to continue to allow telephonic virtual visits.

Here is the current pattern of in person versus virtual visits in the PHC service area:





For 2022 (limited claims so far, and during the Omicron wave), here are the PCP sites with the most PCP virtual visit claims:



New Interpretation Service for PHC Members

Effective November 30, 2021, PHC has a new Interpretive Language Services provider, AMN Healthcare, which will serve both PHC members and providers.

AMN will provide telephone and Video Remote Interpretive (VRI) services, and will replace PHC's current Language Line. The previous interpretive services line was disconnected on November 30, 2021. AMN will provide interpretation for 145 languages by phone more than 40 languages via VRI. VRI can be downloaded to your facility device for interpretation. Please review the VRI guidelines on our website.

Please note to access the Telephone Language Services you will need to give your PHC number as listed in the PHC Provider Directory. Please use the AMN number below to access Telephone Language Services, effective November 30, 2021:

Telephone Language Services: (844) 333-3095

Providers will be asked to provide the following at the start of the call: PHC#, Provider Site, Member Name, City, and Member ID (if applicable).

1. Video Language Services: Determine if the device meets the technical requirements for the app (linked below).
2. Request a license from AMN by completing the VRI Setup Form linked below.
3. Email the completed form back to Elizabeth.Jones@amnhealthcare.com.
4. Set up the application on your device.
5. **AMN will contact you within three business days to confirm your approval status and next steps.**

Please note that each individual device will require a separate license and login. There is no cost for each provider license. PHC will continue to pay for the cost of interpreting services for PHC members. For additional details on how to request a VRI License, refer to the guides linked below.

Resources

- AMN Healthcare Training Video
- VRI Guidelines
- VRI Setup Form
- Where to find your PHC #
- Telephone Language Services: (844) 333-3095

Direct Telehealth Specialty Services Now Available

PHC offers Direct Telehealth Specialty Services through our provider directory to Primary Care Providers (PCPs). Direct Specialty Telehealth Services are being provided by “TeleMed2U” for a select set of specialties. We will continue to expand these services to providers as the need for additional direct specialty telehealth services arise.

Direct specialty telehealth referrals are available for these specialties:

- Dermatology
- Endocrinology
- Infectious Disease
- Rheumatology
- Pulmonology
- Pediatric Dermatology also available for 17 and under

Direct specialty telehealth services are being provided by “TeleMed2U” for a select set of specialties but we will continue to expand these services to providers as the need for additional specialty care services arise.

Any PHC member 18 years and older (except as noted for pediatric services) are eligible to receive care from TeleMed2U specialists and can be referred to TeleMed2U directly.

It’s easy to refer, here’s how:

1. Login to PHC’s provider directory
2. Conduct a search for “Telehealth,” “TeleMed2U” or the “Specialty” needed
3. Locate TeleMed2U’s contact and referral information
4. Send the referral and the patient’s medical records securely by email or fax directly to TeleMed2U
5. TeleMed2U will coordinate patient scheduling
6. TeleMed2U will also send the clinical notes from the telehealth visit back to you

More Information

PHC Medical Equipment Distribution

The PHC Medical Equipment Distribution Services Program offers the following types of monitoring and treatment medical equipment to PHC members at no cost.

- Blood pressure monitors
- Pulse Oximeters
- Digital thermometers
- Humidifiers

- Nebulizers
- Scales
- Vaporizers
- Prescription Lock Boxes

We also supply additional blood pressure monitor cuff sizes, nebulizer replacement parts, and user instructions in the member's preferred language. Since the program launched, PHC has provided more than 2,500 devices to PHC members in over 40 different healthcare organizations, and continues to fulfill equipment requests daily.

To request equipment, providers are required to review the Medical Equipment Distribution guidelines, complete the request form, and submit the completed form to PHC by emailing request@partnershiphp.org or by faxing the form to (707) 420- 7855.

For any questions, please contact request@partnershiphphp.org.

Medication Lock Boxes for PHC Members

Medication lock boxes have been added to PHC's Medical Equipment Distribution program.

Medication lock boxes are used to secure medications and avoid misuse. Like all equipment distributed in the PHC Medical Equipment Distribution, there is no charge to PHC members. Instructions on use will be provided in the language the patient speaks.

All contracted eligible providers and clinicians can now request medication lock boxes (and other medical equipment) by:

1. Completing the request form
2. Emailing the completed form to request@partnershiphp.org or faxing the completed form to (707) 420-7855.

Request guidelines
More information

Pediatric Specialty Telehealth Program

PHC and UC Davis Health (UCD) have partnered to expand access to pediatric specialty care services which is now available through PHC Telehealth Program.

PHC patients 20 years of age and younger with PHC primary or dual coverage are eligible. Patients under age 18 must be accompanied by an adult parent or guardian.

Here are the specialties available:

AVAILABLE PEDIATRIC SPECIALTIES	
• Allergy and Immunology • Cardiology • Dermatology (store and forward) • Endocrinology • ENT/Otolaryngology (cleft and craniofacial) • Gastroenterology • Infectious Disease • Neonatology	• Nephrology • Neurology • Neuromuscular Disease Medicine • Orthopedics • Palliative Care • Pulmonary • Rheumatology • Urology

The six most commonly used specialties are:
1. Dermatology
2. Endocrinology
3. Gastroenterology
4. Neurology
5. Pulmonology
6. Urology

Once your office is signed up, a pediatric telehealth appointment can typically be made in 5-20 days.

Sites that have set up pediatric telemedicine are: Shasta Community, Fairchild, Open Door, Karuk, Northeastern.

Sites that have set up Pediatric cConsult: Open Door, Ole Health, Karuk, Shasta, Mountain Valleys, Northeastern, Fairchild

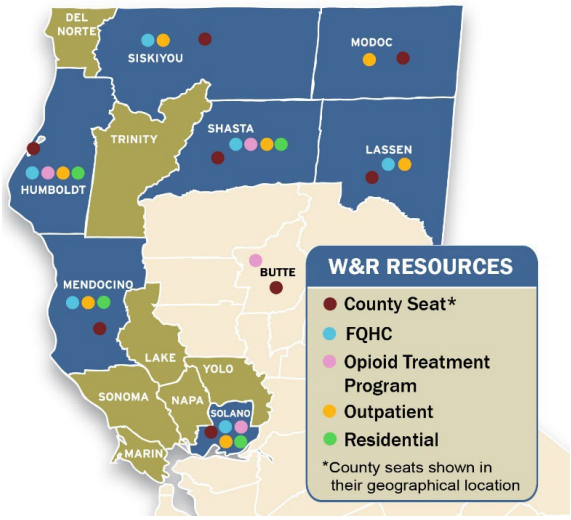
If you are interested in participating in our pediatric telehealth program and would like to learn more about our service offerings, please visit the Pediatric Telehealth Page, on our website.

Behavioral Health Updates

PHC's Wellness and Recovery Program Update

Began providing comprehensive substance use treatment (SUD) services through our new Wellness and Recovery Program in seven of our counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. There

has been to change in the counties covered by PHC. We remain the only managed care plan in California to take on this benefit.



Expanded SUD services are administered through the counties in Napa, Marin, and Yolo. A more limited benefit is administered in the remaining four counties — Del Norte, Lake, Sonoma, and Trinity.

In the seven Wellness and Recovery counties, services are available to all Medi-Cal beneficiaries – not just PHC members – who meet the medical necessity criteria as determined by the American Society of Addiction Management (ASAM) scale.

PHC underwent a comprehensive audit of the SUD benefit, with very favorable results.

The range of SUD services in the Wellness and Recovery counties include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, nine to 19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment
- Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)

Medi-Cal beneficiaries in the seven counties can be screened and connected to a treatment provider by calling Beacon Health Options at (855) 765-9703.

For more information about Wellness and Recovery services, click here.

Members with High Complexity Eating Disorders

PHC has an internal team for case managing patients with complex eating disorders, for whom you are having difficulty finding treatment options.

If you have identified someone with an eating disorder for whom a higher level of care or intervention may be warranted, please complete the Eating

Disorder Collaboration Request Form (posted with meeting materials) and send it to : ED_Collab@partnershiphp.org Partnership will review the form and work with you to identify possible options.

Hints for Getting an Appointment with a Beacon Provider

Scenario: You are seeing a patient who is depressed and anxious and is receptive to mental health counseling. You give them the contact number for Beacon Health Options to call to request a referral to a local contracted mental health professional open to new patients. Your patient is given a list of three numbers to call. When they call all the numbers, none of the mental health professionals are accepting new patients/appointments in the next month. The patient gives up, and her depression and anxiety become worse.

What can you do? Don't give up! Here are three options:

1. Fill out a "PCP Referral Form." This ensures that Beacon works directly with the client to link them to service and keeps you in the loop.
2. Coach your patient to specifically ask Beacon for assistance in contacting the Mental Health Professionals to make an appointment. Per our agreement with Beacon, patients who ask for this help will have Beacon staff do the legwork to find a mental health professional open to a new patient and make the appointment.
3. Have your patient contact PHC's Care Coordination Department to get assistance.

Supporting Behavioral Health Needs in Children: UCSF's Child & Adolescent Psychiatry Portal

Do you have children and adolescents with mental health needs? Do you have difficulty finding local child psychiatry specialists to whom you can refer them? Are you looking for ways to increase your skills to handle common behavioral health challenges yourself?

UCSF has developed a Child & Adolescent Psychiatry Portal (CAPP) to help meet increasing needs of pediatric primary care with mental health in the youth population.

Resources:

- CAPP Services and FAQ
- CAPP Fact Sheet

Obtaining Psychological and Neuropsychological Testing

PHC covers psychological and neuropsychiatric testing though our mental health intermediary, Beacon Health Options.

Q: When is testing commonly recommended?

A: Psychological and neuropsychological testing is the use of standardized assessment tools to gather information relevant to a member's intellectual, cognitive, and psychological functioning. Psychological testing helps determine differential diagnosis and assesses overall psychological and neuropsychological functioning. Testing results usually inform subsequent treatment planning. Neuropsychological testing is most often utilized for members with cognitive impairments that impede functioning on a day-to-day basis.

Q: Does the member require an authorization for testing?

A: No. Beacon does not require an authorization for testing.

Q: How can a PCP refer a member to psych and neuropsychological testing?

A: PCP can complete the "PCP Referral Form" and request testing for a member. Check the box at the bottom of the form, labeled "Request for Psychological or Neuropsychological testing." The "PCP Referral Form" is faxed to Beacon to conduct member outreach to assist with linkage to a psychologist. The psychologist will complete an intake assessment to determine if testing is indicated. Beacon will send a fax notification back to the PCP with the outcome of the request.

Bright Heart Health: On-Demand Behavioral Health

Bright Heart Health is an on-demand mental health, medication-assisted treatment, and pain management telemedicine program providing a wide range of services across the United States. All services are provided remotely. Partnership Health and Beacon Health Options contract with Bright Heart Health for mental health services; medication assisted treatment, and services related to eating disorders. In conjunction with County mental health plans, members may also receive intensive outpatient eating disorder services involving a team.

PHC has contracted with Bright Heart Health to provide services in all 14 counties.

Bright Heart Health can be accessed by either patients or referring providers either by:

1. Calling 1-800-892-2695
2. Visiting the on-line virtual clinic at: https://www.brighthearthealth.com/contact-us/

After intake documentation is competed with a Care Coordinator, the patient will be scheduled to see a licensed physician or therapist through Zoom.

In addition to PHC, Bright Heart Health accepts fee-for-service Medi-Cal, Medicare, most commercial insurances and self-pay.

Public Health Updates

Lead Screening Update: DHCS adds Lead Screening HEDIS measure in 2022

DHCS announced its intent to add the HEDIS measure of blood lead screening by age 2 to its Managed Care Accountability Set (MCAS), effective for calendar year 2022, as a reporting measure with accountability beginning in 2023.

The minimum acceptable screening level proposed would be a screening rate of 73%, corresponding to the 50th percentile nationally. Current screening rates for PHC children are only about 50%, which is around the 10th percentile nationally. Here are the rates in our four regions, for 2019 (before COVID):

- Northwest Region: 72%
- Northeast Region: 15%
- Southwest Region: 52%
- Southeast Region: 51%

PHC is planning to add Lead screening as a PCP QIP unit-of-service measure, starting next year. We urge all PCPs to ramp up efforts to create systems to reliably screen children for elevated lead levels.

For a detailed, recorded presentation on the clinical, public health and regulatory aspects of the lead screening (with CME available): see our website.

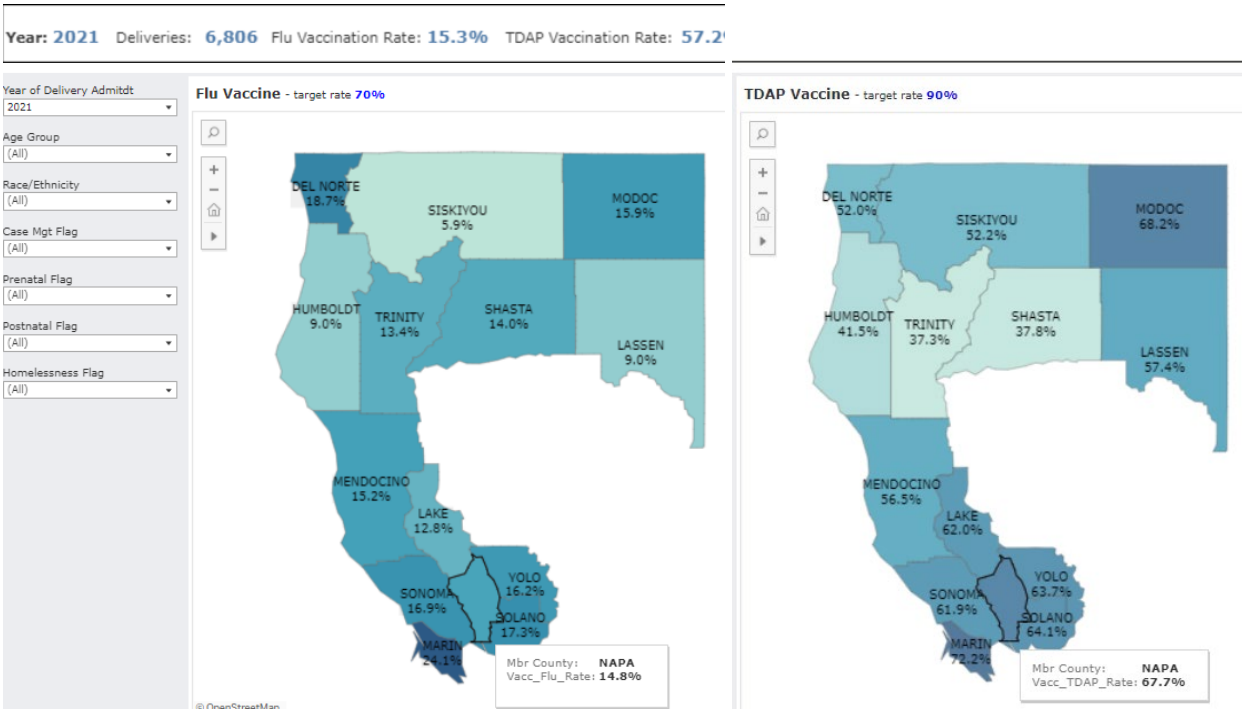
Current Lead Screening Rates:

The following data are for 2021, and are a bit rough, as they may be missing some recent claims, and the screening rate is not based on the HEDIS standard, yet.

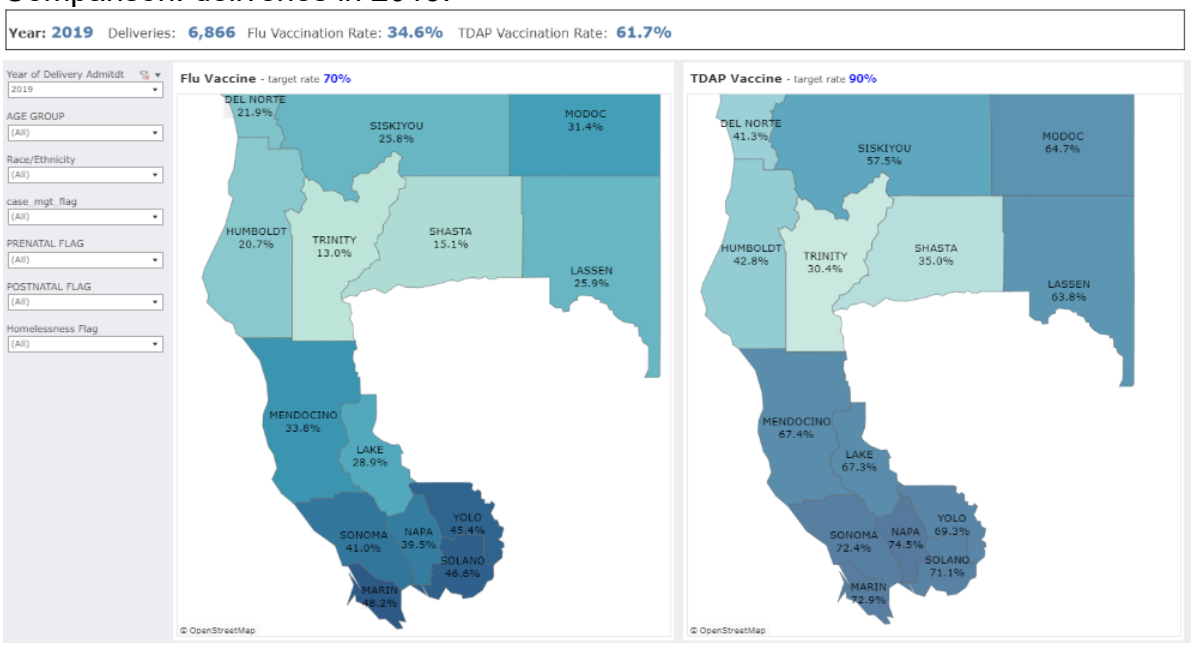
PCPs with highest blood lead screening rates	PCPs with medium blood lead screening rates	PCPs with lowest blood lead screening rates
ALLIANCE MED CT WINDSOR	HILL COUNTRY COMM CLINIC	FAIRCHILD MEDICAL CLINIC
ELICA HEALTH CENTERS	EUREKA COMM HEALTH CENTER	REDWOOD PEDS MEDICAL GROUP
DAVIS COMMUNITY CLN	HILLSIDE HEALTH CENTER	SONOMA COUNTY INDIAN HEALTH
ALLIANCE MEDICAL CENTER	ADVENTIST HLTH HOWARD MEM	BANNER HEALTH CLINIC
MENDOCINO COAST PEDS MG	HOWONQUET CLINIC	LUNDERGAN FAYE
BUTTE VALLEY HEALTH CENTER	ADVENTIST HLTH UKIAH VALLEY	SUTTER MEDICAL GROUP SOLANO
KLAMATH CLINIC UIHS	CENTER FOR PRIMARY CARE	RUSSIAN RIVER HEALTH CENTER
TAMALPAIS PEDIATRICS GB	REDWOOD RURAL HEALTH CENTER	DUNSMUIR COMM HEALTH CENTER
ADVENTIST HLTH UKIAH VALLEY	SUTTER MEDICAL GROUP YOLO	CONNER ALEXANDRIA
MARINHEALTH MED NETWORK	SRCH LOMBARDI CAMPUS	SUTTER MEDICAL GROUP YOLO
MENDOCINO COAST CLINIC	PETALUMA HEALTH CENTER	SURPRISE VLY MEDICAL CLINIC
LOFFLER-BARRY CHRISTINE	ADVENTIST HLTH CLEARLAKE	POINT ARENA COMM HEALTH
MARIN COMM CLN SAN RAFAEL	LASSEN MEDICAL CLINIC	SUTTER MEDICAL GROUP SOLANO
SONOMA VALLEY COMM HLTH CTR	KIMAW MEDICAL CENTER	SHASTA VALLEY COMM HLTH CENT
FALL RIVER VALLEY HC	HORTA ELISA	HILL COUNTRY COMMUNITY CLNC
MARIN COMM SOUTH NOVATO	WOODLAND CLINIC	COMMUNITY MED CENTER ESPARTO
SALUD CLINIC	SWENSON MEDICAL GROUP	SOUTHERN HUMBOLDT COMM
HANSEN FAMILY MEDICAL CENTER	SCOTIA BLUFFS COMMUNITY HC	ADVENTIST HLTH CLEARLAKE
ELICA HEALTH CENTERS	ROHNERT PARK HEALTH CENTER	SHASTA COMM HEALTH CENTER
LIZARRAGA MIGUEL	SRCH PEDIATRIC CAMPUS	SHASTA LAKE FAM HLTH CNTR
MODOC MEDICAL CLINIC	PIT RIVER HEALTH SERVICE	COMMUNITY MED CNTR VACAVILLE
LASSEN MEDICAL CLINIC	SOLANO COUNTY HLTH SVC	CONSOLIDATED TRIBAL HEALTH
WINTERS HEALTHCARE FND	WOODLAND CLINIC	PROVIDENCE MED GROUP SONOMA
SUTTER MEDICAL GROUP YOLO	SOLANO COUNTY HLTH SVC	SHASTA FAMILY CARE
TAMALPAIS PEDIATRICS NOV	TRINITY COMM HEALTH CLINIC	ANNADEL MEDICAL GROUP
LAKE COUNTY TRIBAL HEALTH	PETALUMA HEALTH CENTER	SHINGLETOWN MEDICAL CENTER
ADVENTIST HLTH CLEARLAKE	POTAWOT VILLAGE UIHS	SUTTER MEDICAL GROUP YOLO
ANDERSON VLY HEALTH CENTER	REDDING RANCH TRINITY HEALTH	MERCY FAMILY PRACTICE CLN
TULELAKE HEALTH CENTER	VISTA FAMILY HEALTH CENTER	MT SHASTA MERCY COMM CLN
MCKINLEYVILLE COMM HLTH CTR	LITTLE LAKE CLINIC	PROVIDENCE MED GROUP SONOMA
BIG VALLEY HEALTH CENTER	SRCH DUTTON CAMPUS	ADVENTIST HLTH CLEARLAKE
LAKE COUNTY TRIBAL HEALTH	PROVIDENCE MED GROUP SONOMA	HILL COUNTRY COMM CLINIC
MERCY LAKE SHASTINA COMM	SONOMA PLAZA PED MED GRP	CRESCENT CITY CLINIC UIHS
CANBY FAMILY PRACTICE CLIN	SUTTER MED GRP REDWOODS	GRAVENSTEIN COMM HLTH CTR
WESTWOOD FAMILY PRAC	SUTTER LKSIDE COMM CLINIC	SUTTER LKSIDE MED PRACTICE
NORTHEASTERN RURAL HLTH CLI	DEL NORTE COMM HEALTH CENTER	LA CLINICA NORTH VALLEJO
OLE HEALTH	CENTER FOR PRIMARY CARE	SCOTT VALLEY RURAL HEALTH
REDWOOD COMM HEALTH CENTER	SUTTER MEDICAL GROUP SOLANO	ANDERSON FAMILY HLTHCTR
LAKEVIEW HEALTH CENTER	GUALALA MEDICAL CLINIC	CENTER FOR PRIMARY CARE
ADVENTIST HLTH UKIAH VALLEY	CHURN CREEK HEALTHCARE	LA CLINICA VALLEJO
HUMBOLDT OPEN DOOR CLINIC	NORTHCOUNTRY CLINIC	DIXON FAMILY PRACTICE
HAYFORK COMM HEALTH CLINIC	CONCEPCION MARC	SEBASTOPOL COMM HLTH CTR
FORTUNA COMM HEALTH CENTER	MCCLOUD HEALTHCARE CL	SUTTER MEDICAL GROUP YOLO
		CENTER OF HOPE
		SUTTER MED GRP REDWOODS
		ROUND VALLEY INDIAN HEALTH

Vaccination Rates in Pregnancy: Rates down during pandemic

For deliveries billed in 2021:



Comparison: deliveries in 2019:



Summary: Vaccination rates dropped dramatically for influenza from 2019 to 2021 and slightly for TDAP, with much regional variation.

Clinical Updates

USPSTF Major Updates

Each year, PHC updates its policy on Adult Preventive Care, drawing largely on updates from the U.S. Preventive Services Task Force (USPSTF). See the complete list on our website, which will be updated soon. Here are some major changes that your clinicians should be aware of:

1. **Cervical Cancer Screening.** The USPSTF is in the process of updating this standard. It currently recommends cervical cytology every 3 years in women aged 21 to 29, and then the option of either continuing cervical cytology every 3 years or performing high risk HPV testing every 5 years (potentially with cytology) from age 30 to 65. The WHO recommends screening with hrHPV every 5-10 years starting at age 30. In 2020, the American Cancer Society changed its recommendation to start screening at age 25 and to use hrHPV every 5 years as the preferred screening at all ages through age 65. It seems likely that USPSTF will change its recommendation to follow the ACS recommendation. This opens the door to patient-collected HPV specimens, recently approved by the FDA, and recommended by the WHO as the preferred method of collecting specimens. The infrastructure of such home testing is in the early phases. We encourage providers to test this in women over age 30, and see if we can work out the coding issues. NCQA HEDIS is still following the USPSTF standard for 2022.
2. **Colon Cancer Screening.** Last year, the USPSTF lowered the starting age for colon cancer screening to age 45 years (Age 45 to 49 years old: Class B recommendation; ages 50-75 remains a Class A recommendation; selective screening for ages 76-85 remains a Class C recommendation). PHC will phase in the resulting PCP QIP and audit changes, auditing against the new standard starting in 2023.
3. **Screening for Diabetes.** Last year, the USPSTF recommended that all adults aged 35 to 70 who are overweight should be screened for diabetes no less than every 3 years.

Clinical Practice Guidelines for Primary Care

PHC has posted clinical practice guidelines for adult and pediatric preventive care, depression, chronic pain management, diabetes management, lactation management, and asthma management on our website at: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Health Services Updates

CT Colonography Covered for Colon Cancer Screening

A lesser-used option for colon cancer screening is CT Colonography. Since contrast in the large intestine is needed, it is like a next-generation barium enema.

This test is recognized as an option for colon cancer screening by NCQA and USPSTF. This is rarely ordered (due to patient discomfort), as most clinicians favor FIT tests, fecal DNA tests, or colonoscopy. Due to relatively limited availability, colonoscopy may be best reserved for following up with abnormalities found with other testing modalities.

Medi-Cal and PHC added the code for CT colonography for screening purposes, using CPT 75263. Other codes for CT colonography (75261 and 75262) are used for diagnostic purposes, not screening. PHC now covers all recommended modalities for colon cancer screening, without prior authorization.

As a reminder, the USPSTF added a Class B recommendation for colon cancer screening for individuals aged 45-50. We will not change the age range for our PCP QIP colon cancer screening measure until 2023, to give providers a chance to expand their screening program to include these ages.

Another Option for Medical Nutrition Therapy and Diabetes Education

For almost 20 years, PHC has covered Medical Nutrition Therapy services provided by Registered Dieticians (RDs) and Diabetes Education provided by Certified Diabetes Educators (CDEs). These services require neither prior authorization nor referral pre-authorization. In-person services may be provided in some counties.

Medical Nutrition Therapy services may be provided for most major conditions where medically appropriate, including diabetes, pre-diabetes, renal disease, hepatic disease, obesity/overweight, cardiovascular disease including hypertension and hypercholesterolemia, and eating disorders.

PHC's adult specialty telemedicine provider Telemed2U, added these services a few years ago. Last year Telemed2U began integrating endocrinology visits for diabetes with a virtual care team, including RDs and CDEs. Patients are referred through the Telemed2U platform. Practices interested in working with Telemed2U should reach out to telemedicine@partnershiphp.org to learn more.

Last year, the Center for Wellbeing, based in Santa Rosa, is expanding its telemedicine capacity for RD and CDE services to serve PHC members in **any** of our counties. For more information, call (707) 575-6043 or email info@nccwb.org.

Care Coordination Services at PHC

Did you know that PHC offers comprehensive case management services to all of our members regardless of age or location? PHC's Care Coordination department is comprised of RN Case Managers, Medical Social Workers, Health Care Guides, Behavioral Health Clinical Specialists, and Transportation Specialists ready to assist providers, members, and community partners coordinate care and access services.

These services are voluntary, provided at no cost to the member or provider, and the member can opt-out at any time.

Most of our teams' work is done telephonically, with the possibility of face-to-face engagement in select instances.

When we connect with members, we assign them an Acuity Level that best matches their needs and level of intensity for case management services.

The lowest level is for our members that need help accessing their benefits or providers. The highest levels are for those members that have multiple unmanaged complex conditions and/or for those whom have difficulty navigating the healthcare system without intensive support of a case manager.

If you believe you have a PHC member that would benefit from the services available from our Care Coordination department, please refer then by calling (800) 809-1350 or e-mailing the Care Coordination Help Desk at:

- Southern Region: CareCoordination@partnershiphp.org
- Northern Region: CCHelpDeskRedding@partnershiphp.org

The Intensive Outpatient Palliative Care Benefit

Covered conditions include advanced cancer, advanced liver disease, congestive heart failure, chronic obstructive lung disease, progressive degenerative neurologic disease, or other serious pre-terminal conditions that result in frequent hospitalizations. This benefit is designed for PHC members with limitations in function and limited life expectancy who are at a late stage of illness who have received maximal member-directed therapy or therapy is no longer effective. Palliative care local in-person resources vary by county.

Here is the contact information for active and new Palliative Care Provider Organizations in our service area:

Counties Served	Organization	Referrals
Del Norte, Humboldt, Lassen, Modoc, Siskiyou, Shasta, Trinity, Solano (new county)	Resolution Care	Phone: 707-442-5683
Humboldt	Hospice of Humboldt (new)	Phone: 707-445-3443
Lake	Hospice Services of Lake County	Phone: 707-263-6270 ext 140
Mendocino	Madrone Care Network	Phone: 707-380-5080
Napa, Sonoma, Solano (Vallejo)	Collabria Care	Phone: 707-258-9080
Marin, Sonoma	Hospice By the Bay	Phone: 888-720-2111
Marin	MarinHealth Medical Network (new)	Pending
Sonoma	St. Joseph Health	Phone: 707-522-4307
Yolo	Yolo Hospice	Phone: 530-758-5566
Yolo	Dignity Health - Woodland	Phone: 916-281-3900

Eligible patients should have a year or less of life expectancy, not be a candidate for hospice, be in a state of declining health, in spite of medical treatment.

Re-framing POLST Completion as a Procedure

If a surgeon took a patient with a large colon cancer to the operating room against the previously expressed wishes and consent of a patient, they would be subjected to hospital peer review, investigation by the Medical Board, and potential loss of license to practice medicine.

However, failure to have a goals-of-care conversation, leading to an incorrectly completed POLST, that then leads to a seriously ill patient receiving unwanted CPR/intensive care, almost never results in a referral to peer review or the Medical Board.

It will take a big culture shift for this to change, but perhaps we can learn something from surgeons: using a systematic process. Surgeons have a standard way of documenting a procedure, which is essentially a checklist reflecting the standard of care:

1. Procedure performed
2. Date and time of the procedure
3. Name of surgeon/assistants
4. Indication for procedure
5. Pre-operative diagnosis
6. Post-operative diagnosis
7. Anesthesia
8. Narrative Description of the Procedure
9. Findings
10. Specimens
11. Sponge and needle counts
12. Drains left in after surgery
13. Disposition/Status of the patient

A goals-of-care conversation with a patient and the family should be documented like a procedure, with a few adaptations.

The Physician Order for Life Sustaining Treatment (POLST) was established by AB 3000, passed in 2008, and took effect in 2009. Early on, the California Healthcare Foundation and the Coalition for Compassionate Care of California funded and organized local community coalitions to educate clinicians, emergency medical technicians, and the public, on how to use the POLST appropriately.

For the patient's wishes around intubation, CPR and artificial nutrition to be honored, the following steps must occur:

1. A clinician needs to have a goals-of-care conversation with the patient and potentially their family.
2. When appropriate, a POLST form must be filled out correctly, without missing signatures or inconsistent directives.
3. The POLST form must be available to any EMS responding to an emergency call.
4. The family needs to understand and respect the orders expressed in the POLST (or they may hide the POLST or direct the care team to ignore the POLST).
5. The emergency medical technicians, emergency department physicians and ICU physicians must understand what a POLST is, how

to read the POLST, what it means, what the legal requirements are, and agree to following the directives expressed in POLST forms.

6. The POLST form must be available to the emergency department physician and potentially the ICU physician caring for a patient who is unable to express their own wishes.

A number of organizations in California are piloting electronic POLST forms and POLST registries. One key finding from these pilots is that there are problems with every one of these six steps, such that many patients are not having their wishes honored by one or more providers.

To focus on just the first two steps, which impact you, our primary care providers: Data from the Palliative Care Quality Network shows that PHC contracted palliative care providers in the PHC service area have a high rate of appropriate use of POLST forms.

However, palliative care clinicians often encounter patients who have a POLST form completed by a non-palliative care clinician which have internal inconsistencies or errors, and in which no goals of care conversation is recorded in the medical record.

This sometimes leads to care that is inappropriate and unwanted.

Consider asking your clinicians to document a goals-of-care conversation like they would document any other medical procedure. See VitalTalk for some resources that can help.

CMO Updates

The following articles are extracted from the PHC Primary care blog: http://phcprimarycare.org, containing content from the past 10 years. In addition, an archive of prior Medical Directors newsletters can be found on the PHC website.

Series on Diagnostic Accuracy

Part 1: Introduces the concept of slow and fast thinking described by Nobel Laureate Daniel Kahneman and the notion of cognitive debiasing, where clinicians intentionally shift to slow thinking when the stakes are high.

Part 2: Describes the risk of overthinking clinical scenarios, with resulting over-utilization of diagnostic tests. Summarizes the American College of Physicians principles for accurate diagnosis.

Part 3: Offers a historical framework of four medical epistemologies that clinicians can use to decide on what treatments to offer patients.

Part 4: Describes seven measures and habits that clinicians can use to reduce the likelihood of cognitive biases causing diagnostic inaccuracy or therapeutic errors.

Leveraging Scribes to Improve Quality: Lessons from Shasta CHC

Most organizations that implemented Electronic Medical Record (EMR) systems in the last two decades found that this implementation led to increased clerical workload of clinicians, leading to increased burnout and job dissatisfaction. Additionally, overuse and misuse of templates led to longer but less accurate and less useful clinical notes.

Several primary care organizations in our region added a new position to address these issues like medical scribes, who perform real-time electronic health record documentation, in the exam room (or video call) with the clinician.

A survey of the published literature on medical scribes have shown increased efficiency, clinician productivity and provider experience, while patient experience with scribes is mixed.

Shasta Community Health Center (SCHC) reports that the increased efficiency of scribes leads clinicians to finish their work earlier at the end of the day, with administrative tasks completed which allows them to go home

to their families on time. Since first implementing a scribe program over a decade ago, SCHC has refined their model to increase the quality of documentation in the medical record and to drive quality performance in the Primary Care Providers Quality Incentive Program (PCP QIP) measures.

1. Training: SCHC has developed a training curriculum to train promising candidates in medical language, standards of documentation, etc., which is now being adapted to be offered in community college courses.
2. Continuity: a clinician-scribe diad often develops short cuts and non-verbal communication methods to work rapidly as a team to support the patient. This may include sending instant messages to the clinician during the visit, such as ordering preventive screenings.
3. Quality focus: Assigning the scribe responsibility for measures amenable to their intervention, like ordering labs that are due or scheduling well child visits.
4. Incentives: A pilot showed that a small incentive for scribes linked to a single measure worked well, but Shasta CHC is cautious about unintended negative consequences, such as removing intrinsic motivation for improving quality.

Supporting Clinician Wellness: New Resources

The California Improvement Network (CIN) has released their Connections Summer 2021 Issue, which focuses on Supporting the Primary Care Workforce. Through this issue, they have provided articles on Reflections from a CIN Managing Partner, Joy in Medicine: How to Build an Effective Support System, Successes in Creating a Culture of Well-being, and CIN Partner Action Planning to Support Providers.

CIN Connections Summer 2021 Issue

Customizing your Electronic Health Record for Quality

Each summer, PHC updates a white paper entitled “Optimizing the Configuration of the Electronic Health Record for Quality.” It contains 41 specific, detailed recommendations for how the electronic health record should be configured to optimize the capture of quality measures and improve the quality of care provided.

The 2021 white paper, with an accompanying PowerPoint presentation and a webinar recording can be accessed through our website.

The Will for Change: Finding Time for this Critical Step

"What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!"** —Tom Nolan, one of the creators of the Model for Improvement.

In a tribute to Tom Nolan, who died on March 19, 2019, pediatrician and founder of the Institute for Healthcare Improvement (IHI) Donald Berwick describes what will, ideas, and execution means:

"Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing, as opposed to continuing legacy systems. And **execution** was his term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders." —Milbank Quarterly, August, 2019

Nolan's three conditions, flow roughly in the following order:

- Execution cannot lead to improvement without testing
- Ideas will not be sought out and tested unless organizational leaders make this a personal and organizational priority, an act of will.

It starts with will to improve.

For leaders to decide to make major improvements, fundamentally, we need to challenge the status quo. We must insist on change and provide a vision for a better state that the organization must strive to achieve.

Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas is a central duty of clinical leaders of health care institutions. Yet, it all starts with leadership's willingness to take risks, communicate a vision of excellence that is achievable, and communicate that the problems of the status quo are unacceptable.

Challenging the status quo is uncomfortable, can be mentally and emotionally draining, and potentially socially isolating.

An alternative leadership style –cherishing tradition and stability– has a certain appeal in the short term. All those staff and stakeholders with an

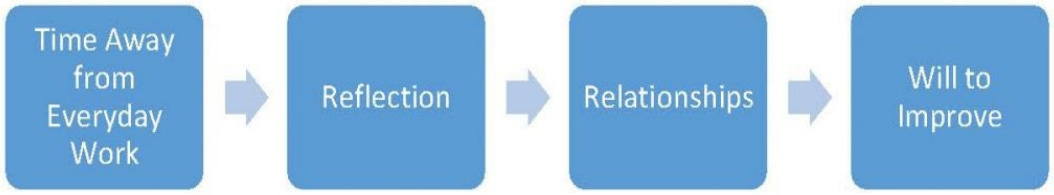
interest in the status quo are happier. There is no need to risk testing new ideas that might fail and make the leader look bad.

When a leader succeeds in upsetting the status quo, particularly in a larger organization, there is significant risk of backlash, which could torpedo the success of the changes. Unless the underlying organizational culture also changes, there is also a probability that improvements will not be sustained and that quality will regress when there is staff turnover.

How do transformational leaders address these challenges? One key tactic is drawing energy from colleagues who are doing the same work in sister organizations. This can help sustain willpower in the face of negative pushback. Another tactic is to develop a group of “true believers” in the quest for quality within different levels of their organization.

Both of these activities require intentionality. They will not naturally happen in the course of our everyday workweek activities. We need to take some time and mental space to build relationships with colleagues outside our organization and with staff within our organization. These relationships must be based on mutual trust, respect, and a shared dedication to lifetime learning. In short, they require some time for reflection, a critical activity that transformational leaders must ensure they do not neglect.

This suggests a causal chain of activities for transformational leaders to be successful at mobilizing the will to improve:



Clinical leaders overwhelmed with patient care and administrative responsibilities lack the time needed to be transformational leaders. The irony is that an improved/transformed health system can use clinician time more efficiently, ultimately giving more potential time for reflection and cultivating relationships. But how can a clinical leader reach this state of improved efficiency if they don’t have time to reflect on the system they are working in?

If the health care system has capacity to add clinical capacity, this can alleviate time pressures for the clinical leaders. This is certainly ideal, if at all possible. Focus first and foremost on recruiting excellent clinicians with a similar dedication to improving quality.

The other options are to work longer hours (which can lead to family stress), or to disappear from everyday work periodically to attend conferences, read

books or listen to podcasts, or even complete formal leadership training. This time away can impact patient care in the short term.

Of course, a combination of these three factors –more staffing, longer hours, and disappearing from everyday work– may also give sufficient time for reflective time and building relationships. Indeed, most transformational leaders have used this combination tactic for their finding time to work on their initial transformational activities.

Early Data on Disparities in HEDIS measures in 2021

Using data from the Primary Care Quality Improvement Program (PCP QIP), we can get some preliminary estimates of health disparities in 2021. A full analysis will be available in the late summer.

Disparities affected Black/African American Members (compared to rates in white members)

Reduced Disparity in 2021:

1. Hypertension Control: Overall Black-White difference disappeared, but the new shared rate of BP control is 58%, less than the Minimum Performance Level (61%) and the Million Hearts Goal of over 80%.

Persistent Disparities in 2021:

1. Well child visits in first 15 months of age: 14% less in Black members
2. Adolescent and Well Child Visits: 4% less in Black members
3. Childhood immunization: 5% less in Black members
4. Colorectal cancer screening: 4% less in Black members

No Disparities in 2021 (equal rates or rates higher in Black members):

1. Asthma Medication Ratio
2. Diabetes Control
3. Retinopathy exam for those with diabetes
4. Breast Cancer Screening
5. Cervical Cancer Screening
6. Adolescent Immunization

Disparities affecting Hispanic Members (compared to rates of non-hispanic white members)

All PCP QIP metrics: Hispanic Members have better performance than non-Hispanic members of all race categories.

We have insufficient data at this time to analyze other groups (Native American, Asian, Pacific Islander etc.) for 2021.

DHCS Quality Measure Changes

In February 2022, DHCS released its final Comprehensive Quality Strategy, which included a roadmap of clinical quality measures that Managed Care Plans will be responsible for reporting or improving for the next few years. In addition, DHCS is asking Managed Care Plans to report certain measures by Race and Ethnicity, to evaluate for health outcome disparities. These are called **Equity Measures** and **are noted with a **.**

The measures that we will be held accountable to are unchanged for measurement year 2022.

Accountable Measures in measurement year 2022:

Adult Measures:

1. Breast Cancer Screening
2. Cervical Cancer Screening
3. Chlamydia Screening
4. Diabetes Control**
5. Blood Pressure Control**

Maternity Care Measures

1. Timely Prenatal**
2. Post-partum visit**

Child Measures:

1. Immunizations by 2 years**
2. Adolescent Immunizations**
3. Well child visits in first 15 and 30 months of age**

Two additional measures which are on the list of accountable measures have data that health plans are missing, so we will be clarifying:

Mental Health

1. Follow up after ED visit for Alcohol or Drug Dependence**
2. Follow up after ED visit for Mental Illness**

In addition, health plans will be reporting on many new measures in 2022, many of which we will be held accountable to in measurement year 2023.

Reporting Only Measures (2022)

Adult Measures

1. Colorectal Cancer**
2. Asthma Medication Ratio (adults and children)
3. Adults Access to Preventive/Ambulatory Health Services

Child Measures

2. Child and Adolescent visits (age 3-21)**
3. Lead Screening in Children (mixed message on year 1 accountability)
4. Dental Fluoride Varnish
5. Developmental Screening in First Three Years of Life (CMS Core Measure)

Maternity Measures

2. NTSV C-Section
3. Prenatal Immunization Status (ECDS measure)

Behavioral Health Measures

4. Use of Antipsychotic Medication: Screen for Diabetes (Adult and Children)
5. Pharmacotherapy of Opioid Use Disorder
6. ADHD Medication follow up. (ECDS measure)
7. Depression Measures: (mostly ECDS measures)
    a. Antidepressant Medication Management: Acute Phase
    b. Antidepressant Medication Management: Continuing Phase
    c. Screening for depression and follow up plan
    d. Prenatal depression screening and follow up plan **
    e. Postpartum depression screening and follow up **
    f. Depression Remission and response

Proposed NCQA Measure Changes for 2023

NCQA has just finished the public comment period for a number of proposed measure changes that would be released in July 2022 and take effect in 2023. Here is a brief summary:

Dental Measures:

Would retire the Annual Dental Visit (ADV) measure and replace it with two measures:

1. Oral Evaluation, Dental Services (OED), the percentage of those age 0-20 who have a comprehensive oral evaluation with a dental provider during the year.
2. Topical Fluoride for Children (TFC), percentage of those age 1-20 years of age with at least two topical fluoride applications by either a dental or medical provider in the year.

Adult Vaccination Measures:

Would discontinue three measures obtained from the CAHPS survey, measuring influenza (FVA and FVO), and pneumococcal (PNU)

vaccinations, and replace it with a single measure, called Adult Immunization Status Measure (AIS-E), an ECDS measure, with includes the following adult vaccinations:

1. Influenza
2. Tdap vaccine
3. Zoster vaccine
4. Pneumococcal vaccine

Health Equity Measure:

Proposes a new measure: Social Need Screening and Intervention (SNS-E), which measures the percentage of patients screening (and referred if screened positive) for food insecurity, housing insecurity, and transportation needs.

Additional New Measure:

1. Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH), for member age 65 and older with risk adjusted ED visits for hypoglycemia in the measurement year.

Changes in Existing Measures:

1. Deprescribing of Benzodiazepines in Older Adults (DBO), a MediCare Measure, with minor changes in calculating the rate.
2. Stratify five measures by race and ethnicity (see list above in DHCS measure changes).

Retiring Measures:

1. Frequency of Selected Procedures (FSP), with reports rates of procedures (surgeries) that show wide regional variation.

Electronic Clinical Data Systems (ECDS) Measures

ECDS is a HEDIS reporting standard for health plans collecting and submitting quality measures to NCQA. This reporting standard defines the data sources and types of structured data acceptable for use for a measure. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

ECDS reporting is part of NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. ECDS measures are indicated by a "-E" after the measure name.

The following measures are currently ECDS measures:

1. Several Depression Related Measures: (DMS-E, DSF-E, DRR-E), including screening for depression in prenatal and postpartum periods, depression screening rates, appropriate follow up for depressed individuals, and improvement depression symptoms.
2. Follow up Care for Children Prescribed ADHD Medication (ADD-E)
3. Breast Cancer Screening (BCS-E)
4. Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

The following are new for 2022:

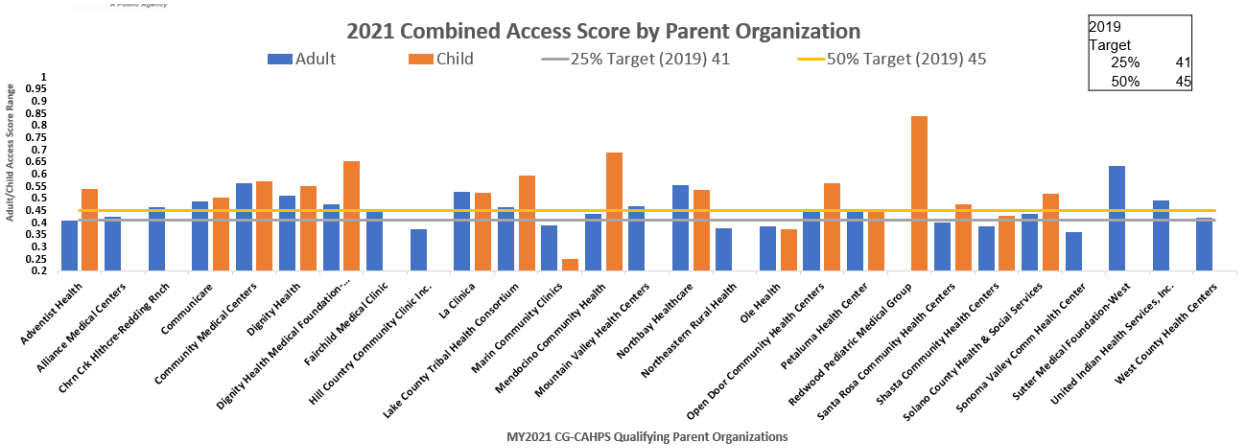
5. Colorectal Cancer Screening (COL-E)
6. Prenatal Immunization Status (PRS-E)
7. Adult Immunization Status (AIS-E)
8. Childhood Immunization (CIS-E)
9. Adolescent Immunization (IMA-E)
10. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

There is an ECDS Unit of service measure in the 2022 PCP QIP, in which PHC has hired a programmer to program the master code for these measures in two commonly used EHRs (eClinicalWorks and NextGen), to assist our PCPs with adopting this measure. Starting in 2023, the submission of ECDS supplemental data from electronic health records will be required for several PCP QIP measures, so using the 2022 unit of service measure to test out this process for your electronic health record is advisable.

PHC has a workgroup building the specifications for the ECDS programming logic. Please contact Dr. Moore if you are interested in participating. We will be having a webinar in a few months to review the ECDS process and review the detailed specification documents (in development) in more details. This webinar will be announced in the Medical Director newsletter.

PCP Patient Experience Results for 2021

After a one year break in 2020, we conducted another round of patient experience surveys for a statistical sample of each of the largest primary care organizations, using AHRQ's CG CAHPS survey designed for individual practices. The results are shown below, for combined access score and for combined clinician communication score. Targets are set based on the results of the previous survey in 2019. These satisfaction parameters represent a subset of the overall measures reported in the Health Plan-level CAHPS, discussed in another setting.



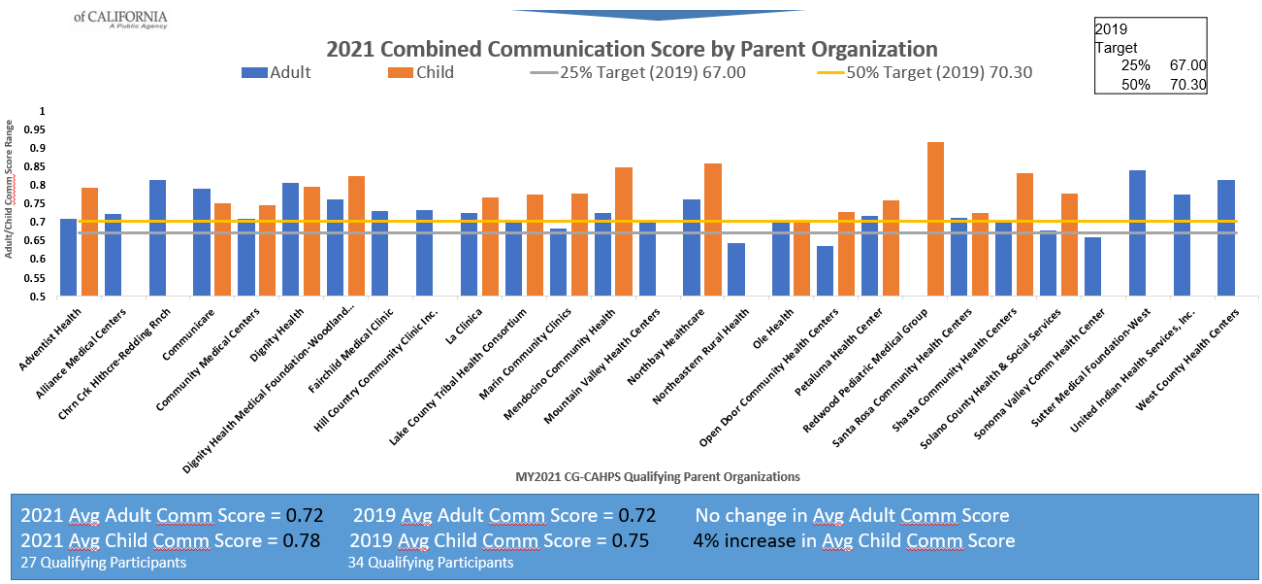
2021 Avg Adult Access Score = 0.45	2019 Avg Adult Access Score = 0.49	8.1% decrease in Avg Adult Access Score
2021 Avg Child Access Score = 0.53	2019 Avg Child Access Score = 0.53	No change in Avg Child Access Score
27 Qualifying Participants	34 Qualifying Participants	

Highest rating for access for providers serving children include:

1. Redwood Pediatric Medical Group
2. Mendocino Community Health Centers
3. Dignity health (Shasta and adjacent counties)
4. Lake County Tribal Health
5. Community Medical Centers
6. Open Door Community Health Centers

Highest rating for access for adults were:

1. Sutter West Medical Foundation (Sonoma)
2. Northbay Medical Center (Center for Primary Care)
3. Community Medical Center



Highest performance for communication for child health providers:

1. Redwood Pediatric Medical Group
2. Northbay Healthcare (Center for Primary Care)
3. Mendocino Community Health
4. Shasta Community Health Center
5. Dignity Woodland

Highest performance for communication for adult health providers:

1. Sutter West Medical Foundation
2. West County Health Centers
3. Churn Creek Healthcare, Redding

Hospital OB Measures, 2020

Data from Cal Hospital Compare.

			NTSV C-Section Rate		Breastfeeding Rate (CDPH)		Episiotomy Rate		VBAC Rate		VBAC Routinely Available	Certified Nurse Midwife Delivery Rate
HOSPITAL NAME	**County**	**City**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Yes/No**	**Score [%]**
Sutter Coast Hospital	Del Norte	Crescent C	21.9	Average	73.2	Average	5.0	Below Aver		Not Rated	No	0.0
Mad River Community Hospital	Humboldt	Arcata	20.8	Above Ave	88.2	Superior	2.5	Average		Not Rated	No	12.0
St. Joseph Hospital, Eureka	Humboldt	Eureka	24.0	Below Ave	68.5	Average	5.1	Below Aver	15.6	Average	Yes	33.8
Adventist Health Clear Lake	Lake	Clearlake	16.4	Superior	69.8	Average	0.0	Superior		Not Rated	No	9.6
Sutter Lakeside Hospital	Lake	Lakeport	17.9	Superior	58.1	Below Aver	1.5	Average		Not Rated	No	0.0
Banner Lassen Medical Center	Lassen	Susanville	13.7	Superior	75.6	Average	3.7	Below Aver		Not Rated	No	1.3
Marin General Hospital	Marin	Greenbrae	15.8	Superior	87.4	Above Aver	1.2	Above Aver	30.4	Above Aver	Yes	42.6
Adventist Health Ukiah Valley	Mendocino	Ukiah	16.5	Superior	71.7	Average	2.5	Average		Not Rated	No	58.9
Queen of the Valley Medical Center	Napa	Napa	21.7	Above Ave	88.2	Superior	3.0	Below Aver	19.9	Average	Yes	0.0
Mercy Medical Center Redding	Shasta	Redding	20.6	Above Ave	30.4	Poor	2.7	Average		Not Rated	No	0.0
Mercy Medical Center Mount Shasta	Siskiyou	Mount Sha	27.8	Below Ave	76.3	Average	2.6	Average		Not Rated	No	0.0
Fairchild Medical Center	Siskiyou	Yreka	30.6	Below Ave	77.3	Average	4.1	Below Aver	16.2	Average	Yes	0.0
Kaiser Permanente Vallejo Medical Center	Solano	Vallejo	22.2	Average	84.8	Above Aver	1.8	Average	19.7	Average	Yes	36.9
Sutter Solano Medical Center	Solano	Vallejo	21.9	Average	76.1	Average	1.5	Average		Not Rated	No	0.0
NorthBay Medical Center	Solano	Fairfield	23.3	Average	78.2	Average	2.2	Average	22.3	Average	Yes	0.0
Kaiser Permanente Vacaville Medical Center	Solano	Vacaville	20.8	Above Ave	85.5	Above Aver	1.3	Above Aver	21.5	Average	Yes	57.2
Sutter Santa Rosa Regional Hospital	Sonoma	Santa Rosa	24.3	Below Ave	69.7	Average	1.4	Above Aver		Not Rated	No	3.8
Petaluma Valley Hospital	Sonoma	Petaluma	24.6	Below Ave	90.2	Superior	2.7	Average	27.4	Above Aver	Yes	6.7
Santa Rosa Memorial Hospital	Sonoma	Santa Rosa	25.9	Below Ave	81.5	Above Aver	0.3	Superior	46.4	Above Aver	Yes	47.9
Kaiser Permanente Santa Rosa Medical Cente	Sonoma	Santa Rosa	19.0	Superior	90.6	Superior	0.6	Above Aver	27.5	Above Aver	Yes	58.8
Woodland Healthcare	Yolo	Woodland	23.0	Average	90.0	Superior	1.1	Above Aver		Not Rated	No	0.0
Sutter Davis Hospital	Yolo	Davis	12.8	Superior	88.4	Superior	1.0	Above Aver	30.7	Above Aver	Yes	60.9

The four highest performing hospitals are noted in green in the first column, scoring well on all parameters. Below is the key used for scoring.

					Key					
Superior	<20		>88		<.5					>15
Above Avg	20-21.7		80-88		.5-1.4		>25			
Avg	21.8-23.6		65-80		1.5 - 2.9		>25			<15
Below Avg	>23.6		<65		3.0+					

Pay for Performance Program for Primary Care (PCP QIP)

PCP QIP Measures for 2022

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. See detailed specifications on our website.

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **and** have a 10% RI score

Family Medicine PCPs

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (70.67%)	50th Percentile (64.78%)	7	5
Breast Cancer Screening	75th Percentile (58.70%)	50th Percentile (53.93%)	7	5
Cervical Cancer Screening	75th Percentile (63.66%)	50th Percentile (59.12%)	7	5
Child and Adolescent Well Care Visits	50th Percentile (53.83%)	50th Percentile (45.31%)	10	8
Childhood Immunization Status: Combo 10	75th Percentile (45.50%)	50th Percentile (38.20%)	7	5
Colorectal Cancer Screening	50th Percentile (TBD %)	25th Percentile (TBD %)	6	5
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (61.63%)	50th Percentile (56.81%)	7	5
Controlling High Blood Pressure	75th Percentile (62.53%)	50th Percentile (55.35%)	7	5
Immunizations for Adolescents – Combo 2	75th Percentile (43.55%)	50th Percentile (36.74%)	7	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.25%)	50th Percentile (54.92%)	10	8
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	TBD	TBD	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access TBD %) 50th Percentile (Communication TBD %)	25th Percentile (Access TBD %) 25th Percentile (Communication TBD %)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8
MONITORING MEASURES				
Comprehensive Diabetes Care - Retinal Eye Exams	Monitoring Measure (50th – 51.36%)	Monitoring Measure (50th – 51.36%)	0	0
PCP Office Visits	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	(Greater than 2.1 visits per member per year on average.)	0	0
		TOTAL POINTS	**100**	**76**

Pediatric PCPs

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (70.67%)	50th Percentile (64.78%)	12	9
Child and Adolescent Well Care Visits	50th Percentile (53.83%)	50th Percentile (45.31%)	12.5	9
Childhood Immunization Status: Combo 10	75th Percentile (45.50%)	50th Percentile (38.20%)	12	9
Immunizations for Adolescents – Combo 2	75th Percentile (43.55%)	50th Percentile (36.74%)	7	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.25%)	50th Percentile (54.92%)	10	8
Counseling for Nutrition for Children/Adolescents	75th Percentile (76.64%)	50th Percentile (70.11%)	12	9
Counseling for Physical Activity for Children/Adolescents	75th Percentile (72.81%)	50th Percentile (66.18%)	12	9
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	TBD	TBD	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access TBD %) 50th Percentile (Communication) (TBD %)	25th Percentile (Access) (TBD %) 25th Percentile (Communication) (TBD %)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8
MONITORING MEASURES				
PCP Office Visits	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	0	0
		TOTAL POINTS	**100**	**75**

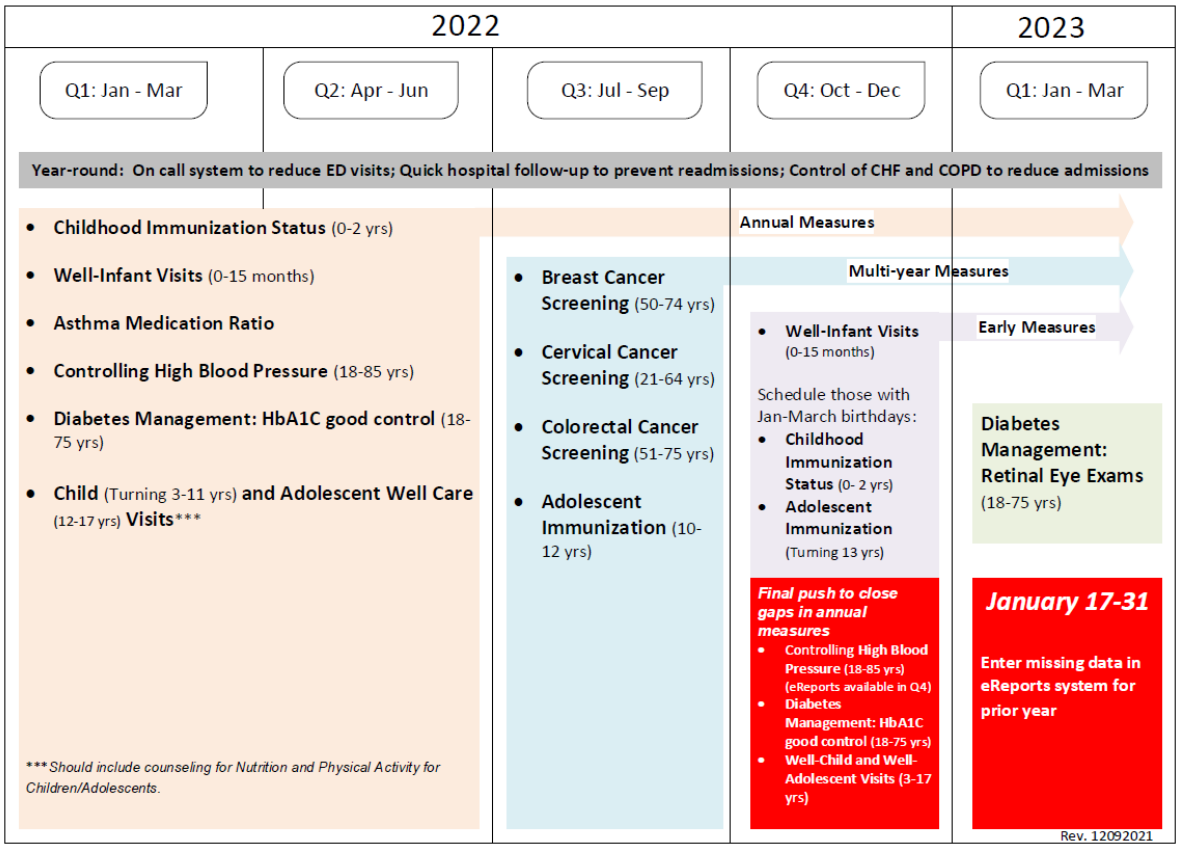
(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Measure	Incentive
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership18 years and older for: • $100 per Attestation, maximum payment $10,000. • $100 per Advance Directive/POLST, maximum payment $10,000
Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups (both new and existing)	$1000 per group (Maximum of 10 groups per parent organization).
Health Information Exchange	One time $3000 incentive for signing on with a local or regional Health Information Exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The $3000 incentive is available once per parent organization.
Initial Health Assessment	$2000 per parent organization for submitting all required parts of improvement plan regardless of visit volume.
Health Equity	$2000 per parent organization for submission of proposed plan to adopt internal best practices supporting a Health Equity initiative.
Blood Lead Screening	Tier 1-3, $1000, $3000, $5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
Dental Varnish	$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.
ECDS	$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

Calendar for Focusing on Measures

Timeline for addressing 2022 and 2023 PCP QIP Measures



Specific Support for Priority Quality Measures

Testing for Streptococcal Pharyngitis

The standard of care for treatment of streptococcal pharyngitis is to confirm infection with a rapid strep test or throat culture prior to prescribing antibiotics, or at the latest concurrent with antibiotic treatment.

As summarized in UpToDate:

Empiric treatment is generally not recommended, as the clinical features of GAS pharyngitis and non-streptococcal pharyngitis broadly overlap. Short delays in therapy (e.g., while awaiting culture results) have not been associated with increased rates of complications such as acute rheumatic fever. However, whether such delays effect rates of other complications (e.g., development of peritonsillar abscess) is not known. If clinical suspicion

for GAS pharyngitis is high and testing results cannot be obtained rapidly, it is reasonable to start antibiotic treatment while test results are pending. If testing does not confirm the diagnosis, antibiotics should be discontinued.

According to the Cochrane Library summary:

Sore throat is a common condition caused by viruses or bacteria, and is a leading cause of antibiotic prescription in primary care. The most common bacterial species is group A streptococcus ('strep throat'). Between 50% to 70% of pharyngitis cases are treated with antibiotics, despite the majority of cases being viral in origin. One strategy to reduce antibiotics is to use rapid tests for group A streptococcus to guide antibiotic prescriptions. Rapid tests can be used alone or in combination with a clinical scoring system. Rapid testing to guide antibiotic treatment for sore throat in primary care probably reduces antibiotic prescription rates by 25% (absolute risk difference).

NCQA has a HEDIS measure that looks at the lack of any strep test associated with antibiotic prescription for strep pharyngitis, called "Appropriate Testing for Pharyngitis" or CWP. Nationally, the 50th percentile for this measure is 77% percent in Medicaid—this means 77 of 100 individuals age three and over with a diagnosis of strep pharyngitis had a test done associate with this diagnosis.

The rate of testing is far lower for PHC members. The overall rate is just 55%, which is far below the 25th percentile. The rate did drop about 20% during the Covid pandemic, likely a product of the increased use of virtual visits, and hesitation to send patients to the office or a lab for confirmatory testing. As Covid wanes, it is important to move back to the standard of care for this illness, and perform confirmatory testing, before or concurrent with treatment.

So you can estimate how much behavior change in your clinicians is needed, here is the data for 2021, by PCP.

PCP site	Numerator Compliant %
ADVENTIST HLTH, UKIAH VALLEY (22860)	94.4%
FALL RIVER, VALLEY HC (22704)	93.3%
LASSEN, MEDICAL CLINIC (39299)	92.9%
SUTTER COAST, COMMUNITY CLIN (20771)	91.3%
WOODLAND, CLINIC (40299)	88.0%
NORTHCOUNTRY, CLINIC (28025)	87.5%
NORTHEASTERN, RURAL HLTH CLI (7477)	86.0%
MCKINLEYVILLE, COMM HLTH CTR (13183)	83.9%
REDWOOD PEDS, MEDICAL GROUP (27937)	83.3%
TULELAKE, HEALTH CENTER (27928)	83.3%
SUTTER MEDICAL, GROUP YOLO (3793)	82.4%
ROHNERT PARK, HEALTH CENTER (35718)	82.1%
LASSEN, MEDICAL CLINIC (39300)	80.0%
HUMBOLDT OPEN, DOOR CLINIC (2520)	79.4%
EUREKA COMM, HEALTH CENTER (3946)	78.4%
WOODLAND, CLINIC (2221)	78.2%
LITTLE LAKE, CLINIC (12602)	77.8%
HANSEN FAMILY, MEDICAL CENTER (4860)	76.9%
ANDERSON, FAMILY HLTHCTR (17323)	75.0%
WOODLAND, CLINIC (6932)	75.0%
MERCY FAMILY, PRACTICE CLN (27956)	75.0%
SHASTA COMM, HEALTH CENTER (27942)	74.7%
HILLSIDE, HEALTH CENTER (22854)	74.5%
SRCH DUTTON, CAMPUS (46609)	73.3%
LAKEVIEW, HEALTH CENTER (3853)	70.8%
BAECHTEL CREEK, MEDICAL CLINIC (22859)	70.4%
PETALUMA, HEALTH CENTER (14857)	69.2%
SONOMA PLAZA, PED MED GRP (15638)	69.2%
SUTTER MEDICAL, GROUP YOLO (3699)	69.2%
MODOC, MEDICAL CLINIC (28003)	68.8%
SRCH LOMBARDI, CAMPUS (9828)	67.7%
SHASTA LAKE, FAM HLTH CNTR (27935)	67.5%
MENDOCINO, COAST CLINIC (4361)	66.7%
SOLANO COUNTY, HLTH SVC (27776)	66.7%
VISTA FAMILY, HEALTH CENTER (18932)	64.7%
POTAWOT, VILLAGE UIHS (27336)	64.3%
BURNEY, HEALTH CENTER (27934)	63.2%
HEALTHPLAN, SONOMA (HEALTHSONO)	62.5%
SUTTER LKSIDE, MED PRACTICE (9505)	61.5%
MARIN COMM, CLN NOVATO (18385)	60.0%
ALLIANCE, MED CT WINDSOR (19393)	60.0%
SRCH PEDIATRIC, CAMPUS (15634)	58.8%
HILL COUNTRY, COMM CLINIC (27936)	57.9%
ADVENTIST HLTH, CLEARLAKE (26801)	56.3%
SOLANO COUNTY, HLTH SVC (1013)	55.6%
DEL NORTE COMM, HEALTH CENTER (2266)	55.3%
CONSOLIDATED, TRIBAL HEALTH (10111)	55.2%
CENTER, OF HOPE (35161)	55.0%
MARIN COMM, CLN SAN RAFAEL (22856)	54.2%
SALUD, CLINIC (6930)	54.2%
ADVENTIST HLTH, CLEARLAKE (26806)	53.3%
FORTUNA COMM, HEALTH CENTER (32561)	53.3%
TRINITY COMM, HEALTH CLINIC (27964)	53.3%
FAIRCHILD, MEDICAL CLINIC (26862)	52.7%
SOLANO COUNTY, HLTH SVC (26994)	48.1%
COMMUNITY MED, CNTR VACAVILLE (10992	47.2%
GRAVENSTEIN, COMM HLTH CTR (32901)	46.7%
HEALTHPLAN, SOLANO (HEALTHPLAN)	46.7%
ADVENTIST HLTH, CLEARLAKE (26800)	46.6%
REDDING RANCH, TRINITY HEALTH (42097)	43.8%
CHURN CREEK, HEALTHCARE (35929)	42.9%
OLE, HEALTH (36802)	41.2%
LA CLINICA, NORTH VALLEJO (18926)	35.9%
ANDERSON, WALK IN CLINIC (17977)	35.3%
ALLIANCE, MEDICAL CENTER (5062)	33.3%
OLE, HEALTH (23435)	31.6%
SOLANO COUNTY, HLTH SVC (1034)	29.6%
OLE, HEALTH (3823)	26.4%
DIXON FAMILY, PRACTICE (1004)	22.7%
LA CLINICA, VALLEJO (11975)	21.9%
KIMAW, MEDICAL CENTER (28020)	19.0%
SONOMA COUNTY, INDIAN HEALTH (16716)	18.8%
LAKE COUNTY, TRIBAL HEALTH (13848)	14.3%
KARUK TRIBAL, HEALTH PROGRAM (28007)	13.3%
LAKE COUNTY, TRIBAL HEALTH (35717)	0.0%
Rate for all PHC members	55.3%

PCPs above the 50th NCQA percentile for Medicaid are in green, those between the 25th and 50th are in blue, those in yellow and red are below the 25th percentile. Numerator Compliant = rapid test or culture done in association with prescription of antibiotics for streptococcal pharyngitis.

COPD Exacerbation Management

For members seen in the Emergency Department (ED) for COPD exacerbation, Partnership HealthPlan of California (PHC) is faxing providers letters informing PCPs of such events. The purpose of these letters is to serve as a notification and possible consideration for an ED follow-up appointment to help address gaps in treatment.

Key Points from the 2022 Global Initiative for Chronic Obstructive Lung Disease (GOLD) report for management of exacerbations include:

- Systemic corticosteroids can improve lung function (FEV1), oxygenation and shorten recovery time and hospitalization duration. Duration of therapy should not be more than 5-7 days.
- Short-acting inhaled bronchodilators (usually a combination of beta adrenergic agent like albuterol with a muscarinic antagonist like ipratropium) are recommended as initial treatment of an acute exacerbation. Long acting bronchodilators should be continued if the patient is using them at baseline, but GOLD does not recommend adding long acting bronchodilators for acute exacerbations of COPD. This is in contrast with asthma exacerbations, in which quick acting but long-lasting formoterol containing MDIs are an option.
- Maintenance therapy with long-acting bronchodilators should be initiated as soon as possible before hospital discharge.

Statin Therapy Lagging in Patients with Cardiovascular Disease or Diabetes

In 2019, about 40% of PHC members with diabetes were not being prescribed recommended cholesterol-lowering medications. For patients with diagnosed cardiovascular disease, about 20% had not received statin therapy.

In formal studies of other populations, the patients not on statins (where statin therapy was indicated:

1. 60% of those not taking statins were not offered them by their doctor/clinician. This study found that women and African American/Black patients were less likely to have been offered statin therapy, suggesting possible underlying bias.
2. 30% had been on treatment and discontinued therapy. Most of these expressed a willingness to reconsider therapy with another medication.
3. 10% had declined statin therapy.

The PHC Pharmacy team will be reaching out to members with cardiovascular disease who are not being prescribed cholesterol lowering medications to encourage them to talk to their clinician about options that would work best for them.

Statin therapy prescriptions and patient adherence to prescribed statin treatment are NCQA HEDIS measures that we will be focusing on in the years ahead. We urge clinician leaders to look at the rates of prescriptions in your practice and remind clinicians of the importance of prescribing statins in these two groups. If you can, set alerts in your Electronic Health Record system (EHRs) to remind clinicians to consider this therapy.

Clinical Background:

Cardiovascular disease is the leading cause of death in the United States. Patients with clinical Atherosclerotic Cardiovascular Disease (ASCVD) are at high risk for future cardiovascular events, including myocardial infarction, stroke, and death from Cardiovascular Disease (CVD). Lipid abnormalities are also common in patients with diabetes, and contribute to an increased risk for developing ASCVD. The American College of Cardiology and American Heart Association (ACC/AHA) as well as the American Diabetes Association (ADA) recommend statin therapy to prevent cardiovascular disease and reduce ASCVD risk.

Summary of Recommendations:

Therapy to reduce the risk of subsequent cardiovascular events includes addressing modifiable risk factors such as smoking, hypertension, diabetes, and elevated levels of low-density lipoprotein cholesterol (LDL-C). The ACC/AHA guidelines state that statins of high intensity or maximally tolerated statin doses are recommended for adults age 75 or under with established clinical ASCVD regardless of the baseline LDL-C. A maximally tolerated statin dose should be used to reduce LDL-C levels by 50% or more.

In patients with diabetes (but without clinical ASCVD), the ADA and the 2019 ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease, based on age and other risk factors. Moderate-intensity statin therapy can be initiated without calculating a 10-year ASCVD risk. For patients with diabetes who are at higher risk, especially those with multiple ASCVD risk factors or aged 50 to 70 years, high-intensity statin therapy should be considered to reduce the LDL-C level by 50% or more. Consideration may be given for addition of a SGLT-2 inhibitor or GLP-1 receptor agonist with proven CVD benefit to improve glycemic control and reduce CVD risk in patients at higher risk.

The HEDIS Measures

The HEDIS measure Statin Therapy for Patients with Cardiovascular Disease assesses the percentage of males 21–75 years of age and females 40–75 years of age with clinical ASCVD who have received and adhered to statin therapy.

The HEDIS measure Statin Therapy for Patients with Diabetes assesses the percentage of adults 40-75 years of age who do not have diagnosed ASCVD.

Best Practices

Here is a summary of best practices for adding appropriate statin therapy and improving adherence for patients with diabetes and/or cardiovascular disease:

1. Members who do not tolerate one statin may be able to tolerate a different statin.
2. Consider statins with fewer drug interactions, such as rosuvastatin, pravastatin, and fluvastatin.
3. Review medication list to confirm a statin has been prescribed when indicated.
4. Provide patient education: explaining goals of statin therapy and need for adherence.
5. Prescribe statins as 90 day supplies, once therapy is stable.
6. Ask your patients open-ended questions to monitor for adverse drug reactions, drug-drug interactions, and other obstacles that may hinder medication adherence.
7. Collaborate with dispensing pharmacies to identify and address medication adherence gaps.
8. Specific medication recommendations:
    a. For high intensity statin therapy (lowers LDL-C by >50%), consider atorvastatin 40-80 mg or rosuvastatin 20-40 mg.
    b. For moderate intensity statin therapy (lowers LDL-C by 30% to <50%), consider atorvastatin 10-20 mg, rosuvastatin 5-10 mg, or simvastatin 20-40 mg.

Thanks for passing this along to your front line clinicians.

Supporting Self-Management of Hypertension: Two New Tools for Patients

In October 2020, the office of the Surgeon General released "A Call to Action to Control Hypertension". With an incidence of nearly one in two US adults and with only about 25% of those with adequately controlled blood pressures (BP), hypertension remains a major preventable risk factor for heart disease and stroke. The document outlines three main goals to help achieve good BP control in 80% of patients with hypertension:

- Goal 1: Make hypertension control a national priority.

- Goal 2: Ensure that the places where people live, learn, work and play, support hypertension control.
- Goal 3: Optimize patient care for hypertension.

PHC acknowledged this call and increased our efforts to help our members with hypertension get their BP under control. In addition to continuing to include Controlling BP in our PCP QIP measure sets, for both Internal Medicine and Family Medicine practices, we expanded our efforts to distribute home BP monitoring devices to eligible members and increased our outreach to members diagnosed with hypertension. More information about the BP distribution program is available here: Medical Equipment Distribution Services Form.

As part of these expanded efforts, we are pleased to announce the release of **new patient facing materials**. The first is a detailed, illustrated information and instruction document for members who receive one of the VIVE Precision Blood Pressure Monitors as part of our expanded blood pressure device distribution program. This document explains how to set up the device and provides detailed instructions in appropriate body/arm positioning and use of the device. The instructions document is available here: Blood Pressure Monitor Instructions. The second document is a log for members to record home BP readings (similar to a blood glucose log). This includes a chart detailing how the member should react to the BP readings they get. In the interest of shared decision-making, members are encouraged to discuss this log/chart with their PCPs to customize their best individual response plans. The log and chart are available here: Blood Pressure Chart and Log. Both of these documents are mailed to members who are participating in our BP device distribution program and are available on the Members Page of the PHC website. The documents are available in English, Spanish and Russian.

Finally, for those of you who were not able to attend our “Benefits of Home Blood Pressure Monitoring” webinar on July 6, 2021, the recording of the program is located here: Benefits of Home Blood Pressure Monitoring Webinar Link. Thank you for your continued efforts towards this life saving goal of controlling blood pressures. Please let us know if you have any questions or suggestions regarding this program.

Quality Measure Highlights

The Quality Measure Highlights are summarize and highlight best practices on the Primary Care Provider Quality Improvement Program (PCP QIP) clinical measures. Each highlight includes the measure specifications, guidance on compliant and non-compliant documentation, and strategies to improve on measure performance. The Highlights can be accessed by clicking here.

A Quick Guide to Starting Your Quality Improvement Projects

The Performance Improvement Team at PHC is pleased to share with you our newest resource, A Quick Guide to Starting Your Quality Improvement Projects. This 10-step guide covers inception to implementation of a quality improvement (QI) project. The guide includes concrete steps on meeting preparation, development of a project charter, how to develop change ideas for QI project, and the use of the PDSA cycle. Additionally, each section includes example documents and links to templates. There are tips throughout the guide for the project lead to successfully manage projects.

You can find the guide on the PHC's Partnership Improvement Academy webpage, under resources.

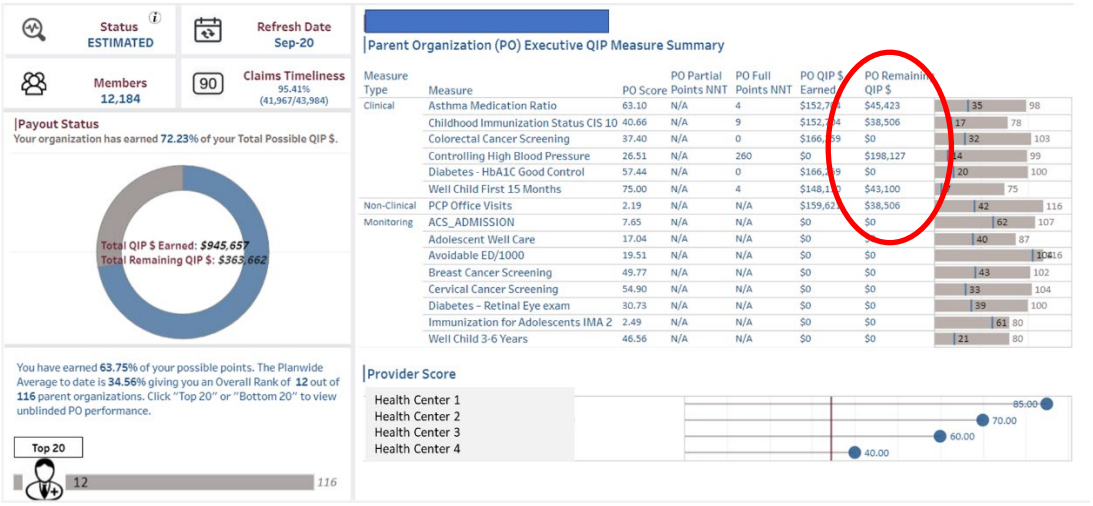
Other Quality Updates

Partnership Quality Dashboard

Our Partnership Quality Dashboard (PQD) is available to primary care providers through the eReports system. The eReports login will allow your staff to access this Dashboard, which includes:

- The interface is built on a Tableau platform, which is very intuitive to navigate.
- The ability to view quality data at the site level, or rolled up to the parent organizational level.
- The ability to compare quality data with other providers in our network.
- Quality Data includes clinical measures, and non-clinical measures.
- Drill down to the patient level for most measures will be available.
- A key performance indicator super-dashboard.

The newest version of PQD includes the popular view showing how much money is at stake for achieving each measure:



Current and previous year PCP QIP data is available on PQD, which is accessed through eReports (Provider Online Services) on the PHC Website.

Other features found on the **Home View**:

- Claims Timeliness score – the percentage of claims at the parent organization level that are received by PHC within 90 days of the date of service. This is to encourage timely billing and data capture

through claims. Providers can export a drill-down report of claims received outside of 90 days.

- Inclusion of the Patient Experience measure performance for measurement years 2018. Performance data for PCPs eligible under the Survey or CAHPS options in 2018-2019 can be viewed. CAHPS scores are displayed and performance is ranked in a bar chart by sub-region. (Due to COVID-19, there was not a 2020 survey.)
- Projected QIP payout at the parent organization level. This snapshot shows a donut chart of Total QIP $ Earned and Total dollars the org stands to earn if performance was 100%.
- Number of patients needed to treat at the parent organization level to meet Full Points targets in 2020.
- Highest and Lowest performing providers identified. Based on overall, year- to-date QIP score. The Top and Bottom 20 ranked organizational providers are displayed.
- New Monitoring Measures shown: On both the Provider and Home views, performance for measures that were removed from the QIP Core Measurement set in 2020 in response to COVID-19 can still be viewed, and are labeled as "Core" or "Monitoring" on the dashboard.

Each primary care provider organization has designated an eReports eAdministrator. You will want to get a username and password from your local administrator, so you are able to use the PQD yourself. If you are a primary care provider for PHC and do not know who your organization's eReports eAdministrator is, please email the QIP Team at QIP@partnershiphp.org for assistance.

We highly recommend that Medical Directors log on to PQD every one to two months to track your progress on all measures, and to see what actions can improve PCP QIP performance in the current year.

Developmental Screening

Payments took **effect on January 1, 2020**. FQHCs, RHCs, Tribal Health and other PPS providers are eligible, but they **MUST bill with a Type 1 (individual NPI) in one of the available fields (rendering, ordering, prescribing, billing) or they will not be paid!** This incentive is paid through claims, but the incentive payment will supplement the usual fee for these services.

a. Developmental screening:
    i. Paid based on use of CPT code: 96110, without a modifier, once for each age group: 2 month-1 year old, 1 - 2 years old, and 2 - 3 years old.

ii. Rate: $59.50
iii. Nine standardized tool options as defined in CMS Core Measure Set Specifications (not the same as AAP). Most commonly used is the Ages and Stages Questionnaire (ASQ). Effective January 1, any claim for 96110 without a KX modifier MUST be for the use of one of these nine specified tools.
iv. Any other tool used (such as the MCHAT for autism screening), must add a KX modifier. These will be paid the usual claim rate, but not be eligible for the bonus payment. **Early audits are showing that many providers are neglecting to use the KX modifier for autism screening.**
v. **Early audits also indicate many providers continue using the MCHAT screening tool, which is not approved for use by DHCS. The approved tools include the following:**
    1. Ages and Stages Questionnaire (ASQ) - 4 months to age 5
    2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
    3. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
    4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
    5. Brigance Screens-II - Birth to 90 months
    6. Child Development Inventory (CDI) - 18 months to age 6
    7. Infant Development Inventory - Birth to 18 months
    8. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
    9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

Audit Shows Many Child-Health Providers Misuse of Developmental Screening Code

Three years ago, DHCS set new rules around the use of CPT Code 96110 to document comprehensive developmental screening. More than half of pediatric and family medicine providers (audited by PHC in 2021) had not performed a comprehensive developmental screening when the 96110 code was used. While several developmental screening tools are allowed, the most commonly used is the Ages and Stages Questionnaire (ASQ).

In most cases, the charts associated with use of the 96110 code documented a screening for autism, neglecting to use the required .KX modifier when the 96110 was used to document the narrower autism screening, with a tool such as the M-CHAT. Prior to 2019, the modifier was not required for autism screening; an educational campaign about the new modifier was conducted in 2019, but not all pediatric providers made the

needed changes.

When autism screening is provided, in addition to a comprehensive developmental assessment, both 96110 without a modifier and 96110.KX may be billed together.

A comprehensive developmental screen is considered standard of care by the American Academy of Pediatrics, the American Academy of Family Physicians, CMS, NCQA, and DHCS. Please ensure your well-child visit process and templates include the use of a comprehensive tool such as the ASQ and documents this appropriately with 96110.

Like ACES screening, developmental screening is carved out of the PPS reconciliation process, so an additional $59.50 is paid when a comprehensive developmental screen is done, regardless of provider type. Many FQHCs are not billing 96110 at all, meaning either that they are doing developmental screening but giving up the revenue from doing so, or they are not following standard of care for pediatric preventive care. Either should be remedied. We ask Medical Directors and CEOs to take a lead in this. Our HC Regional Medical Directors have access to the audits mentioned earlier.

Correct billing practices are a core prerequisite for participating in any Alternative Payment Methodology, as the incentive to bill correctly tends to decrease with global payment arrangements. PHC will repeat this audit of the use of 96110 in about a year.

ACEs Screening

Payments took effect on January 1, 2020. FQHCs, RHCs, and Tribal Health centers are eligible, but they MUST bill with a Type 1 (individual NPI) in one of the available fields (rendering, ordering, prescribing, or billing) or they will not be paid! This incentive is paid through claims; the incentive payment will supplement the usual fee for these services.

a. ACEs screening:
    i. Rate: $29 each
    ii. Paid based on use of the following code:
        10. G9919: Screening performed and positive and provisions of recommendations (4 and greater)
        11. G9920: Screening performed and negative (0 to 3)
    iii. Children up to age 19
b. PEARLS (Pediatric ACEs and Related Life-events Screener; includes screening for several social determinants of health)
        1. Up to every 1 year
        2. Parents may complete age 0-19; child may answer ages 12-19

c. Adults ages 18 to age 65: ACES screening tool, once in a lifetime per provider per patient; OK to repeat for new provider.
d. Age 18 and 19: either tool can be used.
e. DHCS has posted translations of these tools.
f. Providers must complete a 2 hour training and attest to completion of the training to be eligible to be paid the supplemental payment! Training available at: www.acesaware.org

California is dedicating Proposition 56 tax revenue to cover a variety of Medi-Cal services and incentives, including incentives for screening for Adverse Childhood Events (ACEs) and Developmental screening of 1-3 year olds. Unlike other incentive programs, all provider types, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Tribal Health Centers, are entitled to keep the incentives for ACEs ($29 each) and Developmental screening ($59 each), which started on January 1, 2020.

We strongly encourage PCPs caring for children who are not fully taking advantage of these screening dollars to look at their systems and see if they can adapt them to capture this source of revenue.

Screening Rates for ACES

The Department of Health Care Services (DHCS) and the Office of the California Surgeon General (CA-OSG) are leading ACEs Aware, a first-in-the-nation statewide effort to screen children and adults for Adverse Childhood Experiences (ACEs) to prevent and treat toxic stress to improve health and well-being across the state – now and for generations to come.

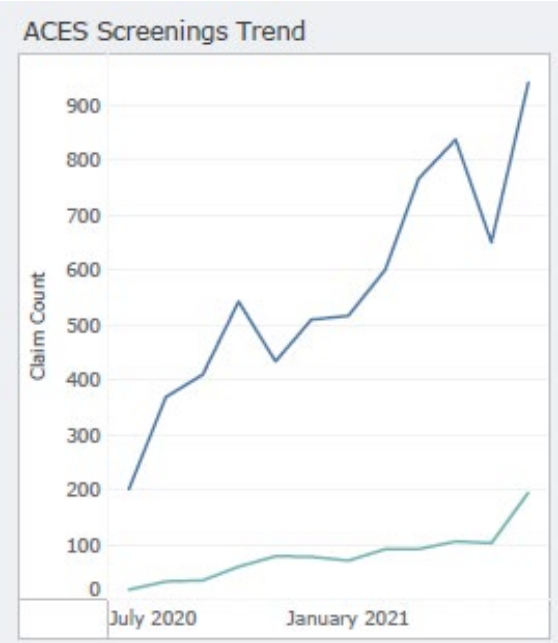
In January, DHCS shared comparative rates of ACES screening of children and adults in different health plans, from dates of service between April 2020 and March of 2021. Of note, this particular measure is not on the list of quality measures required to achieve a particular goal, by DHCS.

ACE Screenings for Beneficiaries by Medi-Cal Managed Care Plan

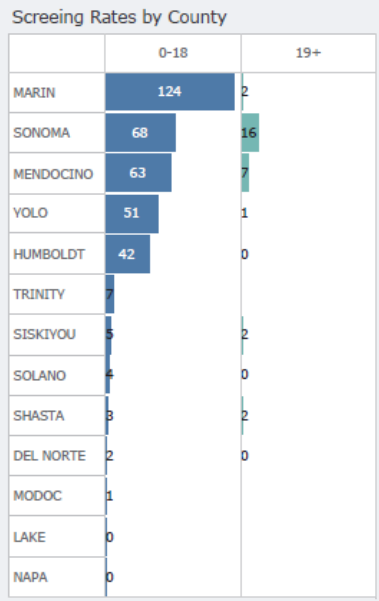
Managed Care Health Plan	Percentage of Medi-Cal Population Screened (Age 0-20)	Percentage of Medi-Cal Population Screened (Age 21-64)
Aetna Better Health of California	10.1%	5.2%
Alameda Alliance for Health	9.4%	0.1%
Anthem Blue Cross Partnership Plan	10.2%	0.5%
Blue Shield of California Promise Health Plan	14.9%	9.2%
California Health & Wellness Plan	1.5%	0.4%
CalOptima	24.2%	2.9%
CalViva Health	9.5%	0.9%
CenCal Health	14.3%	0.5%
Central California Alliance for Health	--	0.2%
Community Health Group Partnership Plan	9.0%	6.6%
Contra Costa Health Plan	0.5%	--
Gold Coast Health Plan	7.2%	1.7%
Health Net Community Solutions, Inc.	10.5%	1.6%
Health Plan of San Joaquin	2.0%	1.2%
Health Plan of San Mateo	6.4%	0.1%
Inland Empire Health	13.9%	3.8%
Kern Health Systems	7.5%	0.8%
Kaiser Permanente	--	--
L.A. Care Health Plan	7.8%	1.5%
Molina Healthcare of California Partner Plan, Inc.	9.7%	3.9%
Partnership HealthPlan of California	2.8%	0.9%
San Francisco Health Plan	0.4%	0.0%
Santa Clara Family Health Plan	4.1%	0.0%
United Healthcare Community Plan	10.4%	8.4%
Total ACE Screenings by MCP	9.3%	1.8%
MCP Screening with ACES score 4+	**4.1%**	**14.2%**
Total ACE Screenings in FFS	19.1%	0.6%
FFS Screening with ACES score 4+	**12.6%**	**14.1%**

Note that if a provider has not successfully completed the required ACES training and attestation, the claim will be denied. Overall, for every claim paid in 2021, there were about 2 other claims that were denied.

Within the PHC network, rates of ACES screening vary by provider, over time, and by county.



Screenings done in a recent month:



PCPs with highest numbers of ACES screening:

By PCP

	0-18			19+		
	Claim Count	Member Count	Claim Count per 1,000 Mbrs	Claim Count	Member Count	Claim Count per 1,000 Mbrs
WEST SAC PED MEDICAL GROUP	860	1,761	488	14	92	152
MARIN COMM CLN SAN RAFAEL	853	6,248	137	16	4,341	4
SRCH PEDIATRIC CAMPUS	719	4,595	156	1	167	6
REDWOOD PEDS MEDICAL GROUP	612	3,336	183	1	140	7
MARIN COMM SOUTH NOVATO	495	2,642	187	1	498	2
MENDOCINO COAST PEDS MG	484	1,317	368			
SONOMA PLAZA PED MED GRP	411	612	672	4	33	121
CUETO SALAS MARTHA	259	442	586			
MARIN COMM CLN CAMPUS	237	1,325	179	8	1,776	5
PETALUMA HEALTH CENTER	224	5,700	39	33	8,259	4
SONOMA VALLEY COMM HLTH CTR	188	1,937	97	476	2,373	201
BAECHTEL CREEK MEDICAL CLINIC	161	728	221	123	814	151
MENDOCINO COAST CLINIC	159	395	403	3	1,764	2
VISTA FAMILY HEALTH CENTER	153	3,457	44	80	5,533	14
SRCH LOMBARDI CAMPUS	111	4,016	28	36	6,983	5
HEALTHPLAN PARTNERSHIP	111	7,841	14	10	8,716	1
SUTTER MEDICAL GROUP SOLANO	101	1,890	53			
ROHNERT PARK HEALTH CENTER	95	1,744	54	15	2,924	5
EUREKA COMM HEALTH CENTER	91	4,954	18	2	7,297	0
MEMBER DIRECT	62	2,416	26	13	4,541	3
SRCH DUTTON CAMPUS	61	1,996	31	24	3,324	7
HEALTHPLAN CCS-WHOLECHILD	57	1,193	48			
LASSEN MEDICAL CLINIC	55	1,094	50	59	744	79

A few sites stand out as screening at least 20% of their assigned children (third column with a number greater than 200).

1. Sonoma Plaza Pediatric Medical Group
2. Martha Cueto Salas
3. West Sacramento Pediatric Medical Group
4. Mendocino Coast Clinic
5. Mendocino Coast Pediatric Medical Group
6. Marin Community Clinic Novato
7. Baechtel Creek Medical Group


ACE Screening Claims by Region in California
Far North/North Coast
Total: 2,460
High-Risk: 34%
Lower Risk: 66%
Sacramento Valley
Total: 24,760
High-Risk: 6%
Lower Risk: 94%
Sierra Range/ Foothills
Total: 4,720
High-Risk: 10%
Lower Risk: 90%
Bay Area
Total: 24,680
High-Risk: 8%
Lower Risk: 92%
Central Valley
Total: 63,640
High-Risk: 6%
Lower Risk: 94%
Central Coast
Total: 21,150
High-Risk: 4%
Lower Risk: 96%
Los Angeles
Total: 133,060
High-Risk: 4%
Lower Risk: 96%
Southern California
Total: 243,600
High-Risk: 6%
Lower Risk: 94%
ACE Screening Claims Data from: January 1, 2020, to March 31, 2021
Note: Percentages are rounded to the nearest whole number and may not add to 100%.
Data labels are rounded to the nearest 10 and may not sum to the total.
Data Source is the Management Information System/Decision Support System (MIS/DSS) and the DHCS Medi-Cal Data Warehouse, as extracted on October 12, 2021.
*Medi-Cal providers must attest to completing a certified ACEs Aware core training to qualify for Medi-Cal payment.
**ACE score refers to the total reported exposure to the 10 ACE categories. An ACE score of 4 or greater indicates that a patient may be at high-risk for toxic stress.

Upcoming Educational Events

PHC Sponsored Events

ABCs of Quality Improvement

The ABCs of Quality Improvement (QI) is a virtual training designed to teach you the basic principles of quality improvement. The five-session course covers the followings topics:

- What is quality improvement?
- Introduction to the Model for Improvement
- How to create an aim statement (project goal)
- How to use data to measure quality and to drive improvement
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

Who Should Attend?

The course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Dates: May 18 and 25; June 1, 8 and 22 from noon to 1 p.m.
Registration: Open on April 1
http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Webinars on Topics Related to Substance Use Disorder

Past webinars on the following topics are available on the PHC website:

- Medication treatment options for Methamphetamine Use Disorder
- Safety and Correct Disposition when Performing a Medical Clearance Exam for Alcohol Withdrawal
- Marijuana in Pregnancy
- Cannabis Use and Cannabis Use Disorder in the Setting of Legalization
- Trauma Informed Care and Addiction
- Inpatient Alcohol and Drug Detoxification Materials
- Pharmacology of Treating Alcohol Use Disorders
- Benzodiazepines
- ASAM Criteria Training

- Gabapentanoids: A Wolf in Sheep's Clothing

Accelerated Learning Education Program Webinars

CME/CE's Available, see linked flyers for more details.

Target Audience: Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures.

Early Cancer Detection (Cervical, Breast, and Colorectal Cancer Screening)
Flyer

Date: Tuesday, April 12, 2022
Time: Noon - 1:30 p.m.
Sign-up Now

Pediatric Health - A Cluster of Services for 0 - 2 Years Old
Flyer

Date: Tuesday, June 7, 2022
Time: Noon - 1 p.m.
Sign-up Now

Pediatric Health – Child and Adolescent Well-Care Visits (3-17 years), Screenings, and Immunizations for Adolescents
Flyer

Date: Tuesday, July 12, 2022
Time: Noon - 1 p.m.
Sign-up Now

Update on Childhood Lead Poisoning Prevention

Update on childhood lead poisoning prevention: counseling, screening, and management for children potentially exposed to lead.

Objectives:

- Discuss risk factors, clinical effects, management and treatment of childhood lead exposure
- Identify cultural risk factors for exposures in all socioeconomic groups

- Explain California's childhood lead screening statuses and regulations, provider mandates, and the role of anticipatory guidance in prevention
- Outline health and environmental interventions for children with exposure, and services provided by state and local programs

Date: Wednesday, April 20, 2022
Time: Noon – 1:30 p.m.
Sign-up now

Quality & Performance Improvement Training Events

For up-to-date events and trainings by the Quality and Performance Improvement department, please view our Quality Events Webpage.

Looking for more educational opportunities? The Quality & Performance Improvement department has many pre-recorded, on-demand courses available to you. Trainings include:

- The Role of Leadership in Quality Improvement Effort: Leaders from top performing organizations share how they were able to build a culture of quality.
- PCP QIP High Performers – How'd They Do That? Learn how other PCPs accelerated in their QIP performance.
- ABCs of Quality Improvement: An introduction to the basic principles of quality improvement.
- Accelerated Learning Educational Program: An overview of clinical measures including improvement strategies and tools.
- Project Management 101 – An introduction to the basic principles and tools used in project management.

You can find these on-demand courses, and more, on our Webinars Webpage.

Improving Access through Office Efficiency

PHC has a series of 5 webinars posted on our website which together bring together the essential elements of "Advanced Access" which can improve productivity, reduce no-shows, reduce office waiting time and increase continuity. Recommended if your leadership team can absorb information and make changes without the structure and leadership of a formal collaborative.

Mandatory Cultural Competency Training

This is a reminder that DHCS requires all providers (clinicians and staff) to complete a cultural competency training, and for your sites to maintain a record of completion of this training. You may use your own training or use the PHC-sponsored training.

Recommended Educational Opportunities Outside of PHC

Annual Palliative Care Summit

Emerging Stronger: Creating a New Normal

The Coalition for Compassionate Care of California will host its annual summit in person. Don't miss the presentations by national thought leaders in advanced illness, palliative care and end-of-life issues. CME available.

Dates: May 4-5, 2022
Location: San Francisco Airport Hyatt Regency
Full Agenda and Registration: Click here

State of the Art Addiction Medicine

Deadline to Submit: April 22, 2022

The California Society of Addiction Medicine (CSAM) invites you and your colleagues to submit a poster abstract for the 2022 State of the Art Addiction Medicine Conference. CSAM encourages physicians, residents, medical students, and no-physician healthcare professionals from diverse organizations and fields to apply. Poster sessions will be held August 25 and August 26.

Dates: August 24 - August 26
Location: Sheraton San Diego Hotel & Marina, San Diego, CA
More Information
Submit an Abstract

VITAL: Relational Health, a New Learning Series for Pediatric Providers

VITAL offers a free online, self-paced course of six modules, each approximately 20 minute long**. CME Available**

Lessons Available:

- Introduction to Relational Health

- The Science of Relational Health
- ACEs, Toxic Stress & Relational Health
- Relational Health as a VITAL sign
- How to Support the Relational Health of Children & Families
- Culture & Relational Health

More information & registration link