PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members:
Jeffrey Bosworth, M.D. 
Shandi Fuller, M.D. *alternates 
Jeffrey Gaborko, M.D. (Chair) 
Michael Ginsberg, M.D. 
Steve Gwiazdowski, M.D. 
Michele Herman, M.D. 
Jeffrey Gaborko, M.D. (Chair) 
Michael Ginsberg, M.D. 
Shandi Fuller, M.D. *alternates 
Willard Hunter, M.D. 
M. Tracy Johnson, M.D. 
Melissa Marshall, MD 
Antoinette Martinez, M.D. 
Mills Matheson, M.D. 
Lisa Ward, M.D.

PHC Staff: 
Liz Gibboney, Chief Executive Officer 
Wendy West, Northern Executive Director 
Willard Hunter, MD, Regional Medical Director 
Jeffrey Gaborko, M.D., Northern Regional Med. Dir. 
James Cotter, MD, Regional Medical Director 
Debra McAllister, RN, Director of Utilization Mgmt. 
Scott Endsley, MD, Associate MD of Quality 
Robert Moore, MD, MPH, Chief Medical Officer 
Peggy Hoover, RN, Senior Director, Health Services 
Mary Kerlin, Senior Dir., Provider Relations (PR) Dept. 
Mark Netherda, MD, Regional Medical Director 
Jeffrey Ribordy, MD, Regional Medical Director 
Jessica Thacher, Director, Quality & Perf. Improvement (on leave) 
Stan Leung, Pharm.D., Director, Pharmacy Services 
Kevin Spencer, Director of Member Services 
Paula Frederickson, Senior Claims Director 
Bettina Spiller, MD, Associate Medical Director 
Mark Glickstein, MD, Associate Medical Director 
Carolyn Stewart, Senior Director of Financial Analysis 
Jennifer Chancellor, Northern Regional Manager 
Nancy Steffen, Northern Region Manager, QI Programs 
Linda Melsheimer, RN, Program Manager 
Carly Fronfield, RN, N. Region, Health Services Director 
Margarita Garcia-Hernandez, Manager, Health Analytics 
Robin Krohn, N. Region Manager, Care Coordination 
Alice Mabry, N. Region Manager, Utilization Management

Ad Hoc PHC 
Sonja Bjork, Chief Operating Officer 

Members: 
Kirt Kemp, Chief Information Officer 
Lynn Scuri, Regional Director 
Kelley Sewell, N. Region Mbr Services & PR Director 
Diane Wong, Pharm.D., Senior Clinical Pharmacist 
Betsy Campbell, Senior Health Educator 
Karen Stephen, Ph.D., Mental Health Clinical Director 
Ledra Guillory, Senior Prov. Relations Rep. Manager 
Rachael French, Manager, Quality Improvement Prgrms 
Rebecca Boyd Anderson, RN, Director, Care Coord. 
Pamela Feidlerson, Senior Claims Director 
Bettina Spiller, MD, Associate Medical Director 
Mark Glickstein, MD, Associate Medical Director 
Carolyn Stewart, Senior Director of Financial Analysis 
Jennifer Chancellor, Northern Regional Manager 
Nancy Steffen, Northern Region Manager, QI Programs 
Linda Melsheimer, RN, Program Manager 
Carly Fronfield, RN, N. Region, Health Services Director 
Margarita Garcia-Hernandez, Manager, Health Analytics 
Robin Krohn, N. Region Manager, Care Coordination 
Alice Mabry, N. Region Manager, Utilization Management

cc: 
PHC Commission Chair 
Marie Mulligan, MD 
Richard Fogg 
Craig Lindquist, MD 
Gregory Baldwin, MD 
Jerry Douglas, MD 
Harris Levin, MD 
Kali Stanger, MD 
Amy Brom, Psy.D. 

FROM: 
DATE: 
SUBJECT:

The Physician Advisory Committee will meet as follows and will continue to meet the second Wednesday of every month (exception / July and December.) Please review the Meeting Agenda and attached packet, as discussion time is limited.

DATE: 
TIME: 
LOCATIONS:

Please contact me at (707) 863-4228, or e-mail llargent@partnershiphp.org if you are unable to attend.
# REGULAR MEETING OF PARTNERSHIP HEALTHPLAN OF CALIFORNIA’S PHYSICIAN ADVISORY COMMITTEE - MEETING AGENDA

**Date:** August 9, 2017  **Time:** 7:30 – 9:00 a.m.  **Location:** PHC

## PUBLIC COMMENTS

### Speaker  |  2 minutes  
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Speaker  |  2 minutes

## Welcome / Introductions

**I.** Approval of Minutes – Chair

**II.** Standing Agenda Items

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<td>A. Status Update</td>
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<td>Ms. Gibboney</td>
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<td>Dr. Moore</td>
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<td>Dr. Cotter</td>
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<td>Dr. Netherda</td>
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<td>Dr. Kubota</td>
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<td>Dr. Vovakes</td>
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<td>A1. Update from County Public Health Departments</td>
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<td>Available Representative(s)</td>
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<td>B. Quality / Utilization Advisory Committee Activities Report with attachments – Consent Review</td>
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<td>Dr. Moore</td>
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<td>Minutes of the June 21, 2017 meeting</td>
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<td>- Autism Spectrum Disorder… (MPUP3126)</td>
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<td>- Palliative Care: Intensive Program New Policy (MCUP3137)</td>
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<td>- Medi-Cal Member Grievance System (CGA 024)</td>
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<td>- Potential Quality Issues Annual Report</td>
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<td>C. Pharmacy &amp;Therapeutics (P&amp;T) Committee / Consent Review</td>
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<td>Dr. Patel / Dr. Moore</td>
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<td>Minutes and Formulary Recommendations of the July 27, 2017 meeting (attached)</td>
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<td>Minutes from meeting July 21, 2017 (attached)</td>
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<td>E. Credentialing Committee Meeting Summary – Committee approved Summary of the May 10, 2017 meeting (attached)</td>
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<td>Dr. Kubota</td>
<td>220 - 232</td>
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<td>F. Recommended Committee Appointments / Resignations</td>
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<td>Dr. Moore</td>
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## Old Business

**III.**

### A. Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Overall Results of Patient Satisfaction Survey (from October 2016 meeting)

Postponement continued pending information from DHCS

### B. Palliative Care Quality Improvement Program (QIP) – Action Required

Dr. Selig / Ms. Liu

### C. Vaccination Refusal: Use of a Form Completed by Parents (discussion / see attached)

Dr. Moore

### D. Drug Medi-Cal Waiver Program (see attached / presentation)

Ms. Kisliuk

### E. Additional Business:

- Meeting Evaluation
- Start Time of Meetings

## New Business

### A. Palliative Care Quality Improvement Program (QIP) – Action Required

Ms. Selig / Ms. Liu

### B. Vaccination Refusal: Use of a Form Completed by Parents (discussion / see attached)

Dr. Moore

### C. Drug Medi-Cal Waiver Program (see attached / presentation)

Ms. Kisliuk

### D. Additional Business:

- Meeting Evaluation
- Start Time of Meetings

## Adjournment

9:00
This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular committee meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The committee has designated the Administrative Assistant to the Chief Medical Officer as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Physician Advisory Committee Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations under the Meeting Notice). It can also be found online at www.partnershiphp.org.

In compliance with the Americans with Disabilities Act, PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Administrative Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (707) 863-4228 or by email at llargent@partnershiphp.org. Notification in advance of the meeting will enable PHC to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

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<th>Meeting Notes – Physician Advisory Committee – 08/09/2017</th>
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Hello Colleagues and Friends:

Courageous leadership is a powerful force for change.

Two years ago, California State Senator Richard Pan courageously led a successful effort to remove the personal belief exemption for immunization required for school attendance. He reassured his colleagues on the public health benefits of this policy, giving them the strength to vote yes, in spite of the most vigorous protests seen in the legislature in a generation.

Last week, a few U.S. Senators courageously opposed their party leadership and their president in a debate over the future of healthcare in the United States.

Ralph Waldo Emerson summarized the challenge of courage in “peacetime.”

“Whatever you do, you need courage. Whatever course you decide upon, there is always someone to tell you that you are wrong. There are always difficulties arising that tempt you to believe your critics are right. To map out a course of action and follow it to an end requires some of the same courage that a soldier needs. Peace has its victories, but it takes brave men and women to win them.”

– Ralph Waldo Emerson

You and your clinicians advocate for the wellbeing of individual patients every day. This is part of the calling we chose when we entered the healing profession. None of us has the energy to take on every underlying challenge we are confronted with each day; we need to choose our battles.

Every once in a while, though, we are given the opportunity to use our influence to advocate for the health of our community, in opposition to those who would prove us wrong, or at least cast doubt on our position. We will be given the opportunity to be courageous leaders, to contribute to the future health of our community.

May we embrace these opportunities with an energy equal to what we invest to resolve our individual patient’s issues!
Here are the topics of this month’s update. Thanks for forwarding these to your clinicians!

1. Monthly Recognition: Colorectal Cancer Screening
2. Addressing More than One Issue in a Visit
3. Breaking News from PHC
   a. Chronic asthma
   b. Transportation: what does PHC cover?
   c. Cultural competency training
   d. PHC Members who are no longer your patients: updating assigned patient list
   e. New incentive program for breast cancer screening
   f. New oral anticoagulant formulary requirements
4. PHC Educational Opportunities
   a. ABCs of QI
   b. Cannabis use disorder in an age of legalization
   c. Case manager training: strategies for helping difficult patients
   d. Palliative Care Conference
5. Recommended Educational Opportunities outside PHC
   a. Addiction Medicine Review Course
   b. Pain Management in Primary Care
   c. Motivational Interviewing and Dialectical Behavior Therapy

1. Monthly Recognition: Colorectal Cancer Screening

Colorectal cancer screening saves lives, but the rates of screening are relatively low for PHC members. For the 2015-2016 QIP year, the following sites had screened over 56.5% of adults over age 50 for colon cancer (which is the 25%ile for Medicare; there are no national NCQA Medicaid benchmarks).

- Sutter Medical Group, Yolo County, Highest rate: 68.8%
- Center for Primary Care (Northbay Hospital), Green Valley, Vacaville and Fairfield, Solano County (all 3 of their sites!)
- Alexander Valley Regional Medical Center, Sonoma County (Highest rate for an FQHC)
- Open Door CHC, Ferndale, Humboldt County
- Sutter Medical Group of the Redwoods, Sonoma County
- Annadel Medical Group, Sonoma County

Congratulations to these sites for excellent performance on the first year of this measures.
Note: the threshold for this measure dropped for 2016-2017, as we started to benchmark against Medi-Cal and our own data.

Fecal DNA testing may now also satisfy this measure (in addition to Colonoscopy, Flexible sigmoidoscopy and testing for hemoglobin in stool).

2. **Balancing Efficiency and Caring: Addressing More than One Issue in a Visit**
(From [PHC Primary Care Blog](http://example.com))

An established patient makes an appointment with her primary care provider to evaluate progressive shoulder pain, not getting better in spite of taking ibuprofen three times a day. The next available appointment was 1 month away with a new clinician working at the office. The patient accepts that appointment. By the time she is seen, she is starting to also have significant abdominal pain and weight loss.

When she arrives at the appointment, the medical assistant asks her why she is there, and she says she made the appointment for shoulder pain, but she now also is worried about the abdominal pain and weight loss. The doctor comes in and tells the patient that he will only address one problem for the visit, asking the patient to choose the problem. The doctor says that he has a policy of only addressing one acute problem at a time. The patient decides to have the shoulder pain addressed, the physician diagnoses probable rotator cuff injury and prescribes physical therapy, telling her to continue taking the ibuprofen. The patient is advised to make a return appointment to have the abdominal pain addressed. She is given an appointment 6 weeks into the future.

The patient calls Partnership to complain and requests re-assignment to a new primary care provider. The case is referred for investigation as a potential quality of care issue to PHC’s peer review process.

**Comments on limiting a visit to one complaint:**

In this particular case, the “policy” of only addressing one problem clearly led to a significant *quality of care* issue (missed diagnosis of NSAID-induced gastritis or peptic ulcer disease), in other cases we have observed from patient complaints, this “policy” may not harm a patient medically, but nonetheless represents a very non-patient-centric approach to patient care, resulting in what we characterize as a *quality of service* issue.

As clinicians, we have a duty not just to efficiency (keeping our schedule moving along), but to provide excellent quality of care, and to demonstrate respect and caring for these patients. Experienced clinicians know this and have developed mechanisms for maximizing both efficiency and caring/respect/excellent outcomes. To view these, see the rest of this article on the [PHC Primary Care Blog](http://example.com).
3. **Breaking news from PHC**

   a. **Montelukast good PO option for chronic asthma not controlled with inhalers**

   Partnership HealthPlan of California (PHC) is collaborating with community pharmacies and physicians to help optimize asthma medication therapy by improving the Asthma Medication Ratio (AMR) score for patients with persistent asthma. Appropriate ratios for control and rescue asthma medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits, missed work and school days). (See [https://www.qualitymeasures.ahrq.gov/summaries/summary/49708](https://www.qualitymeasures.ahrq.gov/summaries/summary/49708) for references).

   The AMR is the ratio of controller medications to total asthma medications used by a patient with asthma. A ratio below 0.5 is a strong indicator the patient may benefit from a discussion about their current medication regimen and usage. PHC is working with prescribers and pharmacists to help optimize patient’s AMR and improve asthma therapeutic outcomes. Below is an intervention that may help improve AMR for your patients.

   According to the Global Initiative for Asthma (GINA) guidelines, 2017, addition of leukotriene receptor agonist such as, montelukast (brand name: Singulair) may be of benefit for those that may continue to have exacerbations despite regular use of an inhaled corticosteroid (ICS) or for those that may be candidates to step down therapy.

   As recommended by the GINA 2017 guidelines, please consider the addition of a leukotriene receptor agonist (i.e. montelukast (Singulair)) for patients who may benefit from this category of asthma medications. PHC covers montelukast up to 90 days and you can write a 90 day prescription for montelukast to help improve medication adherence.

   b. **Transportation for PHC members: what providers need to know**

   PHC offers 3 types of transportation benefits described below for members requiring assistance to and from PHC covered appointments/services.

   1. MTM, Inc. will arrange, cancel, and/or reschedule non-medical transportation (NMT) for ambulatory (curb to curb service **without** assistance needed) eligible members who qualify for the least costly means of transportation deemed appropriate. The member must exhaust all other transportation options prior to approval of transportation request.

      - For non-medical transportation(NMT) please contact MTM at (888) 828-1254

   2. PHC’s Care Coordination team will arrange non-emergent **medical** transportation (NEMT) for non-ambulatory eligible members (door to door service **with** assistance needed) as appropriate.
Medical rides will require a written prescription from a physician and an approved prior authorization (TAR).

- For non-emergent medical transportation (NEMT) please contact Care Coordination at (800) 809-1350

3. Emergency Medical rides provided by an **ambulance**, or **helicopter** (air ambulance) to a hospital for an emergency condition will not require prior authorization (TAR) if called via 911. If emergency transportation is needed, please dial **911**.

c. **Required Cultural Competency Training**

The Department of Health Care Services (DHCS) requires PHC to include a requirement for all contracted providers to complete regular Cultural Competency Training.

This July, they enacted a new requirement for managed-care plans to more closely monitor compliance with this training. Under this new requirement, all providers that have completed the Cultural Competency Training will have this noted in the official PHC Provider Directory.

The Cultural Competency Training for Healthcare Providers can be performed by your organization, either in person or on-line, using content you select and choose. Some on-line options for Cultural Competency Training can be found on our website: [http://www.partnershiphp.org/Providers/HealthServices/Pages/Providers-Language-Assistance.aspx](http://www.partnershiphp.org/Providers/HealthServices/Pages/Providers-Language-Assistance.aspx)

Including a PDF of a webinar with core concepts that can be read and reviewed by your staff.

The management of each provider site can use the attestation on the website listing all staff that have completed an annual training; it should be retained in a training log to be reviewed at PHC facility site reviews.

In addition, in the coming months, our local PHC Provider Relations staff will be reaching out to your organization to confirm completion of this requirement.

d. **Reassignment of members who are no longer your patients**

Providers often ask the QIP team regarding seeing PHC members that are not assigned to them, or not having established care with patients that are assigned to them, or members who are deceased. The QIP works from eligibility lists that PHC receives through the county. The QIP team is not authorized to remove or change patients’ status because it is tied to their eligibility with Medi-Cal as a whole.

PHC’s Member Services can help a bit more, though they are still required to get confirmation from the member. They are able to take a verbal authorization from members, or a form completed by the member and faxed by the provider. The QIP team has more details.
e. **Breast Cancer Screening Special Quality Improvement Project**

Breast Cancer Screening will be a QIP measure in 2018. Since the look-back period for compliance is 27 months, we hope you are ramping up for this measure! Let us know if you would like the specifications of this measure.

The QI department is designing a special incentive program focused on improving Breast Cancer Screening rates. Watch for more details later this month about this exciting opportunity!

f. **New Oral Anticoagulation Treatment Options**

Effective July 1, 2017, a number of newer generation oral anticoagulants will be available with a “Code 1” status for certain diagnoses:

- Rivaroxaban: Atrial fibrillation, treatment of DVT/PE, prevention recurrence of DVT/PE when at risk, following hip/knee replacement
- Apixaban: Same as Rivaroxaban
- Dabigatran: Atrial fibrillation, treatment of DVT/PE, prevention recurrence of DVT/PE when at risk, following hip replacement (not indicated for knee replacement)
- Edoxaban: Atrial fibrillation, treatment of DVT/PE


g. **Hepatitis A Vaccine recommend for Homeless Persons**

Due to two outbreaks of Hepatitis A in groups of homeless individuals in Santa Cruz and San Diego, the California Department of Public Health is recommending Hepatitis A vaccination be offered to individuals who are homeless or in contact with homeless persons. See the CDPH [*Clinical Advisory*](https://www.cdph.ca.gov/Programs/PPOD/PreventiveHealth/ChildhoodImmunizations/Pages/ImmunizationForHomelessPersons.aspx) for details.

PHC covers Hepatitis A immunization done in the office or a community pharmacy.

4. **PHC Educational Opportunities and Events**

   a. **ABC’s of QI in Eureka and Napa**

PHC is offering two ABC’s of QI in-person trainings again this fall. These are one-day in-person trainings designed to teach you the basic principles of Quality Improvement. The course covers the following 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 drive improvement
• Tips for developing change ideas that lead to improvement
• Testing changes with the Plan-Do-Study-Act (PDSA) cycle

The course is designed for individuals working on quality improvement projects, including: medical directors, clinicians, QI managers/coordinators, data analysts, front and back office staff.

**Date:** September 19, 2017 (Tuesday)
**Time:** 8:30 a.m. to 4:30 p.m.
**Location:** Sequoia Conference Center - 901 Myrtle Avenue, Eureka, CA
**Register:** [https://www.eventbrite.com/e/abcs-of-quality-improvement-tickets-36617301334](https://www.eventbrite.com/e/abcs-of-quality-improvement-tickets-36617301334)
Email questions to Amanda akim@partnershiphp.org or Staci svercelotti@partnershiphp.org

**Date:** October 24, 2017 (Tuesday)
**Time:** 8:30 a.m. to 4:30 p.m.
**Location:** Springhill Suites Marriott - 101 Gateway Road East, Napa, CA
**Registration:** [https://abcsofqi102417.eventbrite.com](https://abcsofqi102417.eventbrite.com)
Email questions to Karen Goelz at kgoelz@partnershiphp.org

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b. **Cannabis Use and Cannabis Use Disorder in the Setting of Legalization**

Addiction specialist Dr. Tauheed Zaman, Assistant Clinical Professor at UCSF and Medical Director of the Addiction Consult Team at SF Veterans Administration, will be discussing treatment options for marijuana use disorder in the setting of increased use of marijuana due to legalization of recreational use
of marijuana in California. Dr. Zaman gave a great presentation on withdrawal management in January, so we expect this webinar to be especially valuable to primary care providers.

Date: September 6 (Webinar)
Time: 12:30-1:30 PM
Registration: [https://register.gotowebinar.com/register/5028910382543955459](https://register.gotowebinar.com/register/5028910382543955459)

c. Strategies for Dealing with Difficult Interactions with Members
Dr. Karen Stephen, Mental Health Clinical Director of Partnership HealthPlan of California, will be presenting didactic material and leading small group training exercises to better:

- Understand the Behavioral Health issues that underlie difficult interactions with Members
- Learn new communication skills that have emerged from Dialectical Behavior Therapy (DBT) that offer a workable approach
- Diffuse the negative feelings in you that arise from such interactions.

Intended Audience: Case managers caring for complex patients (nurses, health care navigators/guides, community health workers) from organizations located in PHC 14 county region.

Fairfield Training (Video link to Santa Rosa office)
Date: Monday October 2, 8:30am to noon
Location: PHC offices in Fairfield (4665 Business Center Drive) and Santa Rosa (495 Tesconi Circle)

Redding Training (Working on video link to Eureka office)
Date: Tuesday October 17, 8:30am to noon
Location: 3688 Avtech Parkway, Redding

d. Palliative Care Conference: Taking the High Road in Healthcare
Collabria Care (Napa) and PHC are co-sponsoring our annual palliative care conference. Featured nationally renowned speakers include: Dr. Steven Pantilat: discussing thinking about palliative care in the
context of population health (interviewed on the August 2 edition of KQED radio’s Forum), and Dr. Vanessa Grubbs: discussing how to integrate palliative care with dialysis.

Date: Thursday Nov 2, all day
Location: Embassy Suites, Napa
Registration: https://collabriacare.org/apcc/

5. Recommended Educational Opportunities Outside PHC

a. Addiction Medicine Review Course

The California Society of Addiction Medicine’s very comprehensive annual Addiction Medicine Review Course is a great way for primary care providers to gain skills in treating patients with substance use disorder.

Dates: August 25-27, 2017
Location: Hilton Union Square, San Francisco
Link for registration and more information

b. Pain Management for Primary Care

UC Davis is offering a two-day course on pain management, geared towards primary care clinicians. This two-day event will include presentations and small-group discussions on pain-related topics that are most frequently faced by primary-care clinicians. UC Davis is offering clinicians associated with PHC a discount on registration: use code ECHOPAIN to save $70 for physicians and $15 for other health care providers.

Dates: September 16-17; 8am to 4:30pm
Location: UC Davis Sacramento Campus: 4610 X Street, Lecture Hall 1222, Sacramento
For more information and to register: https://goo.gl/FSNa4Z

c. Motivational Interviewing and Dialectical Behavior Therapy: Integration Strategies for Behavioral Health Providers

The California Institute for Behavioral Health Solutions is sponsoring a two-day training on integration of two effective practices: Motivational Interviewing (MI) and Dialectical Behavioral Therapy (DBT). Intended for behavioral health providers who have received some basic instruction in DBT and MI.

Date: Tuesday and Wednesday, September 26 and 27, 2017
Time: 8:30 AM to 3:30 PM
Location: CIBHS – Sequoia Room, 2125 19th Street, 2nd Floor, Sacramento, CA 95818

Registration Fee: $350 (includes continuing education). Morning coffee and afternoon snack provided. Lunch is on your own.

Registration: https://cibhs.networkofcare4elearning.org/EventDetail.aspx?pId=690&OrgId=223

Many thanks for all you are doing to help the vulnerable members of our community!

Robert L. Moore, MD, MPH, MBA
Chief Medical Officer
Visit our blog at http://phcprimarycare.org
PHC website: www.partnershipphp.org

Helping our members, and the communities we serve, be healthy!
I. Approval of Minutes

Committee Chairman, Dr. Gaborko, asked for public comments, and visitor acknowledgement. Ms. Speer of Eli Lilly introduced herself, and noted that she was attending as part of her familiarity of the region.

MOTION: Dr. Gwiazdowski moved to approve Agenda Item [I.] as presented, seconded by Dr. Stacey. ACTION SUMMARY: [14] yes, [0] no, [0] abstentions. Motion carried.

II.A. Status Update Administration

The HealthPlan’s Chief Executive Officer (CEO) provided the following status report on PHC activities.

Federal
- Affordable Care Act (ACA) – Efforts around repealing and replacing the ACA with the American Health Care Act (AHCA) continue. The Senate is quietly deliberating, and developing their own draft Bill, though in a much less public fashion than the Bill prepared by the House of Representatives.

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<td>II.A. Status Update Administration, Continued</td>
<td>Partnership has heard that the Senate intended to bring their Bill forward before the July 4th Recess. So far, the timing has not worked. The closer they get to the deadline, the less likely a vote will be taken before the holiday. A Congressional Budget Office (CBO) score before proceeding. Once a vote comes up, it is not expected to go through committee hearings. Partnership’s message continues to be its support around the ACA, and against the AHCA. Staff and Committee members are encouraged to reach out to their elected officials about rollback of the Medicaid Expansion, and inadequate funding through block grants or per capita caps. The HealthPlan has not received any details regarding the AHCA, and many lawmakers are complaining of the same issue. This is still very much a concern for Republican-led states that have expanded their Medicaid programs and would see a significant budget hole, as well as many thousands of people being uninsured if the expansion does roll back. At this point, the Single Payor System is getting a lot of attention at the State level, due to the excessive price tag, but it is not getting much traction. The program would also require the Federal Government to approve various components, one of which would allow California to receive its Medicaid allocation, without strings attached. That would be unlikely in today’s political environment. It was noted that the California Medical Association is opposed to this Bill. Aside from the exorbitant cost, the Bill was developed without any physician input and does not include any utilization review or restraints. - Federal Budget – There is still several months before the Federal fiscal year starts on October 1, but discussions around budget priorities are underway. There are significant cuts proposed for health care, including $1.5 trillion from Medicaid over ten years.</td>
<td>For information only, no formal action required.</td>
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<td>State</td>
<td>- Budget and May Revise – There were a number of provisions included in the May Revise, a couple of which directly effects PHC. One is the statewide Palliative Care Benefit, which was scheduled to go into effect January 1, 2018. The State has proposed a delay to this program until July 2018, which will be good news if finalized. There is considerably more funding for In-Home Supportive Services (IHSS) at the county level, but still less than what they have been receiving. This would place pressure on California counties to make up the difference. There is also an issue of recoupment of Medicaid Expansion funds for Medicare / Medi-Cal recipients, who have Part A coverage. Partnership will be impacted by this, but believes it has sufficient funds set aside to handle. - Proposition 56 (Tobacco Funds) – Funds were originally generated to provide a rate increase for Medi-Cal providers. The Governor has now proposed that those funds be used toward expanded eligibility. It was noted that the current Budget puts $1 billion back into Medi-Cal. The only negotiation was to whether funds should go to counties with bad access or specialty needs, or whether the funds would be applied to the General Medi-Cal Fund. Details are still being worked on by the State.</td>
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<td>II.A. Status Update Administration, Continued</td>
<td>- Healthy California Act (aka Lara Bill), Senate Bill (SB) 562 – This has been getting considerable attention. The California Nurses Association sponsored the Bill. Due to the amount of controversy around the Bill, the HealthPlan has declined to comment when approached by local media.</td>
<td>For information only, no formal action required.</td>
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<td>HealthPlan - Budget – The proposed budget is due to the Plan’s Finance Committee next week, and to the Board later in the month. - Housing and Homelessness – The Board previously approved $25 million under Strategic Use of Reserves to fund local housing and homeless initiatives. Staff expects to have the Request for Proposal (RFP) out in early July. - Big 5 Initiatives (California Children Services [CCS], Drug Medi-Cal, Palliative Care, Prospective Payment Services [PPS] Redesign, and Health Homes) – • Drug Medi-Cal – The HealthPlan is putting together its regional application for eight of the fourteen counties (Shasta, Siskiyou, Lassen, Modoc, Humboldt, Trinity, Mendocino, and Solano). Staff expects the application to be approved by the State without issue. The expectation is that the benefit will go live this time in 2018.</td>
<td>Proposed changes to the Quality Improvement Program will be brought to the Committee.</td>
<td>9/13/17 (Updated to Oct. Meeting)</td>
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<td>The HealthPlan’s Chief Medical Officer (CMO) presented an overview of some Health Services activities. - 340B Program – There was a Department of Health Care Services (DHCS) Bill proposed through legislation to disallow any use of contracted pharmacies for the 340B Program (Program). The Bill was defeated. The current policy persists, though there is still a lot of vagueness. The Plan is considering its current compliance program to be the most coherent policy available. The number of PHC contracted hospitals and primary care physician (PCP) sites participating in the Program has increased. Plan staff believes its model could be adapted by the State for better clarity, versus them trying to dismantle it and creating a severe cost to entities participating in the Program. - Transportation Benefit – This benefit is scheduled to start July 1, and will be reviewed later on the agenda. - Pay-for-Performance (P4P) Program – As discussed at previous meetings, there was a finding against the San Mateo Medical Center (SMMC) on its P4P Program by DHCS. The Local Health Plans of California (LHPC) had a phone conference with two senior staff at DHCS regarding the issue. The two staff presented a third vision (separate to the DHCS auditor or judge), on what could be included / excluded in P4P programs. This is not in writing, though it is hoped that the LHPC can obtain an approval on the minutes outlining their understanding of the discussion. They concluded that the measures must have thresholds, or show improvement. Measures are not strictly limited to those that save money or reduce utilization. Overall, this is good news. However, as a result of the clarification, several of the Plan’s measures do not meet those criteria. PHC’s Quality Improvement Program (QIP) team is putting together a collection of recommended changes for the PCP QIP. This is to ensure that the various Prospective Payment System (PPS) providers will be able to exclude those quality dollars from their PPS calculations. Staff is targeting September to present the recommended changes to the Committee.</td>
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<td>II.A. Status Update Medical, Continued</td>
<td>Prenatal Care Quality Improvement Program (QIP) – A new QIP for prenatal providers is being developed (prenatal and postpartum visits, and timeliness). Unfortunately, the three measures staff planned to use do not meet the criteria outlined by DHCS staff, so the measures have been amended. There are two provider sites that will pilot the new QIP (ABC Program in Fairfield and Mercy Maternity in the North). After testing, it will be presented to this Committee for review and approval in the fall, with expected kick-off in January 2018.</td>
<td>Once piloted several months, the new Prenatal Care QIP will be brought to the Committee for review and approval.</td>
<td>Oct./Nov. 2017</td>
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<td>Palliative Care Benefit – As previously noted, the State’s benefit is expected to start in January 2018. Partnership is expanding its existing pilot to include a number of additional sites, starting July 1, 2017. A meeting was held earlier this month, and included a variety of organizations interested in the program. Aside from the three sites that participated in the pilot (Resolution Care of Humboldt, which intends to expand into their sites in Mendocino and Redding, Collabria Care in Napa and Hospice in Yolo), applications have been received from major players in Marin, Sonoma, Yolo and Solano counties, with the possibility of one provider in Siskiyou County. The Resolution Care model may be able to accommodate Trinity, Modoc, and Lassen County through Tele-Palliative Care.</td>
<td>For information only, no formal action required.</td>
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<td>California Endowment Grant – A $25,000 grant is being awarded to Napa County for housing, and is in honor for their work around whole person care (housing summits sponsored, Project Nightingale, and other efforts to deal with the housing issue). Napa County has a high number of people that commute into the county for work, but cannot afford to live there. There is also a need for low-income or senior housing. So, focusing on housing for the homeless can be a difficult sale. Considering the dynamics around housing, the medical piece is very small in relationship to the whole. At the last meeting on housing that was attended, representatives from the City Council and Board of Supervisors were present, and are very eager to fix this problem.</td>
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<td>Access – Primary care access in Napa County is interesting, and not very good for the general community. A number of physicians in the county have become concierge physicians, limiting their patient numbers. With the exception of Kaiser and Ole Health, patients with commercial insurance or Medicare have few options for a physician. However, PHC has 26,000 members in Napa County, who have plenty of access.</td>
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<td>Medical Directors’ Forums – Two of the Regional Medical Directors’ Forums were held for this region, one in Ukiah and one in Novato. They were both well attended. Judging by the number who attended, providers are finding these meetings relevant.</td>
<td>For information only, no formal action required.</td>
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### II.A. Status Update

**Medical, Continued**

- West County Health Centers & Coastal Health Alliance have merged. This ties a number of areas into one large Federally Qualified Health Center (FQHC).
- Sonoma West Hospital continues to keep their doors open. There was an issue with equipment sterilization in the surgical unit, but the hospital is otherwise still accessible.

PHC’s Regional Medical Director for the Northwestern (NW) counties presented a brief overview.

- Access – Dr. Walter, orthopedist in Fortuna, will be leaving this month, though he announced this change back in the fall. Since he is moving to Petaluma, he will still be part of the Plan’s network. There are a number of providers leaving private practice. Gynecology and obstetrics (OBGYN) in Eureka has been limited to Dr. Stokes and a couple of nurse practitioners. They are in negotiations to join St. Joseph Medical Center (SJMC). The only family private practice group, Eureka Family Practice, in the area will also be joining St. Joseph’s. Since they have never taken Medi-Cal, it does not really impact the HealthPlan. This may change with the merger. The primary care side of SJMC takes very few PHC patients, but this may be an area for expansion. The majority of local surgeons are also joining SJMC. Recently, SJMC completed their Trauma, Level 3 designation, which is a big accomplishment for a rural area. David Southerland, Chief Operating Officer for SJMC, has stepped into the position left vacant by Dr. David Obrien, as Interim Chief Executive.

- Residency Program – This continues to move forward. In October, the Program will go before the Accreditation Council for Graduate Medical Education (ACGME). Dr. Hunter advised that the goal is to have residents starting the summer of 2018, though the timing may be too tight. If they are not able to make that goal, it will be the summer of 2019 for residents to start.

- Humboldt County – Yesterday it was announced that the County was one of fifteen counties statewide that received almost $4 million in grant funds toward dental case management of school-aged children. Humboldt was the only rural county to be awarded funds.

The HealthPlan’s Northern Regional Medical Director presented a brief overview on activities for the Northeastern (NE) counties.

- Access – There will be a groundbreaking in October for a new facility, Scott Valley Health Center, which is close to the Oregon border. Redding has some new providers (chiropractors and ophthalmology), and one of the women’s health care sites is getting certified in perinatal services. Redding Rancheria will be setting up a PCP site in Trinity County, which will include dental, physical therapy, and possibly medication assisted treatment (MAT) for opioid use. It is expected that the facility will open in July, as they tend to move quickly with these expansions.

- Project Homeless Connect – Every year in Redding, a day-long community event, Project Homeless Connect, is held. The event offers homeless or disadvantaged individuals services that they may not be able to access. Services included some health exams (by way of Shasta Community Health Center’s medical van), haircuts, and veterinary services for pets. PHC staff from Member Services (MS), Provider Relations and Quality volunteered for the event. The number of adult participants were 406, 315 of whom engaged with MS staff, 81% of that number were PHC members.

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<td>II.A1. Update – County Public Health</td>
<td>Dr. Stacey presented a brief epidemiology update to the Committee. The Health Department is in a quiet period, from a communicable disease standpoint. However, conditions are potentially ripe for the West Nile Virus. Though Solano County has not had much activity. There is one human case in the state.</td>
<td>For information only, no formal action required.</td>
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<td>II.B. Quality/Utilization Advisory, II.D. Provider Advisory, &amp; II.E. Credentialing committees</td>
<td>The Plan’s CMO acknowledged the additional documents sent out separately to the meeting packet. Two policies that were overlooked and were not included in the May packet. Those too are part of the consent calendar. There were no items pulled for further discussion.</td>
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<td>II.F. Committee Membership</td>
<td>The Plan’s CMO advised that there are three changes to membership for the Pharmacy &amp; Therapeutics (P&amp;T) Committee. Haley Park, pharmacist with Walgreens, and Harvey Katzman, pharmacist with Ole Health in Napa, have agreed to participate on the committee. Kathy DiMaggio, registered dietician, has resigned from the committee. Approval of changes is recommended.</td>
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<td>IV.A. Physician Advisory Committee policy</td>
<td>Partnership’s CMO presented the Committee’s policy for regular review and approval. There were no changes to the policy, which outlines the various duties and responsibilities of the Committee members.</td>
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<td>IV.B. Transportation Benefit</td>
<td>PHC’s Senior Director of Health Services (Senior HS Director) advised that legislation was passed several months ago requiring Medi-Cal plans to increase the transportation benefit, effective July 1, 2017. The HealthPlan has always provided transportation for members who met the criteria for medically necessary appointments, including perinatal members who required high risk OB provider services. The new benefit is expanded significantly, and requires the Plan to offer mileage reimbursement, and/or arrange transportation for any member going to a medically necessary appointment, who has no other means of transportation. To administer this benefit will cost the HealthPlan a considerable amount of money. Areas that the HealthPlan has always covered remains unchanged (i.e. transportation for wheelchair vans, covering paratransit tickets for members needing wheelchair transportation, and/or arrangement of taxi service when necessary). The changes to the benefit come with the non-medical transportation segment. The biggest challenge will be with the Northern Counties, due to its rural structure and provider access. The HealthPlan has contracted with a company called MTM, which will start handling</td>
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**MOTION:** Dr. Johnson moved to approve Agenda Items [II.B., II.D., & II.E.] as presented, seconded by Dr. Stacey. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions. Motion carried.

**MOTION:** Dr. Stacey moved to approve Agenda Item II.F., as presented, seconded by Dr. Gwiazdowski. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions. Motion carried.

**MOTION:** Dr. Gwiazdowski moved to approve Agenda Item IV.A., as presented, seconded by Dr. Stacey. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions. Motion carried.
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| IV.B. Transportation Benefit, Continued | non-medical transportation effective July 1. Plan staff will continue to coordinate medical transportation for members. PHC has been working with MTM the past several months, establishing protocols to follow.  

Last Friday, Partnership staff participated in an All-Plan conference call with DHCS and learned that additional provisions have been added to the expanded benefit. Along with services covered under contracted benefits, the HealthPlan will be required to transport patients for carved-out services (i.e. dental and mental health appointments). During this communication with DHCS, they also stated that a Treatment Authorization Request (TAR) would be necessary.  

The additional requirements were an unexpected curve for all of the health plans, recognizing the potential costs associated with the changes. Basic logistics of the added services are also a major consideration. The HealthPlan’s practice has always required verification of a medical appointment, prior to arranging transportation. It is unlikely that Plan staff will be able to verify appointments by calling a county mental health department, as that would be perceived as a Health Insurance Portability and Accountability Act (HIPAA) violation. Due to the amount of push-back by the health plans, there is an unconfirmed update that DHCS will delay the requirement of transportation for carved-out services until October, 2017. Due to the sheer volume and logistics that transportation vendors will encounter, it is anticipated that a lot of stress will be placed on available resources.  

Information regarding the Transportation Benefit will be included in the Plan’s Member and Provider newsletters, and will be addressed at all meetings that include members or providers. As of today, the HealthPlan is not intending to send out letters to all of its members, as that would be costly and the standard communication method is through the Member Newsletter or via their providers.  

As of July 1, 2017, members who have a prescription from their provider will be able to contact MTM directly for non-medical transportation. The provider will need to designate the level of transportation needed by their patient. MTM will also be responsible for confirming and overseeing mileage reimbursements for members. Protocols established with MTM may need revising by the HealthPlan, once the carved-out services portion is added.  

To date, the Plan has not required TARs for non-medical transportation, as it was determined that the process would be too cumbersome. However, staff conducts a screening with the member for appropriateness of transportation, but that has not involved the provider unless medical necessity required verification. Since the TAR requirement is new, PHC staff has not worked out the process, nor how to document recurring transportation needs for a member. DHCS is giving the health plans leave on that determination. It is the intent of the HealthPlan to streamline the TAR process as much as possible for providers, and its staff. Details have not been worked out regarding the process for these new requirements, which are currently still too fluid to pin down.  

Areas addressed by the Committee included:  
- Dr. Herman asked whether a prescription would be required for every recurring visit, or would one prescription suffice for the year? – Plan staff will devise a way to have the prescription valid for one year.  
- If the HealthPlan could find a way around providers having to participate in this process, if would be helpful for them. – The prescription requirement is a direct order from the State. The flexible portion is how the Plan will administer the TAR process.  
- Dr. Townsend asked if there can be clinician input during the Plan’s discussions, as it determines how to proceed with the logistics of the new requirements. – Though Plan staff is under a tight time constraint, it would welcome input from providers on the process. A call can be scheduled to include members of this Committee, as there would not be sufficient time to coordinate with the provider network. Volunteers from the Committee included Dr. Herman, Dr. Townsend, Dr. Gwiazdowski, and Dr. Stacey.
### AGENDA ITEM

**IV.B. Transportation Benefit, Continued**

The Plan’s CEO advised that this topic will also be discussed at the Quarterly Clinic Consortia meeting. It is expected to be an ongoing discussion among these leaders. Providers’ understanding and flexibility as the HealthPlan rolls this benefit out is greatly appreciated. With each attempt at clarification from the State by Plan staff comes a delay in response, as DHCS staff weigh the answer(s). Partnership would like to make the process as efficient as possible, and appreciate input from its providers.

- Dr. Gwiazdowski asked who would make the determination that there are no other means of transportation for the member. – Currently, Plan staff use a worksheet when determining transportation needs, and MTM would have something similar. The HealthPlan is obligated to go by what the patient indicates.
- Dr. Stacey asked for clarification regarding what the physician should indicate on the prescription (i.e. “this patient is in need of non-medical transportation to a medical appointment”). – The level of transportation will be needed by the HealthPlan. Whether the patient is capable of using a private vehicle, taxi, or public transportation would be helpful in determining the arrangements. Providers could use pre-printed prescriptions for medical and non-medical transportation.
- Dr. Gwiazdowski addressed the concern and potential liability a provider may encounter, should they indicate a lower level of transportation for a patient and an adverse occurrence happens, due to delay in travel.
- The Plan’s Senior HS Director shared that the vendor, MTM, will provide mileage reimbursement and taxis. There have been discussions around paratransit tickets. In the N. Counties, there are Community Organized Transportation (COT) services, which may also be used.
- Is there any idea what the budget impact will be from these new requirements? – The Plan’s Chief Financial Officer (CFO) advised that this is a zero-sum issue. The State predicted an annual statewide cost of $6 million. PHC believes these changes will cost at least $10 million per year just for the Plan. The CFO shared her experience at Central California Alliance for Health (CCAH), when they similarly expanded their transportation benefit. When reconciled, there were an inordinate number of physician appointments that occurred adjacent to shopping malls. It was extremely tough for the health plan to rescind the expanded benefit, once members were used to it. At that time (over 10 years ago), CCAH was spending $10 million per year on transportation, and that was a smaller organization. Providers will need to be cognizant of prescribing unjustified levels of transportation, when considering the potential impact on medical service dollars. Plan staff is very concerned with how this benefit progresses, especially at a time when funding cuts are likely with Medi-Cal.
- The Plan’s SW Regional Medical Director reiterated the importance of providers being judicious with the transportation costs and the level prescribed. Medical necessity will be paramount.
- The Committee’s Chair acknowledged the importance for the HealthPlan to give some guidance on how the transport determination should be made. Kaiser Permanente has a set of due diligence criteria whenever a patient is transferred from the emergency room to another hospital. Setting priorities will help providers on how to make the level selection choices. Then, if something unforetold occurs, at least there would be guidelines to refer back to.
- Dr. Herman addressed her concerns on how providers and the practice site will be adversely impacted by including them in the process. She sees this being compounded by the patient, by being argumentative, and in terms of how positive the relationship is between patient and provider. It is hard to comprehend the extent to which this will interfere with a provider’s ability to address medical issues. – The Plan’s CMO recognized the concerns, but the HealthPlan does not have any power to change DHCS regulations, however, physicians do. This would be a good case to pursue through respective advocacy organizations. Partnership will do what it can, but it is mandated to follow DHCS regulations, which is reacting to legislation passed.
- Dr. Martinez shared that this benefit is highly needed, and has been needed for a long time. She agrees with Dr. Herman’s concerns around the relationship with the provider. Her facility has a system where referrals are sent through a referral section, which indicates the necessity of a prescription. Some global criteria guidance from the HealthPlan would benefit the providers.
- Dr. Stacey concurred with the comments by Drs. Herman and Martinez. His vision is where the provider would indicate medical / non-medical transportation, and MTM triages the transportation level. Based on PHC’s criteria, MTM will determine the type of transportation needed. – The Plan’s Senior HS Director believes that that process should be doable, and the suggestion is great for non-medical transportation. However, there will need to be a level designation by the physician when it is medically needed (i.e. wheelchair, etc.)

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<tr>
<td>IV.B. Transportation Benefit, Continued</td>
<td>• Where does the TAR process come into play? – PHC will be working the TAR process out with MTM. Plan staff will be reviewing for medical necessity. The non-medical transportation TAR requirement is the new portion, and there is pushback to the State on that issue. Staff has not had an opportunity to discuss this change, since the All-Plan call with DHCS was last Friday. Staff will be looking at ways to minimize the disruption to providers. The Plan’s CMO noted that this discussion was to make the Committee aware of the upcoming changes, so that it was not a complete surprise. The process is not finalized. While the Committee was discussing this topic, the CMO went on-line to review the legislation, which does not require a physician prescription. DHCS added that requirement to the regulation. This is a feature that work through advocacy groups (i.e. California Medical Association [CMA]) could influence. From the HealthPlan’s perspective, the foremost concern is around the financial impact. • Physicians will not have an issue making the medical determination for the level of service needed, but they cannot be the authority to determine whether the patient’s request for transportation is justified. With that said, physicians will also be concerned with the stewardship of the dollars, as that will impact funds for health care. – The Plan’s Senior HS Director acknowledged these concerns, noting that PHC staff and MTM will be making the determination of non-medical needs. The Plan’s Senior HS Director will be in contact with the Committee members who volunteered to review the information and offer input on the communication plan. Partnership’s CMO presented the topic for discussion - How many issues should be addressed by a provider in a medical visit? Over the past several months, he has had the opportunity to review a number of cases that fell under the Plan’s category of “exempt grievances”. There is a significant number where the patient has complained that they saw their provider (having two or more issues they wanted to discuss), but the provider limited the visit to only one issue. In some cases, the next appointment is another three months out, which equates to addressing four medical problems per year. PHC’s CMO has the perspective that this restriction is not patient centric. With those cases in mind, he hopes to get a consensus from this group regarding a guideline that the HealthPlan can use as a non-binding standard, to be used when communicating with specific providers. Does your organization have an official policy around this? Is there an informal agreement you use? How does your organization handle these, and, how should the Plan address the complaint issues when they come up?</td>
<td>For information only, no formal action required.</td>
<td>06/14/17</td>
<td>June 2017</td>
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IV.C. Discussion Topic: How many issues should be addressed by a provider in a medical visit? |                                                                                                                                                                                                                   | PHC’s Senior HS Director will coordinate a phone meeting with Committee volunteers to discuss this issue. | | |
AGENDA ITEM | DISCUSSION / CONCLUSIONS
---|---
IV.C. Discussion  
Topic: How many issues should be addressed by a provider in a medical visit?, Continued

Dr. Ginsberg advised that NorthBay’s Centers for Primary Care does not have a policy in place regarding the number of issues a provider should address. Within reason, they do not tell physicians what they should be doing in an exam room with a patient. There may be five simple issues they can easily address, or two very complex issues. These are handled on a case by case basis. In some incidences, it may be valid for all the issues to be addressed. Whereas, a mother may bring in a child who is very sick with the Norovirus, but she wants to discuss behavioral issues at school. A reasonable boundary can be established by the provider, recognizing the immediate problem and the child’s discomfort, and suggesting that the other concern be addressed at a future appointment. Thus, validating the mother’s concern, approaching politely, but recommending to address in the future. For himself, Dr. Ginsberg is leery with policies or guideline statements, due to the degree of variability and differences between physician styles, and patients.

Dr. Herman noted that it is difficult for patients to get appointments at La Clinica. She sees patients having a backlog of issues that have not been addressed for a long time. She agrees with Dr. Ginsberg that it is difficult to make hard policies around this, and it is her opinion that there is a clear financial incentive to physicians that they are reimbursed, no matter the number of issues addressed during the visit. Many physicians are backed-up, running behind, and being pushed to be more productive and see more patients faster (at least in their organization). Unless there is something to counter this perception, patient care is turned into sequential urgent care visits. This is especially problematic for elderly patients. Her patients are taken back when she allows them to talk about more than one issue, and she is trying to get staff to conduct more whole-patient visits. But, there are hurdles to overcome first, which could be corrected through education, policy, or incentive to change that behavior through a quality improvement measure.

Dr. Hunter shared that this issue tends to occur more with brand new providers, as their time management skills have not developed to the level of efficiency. And, patients are leaving due to the extended wait. Having seen patients for a long time, Dr. Hunter does not limit his patients, and encourages them to bring a whole list of concerns. However, he recognizes the mixed messages given to new staff, and it is unclear how these issues will be addressed with the new Residency Program. Nurses from the Family Nurse Practitioner Program are currently working with mentors, who are helping them get through the day by telling them to limit the number of medical issues during the visit. It is unclear to him how to shift from the process of a new provider getting through a day’s appointments and addressing all the needs of the patient within a visit’s timeframe.

Dr. Popat advised that he too has strong feelings against limiting an office visit to one medical condition. His usual approach with providers has been for them to do some agenda setting the first two minutes of the visit. It does not take long to get all the issues acknowledged. There are concerns the patient has, and those the provider has, based on the review of the patient’s self-care maintenance, abnormal results, etc. There needs to be agreement on what will be addressed that day, and bring the patient back if needed. The key part is to make the patient feel heard, not shut down the conversation. This process does not take much longer, while still being productive. Dr. Popat believes this is as much a timing issue, as it is an incentive and payment issue.

Dr. Stacey shared that he believes newness as a practicing provider, or to a clinic, is more challenging, since all the patients are new and it takes time to get to know them. There are two things he believes are helpful: 1) patient empanelment and assuring the system that they most frequently see their primary care physician (PCP) for their ongoing issues. If it an urgent care issue, then providers should address that concern. An urgent visit is not the time for a patient to come in with a laundry list of issues. By assuring the patient sees their PCP, the list is easier to manage. 2) Schedule a series of appointments (i.e. monthly visits for a period of time) for patients who regularly come in with a long list. When they do come in, the patient will already be aware that another appointment is on the books. This minimizes the stress for the patient, who may not be as concerned if everything is not addressed that day.

PHC’s Regional Medical Director for Napa County reflected on his experience as a department chief, having heard the complaints from physicians, generally from those who were new and feeling overwhelmed. The suggestions noted are helpful, and he believes that providers can be mentored out of
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<td>IV.C. Discussion Topic: How many issues should be addressed by a provider in a medical visit?, Continued</td>
<td>the time-management issue. Those who have done this a long time have figured out a system. He does not believe the HealthPlan needs a policy to speak on the number of issues addressed at a medical visit. Dr. Townsend fully agreed with comments made by Drs. Cotter and Stacey. Primary care is a learning process. At Ole Health, many providers start that agenda setting, which: 1) helps to remind the patient about the length of their appointment, and, 2) allows providers to address more issues as time permits, or based on the urgency of the patient’s condition. Aside from the patient’s perspective, Dr. Townsend would be interested in the provider’s view point on the appointment. It could be that the patient believed only one issue was addressed. When, in fact, several issues were addressed when looking at the medical record. The Committee’s Chair advised that Kaiser Permanente does not have a policy. The organization is big on mentoring their staff, along with promoting shared decision making. Kaiser’s focuses include clinical excellence and efficiency, along with compassion and respect to the patients. Using all four principles, physicians are taught from the onset of their Kaiser relationship that finding a balance and building the trust of patients is key. The Plan’s CMO thanked the Committee for their input and summarized the comments. Instead of a policy or guideline, they will incorporate the provider’s perspective of the appointment into the evaluation, when reviewing a patient’s complaint, and look at potential mentorship of the provider. The Plan’s Regional Medical Directors are all experienced physicians who could potentially have a conversation with the clinician, and offer some of these best practices.</td>
<td>For discussion purposes only, no formal action required.</td>
<td>06/14/17</td>
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<tr>
<td>IV.D. Additional item</td>
<td>The Committee’s Chair announced that there will be no meeting in July. The next meeting of the Committee will be in August.</td>
<td>The Committee will not convene in July.</td>
<td></td>
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<tr>
<td>Adjournment</td>
<td>The Committee adjourned at 9:02 AM Respectfully submitted: Linda Largent</td>
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The foregoing minutes were APPROVED AS PRESENTED on:

______________________________  ________________________
Date                  Jeffrey Gaborko, M.D., Committee Chairman

The foregoing minutes were APPROVED WITH MODIFICATION on:

______________________________  ________________________
Date                  Jeffrey Gaborko, M.D., Committee Chairman
# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## MEETING MINUTES

**Committee:** Quality and Utilization Advisory Committee  
**Date/Time:** Wednesday, June 21, 2017 - 7:30AM - 9:00AM Napa/Solano 1st Floor

### Members Present:
- Barresi, Katherine, RN, Associate Director of Care Coordination  
- Boyd-Anderson, Rebecca, Director of Care Coordination  
- Cotter, James, MD, Associate Medical Director  
- Cuellar, Dina, Director Regulatory Affairs  
- French, Rachael, Senior Manager Quality Compliance and Accreditation  
- Fromefield, Carly, Northern Region Health Services Director  
- Guillory, Ledra, Senior Director Provider Relations  
- Hoover, Peggy, RN, Senior Director, Health Services  
- Kerlin, Mary, Senior Director of Provider Relations  
- Krohn, Robin, Care Coordination Team Manager  
- Kubota, Marshall, MD, Regional Medical Director  
- Leung, Stan, Pharmacy Services Director  
- Moore, Robert, MD, Chief Medical Officer  
- Russell, Joan, Senior Manager of Provider Education  
- Santos, Rose, Manager, Quality and Patient Safety  
- Sciri, Lynn, Regional Director  
- Stamps, Sara, QI Project Coordinator  
- Stevenson, Lauri, Manager of Clinical Quality and Patient Safety  
- Thacher, Jessica, MPH, Director, QI/PI  
- Villanueva, Angelica, Quality Manager, Health Services  
- Vovakes, Michael, MD, Northern Region Medical Director

### Members Absent:
- Bjork, Sonja, JD, Chief Operating Officer  
- Campbell, Betsy, MPH, Senior Health Educator  
- Chancellor, Jennifer, Regional Manager  
- Frederickson, Paula, Senior Claims Director  
- Garcia-Hernandez, Margarita, Manager of Health Analytics  
- Gibboney, Elizabeth, MA, Chief Executive Officer  
- McAllister, Debra, RN, Director of Utilization Management  
- Netherda, Mark, MD, Regional Medical Director  
- Ribordy, Jeff, MD, Regional Medical Director  
- Rosel, Melissa, Team Manager, Utilization Management  
- Siblisky, Susanna, Northern Region Health Educator  
- Smith, Lyle, Director of Operations Excellence and PMO  
- Steffen, Nancy, Northern Region Associate Director of QI, Analytics, PMO  
- Turnipseed, Amy, Senior Director of External and Regulatory Affairs

### Guests:
- Carter, Danielle, Quality Improvement Project Manager  
- Cabrera, Maria, Member Services Lead Representative  
- Garcia, Rebecca, Provider Relations Representative

### Agenda

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<tr>
<td>I. Call to Order Approval of Minutes</td>
<td>Dr. Moore called the meeting to order at 7:35 a.m. Minutes from the 5/9/2017 IQI meeting were reviewed. Minutes from the 5/17/2017 Q/UAC meeting were reviewed and accepted by the committee</td>
<td>Motion: Dr. Quon Second: Dr. Pirruccello Approved without changes</td>
<td>6/21/2017</td>
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<tr>
<td>II. Standing Agenda Items</td>
<td>There were no action items discussed.</td>
<td></td>
<td>6/21/2017</td>
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<tr>
<td>1. Status of Open Action Items</td>
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<td>6/21/2017</td>
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| 2. QI Department Update | Rachael French  
- Pay for Performance, Quality Incentive Programs – The Hospital and Primary Care incentive programs are winding down for the 2016-2017 fiscal year. In the next coming months, the QI department | | 6/21/2017 |  |
will focus on wrapping up the current year along with launching the next year.
  
  - **Primary Care QIP**—July 1st will mark the first half year of the program as we transition the project from a fiscal year to a calendar year to align with HEDIS.
  - **PHC** is actively exploring a number of changes to the PCP/QIP program. Potential changes include, payment methodology, relative improvement targets and changes to the measurement set.

- **QI Trainings**—QI hosted an ABC’s of QI in Yreka in May, a second will be held in Ukiah July 25th.
- **Hospital Quality Symposium** planned for August 8th in American Canyon and August 10th in Redding.
- **HEDIS Score Improvement**—the organization is currently working on a 5-year strategic plan to improve HEDIS outcomes.
- **Project Homeless Connect**—recently took place in Shasta County and had multiple departments, including QI attend. 406 Adults experiencing or at-risk for homelessness attended and were connected to a variety of resources. PHC was able to make contact with 254 confirmed members to update their contact information and discuss connection to primary care. In response to a member incentive offer, members completed 20 key preventative care offerings while at the event, such as; cervical cancer screening and HbA1c testing. 25 members requested help coordinating their preventative screening after the event. The turnout was a great success.

- **HEDIS Project Update**—PHC has wrapped up the medical record project, the rates were locked in on June 15th—we have passed the medical record review audit, which is a very extensive review at the end of the HEDIS, which is where they validate the data which we collected from the medical record charts. Preliminary Plan-Wide performance has shown improvement in each region, which is exciting. Looking at improvement work relative to our HEDIS this year to try and drive immediate improvement since there is only about 6 months left, measures currently under the MPL are; 1) Annual Monitoring for Patients on Persistent Medications (MPM) for ACE/ARBs and Diuretics; Southwest and Northeast are below in both ACE/ARBs and Diuretics and Northwest Region is below in ACE/ARBs. 2) Childhood Immunizations Combo 3 in our Northeast and Northwest regions. We know this continues to be an area of opportunity. Southwest and Northwest fell below the MPL in 2) Comprehensive Diabetes Care indicator-Attention for Nephropathy. the target increased from 77.95% to 88.32% for the minimum performance level. First year reporting measures, 3) Asthma Medication Ratio fell below the MPL in our Northeast and Northwest regions. 4) Breast Cancer Screening in our Southwest, Southeast and Northeast Regions. Year one we are not held accountable for but year two we will be, which is why it is a focus to improve these rates.

We are also watching Immunizations for adolescents since they added the new HPV vaccine. There is very low performance in that area, however
3. HealthPlan Update

Robert Moore, MD gave the HealthPlan update

- **340B** – The DHCS/ Governors Trailer Bill to eliminate 340 B in contract pharmacies was defeated, it was one of only two of the trailer bills that were defeated. This means the old program still exists, which is our 340B Compliance program. We have several entities still using that program which brings in millions of dollars into our primary care providers and hospitals.

- **New Transportation benefit** – is scheduled to go live July 1st. This has been very challenging to prepare for because the state has been changing the guidelines, rules and regulations almost daily this last month. Communication will be sent out to the whole network once everything is finalized.

- **San Mateo** – QIP program, there has been a lack of transparency and clarity. In 2014 an auditor disallowed certain measures in their pay for performance program at San Mateo Health Center, in an appeal a DHCS judge over ruled and said they were all fine in the first place, a second appeal said they were not fine, not a single measure was valid. Then in a phone call with no supporting documentation but with people at DHCS and local people at the state of California, they too laid out another interpretation of what is allowed. The push for PHC is to memorialize the conversation and figure out if that is what was said so there is some backing and room to stand on 4 years from now when they go back an audit people. The 4th interpretation is for a measure to be valid there needs to be a threshold that is achieved or some improvement that has been achieved. Our goal is to eventually get their ruling in writing. Internally we are looking at all our measures to see if any measures need to be changed to meet this verbal conversation pending written policy. The earliest this could be done is in August. We have a QIP advisory committee; we will be presenting the changes to that committee. When we will be making changes, we will try not to make changes to the measurement set but instead changes to the specifications so they come in line with something that will meet the threshold or improvement standard.

- **Perinatal Quality Improvement Pilot** – This is running into problems due to the 4th definition in the San Mateo ruling. The pilot measures that were being considered unfortunately do not meet the standards outlined in the 4th definition. We are working hard to tweak those measures so there is a threshold to be achieved, which is proving to be challenging.

- **Palliative Care Expanded Pilot** – Agreements are starting to go out and contracts are starting to be evaluated. Looks like the first additional sites, beyond the three that are currently doing services will have a start date of August 1st or later so they will be gradually coming in over the next few months. We have good coverage; so far, we have Shasta, Humboldt, Mendocino, Lake, Napa, Solano and Yolo counties. The resolution care model which allows tele-palliative care will provide some level of
coverage for Del Norte, Trinity Siskiyou and Modoc counties. We are hopeful to get pending agreements from Marin and Sonoma, which would just leave Lassen as the only county uncovered which is not bad when you think about how diverse our regions are.

- **Budget** – The budget just came out last week. The three things highlighted are:
  
  - The state did prove adding back adult dental coverage in 2018 and adult vision in 2020, assuming they find funding. They did not commit to the funding, they just committed to adding it back in. This is exciting, right now we are paying out of our reserves for vision, once the state reinstates that they will start reimbursing us.
  
  - As of July 2018, it is a requirement that Medi-cal offers a Diabetes Prevention Program Benefit. This benefit must be certified and meet the specifications put out by the CDC. There will be a bit of a scramble getting that complete. It will be a little reminiscent to other brand new benefits like palliative care where there are a few people doing it but now it will be a Medi-cal benefit so 14 million suddenly covered people will be doing it. Not everyone will jump into this benefit but there will be a huge upswing.
  
  - **Medically Tailored Meals** – This benefit will only be in certain counties. In our region, Sonoma County is the only county so far piloting this program with two organizations in Sonoma County that are in the bill to do this pilot. These are medically tailored meals for individuals with certain chronic diseases. One study showed that this could potentially save money. They are formulating it, as a pilot while studying it, which means Partnership, will be responsible for the analytics since it is Medi-cal to see if those medically tailored meals do actually resolve decreased medical utilization. The groups that have already been doing this for individuals with HIV, this is an extension of that program for other chronic diseases. It includes renal disease, heart failure and other diseases. Starts in January 2018.

### III. Old Business

There was no old business discussed.

### IV. New Business (Committee Members as Applicable)

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<tr>
<th>Consent Calendar</th>
<th>Utilization Management / Care Coordination</th>
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<tr>
<td>MCU3008 – Bathroom Equipment Guidelines</td>
<td>MCU3011 – Criteria for Home Health Services</td>
</tr>
<tr>
<td>MCU3003 – Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services</td>
<td>(previously: Acute Inpatient or Long Term Care Rehabilitation Institution Services)</td>
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Motion: Dr. Gwiazdowski  
Second: Dr. Montenegro  
Approved without changes  

6/21/2017
## Provider Relations
- MP CR 4B – Identification of HIV/AIDS Specialists
- MP CR 6 – Non-Physician Medical Practitioner Credentialing Criteria
- MP CR 8 – Non-Physician Medical Practitioner Re-credentialing Criteria
- MP CR 9 – Fair Hearing Process for Adverse Decisions
- MP CR 11 – Delegation of Credentialing and RE-credentialing Activities
- MP CR 17 – Standards for Contracted Primary Care Providers
- MP PR 200 – PHC Provider Contracts
- MP PR 201 – PCP Availability and Capacity Policy and Procedure
- MP PR 201A – Network Availability Standards Policy and Procedure
- MP PR 202 – Monitoring of PHC Specialist Physician Network Availability Policy and Procedure
- MP PR 202A – Network Availability Standards Policy and Procedure
- MP PR 203 – Provider Enrollment Status Guidelines
- MP PR 205 – Monitoring of PCP Accessibility of Services Policy and Procedure
- MP PR 207 – PHC Annual Physician Satisfaction Survey
- MP PR-GR 210 – Provider Grievance

## Quality
- MPQP1003 – Physician Advisory Committee

## Archived
- MCUP3122 – Palliative Care
- CGA 001 – Evaluating and Reporting Data on Complaints and Appeals
- CGA 002 – Member Grievance Review Committee
- CGA 003 – Medi-Cal Member Grievance System
- CGA 014 – Clinical vs. Non-Clinical Grievances
- CGA 021 – Aid Paid Pending Process

### V. Discussion Policies

1. **MPQP1016**
   Rose Santos presented on MPQP1016 - Potential Quality Issue Investigation and Resolution.
   In addition to formatting the following changes were made:
   1. Addressing Medical Board of California requirement
   2. Inserting a time frame of 120 days allotted for process cases
   3. Added reference to the following related policy; MPCR9A- Reporting to the Medical Board of California which addresses the filing for an 805 report.
   4. Added reference to the following related policy; CMP30 Record Retention Process
   5. Adjusted verbiage on Page 89 in 7A
   **Action:** Changes above will be made. Committee approved with changes
   **Motion:** Dr. Gwiazdowski
   **Second:** Dr. Quon
   **Approved with changes**
   **6/21/2017**

2. **MPCD2013**
   Rebecca Boyd- Anderson presented on MPCD2013 - Care Coordination Program Description.
   Revised the program description to address current day to day operations of the care coordination activities and aligned with DHCS contractual requirements. Revised
   **Motion:** Dr. Quon
   **Second:** Dr. Gwiazdowski
   **Approved without changes**
   **6/21/2017**
Episodic Case Management to be called Adult Basic Case Management. The maternal child description, the perinatal activities (GTTP) are called out and we are currently working on building out the pediatric program.

3. **MPUP3126**  
Rebecca Boyd-Anderson presented on MPUP3126 - Autism Spectrum Disorder.

This policy was updated to reflect the requirements of, APL15-025. The changes state that not only every autism BHT service requires a care plan but they also require an exit plan and a crisis management strategy.

Motion: Dr. Gwiazdowski  
Second: Dr. Quon  
Approved without changes  
6/21/2017

4. **MCUP3137**  
Dr. Moore presented on MCUP3137 - Palliative Care: Intensive program.

In preparation for the palliative care expanded pilot, we created a new policy. was created to memorialize how the system will work. There are several attachments in the policy, including an application. The eligibility criteria are similar to what the state has put forth in their earlier drafts, a key part is, it has to be adults with a life expectancy of 12 months or less. The diagnoses are limited to the 4 diagnoses the state has outlined; COPD, Advanced Caner, Liver Disease and CHF. A TAR process is required, although no referral is required. The reason for the TAR process is, before a complete evaluation, it is hard to know if a patient is going to qualify or not, therefore a process for patient engagement, which is intensive assessment of the patient has been set up. Over a 7 Day span, the patient is assessed to determine whether they qualify or not. If they do not qualify, they can be stabilized, do an advanced care plan, do the PULSE and have good conversations with them. If they do qualify, they would then be placed into the intensive program. The intensive program is covered in 14-day blocks, there needs to be at least one visit in that 14 days either tele-medicine or face-to-face. Comprehensive wrap around care is offered as well; 24/7 call support and a variety of other things. TARS will be completed 3 months at a time to ensure the patient still qualifies.

**Action**, Attachment A, add member CIN number. Change III, C, 1, to state “if a patient is diagnosed with stage 3 or 4 cancer”.

Motion: Dr. Quon  
Second: Dr. Gwiazdowski  
Approved with changes  
6/21/2017

5. **MPXG5003**  
Major Depression in Adults Clinical Practice Guidelines – PULLED - Deferred  
**Action** – Add MBA to Dr. Moore’s credentials

PULLED  
6/21/2017

6. **CGA024**  
Dina Cuellar presented on CGA024 - Medi-Cal Member Grievance System.

Several policies have been archived to wrap everything into this one global policy. This will be the overall plan policy as it relates to the members grievances which includes complaints and appeals.

The complaints time frame changed per the most recent APL from DHCS as well as the Final Rule amendment. Previously PCH had a time frame of 180 days from the incident or actions. The plan is now required to respond within 72 hours of expedited appeals or grievances. PHC needs to make every attempt to respond to the member verbally as well as in writing.

Complaints must be resolved in 30 calendar days. Previously the plan was able to extend if we were waiting on medical records or clarity, we are no longer able to extend on complaints. We can still extend out on an appeal.

Inter-rater Reliability was added per the contract which states we have to have an

Motion: Dr. Pirruccello  
Second: Dr. Quon  
Approved with Changes  
6/21/2017

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appropriate level of oversight of the grievance system, which involves the Chief Medical Officer or designee. This includes the Inter-rater Reliability process within the grievance resolution process.

Appeals time frame for filing was changed from 90 days to 60 days.

**Action:** Section, VI, I, 4, change the word from “with” to “within” 72 hours

### VI. Presentations

#### Managing Pain Safely (MPS)

Danielle Carter presented on Managing Pain Safely. This is an overview of what has been happening over the last year. This project is now in the closeout stage. This project started in 2014, in which time; Partnership HealthPlan knew that the state of California was in a state of crisis with the opioid epidemic.

The ultimate goal was –

- By December 31, 2016, decrease the total number of initial prescriptions by 75% for opioids.
- Be December 31, 2016, decrease the total number of inappropriate prescription escalation by 90%
- Decrease the total number of patients on inappropriate high dose opioids by 75%

The overall project data update shows –

Members on opioids on unsafe dose reached its goal and surpassed it by 4%. The target goal was a 75% decrease, the project ended with a 79% decrease. The average MED’s prescribed by county showed that there has been a drastic decrease in each county. There will be a continued coalition support. The hospitalization feedback pilot support will continue. Also, continued support for the substance use treatment with the roll out of drug Medi-cal.

**Deferred until August**

#### Annual Monitoring for Patients on Persistent Medications Incentive Pilot- Update

Rose Santos presented on the 2016 Potential Quality Issue Annual Report. There were 915 PQI referrals received last year, which is much higher than previous years. In 2016, 2nd quarter we saw a spike in referrals, the reason is, there was a pilot program done by member services, grievance and appeals, with regards to the end of next business day for all PQI’s were generated for that report. We are no longer processing service issues, so the referrals that come to us are reviewed by the CMO and the nurses.

The PQI counts by referral source, the two top sources remain from member services and the complaints grievances and appeals department. The two top referral types are assessments and treatment diagnosis. There were 572 referrals. 151 complaints about access and availability.

**Deferred until August**

### VII. Additional Business

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*Page 8 of 8 for Signature Only*
### Members Present:
- Boyd-Anderson, Rebecca, Director of Care Coordination
- Cotter, James, MD, Associate Medical Director
- French, Rachael, Senior Manager Quality Compliance and Accreditation
- Fronefield, Carly, Northern Region Health Services Director
- Gibboney, Elizabeth, MA, Chief Executive Officer
- Hoover, Peggy, RN, Senior Director, Health Services
- Krohn, Robin, Care Coordination Team Manager
- Kubota, Marshall, MD, Regional Medical Director
- Leung, Stan, PharmD, Pharmacy Services Director

### Members Absent:
- Bjork, Sonja, JD, Chief Operating Officer
- Campbell, Betsy, MPH, Senior Health Educator
- Chancellor, Jennifer, Regional Manager
- Cuellar, Dina, Associate Director, Pharmacy Operations
- Frederickson, Paula, Senior Claims Director
- Garcia-Hernandez, Margarita, Manager of Health Analytics
- Kerlin, Mary, Senior Director of Provider Relations
- McAllister, Debra, RN, Director of Utilization Management

### Guests:
- Funnell, Stacia, Lead Grievance Coordinator
- Hoerber, Ely, Program Manager
- Lasher, Amy, Project Coordinator
- Liu, Jess, Manager of Quality Incentive Programs

### Members Present:
- Moore, Robert, Chief Medical Officer
- Russell, Joan, Senior Manager of Provider Education
- Scari, Lynn, Regional Director
- Stamps, Sara, QI Project Coordinator
- Stevenson, Lauri, Manager of Clinical Quality and Patient Safety
- Thacher, Jessica, MPH, Director, QI/PI
- Vovakes, Michael, MD, Northern Region Medical Director

### Members Absent:
- Netherda, Mark, MD, Regional Medical Director
- Ribordy, Jeff, MD, Regional Medical Director
- Rosel, Melissa, Team Manager, Utilization Management
- Santos, Rose, Manager, Quality and Patient Safety
- Steffen, Nancy, Northern Region Associate Director of QI, Analytics, PMO
- Turnipseed, Amy, Senior Director of External and Regulatory Affairs
- Villanueva, Angelica, Quality Manager, Health Services

### AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS / ACTION | TARGET DATE | DATE RESOLVED
| I. Call to Order Approval of Minutes | Dr. Moore called the meeting to order at 1:35 p.m. Minutes from the 4/11/2017 IQI meeting were reviewed. | Motion: Peggy Hoover Second: Dr. James Cotter Approved without changes | 5/9/2017 | |

### II. Standing Agenda Items

| 1. Status of Open Action Items | MCQP1047 – Advance Directives. Follow up question from April IQI meeting. Based on the language in MCQP1047 stating that PHC will notify members within 90 days if there are changes in state law, regarding advance directives. Does PHC notify members within 90 days if any changes in state law? Dr. Moore responded, MCQP 1047 does not change state law, hence PHC is not required to notify members. | 5/9/2017 | |
Jessica Thacher gave the Quality Improvement program update.

### Quality Improvement Programs
- The 2015-16 Primary Care Provider (PCP) QIP Evaluation is complete.

  Key findings include:
  - The total pay-out for the 2015-2016 QIP was $44.8 million. The median score remained consistent at 65 out of 100 points.
  - Provider engagement with the program remained high.
  - 2015-16 was the first year payment was calculated using two payment pools: Institutional vs. Independent. Practices with no affiliation with large hospitals, medical groups, or federally qualified health centers are considered “independent.” The median points earned among independent providers was 56.3, compared to 70.0 among institutional providers.
  - Across all clinical measures, providers in both regions heavily rely on relative improvement to earn points, especially for challenging measures such as Cervical Cancer Screening.
  - Across hospital utilization measures, the proportion of providers that met the risk-adjusted targets remained above 80%, suggesting room for lowering the targets to drive improvement.
  - For QIP measures that align with HEDIS, the QIP denominators are on average 42% of the HEDIS denominators. Greater overlap between the QIP and HEDIS eligible populations will increase the QIP’s leverage to improve our HEDIS rates.

### Long Term Care
The first year of the program has come to an end. The check payments were issued in April.

- 50 Participating sites
- 6 of the 50 facilities earned 100 points (range was 25-100 points)

### Advanced Access Collaborative
- The final in-person learning session for the Advanced Access Collaborative was held in April in American Canyon. Three of the six clinics participating in the collaborative achieved the “gold standard” in access, which is, “To offer a patient an appointment today for any problem (urgent or routine) or any reason with their PCP or a teammate in the absence of the PCP.”

### HEDIS Improvement Strategic Plan
The overall focus is to improve HEDIS scores through a Population Health Management Strategy. More health plans are participating in a Population Health Management Strategy and NCQA is saying health plans should be doing a Population Health Management Strategy. This strategy includes 3 focus areas which are:

- Primary care provider networks ability to do Population Health Management and the how the health plan can support that.
- PHC direct to member Population Health Management and engagement strategy. How does PHC interact with their members outside of the Primary Care Provider.
- Data and Analytics structure and how these items can support the above mentioned focus areas.

Rachael French gave the HEDIS update.

**HEDIS**
*All findings are contingent upon passing the upcoming audit at the end of the month.*

- Last year, measurement year 2015, PHC had 16 measures that fell below the minimum performance level (MPL), this year, measurement year 2016 we currently have 9 measures projected to fall below the MPL. 5 of those 9 measures remain under the Annual Monitoring for Patients on Persistent Medications (MPM), which we will continue to focus improvement efforts on. The benchmarks for MPM have changed for measurement year 2016, performance to date had the benchmarks remained the same from measurement year 2015, we would be above the MPL. These benchmarks are changing every year so we will continue to work on them to get exceed the MPL.

- Comprehensive Diabetes Care- Monitoring for Nephropathy, is one of two of our hybrid measures projected to fall below the MPL. Typically, this measure does not fall below the MPL; however, the benchmark for this measure has increased by 10% so we did see this measures fall below the MPL in 2 out of our 4 regions. Childhood Immunizations Combo 3 (CIC3) is another hybrid measure that has fallen below the MPL, in our Northeast and Northwest regions.

### III. Old Business

There was no old business discussed.

### IV. New Business (Committee Members as Applicable)

<table>
<thead>
<tr>
<th>Consent Calendar</th>
<th>Utilization Management / Care Coordination</th>
<th>Delegation Reports</th>
<th>MCUP3101 – Chiropractor Services, policy pulled and brought back to committee in June.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>MCUP3041</strong> – TAR Review Process (Changes apply to attachment only; PHC TAR REQUIREMENTS. Attachment starts on page 34)</td>
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<td><strong>MCUP3049</strong> – Pain Management Specialty Services (Changes apply to attachment only; PHC TAR REQUIREMENTS. Attachment starts on page 34)</td>
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<td><strong>MCUP3007</strong> – Authorization of Ambulatory Procedures (Changes apply to attachment only; PHC TAR REQUIREMENTS. Attachment starts on pages 34)</td>
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<td></td>
<td><strong>MCCD2012</strong> – Chronic Kidney Disease</td>
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<td><strong>MCUG3010</strong> – Chiropractor Services</td>
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<td><strong>MCUP3105</strong> – Coordination of Services for Members Requiring Long Term Care</td>
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<td><strong>MCUP3128</strong> – Cardiac Rehabilitation</td>
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<td></td>
<td><strong>MCUP3130</strong> – Osteopathic Manipulation Therapy</td>
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### Provider Relations

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<thead>
<tr>
<th>Provider Relations</th>
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<tbody>
<tr>
<td>MP CR 4B – Identification of HIV/AIDS Specialists</td>
<td>Motion: Peggy Hoover</td>
<td></td>
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<tr>
<td>MP CR 6 – Non-Physician Medical Practitioner</td>
<td>Second: Dr. James Cotter</td>
<td></td>
</tr>
<tr>
<td>MP CR 8 – Non-Physician Medical and Allied Health Practitioner Re-Credentialing</td>
<td>Approved with change</td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td></td>
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<tr>
<td>MP CR 9 – Fair Hearing Process for Adverse Decisions</td>
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<tr>
<td>MP CR 11 – Delegation of Credentialing and Re-credentialing Activities</td>
<td></td>
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<tr>
<td>MP CR 17 - Standards for Contracted Primary Care Providers</td>
<td></td>
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</tr>
</tbody>
</table>

### Motion: Peggy Hoover  Second: Dr. James Cotter  
Approved with change

#### 5/9/2017

1. **MPQP1055**

Jessica Thacher moved this policy to first on the discussion list. Policy MPQP1055 – Provider Preventable Condition (PPC). This policy is coming through committee early to bring in to Final Rule compliance.

- Added related policy 700405 – Treatment of recoveries and overpayment to providers. This policy lays out the mechanism to recoup money for PPC’s. In addition, attachments were updated.
- Potential PPC was updated to reflect if/when an incident or activity occurs or flagged within our encounter data, it gets reported to PHC or that PHC flags the incident in our own internal review. The overall final rule requirement is that we have a process in place to monitor our encounter data and flag potential PPC’s that are not necessarily reported to us. Under attachments, we removed attachment A which was a form which could be faxed to PHC then to DHCS to report a PPC which is going away, an online portal is now in place for reporting PPC’s.
- Attachment B was updated to just include ICD10 codes the plan uses to screen PPC’s, ICD9 codes were removed since they are no longer being used.
- Clarified the provider requirement; Providers are required to report directly to DHCS (audit and investigation unit) and notify Partnership HealthPlan in the PQI inbox of a PPC and processed and is a Potential Quality Issue.
- Provider reporting and PHC screening are the two ways we screen for PPC. Claims department worked closely with the data warehouse team to create a monthly report to screen for PPC’s. The report is then forwarded to the Quality Department monthly to review and flag for investigation of PPC. Clarified the role of payment recoupment that this lies in the Finance department along with record retention, which lied in the claims department previously. Quality will continue to hold on to records associated with a Potential Quality Issue.

Motion: Dr. James Cotter  Second: Peggy Hoover  
Approved without changes

#### 5/9/2017

2. **MPCD2013**

Rebecca Boyd Anderson presented on policy MPCD2013 - Care Coordination Program Description. The attached Care Coordination Program Description has been completely redrafted to address final rule requirements and also represent the ways Care Coordination has been reorganized to deliver care. The program has been divided between adult and maternal child. Within adult, subcategories of case management are; 1) Basic Case Management and 2) Complex Case Management. Under Complex Case Management, this includes the Intensive Outpatient Case Management Program and Chronic Kidney Disease Program, Care Transitions and Community Based Adult Services. Within Perinatal and Pediatric Case Management are 1) Growing Together Perinatal Program 2) Pediatric Based Case Management 3) California Children Services 4) Early intervention for developmentally delay and 5) Behavioral Health. Roles and responsibilities were further outlined under the quality monitoring oversight and responsibilities section of the program description. Once

The committee made mention of grammatical errors and approved the policy with the understanding a re-review will be complete to ensure grammatical errors are fixed.
the new case management system, Essette goes live, Care Coordination is anticipating additional revisions to the program description and will bring back through committee as necessary.

<table>
<thead>
<tr>
<th>3. MCUP3126</th>
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<tbody>
<tr>
<td>Peggy Hoover presented on policy MCUP3126 – Fecal Microbiota Transplant. PHC now covers Fecal Microbiota Transplant. A new policy has been created that addresses the need for Fecal Microbiota Transplant for adults &gt;18 years of age with Chronic Clostridium Difficile Infection (CDI).</td>
</tr>
</tbody>
</table>

Motion: Liz Gibboney
Second: Dr. Marshall Kubota
Approved with changes

<table>
<thead>
<tr>
<th>Hospital Quality Improvement Program</th>
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<tbody>
<tr>
<td>Amy Lasher presented on the Hospital Quality Improvement Program. This was a high-level overview of the approved Hospital Quality Improvement Program measurement set for the 2017 – 2018 Measurement year.</td>
</tr>
</tbody>
</table>

Changes to the 16/17 measurement set, 5 measures were removed.
- Advanced Care Planning (ACP) due to high performance in this measure. Introducing Palliative Care measure.
- Vaginal Birth after Cesarean (VBAC), due to the extensive feedback from the hospitals we learned this is a complicated, expensive and risky option for our providers, especially with our smaller hospitals.
- VTE-5 - Venous Thromboembolism (VTE) Warfarin Therapy Discharge Instructions was removed due to being aligned with the joint commission, which has phased out this measure to align with CMS.
- STK-4 – Thrombolytic Therapy was removed due to being aligned with the joint commission, which has phased out this measure to align with CMS.
- Electronic Treatment Authorization Requests (E-TARS) due to topped out performance at 95.9% timely in reporting the E-TARS since 2015-2016.

Slight change to existing Health information exchange requirement; added for existing participants we will require lab result and medication data exchange in addition to admission data exchange.

The new measures being introduced are:
- C-Section rate for First time Mothers.
- Palliative Care Capacity.
- California Hospital Patient Safety Organization (CHPSO) Participation
- Quality Improvement Training Option

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<tr>
<th>Hospital Quality Improvement Program Evaluation</th>
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<tr>
<td>Amy Lasher presented on the Hospital Quality Improvement Program Evaluation for the 2015-2016 Measurement year.</td>
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</table>

10 participating hospitals and $12.6 million within the fiscal year was distributed.

10 measures covering the following domains within the measurement year were:
- Readmissions
- Advanced Care Planning
- Maternal and Perinatal Health
- Patient Safety
- Operations and Efficiency

Motion: Dr. James Cotter
Second: Dr. Marshall Kubota
Approved without changes

5/9/2017
The purpose of the hospital QIP is to help improve the health outcomes of our PHC members served by our contracted hospitals and to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts.

In 5 of the measures, a moderate upwards trend shows improvement over the last 3 years.

The 3 District hospitals when compared to the 7 System Hospitals performed lower within the QIP scoring.

Within this measurement set, all hospitals were reporting on the same measurement set, even hospitals with fewer than 50 beds.

The average QIP score for large hospitals was 93%; the average QIP score for small hospitals was 61%.

Overall, there was improvement in 6 of the 8 existing measures. PHC is viewed as a partner in Quality Improvement within the participating hospitals; the Hospital QIP is being used as a driving tool to promote quality improvement.

V. Additional Business

Respectfully submitted by Sara Stamps, Quality Improvement Project Coordinator

Signature of Approval: ___________________________ Date: ___________________________

Robert Moore, MD, MPH, Chairman
Quality Improvement Programs (QIPs)

- A wrap-up webinar will be hosted on June 13 to share important information on program deadlines to help providers maximize their point earnings in the Primary Care Provider Quality Improvement Program (PCP QIP). The team will also share highlights of the 2015-16 PCP QIP Evaluation.
- We are conducting User Acceptance Testing (UAT) for Module 1 of the Partnership Quality Dashboard (PQD), which will provide PCPs with real-time, interactive data on their PCP QIP Non-Clinical Measure performance. Select PCPs will begin pilot testing the new system in July.
- UAT for the 2017 eReports system will begin in July. Work is also underway with PHC’s IT department to complete the 2018 eReports Business Requirements Document (BRD). The 2018 development effort will contain enhancements based on user feedback and major specification changes that of updates to correlating HEDIS measures and changes to the PCP QIP measurement set.
- The 2016 Long Term Care (LTC) QIP payments were mailed April 30. An evaluation was completed based on the year-end performance data. Some highlights include: high level of participation (50 out of 60 outreached sites) in the program; over 70% of participating facilities submitted data for the pay-for-reporting measures; 50% - 80% of facilities earned points for each of the measures.

QI Trainings

- An ABCs of Quality Improvement event was hosted in Yreka in May; there will be a second session in Ukiah on July 25.
- ADVANCE Cohort 3 participants will meet in-person for the first time on June 8 and 9 in American Canyon. Curriculum delivery during the two-day meeting will include “Leading Effective Meetings” and “Testing Change Ideas/PDSAs.”
- Marketing for the 2017 Hospital Quality Symposium is underway. Our first event will take place on August 8 in American Canyon, and a second event will take place August 10 in Redding.
- The Health Alliance of Northern California (HANC) invited all PHC PCPs in the Northern Region to join the Shasta County Primary Care Practice Transformation Summit on May 23. This summit offered providers an opportunity to learn and develop action plans for meeting their improvement goals.

Improvement Initiatives

**Offering & Honoring Choices**

- Palliative Care Expanded Pilot: Application packets were sent to a select group of palliative care providers. Approximately 10-15 providers will be selected to join our palliative care provider network. The expanded palliative care pilot is on track to begin July 1.
- Palliative Care Quality Improvement Program (QIP): To align the structure of the palliative care program with the hospital savings that were expected to underwrite it, the initial palliative care pilot program included an attached value-based incentive program. This same quality-based financial model is being scaled for the expanded palliative care pilot and has been named the Palliative Care Quality Improvement Program (QIP). The QIP includes the same measures used in PHC’s first pilot:
  - Avoiding hospitalization and emergency room visits: $200 per patient enrolled in the palliative care program per month, only if there are no hospital admissions or ED visits that month.
  - Use of Palliative Care Quality Monitoring Tool: $200 per month for active use.
• Advance Care Planning (ACP) for PHC staff: In May, PHC hosted National HealthCare Decisions Week to internally promote advance care planning and completion of an advance directive among staff.

**HEDIS Score Improvement**

• Multiple PHC departments, including QI, recently attended Project Homeless Connect in Shasta County. 406 adults experiencing or at risk for homelessness attended and were connected to a variety of resources. PHC was able to connect with 254 confirmed members to update contact information and discuss connections to primary care. In response to a member incentive offering, members completed 20 key preventive screenings while at the event, such as cervical cancer screening and HbA1c testing, and 25 members requested help coordinating preventive screenings after the event.

• Cervical Cancer Screening: The final cycle 3 summary for the DHCS mandated PDSA (Plan-Do-Study-Act) was submitted on May 8 and accepted by DHCS. The remarkable 10% improvement reported was largely due to the aggressive and repeated member outreach conducted by Shingletown Medical Clinic’s dedicated staff, and the CMO driven sneak-a-PAP methodology. Further spread of best practices within the Northern Region will occur via Provider Education visits and consortia led QI Peer Network interactions.

• Diabetic Retinopathy Screening: Two new clinics have been allocated retinal cameras, Mountain Valleys Health Center and Fairchild Medical Center. The four clinics moving into the second year of the DRS program are working to each complete a Memorandum of Understanding (MOU) with PHC.

**Healthcare Effectiveness Data Information Set (HEDIS)**

• On May 15, we completed the medical record collection and abstraction portion of the HEDIS audit.

• We passed the medical record review validation audit with zero findings. This purpose of the audit is to ensure accuracy in PHC’s medical record abstraction process. This is the most successful audit PHC has undergone since NCQA implemented the new requirement a few years ago.

• Final HEDIS rates will be submitted to DHCS and NCQA in early June.

• Preliminary data show improvements in plan-wide performance relative to last year. A complete summary of performance will be available in August.

**Quality Compliance and Accreditation**

• Work continues on the NCQA Accreditation project plan and the identification of business owners at the element and factor level for each NCQA requirement. In addition, planned start and end dates along with current status is being captured.

• An executive-level NCQA Accreditation Steering Committee held its first meeting in May.

**Patient Safety**

• For the period April 25 through May 23, PHC conducted 11 Facility Site Reviews (10 Southern Region and 1 Northern Region), 13 Medical Record Reviews (12 Southern Region and 1 Northern Region), and 2 Physical Accessibility Review Surveys (Southern Region). There were 4 Corrective Action Plans (CAPS) issued (3 Southern and 1 Northern).

• For the same time period, there were 33 Potential Quality Issue (PQI) referrals received (16 Southern Region and 17 Northern Region) and 13 cases closed (5 Southern Region and 8 Northern Region).

• One RN new to the Fairfield QI department received Certification as a DHCS Site Reviewer.

• The Patient Safety team continues conducting User Acceptance Testing for the eSiteReview tool and is in the midst of shifting its focus to the validation of the tool’s reporting function.
<table>
<thead>
<tr>
<th>Policy/Procedures/Guidelines</th>
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<th>New Assigned Number</th>
<th>Comments</th>
<th>Provider Manual</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Services – Utilization Management</strong></td>
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<tr>
<td>Bathroom Equipment Guidelines</td>
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<td>MCUG3008</td>
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<td>Criteria for Home Health Services</td>
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<td>Regular review; no changes to policy content</td>
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<tr>
<td>Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services (Previously - Acute Inpatient or Long Term Care Rehabilitation Institution Services)</td>
<td></td>
<td>MCUP3003</td>
<td>Regular review; minor language clarifications made</td>
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<td>Chiropractor Services</td>
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<td>MCUG3010</td>
<td>Regular review; language edited to reflect current process; potential number of visits authorized per year increased from 12 to 24</td>
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<td>Hospice Services Guidelines</td>
<td></td>
<td>MCUP3020</td>
<td>Regular review; definition of terminal illness extended; criteria for admission to hospice program for patient with limited life expectancy of 6 months (vs. 1 year)</td>
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<td>Autism Spectrum Disorder</td>
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<td>MPUP3126</td>
<td>Regular review; policy updated per contractual obligations / DHCS’ latest All Plan Letter regarding this benefit; references updated to reflect same</td>
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<td>Palliative Care: Intensive Program</td>
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<td>MCUP3137</td>
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<td>PCP Availability and Capacity Policy and Procedure</td>
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<td>CGA 024</td>
<td>Policy revised to incorporate several policies (archived) into one global document</td>
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**Health Services Care Coordination**

| Care Coordination Program Description                    | MPCD2013   | Regular review; Description updated to reflect current practices, programs, and staff; sections added for Protected Health Information, Statement of Confidentiality, Non-Discrimination Statement, Provider & Member Satisfaction, and Annual Program Evaluation | X               |

**Health Services – Quality**

| Potential Quality Issue Investigation and Resolution     | MPQP1016   | Regular review; policy revised for clarification, and to reflect current standards, processes, and State requirements | X               |
I. RELATED POLICIES:
A. MPCR #9 Fair Hearing Process for Adverse Decisions
B. MPQP1053 - Peer Review Committee Policy
C. MP CR #9A - Reporting to the Medical Board of California and the National Practitioner Data Bank
D. CMP 30 – Offsite Storage and Record Retention

II. IMPACTED DEPTS:
A. All Departments

III. DEFINITIONS:
A. A Potential Quality Issue (PQI) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
B. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
C. A clinician or provider is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.
D. A Corrective Action Plan (CAP) is a plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and time frames for completion.
E. Severity Level: Refer to Attachment B: Practitioner Performance and Systems Scores Case Leveling Grid
F. Egregious: Where the quality of care was significantly outside accepted and common standards of practice and/or where the adverse outcome of the care provided was especially serious.

IV. ATTACHMENTS:
A. PQI Referral Form and Reference Table
B. Practitioner Performance and Systems Scores Case Leveling Grid

V. PURPOSE:
To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue
(PQI), to determine opportunities for improvement in the provision of care and services to Partnership HealthPlan of California (PHC) members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

VI. POLICY / PROCEDURE:
A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES
1. PQIs are identified through the systematic review of a variety of data sources, including but not limited to:
   a. information gathered through concurrent, prospective, and retrospective utilization review;
   b. referrals from any health plan staff or clinicians;
   c. facility site reviews;
   d. claims and encounter data;
   e. pharmacy utilization data;
   f. HEDIS® medical record abstraction process;
   g. medical records audits;
   h. phone log detail; or Complaints/Grievances and Appeals grievances
2. TPQI reviews can be shall be conducted on services provided by:
   a. contracted clinicians or providers, who provide inpatient and outpatient services; and complaints involving pharmacists;
   b. non-contracted clinicians and providers: cases complaints involving non-contracted providers will be discussed with the Chief Medical Officer (CMO)/designee to determine next steps prior to embarking on a review of the PQI ordering medical records;
   c. durable medical equipment (DME) and medical supply providers; transportation and respiratory supply vendors;
   d. pharmacy providers; home health vendors; skilled nursing facilities; long term care and rehabilitation facilities; ancillary service providers including but not limited to laboratory and pharmacy, radiology; and Emergency Medical Services;
   e. Division providers: complaints are tracked to their resolution by the Complaints, Grievances and Appeals (CGA) Department. CGA refers vision complaints to the Peer Review Lead (PRL) to monitor and trend.
   f. Complaints regarding Vision Service Plan (VSP) are referred to the complaints and appeals division of VSP. VSP is not delegated for grievances however VSP contacts the provider of complaint, researches the issue and provide a summary to the PICS Nurse.
   g. Behavioral health: member complaints regarding behavioral health are referred to the Behavioral Health staff in the Health Services Department for tracking, intervention, and resolution.

B. PQI REFERRAL
1. A PQIs may be reported by any of the following:
   a. any PHC staff member;
   b. anonymously using the PHC "confidential line" which is available 24 hours a day, 7 days a week (1-800-601-2146);
   c. any member of the community or ;
   d. any contracted or non-contracted clinician or provider.
2. A PQI is referred reported to the PRL—Quality Department via the PQI@partnershipphp.org inbox using the PQI Referral Form (RF). See Attachment A.
   a. The following information, at a minimum, should be documented and promptly forwarded to the via the PQI inbox: PRL with a cc to the QI Administrative Assistant (QI AA).
      1) the member's name, date of birth, gender, PHC member number, and or Client Identifying Number (CIN);
3. Time frame limitations: In general, PHC will not routinely investigate a PQI which occurred more than 2 years prior to the first notification of the complaint to the QI department, of the issue. Cases that may have a potential serious matter may be reviewed on an ad-hoc basis upon the discretion of the CMO/designee. If a PQI is identified that occurred more than 2 years prior to the first notification, no investigation will be routinely started. The PQI form will be reviewed by the CMO or designee. If the CMO or designee believes a serious quality issue may have occurred and that the case warrants investigating, the CMO or designee may request the PICS Nurse to start an investigation or refer it to PHC’s Per Review Committee (PRC) or to another peer review body or regulatory agency, depending on the findings in the case.

C. PQI REVIEW PROCESS-
During case review, professionally recognized standards of care will be used to assess the care provided. A PQI may be a single event or occurrence. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening of a case previously reviewed or closed.

1. PRIMARY REVIEW BY PERFORMANCE IMPROVEMENT CLINICAL SPECIALIST (PICS) RN – Upon receipt of a PQI referral, the QI Project Coordinator opens a new case file in the PQI database, and assigns the case to a PICS RN to conduct the primary review and manage case to completion.
   a. If the issue is urgent or the potential severity may represent an egregious lapse in the quality of care, the PICS RN will immediately contact the CMO/designee for resolution and next steps. The CMO/designee may refer to outside Peer Review Organization (PRO) depending on the case.
   b. If the PQI occurred at an organization with an accredited PRO responsible for oversight of the care provided by the Clinician or Providers of Concern (POC), the POI is found to be urgent, and the potential severity of the POI has been determined by the CMO/designee to not reflect an egregious lapse in quality, the POI will be referred to PRO. A response will be required from the PRO acknowledging they have received the letter of concern. When a referral is sent to the outside PRO, a copy will be sent to the Chief of Quality and Quality Director at the outside organization and the POC will be notified of the PRO referral. If the severity score is not determined prior to the referral, the case will be leveled as: Provider Unable to Determine (PUTD).
   c. If the PICS RN initial review determines that there are no clinician or provider or system issues, the case is leveled as P0 or S0 and the PQI is closed in the database. See Attachment B for the Practitioner Performance and Systems scores.
   d. If the PICS RN determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other involved departments for action and follow-up.
   e. If the PICS RN determines that the PQI may be beyond a P0/S0, the case is forwarded to the CMO/designee for secondary review.
2. SECONDARY REVIEW BY CMO/DESIGNEE – The CMO/designee review includes assessment of, but not limited to: appropriate level of care; appropriate tests; therapy and treatment; technical expertise; referral; consultation; timeliness; and adequate documentation. During the CMO/designee review, the CMO/designee may:
   a. Assign a severity level of P0/S0 and instruct the PICS RN to close case (see attachment B for the Practitioner Performance and Systems Scores).
   b. Assign a potential severity of P1/S1 or P2/S2 and send a letter to the provider of concern with a response required. If the provider’s response satisfies the secondary reviewer’s concerns, the CMO/designee may instruct the PICS RN to close the case or prepare the case for presentation to the Peer Review Committee (PRC), depending on the significance of the findings.
   c. Generate a letter to the provider of concern describing the issue and request investigational response and may also request additional documentation including related to system issues. If no response within the requested timeline, a rate severity is given based upon available documentation.
   d. Upon determination that a PQI case requires a second opinion review by a specialty physician or by a subject matter expert, a request for investigational review and response will be sent.
   e. Emergency action: If the CMO/designee determines that a situation exists where immediate action is required to protect the life of well-being of a PHC member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, or safety of any patient or person, the CMO may summarily suspend or terminate the POC’s credentialed status. See policy MP CR #9 “Fair Hearing Process for Adverse Decisions.”

4. TERTIARY REVIEW BY THE PEER REVIEW COMMITTEE (PRC) – Upon determination by the CMO/designee that a PQI case requires review by the PRC, the Project Coordinator and PICS RN prepare the PQI case file for Peer Review. See MPQP1053 for the Peer Review Committee policy.

A-3. PQI REVIEW TERTIARY
1. All cases designated a severity level S3 or P3 must be referred by the CMO/designee to the PRC for review and determination of next steps.
2. PRC recommendations for cases determined to be S3/P3 may be forwarded to the Credentialing Committee for possible action.
3. For In cases where the PRC recommends that the Credentialing Committee requests a Corrective Action Plan (CAP) for an S3/P3 problem:
   a. A notice shall be given to the POC within 7 calendar days of the recommendation of a CAP being required. Grounds for recommending a CAP include but are not limited to:
      1) failure to provide professional services of acceptable quality;
      2) failure to follow PHC utilization review policies;
      3) failure to follow PHC quality improvement policies;
      4) failure to treat patients for whom the provider is responsible;
      5) failure to adhere to the provider contract or PHC policies;
      6) acts constituting disruptive behavior or an inability to work collaboratively with others;
      7) failure to report adverse action by another peer review body or a hospital.
   b. If a CAP is recommended, it is included in the PQI case file. A CAP includes the goals, objectives, desired outcomes, time frames, persons responsible, follow-up, and CAP evaluation. The time frame for clinicians to respond to a CAP is 30 calendar days. The POC will be sent a reminder notice on day 15. If the CAP is not received by PHC by day 31, the PRL-PICS RN will contact the POC. A 15 day extension may be granted for reasonable concerns. If the CAP has not been received by day 46, the case is forwarded to the CMO for further determination, including possible review by the Credentialing Committee. Upon completion, the CAP will be reviewed and the results reported to the PRC.
c. The CAP may include but is not limited to:
   1) required attendance at continuing education programs applicable to the issue identified and approved by PHC;
   2) required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification;
   3) continuing concurrent trend analysis of the adverse quality issues identified in the clinician's practice patterns;
   4) monitoring of POC’s medical record documentation by physicians selected by the PRC for a prescribed length of time; and
   5) in-service training for clinicians and/or their staff.

4. The PRC may also recommend that the Credentialing Committee review the POC’s status, including but not limited to the following:
   a. clinician or provider contract changes, including modification, restriction, or termination of participation privileges with PHC;
   b. summary suspension: immediate suspension from credentialed status based on the need to take immediate action to protect the life or well-being and or reduce the possibility of substantial or imminent threat to the life, health, or safety of any PHC member or other person;
   c. recommendation of counseling for behavior modification;
   d. focused review of the provider’s cases including but not limited to:
      1) second opinion for invasive procedures;
      2) retrospective or prospective medical claims reviews;
   e. preceptorship with a physician of the same specialty;
   f. institute a monitoring process through proctoring by another qualified, specialty-matched physician; or
   g. recommendation to the Credentialing Committee for suspension, restriction, or termination of the clinician’s PHC credentials.

5. In the following situations, in addition to the other measures applicable to S3/P3 cases, immediate referral will be made to the CMO for consideration of the need for immediate follow-up and potential rapid escalation to the Credentials Committee, Board of Commissioners, Medical Board of California, and other regulatory and/or law enforcement agencies, depending the severity of the concern:
   a. actions or omissions constituting unethical or unprofessional conduct;
   b. sexual misconduct with a patient;
   c. sexual harassment of a patient and
   d. discriminatory actions or behaviors towards a patient based on racial, gender, gender identity, religious beliefs, disability status, or other factors generally viewed as constituting unfair bias.

6. The clinician has the right to request a Fair Hearing for certain adverse actions as outlined in PHC policy. Please refer to the Fair Hearing Process for Adverse Actions. This Policy also describes reporting requirements to the PHC Board of Commissioners.

7. In Accordance with the Medical Board of California’s requirement, effective 1/11/11, PHC will need to file an 805.01 when a final decision or recommendation has been made by the peer review board regarding evidence any of the following four reasons.
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
   b. The use of, or prescribing for or administering to himself or herself of an controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that
the licentiate’s ability to practice safely is impaired by that use;
c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and

d. Sexual misconduct with one or more patients during a course of treatment or an examination.

e. If required under the 805.01, a report is filed per policy MP CR #9A.

6.8. These four reasons do not have to go to hearing before the 805.01 form is filled out. The proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision. Another change with this law is that the practitioner can submit the reports and file electronically, but it will be made public for those who request it.

7.9. All PRC/Credentialing Committee recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action. If a quality issue has multiple clinicians or providers involved in care who are separately evaluated by a clinical reviewer or the PRC, determinations of severity ratings will not be final until all involved clinicians have been assigned final severity ratings. If any data is pending before making a final determination for one involved clinician, the other clinicians’ determinations will be pending and notifications will not be made until all determinations are complete.

8.10. For contracted providers who are not individuals (for example: hospitals, skilled nursing facilities, community clinics), where a final determination is an S1, S2, or S3, the case will be referred in writing to the quality assurance committee of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has or will be taken to prevent similar system issues in the future. These system issues will be tracked and reviewed at the time of the facility’s re-contracting. If the CMO or PRC determines that the system issue at a facility places our members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.

9. The PHC Board of Commissioners has the ultimate authority for final decisions regarding credentialing and appeals. Credentialing Committee recommendations for adverse action are forwarded to the next regularly scheduled Board of Commissioners meeting for a final decision.
E. If the PQI occurred exclusively at one or more organizations with an accredited Peer Review Organization (PRO) responsible for oversight of the care provided by the Clinician or Provider(s) of Concern (POC), the PQI is not found to be urgent, and the potential severity of the PQI has been determined by the CMO/designee to not reflect an egregious lapse in quality, the PQI will be referred to the PRO. A response will be required from the PRO acknowledging they have received the letter of concern. After this response is received, the case will be closed by the CMO/designee. When a referral is sent to the outside PRO, a copy will be sent to the Chief of Quality and the Quality Director at the outside organization. Concomitantly, the POC will be notified of the PRO referral. No medical records will be requested. If the PQI cannot be leveled prior to referral, the case will be leveled as either: Provider Unable to Determine or Facility Unable to Determine.

F. If the PQI is determined by the CMO/designee to be urgent or the potential severity may represent an egregious lapse in the quality of care, the case will be referred to the outside PRO, but the CMO/designee may elect to request medical records and review the case.

G. During case review, professionally recognized standards of care will be used to assess the care provided. A PQI may be a single event or occurrence. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening

1. If the PRL’s PICS Nurse initial review determines there are no clinician/provider or system issues, the case is leveled as a P0 (no provider issues) or an S0 (no system issues) and the PQI is closed in the database. If the PRL determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other involved departments for action and follow up. If the PRL determines that the PQI may be beyond a P0/S0, the case is forwarded to the CMO/designee for secondary review.

11.
H. REVIEW-SECONDARY

1. During secondary review, the CMO/designee may:
   a. assign a potential severity level of P0/S0 and instruct the PRL-PICS Nurse to close the case;
   b. assign a potential severity level of P1/S1 and instruct the PRL-PICS Nurse to send a letter to the POC with a response required within 14 calendar days. During routine secondary review, when a letter is sent to the POC, a copy will be sent to the Chief of Quality and/or Quality, the Quality Director of the affected organization. The letter will request a coordinated response. A 14 calendar day extension may be granted by the CMO/designee/PRL-PICS Nurse for reasonable concerns. If the clinician or provider’s response satisfies the secondary reviewer’s concerns, the CMO/designee may instruct the PRL-PICS Nurse to close the case or prepare the case for presentation to PHC’s PRC, depending on the significance of the findings;
   c. assign a potential severity level of P1/S1 or P2/S2 and instruct the PRL-PICS Nurse to send a letter to the POC with a response required within 14 calendar days. During routine secondary review, when a letter is sent to the POC, a copy will be sent to the Chief of Quality and/or Quality, the Quality Director of the affected organization. The letter will request a coordinated response. A 14 calendar day extension may be granted by the CMO/designee/PRL-PICS Nurse for reasonable concerns. If the clinician or provider’s response satisfies the secondary reviewer’s concerns, the CMO/designee may instruct the PRL-PICS Nurse to close the case or prepare the case for presentation to PHC’s PRC, depending on the significance of the findings;
   d. request that the PRL-PICS Nurse send the case to be reviewed by a physician of the same specialty as the POC. The specialist has 14 calendar days to return the case to the PICS Nurse PRL with a written response. The PICS Nurse PRL will discuss the specialist’s findings with the CMO/designee;
   e. determine that the case is potentially greater than a P2/S2 and instruct the PICS Nurse PRL to prepare the case for presentation to the PRC;
   f. instruct the PICS Nurse PRL to prepare a case for the PRC at any time, for any case, regardless of the severity level;
   g. final severity levels can be determined by the secondary reviewer for cases assigned a severity level less than P3/S3 after all information requested has been received and reviewed.

2. Emergency action: If the CMO determines that a situation exists where immediate action is required to protect the life or well-being of a PHC member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient or person, the CMO may summarily suspend or terminate the POC’s credentialed status. See policy MP CR #9 “Fair Hearing Process for Adverse Decisions.”

I.B. OPPORTUNITIES FOR DISCUSSION BY THE CLINICIAN OR PROVIDER OF CONCERN

1. When the PQI is assigned a potential severity level of S1-S3 or P1-P3, the POC will be sent a letter of concern including the following:
   a. patient demographics;
   b. brief statement explaining the purpose of quality review activities;
   c. brief summary of the background of the case;
   d. potential severity level;
   e. confidentiality statement; and
   f. CMO or designee signature.

2. The POC will be given an opportunity to discuss the case by one of 4 methods: written, telephonic, in-person, or by encrypted e-mail. The POC will have 14 calendar days to respond.

3. If the POC fails to provide additional information within the required timeframe, the PICS RN will send a reminder letter with an immediate response required. If no response, the CMO or designee may choose to make a decision or the case may be referred to the level the case using the information on hand. PRC. If the PRC desires additional information before making a determination, a follow-up letter will be sent to the clinician or provider. If an individual clinician is a member of a contracted medical group, the Director of the QA Department and/or Medical Director of the group will also be sent a copy of the request for additional information. In addition to the content in the original letter, the following will be included:
   a. A reminder that the organization’s PHC contract requires them to adhere to PHC policies and
procedures, which includes timely response to potential quality incidents.

b. An additional 14 calendar day deadline for response.

4. When additional information is received from the POC, the CMO or designee may refer the case to the PRC, a physician on the Peer Review Committee within the same or a similar specialty, or to an outside physician within the same specialty. The original reviewer should be among those who review the additional information. In all such cases, the initial physician reviewer will conduct the second-final review and make a recommended determination recommend a level, which is then presented to the PRC for final approval.

5. The POC will receive a final determination letter that will include the following:
   a. a summary of the case findings, including a preferred course of action;
   b. final severity level and any actions to be taken;
   c. a statement of any opportunity to provide additional information;
   d. CMO/designee signature.

6. Phone conversations between a POC and a peer reviewer or the CMO/designee will be documented with written notes, which will be entered into the peer review file and sent to the clinician in a subsequent peer review letter, to offer the opportunity to make corrections.

   - If no response is heard from the POC for a second time the CMO or designee will contact the POC to ensure the letter was received.

7. If no response is heard from the POC for a second time, the CMO/designee or PRL will contact the clinician to ensure the peer review letter was received and reviewed.

J.C. MEDICAL RECORD REQUESTS

1. Upon determination that medical records and other related documents are required for the case review, the POC is requested to submit documents Contracted clinicians or providers are to forward a copy of the PHC QI department member’s medical records to the QI AA within 30 calendar days from the date of the request.

2. The PQI Coordinator QI AA will call the clinician or provider weekly to inquire about the status of the request. If the PQI Coordinator QI AA has not received the requested records by day 35, she/he will inform the PRL PICS Nurse and request the assistance of the Provider Relations Department. The PQI Coordinator QI AA is to inform the PICS Nurse PRL at any time if she/he is having difficulty retrieving medical records.

3. If PHC does not receive a copy of the member’s medical records within 45 calendar days of the request, the POC will forward the concern to the CMO for further assistance. The CMO or designee may contact the clinician personally to ensure he or she is aware of the request for information. In addition, if the individual POC works at a facility, the Chief of Quality, the Quality Director, the CMO, and/or the CEO of the facility may be contacted to inform them of the delay in obtaining medical records.

4. If medical records are not received within the requested timeframe following the procedure above, the CMO will be notified. The CMO/designee will use all available information to rate the PQI. If the PQI cannot be rated due to the lack of medical records, the PQI will be referred to the licensing body that oversees the clinician or facility for investigation and disposition. Concomitantly, a letter will be sent to the CMO of the POC or facility of concern informing them of the lack of response to the request for medical records.

5. Further action may be necessary including but not limited to termination from the provider network.

K.D. CASE COMPLETION

1. All PQI cases will be processed and closed with a final severity level within 120 days from the date the case is received by the Quality department. If the reviews are not completed in a timely manner, the CMO/designee will institute plans for compliance with standards for completion and timeliness. Each confirmed quality issue is assigned a final severity level with an action code by the CMO, designee, or PRC to denote the severity of the problem and action taken as a result of review.
2. While under review, all PQI cases and related documentation are kept in a secure file cabinet in the QI department and only designated personnel have access to these files. Each file includes the PQI RF, all correspondence, pertinent copies of medical records, reports, and other documents associated with the review and disposition of the PQI case.

L.E. REPORTING REQUIREMENTS

1. If a recommendation is made to revoke, suspend, or restrict the privileges of a clinician, or to terminate the provider's contract with PHC, the following individuals and committees will be notified:
   a. CEO of PHC.
   b. Credentialing Committee recommendations are forwarded to the next regularly scheduled Board of Commissioners meeting for final action.
   c. Chief of Staff and Hospital Administrators of facilities where clinician has hospital privileges.
   d. The CEO of the medical group that employs the clinician, if applicable, and/or the Medical Director of the clinic where the clinician is employed.
   e. The Department of Health Care Services (DHCS) requires PHC to notify them when a sub-contracted provider has been terminated from being a Medi-Cal or Medicare provider and has been placed on the Suspended and Ineligible Provider list. Providers on the Medi-Cal/Medicaid suspended and ineligible provider list cannot participate in the PHC provider network.
   f. If the provider is a member of a medical group or clinic, a paraphrased summary of the final determinations of levels S1, S2, S3, P1, P2, and P3 will be reported to the supervising Medical Director. If the final determination is an S3, the CEO of the institution will also be notified.

M.E. INTER-RATER RELIABILITY (IRR)

1. Inter-rater reliability studies will be performed bi-annually quarterly to ensure cases reviewed by the PRL were appropriately assessed to ensure that the reliability of the PQI case scoring process can be evaluated. Ten cases will be randomly selected for review by the Manager of Quality and Compliance for the quarterly assessment. The goal is to achieve a 90% inter-rater reliability score.

N.G. RECORD RETENTION

1. Please refer to Policy CMP-30 Offsite Storage and Record Retention. Medical records received for cases with a P0/P1/S0/S1 severity rating will be scanned into the PHC system by the QI AA along with all pertinent supporting documentation. After scanning is complete, the documents will be destroyed. The scanned file will be maintained for a period of 10 years. Cases assigned a P2/P3/S2/S3 will be scanned into the system. All original documentation—such as certified letters, responses to letters, policies and procedures—will be kept in-house along with the scanned file for a minimum of 3 years and offsite for a minimum of 7 additional years.

O.H. CONFIDENTIALITY

1. Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality Department and are not released to anyone for purposes other than peer review. Records are maintained in a locked file cabinet with access restricted to the CMO, the Director of Quality Performance and Improvement, Manager of Quality and Compliance, PRLs, the QI Project Coordinator, and peer reviewers. While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. If a subpoena is served to PHC regarding a peer review case, the PRL may act as the “certifier of the medical records” being requested.

P.L. SUBCOMMITTEES

1. The Pain Management Oversight Committee is a subcommittee of the PRC.
<table>
<thead>
<tr>
<th>Policy/Procedure Number: MPQP1016 (previously QP100116)</th>
<th>Lead Department: Health Services</th>
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<tbody>
<tr>
<td>Policy/Procedure Title: Potential Quality Issue Investigation and Resolution</td>
<td>☐☒ External Policy ☐ Internal Policy</td>
</tr>
<tr>
<td>Original Date: 01/20/1996 - Medi-Cal 07/16/2008—Healthy Kids</td>
<td>Next Review Date: 06/15/2017 06/21/2018</td>
</tr>
<tr>
<td>Applies to: ☐☒ Medi-Cal ☐☒ Healthy-Kids ☐ Employees</td>
<td></td>
</tr>
</tbody>
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VII. REFERENCES:
- Q.J. Exhibit A, Attachment 9 Quality Improvement System from the DHCS contract
- Please refer to the Delegation Policy for Delegated Providers

VIII. DISTRIBUTION:
A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Performance Improvement Clinical Specialist (PICS) II

X. REVISION DATES:
Medi-Cal
07/01/96; 06/02/97; 10/10/97 (name change only); 01/13/99; 06/16/99; 06/21/00; 05/16/01; 05/15/02; 08/20/03; 04/20/05; 07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16; 06/12/17

Healthy Kids
07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16

PREVIOUSLY APPLIED TO:
Healthy Families
MPQP1016 - 10/19/2011 to 03/01/2013
I. RELATED POLICIES:
A. MPCR #9 Fair Hearing Process for Adverse Decisions
B. MPQP1053 - Peer Review Committee Policy
C. MP CR #9A - Reporting to the Medical Board of California and the National Practitioner Data Bank
D. CMP 30 – Offsite Storage and Record Retention

II. IMPACTED DEPTS:
A. All Departments

III. DEFINITIONS:
A. A Potential Quality Issue (PQI) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
B. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
C. A clinician or provider is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.
D. A Corrective Action Plan (CAP) is a plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and time frames for completion.
E. Severity Level: Refer to Attachment B: Practitioner Performance and Systems Scores Grid
F. Egregious: Where the quality of care was significantly outside accepted and common standards of practice and/or where the adverse outcome of the care provided was especially serious.

IV. ATTACHMENTS:
A. PQI Referral Form and Reference Table
B. Practitioner Performance and Systems Scores Grid

V. PURPOSE:
To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue (PQI), to determine opportunities for improvement in the provision of care and services to Partnership HealthPlan of California (PHC) members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

VI. POLICY / PROCEDURE:
A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES

1. PQIs are identified through the systematic review of a variety of data sources, including but not limited to:
   a. information gathered through concurrent, prospective, and retrospective utilization review;
   b. referrals from any health plan staff;
   c. facility site reviews;
   d. claims and encounter data;
   e. pharmacy utilization data;
   f. HEDIS® medical record abstraction process;
   g. medical record audits;
   h. Complaints/Grievances and Appeals

2. PQI reviews shall be conducted on services provided by:
   a. contracted clinicians or providers, including subcontractors, who provide inpatient and outpatient services and complaints involving pharmacists;
   b. non-contracted providers: complaints involving non-contracted providers will be discussed with the Chief Medical Officer (CMO)/designee to determine next steps prior to ordering medical records;
   c. durable medical equipment (DME) transportation and respiratory supply vendors;
   d. home health vendors; skilled nursing facilities; long term care and rehabilitation facilities; ancillary service providers including but not limited to laboratory and radiology;
   e. .
   f. Behavioral health: complaints regarding behavioral health are referred to the Behavioral Health staff in the Health Services Department for research, intervention, and resolution.

B. PQI REFERRAL

1. A PQI may be reported by any of the following:
   a. any PHC staff member;
   b. anonymously using the PHC "confidential line" which is available 24 hours a day, 7 days a week (1-800-601-2146);
   c. any member of the community or
   d. any contracted or non-contracted clinician or provider.

2. A PQI is referred to the Quality Department via the PQI@partnershiphp.org inbox using the PQI Referral Form. See Attachment A.

3. Time frame limitations: PHC will not routinely investigate a PQI which occurred more than 2 years prior to the notification of the complaint to the QI department. Cases that may have a potential serious matter may be reviewed on an ad-hoc basis upon the discretion of the CMO/designee

C. PQI REVIEW PROCESS

During case review, professionally recognized standards of care will be used to assess the care provided. A PQI may be a single event or occurrence. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening of a case previously reviewed or closed.

1. PRIMARY REVIEW BY PERFORMANCE IMPROVEMENT CLINICAL SPECIALIST (PICS) RN – Upon receipt of a PQI referral, the QI Project Coordinator opens a new case file in the PQI database, and assigns the case to a PICS RN to conduct the primary review and manage case to completion.
   a. If the issue is urgent or the potential severity may represent an egregious lapse in the quality of care, the PICS RN will immediately contact the CMO/designee for resolution and next steps. The CMO/designee may refer to outside Peer Review Organization (PRO) depending on the case.
   b. If the PQI occurred at an organization with an accredited PRO responsible for oversight of the
care provided by the Clinician or Providers of Concern (POC), the PQI is found to be urgent, and the potential severity of the PQI has been determined by the CMO/designee to not reflect an egregious lapse in quality, the PQI will be referred to PRO. A response will be required from the PRO acknowledging they have received the letter of concern. When a referral is sent to the outside PRO, a copy will be sent to the Chief of Quality and Quality Director at the outside organization and the POC will be notified of the PRO referral. If the severity score is not determined prior to the referral, the case will be leveled as: Provider Unable to Determine (PUTD).

c. If the PICS RN initial review determines that there are no clinician or provider or system issues, the case is leveled as P0 or S0 and the PQI is closed in the database. See Attachment B for the Practitioner Performance and Systems scores.

d. If the PICS RN determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other involved departments for action and follow-up.

e. If the PICS RN determines that the PQI may be beyond a P0/S0, the case is forwarded to the CMO/designee for secondary review.

2. SECONDARY REVIEW BY CMO/DESIGNEE – The CMO/designee review includes assessment of, but not limited to: appropriate level of care; appropriate tests; therapy and treatment; technical expertise; referral; consultation; timeliness; and adequate documentation. During the CMO/designee review, the CMO/designee may:

a. Assign a severity level of P0/S0 and instruct the PICS RN to close case (see attachment B for the Practitioner Performance and Systems Scores).

b. Assign a potential severity of P1/S1 or P2/S2 and send a letter to the provider of concern with a response required. If the provider’s response satisfies the secondary reviewer’s concerns, the CMO/designee may instruct the PICS RN to close the case or prepare the case for presentation to the Peer Review Committee (PRC), depending on the significance of the findings.

c. Generate a letter to the provider of concern describing the issue and request investigational response and may also request additional documentation including related to system issues. If no response within the requested timeline, a rate severity is given based upon available documentation.

d. Upon determination that a PQI case requires a second opinion review by a specialty physician or by a subject matter expert, a request for investigational review and response will be sent.

e. Emergency action: If the CMO/designee determines that a situation exists where immediate action is required to protect the life or well-being of a PHC member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, or safety of any patient or person, the CMO may summarily suspend or terminate the POC’s credentialed status. See policy MP CR #9 “Fair Hearing Process for Adverse Decisions.”

3. TERTIARY REVIEW BY THE PEER REVIEW COMMITTEE (PRC) – Upon determination by the CMO/designee that a PQI case requires review by the PRC, the Project Coordinator and PICS RN prepare the PQI case file for Peer Review. See MPQP1053 for the Peer Review Committee policy).

1. All cases designated a severity level S3 or P3 must be referred by the CMO/designee to the PRC for review and determination of next steps.

2. PRC recommendations for cases determined to be S3/P3 may be forwarded to the Credentialing Committee for possible action.

3. In cases where the PRC recommends that the Credentialing Committee request a Corrective Action Plan (CAP):

a. A notice shall be given to the POC within 7 calendar days of the recommendation of a CAP being required. Grounds for recommending a CAP include but are not limited to:
Policy/Procedure Number: MPQP1016 (previously QP100116)  
Policy/Procedure Title: Potential Quality Issue Investigation and Resolution  
Lead Department: Health Services

Original Date: 01/20/1996 - Medi-Cal  
Next Review Date: 06/21/2018  
Last Review Date: 06/21/2017

Applies to: ☐ Medi-Cal  ☐ Employees

1) failure to provide professional services of acceptable quality; 
2) failure to follow PHC utilization review policies; 
3) failure to follow PHC quality improvement policies; 
4) failure to treat patients for whom the provider is responsible; 
5) failure to adhere to the provider contract or PHC policies; 
6) acts constituting disruptive behavior or an inability to work collaboratively with others; 
7) failure to report adverse action by another peer review body or a hospital.

b. If a CAP is recommended, it is included in the PQI case file. A CAP includes the goals, objectives, desired outcomes, time frames, persons responsible, follow-up, and CAP evaluation. The time frame for clinicians to respond to a CAP is 30 calendar days. The POC will be sent a reminder notice on day 15. If the CAP is not received by PHC by day 31, the PICS RN will contact the POC. A 15 day extension may be granted for reasonable concerns. If the CAP has not been received by day 46, the case is forwarded to the CMO for further determination, including possible review by the Credentialing Committee. Upon completion, the CAP will be reviewed and the results reported to the PRC.

c. The CAP may include but is not limited to:
   1) required attendance at continuing education programs applicable to the issue identified and approved by PHC; 
   2) required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification; 
   3) continuing concurrent trend analysis of the adverse quality issues identified in the clinician's practice patterns; 
   4) monitoring of POC’s medical record documentation by physicians selected by the PRC for a prescribed length of time; and 
   5) in-service training for clinicians and/or their staff.

4. The PRC may also recommend that the Credentialing Committee review the POC’s status, including but not limited to the following:
   a. clinician or provider contract changes, including modification, restriction, or termination of participation privileges with PHC; 
   b. summary suspension: immediate suspension from credentialed status based on the need to take immediate action to protect the life or well-being and or reduce the possibility of substantial or imminent threat to the life, health, or safety of any PHC member or other person; 
   c. recommendation of counseling for behavior modification; 
   d. focused review of the provider’s cases including but not limited to:
      1) second opinion for invasive procedures; 
      2) retrospective or prospective medical claims reviews; 
   e. preceptorship with a physician of the same specialty; 
   f. institute a monitoring process through proctoring by another qualified, specialty-matched physician; or 
   g. recommendation to the Credentialing Committee for suspension, restriction, or termination of the clinician’s PHC credentials.

5. In the following situations, in addition to the other measures applicable to S3/P3 cases, immediate referral will be made to the CMO for consideration of the need for immediate follow-up and potential rapid escalation to the Credentials Committee, Board of Commissioners, Medical Board of California, and other regulatory and/or law enforcement agencies, depending the severity of the concern:
   a. actions or omissions constituting unethical or unprofessional conduct; 
   b. sexual misconduct with a patient; 
   c. sexual harassment of a patient and discriminatory actions or behavior towards a patient based on gender, gender identity, or sexual orientation.
on racial, gender, gender identity, religious beliefs, disability status, or other factors generally viewed as constituting unfair bias.

6. The clinician has the right to request a Fair Hearing for certain adverse actions as outlined in PHC policy. Please refer to the Fair Hearing Process for Adverse Actions. This Policy also describes reporting requirements to the PHC Board of Commissioners.

7. In Accordance with the Medical Board of California’s requirement, effective 1/11/11, PHC will need to file an 805.01 when a final decision or recommendation has been made by the peer review board regarding evidence any of the following four reasons.
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
   b. The use of, or prescribing for or administering to himself or herself of an controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate’s ability to practice safely is impaired by that use;
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.
   e. If required under the 805.01, a report is filed per policy MP CR #9A.

8. These four reasons do not have to go to hearing before the 805.01 form is filled out. The proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision. Another change with this law is that the practitioner can submit the reports and file electronically, but it will be made public for those who request it.

9. All PRC/Credentialing Committee recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action. If a quality issue has multiple clinicians or providers involved in care who are separately evaluated by a clinical reviewer or the PRC, determinations of severity ratings will not be final until all involved clinicians have been assigned final severity ratings. If any data is pending before making a final determination for one involved clinician, the other clinicians’ determinations will be pending and notifications will not be made until all determinations are complete.

10. For contracted providers who are not individuals (for example: hospitals, skilled nursing facilities, community clinics), where a final determination is an S1, S2, or S3, the case will be referred in writing to the quality assurance committee of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has or will be taken to prevent similar system issues in the future. These system issues will be tracked and reviewed at the time of the facility’s re-contracting. If the CMO or PRC determines that the system issue at a facility places our members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.

11. The PHC Board of Commissioners has the ultimate authority for final decisions regarding credentialing and appeals. Credentialing Committee recommendations for adverse action are forwarded to the next regularly scheduled Board of Commissioners meeting for a final decision.

B. OPPORTUNITIES FOR DISCUSSION BY THE CLINICIAN OR PROVIDER OF CONCERN

1. When the PQI is assigned a potential severity level of S1-S3 or P1-P3, the POC will be sent a letter of concern including the following:
   a. patient demographics;
b. brief statement explaining the purpose of quality review activities;
c. brief summary of the background of the case;
d. confidentiality statement; and
e. CMO or designee signature.

2. The POC will be given an opportunity to discuss the case by one of methods: written, telephonic, in-person, or by encrypted e-mail. The POC will have 14 calendar days to respond.

3. If the POC fails to provide additional information within the required timeframe, the PICS RN will send a reminder letter with an immediate response required. If no response the CMO or designee may choose to level the case using the information on hand. If an individual clinician is a member of a contracted medical group, the Director of the QA Department and/or Medical Director of the group will also be sent a copy of the request for additional information. In addition to the content in the original letter, the following will be included:
   a. A reminder that the organization's PHC contract requires them to adhere to PHC policies and procedures, which includes timely response to potential quality incidents.
   b. An additional 14 calendar day deadline for response.

4. When additional information is received from the POC, the CMO or designee may refer the case to the PRC, a physician on the Peer Review Committee with the same or a similar specialty, or to an outside physician with the same specialty. The original reviewer should be among those who review the additional information. In all such cases, the initial physician reviewer will conduct final review and recommend a level, which is then presented to the PRC for final approval.

5. The POC will receive a final determination letter that will include the following:
   a. a summary of the case findings, including a preferred course of action;
   b. final severity level and any actions to be taken;
   c. a statement of any opportunity to provide additional information;
   d. CMO/designee signature.

6. Phone conversations between a POC and a peer reviewer or the CMO/designee will be documented with written notes, which will be entered into the peer review file and sent to the clinician in a subsequent peer review letter, to offer the opportunity to make corrections.

7. If there is no response from the POC for a second time the CMO or designee will contact the POC to ensure the letter was received.

C. MEDICAL RECORD REQUESTS

1. Upon determination that medical records and other related documents are required for the case review, the POC is requested to submit documents to PHC QI department within 30 calendar days from the date of the request.

2. If medical records are not received within the requested timeframe the CMO/designee will use all available information to rate the PQI. If the PQI cannot be rated due to the lack of medical records, the PQI will be referred to the licensing body that oversees the clinician or facility for investigation and disposition. A letter will be sent to the CMO of the POC or facility of concern informing them of the lack of response to the request for medical records.

D. CASE COMPLETION

1. All PQI cases will be processed and closed with a final severity level within 120 days from the date the case is received by the Quality department. If the reviews are not completed in a timely manner, the CMO/designee will institute plans for compliance with standards for completion and timeliness.

2. While under review, all PQI cases and related documentation are kept in a secure file cabinet in the QI department and only designated personnel have access to these files.

E. REPORTING REQUIREMENTS

1. If a recommendation is made to revoke, suspend, or restrict the privileges of a clinician, or to terminate the provider's contract with PHC, the following individuals and committees will be notified:
Policy/Procedure Number: MPQP1016 (previously QP100116)  
Lead Department: Health Services

Policy/Procedure Title: Potential Quality Issue Investigation and Resolution

☐ External Policy
☐ Internal Policy

Original Date: 01/20/1996 - Medi-Cal  
Next Review Date: 06/21/2018

Last Review Date: 06/21/2017

Applies to:  ☐ Medi-Cal  ☐ Employees

a. CEO of PHC.
b. Credentialing Committee recommendations are forwarded to the next regularly scheduled Board of Commissioners meeting for final action.
c. Chief of Staff and Hospital Administrators of facilities where clinician has hospital privileges.
d. The CEO of the medical group that employs the clinician, if applicable, and/or the Medical Director of the clinic where the clinician is employed.
e. The Department of Health Care Services (DHCS) requires PHC to notify them when a sub-contracted provider has been terminated from being a Medi-Cal or Medicare provider and has been placed on the Suspended and Ineligible Provider list. Providers on the Medi-Cal/Medicaid suspended and ineligible provider list cannot participate in the PHC provider network.
f. If the provider is a member of a medical group or clinic, a paraphrased summary of the final determinations of levels S1, S2, S3, P1, P2, and P3 will be reported to the supervising Medical Director. If the final determination is an S3, the CEO of the institution will also be notified.

F. INTER-RATER RELIABILITY (IRR)
1. Inter-rater reliability studies will be performed bi-annually to ensure cases were appropriately reviewed and to ensure that the reliability of the PQI case scoring process can be evaluated.

G. RECORD RETENTION
1. Please refer to Policy CMP-30 Offsite Storage and Record Retention.

H. CONFIDENTIALITY
1. Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality Department and are not released to anyone for purposes other than peer review. Records are maintained in a locked file cabinet with access restricted to the CMO, the Director of Quality Performance and Improvement, Manager of Quality and Compliance, PRLs, the QI Project Coordinator, and peer reviewers. While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. If a subpoena is served to PHC regarding a peer review case, the Peer Review Lead may act as the “certifier of the medical records” being requested.

I. SUBCOMMITTEES
1. The Pain Management Oversight Committee is a subcommittee of the PRC.

VII. REFERENCES:
J. Exhibit A, Attachment 9 Quality Improvement System from the DHCS contract
K. Please refer to the Delegation Policy for Delegated Providers

VIII. DISTRIBUTION:
A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Performance Improvement Clinical Specialist (PICS) II

X. REVISION DATES:
Medi-Cal
07/01/96; 06/02/97; 10/10/97 (name change only); 01/13/99; 06/16/99; 06/21/00; 05/16/01; 05/15/02; 08/20/03; 04/20/05; 07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16; 06/12/17

Healthy Kids
07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16
Partnership HealthPlan of California

CARE COORDINATION PROGRAM DESCRIPTION

MPCD2013

April-June 2017

Original Date: 01/20/2016
Revision Date(s): 06/21/2017

November 2015
MPCD2013
PROGRAM PURPOSE

To define the scope of services provided by Partnership HealthPlan of California’s (PHC’s) Care Coordination Department.

To define the scope of services provided by the Partnership HealthPlan of California (PHC) Care Coordination program across all product lines.

Introduction

Partnership HealthPlan of California (PHC) offers comprehensive care management services, on a voluntary basis, to any plan enrollee in which PHC is the primary coverage source or when services may not available from the primary carrier. The process includes assessment, planning, facilitation, care coordination, evaluation and advocacy in order to meet the comprehensive medical, behavioral health and psychosocial needs of the individual while promoting quality and cost-effective outcomes.

Partnership HealthPlan of California (PHC) offers basic and complex case management services, on a voluntary basis, to any plan enrollee for whom in which PHC is the primary source of coverage. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the member’s health and human service’s needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. These services assist PHC in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

Program DevelopmentDepartment Objectives & Goals

The objectives and goals of PHC’s Care Coordination Department are to:

- Proactively invite members and their care team to participate in programs that will promote positive health outcomes
- Improve member and provider satisfaction
- Minimize gaps between healthcare settings by streamlining transitions across the healthcare continuum
- Provide education to providers about case management programs offered by PHC and encourage referrals when needs or barriers are identified
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources where available
- Facilitate cost-effective care with public resources through the coordination of services in the right setting

The Care Coordination Department is not intended to replace or substitute for physician management of the member’s medical conditions. PHC staff works collaboratively with the
practitioner to coordinate clinical and support services for members and thus decrease the potential for fragmentation of care.

Services offered through PHC’s Care Coordination Department are available to each member we-servewhere PHC is the primary payer; however, outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of the targeted population:

- Medi-Cal PHC eligible enrollees who are designated by aid code as Seniors and Persons with Disabilities (SPD)
- Members who are chronically ill or who have multiple complex medical conditions
- Members needing assistance in accessing community-based programs and/or services
- In conjunction with DHCS, members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support.
- Members preparing for organ transplant.
- Members challenged by managing their health within PHC’s managed care network.
- High-Risk Pregnancies.
- In conjunction with California Children Services (CCS), special needs children under age 21 requiring assistance and support.
- Children and adults with developmental disabilities in collaboration with the California Regional Centers
- Children in Foster Care

CARE COORDINATION SCOPE OF SERVICES

The Care Coordination Department offers a variety of evidence-based services and interventions in order to coordinate care for members. Our team of Case Managers and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Through the utilization of key approaches such as Motivational Interviewing, the staff in the Care Coordination Department ensure that the member’s goals are at the center of the individualized care plan and assist the member in enhancing their autonomy and collaboration within their care team.

ADULT BASIC CASE MANAGEMENT

A voluntary, telephonic service available to all eligible members available both through primary care providers (PCPs) as well as through PHC whose primary insurance coverage is PHC, Adult Basic Case Management Services assists members with needs and barriers including but not limited to:

- Access to Care – Primary or Specialty Care
- Referrals to Non-Medi-Cal/ PHC Covered Services: IHSS, Denti-Cal, Meals on Wheels, etc.
- Assistance with Ancillary Services or DME
- Assistance with Prescriptions
- Requests to see out-of-network providers (Continuity of Care)
- Disease Management or Health Education
- Education for resources available in their area/community (housing, transportation, support groups, etc.)

**Identification and Referrals**

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Adult Basic Case Management Services. These activities include things such as:

- Active review of Advice Nurse Triage Report
- Screening of internal reports
- Review of referrals sent to the Care Coordination Department Help Desk email
- Health Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available

Referrals for Adult Basic Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Adult Basic Case Management from PHC’s own Pharmacy, Utilization Management, Grievance and/or Member Services Departments. Externally, members may self-refer or they may be referred by their caregivers, Primary Care Physicians, Providers, Specialists, Hospital Case Managers, and/or Community Partners such as Public Health Nurses or Home Visiting Program Providers.

Referrals for Adult Basic Case Management can be sent to the department directly via the department’s email help desk or phoned in directly to the 800 toll-free line. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Adult Basic Case Management and will be routed to the appropriate team for case assignment.

**Interventions**

Based on the member’s stated goals and needs, each member enrolled in Basic Adult Case Management will receive an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Adult Basic Case Management include, but are
Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff to evaluate progress and update when necessary.

Process

When referred for Adult Basic Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity, and the member’s individualized care plan will be stored in the Care Coordination Department’s Case Management software Essette. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Member’s whose needs change and cannot be met by Basic Adult Case Management will be screened and directed to other available services when appropriate.

ADULT COMPLEX CASE MANAGEMENT

Voluntary Complex Case Management is a voluntary service offered to PHC members in collaboration with the member’s PCP both telephonically and face-to-face. Complex Case Management encompasses a variety of delivery options tailored to the needs of the member models— including:

- Transitions of Care
- Telephone Complex Case Management
- Intensive Outpatient Case Management
Below is a description of the delivery model and criteria for each Complex Case Management Service provided by PHC’s Care Coordination Department:

<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
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</table>
| Care Transitions     | A face-to-face & telephonic service model that utilizes a Case Manager and Health Care Guide who assist members transitioning from inpatient hospitalization to home. | PHC primary insurance payor  
Current inpatient at participating PHC Hospital  
Anticipated discharge to home  
Willingness to participate in services |

- Chronic Kidney Disease Program
- Care Transitions
- Community Based Adult Services (CBAS)
<table>
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<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
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<tr>
<td><strong>Telephonic Complex Case Management</strong></td>
<td>A six to twelve month, telephonic-service model that utilizes an RN Case Manager and Health Care Guide for members motivated to improve their modifiable health conditions.</td>
<td><strong>PHC primary insurancepayor</strong></td>
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<td>2+ Chronic Conditions; modifiable</td>
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<td>8+ Medications</td>
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<td>Poor Access to care; care or lack of awareness of community resources</td>
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<td>In need of specialty care or currently seeing multiple specialists</td>
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<td>Poor support network; limited or no family assistance</td>
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<td>Poor understanding/education of medical illnesses</td>
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<td>High Utilization of health care resources</td>
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<td>Willingness to participate in services</td>
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<td>Physician agreement for services</td>
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<td><strong>Intensive Outpatient Case Management (IOPCM)</strong></td>
<td>A face-to-face &amp; telephonic-service model that utilizes an RN Case Manager and Health Care Guide who work with identified PHC Primary Care Physicians to manage members with multiple complex medical conditions.</td>
<td><strong>PHC primary insurancepayor</strong></td>
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<td>Physician agreement for services</td>
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<tr>
<td><strong>Chronic Kidney Disease</strong></td>
<td>A face-to-face &amp; telephonic-service model that utilizes an RN Program Manager and Health Care Guide who work with identified PHC Nephrologists and Primary Care Physicians to manage members with Chronic Kidney Disease and delay onset of Dialysis when applicable.</td>
<td><strong>PHC primary insurancepayor</strong></td>
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<td>Stage II or Stage III CKD; no dialysis</td>
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<td>Poor Access to Care</td>
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<td>High Utilization of health care resources</td>
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<td>Physician agreement for services</td>
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</tbody>
</table>
**Care Transitions**

A face-to-face & telephonic service model that utilizes a Case Manager and Health Care Guide who assist members transitioning from inpatient hospitalization to home.

- PHC primary insurance
- Currently inpatient at participating PHC Hospital
- Anticipated discharge to home
- Willingness to participate in services

**Community Based Adult Services (CBAS)**

A face-to-face service model that utilizes an RN Case Manager to evaluate referrals and complete assessments for Community Based Adult Services (CBAS).

- PHC primary insurance
- Meets Category 1-5 on DHCS CBAS CEDT Tool
- Once approved, CBAS center to provide continued Case Management Services if needed

**Identification and Referrals**

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Adult Complex Case Management Services. These activities include:

- Active review of Advice Nurse Triage Report
- Screening of internal reports (High Utilizer Report, Inpatient Reports, Laboratory/Pharmacy Data, etc.)
- Review of referrals sent to the Care Coordination Department Help Desk email
- Health Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available
- Internal Department Meetings (Utilization Management Rounds, Home Visiting Program Rounds, etc.)
- External Department Meetings (Hospital Case Management Rounds, County Collaborative, etc.)

Referrals for Adult Complex Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Adult Complex Case Management from PHC’s own Care Coordination, Pharmacy, Utilization Management, Grievance and/or Member Services Departments. Externally, members may be self-referred or they may be referred by red for these services directly from members themselves or their caregivers, Primary Care Physicians, Specialists, Hospital Case Managers, and/or county or community partners such as county mental health programs or CBAS Centers.
Referrals for Adult Complex Case Management can be sent to the department directly via the department’s email helpdesk or phoned in directly to the 800 toll-free line. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Adult Complex Case Management and will be routed to the appropriate team for case assignment.

**Interventions**

Based on the member’s stated goals and needs, each member enrolled in Adult Complex Case Management will receive an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Adult Complex Case Management include, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support / Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques
- Medication Reconciliation
- Coordination of Services (Appointments, Referrals, DME, etc.)
- Collaboration with county / community agencies

Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff and the member’s provider(s) to evaluate progress and update when necessary.

**Process**

When referred for Adult Complex Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity and the member’s individualized care plan will be stored in the Care Coordination Department’s Case Management software, Essette. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Member’s whose needs change and cannot be met by Adult Case Management will be screened and directed to
other available services when appropriate.

**PERINATAL & PEDIATRIC CASE MANAGEMENT**

Voluntary Case Management services are offered to PHC members and/or caregivers telephonically. Perinatal & Pediatric Case Management services encompass a variety of delivery models including:

- Growing Together Perinatal Program (GTPP)
- Pediatric Basic Case Management
- California Children Services (CCS)
- Early Intervention/ Developmental Delay (Regional Center)
- Behavioral Health Therapy for Autism (BHT)
- Genetically Handicapped Persons Program (GHPP)

Below is a description of the delivery model and criteria for each Complex Perinatal and Pediatric Case Management Service provided by PHC’s Care Coordination Department:

<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
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| **Growing Together Perinatal Program (GTPP)** | A telephonic service model that utilizes a Perinatal Enrollment Specialist who works with members to assist with access to timely prenatal and postpartum care, and to support their needs for a healthy pregnancy and delivery. | - PHC primary payor insurance  
- Currently Pregnant or High Risk Pregnancy  
- Incentive Program  
- Demonstrated need or barrier  
- Assistance with available community resources |

| **Pediatric Basic Case Management** | A telephonic service model that utilizes an RN Case Manager and Health Care Guide who work with the member/parent/caregiver to assist with access to care, coordination of services, and/or linkages to community resources when necessary. | - PHC primary payor insurance  
- Demonstrated need or barrier  
- Willingness to participate in services |
| California Children Services (CCS) | A telephonic service model that utilizes an RN Case Manager and Health Care Guide who work with identified county CCS staff to coordinate care and services for members connected with the CCS Program. | • PHC primary payer insurance  
• CCS Eligible Condition, or currently open to CCS  
• Demonstrated need or barrier  
• Primary Case Management Services to be provided by county CCS Program Staff.  
• Assist with Age-Out of CCS Program into Adult Medical Setting |
| Early Intervention/ Developmental Delay (Regional Center) | Working closely with the Regional Center, PHC Providers, and the family, a telephonic service model that utilizes a Case Manager and Health Care Guide who refer and assist members with services from the Regional Center. | • PHC primary payer insurance  
• Possible or confirmed Developmental Delay  
• Demonstrated need or barrier  
• Assistance with available community resources |
| **Delivery Model** | **Description** | **Criteria** |
| Behavioral Health Therapy (BHT) | Working closely with Regional Center, PHC’s Providers, and the family, a telephonic service model that utilizes an RN Case Manager and Health Care Guide to assist and refer members for applicable testing and Behavioral Health Therapy related to an Autism Diagnosis. | • PHC primary payer insurance  
• Referral for Comprehensive Diagnostic Evaluation or Behavioral Health Therapy Services |
| Genetically Handicapped Persons Program (GHPP) | A telephonic service model that utilizes an RN Case Manager and Health Care Guide to assist and refer members, when appropriate, to the California State GHPP Program. Assists with access to care and disease management education. | • PHC primary payer insurance  
• Eligible GHPP Diagnosis  
• Demonstrated need or barrier |
Identification and Referrals

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Perinatal and Pediatric Case Management Services. These activities include things such as:

- Active review of Advice Nurse Triage Report
- Screening of internal reports (CCS Open/Close Report, Inpatient TARs, Lab/Pharmacy Reports, etc)
- Review of referrals sent to the Care Coordination Department Help Desk email
- Health Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available
- Internal Department Meetings (Utilization Management Rounds)
- External Department Meetings (Maternal-Child Advisory Board Meetings, WIC Meetings, Regional Center Meetings, PHC/CCS Quarterly Meeting, etc.)

Referrals for Perinatal and Pediatric Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Perinatal and Pediatric Case Management from PHC’s own Care Coordination, Utilization Management, Grievance and/or Member Services Departments. Externally, members may self-refer or they may be referred by red for these services directly from members themselves or their caregivers, Primary Care Physicians, Providers, Specialists, Hospitals, and/or County or Community Partners such as CCS staff, Regional Center Staff, WIC staff, or School Nurses.

Referrals for Perinatal and Pediatric Case Management can be sent to the department directly via the department’s email helpdesk or phoned in directly to the 800 toll-free line. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Perinatal and Pediatric Case Management and will be routed to the appropriate team for case assignment.

Interventions

Based on the member’s stated goals and needs, each member enrolled in Perinatal and Pediatric Case Management will received an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Perinatal and Pediatric Case Management includes, but is not limited to:

- Personalized Assessments
• Motivational Interviewing
• Emotional Support/ Active Listening
• Review of disease signs/symptoms
• Teach-back techniques
• Medication Reconciliation
• Coordination of Services (Appointments, Referrals, DME, etc.)
• Collaboration with county/community agencies

Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff and the member’s provider(s) to evaluate progress and update when necessary.

Process

When referred for Perinatal and Pediatric Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity and the member’s individualized care plan, will be stored in the Care Coordination Department’s Case Management software, Essette. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Member’s whose needs change and cannot be met by Perinatal and Pediatric Case Management will be screened and directed to other available services when appropriate.

Additionally, Care Coordination staff review each case to ensure that Case Management services are not being duplicated either by another provider or agency. The Care Coordination Department has existing MOUs in place with County and Regional Center partners that allow for information and data sharing supporting these efforts.

PROGRAM QUALITY MONITORING AND OVERSIGHT

PHC’s programs have been developed using evidence from a number of resources, including but not limited to evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

• Business Case for King County Health Reform Initiative, April 1, 2005, Mercer Consulting
- **Reductions in Costly Healthcare Services Utilization; Findings from the Care Advocate Program**, The Journal of the American Geriatric Society. 2006
- **Standards of Care in Diabetes**; American Diabetes Association
- **At a Glance Outpatient Management Reference for Chronic Obstructive Pulmonary Disease, Global Initiative for Chronic Obstructive Lung Disease**, updated 2013.

Not less than annually, PHC assesses the characteristics of its population, the needs of members, and the programs and resources available. Revisions are made as necessary to continue to address the members’ changing needs.

**TEAM ROLES AND RESPONSIBILITIES**

**Senior Director of Health Services:** At the senior level, provides overall direction to the HS Care Coordination/Utilization Management Leadership Team. This position has the ultimate responsibility to ensure that all workflow processes and Department Programs and services are consistent and meet all regulatory requirements in every office location.

**Director of Health Services and Utilization Management – Northern Region:** Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer, Senior Director of Health Services, Director of Care Coordination, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services staff to ensure appropriate integration of HS policies and procedures.

**Director of Care Coordination – Southern Region:** Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer, Senior Director of Health Services, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services (HS) staff to ensure appropriate integration of HS policies and procedures.

**Associate Director of Care Coordination:** Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and to produce a summary at least annually or upon request, that includes documentation of department services, member outcomes, return on investment, and
Management team and PHC Health Services leadership, this position is responsible for developing, implementing, presenting, and/or facilitating trainings within the Care Coordination Department. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PHC Care Coordination activities and programs to internal and external stakeholders alike.

**Project Coordinator I:** Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

**Clerk:** Provides administrative support to the Care Coordination Team by answering phones, relaying messages, maintaining department files and calendars, preparing documentations/reports for distribution. Interfaces with the Health Services Department Administrative Assistants to assist with updating documents, ordering and managing department inventory and supplies.

**Administrative Assistant:** Provides direct administrative assistance and support to the department leadership. Manages calendar, organizes meetings, and prepares documentation and written correspondences. Interfaces with other PHC Department Administrative Assistants to organize meetings and activities, responds to requests, and maintain department policies and files.

**Transportation Specialist:** Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process.

**Transportation Specialist Lead:** Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process. Provides on-going training and support to less experienced and newly hired Transportation Specialists.

*Note: Staffing subject to change based upon program need and organizational growth.*

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**Protected Health Information**

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule-as of April 14, 2003. The Privacy Officer, Government Relations Specialist also serves as the Privacy Officer for the Health Plan. and has implemented a
comprehensive program that includes “Notice of Privacy Practices“ sent to ALL members, implementation of a confidential toll-free complaint line available to members, providers and PHC staff, and Business Associate Agreements with all PHC vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

**STATEMENT OF CONFIDENTIALITY**

Confidentiality of provider and member information is ensured at all times in the performance of UMCC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- UMCC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, UMCC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

**NON-DISCRIMINATION STATEMENT**

Partnership HealthPlan of California (PHC) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. PHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.
PHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- PHC provides free language services to people whose primary language is not English, such as:
  - Qualified sign language interpreters
  - Information written in other languages

**Provider and Member Satisfaction**

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UMCC program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results as well as plans for corrective action are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless committee feels an expedited time frame needs to be implemented.

**Annual Program Evaluation**

The overall effectiveness of the Utilization Management Care Coordination program is evaluated in writing annually by the Q/UAC, and is approved by the PAC. The evaluation includes, at a minimum:

- A description of completed and ongoing CC activities.
- Trending of indicators to assess performance.
- Changes in staffing, reorganization, structure or scope of the program during the year.
- An analysis of the overall of the program, including an assessment of barriers and/or limitations.
- An evaluation of delegated activities.
- Recommendations for changes to be incorporated into the subsequent annual CC work plan.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. When the evaluation is complete, an announcement indicating the availability of UMCC information will be published in the member and provider newsletters.
**Program Objectives**

**Care Coordination Program Objectives**

The goal of PHC’s Care Coordination Department is to invite members and their providers proactively to participate in programs that will maximize positive health outcomes and satisfaction; educate providers about all case management programs with the latest protocols; and encourage providers to refer members to the appropriate programs.

**Program Goal**

The goal of care management and coordination is to help the member regain optimum health or improved functional capability, cost-effectively, and in the right setting. Each level of care coordination services offered involves a comprehensive assessment of the member’s condition and/or care needs, determining available benefits and resources, and developing and implementing a plan to meet those needs.

The Care Coordination Department is not intended to replace or substitute for physician management of the member’s medical conditions. PHC staff works collaboratively with the practitioner to coordinate clinical and support services for members and thus decrease the potential for fragmentation of care.

PHC’s Care Management programs are available to each member we serve, however, outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of the targeted population:

- Medi-Cal PHC Eligible Enrollees who are designated by aid code as Seniors and Persons with Disabilities (SPD)
- Members who are chronically ill
- Coordination of care for those needing community-based programs or services
- Genetically handicapped persons in conjunction with the State of California program
- Members preparing for organ transplant
- Members challenged by the complexity of entering and/or complying with the treatment in a managed care network
- High Risk Pregnancies
- Special needs children under age 21 in conjunction with California Children’s Services
- Children and adults with developmental disabilities in collaboration with the California Regional Centers
Standard tools utilized by the Care Coordination Department to screen for the appropriate case-management programs are:

- Health Risk Assessment Tool
- Health Risk Assessment Scoring Protocol Matrix
- Internal/External Data Reports
- Program-Specific Stratification Criteria

**Care Coordination Program Scope**

Targeted programs developed to allow for customization to meet member-specific needs. The overall aim of each program is to provide appropriate interventions to improve the member’s quality of life and care by promoting acceptance and self-management of his/her illness. This is accomplished with frequent personalized communication.
The Care Coordination program is divided into three tiers. The tiers include Episodic, Maintenance, and Complex Coordination of Care. The purpose of this tiered system is to subdivide those members requiring short term intervention from those needing more prolonged care management services. This allows improved tracking and monitoring of case progress. A member may move between any of these programs depending on the identified need. PHC staff is committed to ensuring consistent communication and collaboration with the member, caregivers, providers, and internal team members to best meet the needs of our members.

**Tier 1: Episodic Coordination of Care**
This level of Coordination Services provides acute episodic coordination of care with the goal of barrier resolution within 3 business days for non-urgent needs or within 24 hours for urgent needs.

**Identification**
All call transfers from the Member Services Department and direct calls from any outside source that enter Care Coordination are considered for episodic care coordination.

Referrals are reviewed by the designated Care Coordination staff who, based on the intake information received, will identify the initial needs of the member and will forward the referral to the appropriate.

**Interventions**
Members can receive a broad level of services including but not limited to:
- Education of available Community Resources within their area
- Meals on Wheels
- Housing
In Home Support Services (IHSS)
Multi-Purpose Senior Services Program (MSSP)
Transportation
Emotional Support/Active Listening
Advocacy
Coordination of Services (Appointments, Referrals to Specialty Care, etc.)
Interface/Liaison with special programs staff where others may be approving care and services for PHC members i.e. CCS, GHPP, EPSDT, Regional Centers

Documentation will be stored in the Care Coordination Case Management Referral System to track 3 day response time, and charting of interventions.

If services cannot be resolved within 3 business days a referral to the appropriate Case Management Program will be coordinated.

Process
Using established guidelines, incoming calls will be reviewed by the Care Coordination assigned designee who will, based on the information received during telephonic intake, forward the referral to the appropriate staff member to best provide coordination.
The number of members who were identified with an episodic need for coordination of care whose needs were referred to other appropriate programs available within that region.

**Tier 2: Maintenance Case Management**

PHC’s Care Coordination Maintenance Case Management Team provides services to our Partnership HealthPlan members who require a Case Manager and/or Healthcare Guide on a regular basis but are less intensive than needed for Tier 3. This service is not time-limited and may assist with a broad range of services with the goals of improving health outcomes, increasing appropriate utilization, maximizing the members and self-management skills.

**Identification**

All PHC primary insured members are eligible to receive services in the Maintenance Case Management program. PHC identifies these members through the episodic case management process and takes referrals from a variety of resources including, but not limited to:

- Other PHC Departments (Member Services, Utilization Management, etc.)
- Care Coordination Team
Facility Discharge Planners
Member self-referral
Care Giver and/or Representative
Primary Care Physician/Specialist
Other external agencies (e.g. Area on Aging, Social Service Agencies)
DHCS Data provided for newly enrolled SPD members when available
Health Risk Assessment

Every newly enrolled Medi-Cal Member identified with a Seniors and Persons with Disability aid code is sent the Health Risk Assessment form (HRA) via mail within 10 days of enrollment and annually.

Results from HRA will be received via mail. Members who have not returned the HRA within 2 weeks of the initial mailing are contacted by phone. At least 2 attempts will be made to contact the member within a 14 day period.

HRA answers are entered into a database, and a stratification report is generated daily by PHC staff that will place members in risk categories.

Those members considered low risk may be referred to a case management program if indicated. Those members identified as high risk will be evaluated for the complex case management program.

Process
The Maintenance Case Management process is collaborative, utilizing resources throughout the plan and involving the primary care provider. The Maintenance Case Management Team meets at least quarterly and as needed to discuss active case load and/or barriers identified.

Interventions
Based on the member’s identified needs, a Health Care Guide and/or Case Manager will provide the following:

Outreach to the member to obtain willingness to participate/enroll in the program
Build an individualized care plan addressing both Clinical and Non-Clinical Components
Work with the Primary Care Provider to develop an Individualized Care Plan
Telephonic outreach no less than bi-monthly
Capture and communicate all Care Plan revisions
Apply interventions based on the member’s agreed upon goals

Case Closure
Maintenance Case Management Program will discharge/close a case when the following has occurred:

Member’s stated goals are met and services are no longer needed
Member wishes to opt out
Member loses eligibility for 60 consecutive days
Member has been unable to be contacted with 2 telephonic attempts and 1 letter mailed. If the member later contacts PHC a new case may be opened at that time.
Measure
The following measures are used to evaluate program effectiveness:
- Total number of members enrolled in Maintenance Case Management who have a decrease in utilization costs compared to members not enrolled.
- Total active case load per care coordination staff.
- Percentage of received HRAs resulting in case management need identified.
- Percentage of cases where the referral was addressed within 3 business days of receipt for non-urgent or within 24 hours for urgent requests.

Tier 3: Complex Case Management (CCM)
Provides intervention and care coordination for those members with complex or multiple chronic conditions who have modifiable risk factors. Care Managers and Health Care Guides work closely with members to educate them regarding their health conditions and assist them in modifying habits or lifestyles that put them at risk for exacerbation of their condition. A team approach which may include the attending physician, specialist provider, home health agencies, discharge planners, physical therapists, social workers, and other providers as appropriate is initiated by the nurse coordinating care. Enrollment in CCM is voluntary and the member may disenroll at any time.

Identification
PHC identifies eligible members using a variety of data. Reports are generated and reviewed monthly. In addition, members may be referred for evaluation by:
- Other PHC Departments (Member Services, Utilization Management, etc.)
- Care Coordination Team
- Facility Discharge Planners
- Member self-referral
- Care Giver and/or Representative
- Primary Care Physician/Specialist
- Other external agencies (e.g. Area on Aging, Social Service Agencies)

Process
The services provided to the member by the team are collaborative, utilizing resources throughout the plan and involving the primary care provider. The Team meets to discuss members assessed for participation in the program.

During the meeting various fields of intervention are discussed, such as:
- What are the health issues?
- Medical Home: Is the member established in a medical home and how strong is the relationship?
- Access to Medical Systems: What are the barriers in accessing the medical system?
- Self-Management Skills: What self-management skills does the member have?
Once the proposed care plan is presented to the primary care physician, the plan is implemented by the Team. Documentation of the standardized care plan is maintained in a secure, shared patient file accessible to the interdisciplinary team. The care plan is reviewed and revised as necessary during all follow-up contacts with the member, PCP and or Specialty Care. Contacts are documented in an electronic case management record which includes a reminder feature.

**Interventions**
Interventions are designed and carried out based upon the member’s specific needs. They may include, but are not limited to:
- Exchanging appropriate medical record documentation with primary care physician
- Providing education to the member and/or the caregiver regarding his/her complex medical conditions, what warning signs to look for and appropriate actions to take based on clinical best practice information
- Utilization of disease specific educational checklists that align with health organizations such as American Diabetes Association, American heart Association and American Lung Association
  - Coordinating delivery of necessary durable medical equipment
  - Assessing fall risk and coordinating interventions
  - Medication Reconciliation
- Referral to appropriate behavior modification resources such as smoking cessation classes or other support groups
- Providing assistance in accessing In Home Support Services or other community resources
  - Encouraging and monitoring of adherence with medical appointments
  - Encouraging and monitoring adherence with medications and therapies
- Coordinating services among the member’s multiple providers, facilitating appropriate communication to achieve continuity of care
- For members with transportation barriers, coordination of transportation services is provided
- Advanced Care Planning

**Home Visiting Nurse Practitioner (where available):**
Where available, members can be referred to this program by PCH staff. Once enrolled in this program, the member is able to reach the Nurse Practitioner via cell phone 24 hours per day, 7 days a week. The Nurse Practitioner is able to treat a member early in an exacerbation of illness thus often avoiding an emergency room visit and/or hospitalization. The Nurse Practitioner and CCM staff work to maintain appropriate communication with the PCP to ensure continuity of care.
Total amount of claims paid in the 6 months post enrollment compared to the population who qualified for CCM and declined participation and/or unable to contact.

Hospital Days per 1000 for CCM Enrollees compared to the population who qualified for CCM and declined participation and/or unable to contact.

Outcome of Member Satisfaction Survey distributed at the end of enrollment in CCM or after 6 months of enrollment, whichever comes first.

Goal: 90% Satisfaction Rate

Return On Investment

The outcome of this report is evaluated to determine trends and appropriateness of interventions. Revisions are made to improve the program as necessary.

**Hospital Care Transitions Program**

The objective of the Care Transitions Program is the early identification of members at risk for readmission. The goal of the Care Transitions Program is the early identification of risk for hospital readmission, and to successfully transition them to the appropriate level of care.

**Identification**

The identification process begins with the Care Transitions Coach reviewing the hospital census report and completing the screening tool. Once identified as a potential candidate the Care Transitions Coach meets with the member in the hospital to assess for voluntary enrollment in the program.

**Interventions**

**Hospital Visit(s)**

The Transitions Coach will visit the member in the hospital to establish rapport, initiate the assessment and begin the education process. For prolonged hospitalizations, the Coach will visit the member every 2 to 3 business days. The Transitions Coach will collaborate with the member and facility discharge team for prompt notification of hospital discharge.

**Residential Visit**

Once the member is discharged, the Care Transitions Coach will visit the member wherever the member resides, the PCP office, or an agreed upon location. This visit is to take place as soon as possible after discharge but no later than 5 days from discharge. Interventions during this visit will include:

- Working with the member and/or caregiver to complete a Personal Health Record during the home visit. This record will include a list of pertinent diagnoses, medications, and written questions to ask provider(s). Member will be encouraged to keep this record with him/her at all times and to share it with all healthcare providers.
- Medication Review
x Provide education concerning the member’s condition and warning signs and how to access health systems as necessary, including after hours and on weekends

Telephone Follow Up
Telephonic communication with the member will take place not less than four (4) times. The first call is to be within 2 days of the hospital discharge. The goal is to schedule the residential visit. Subsequent calls will be approximately at day 7, day 14, day 21 and 45 days following discharge. The calls on days 7, 14 and 21 will be tailored to meet the individual needs of the member, but the general goals are reinforcement of education, self-management skills, warning signs, and continuity of follow up care.

Case Closure/Transfer
The Care Transitions Coach will evaluate the member’s needs throughout the course of the program. At any time the member may benefit from one of the other programs offered by Partnership HealthPlan, the Coach will make the appropriate referral. Care Transitions coach will close the case to the Care Transitions Program if it is referred to another program or no more than 45 days after the member’s discharge.

Outcome Measurement
The effectiveness of the Care Transitions Program will be measured by comparing hospital readmission rates, appointment compliance with physician (PCP or specialist) within two (2) weeks of discharge or as ordered and member satisfaction surveys.

x The readmission rate at 30 days post hospital discharge for those members enrolled in the Care Transitions program will be compared to a comparison group (good candidates, not enrolled, for any reason)
x Percentage of patients screened for enrollment who are candidates for enrollment in the program
x Average risk score for patients enrolled

OTHER TRANSITION MANAGEMENT

Growing Together Perinatal Program (GTPP)
The objective of the GTPP is to provide early access to and ongoing prenatal care with the goals of improving birth outcomes and reducing maternal/infant complications. It is the goal of PHC to identify 100% of pregnant PHC members early in the pregnancies, to facilitate entry into prenatal care prior to 12 weeks of pregnancy and assess risks. The focus of care management for GTPP is on members with high risk factors, providing high intensity interventions, and education to improve birth outcomes.

Identification
An analysis was completed to determine effective ways to identify pregnant women both internally and externally. The following methods are now used:
Internal
- Lab Data & Prenatal Profiles
- Welcome Calls
- Pharmacy Reports of Prenatal Vitamin prescriptions and Diabetic Supplies
- Member Services Department Referrals
- Provider Relations Department Referrals
- Inpatient Admission Treatment Authorization Request Forms (TARS)
- Hospital Days Report
- Advice Nurse Triage Reports

External
- WIC Program outreach
- County eligibility department outreach
- Lab Data
- OB/CPSP provider log
- Providers’ semi-annual newsletters
- Transportation requests
- Outreach to Provider Network
- Member notification of program using rack cards in provider offices

Process and Interventions:
Each pregnant woman, regardless of risk, will receive patient education materials about the GTPP incentive program. Information and referral to other community-based resources are provided as appropriate as well. Women determined to be at low risk will be encouraged to contact the GTPP should they need assistance but will not receive active case management services unless requested by the woman. The team will contact the low-risk pregnancies at least once more during the pregnancy to determine if their risk factor has changed.

Measurement
- 90% or above confirmation of post partum visit
- Patient Satisfaction Survey
- A reduction in the rate of preterm births
  - Numerator: # deliveries prior to 37 weeks
  - Denominator: Total # of deliveries

Responsibility

Program Staff

Director of Care Coordination:
Provides oversight of Care Coordination programs and initiatives implemented by the Care Coordination Team designed to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer and Associate/Regional Directors to meet department goals and objectives, while
developing and tracking measurable outcomes of individual Care Coordination Programs. Works collaboratively with Health Education Department Staff, Utilization Management (UM) Leadership, Senior Director of Health Services to ensure appropriate integration of HS policies and procedures.

**Associate Director of Care Coordination:**
Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all product lines. Responsible for establishing and maintaining reports that will support the efficacy of each CC activity/program and to produce a summary at least annually or upon request that includes a summary of CC program activities, member outcomes, return on investment, and quality improvement activities.

**Care Coordination Team Manager:**
Assists the Associate Director of Care Coordination and Director of Care Coordination in the development, implementation and evaluation of PHC’s case management programs. The Manager has day to day direction and management responsibility for the implementation of the care coordination department and reviews and submits issues, updates, recommendations, and information to the Associate Director, Director of Care Coordination, Senior Health Services Director, Chief Medical Officer, Quality/Utilization Advisory Committee (Q/UAC) and Physician Advisory Committee (PAC).

**Manager Chronic Kidney Disease Program:**
Identifies, coordinates and implements the Chronic Kidney Program. The Manager works with the Chief Medical Officer/Physician Designee and the Health Services Senior Director to establish criteria and build reports to identify those members with Chronic Kidney Disease (CKD), who are not on dialysis to coordinate care, provide education, and promote self-management skills to improve outcomes. Key partners in the process are the member, his or her primary care provider (PCP), and nephrologist.

**Care Coordination Team Supervisor:**
Provide supervisory oversight during the daily operations of the care coordination process. Supervise and train assigned Team Members that may include those assigned to the Fairfield Office, Regional Office or those working remotely. Provide leadership, support, resources and direction to staff. Using best clinical expertise and sound judgment (and in consultation with providers and staff), design and implement high quality, cost effective care plans to enable members to achieve maximum medical improvement. Assist in determining appropriateness, quality and medical necessity of treatment plans. This position requires a modified case load with a secondary job description that states the essential duties and responsibilities specific to that secondary role i.e. Intensive Care Manager.

**Care Coordination Assistant:**
Provides administrative support to the Care Coordination Team, answer phones, schedules, maintains department files, and prepares orientation training. Records, transcribes and prepares minutes for distribution. Interfaces with the Health Services
Department Administrative Assistant in assisting with Policy & Procedure updating and reformatting. Manages the Care Coordination department’s inventory of office supplies.

Case Manager I:
Initiates and coordinates a multidisciplinary team approach to case management with members, health care providers, Partnership HealthPlan of California’s Chief Medical Officer or designee, and any patient identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member, while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage his/her condition(s). This position may be assigned cases requiring case management, disease management, or special initiative programs.

Case Manager II:
Initiates and coordinates a multidisciplinary team approach to case management with members, providers, Partnership HealthPlan of California’s Chief Medical Officer or physician designee, and any patient identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member, while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage his/her condition(s). This position may be assigned cases requiring case management, disease management, or special initiative programs.

Case Manager, Special Programs:
Initiates and coordinates within the Maintenance Case Management Program a multidisciplinary team approach to case management with providers, plan medical directors, and community resources to evaluate, monitor and assure that medically necessary care and services are provided in the most cost effective manner. This position will serve as the primary interface with the special programs staff where others may be approving care and service for PHC assigned members. Special Programs may include but are not limited to CCS, Regional Centers, GHPP, EPSDT, SS, and CBAS.

Care Transitions Coach:
The Care Transitions Coach will act as a liaison for selected PHC members to facilitate a smooth and medically appropriate transition when the member moves from the acute hospital to a skilled nursing facility, home or a board and care.

Care Transitions Coach II:
The Care Transitions Coach will act as a liaison for selected PHC members to facilitate a smooth and medically appropriate transition when the member moves from the acute hospital to a skilled nursing facility, home, or a board and care. The Care Transitions Coach II serves as subject matter expert for the Care Transitions Program and provides ongoing leadership and mentoring to the Care Transitions Coach and outside provider agencies.
Health Care Guide I:
In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide I that works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner, while connecting members to available internal and external resources.

Health Care Guide II:
In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide II exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Health Care Guide III:
In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide III serves as a subject matter expert in PHC and departmental policies, procedures and programs and provides ongoing mentorship to HCGIs and HCGHs. This position exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Behavioral Health Liaison:
Under the direction of the Care Coordination Managers, this position will work as part of a multisystem team to act as the Care Coordination Liaison between BEACON Health Strategies, PHC Care Coordination, providers, local and state governments, advocacy groups, and community agencies. This position is responsible for engaging key stakeholders within PHC and in the community/region, including behavioral health and medical providers, to expand their knowledge of PHC’s Behavioral Health, Behavioral Health Therapy (BHT) benefit, positions, and initiatives and to coordinate efforts to increase collaboration and improve access to behavioral health services and provision of services.

Care Coordination Department Trainer:
Under the direction of the Care Coordination Management team and PHC Health Services leadership, this position is responsible for developing, implementing, presenting, and/or facilitating trainings within the Care Coordination Department. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PHC Care Coordination activities and programs to internal and external stakeholders alike.

Perinatal Program Coordinator:
Co-manages perinatal care for PHC members with Comprehensive Perinatal Services Program (CPSP) Case Managers and Perinatal providers. Provides geographically assigned outreach services to providers to identify members appropriate for enrollment.
into PHC’s Growing Together Perinatal Program (GTPP). Participates in activities to promote early entry into prenatal care and identification of women at risk for poor birth outcomes and coordinates appropriate interventions.

**Lead Perinatal Enrollment Specialist:**
Provides guidance and responds daily to a group of 4 Perinatal Staff within the Growing Together Perinatal Program with all identified coordination of care issues. Manages the incentive program, and carries a case load as well.

**Perinatal Enrollment Specialist:**
Responsible for GTTP enrollment; performs initial assessment of new enrollee and, based on criteria, identifies those members at risk for poor birth outcomes. Based on the health risk assessment results, follows appropriate clinical pathway to provide care management interventions for the high risk members throughout pregnancy, prenatal through post-partum. Ensures all women enrolled in the GTPP program have the appropriate community resources to assist them during their pregnancy and postpartum period.

**Perinatal Enrollment Specialist II:**
Responsible for GTTP enrollment; performs initial assessment of new enrollee and, based on criteria, identifies those members at risk for poor birth outcomes. Ensures all women enrolled in the GTPP program have the appropriate community resources to assist them during their pregnancy and postpartum period. Assists Perinatal Program Coordinators when requested with provider communications and provides ongoing training and support to less experienced and newly hired Perinatal Enrollment Specialists.

**Data Coordinator, Special Programs:**
Provides data support to the Care Coordination Team Manager, and Special Program Case Managers. Coordinates meetings with CCS county offices, PHC representatives and Regional Centers. Maintains and distributes updates to policies, procedures, protocols, guidelines and correspondence from the State of California as applicable to Care Coordination and Special Programs for CCS/GHPP/EPSDT and Regional Center programs and services.

**Communications Coordinator:**
Provides day-to-day operations and management of the Health Services / Care Coordination Call Center. Supports the Care Coordination department in inquiries, referral entry, and referral tracking.

**Transportation Specialist:**
Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process.

**Transportation Specialist Lead:**
Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position
includes care coordination as identified during the transportation process. Provides ongoing training and support to less experienced and newly hired Transportation Specialists.

*Medical Services Case Manager:* An embedded Care Coordination staff member who helps facilitate the Patient Centered Medical Home (PCMH) by working in close collaboration with one primary care Provider and/or clinic to provide coordination, education, support and referral services. This position works with a designated group of high-risk members to improve health, connect with community and social services when available.

*Note: Staffing subject to change based upon program need and organizational growth.*
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PROGRAM PURPOSE

To define the scope of services provided by Partnership HealthPlan of California’s (PHC’s) Care Coordination Department.

Introduction

Partnership HealthPlan of California offers basic and complex case management services, on a voluntary basis, to any plan enrollee for whom PHC is the primary source of coverage. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member’s health and human services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. These services assist PHC in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

Department Objectives & Goals

The objectives and goals of PHC’s Care Coordination Department are to:

- Proactively invite members and their care team to participate in programs that will promote positive health outcomes
- Improve member and provider satisfaction
- Minimize gaps between healthcare settings by streamlining transitions across the healthcare continuum
- Provide education to providers about case management programs offered by PHC and encourage referrals when needs or barriers are identified
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources where available
- Facilitate cost-effective care with public resources through the coordination of services in the right setting

The Care Coordination Department is not intended to replace or substitute for physician management of the member’s medical conditions. PHC staff works collaboratively with the practitioner to coordinate clinical and support services for members and thus decrease the potential for fragmentation of care.

Services offered through PHC’s Care Coordination Department are available to each member where PHC is the primary payer; however, outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of the targeted population:

- Medi-Cal PHC eligible enrollees who are designated by aid code as Seniors and Persons with Disabilities (SPD)
• Members who are chronically ill or who have multiple complex medical conditions
• Members needing assistance in accessing community-based programs and/or services
• In conjunction with DHCS, members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support
• Members preparing for organ transplant
• Members challenged by managing their health within PHC’s managed care network
• High-Risk Pregnancies
• In conjunction with California Children Services (CCS), special needs children under age 21 requiring assistance and support
• Children and adults with developmental disabilities in collaboration with the California Regional Centers
• Children in Foster Care

CARE COORDINATION SCOPE OF SERVICES

The Care Coordination Department offers a variety of evidence-based services and interventions in order to coordinate care for members. Our team of Case Managers and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Through the utilization of key approaches such as Motivational Interviewing, the staff in the Care Coordination Department ensure that the member’s goals are at the center of the individualized care plan and assist the member in enhancing his or her autonomy and collaboration within his or her care team.

ADULT BASIC CASE MANAGEMENT

A voluntary service available to all eligible members available both through primary care providers (PCPs) as well as through PHC, Adult Basic Case Management Services assists members with needs and barriers including but not limited to:

• Access to Care – Primary or Specialty Care
• Referrals to Non-Medi-Cal/ PHC Covered Services: IHSS, Denti-Cal, Meals on Wheels, etc.
• Assistance with Ancillary Services or DME
• Assistance with Prescriptions
• Requests to see out-of-network providers (Continuity of Care)
• Disease Management or Health Education
• Education for resources available in their area/community (housing, transportation, support groups, etc.)
Identification and Referrals

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Adult Basic Case Management Services. These activities include things such as:

- Screening of internal reports
- Review of referrals sent to the Care Coordination Department Help Desk email
- Heath Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available

Referrals for Adult Basic Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Adult Basic Case Management from PHC’s own Pharmacy, Utilization Management, Grievance and/or Member Services Departments. Externally, members may self-refer or they may be referred by their caregivers, Primary Care Providers, Specialists, Hospital Case Managers, and/or County or Community Partners such as Public Health Nurses or Home Visiting Program Providers.

Referrals for Adult Basic Case Management can be sent to the department directly via email or phone. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Adult Basic Case Management and will be routed to the appropriate team for case assignment.

Interventions

Based on the member’s stated goals and needs, each member enrolled in Basic Adult Case Management will receive an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Adult Basic Case Management include, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques
- Coordination of Services (Appointments, Referrals, DME, etc)
- Collaboration with county/ community agencies

Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff to evaluate progress and update when necessary.
Process

When referred for Adult Basic Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity, and the member’s individualized care plan will be stored in the Care Coordination Department’s Case Management software system. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Members whose needs change and cannot be met by Basic Adult Case Management will be screened and directed to other available services when appropriate.

ADULT COMPLEX CASE MANAGEMENT

Complex Case Management is a voluntary service offered to PHC members in collaboration with the member’s PCP both telephonically and face-to-face. Complex Case Management encompasses a variety of delivery options tailored to the needs of the member including:

- Transitions of Care
- Complex Case Management
- Intensive Outpatient Case Management
- Chronic Kidney Disease Program
- Community Based Adult Services (CBAS)

Below is a description of the delivery model and criteria for each Complex Case Management Service provided by PHC’s Care Coordination Department:

<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Transitions of Care| A service model that utilizes a Case Manager and Health Care Guide who assist members transitioning from inpatient hospitalization to home. | • Currently inpatient at participating PHC Hospital  
• Anticipated discharge to home  
• Willingness to participate in services |
<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **Complex Case Management**                | A service model that utilizes an RN Case Manager and Health Care Guide for members motivated to improve their modifiable health conditions.                                                                     | • 2+ Chronic Conditions  
• Modifiable conditions  
• 8+ Medications  
• Poor access to care or lack of awareness of community resources  
• In need of specialty care or currently seeing multiple specialists  
• Poor support network; limited or no family assistance  
• Poor understanding/education of medical illnesses  
• High utilization of health care resources  
• Willingness to participate in services |
| **Intensive Outpatient Case Management (IOPCM)** | A service model that utilizes an RN Case Manager and Health Care Guide who work with identified PHC Primary Care Physicians to manage members with multiple complex medical conditions.                                                                 | • 2+ Chronic Conditions; modifiable  
• 8+ Medications  
• Poor Access to Care  
• High Utilization of health care resources  
• Willingness to participate in services  
• Physician agreement for services |
| **Chronic Kidney Disease**                 | A service model that utilizes an RN Program Manager and Health Care Guide who work with identified PHC Nephrologists and Primary Care Providers to manage members with Chronic Kidney Disease and delay onset of dialysis when applicable. | • Stage II or Stage III CKD; no dialysis  
• Poor Access to Care  
• High Utilization of health care resources  
• Willingness to participate in services  
• Physician agreement for services |
| **Community Based Adult Services (CBAS)**  | A service model that utilizes an RN Case Manager to evaluate referrals and complete assessments for Community Based Adult Services (CBAS).                                                                        | • Meets Category 1-5 on DHCS CBAS CEDT Tool  
Once approved, CBAS center to provide continued Case Management Services if needed.             |
Identification and Referrals

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Adult Complex Case Management Services. These activities include:

- Screening of internal reports (High Utilizer Report, Inpatient Reports, Laboratory/Pharmacy Data, etc.)
- Review of referrals sent to the Care Coordination Department Help Desk email
- Heath Information Form(HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available
- Internal Department Meetings (Utilization Management Rounds, Home Visiting Program Rounds, etc.)
- External Department Meetings (Hospital Case Management Rounds, County Collaborative, etc.)

Referrals for Adult Complex Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Adult Complex Case Management from PHC’s own Care Coordination, Pharmacy, Utilization Management, Grievance and/or Member Services Departments. Externally, members may self-refer or they may be referred by their caregivers, Primary Care Providers, Specialists, Hospital Case Managers, and/or county or community partners such as county mental health programs or CBAS Centers.

Referrals for Adult Complex Case Management can be sent to the department directly via email or phone. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Adult Complex Case Management and will be routed to the appropriate team for case assignment.

Interventions

Based on the member’s stated goals and needs, each member enrolled in Adult Complex Case Management will received an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Adult Complex Case Management include, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques
- Medication Reconciliation
- Coordination of Services (Appointments, Referrals, DME, etc.)
- Collaboration with county/ community agencies
Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff and the member’s provider(s) to evaluate progress and update when necessary.

**Process**

When referred for Adult Complex Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity and the member’s individualized care plan will be stored in the Care Coordination Department’s Case Management software. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Members whose needs change and cannot be met by Adult Case Management will be screened and directed to other available services when appropriate.

**PERINATAL & PEDIATRIC CASE MANAGEMENT**

Voluntary Case Management services are offered to PHC members and/or caregivers telephonically. Perinatal & Pediatric Case Management services encompass a variety of delivery models including:

- Growing Together Perinatal Program (GTPP)
- Pediatric Basic Case Management
- California Children Services (CCS)
- Early Intervention/Developmental Delay (Regional Center)
- Behavioral Health Therapy for Autism (BHT)
- Genetically Handicapped Persons Program (GHPP)

Below is a description of the delivery model and criteria for each Perinatal and Pediatric Case Management Service provided by PHC’s Care Coordination Department:
<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **Growing Together Perinatal Program (GTPP)**     | A telephonic service model that utilizes a Perinatal Enrollment Specialist who works with members to assist with access to timely prenatal and postpartum care, and to support their needs for a healthy pregnancy and delivery. | • Currently Pregnant or High Risk Pregnancy  
• Incentive Program  
• Demonstrated need or barrier  
• Assistance with available community resources |
| **Pediatric Basic Case Management**                | A telephonic service model that utilizes an RN Case Manager and Health Care Guide who work with the member/parent/caregiver to assist with access to care, coordination of services, and/or linkages to community resources when necessary. | • Demonstrated need or barrier  
• Willingness to participate in services |
| **California Children Services (CCS)**            | A telephonic service model that utilizes an RN Case Manager and Health Care Guide who work with identified county CCS staff to coordinate care and services for members connected with the CCS Program. | • CCS Eligible Condition, or currently open to CCS  
• Demonstrated need or barrier  
• Primary Case Management Services to be provided by county CCS Program Staff.  
• Assist with Age-Out of CCS Program into Adult Medical Setting |
| **Early Intervention/Developmental Delay (Regional Center)** | Working closely with the Regional Center, PHC Providers, and the family, a telephonic service model that utilizes a Case Manager and Health Care Guide who refer and assist members with services from the Regional Center. | • Possible or confirmed Developmental Delay  
• Demonstrated need or barrier  
• Assistance with available community resources |
<table>
<thead>
<tr>
<th>Delivery Model</th>
<th>Description</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Therapy (BHT)</td>
<td>Working closely with Regional Center, PHC’s Providers, and the family, a telephonic service model that utilizes an RN Case Manager and Health Care Guide to assist and refer members for applicable testing and Behavioral Health Therapy related to an Autism Diagnosis.</td>
<td>• Referral for Comprehensive Diagnostic Evaluation or Behavioral Health Therapy Services</td>
</tr>
<tr>
<td>Genetically Handicapped Persons Program (GHPP)</td>
<td>A telephonic service model that utilizes an RN Case Manager and Health Care Guide to assist and refer members, when appropriate, to the California State GHPP Program. Assists with access to care and disease management education.</td>
<td>• Eligible GHPP Diagnosis • Demonstrated need or barrier</td>
</tr>
</tbody>
</table>

**Identification and Referrals**

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Perinatal and Pediatric Case Management Services. These activities include things such as:

- Screening of internal reports (CCS Open/Close Report, Inpatient TARs, Lab/Pharmacy Reports, etc)
- Review of referrals send to the Care Coordination Department Help Desk email
- Health Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) tool
- SPD Claims Data when available
- Internal Department Meetings
- External Department Meetings (Maternal-Child Advisory Board Meetings, WIC Meetings, Regional Center Meetings, PHC/CCS Quarterly Meeting, etc.)

Referrals for Perinatal and Pediatric Case Management Services originate from a variety of both internal and external sources. Internally, members are commonly referred for Perinatal and Pediatric Case Management from PHC’s own Care Coordination, Utilization Management, Grievance and/or Member Services Departments. Externally, members may self-refer or they may be referred by their caregivers, Primary Care Providers, Specialists, Hospitals, and/or County or Community Partners such as CCS staff, Regional Center staff, WIC staff, or School Nurses.
Referrals for Perinatal and Pediatric Case Management can be sent to the department directly via email or phone. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member as Perinatal and Pediatric Case Management and will be routed to the appropriate team for case assignment.

**Interventions**

Based on the member’s stated goals and needs, each member enrolled in Perinatal and Pediatric Case Management will receive an individualized care plan addressing both clinical and non-clinical components. Typical interventions utilized during Perinatal and Pediatric Case Management includes, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques
- Medication Reconciliation
- Coordination of Services (Appointments, Referrals, DME, etc.)
- Collaboration with county/ community agencies

Interventions are tailored in response to the member’s assessed needs or stated goals. The individualized care plan and corresponding goals are routinely evaluated by Care Coordination staff and the member’s provider(s) to evaluate progress and update when necessary.

**Process**

When referred for Perinatal and Pediatric Case Management, members are advised of the voluntary services that are being offered. If a member declines assistance or is unable to be reached, this is noted in the case record and the case is closed. Furthermore, all case documentation of assessments, interventions, activity and the member’s individualized care plan, will be stored in the Care Coordination Department’s Case Management software. Upon request, copies of the individualized care plan can be mailed to the member, caregiver and/or designee, as well as the interdisciplinary care team.

Upon completion of the goals, the case will be closed unless new barriers or needs are identified. At any time during the course of services, if the member’s status or needs change, the case will be evaluated by the assigned Case Manager to determine service level appropriateness. Members whose needs change and cannot be met by Perinatal and Pediatric Case Management will be screened and directed to other available services when appropriate.
Additionally, Care Coordination staff review each case to ensure that Case Management services are not being duplicated either by another provider or agency. The Care Coordination Department has existing MOUs in place with County and Regional Center partners that allow for information and data sharing supporting these efforts.

PROGRAM QUALITY MONITORING AND OVERSIGHT

PHC’s programs have been developed using evidence from a number of resources, including but not limited to, evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

- Business Case for King County Health Reform Initiative, April 1, 2005, Mercer Consulting
- Reductions in Costly Healthcare Services Utilization; Findings from the Care Advocate Program, The Journal of the American Geriatric Society. 2006
- Standards of Care in Diabetes; American Diabetes Association
- At a Glance Outpatient Management Reference for Chronic Obstructive Pulmonary Disease, Global Initiative for Chronic Obstructive Lung Disease, updated 2013.

Not less than annually, PHC assesses the characteristics of its population, the needs of members, and the programs and resources available. Revisions are made as necessary to continue to address the members’ changing needs.

TEAM ROLES AND RESPONSIBILITIES

**Senior Director of Health Services:** At the senior level, provides overall direction to the HS Care Coordination/Utilization Management Leadership Team. This position has the ultimate responsibility to ensure that all workflow processes and Department Programs and services are consistent and meet all regulatory requirements in every office location.

**Director of Health Services and Utilization Management – Northern Region:** Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer, Senior Director of Health Services, Director of Care Coordination, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services staff to ensure appropriate integration of HS policies and procedures.
**Director of Care Coordination – Southern Region:** Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer, Senior Director of Health Services, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services (HS) staff to ensure appropriate integration of HS policies and procedures.

**Associate Director of Care Coordination:** Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and to produce a summary at least annually or upon request, that includes documentation of department services, member outcomes, return on investment, and quality improvement activities.

**Team Manager UM/CC:** Assists the Associate Director of Care Coordination and Director of Care Coordination in the development, implementation and evaluation of PHC’s case management services. The Manager has day-to-day direction and management responsibility for the implementation of the care coordination department and reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate.

**Program Manager:** Identifies, coordinates and implements the Chronic Kidney Program. The Manager works with the Chief Medical Officer and/or Physician Designee and the Health Services Senior Director to establish criteria and build reports to identify those members with Chronic Kidney Disease (CKD) who are not on dialysis to coordinate care, provide education, and promote self-management skills to improve outcomes. Key partners in the process are the member along with his or her primary care provider (PCP) and nephrologist.

**Case Management Supervisor:** Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best clinical expertise and sound judgment (and in consultation with providers and staff), designs and implement high quality, cost effective care plans to enable members to achieve maximum medical improvement. Assists in determining appropriateness, quality and medical necessity of treatment plans. This position requires a modified case load with a secondary job description that states the essential duties and responsibilities.

**GTPP and CHDP Team Supervisor – Care Coordination:** Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Works closely with Perinatal Coordinators and Perinatal Enrollment Specialists to ensure smooth implementation of GTPP Program Services. Collaborates routinely with county CHDP staff to implement activities as outlined in PHC’s MOUs.

**Care Coordination Case Manager I:** Initiates and coordinates a multidisciplinary team approach to
case management with members, health care providers, PHC’s Chief Medical Officer or physician designee, and any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, disease management, or special initiative programs.

**Care Coordination Case Manager II:** Initiates and coordinates a multidisciplinary team approach to case management with members, providers, PHC’s Chief Medical Officer or physician designee, and any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, disease management, or special initiative programs.

**Care Transitions Coach II:** The Care Transitions Coach will act as a liaison for selected PHC members to facilitate a smooth and medically appropriate transition when the member moves from the acute hospital to a skilled nursing facility, home, or a board and care. The Care Transitions Coach II serves as subject matter expert for the Care Transitions Program and provides ongoing leadership and mentoring to the Care Transitions Coach and outside provider agencies.

**Health Care Guide I/CC:** In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide I works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.

**Health Care Guide II/CC:** In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide II exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

**Health Care Guide III/CC:** In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide III serves as a subject matter expert on PHC and departmental policies, procedures and programs, and provides ongoing mentorship to HCG I’s and HCG II’s. This position exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.
**Medical Services Case Manager:** An embedded Care Coordination staff member who helps facilitate the Patient Centered Medical Home (PCMH) by working in close collaboration with one primary care provider and/or clinic to provide coordination, education, support and referral services. This position works with a designated group of high-risk members to improve health and connect them with community and social services when available.

**Behavioral Health Liaison:** Under the direction of the Care Coordination Managers, this position will work as part of a multisystem team to act as the Care Coordination Liaison between BEACON Health Strategies, PHC Care Coordination, providers, local and state governments, advocacy groups, and community agencies. This position is responsible for engaging key stakeholders within PHC and in the community/region, including behavioral health and medical providers, to expand their knowledge of PHC’s Behavioral Health, Behavioral Health Therapy (BHT) benefit, positions, and initiatives and to coordinate efforts to increase collaboration and improve access to behavioral health services and provision of services.

**Perinatal Program Coordinator I:** Co-manages perinatal care for PHC members with Comprehensive Perinatal Services Program (CPSP) Case Managers and Perinatal providers. Provides geographically assigned outreach services to providers to identify members appropriate for enrollment into PHC’s Growing Together Perinatal Program (GTPP). Participates in activities to promote early entry into prenatal care and identification of women at risk for poor birth outcomes and coordinates appropriate interventions.

**Lead Perinatal Enrollment Specialist:** Provides guidance and responds daily to Perinatal Staff within the Growing Together Perinatal Program with all identified coordination of care issues. Manages the incentive program, and carries a case load as well.

**Perinatal Enrollment Specialist I/CC:** Responsible for GTPP enrollment; performs initial assessment of new enrollees and, based on criteria, identifies those members at risk for poor birth outcomes. Based on the health risk assessment results, follows appropriate clinical pathway to provide care management interventions for the high risk members throughout pregnancy, prenatal through post-partum. Ensures all women enrolled in the GTPP program have the appropriate community resources to assist them during their pregnancy and postpartum period.

**Perinatal Enrollment Specialist II/CC:** Responsible for GTPP enrollment; performs initial assessment of new enrollees and, based on criteria, identifies those members at risk for poor birth outcomes. Ensures all women enrolled in the GTPP program have the appropriate community resources to assist them during their pregnancy and postpartum period. Assists Perinatal Program Coordinators when requested with provider communications and provides ongoing training and support to less experienced and newly-hired Perinatal Enrollment Specialists.
**Data Coordinator, Special Programs:** Provides data support to the Care Coordination Team Manager and Special Program Case Managers. Coordinates meetings with CCS county offices, PHC representatives and Regional Centers. Maintains and distributes updates to policies, procedures, protocols, guidelines and correspondence from the State of California as applicable to Care Coordination and Special Programs for CCS/ GHPP/ EPSDT and Regional Center programs and services.

**Care Coordination Department Trainer:** Under the direction of the Care Coordination Management team and PHC Health Services leadership, this position is responsible for developing, implementing, presenting, and/or facilitating trainings within the Care Coordination Department. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PHC Care Coordination activities and programs to internal and external stakeholders alike.

**Project Coordinator I:** Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

**Clerk:** Provides administrative support to the Care Coordination Team by answering phones, relaying messages, maintaining department files and calendars, preparing documentations/ reports for distribution. Interfaces with the Health Services Department Administrative Assistants to assist with updating documents, ordering and managing department inventory and supplies.

**Administrative Assistant:** Provides direct administrative assistance and support to the department leadership. Manages calendar, organizes meetings, and prepares documentation and written correspondences. Interfaces with other PHC Department Administrative Assistants to organize meetings and activities, responds to requests, and maintain department policies and files.

**Transportation Specialist:** Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process.

**Transportation Specialist Lead:** Works directly with members, providers and facilities to coordinate appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process. Provides on-going training and support to less experienced and newly hired Transportation Specialists.

*Note: Staffing subject to change based upon program need and organizational growth.*
Protected Health Information

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule as of April 14, 2003. The Privacy Officer, Government Relations Specialist also serves as the Privacy Officer for the Health Plan and has implemented a comprehensive program that includes “Notice of Privacy Practices” sent to ALL members, implementation of a confidential toll-free complaint line available to members, providers and PHC staff, and Business Associate Agreements with all PHC vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of CC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- CC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, CC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

NON-DISCRIMINATION STATEMENT

Partnership HealthPlan of California (PHC) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. PHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the
one to which such health services are ordinarily are exclusively available. Also, PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

PHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- PHC provides free language services to people whose primary language is not English, such as:
  - Qualified sign language interpreters
  - Information written in other languages

**PROVIDER AND MEMBER SATISFACTION**

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the CC program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results as well as plans for corrective action are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless committee feels an expedited time frame needs to be implemented.

**ANNUAL PROGRAM EVALUATION**

The overall effectiveness of the Care Coordination program is evaluated in writing annually by the Q/UAC, and is approved by the PAC. The evaluation includes, at a minimum:

- A description of completed and ongoing CC activities.
- Trending of indicators to assess performance.
- Changes in staffing, reorganization, structure or scope of the program during the year.
- An analysis of the overall of the program, including an assessment of barriers and/or limitations.
- An evaluation of delegated activities.
- Recommendations for changes to be incorporated into the subsequent annual CC work plan.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. When the evaluation is complete, an announcement indicating the availability of CC information will be published in the member and provider newsletters.
**CARE COORDINATION PROGRAM APPROVAL**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Moore, MD, CMO</td>
<td>Quality/Utilization Advisory Committee Chairperson</td>
<td>06/21/2017</td>
</tr>
<tr>
<td>Jeffrey Gaborko, MD</td>
<td>Physician Advisory Committee Chairperson</td>
<td></td>
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<tr>
<td>Kathryn Powell</td>
<td>Board of Commissioners Chairperson</td>
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</tbody>
</table>
E. Treatment Plan Criteria

1. BHT services in compliance with Health and Safety Code 1374.73 and Welfare and Institution Code 4686.2 shall be rendered in accordance with the beneficiary’s treatment plan. The treatment plan shall have measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific member being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
   a. Describes the patient’s behavioral health impairments or developmental challenges that are to be treated
   b. Designs an intervention plan that includes the service type, number of hours and parent participation needed to achieve the plan’s goal and objectives, and the frequency at which the member’s progress is evaluated and reported
   c. Provider’s intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
   d. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate

2. In compliance with DHCS All Plan Letter 14-01115-025, the treatment plan shall:
   a. Be developed by a qualified autism service provider for the specific beneficiary being treated
   b. Be person-centered and based upon individualized measurable goals and objectives over a specific timeline
   c. Include a description of patient information, reason for referral, brief background information (demographics, living situation, home/school/work information), clinical interview, review of recent assessment/reports, assessment procedures and results and focused or comprehensive ABA requirements
   d. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors
   e. Identify measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant measurable, and based upon clinical observation
   f. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives
   g. Utilize evidence-based BHT services with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary
   h. Ensure that interventions are consistent with evidenced-based BHT techniques. Include the current level (baseline, behavior parent/guardian is expected to demonstrate), including condition under which it must be demonstrated and mastery criteria [the objective goal], date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, modified (include explanation)
   i. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the patient’s progress is measure and reported, transition plan, crisis plan and the individual providers responsible for delivering the services and supervision, and parent or guardian participation needed to achieve the plan’s goals and objectives, the frequency at which the beneficiary’s progress is reported, and identifies the individual providers responsible for delivering the services
   j. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable;
kj. Consider the patient’s age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.

l. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT service that is provided in school must be clinically indicated as well as proportioned to the total BHT services received in the home and community.

m. Include and exit plan/criteria include parent/caregiver training, support, and participation.

F. BHT Service Limitations

1. Services must give consideration to the child’s age, school attendance requirements, and other daily activities as documented in the treatment plan.

2. Services must be delivered in a home or community-based settings, including clinics.

3. Services will be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.

4. PHC will comply with requirements related to coordination with Local Education Agencies.

5. PHC may cease to authorize continued services that do not meet medical necessity criteria, nor qualify for covered BHT services for reimbursement, including:

   a. Therapy services rendered when continued clinical benefit is not expected.

   b. Providing or coordinating Services that are primarily respite, daycare or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan in nature and are used to reimburse a parent for participating in the treatment program.

   c. Treatment whose sole purpose is vocationally or recreationally-based.

   d. Custodial care defined as provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety; care that is provided primarily for maintaining the recipient’s or anyone else’s safety; and care that could be provided by persons without professional skills or training.

   e. Services, supplies, or procedures performed in a non-conventional setting including but not limited to resorts spas or camps.

   f. Services rendered by a parent, legal guardian, or legally responsible person.

   g. Services that are not evidence-based practices used in the treatment of ASD.

G. Transition of Members Receiving Services from Regional Centers

1. Effective on or after the transition date and phased in approach (to be determined by DHCS), PHC will assume financial responsibility for BHT service for children under the age of 21 who had previously received BHT under a Regional Center. All Regional Center services, other than BHT services for children diagnosed on the Autism Spectrum disorder, will remain the responsibility of the Regional Center.

2. PHC and the member’s local Regional Center will work together to ensure that the needs of the member are met. A Memorandum of Understanding (MOU) that clearly defines roles and responsibilities will be executed between the Regional Centers and PHC.

3. The member and responsible party (parent, guardian) will receive notice of the transition at 60 and 30 days prior to transition implementation. PHC’s Special Program Case Managers and Member Services staff will also attempt outreach to each member’s parent/guardian via telephone to discuss the transition, answer any questions, and to assure them that the transition should not interrupt treatment.

4. Continuity of Care

   a. For members under 21 years of age with a diagnosis of ASD transitioning from a Regional Center, PHC must automatically generate a continuity of care request. Members do not have to independently request continuity of care from PHC. DHCS will provide PHC with a list of transitioning members who services will transfer from the Regional Center to PHC. PHC will make
Continuity of Care for an out-of-network BHT provider can be granted for a member for up to 12 months when all of the following DHCS criteria is met: If the member is receiving services from an out-of-network provider, PHC will enter into a continuity of care agreement for up to 12 months when:

1. The beneficiary member has a pre-existing relationship with the provider as defined by DHCS (pre-existing relationship is defined as: the member has seen the out-of-network BHT provider at least one time during the previous six months of transition from a Regional Center or date of assignment to PHC)
2. The plan and the provider can agree to a minimum of the Medi-Cal FFS rate
3. The BHT provider meets professional standards and has no identified quality of care issues
4. The BHT provider is a California State Plan CMS approved provider as defined in the Health & Safety Code 1374.73 and
5. The BHT provider supplies PHC with relevant treatment information for the purpose of determining medical necessity, as well as current treatment plan, as long as it is allowable under federal and state privacy laws and regulations. Documents (i.e., assessment and treatment plan) are provided to PHC by the provider to facilitate continuity of care.

If PHC and the existing member’s provider are unable to reach a continuity of care agreement, PHC will reach out to the member to transition through a warm handoff to an in-network BHT provider to ensure no gaps in services will apply.
VII. REFERENCES:
E. Diagnostic and Statistical Manual (DSM) V
F. Health & Safety Code Section 1374.73(c)
G. Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532
H. Welfare & Institutions Code Section 14132(v) and 4686.2
I. Department of Health Care Services All Plan Letter 15-019: *Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care* (8/25/15)

VIII. DISTRIBUTION:
A. Department Directors
B. Provider Manual

 IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 08/19/15 effective 09/15/14 per DHCS; 11/18/15; 09/21/16; 06/21/17

PREVIOUSLY APPLIED TO:
N/A

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
I. RELATED POLICIES:
A. MCCP2022 - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
B. MPCP2006 - Coordination of Services for Members with Special Health Care Needs (MSHCNS) and Persons with Developmental Disabilities
C. MCUP3041 - TAR Review Process
D. MCCP2014 - Continuity of Care

II. IMPACTED DEPTS:
A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:
A. Autism Spectrum Disorder (ASD) is characterized by varying degrees of difficulty in social interaction, verbal and non-verbal communication, and manifestation of repetitive behavior and restricted interests. According to Diagnostic and Statistical Manual (DSM) V, a diagnosis of ASD includes several conditions including Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) and Asperger Syndrome.

B. Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. (BACB Certification Board Guidelines 2012)

C. Behavioral Health Treatment (BHT) means professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation and evaluation of environmental modification using behavioral stimuli and consequences to produce significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental. (Department of Health Care Services [DHCS] All Plan Letter 15-025)

D. Behavior Analyst Certification Board (BACB) is a corporation established to meet professional credentialing needs identified by behavior analysts and government agencies. They have defined requirements for behavior provider certification. They are accredited by the National Commission for Certifying Agencies.
E. California Association for Behavioral Analysis (CalABA) is the state association for professional behavior analysts in California. The association publishes guidelines and offers support and resources for behavior analysts. It has provided guidelines and recommendations to the Department of Developmental Services (DDS) and other entities toward ensuring appropriate, cost-effective behavior services, and utilization of qualified experts in the delivery of services.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services is a federally mandated Medicaid/Medi-Cal benefit for Medi-Cal beneficiaries under age 21 for medically necessary treatment services needed to correct or ameliorate a defect, physical illness, mental illness or a condition, even if the service or item is not otherwise included in the State’s Medicaid Plan. (Source: Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532)

G. Parent Training - Service Type refers to instruction, observation and/or modeling behavior techniques under the direct guidance/supervision of the behavior therapy agency staff who developed the behavior treatment plan.

H. Release of Information (ROI) Consent Form is a form valid one calendar year from the date of signature of the member to allow the Regional Center and/or Regional Center Behavioral Health Treatment (BHT) provider to share the treatment information with the managed care plan.

I. Skills Training - Service Type refers to treatment toward development of improvement of adaptive functioning. Domains of adaptive function may include communication (receptive/expressive and pragmatic language); socialization; fine and gross motor development; self-help/daily living skills-eating, toileting, dressing, hygiene; and social emotional functioning. (Source: Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment, California Department of Developmental Services, pg 51-52.)

J. Therapeutic Behavior Service - Service Type refers to treatment that seeks to identify the stimulus of challenging behaviors and then developing a plan that promotes the development of new skills while reducing the adverse behavior. Challenging behaviors may include tantrums, aggression, self-injury. (Source: Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment, California Department of Developmental Services, pg 64-65.)

IV. ATTACHMENTS:
N/A

V. PURPOSE:
To define Partnership HealthPlan of California’s (PHC’s) financial responsibility to provide for Behavioral Health Treatment (BHT) services to PHC Medi-Cal eligible beneficiaries under age 21 diagnosed with Autism Spectrum Disorder (ASD) under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Supplemental Services benefit. To provide an overview of best practices per California Association for Behavior Analysis (CalABA March 2011) and Behavior Analyst Certification Board (BACB report 2012) that meet the expectations of Department of Health Care Services (DHCS) and Partnership HealthPlan for delivery of quality behavioral services.

VI. POLICY / PROCEDURE:
A. General Criteria for BHT Services
In order to be eligible for BHT services, a PHC Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:
1. Be under 21 years of age and have a completed diagnostic evaluation confirming ASD or a provisional diagnosis of ASD if under the age of 3
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (including, but not limited to, aggression, self-injury,
elopement, and/or social interaction, independent living, play and/or communication skills) requiring behavioral assessment and treatment

3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID)

B. Diagnostic Evaluation

1. Member must have undergone a comprehensive diagnostic evaluation by an appropriately licensed and/or certified behavior professional that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate. The diagnostic evaluation should include clinical history, direct observation, review of available records and standardized measures including but not limited to ASD features, cognitive abilities and adaptive functioning using published instruments such as Autism Diagnostic Observation Schedule (ADOS). If a copy of the diagnostic evaluation is not available and other reports are provided, such as school reports, those reports will be reviewed. If those reports are not determined to be sufficient, PHC may obtain/authorize a comprehensive diagnostic evaluation.

2. If member does not have a diagnostic evaluation PHC will authorize up to 8 hours for the diagnostic evaluation, which is to include the written report. If, due to special circumstances, it is anticipated that additional time will be needed, the Provider must request the additional time and it must be pre-approved by PHC. Diagnostic evaluation will include:
   a. Clinical history with informed parent/guardian, inclusive of developmental and psychosocial history
   b. Direct observation
   c. Review of available records
   d. Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team

C. Covered Services for Behavior Assessment and Behavioral Health Treatment (BHT)

1. TARS will be required for all BHT services and should be faxed or electronically submitted from the Provider to the Health Services Department for review based upon medical necessity criteria and procedures otherwise in compliance with PHC Policy MCUP3041 TAR Review Process.

2. A signed and dated ROI consent form must be submitted with any BHT related clinical documentation or TAR. The ROI is valid for one calendar year from the date of signature and may be cancelled by the member at any time. A copy of the ROI must be submitted with any BHT related clinical documentation. Failure to do so may result in a delay of service.

3. EPSDT covered BHT services must be:
   a. Prescribed by a licensed physician or surgeon or developed by a licensed psychologist
   b. Determined as medically necessary as defined by Welfare & Institutions Code Section 14132(v)
   c. Authorized prior to provision of service in accordance with PHC Policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services; and
   d. Delivered in accordance with the member’s approved treatment plan

D. Providers of Services

BHT services must be provided and supervised under an approved treatment plan developed by a “qualified autism service provider” as defined by Health & Safety Code Section 1374.73(c). In accordance with DHCS, treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3)

2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider

3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is
supervised and employed by a qualified autism service provider.

E. Treatment Plan Criteria

1. BHT services in compliance with Health and Safety Code 1374.73 and Welfare and Institution Code 4686.2 shall be rendered in accordance with the beneficiary’s treatment plan. The treatment plan shall have measureable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific member being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

a. Describes the patient’s behavioral health impairments or developmental challenges that are to be treated

b. Designs an intervention plan that includes the service type, number of hours and parent participation needed to achieve the plan’s goal and objectives, and the frequency at which the member’s progress is evaluated and reported

c. Provider’s intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

d. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate

2. In compliance with DHCS All Plan Letter 15-025, the treatment plan shall:

a. Be developed by a qualified autism service provider for the specific beneficiary being treated

b. Be person-centered and based upon individualized measurable goals and objectives over a specific timeline

c. Include a description of patient information, reason for referral, brief background information (demographics, living situation, home/school/work information), clinical interview, review of recent assessment/reports, assessment procedures and results and focused or comprehensive ABA requirements

d. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors

e. Identify measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant and based upon clinical observation

f. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives

g. Utilize evidence-based BHT services with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary

h. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal], date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, modified (include explanation)

i. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the patient’s progress is measure and reported, transition plan, crisis plan and the individual providers responsible for delivering the services

j. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable

k. Consider the patient’s age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision

l. Deliver BHT services in a home or community-based setting, including clinics. Any portion of
medically necessary BHT service that is provided in school must be clinically indicated as well as proportioned to the total BHT services received in the home and community, and
m. Include and exit plan/criteria

F. BHT Service Limitations
1. Services must give consideration to the child’s age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. Services will be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. PHC will comply with requirements related to coordination with Local Education Agencies.
5. PHC may cease to authorize continued services that do not meet medical necessity criteria, nor qualify for covered BHT services for reimbursement, including:
   a. Therapy services rendered when continued clinical benefit is not expected
   b. Providing or coordinating respite, daycare or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan
   c. Treatment whose sole purpose is vocationally or recreationally-based
   d. Custodial care defined as provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety; care that is provided primarily for maintaining the recipient’s or anyone else’s safety; and care that could be provided by persons without professional skills or training.
   e. Services, supplies, or procedures performed in a non-conventional setting including but not limited to resorts spas or camps
   f. Services rendered by a parent, legal guardian, or legally responsible person, and
   g. Services that are not evidence-based practices used in the treatment of ASD

G. Continuity of Care
1. For members under 21 years of age with a diagnosis of ASD transitioning from a Regional Center, PHC must automatically generate a continuity of care request. Members do not have to independently request continuity of care from PHC. DHCS will provide PHC with a list of transitioning members who services will transfer from the Regional Center to PHC. PHC will make a good faith effort to proactively contact the current treating provider(s) to begin the continuity of care process. For all members assigned to PHC on or after September 15, 2014, who were not receiving BHT services from a Regional Center, PHC will offer the same continuity of care as outlined below.
2. Continuity of Care for an out-of-network BHT provider can be granted for a member for up to 12 Months when all of the following DHCS criteria is met:
   a. The member has a pre-existing relationship with the provider as defined by DHCS (a pre-existing relationship is defined as: the member has seen the out-of-network BHT provider at least one time during the previous six months of transition from a Regional Center or date of assignment to PHC)
   b. The plan and the provider can agree to a minimum of the Medi-Cal FFS rate
   c. The BHT provider meets professional standards and has no identified quality of care issues
   d. The BHT provider is a California State Plan CMS approved provider and
   e. The BHT provider supplies PHC with relevant treatment information for the purpose of determining medical necessity, as well as current treatment plan, as long as it is allowable under federal and state privacy laws and regulations

If PHC and the existing member’s provider are unable to reach a continuity of care agreement, PHC will reach out to the member to transition through a warm handoff to an in-network BHT
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<th>Lead Department: Health Services</th>
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provider to ensure no gaps in services will apply.
VII. REFERENCES:


D. Department of Health Care Services All Plan Letter 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder (12/3/15)

E. Diagnostic and Statistical Manual (DSM) V

F. Health & Safety Code Section 1374.73(e)

G. Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532

H. Welfare & Institutions Code Section 14132(v) and 4686.2

I. Department of Health Care Services All Plan Letter 15-019: Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care (8/25/15)

VIII. DISTRIBUTION:

A. Department Directors

B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 08/19/15 effective 09/15/14 per DHCS; 11/18/15; 09/21/16; 06/21/17

PREVIOUSLY APPLIED TO:

N/A

******************************************************

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
## PARTNERSHIP HEALTHPLAN OF CALIFORNIA
### POLICY/PROCEDURE

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<td><strong>Approval Signature:</strong> Robert Moore, MD MPH MBA</td>
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### I. RELATED POLICIES:
A. MCUP3020 Hospice Service Guidelines
B. MCUP3041 TAR Review Process
C. MCUP3124 RAF Review Policy
D. MPCR #4 Initial Credentialing Requirements

### II. IMPACTED DEPTS:
A. Health Services
B. Provider Relations
C. Member Services
D. Claims

### III. DEFINITIONS:
A. **ED:** Emergency Department
B. **Hospice Care:** Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course.
C. **Medical Necessity:** Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. **Palliative Care:** Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
E. **Palliative Care Team:** A group of healthcare individuals such as a Doctor of Medicine or Osteopathy, Physician Assistant, Nurse Practitioner, Registered Nurse, Social Worker and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a member and his/her family and assist in identifying sources of pain and discomfort.
F. **RAF:** Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (PHC) to refer a PHC member to a specialist for evaluation and/or treatment.
G. **TAR:** Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner’s office.

### IV. ATTACHMENTS:
A. Palliative Care Eligibility Assessment
B. Certification of Terminal Illness
C. Engagement and Intensive Home Based Palliative Care Enrollment Process
D. Application to be a Contracted Intensive Home-Based Palliative Care Provider
V. PURPOSE:
To define Partnership HealthPlan of California (PHC’s) Palliative Care services to PHC Medi-Cal eligible beneficiaries.

VI. POLICY / PROCEDURE:
A. GENERAL ELIGIBILITY CRITERIA
1. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment D) and have a palliative care contract in place with PHC.
2. The Intensive Palliative Care Management benefit is limited to members who have Partnership HealthPlan of California as their primary insurance.
3. A member must meet all criteria below and at least one of the four disease-specific criteria outlined in Section VI.B.3 to be eligible for Intensive Palliative Care services.
   a. Eighteen years of age or older
   b. The patient is likely to or has started to use the hospital or emergency department as a means to manage unanticipated decompensation in his/her late stage of illness.
   c. Patient is in a late stage of illness (section VI.B.1.a.) and is not eligible for or declines hospice enrollment.
   d. The patient’s death within 12 months would be expected based on clinical status as documented by the “Certification of Terminal Illness” (Attachment B).
   e. Patient has received appropriate medical therapy or for whom treatment is no longer effective. Patient is not in reversible acute decompensation.
   f. Patient is willing to attempt in-home, residential or outpatient disease management as recommended by the Palliative Care team instead of first going to the emergency department.
   g. Patient is willing to participate in Advance Care Planning discussions.
   h. Patient has a Palliative Performance Scale score of 70 or less

B. PATIENT ENGAGEMENT AND ENROLLMENT PROCESS
1. **Patient Palliative Care Assessment and Consultation (Engagement):**
   a. No prior authorization is required for the engagement process for members who meet one or more of the following diagnostic categories.
      1) CHF
      2) COPD
      3) Advanced Cancer
      4) Liver Disease
   b. If the patient has one of the four covered diagnoses, and does not meet the general or specific criteria or life expectancy for enrollment, submit a TAR for the engagement only. However, if the patient meets the criteria for engagement AND enrollment criteria, submit a TAR for engagement along with the TAR for enrollment. Submit the TAR for engagement with progress or consultation notes documenting the following:
      1) One of the four covered diagnoses
      2) Date of face to face or telemedicine visit with MD, FNP, PA, or RN team member in Palliative Care Quality Network (PCQN)
      3) Advanced care discussion with goals of care document
      4) Care Plan addressing medical, social, emotional and spiritual needs
   c. A multidisciplinary comprehensive assessment is required.
   d. Engagement will occur after discharge from the hospital.

2. **Intensive Home Based Palliative Care (Enrollment)** (see Attachment C for detailed requirements)
   For patients who meet the disease specific criteria (VI.B.3)
   a. Submit a TAR for the member’s enrollment into the Intensive Home Based Palliative Care program to PHC in accordance with PHC policy MCUP 3041 TAR Review Process. For the
enrollment TAR, Provider must submit the information required for the engagement TAR [VI.B.1.b. 1) thru 4)] as well as:
   1) Eligibility Assessment Form (Attachment A)
   2) Certification of Terminal Illness for life expectancy of less than 12 months (Attachment B)
   b. For members in the hospital, enrollment will take place after discharge. The Palliative Care Management TAR will be approved for three months. Continued approval will require subsequent TAR submission with the following information included:
      1) Progress notes, documenting current disease status
      2) Certification of Terminal Illness (Attachment B)
      3) Date of face to face or telemedicine visit
3. Disease Specific Criteria
   a. **Congestive Heart Failure (CHF)**: Member must meet 1) and 2)
      1) The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
      2) The member has an ejection fraction of < 30% for systolic failure OR significant comorbidities.
   b. **Chronic Obstructive Pulmonary Disorder (COPD)**: Member must meet 1) or 2)
      1) The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
      2) The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
   c. **Advanced Cancer**: Member must meet 1) and 2)
      1) The member has a diagnosis of stage III or IV solid organ cancer, lymphoma, or leukemia, AND
      2) The member has a Palliative Performance Scale (PPS) score less than or equal to 70, or has failure of two lines of standard chemotherapy.
   d. **Liver Disease**: Member must meet 1) and 2) combined, or 3) alone
      1) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
      2) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
      3) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
4. Providers of Services
   a. PHC will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities who utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with PHC policy MP CR #4 Initial Credentialing Requirements. PHC will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a member’s home must comply with existing PHC policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.
   b. PHC will inform and update providers regarding this benefit through outreach, engagement and education activities in both the Provider Relations and Health Services Departments. Additionally, all approved Palliative Care service providers shall be listed in PHC’s Provider Directory.
   c. Provider organization must submit an application to become contracted Intensive Home Based
Palliative Care Providers (See Attachment D for application). Criteria for consideration includes the following:

1) Completed application (Attachment D)
2) Organization or all providers are contracted Medi-Cal providers
3) Organization must have the capacity to bill PHC for services provided
4) Organizations that are already contracted with PHC for other services must be providers in good standing
5) Clinical staff are trained in palliative care. Minimum training is the Cal State San Marcos Institute for Palliative Care Training Curriculum, or equivalent, which must be completed by a staff member no later than 3 months after beginning to work for the Intensive Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
6) Ability to collect and submit data using the Palliative Care Quality Network system (PCQN) (system access is purchased by PHC for contracted providers). Provider will be required to enter into a Data Sharing Agreement with PCQN in order to submit data through the PCQN System.
7) Core staffing identified (hired or contracted to be hired by contract start date):
   a) Medical Director
   b) RN
   c) Social Worker
   d) Administrator
8) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting.

d. Submission of an application does not guarantee that PHC will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.

e. Contracted sites must pass a PHC facility and medical record site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in PHC Policy MPQP1022 Site Review Requirements and Guidelines.

VII. REFERENCES:
A. Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual
B. Department of Health Care Services, SB 1004 Medi-Cal Palliative Care October 2, 2015 (2015).
C. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
D. Social Security Act 1812(d)(1)
E. Welfare and Institutions Code Section 14132.75

VIII. DISTRIBUTION:
A. Department Directors
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES:
N/A
PREVIOUSLY APPLIED TO:
MCUP3122 Palliative Care was archived 06/21/2017

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
Partnership HealthPlan of California
Palliative Care Eligibility Assessment

Name: ______________________________________
DOB: _____________________________
Type of Insurance: _____________________________
Name of Palliative Care Program: ______________________________

**General criteria:** Check each of the following that apply (All needed for eligibility).
- ☐ Patient who is likely to or has started to use the hospital as a means to manage his/her late stage disease. This refers to unplanned ‘decompensation’, not elective procedures
- ☐ Patient evaluated in his/her best compensated state
- ☐ Life expectancy of 12 months or less
- ☐ Patients and Families are both
  - a. Willing to attempt in-home disease management by the Transitions team instead of first going to the emergency department AND
  - b. Willing to participate in Advance Care Planning
- ☐ At least one of the following is true:
  - a. Patient is intolerant to further therapy
  - b. Patient declines further therapy
  - c. Patient repeatedly decompensates due to severe non-compliance

In addition, one of the following diagnoses must be selected, and the associated severity criteria met:

1. **Congestive Heart Failure (CHF)**
   - ☐ Any patient who is hospitalized due to CHF as the primary diagnosis. No further invasive interventions planned although access to curative care is maintained, or
   - ☐ NYHA III (Definition of NYHA III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.)

   AND one of the following:
   - ☐ Ejection Fraction < 30 for systolic failure
   - ☐ Significant comorbidities: e.g. renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/ Creatinine (patient is in his/her best compensated state), and CAD.

2. **Chronic Obstructive Pulmonary Disease (COPD):**
   - ☐ Severe airflow obstruction: FEV1 < 35 % predicted AND
   - ☐ 24-hour oxygen requirement at less than 3L/minute
      - OR
   - ☐ 24-hour oxygen requirement at greater than or equal to 3 L/minute

3. **Advanced Cancer:**
   - ☐ Any Stage III or IV cancer, locally advanced or metastatic cancer, leukemia or lymphoma
      AND one of the following:
   - ☐ Palliative Performance Scale (PPS) score < or equal to 70
   - ☐ Being failed by two lines of standard chemotherapy.
4. Liver Disease:
   Irreversible Liver Damage AND
   BOTH of the following:
   - Albumin <3.0
   - INR > 1.3
   PLUS one of the below
   - Ascites
   - Subacute bacterial peritonitis
   - Hepatic encephalopathy
   - Hepatorenal syndrome
   - Recurrent esophageal bleeds

OR Model for End Stage Liver Disease (MELD) score of greater than 19

To calculate MELD Score: [https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/](https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/)

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Palliative Performance Scale
Certification or Re-certification of Terminal Illness:

I certify that (patient’s name) is terminally ill with a life expectancy of twelve months or less if the terminal illness runs its normal course.

Patient Summary:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

I confirm that I composed this narrative statement and that it is based on my review of the patient’s medical record and/or my personal examination of the patient.

__________________________________________________________________________________

Physician                                      Date
Engagement and Intensive Home Based Palliative Care Enrollment Process

PHC does not require a RAF from a primary care provider (PCP) to refer patients for palliative care services. A Treatment Authorization Request (TAR) will be required for all Palliative Care Services (engagement and enrollment) and should be faxed or electronically submitted from the palliative care provider to the Health Services Department for review, no less than once every three months, based upon medical necessity criteria and in accordance with PHC Policy MCUP3041 TAR Review Process. The TAR request for Palliative Care services must include, at a minimum, documentation and/or treatment plan addressing the following:

1. **Advanced Care Planning:** includes discussions about advance directives and Physicians Authorization for Life Sustaining Treatment (POLST) forms. These discussions take place between a physician and other qualified healthcare professional and a member, family member or surrogate in counseling.

2. **Assessment and Consultation:** palliative care assessment and consultation services may be provided at the same time as advanced care planning, or in subsequent patient conversations. The goal of the palliative care consultation is to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include but are not limited to:
   a) Treatment plans, including palliative care and curative care
   b) Pain and medication side effects
   c) Emotional and/or social challenges
   d) Spiritual concerns
   e) Patient goals
   f) Advance Directives, including POLST forms

3. **Plan of Care:** a plan of care should be developed with the engagement of the member and/or his healthcare representative. If a member already has a plan of care in place, that plan should be updated to reflect any changes resulting from the palliative care consultation. A member’s plan of care must include all authorized palliative care including, but not limited to, symptom management and curative care.

If a member continues to meet the above minimum eligibility criteria, he/she may continue to access both palliative care services and curative care until the condition improves, stabilizes, or results in death. PHC will review treatment plan notes with TAR submission to assess for changes in the member’s condition and continued palliative care needs. PHC may discontinue palliative care for members who no longer meet the criteria outlined above, or for whom palliative care is no longer medically necessary.

All contracted palliative care sites will automatically be eligible for a Palliative Care Intensive Program Quality Improvement Program (PC QIP). Details of this PC QIP change from year to year; current versions are documented in the Quality Improvement section of the PHC website.
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300) Lead Department: Administration

Policy/Procedure Title: Medi-Cal Member Grievance System

External Policy Internal Policy

Original Date: 02/11/99 (MS 300) Next Review Date: 6/21/2018
Last Review Date: 6/21/2017

Applies to: ☒ Medi-Cal ☐ Employees

Reviewing Entities: ☒ IQI ☐ P & T ☒ QUAC
☐ OPERATIONS ☐ EXECUTIVE ☐ COMPLIANCE ☐ DEPARTMENT

Approving Entities: ☐ BOARD ☐ COMPLIANCE ☐ FINANCE ☐ PAC
☐ CEO ☐ COO ☐ CREDENTIALING ☐ DEPT. DIRECTOR/OFFICER

Approval Signature: Robert Moore, MD, MPH Approval Date: 6/21/2017

I. RELATED POLICIES:
A. MCLP7002 Cultural and Linguistic Services
B. MPQP1016 Potential Quality Issue Investigation and Resolution
C. MCUP3037 Appeals/Expedited Appeals of UM Decisions for Medical Necessity Determination (Non-Administrative)

II. IMPACTED DEPTS:
A. Member Services
B. Grievance
C. Provider Relations
D. Health Services
E. Claims
F. Quality
G. Pharmacy

III. DEFINITIONS:
A. Acknowledgement Letter is a written notification of receipt of a grievance or appeal that is sent to the member or member’s authorized representative.
B. Appeal is a member’s request to Partnership HealthPlan of California (PHC) for reconsideration of an initial utilization review decision resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.
C. Adverse Benefit Determination encompasses all previously existing elements of “Action” under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability.
D. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent him/her in matters regarding his/her healthcare.
E. Complaint is the same as a Grievance. Where PHC is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
F. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are received over the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.
G. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of
life, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.

H. **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

I. **Grievance Clinical Lead** (GCL) is the clinical staff member responsible for initiating and coordinating a multidisciplinary team approach to handling of grievances with members, providers, plan Medical Director, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to non-clinical staff as needed. The clinical lead may also provide input or participate in state hearings.

J. **Grievance Coordinator** is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgements and resolutions to member grievances and appeals. The Grievance Coordinator also represents PHC during state hearings.

K. **Grievance system** is the computer system that PHC uses to log and track member grievances, appeals, and state hearing requests which are logged by specific grievance types.

L. **Inquiry** is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to; questions pertaining to eligibility, benefits, or other PHC processes.

M. **Member** is the Medi-Cal eligible individual receiving health care through PHC to whom reference will be made as "member" in all protocols.

N. **Member Grievance Review Committee (MGRC)** is a forum to conduct multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representatives from Grievances, Member Services, Provider Relations, Care Coordination, Quality, Pharmacy, Utilization, and Compliance.

O. **Member Services Representatives (MSR’s)** are the PHC staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through PHC, including the grievance, appeal and hearing procedures, and assist members in obtaining resolution to their issues.

P. **Non-Contracting Provider or Practitioner** is a health care provider who does not have a contract with PHC, but may do business with PHC for specific reasons, e.g., provision of emergency, out-of-area or one-time member care.

Q. **Notice of Action** is a formal letter informing a member of an Adverse Benefit Determination.

R. **Practitioner** is a licensed individual who provides medical care.

S. **Primary Care Provider (PCP)** is a physician who has executed an agreement with PHC to provide the services of a primary care physician.

T. **Provider** is an organization such as a hospital, residential treatment center or rehabilitation facility.

U. **Remark System (RS)** is the AMISYS computer system that PHC uses to log and track specific grievance types that are resolved by the end of the following business day. This system is also used by staff to make notes and document other issues relating to a grievance, appeal or state hearings.

V. **Resolution Letter** is written notice of the outcome of a grievance or an appeal. This letter will include information regarding any applicable next steps and appeal rights.

W. **Standard Grievance** is a grievance that cannot be resolved by the end of the following business day. These grievances are handled by the designated grievance staff.

X. **State Hearing** is a grievance or appeal filed by the member or member’s representative to the California Department of Social Services to be heard by an Administrative Law Judge (ALJ).

IV. **ATTACHMENTS:**

A. Appeal Acknowledgement Letter
B. Grievance Acknowledgment Letter
C. Appeal Extension Letter
D. Appeal Modify Letter
E. Appeal Overturned Letter

F. Your Rights Under Medi-Cal Managed Care Letter
G. Resolution Letter
H. Appeal Decision Upheld Letter
I. Appeal Withdrawn Letter
J. Grievance Withdrawn Letter
K. Member Grievance Form

V. PURPOSE:
To ensure the thorough, appropriate, and timely resolution to member grievances, appeals, and state hearing requests as well as to ensure PHC’s responsiveness to issues raised by PHC members. The sections below outlines the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with PHC’s contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 17-006, Title 28 §1300.68 [except Subdivision §1300.68(c) g) and (h)], §1300.68.01[except Subdivision §1300.68.01(b) and (c)], Title 22 §53858, 42 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY/PROCEDURE:
A. Member Rights
PHC takes member grievances, appeals and state hearings seriously and strives to reach a fair resolution after a thorough evaluation of each issue. PHC will address all grievances, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present in writing or in person before the individual(s) resolving the grievance, evidence, facts and law, in support of their grievance. The objectives of the grievance resolution process are as follows:
1. To protect the rights of members.
2. To ensure that there is no discrimination by PHC against a member on the grounds that the member filed a grievance, appeal or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically-related issues by the Medical Director and Health Services staff.
6. Any member whose grievance is resolved or unresolved has the right to request a state hearing. Submissions of a grievance are not constructed as a waiver of the member’s right to request a state hearing.
7. To report and evaluate aggregate data on member grievances to determine areas requiring corrective action and/or opportunities for improvement. To develop and implement necessary corrective actions with the intent of achieving increased member satisfaction.
8. To ensure that all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to; translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.
9. Ensure members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 14 calendar days to submit the documentation.
B. Cultural and Linguistic Requirements
1. A member has the right to language translation during any part of the grievance process, within a
reasonable timeframe, including standard documents and correspondence. PHC’s policy MCLP7002 Cultural & Linguistic Services details PHC’s system for addressing cultural and linguistic requirements. The procedure for review of member grievances ensures that all grievances are reviewed by grievance coordinators for any cultural and linguistic issues. Training is provided on a yearly basis.

D. How grievance processes are communicated to PHC members

Members will be advised of their rights and access to grievance processes by the following means:

1. Written Materials - The PHC member grievance process explaining how to file a grievance is printed in the PHC Evidence of Coverage/Disclosure Form. It is included in the PHC Member Newsletter at least once each year, mailed with all grievance and appeal acknowledgement and resolution letters and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication - Telephone calls with PHC staff and PHC Providers and/or Practitioners.
3. Contracting Provider – Member Grievance forms and a description of the grievance process is available at each contracting provider’s office.
4. PHC Website - PHC maintains a Website on the Internet which provides member grievance forms and information to members on how to file a grievance with PHC and the expedited medical review process.
5. Items 1, 3 & 4 above all include the toll-free phone number, Internet address, and the toll-free phone number for the hearing and speech impaired for PHC. PHC address is also included.

E. Member Grievance Process

Grievances may be filed at any time following any incident or action that is the subject of the member’s dissatisfaction. Grievances may address, but are not limited to, the following issues:

1. Difficulty obtaining an appointment
2. Customer service at the provider or practitioner office
3. Billing issues
4. Appointment waiting times
5. Facility Conditions
6. Confidentiality issues
7. Appeals of denied Treatment Authorization Requests (TAR)
8. Appeals of level-of-care determinations
9. Appeals of PHC claims payment denials
10. Appeals of primary care provider (PCP) request for disenrollment
11. Refusals of PCP to refer the member for care

F. Grievances Filed

Members can receive assistance in filing a grievance or appeal from a patient advocate, a provider filing on behalf of the member, an ombudsperson or any other persons chosen by the member. There are five methods members or a member's authorized representative may use to file a grievance:

1. By Telephone
   The member can contact PHC’s Member Services Department to file a verbal grievance. PHC uses both bilingual staff and interpreter services for members who speak other languages (in accordance with Title 22 CCR 53858). A Member Services Representative (MSR) will record the grievance into PHC’s grievance system.
2. In Writing
   The member may also submit his/her grievance in writing to PHC. Upon request, members can request a member grievance form from PHC or from a contracted provider office. The member grievance form contains information regarding the PHC member grievance system as well as an authorized representative form.
3. In Person
Members may also visit PHC’s offices in Fairfield and Redding and request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a grievance from the MSR or grievance staff. If the member is under the age of 18, a parent or guardian may file a grievance on their behalf. Members may also fill out an Authorized Representative Form to authorize someone of their choice to represent them.

4. Contracted Provider
   Members may file a grievance at one of PHC’s contracting providers’ offices. The form titled “Member Grievance Form” is available at all contracted provider offices (in accordance with Title 22 CCR 53858).

5. PHC website
   Members can file a grievance by visiting PHC’s website at: [http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspx](http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspx) and select “Online Grievance Form” to file their grievance electronically through PHC’s secure server.

G. Delegation
   1. PHC delegates the grievance process, or portions thereof, to Kaiser Health Plan and Beacon Health Strategies (Beacon).
   2. PHC oversees the delegation of the grievance process conducted by these entities through quarterly reviews of the grievance logs and annual audits.
   3. PHC requires corrective action plans whenever PHC designated staff identifies a problem in any of these entities process and assigns a deadline for receiving evidence that the problem has been resolved.

H. Resolving Member Grievances
   The steps to resolve a member's grievance will occur as outlined below, which is established by the date PHC receives the grievance.
   1. The following documents are sent to the member by the grievance staff within five (5) calendar days of receipt of the member’s grievance:
      a. Acknowledgement Letter- acknowledges the date the grievance was received and the name, address and phone number of the Grievance Coordinator who may be contacted about the grievance or the appeal and the toll-free phone number for hearing and speech impaired members.
   2. “Frequently Asked Questions about the Grievance Process,” which describes PHC’s procedures for filing and resolving grievances and the telephone number and address for presenting a grievance. As appropriate, the Grievance Coordinator will conduct a preliminary investigation by contacting medical staff, PHC’s medical staff or other appropriate individuals to gather information.
      a. If the grievance is about quality of care, denial of care, diagnosis or treatment, or other medical quality issues, the Grievance Coordinator will consult with the Grievance Clinical Lead Nurse.
      b. The Grievance Clinical Lead reviews all grievances for potential quality issues and forwards them to the Nurse in the Quality Department for review. PHC’s responses to grievances involving a decision that the requested service is not a covered benefit shall specify the provision in the contract, and Evidence of Coverage/Disclosure that excludes the service. The Grievance Resolution Letter shall either identify the document and page number where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision that explains in a clear concise language how the exclusion applied to the specific health care service or benefit requested by the member.

I. Expedited Grievance Process
   If a member or a treating physician requests an expedited review or if the MSR or other PHC staff determines expedited review is needed, the issue will be immediately forwarded to PHC’s Medical Directors to render a determination as to whether an expedited review is appropriate. Resolutions on
expedited reviews include an oral and written notification. The process is as follows:

1. Presentation of evidence, facts and law in support of member’s grievance.
   Members are advised of their rights to submit evidence, facts and law in support of their grievance. Members are also informed by the grievance coordinators of the limited time available to present evidence due to the nature of the expedited review request.

2. Expedited Review/Grievance Request Approved
   If PHC’s Medical Director determines that the grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function, the grievance will be handled as an expedited grievance.

3. When expedited review is necessary and the Medical Director determines that he/she will not reverse the decision (if a decision was previously made by him/her), the Medical Director will facilitate a review of the grievance by another medical professional, including at least one practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment at issue.
   a. Decisions
      1) The Medical Director will render the expedited decision and the grievance staff will notify the member as expeditiously as the medical condition requires, but no later than 72 hours from when expedited review was requested. PHC will provide oral notification of the decision to the member.
      2) PHC will issue a written confirmation of its decision within 2 working days of providing verbal notification of the decision, if the initial decision was not in writing but no later than 5 calendar days from when the initial expedited request was filed.

4. Expedited Request Denied
   If PHC’s Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by grievance staff that their request for an expedited review has been denied with 72 hours of their request and the grievance will be processed using standard timeframe (30 calendar days).

J. Incoming Grievances
   1. When a grievance is received into the grievance unit, the Grievance Resolution Specialist (or designee) will assign the grievance to a grievance coordinator using the Grievance Rotation Tracker.
   2. Upon assigning the case, an email is generated to all grievance staff, including the Grievance Clinical Lead (GCL). The GCL will log into the grievance system to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in the grievance system under the “Clinical vs Non-Clinical” action by the GCL. Grievance staff will utilize the grievance categories worksheet to assess the grievance for other referrals to PHC departments and will proceed as directed in the worksheet.
   3. All clinical cases are reviewed by the GCL or designee to evaluate the need to forward the case to the Quality Improvement (QI) Department for a PQI and/or order records for further evaluation. The GCL or designee will direct grievance staff if a PQI referral is needed. The GCL or designee will also make recommendations for case work on any clinical cases.

K. Clinical Grievance
   A clinical grievance is defined as any issue concerning the services provided by a clinic, hospital, provider or pharmacy. The types of grievances considered to be clinical in nature include:
   1. Quality of Service (by clinic/hospital/provider/dental provider)
   2. Access
   3. Pharmacy issues
   4. Quality of Medical Care
   5. Denials, Refusals (formulary, denial of service/treatment)
6. Cultural, Linguistic, and Health Education (by clinic/hospital/provider/dental provider)

L. Non-Clinical Grievance

A non-clinical grievance is defined as any issue concerning the services provided by PHC and its non-clinical components. The types of grievances considered to be non-clinical in nature include:

1. Billing
2. Benefits/Coverage (benefits)
3. Cultural, Linguistic, and Health Education (by PHC staff, PHC materials)
4. Quality of Service (by PHC staff)
5. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
6. Cab grievances

M. Quality of Medical Care Grievances

1. All quality of medical care grievances are reviewed by PHC clinical staff to assess the member’s concern for accuracy. For example, it is not unusual for a patient to feel his/her treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound). Or they feel they were denied care, where the medical records show that the service is not necessary and an alternative treatment option was provided.
2. The designated PHC clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history.
3. All quality of care grievances are reviewed by a GCL and submitted to the CMO or his/her physician designee for review within a timeframe which is appropriate for the nature of the member’s condition. If there is a potential safety issue determined by the GCL or Quality Improvement RN, documentation of the issue will be reviewed by the QI Department.

N. Inter-Rater Reliability (IRR)

1. To ensure that grievances are appropriately designated by the GCL as clinical versus non-clinical and referrals for PQIs are accurately being referred to the QI department, inter-rater reliability studies will be conducted every quarter.
2. Sample will be prepared by the Grievance System Manager or designee.
   a. PQI Referral Sample - A random selection of a minimum of 10 grievances will be pulled for review by the CMO or his/her designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
   b. Clinical vs Non-Clinical Sample - A random selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the categorization of a grievance, clinical or non-clinical was appropriate.
3. Time frame – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
4. Results - A 90% inter-rater reliability is required. Where a 90% score is not achieved, additional training will be provided to the GCL by the QI designated staff member and subsequent inter-rater reliability studies will be conducted until the passing score is achieved.

O. Grievances Involving Coverage For Terminally Ill Members

A member who has a terminal illness (incurable or irreversible condition that has a high probability of causing death within one year or less) requires the following procedure for addressing a coverage denial.

1. Within five (5) business days of a denial of a benefit for treatment, services, or supplies deemed experimental as recommended by a participating plan provider, PHC will provide to the member the following information.
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment services or supplies covered by the plan, if any.

Compliance with this subdivision Section 1368.1 of the Act, by a plan shall not be construed to
mean that the plan is engaging in the unlawful practice of medicine.

c. Copies of the plan’s grievance procedures or grievance form. The grievance form shall provide
an opportunity for the member to request a conference as part of the plan’s grievance system
provided under Section 1368.1.

2. If the member requests a conference, the conference will be held within five (5) business days if the
treating participating physician determines, after consultation with the health plan Medical Director,
based on standard medical practice, that the effectiveness of either the proposed treatment, services,
or supplies, or any alternative treatment, services, or supplies covered by the plan, would be
materially reduced, if not provided at the earliest possible date. The member will also be given the
option to extend the timeframe to request to participate in the conference up to 30 calendar days.

P. Contacting providers regarding grievances filed against them
1. Members are notified at the time of the filing that their grievance may be sent to the provider they
are grieving about to receive a response regarding their grievance. Members may request that any
notification to their provider or practitioner regarding the grievance be delayed until a relationship
with a new provider or practitioner is effective. Such a request is noted when the grievance is filed
by the PHC staff member. PHC staff will assure the member that there will be no discrimination
against them by PHC or its providers or practitioners on the grounds that they have filed a grievance.

Q. Member Grievance Correspondence
1. There are two (2) types of member correspondence that are issued by grievance staff. Of note, each
member correspondence includes PHC’s notice “Member Complaint, Appeal and Hearing
Information”. This notice provides the member information regarding PHC’s grievance process
including the member’s rights to file for a state hearing.
   a. Acknowledgement Letter
      1) An acknowledgement letter is issued within 5 calendar days of receipt of a grievance. This
         letter will include the name, address and phone number of the PHC grievance coordinator
         who has been assigned to their case and the phone number for the California Relay Service.
      2) Exception to sending the acknowledgement letter
         a) If a grievance is resolved within 5 calendar days of receipt, the grievance coordinator
            will issue only the Grievance Response/Resolution.
   b. Resolution Letter
      1) The grievance coordinator mails a Grievance Response/Resolution within 30 calendar days
         of the date the grievance was received. The letter summarizes the grievance and describes
         the resolution.

R. Timeframe - Grievance
1. Standard:
   a. Resolution – member grievances are resolved within 30 calendar days of the member’s request
      for a grievance [Title 22 CCR 53858 (f) (1)].
2. Expedited:
   a. Grievance staff will process the case within 72 hours from the date of receipt of the
      grievance/appeal.
3. Grievance Response/Resolution will be sent to the member within 2 calendar days of providing
   verbal notification of the decision but no later than 5 calendar days of receiving the grievance.

S. Grievance File Maintenance
   Documentation for each grievance is maintained by the Grievance Coordinator. Documentation may
   include, but is not limited to the following:
   1. Memo outlining the grievance and the steps taken to resolve the issue;
      a. The date of the call
      b. The name of the complainant
c. The complainant’s member identification number

2. Copies of grievances and responses shall be maintained by PHC for five (5) years. They are maintained on-site for two (2) years, and include a copy of all medical records, documents, evidence of coverage and other relevant information upon which PHC relied in reaching its decision.

VII. MEMBER APPEAL PROCESS

A. Time Frame – Appeal

Appeals must be filed within 60 calendar days following any denial action that is the subject of the member’s dissatisfaction. Appeals can be filed by the member, his/her authorized representative (AR), or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the member service representative (MSR) or grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal.

B. Resolving Member Appeals

1. Confirmation of member appeal

   a. Upon receipt of an appeal, grievance staff conducts a preliminary investigation of the request by contacting the treating provider, PHC staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the appeal and to also provide the member an opportunity to submit a statement for the reason for the appeal.

2. Presentation of evidence, facts and law in support of member’s grievance

   a. Members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 14 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medical records and any other documents before and during the appeal process.

3. Continuation of benefits (also known as aid paid pending)

   a. Upon request, the member’s benefit/service can continue pending the outcome of the appeal decision.

      1) The criteria for continuation of benefits is listed below per 42 CFR 438.420

         a) Requests must occur within 10 calendar days from the date the notice of action was mailed to the member.
         b) The appeal must be filed timely.
         c) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
         d) The service was ordered by an authorized provider.
         e) The original period covered by the original authorization has not expired.
         f) The member requests extension of benefits.

   b. Duration of continued or reinstated benefits

      1) If, at the member’s request, PHC continues or reinstates the member’s benefits while the
appeal is pending, the benefits will be continued until one of the following occurs:
   a) The member withdraws from the appeal
   b) 10 days pass after PHC mails the notice, providing resolution of the appeal against the
      member, unless the member, within the 10 day time frame has requested a state hearing
      with continuation of benefits until a state hearing decision is reached.
   c) The state hearing office issues a hearing decision adverse to the member.
   d) The time period or service limits of a previously authorized service has been met.

C. Examples of Member Appeals
   1. An appeal is a member’s request for reconsideration of an initial decision resulting in the denial of
      service, benefit or claim. Appeals may address, but are not limited to, the following issues:
      a. Appeals of denied Treatment Authorization Requests (TAR)
      b. Appeals of level-of-care determinations
      c. Appeals of PHC claims payment denials
      d. Appeals of primary care physician request for disenrollment
   2. Members filing grievance regarding their Medi-Cal eligibility are referred to their local county
      Health and Social Services Department or the Social Security Administration office for assistance.

D. Resolving Member Appeals
   1. Confirmation of member appeal
      a. Upon receipt of an appeal, grievance staff conducts a preliminary investigation of the request by
         contacting the treating provider, PHC staff and any other appropriate individuals to gather
         information. Grievance staff will also contact the member to confirm the appeal and to also
         provide the member an opportunity to submit a statement for the reason for the appeal.
   2. Presentation of evidence, facts and law in support of member’s grievance
      a. Members are advised of their rights to submit evidence, facts and law in support of their
         grievance and are given 14 calendar days to submit the documentation. Upon request, the
         member has the right to request reasonable access to his/her appeal case file, including medical
         records and any other documents, before and during the appeal process.
   3. Continuation of benefits (also known as aid paid pending)
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            to the member.
         2) The appeal must be filed timely.
         3) The appeal involves the termination, suspension, or reduction of a previously authorized
            course of treatment.
         4) The service was ordered by an authorized provider.
         5) The original period covered by the original authorization has not expired.
         6) The member requests extension of benefits.
      b. Duration of continued or reinstated benefits
         1) If at the member’s request, PHC continues or reinstates the member’s benefit while the
            appeal is pending, the benefits will be continued until one of the following occurs:
            a) The member withdraws from the appeal
            b) 10 days pass after PHC mails the notice, providing resolution of the appeal against the
               member, unless the member, within the 10 day time frame has requested a state hearing
               with continuation of benefits until a state hearing decision is reached.
            c) The state hearing office issues a hearing decision adverse to the member.
            d) The time period or service limits of a previously authorized service has been met.
   4. Review of Appeals
a. Medically-Related Appeals
   1) Grievance staff will refer medically-related appeals and all documentation to the Medical Director for review who was not part of the original decision to deny unless the final decision is in favor of the member (Contract Exhibit A, Attachment 14, 2, F). The “health care professional with appropriate expertise” is not determined by specialty, but by expertise and experience which varies with the career and experience of the particular Medical Director. In general, if the appeal is about a child, then a pediatrician or family physician Medical Director would be consulted. If the appeal is about an adult, then one of the internal medicine physicians or family physicians would be consulted. If the Medical Director reviewing the appeals feels that the particular clinical issue in question is outside his/her expertise or experience, he/she may refer the case to another Medical Director for review (who was not part of the original decision to deny) or to an outside physician consultant with expertise in this area (Contract Exhibit A Attachment 14, 2, C).

a) Ordering Medical Records
   The Medical Director will direct grievance staff to order medical records from primary care providers and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within 5 working days.

b. Other Appeals
   1) Appeals regarding claims, billing issues, special cases status and other non-medically-related cases will be presented to the Member Grievance Review Committee for direction on which department/personnel should review the appeal. Grievance staff will work with other appropriate PHC staff to develop a resolution for non-medically related appeals as needed. The staff reviewing the appeal will be individuals who were not involved in the initial determination unless the final decision is in favor of the member.

c. Expedited Appeals
   1) Requests for expedited appeals will be immediately forwarded to a Medical Director for review. If the expedited review is deemed medically necessary, the appeal resolution will be provided within 72 hours. The grievance coordinator will make reasonable efforts to notify the member orally and provide written notice within two (2) calendar days.

5. Member Correspondence
   a. There are 3 types of member correspondence that are issued by grievance staff. Of note, each member correspondence includes PHC’s notice, “Member Complaint, Appeal and Hearing Information”. This notice provides the member information regarding PHC’s grievance process including the member’s rights to file for a state hearing.

   1) Acknowledgement Letter
      a) An acknowledgement letter is issued within 5 calendar days of receipt of an appeal.
      b) This letter will include the name, address and phone number of the PHC grievance coordinator who has been assigned to their case and the phone number for the California Relay Service.
      c) Exception to sending the acknowledgement letter
         i. If an appeal decision is rendered within 5 calendar days of receipt, the grievance coordinator will issue only the appeal decision letter.
      d) Denial of Expedited Review
         i. If a request for an expedited review has been denied by a Medical Director, grievance staff will also include in the acknowledgment notice that the request for an expedited review has been denied and the reason why the request was denied.

b. Appeal Resolution Letter
1) The grievance coordinator mails an appeal resolution letter within 30 calendar days from the
date the appeal was received. The letter summarizes the appeal and describes the appeal
decision. If any appeal resolution timeframe is not met (i.e., standard, expedited, extension),
the member is considered to have exhausted PHC’s appeals process and may proceed to
State Hearing.
2) PHC will authorize or provide services for overturned adverse benefit determinations (as the
result of an appeal determination) within 72 hours of the decision.
c. Extension Letter
   1) In the event an appeal decision cannot be resolved within the 30 calendar days, an extension
      letter will be mailed to the member before the thirtieth day, informing the member that PHC
      will take up to 14 additional calendar days to render a decision and a notice will be sent
      once the appeal decision is rendered. Reasons for the delay will be clearly documented in
      the extension letter. The grievance coordinator will make reasonable efforts to notify the
      member orally and provide written notice within two (2) calendar days.
d. Notification
   1) Each notification sent to the member will also include the member’s right to file a state
      hearing (Title 22 CCR 53858 (f) (3)].

VIII. MEMBER STATE HEARING PROCESS
A. Member State Hearing Timeframe
   State Hearings must be filed within 120 calendar days following the date of the Notice of Appeal
   Resolution (NAR) that is subject of the member’s dissatisfaction. State Hearings can be filed by the
   member or his/her authorized representative (AR). For the purpose of this policy, member will be used to
   refer to the member and the AR unless otherwise noted.
B. Filing a State Hearing
   1. Members have the right to file for a state hearing after exhausting PHC’s appeal process.
   2. Members can file for a State Hearing with the California Department of Social Services. There are
      four ways to request a state hearing.
      a. By Phone
         Members can call the State Hearing Office at 1-800-952-5253. Hearing impaired members may
            use TTY by calling 1-800-952-8349.
      b. By Mail
         Members can send a hearing request form or their own written request directly to:
         California Department of Social Services
         State Hearings Division
         P.O. Box 944243, Mail Station 9-17-37
         Sacramento, CA 94244-2430
      c. By Fax
         Members can fax their hearing request form or their own written request directly to the state at
         916-651-5210 or 916-651-2789.
      d. In Person
         Members can also turn in their hearing request form or their own written request at one of the
         local county offices.
C. Responding to State Hearing Requests
   1. Notification of Hearing Request
      PHC receives a notice of the member’s request for a state hearing from the SCOPE unit in the
      California State Department of Social Services and from the Office of the Ombudsman.
      Notifications include the case name, the request for hearing and filing date.
2. Review of Hearing Request
   Upon receipt, grievance staff conducts a preliminary investigation of the request by contacting the
treating provider, PHC staff and any other appropriate individuals to gather information. Grievance
staff will also contact the member to confirm the state hearing and to also provide the member an
opportunity to submit a statement for the reason for the hearing. If the member has not opened an
appeal with PHC, staff will offer to open an appeal as well.

3. Parties to State Hearings
   The parties to the state hearings include PHC, the member and their representative or the
representative of a deceased member’s estate.

4. Continuation of benefit
   a. Upon request, the member’s benefit/service can continue pending the outcome of the state
      hearing decision.
   b. The criteria for continuation of benefits is listed below per 42 CFR 438.420.
      1) Request must occur within 10 calendar days from the date the notice of action was mailed to
         the member.
      2) The state hearing must be filed timely.
      3) The state hearing involves the termination, suspension, or reduction of a previously
         authorized course of treatment.
      4) The service was ordered by an authorized provider.
      5) The original period covered by the original authorization has not expired.
      6) The member requests extension of benefits.
   c. Duration of continued or reinstated benefits
      If, at the member’s request, PHC continues or reinstates the member’s benefit while the state
      hearing is pending, the benefits will be continued until one of the following occurs:
      1) The member withdraws from the state hearing
      2) The state hearing office issues a hearing decision adverse to the member
      3) The time period or service limits of a previously authorized service have been met
   d. Disputes regarding continuation or reinstated benefits
      In the event grievance staff finds that the member does not meet criteria for continuation or
      reinstated benefits, the member will be referred back to the Office of the Ombudsman to review
      and render a decision if aid paid pending applies.

D. Statement of Position
1. Creation of Statement of Position
   Grievance staff, while working with clinical PHC staff, will prepare the Statement of Position
   (SOP). The SOP will state the following information:
   a. The Issue
   b. The Background
   c. Pertinent Facts
   d. Guidelines
   e. History of TAR
   f. Applicable Law
   g. Conclusion
2. Submission of Statement of Position
   Statements of Positions are submitted directly to the state hearing SCOPE office, the Office of the
   Ombudsman, and to the member, at least 2 working days prior to the scheduled hearing. To ensure
   receipt prior to the hearing, PHC will email the statement of position via secure email to
   scopeofbenefits@dss.ca.gov and the Office of the Ombudsman. Grievance staff will send the
Policy/Procedure Number: CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)

Lead Department: Administration

Policy/Procedure Title: Medi-Cal Member Grievance System

☒ External Policy
☐ Internal Policy

Original Date: 2/11/99 (MS 300)  
Next Review Date: 6/21/2018

Last Review Date: 6/21/2017

Applies to: ☒ Medi-Cal
☐ Employees

Statement of Position via FedEx to the member. FedEx envelopes will require direct signature for delivery. In the event a physical address cannot be obtained or is not available, Statement of Positions will be mailed via certified mail to the member’s PO Box.

E. Representation during the State Hearing
   1. Grievance staff will appear at the state hearings to represent PHC and explain PHC’s position. Appropriate PHC staff and/or other representatives may be asked to appear at the state hearings as determined necessary by the Medical Director.

F. Expedited State Hearings
   1. Within 2 working days of being notified by the Department of Social Services (DSS) or the Office of the Ombudsman that a member has filed a request for a state hearing which meets the criteria for expedited resolution, PHC will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which PHC considered in connection with, the action which is the subject of the expedited state hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request (TAR) and Notice of Action (NOA), plus any pertinent grievance resolution notices. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and grievance resolution notices. One or more plan representatives with knowledge of the member’s condition and the reason(s) for the action, which is the subject of the expedited state hearing, shall be available by phone during the scheduled state hearing.

G. State Hearing Decisions
   1. The notice of the Administrative Law Judge’s decision will provide members with information on how to request a rehearing of their issue if they disagree with the decision. A member may obtain judicial review of the decision by filing a petition in Superior Court under Code of Civil Procedure §1094.5 within one year after the date of the decision.
      a. Upheld Decisions
         Decisions favorable to PHC will be noted in the grievance system case file and closed. A copy of the decision is forwarded to the department that rendered the adverse decision to the member.
      b. Overturned Decisions
         Adverse decisions to PHC will be noted in the grievance system case file. A copy of the decision is forwarded to the department that rendered the adverse decision to the member and will be given 72 hours to overturn the decision; expedited hearings will require the denial be overturned within 24 hours. Once confirmation is received that the decision is overturned, grievance staff will contact the member and the Office of the Ombudsman and verbally notify that the denial has been overturned. Interactions with the member and the Office of the Ombudsman are documented in the grievance system case file and the case is closed once a copy of the overturned decision is available.

H. State Hearing File Maintenance
   1. All documentation relating to a state hearing is scanned and uploaded into the grievance system under the member’s case number. Documentation includes but is not limited to the following:
      a. Case Summary (produced out of grievance system) outlining the state hearing and the steps taken to resolve the issue
      b. Notification of State Hearing
      c. All written correspondence between PHC, the member, providers and/or practitioners
      d. Billing and claims information (if applicable)
      e. Statement of Position
      f. Administrative Law Judge’s decision on the hearing

I. Monitoring of Timeliness of Grievances
   1. All grievances, appeals and state hearing requests with their resolutions are documented in the
2. At the end of each month, the grievance system manager or his/her designee will review the grievance staff cases as part of his/her performance review. In addition, weekly one-on-one meetings are conducted with staff to ensure that member grievances and appeals are resolved within established time frames as well as to review open member grievances and appeals and determine appropriate resolutions.

J. Reporting Grievances to HealthPlan Committees for Review
1. Individual and aggregate data on member grievances and appeals is reviewed by the Member Grievance Review Committee (MGRC), Internal Quality Improvement (IQI), Quality/Utilization Advisory Committee (Q/UAC), and PHC’s Consumer Advisory Committee (CAC) no less than 4 times per year. Each committee reviews the data for possible actions as determined appropriate according to PHC Quality Assurance Protocol. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be reviewed and analyzed by committee to remedy any problems identified.

IX. – EXEMPT GRIEVANCE PROCESS
A. Each night the Information Technology (IT) Department generates the grievance report of all grievances resolved by the end of the business day in the Member Services (MS) Department.
B. The assigned grievance staff member will review each log on the report to check for the following:
   1. Resolution is clearly listed
   2. Only one (1) issue is listed per log on the report
   3. The remark code category matches the content of the log
C. Logs that have resolutions which are not clear, severe grammar issues that prevent the log from being read clearly, the remark code category does not match the content of the log, and/or if more than one issue is listed on the log will be sent to the MS representative’s supervisor for review.
D. The designated MS supervisor will review and respond to the designated grievance staff member regarding the outcome of his/her review.
E. All exempt grievances will be reviewed by GSL to assess the member’s concern and screen for potential quality of medical care issues.
F. The designated GSL will base his/her determination on the review of information submitted by the member or his/her authorized representative. The review will also consist of review of medical records and claims history.
G. All exempt grievances that are identified by the GSL as potential quality of care grievances are submitted to the Chief Medical Officer or his/her physician designee for review within a timeframe which is appropriate for the nature of the member’s condition. If there is a potential safety issue determined by the GSL or Chief Medical Officer or physician designee, documentation of the issue will be reviewed by the Quality Improvement Department.
H. The Member Grievance Review Committee will review the aggregate data on a quarterly basis. The committee is responsible for identifying trends and any potential issues that require action.

X. REPORTING REQUIREMENTS
1. PHC maintains an inquiry log of all requests for information that do not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other PHC processes.
2. PHC maintains and has available for DHCS’ review, PHC’s grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances and the PHC exempt grievance log. Grievance logs are maintained based on the requirements set forth in Title 22 CCR Section 53858 (e).
   a. Date and time the grievance was filed

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**Policy/Procedure Number:** CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)  
**Lead Department:** Administration  
**Policy/Procedure Title:** Medi-Cal Member Grievance System  
☒ External Policy  
☐ Internal Policy  
**Original Date:** 2/11/99 (MS 300)  
**Next Review Date:** 6/21/2018  
**Appplies to:** ☒ Medi-Cal  
☐ Employees  
**Last Review Date:** 6/21/2017
b. The name of the member filing the grievance

c. The name of the person receiving the grievance

d. A description of the grievance

e. A description of the action taken to resolve the grievance

f. The proposed resolution by the plan

g. The name of the person responsible for resolution

h. The date of notification to the member

3. PHC also submits quarterly grievance reports based on Title 28 CCR Section 1300.68(f).

XI. MEDICAL RECORDS/DOCUMENT REQUESTS

A. Members and providers may call to request materials and/or letters to be sent to them by mail or by fax (upon request).

B. Members can request materials/documents/records free of charge by calling PHC’s member services department or by filling out the Grievance Records Request form.

XII. REFERENCES:

B. PHC Contract 08-85215 A19

C. 22 CCR §53858

D. 28 CCR §1300.68 [except subdivision §1300.68(c),(g) and (h)]

E. 28 CCR §1300.68.01 [except subdivision §1300.68.01(b) and (c)]

F. 42 CFR 438.420(a)(b) and (c)

G. 42 CFR 438.406(b)(3)

H. APL 17-006 May 9, 2017 Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments

XIII. DISTRIBUTION:

A. PHC Department Directors

B. PHC Provider Manual

XIV. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance System Manager

XV. REVISION DATES:

Medi-Cal

MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06; 01/16/08; 03/18/09; 07/21/10; 03/20/13; 11/18/15; 06/21/17

PREVIOUSLY APPLIED TO: N/A
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/PROCEDURE

Policy/Procedure Number: CGA-001 (previously Health Services [HS] MPQP1035; Member Services [MS] policy #302 and HK #302)

Policy/Procedure Title: Evaluating and Reporting Data on Complaints and Appeals

Lead Department: Administration

☑ External Policy
☒ Internal Policy

Original Date: 2/2/1999

Next Review Date: 11/18/2017

Last Review Date: 12/20/2016

Applies to:

☒ Medi-Cal
☒ Healthy Kids
☐ Employees

Reviewing Entities:

☒ IQI
☐ P & T
☒ QUAC

☑ OPERATIONS
☐ EXECUTIVE
☐ COMPLIANCE
☐ DEPARTMENT

Approving Entities:

☐ BOARD
☐ COMPLIANCE
☐ FINANCE
☒ PAC

☐ CEO
☐ COO
☐ CREDENTIALING
☒ DEPT. DIRECTOR/OFFICER

Approval Signature: Robert Moore, MD, MPH

Approval Date: 12/20/2016

I. RELATED POLICIES:
A. CGA002 Member Grievance Review Committee
B. CGA003 Medi-Cal Member Grievance System
C. CGA004 Healthy Kids Member Grievance System

II. IMPACTED DEPTS:
A. Grievances and Member Services

III. DEFINITIONS:
A. Appeal – a request for reconsideration of a denial or modified service of an initial utilization review decision.
B. Complaint – a member’s oral or written expression of dissatisfaction regarding PHC and/or a provider, including quality of care concerns.
C. Grievances – an expression of dissatisfaction. The term “grievance” is used to define the process used to process complaints and all appeal levels including state hearings.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To specify the procedure and frequency for evaluating and reporting aggregate data on member complaints, appeals and state hearings. This information is used to determine areas requiring corrective action or opportunities for improvement as well as to develop and implement necessary corrective actions to improve service and increase member satisfaction.

VI. POLICY / PROCEDURE:
A. Problem and Complaints Logs (Level 1 Grievances)
   a. Each night the IT Department generates grievance report of all grievances resolved by the end of the business day by the Member Services (MS) Department.
   b. The assigned grievance staff member will review each log on the report to see if a:
      1) Resolution is clearly listed,
      2) Only one issue is listed per log on the report,
      3) The remark code category matches the content of the log.
# Partnship Healthplan of California
## Policy / Procedure

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<th>Policy/Procedure Number: CGA-002</th>
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<td>Approval Signature: Robert Moore, MD, MPH</td>
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### I. RELATED POLICIES:
- CGA001 Evaluating and Reporting Data on Complaints and Appeals
- CGA003 Medi-Cal Member Grievance System
- CGA004 Healthy Kids Member Grievance System

### II. IMPACTED DEPTS:
- Grievance

### III. DEFINITIONS:

### IV. ATTACHMENTS:
- Attachment A – Member Grievance Review Committee Charter

### V. PURPOSE:
The Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary retrospective review of member grievances (complaints and all level appeals) identify systemic internal and external issues to prevent further occurrences, discuss complex grievance data, and analyze data for tracking and trending.

### VI. POLICY / PROCEDURE:

#### A. Frequency of Meetings
The MGRC shall meet no less than 4 times per year.

#### B. Agenda Items
- The Grievance System Manager (or designee) and the designated Medical Director have the responsibility to bring appropriate cases for the committee to review and to gather facts for presentation. Items appropriate for presentation include but are not limited to:
  1. Issues that require multidisciplinary input to resolve the grievance when normal pathways have been exhausted by the grievance staff.
  2. Resolved issues that represent opportunities for improvement in internal or external systems or processes.
  3. Cases overturned by 2nd level appeal process.
  4. Quarterly grievance summary reports.
  5. Issues which have the potential of legal action.
  6. Member suggestions for process and system improvements.
  7. Other issues that the grievance system manager or medical director deems appropriate for committee.
review

C. Case Presentations
   The grievance coordinator will send a summary of the issue, appropriate facts, and actions taken to date to resolve the issue on week prior to the meeting to the Grievance System Manager and the Medical Director using a predetermined format. Committee members will discuss the case, recommend actions to resolve, and assign responsibility for actions to committee members. Committee members with assigned tasks will update the grievance coordinator of outcomes by the assigned date.

D. Aggregated Data Review
   The MGRC will review aggregate data for trends and make recommendations for interventions when opportunities for improvement are identified. This includes but is not limited to quarterly submission reports to regulatory agencies, exempt grievances, and delegated grievance reports.

E. Record of Activities:
   1. The grievance system manager or designee will record contemporaneous minutes and distribute to the MGRC members (minutes will not be distributed outside the MGRC due to PHI). Minutes will include actions taken, follow-up items, and the person responsible for completion.
   2. Minutes will be reviewed and approved as an item of business at the next meeting.
   3. The grievance system manager will prepare and present quarterly summary reports to the Internal Quality Improvement Committee (IQI) to apprise the IQI about systemic and policy issues identified through the grievance process and actions taken or planned to improve processes. The same report will also be presented to the Quality Utilization Advisory Committee for review.

F. Committee Structure
   1. The Grievance Review Committee is comprised of the following:
      a. Grievance System Manager (co-chair)
      b. Medical Director (co-chair)
      c. Health Services Director or designee
      d. Provider Relations Director or designee
      e. Member Services Director or designee
      f. Care Coordination Team Manager or designee
      g. Grievance Clinical Lead
      h. Compliance Manager or designee
      i. Pharmacy Director or delegate (ad hoc)

VII. REFERENCES:
   PHC Contract 08-85215 A19, Title 28 §1300.68 Grievance System and Title 22 §53858 Member Grievance Procedures

VIII. DISTRIBUTION:
   A. PHC Department Directors
   B. Provider Manual
   C. SharePoint

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance System Manager

X. REVISION DATES:
I. RELATED POLICIES:
A. MP302 Cultural and Linguistic Services
B. CGA-014 Clinical vs Non-Clinical Grievances
C. CGA-002 Member Grievance Review Committee
D. CGA-003 Medi-Cal Member Grievance System
E. CGA-021 Aid Paid Pending Process
F. MPQP1016 Potential Quality Issue Investigation and Resolution
G. MS319 Documenting Member Complaints and Appeals

II. IMPACTED DEPTS:  Grievance

III. DEFINITIONS:
A. Acknowledgment Letter is a written notification of receipt of a complaint or appeal that is sent to the member or member’s authorized representative. An expedited review is also acknowledged verbally, whenever possible.
B. Appeal is a member’s request to PHC for reconsideration of an initial utilization review decision resulting in the denial of a service, benefit or claim.
C. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent them in matters regarding their health care.
D. Complaint is a member's oral or written expression of dissatisfaction with PHC and/or a provider, including quality of care concerns.
E. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function. Expedited reviews are approved by physician reviewers.
F. Grievance Coordinator is the staff member who is responsible for summarizing, analyzing, investigating and issue acknowledgements and resolutions to member complaints and appeals. The grievance coordinator also represents PHC during state hearings.
G. Grievance is the process by which PHC member complaints and appeals are addressed and resolved.
H. Grievance Clinical Lead is the clinical staff member responsible for initiating and coordinating a multidisciplinary team approach to handling of grievances with members, providers, plan Medical Director, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to non-clinical staff as needed. The clinical lead may also provide input or participate in state hearings.
I. Level I Complaint is a complaint that is resolved by the end of the following business day. These complaints are handled by the Member Services Representatives or grievance staff.
J. Level II Complaint is a complaint that cannot be resolved by the end of the following business day. These complaints are handled by the designated grievance staff.

K. Member is the Medi-Cal eligible individual receiving health care through PHC to whom reference will be made as "members" in all protocols.

L. Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary review of member grievances (complaints and all level appeals). The committee is made up of representatives from Grievances, Member Services, Provider Relations, Care Coordination, Pharmacy, Utilization, and Compliance.

M. Member Services Representatives (MSR’s) are the PHC staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through PHC, including the complaint, appeal and hearing procedures, and assist members in obtaining resolution to their issues.

N. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with PHC, but may do business with PHC for specific reasons, e.g., provision of emergency, out-of-area or one-time member care.

O. Everest is the computer system that PHC uses to log and track member complaints, appeals, and state hearing requests and are logged by specific grievance types.

P. Remark System (RS) is the AMISYS computer system that PHC uses to log and track specific complaint types that are resolved by the end of the following business day. This system is also used by staff to make notes and document other issues relating to a complaint, appeal or state hearings.

Q. Primary Care Provider (PCP) is a physician who has executed an agreement with PHC to provide the services of a primary care physician.

R. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.

S. Practitioner is a licensed individual who provides medical care.

T. Resolution Letter is written notice of the outcome of a complaint or an appeal. This letter will include information regarding any applicable next steps and appeal rights.

U. State Hearing is a complaint or appeal filed by the member or member’s representative to the California Department of Social Services to be heard by an Administrative Law Judge (ALJ).

IV. ATTACHMENTS:
A. Member Grievance Form
B. 
C. Member Complaint, Appeal and Hearing Information Notice

V. PURPOSE:
To ensure the thorough, appropriate, and timely resolution to member complaints, appeals, and state hearing requests as well as to ensure Partnership HealthPlan of California’s (PHC’s) responsiveness to issues raised by PHC members. The sections below outlines the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with PHC’s contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13 (provision 4, paragraph D.12) and Attachment 14,Title 28 §1300.68 (except Subdivision §1300.68(c) g) and (h), §1300.68.01((except Subdivision §1300.68.01(b) and (c)), Title 22 §53858, 42 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3)).

VI. POLICY / PROCEDURE:
A. Member Rights
PHC takes member complaints, appeals and state hearings seriously and strives to reach a fair resolution after a thorough evaluation of each issue. PHC will address all complaints, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present in writing or in person before the individual(s) resolving the grievance, evidence, facts and law, in support of their grievance. The objectives of the grievance resolution process are as follows:
1. To protect the rights of members.
2. To ensure that there is no discrimination by PHC against a member on the grounds that the member filed a complaint, appeal or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically-related issues by the Medical Director and Health Services staff.
6. Ensure members are given a reasonable opportunity to present in writing or in person before the individual(s) resolving the grievance, evidence, facts and law, in support of their grievance.
7. Any member whose grievance is resolved or unresolved has the right to request a state hearing. Submissions of a grievance are not constructed as a waiver of the member’s right to request a state hearing.

B. Cultural and Linguistic Requirements
1. A member has the right to language translation during any part of the grievance process, within threshold languages, including standard documents and correspondence. Member Services policy (MP302) details PHC’s system for addressing cultural and linguistic requirements. The procedure for review of member grievances ensures that all grievances are reviewed by grievance coordinators for any cultural and linguistic issues. Training is provided on a yearly basis.

C. Grievances communicated to PHC members
Members are advised of their rights and access to the complaint, appeal and state hearing process by the following means:
1. Written Materials: The member grievance process explaining how to file a complaint, appeal or state hearing is printed in the PHC Member Handbook. It is periodically included in the PHC Member Newsletter and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication: Telephone calls with PHC staff, PHC providers or practitioners.
3. Contracting Provider: The Member Grievance form and a description of the grievance resolution process is available at each contracting provider’s office. This information provides the address and phone number where complaints, appeals or state hearings should be directed.
4. PHC Web Site - PHC maintains a Web Site on the internet, which offers information to members on how to file a complaint, an appeal and State Hearing and the grievance resolution process.

D. Grievances Filed
There are five ways a grievance (complaint or an appeal) can be filed.
1. By Telephone
   The member can contact PHC’s Member Services Department to file a verbal grievance. PHC uses
both bilingual staff and interpreter services for members who speak other languages (in accordance with Title 22 CCR 53858). A Member Services Representative (MSR) will record the complaint into PHC’s grievance system, Everest.

2. In Writing

The member may also submit their grievance in writing to PHC. Upon request, members can request a member grievance form from PHC or from a contracted provider office. The member grievance form contains information regarding the PHC’s member grievance system as well as an authorized representative form.

3. In Person

Members may also visit PHC’s offices in Fairfield and Redding and request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a complaint from the MSR or grievance staff. If the member is under the age of 18, a parent or guardian may file a complaint on their behalf. Members may also fill out an Authorized Representative Form to authorize someone of their choice to represent them.

4. Contracted Provider

Members may file a grievance at one of PHC’s contracting providers’ office. The form titled “Member Grievance Form” is available at all contracted provider offices (in accordance with Title 22 CCR 53858).

5. PHC website

Members can file a grievance by visiting PHC’s website at http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspx and select “Online Grievance Form” to file their grievance electronically through PHC’s secure server.

E. Delegation

1. PHC delegates the grievance process to Kaiser Health Plan and Beacon.

2. PHC oversees the delegation of the grievance process conducted by Kaiser Health Plan and Beacon through quarterly reviews of the grievance logs and annual audits.

3. PHC requires corrective action plans whenever PHC designated staff identifies a problem in Kaiser Health Plan’s or Beacon’s grievance process and assigns a deadline for receiving evidence that the problem has been resolved.

F. Expedited Grievance Process

If a member or a treating physician requests an expedited review or if the MSR or other PHC staff determines expedited review is needed, the issue will be immediately forwarded to PHC’s Medical Directors to render a determination if an expedited review is appropriate. Resolutions on expedited reviews include an oral and written notification.

1. Presentation of evidence, facts and law in support of member’s grievance

Members are advised of their rights to submit evidence, facts and law in support of their grievance. Members are also informed by the grievance coordinators of the limited time available to present evidence due to the nature of the expedited review request.

2. Expedited Request Approved

If PHC’s Medical Director determines that the grievance involves an imminent and serious threat to the health of the member, including but not limited to, severe pain, potential loss of life, limb or major bodily function, the grievance will be handled as an expedited grievance.
When expedited review is necessary and the Medical Director determines that they will not reverse the decision (if a decision was previously made by them), the Medical Director will facilitate a review of the grievance by another medical professional, including at least one practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment at issue.

a. Decisions

1) The Medical Director will render the expedited decision and the grievance staff will notify the member as expeditiously as the medical condition requires, but no later than 3 calendar days from when expedited review was requested. PHC will provide oral notification of the decision to the member.

2) PHC will issue a written confirmation of its decision within 2 working days of providing verbal notification of the decision, if the initial decision was not in writing but no later than 5 calendar days from when the initial expedited request was filed.

3. Expedited Request Denied

If PHC's Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by grievance staff that their request for an expedited review has been denied with 3 calendar days for their request and the grievance will be processed using standard timeframe (30 calendar days).

G. Extension Grievance Process

Every effort will be made by the grievance coordinator and PHC staff to resolve the member's complaint within 30 calendar days of receipt (in accordance with Title 28 CCR Section 1300.68). However, circumstances may arise that are beyond PHC's control and prevent resolution within the thirty (30) calendar day time frame. In this situation the grievance is considered to be in a “pending” status. Examples of such circumstances include, but are not limited to:

1. Failure of medical provider or practitioner to provide billing or medical records in a timely manner;
2. Temporary unavailability of a medical practitioner whose expertise is necessary in the evaluation process;
3. Inability to obtain a necessary appointment for a second opinion for a member within the thirty (30) calendar day time frame. If PHC will not meet the thirty (30) calendar day timeframe for issuing a proposed resolution to the member, the member will be notified in writing on or before day 30, that additional time is required. In these circumstances, PHC will have up to 14 additional calendar days to resolve the matter and notify the member (in accordance with Title 22 CCR 53858). Reasons for the delay are clearly documented in the extension letter that is mailed to the member and is also noted in Everest.

H. Quality of Medical Care Grievances

All quality of medical care grievances are reviewed by PHC clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel their treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound). Or they feel they were denied care, where the medical records show that the service is not necessary and an alternative treatment option was provided.

The designated PHC clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history. For the grievance department, the Grievance Clinical Lead is responsible for reviewing all clinical grievances and sending potential quality issues (PQI) to the Quality Improvement Department for processing.

All quality of care grievances are submitted to the Chief Medical Officer or their physician designee for
review immediately if there is a potential safety issue determined by the Quality Improvement RN and otherwise after documentation of the issue is received by the Quality Improvement Department.

I. Timeframes

1. Standard:
   a. Resolution – member grievances are resolved within 30 calendar days of the member’s request for a grievance (Title 22 CCR 53858 (f)(1).

2. Extension:
   a. Resolution – up to 14 additional calendar days; a notice will be sent to the member including an estimated completion date of resolution (Title 22 CCR 53858 (f)(2).

3. Expedited:
   a. Grievance staff will process the case within 3 calendar days from the date of receipt of the complaint/appeal.

Grievance Response/Resolution will be sent to the member within 2 calendar days of providing verbal notification of the decision but no later than 5 calendar days of receiving the complaint.

J. Notification

1. Each notification sent to the member will also include the member’s right to file a state hearing (Title 22 CCR 53858 (f)(3).

K. Grievance File Maintenance

1. Copies of all grievances, including but not limited to, grievance description, resolution and correspondence is maintained for five years from the date the grievance was filed.

L. Monitoring of Timeliness of Grievances

1. All complaints, appeals and state hearing requests with their resolutions are documented in Everest.

2. At the end of each month, the grievance system manager or their designee will review the grievance staff cases as part of their performance review. In addition, weekly one-on-one meetings are conducted with staff to ensure that member complaints and appeals are resolved within established time frames as well as to review open member complaints and appeals and determine appropriate resolutions.

M. Reporting Complaints and Appeals to HealthPlan Committees for Review

1. Individual and aggregate data on member complaints and appeals is reviewed by the Member Grievance Review Committee (MGRC) no less than 4 times per year. The MGRC reviews the data for possible actions as determined appropriate according to PHC Quality Assurance Protocol. Refer to CGA001 Evaluating and Reporting Data on Complaints and Appeals. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be reviewed and analysis by committee to remedy any problems identified.

N. Reporting Requirements to DHCS

1. PHC maintains and has available for DHCS’ review, PHC’s grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances. Grievance logs are maintained based on the requirements set forth in Title 22 CCR Section 53858 (e).
   a. Date and time the grievance was filed
   b. The name of the member filing the grievance
   c. The name of the person receiving the grievance
   d. A description of the complaint
e. A description of the action taken to resolve the grievance  
f. The proposed resolution by the plan  
g. The name of the person responsible for resolution  
h. The date of notification to the member  

2. PHC also submits quarterly grievance reports based on Title 28 CCR Section 1300.68(f).  
3. .  

VII. REFERENCES:  
A. PHC Contract 08-85215 A19  
B. Title 22 §53858  
C. Title 28 §1300.68 (except subdivision §1300.68(c),(g) and (h))  
D. Title 28 §1300.68.01 (except subdivision §1300.68.01(b) and (c))  
E. 42 CFR 438.420(a)(b) and (c)  
F. 42 CFR 438.406(b)(3)  
G.  

VIII. DISTRIBUTION:  
A. PHC Department Directors,  
B. PHC Provider Manual,  

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:  
Grievance System Manager  

X. REVISION DATES:  
Medi-Cal  
MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06; 01/16/08; 03/18/09; 07/21/10; 05/20/13; 11/18/15  

PREVIOUSLY APPLIED TO:
I. RELATED POLICIES:
   A. MPQP1016 Peer Review Process

II. IMPACTED DEPTS:
   A. Health Services and Grievance

III. DEFINITIONS:
   N/A

IV. ATTACHMENTS:
   A. Grievance Categories

V. PURPOSE:
   Provide guidelines to the grievance clinical lead for categorizing incoming grievances (complaints) as “clinical” or “non-clinical”. Cases that are identified as clinical in nature will be reviewed by the grievance lead nurse (GCL) or designee to assess if the case needs to be forwarded to the Quality Improvement Department as a potential quality issue (PQI). Grievances are categorized by the grievance clinical lead based on the member’s perspective.

VI. POLICY / PROCEDURE:
   A. Incoming Grievances
      1. When a grievance is received into the grievance unit, the grievance resolution specialist (or designee) will assign the grievance to a grievance coordinator using the Grievance Rotation Tracker.
      2. Upon assigning the case, an email is generated to all grievance staff, including the GCL. The GCL will log into the grievance system, Everest, to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in Everest under the “Clinical vs Non-Clinical” action by the GCL. Grievance staff will utilize the grievance categories (attachment A) worksheet to assess the grievance for other referrals to PHC departments and will proceed as directed in the worksheet.
      3. All clinical cases are reviewed by the GCL or designee to evaluate the need to forward the case to the Quality Improvement Department for a PQI and/or order records for further evaluation. The GCL or designee will direct grievance staff if a PQI referral is needed. The GCL or designee will also make recommendations for case work on any clinical cases.

   B. Clinical Grievance:
      1. A clinical grievance is defined as any issue concerning the services provided by a clinic, hospital, provider or pharmacy. The types of grievances considered to be clinical in nature include:
Policy/Procedure Title: Clinical vs. Non-Clinical Grievances

C. Non-Clinical Grievance:
   1. A non-clinical grievance is defined as any issue concerning the services provided by PHC and its non-clinical components. The types of grievances considered to be non-clinical in nature include:
      a. Billing
      b. Benefits/Coverage (benefits)
      c. Cultural, Linguistic, and Health Education (by PHC staff, PHC materials)
      d. Quality of Service (by PHC staff)
      e. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
      f. Cab complaints

D. Quality of Medical Care Grievances
   1. All quality of medical care grievances are reviewed by PHC clinical staff to assess the member’s concern for accuracy. For example, it is not unusual for a patient to feel their treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound). Or they feel they were denied care, where the medical records show that the service is not necessary and an alternative treatment option was provided.
   2. The designated PHC clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history.

E. Inter-Rater Reliability
   1. To ensure that grievances are appropriately designated by the GCL as clinical versus non-clinical and referrals for PQIs are accurately being referred to the QI department, inter-rater reliability studies will be conducted every quarter.
   2. Sample will be prepared by the Grievance System Manager or designee.
      a. PQI Referral Sample - A random selection of a minimum of 10 complaints will be pulled for review by the Chief Medical Officer (CMO) or their designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
      b. Clinical vs Non-Clinical Sample- A random selection of a minimum of 10 complaints will be pulled for review by the CMO or designee to determine whether the categorization of a grievance, clinical or non-clinical was appropriate.
   3. Time frame – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
   4. Results - A 90% inter-rater reliability is required. Where a 90% score is not achieved, additional training will be provided to the GCL by the Quality Department designated staff member and subsequent inter-rater reliability studies will be conducted until the passing score is achieved.

VII. REFERENCES:

VIII. DISTRIBUTION:
A. Grievance Reference Manual
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: CGA-021
Policy/Procedure Title: Aid Paid Pending Process
Lead Department: Administration

External Policy
Internal Policy

Original Date: 05/07/2013
Next Review Date: 11/10/2017
Last Review Date: 1/10/2017

Applies to:
- Medi-Cal
- Healthy Kids
- Employees

Reviewing Entities:
- IQI
- P & T
- QUAC
- OPERATIONS
- EXECUTIVE
- COMPLIANCE
- DEPARTMENT

Approving Entities:
- BOARD
- COMPLIANCE
- FINANCE
- PAC
- CEO
- COO
- CREDENTIALING
- DEPT. DIRECTOR/OFFICER

Approval Signature: Robert Moore, MD, MPH
Approval Date: 1/10/2017

I. RELATED POLICIES:
A. CGA-003 Medi-Cal Member Grievance System
B. CGA-019 Medi-Cal Appeal process
C. CGA-020 Medi-Cal State Hearing Process

II. IMPACTED DEPTS:
- Health Services and Grievance

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. Handling incoming appeals work flow
B. Processing appeals work flow
C. Frequently Asked Questions

V. PURPOSE:
Provide guidelines on how to process and handle aid paid pending request through the grievance process. This policy is written in accordance with Partnership HealthPlan of California’s (PHC) contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13 and 42 CFR 438.420 (a) (b) and (c).

VI. POLICY / PROCEDURE:
A. Aid Paid Pending (APP)
   1. When a PHC member or their authorized member files a timely request for an appeal and/or state hearing on a notice of action (NOA) which is proposing to reduce, discontinue, or terminate services that the member has already been receiving, the member may be entitled to APP.

B. Determination of APP
   1. The Grievance Department is solely responsible of the initial determination regarding APP. APP must not be initiated or discontinued without instructions from the Grievance Department. Disputes regarding APP are referred to the Office of the Ombudsman by the Grievance Coordinator assigned to the case.

C. Criteria
   1. In order for a member to qualify for APP, PHC or Medi-Cal would have had to previously approve the request prior to the denial. New requests for treatment or services do not qualify under aid paid pending. The criteria for continuation of benefits is listed below per 42CFR 438.420.
a. Request must occur within 10 calendar days from the date the notice of action was mailed to the member.
b. The appeal must be filed timely.
c. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
d. The service was ordered by an authorized provider.
e. The original period covered by the original authorization has not expired.
f. The member requests extension of benefits.

D. Duration of continued or reinstated benefits
1. If, at the member’s request, PHC continues or reinstates the member’s benefit while the appeal is pending, the benefits will be continued until one of the following occurs:
   a. The member withdraws from the appeal.
   b. 10 days pass after PHC mails the notice, providing resolution of the appeal against the member, unless the member within the 10 day time frame has requested a state hearing with continuation of benefits until a state hearing decision is reached.
   c. The state hearing office issues a hearing decision adverse to the member.
   d. The time period or service limits of a previously authorized service has been met.

E. Requesting Aid Paid Pending
1. Members must request continued service if they are eligible under aid paid pending. For state hearings, the request must be made to the hearing office. For appeals, member must request continuation of benefits with the PHC staff member who takes the intake for the appeal (Attachment A).

F. Activating Aid Paid Pending
1. When a case has been identified as eligible for APP, the grievance coordinator will send a notice directly to the department who issued the adverse or modified NOA (Attachment B).

G. Deactivating Aid Paid Pending
1. Aid paid pending will be deactivated when a decision is rendered or if the appeal/state hearing is withdrawn. For appeals, aid paid pending will be discontinued when the appeal decision has been rendered. For state hearings, aid paid pending will be discontinued when the hearing decision has been rendered by the Administrative Law Judge.

VII. REFERENCES:
A. PHC Contract 08-85215 A19
   42 CFR 438.420(a)(b) and (c)

VIII. DISTRIBUTION:
A. PHC Department Directors
B. PHC Provider Manual
C. SharePoint

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance System Manager

X. REVISION DATES:
Medi-Cal
PREVIOUSLY APPLIED TO:
Managing Pain Safely:
A Plan’s approach to combating the opioid epidemic

Danielle Carter, MPH
Project Manager, Quality Department

Our challenge

- The death rate from opioid overdose has quadrupled in the US in the last decade
  - **15,000**
    - Nearly 15,000 people die every year of overdoses involving prescription painkillers
  - **1 in 20**
    - In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year
  - **1 Month**
    - Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month
Managing Pain Safely – Aim Statement

• By December 31, 2016, we will improve the health of PHC members by ensuring that prescribed opioids are for appropriate indications, at safe doses, and in conjunction with other treatment modalities as measured by a:
  – Decrease in total number of initial prescriptions by 75%
  – Decrease in total number of inappropriate prescription escalations by 90%
  – Decrease in total number of patients on inappropriate high-dose opioids* by 75%

*Defined as greater than 120 mg, MED

Addressing Opioid Overuse: Health Plan Stakeholders
What Have We Accomplished?
Plan-wide Changes

- Outreach and Understanding Can Help (OUCH) program
- Prior authorization changes
  - High dose formulary change (escalations and then stable)
  - Formulary alterations (removing/adding medications)
  - Schedule II/III/IV prescription limit (30 day supply)
  - Immediate release quantity limit
- QIP incentives (PCP and Pharmacy QIP)
- Naloxone Program
- Tele-consult Pilot
- Pain Management Oversight Committee
- Pain Management Registry
- Opioid-related data analysis and sharing
- Hospitalization Feedback Loop Pilot
- Enhanced offerings for alternative modalities to treat pain

What Have We Accomplished?
Provider and Community Engagement

- Education
  - 5 in person all-day conferences, 11 webinars
- Provider to Provider Academic Detailing
- Safe Use Now
- County Coalitions
  - 12 counties have county coalitions of some sort, 10 of those 12 are funded (via CHCF, CDPH, or PHC)
- Project ECHO
  - Partner and fund five cohorts for Project ECHO
- MPS Toolkits- Naloxone, PCP, Tapering, Pharmacy
PHC Counties Participating in CHCF Regional Opioid Safety Coalition Grant Program

10 PHC Counties are participating in CHCF’s Regional Opioid Safety Coalition Grant Program

Coalition Success: Data from Marin

Decrease in Average Opioid Dose per Resident by Coalition and Health Plan Status, California Counties: 2014-2016

Q3 2014 Rate (Baseline)

Q3 2016 Rate

Source: Marin County Department of Health & Human Services
Coalition Success: Data from Marin

Source: Marin County Department of Health & Human Services

*High dose opioid defined as rate per 1,000 residents prescribed >90 Morphine Equivalent for 30 days or more

Success Stories

- Because of the distance [to the patient’s home] we ensured the patient had extra doses [of naloxone] and atomizers as the drive to town is lengthy. This patient was able to convert 3 people who overdosed within the same home.

- Another patient in Eureka converted a patient who had injected heroin that later was revealed to be laced with fentanyl

- Open Door Mobile Health Services
"Since Partnership has started taking a leadership role in bringing this problem under control [inappropriate opioid use], much to my surprise, I have seen a dramatic improvement for the patients and for the staff."

- Gary Pace, Alexander Valley

"I have my life back"
-Alexander Valley patient

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**MPS Project Update: Data**

**Project Update**
Reporting period January 1, 2014- May 31, 2017

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal (by December 31, 2016)</th>
<th>Current % Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Prescriptions</td>
<td>90% decrease</td>
<td>68% decrease</td>
</tr>
<tr>
<td>Initial Prescriptions</td>
<td>50% decrease</td>
<td>44% decrease</td>
</tr>
<tr>
<td>Rate of Chronic Opioid Users Escalations, January 2014 cohort</td>
<td>90% decrease</td>
<td>77% decrease</td>
</tr>
<tr>
<td>Members on Opioids on Unsafe Dose</td>
<td>75% decrease</td>
<td>79% decrease</td>
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<td>MED P100MPM</td>
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<td>73% decrease</td>
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</table>
MPS Data: Members on Opioids on Unsafe Dose

PHC Data Update: Change in MED PMPM
Next Steps/ Close-Out

- Continued coalition support
- Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT)- enhanced MAT benefits will be a part of the new Drug Medi-Cal benefit
- UC Davis Project ECHO
- UC Davis Pain Mentoring/ Fellowship
- Hospitalization Feedback Loop Pilot

Contact Information

Danielle Carter, MPH, Project Manager
Partnership HealthPlan of California
dcarter@partnershiphp.org
Goal: Describe and evaluate impact of PHC’s Annual Monitoring for Patients on Persistent Medications (MPM) Provider Staff Incentive Program and determine future directions.

1. Background and Program Goal
2. Program Description & Supporting Efforts
3. Quantitative Results
   A. Overall, was there an improvement in the MPM regional scores?
   B. Was the improvement associated with the staff incentive program?
4. Qualitative Feedback
5. Conclusions and Next Steps
Measure Definition: The percentage of members 18 years of age and older who received at least 180 treatment days of ACE/ARB or Diuretics medication and at least one therapeutic monitoring event (lab test) during the measurement year. Report a separate rate for members on ACE/ARB and Diuretics.

Baseline Data: In 2015, we were below the minimum performance level (MPL) in 6 MPM measures. In 2016, we were below MPL in 5 MPM measures. (Gray = < MPL; Green = > MPL)

<table>
<thead>
<tr>
<th>Region</th>
<th>Submeasure</th>
<th>2015 Rate</th>
<th>2015 MPL</th>
<th>2016 Rate</th>
<th>2016 MPL</th>
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</thead>
<tbody>
<tr>
<td>SE</td>
<td>ACE or ARB</td>
<td>88.26%</td>
<td>85.76%</td>
<td>86.39%</td>
<td>84.88%</td>
</tr>
<tr>
<td>SW</td>
<td>ACE or ARB</td>
<td>83.20%</td>
<td>85.76%</td>
<td>81.40%</td>
<td>84.88%</td>
</tr>
<tr>
<td>NE</td>
<td>ACE or ARB</td>
<td>82.11%</td>
<td>85.76%</td>
<td>81.68%</td>
<td>84.88%</td>
</tr>
<tr>
<td>NW</td>
<td>ACE or ARB</td>
<td>80.41%</td>
<td>85.76%</td>
<td>78.82%</td>
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<tr>
<td>SE</td>
<td>Diuretics</td>
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<td>85.33%</td>
<td>84.70%</td>
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<td>NW</td>
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<td>83.65%</td>
<td>85.69%</td>
<td>80.46%</td>
<td>84.70%</td>
</tr>
</tbody>
</table>

Program Goal: Achieve above MPL performance on MPM-ACE/ARB and MPM-Diuretics across all regions for HEDIS 2017 reporting.

Program Description

- Designed staff incentive program to motivate clinic staff to recruit members to complete needed labs by December 31st
- $100K in Strategic Use Reserve (SUR) funds approved to be distributed to sites who achieve goals:
  - Full incentive (above the 90th percentile for ACE/ARB and Diuretic)
  - Partial incentive (30% relative improvement from HEDIS 2016 rate)
  - Engagement incentive (40% of non-compliant labs sent)
- Stipulation that funds had to be spent on front-line staff incentives. Exact spending plans could be determined by the participating clinics.
Supporting Efforts

1. Provider Education Webinar
2. Data Sharing with Provider Practices
3. Provider Practice Site Visits

Who Participated?

- **86** sites voluntarily enrolled
- Approximately **49%** of the total MPM eligible population was covered by this program (cared for by 86 participating sites)
  - NW had the highest participation rate
  - SW had the lowest participation rate

<table>
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<th>2695</th>
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<tr>
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<td>13259</td>
<td>6931</td>
<td>49.00%</td>
<td>25.61%</td>
</tr>
</tbody>
</table>
Outcomes

- **619** compliant labs sent
- Of 86 participating clinics, **46** received incentives
  - 31% received full incentive (27)
  - 11% received partial incentive (10)
  - 10% received engagement incentive (9)
- **$75,178** total incentives sent

Did It Work?
Performance Relative to Program Goal (ACE/ARB)

<table>
<thead>
<tr>
<th>Region</th>
<th>Submeasure</th>
<th>2015 Rates</th>
<th>2015 MPL</th>
<th>2016 Rate</th>
<th>2016 M</th>
<th>2017 Rate</th>
<th>2017 M</th>
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<tbody>
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</tbody>
</table>

- PHC remains below MPL for the ACE/ARB sub-measure in 3 of 4 regions.
- Performance scores in these three regions did improve and were higher than in any prior year. Significant improvement in NW.
- If MPL target hadn’t increased, would have met goal in SW and NW.
Did It Work?
Performance Relative to Program Goal (Diuretics)

<table>
<thead>
<tr>
<th>Region</th>
<th>Submeasure</th>
<th>2015 Rated</th>
<th>2015 MPL</th>
<th>2016 Rate</th>
<th>2016 MPL</th>
<th>2017 Rate</th>
<th>2017 MPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE</td>
<td>Diuretics</td>
<td>88.88%</td>
<td>85.69%</td>
<td>85.33%</td>
<td>84.70%</td>
<td>86.20%</td>
<td>85.18%</td>
</tr>
<tr>
<td>SW</td>
<td>Diuretics</td>
<td>83.30%</td>
<td>85.69%</td>
<td>85.03%</td>
<td>84.70%</td>
<td>84.85%</td>
<td>85.18%</td>
</tr>
<tr>
<td>NE</td>
<td>Diuretics</td>
<td>83.23%</td>
<td>85.69%</td>
<td>83.40%</td>
<td>84.70%</td>
<td>84.77%</td>
<td>85.18%</td>
</tr>
<tr>
<td>NW</td>
<td>Diuretics</td>
<td>83.65%</td>
<td>85.69%</td>
<td>80.46%</td>
<td>84.70%</td>
<td>84.06%</td>
<td>85.18%</td>
</tr>
</tbody>
</table>

- PHC remains below MPL for the Diuretics sub-measure in 2 of 4 regions. Regions below MPL changed from NE and NW to NE and SW.
- Performance scores remained consistent or improved with significant improvement in NW.
- If MPL target hadn’t increased, would have met goal in NE and SW.

Is the Incentive Associated with Improvement?

Average Percent Increase per Site, by Enrolled and Not Enrolled Status –

Clinics that enrolled in the program saw more improvement than clinics that did not, with the exception of the NW region.

<table>
<thead>
<tr>
<th></th>
<th>ACE/ARBs</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrolled Average Percent Increase per Site</td>
<td>Not Enrolled Average Percent Increase per Site</td>
<td>Enrolled Average Percent Increase per Site</td>
<td>Not Enrolled Average Percent Increase per Site</td>
<td></td>
</tr>
<tr>
<td>SE</td>
<td>6.94%</td>
<td>-2.97%</td>
<td>2.39%</td>
<td>-3.91%</td>
<td></td>
</tr>
<tr>
<td>SW</td>
<td>6.43%</td>
<td>1.64%</td>
<td>5.01%</td>
<td>-2.91%</td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>-0.07%</td>
<td>-6.65%</td>
<td>5.25%</td>
<td>-5.74%</td>
<td></td>
</tr>
<tr>
<td>NW</td>
<td>7.76%</td>
<td>10.63%</td>
<td>6.96%</td>
<td>8.6%</td>
<td></td>
</tr>
</tbody>
</table>

Calculation: Sum(2017 score – 2016 score)/total number of clinics
Is the Incentive Associated with Improvement?

**Weighted Average (by denominator size) Percent Increase per Site, by Enrolled and Not Enrolled Status –**

When we weight by membership, there is not a clear association between enrollment status and improvement.

<table>
<thead>
<tr>
<th></th>
<th>ACE/ARBS</th>
<th>Diuretics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrolled</td>
<td>Not Enrolled</td>
</tr>
<tr>
<td>SE</td>
<td>3.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>SW</td>
<td>2.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>NE</td>
<td>-1.0%</td>
<td>-2.6%</td>
</tr>
<tr>
<td>NW</td>
<td>5.1%</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

Calculation: \( \frac{\text{Sum}(2017 \text{ score} - 2016 \text{ score}) \times 2017 \text{ denominator}}{\text{sum}(2017 \text{ denominator})} \)

Is the Incentive Associated with Improvement?

**Regional Rate Improvement Compared with Program Coverage –**

*Greatest regional improvement seen in NW region, where program penetration was highest.*

<table>
<thead>
<tr>
<th>Region</th>
<th>ACE/ARBS Improvement</th>
<th>Diuretics Improvement</th>
<th>Enrollment Coverage*</th>
<th>Incentive Coverage**</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>6.73%</td>
<td>5.60%</td>
<td>70.00%</td>
<td>38.57%</td>
</tr>
<tr>
<td>SW</td>
<td>1.52%</td>
<td>-0.18%</td>
<td>31.26%</td>
<td>24.39%</td>
</tr>
<tr>
<td>SE</td>
<td>0.72%</td>
<td>0.87%</td>
<td>63.00%</td>
<td>25.63%</td>
</tr>
<tr>
<td>NE</td>
<td>0.54%</td>
<td>1.37%</td>
<td>38.51%</td>
<td>19.65%</td>
</tr>
</tbody>
</table>

*% of Members on ACE/ARBS and Diuretics Enrolled in the Program vs. Total Denominator of ACEs/ARBs and Diuretics

**% of Members on ACE/ARBS and Diuretics Who Qualified For The Incentive vs. Total Denominator of ACE/ARBS and Diuretics
• [We provided] messaging about the importance of monitoring these medications and then ordering lab tests for patients prior to medication refills, or decreasing the refill amount sufficient to carry the patients needs until labs are completed. This is not just to be done at the office but to be spread across the other practices in the organization.
  -Sutter Pacific Medical Center

• We opened a resource schedule in the EMR for the preventative care coordinator at each site. As former medical assistants they are able to draw blood and can work off standing orders. With an open schedule, appointments could be easily scheduled. This extra schedule has also proved useful for clients that need retinal eye exams and haven’t kept referral appointments and we foresee that it will help with BP and hgba1c rechecks.
  -CommuniCare Health Centers
Learnings

• **Challenges:**
  • Short turn-around for program
  • Timing – holiday season
  • Unchartered territory
  • Engaging large providers (i.e. St. Helena)
  • Equitable work load for large vs. small provider sites
  • Gathering attention of provider network
  • Confusion over different programs
  • Sensitivity around targeting front-line staff

• **Successes:**
  • Improvement shown across regions and clinics
  • Still hearing about it today
  • Portfolio of best practices

Conclusions

• Regional MPM scores improved relative to HEDIS 2016 with the most significant improvement in the NW region.
• Using our 2016 MPL targets, we would have reduced the number of measures below MPL from 5 to 1. The HEDIS 2017 targets were higher than the HEDIS 2016 targets, so our performance remained consistent at 5 measures below MPL.
• The exact measures below MPL vary slightly from prior year. MPM-Diuretics is below MPL in the SW region, versus the NW region this year.
• Clinics that enrolled in the program saw more improvement than clinics that did not, with the exception of the NW region; however, when we weight by membership, there is no clear association between enrollment status and improvement.
• The greatest regional improvement seen is in NW region, where program penetration was highest.
• Qualitative data from program participants supports that the intervention impacted clinic behavior and population health outreach.
**Adapt, Adopt, or Abandon?**

**ADAPT!!**

- More time to plan & gather input from provider network
- Strategic engagement of high volume sites
- Different time of year
- More best practice sharing
- Recommend trying with new measure – Breast Cancer Screening

**Questions?**
### Potential Quality Issues

2016 Q1 & 2016 Q2, Region: All

Select Q
Multiple values

Region
- All
- North
- South

#### PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th></th>
<th>2016 Q1</th>
<th>2016 Q2</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>North</td>
<td>South</td>
<td>North</td>
</tr>
<tr>
<td>PQI Count</td>
<td>147</td>
<td>84</td>
<td>199</td>
</tr>
<tr>
<td>Members Months</td>
<td>463,992</td>
<td>1,226,771</td>
<td>469,548</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>3.80</td>
<td>0.82</td>
<td>5.09</td>
</tr>
</tbody>
</table>

#### Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODOC</td>
<td>13</td>
<td>11,729</td>
<td>13.30</td>
</tr>
<tr>
<td>SHASTA</td>
<td>194</td>
<td>370,148</td>
<td>6.29</td>
</tr>
<tr>
<td>LASSEN</td>
<td>14</td>
<td>28,867</td>
<td>5.82</td>
</tr>
<tr>
<td>SISKIYOU</td>
<td>35</td>
<td>101,873</td>
<td>4.12</td>
</tr>
<tr>
<td>TRINITY</td>
<td>9</td>
<td>27,102</td>
<td>3.98</td>
</tr>
<tr>
<td>DEL NORTE</td>
<td>14</td>
<td>56,916</td>
<td>2.95</td>
</tr>
<tr>
<td>HUMBOLDT</td>
<td>60</td>
<td>305,416</td>
<td>2.36</td>
</tr>
<tr>
<td>YOLO</td>
<td>29</td>
<td>320,862</td>
<td>1.08</td>
</tr>
<tr>
<td>LAKE</td>
<td>15</td>
<td>175,438</td>
<td>1.03</td>
</tr>
<tr>
<td>NAPA</td>
<td>6</td>
<td>85,540</td>
<td>0.84</td>
</tr>
<tr>
<td>SOLANO</td>
<td>47</td>
<td>681,236</td>
<td>0.83</td>
</tr>
<tr>
<td>MARIN</td>
<td>13</td>
<td>218,975</td>
<td>0.71</td>
</tr>
<tr>
<td>MENDOCINO</td>
<td>12</td>
<td>224,628</td>
<td>0.64</td>
</tr>
<tr>
<td>SONOMA</td>
<td>30</td>
<td>672,970</td>
<td>0.53</td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (L.vaisenberg@partnershiphp.org).

### Trend of Rate per 1,000 members

![Trend of Rate per 1,000 members graph]
## Potential Quality Issues

2016 Q1 & 2016 Q2, Region: South

Select Q

Multiple values

Region

South

### PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th></th>
<th>2016 Q1 South</th>
<th>2016 Q2 South</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Count</td>
<td>84</td>
<td>93</td>
<td>177</td>
</tr>
<tr>
<td>Members Months</td>
<td>1,226,771</td>
<td>1,238,609</td>
<td>2,465,380</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>0.82</td>
<td>0.90</td>
<td>0.86</td>
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</table>

### Trend of Rate per 1,000 members

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Q4</td>
<td>0.0</td>
</tr>
<tr>
<td>2014 Q2</td>
<td>0.5</td>
</tr>
<tr>
<td>2014 Q4</td>
<td>1.0</td>
</tr>
<tr>
<td>2015 Q2</td>
<td>1.5</td>
</tr>
<tr>
<td>2015 Q4</td>
<td>1.0</td>
</tr>
<tr>
<td>2016 Q2</td>
<td>0.5</td>
</tr>
<tr>
<td>2016 Q4</td>
<td>0.2</td>
</tr>
<tr>
<td>2017 Q2</td>
<td>0.1</td>
</tr>
</tbody>
</table>

### Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yolo</td>
<td>29</td>
<td>320,862</td>
<td>1.08</td>
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<td>15</td>
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<td>672,970</td>
<td>0.53</td>
</tr>
</tbody>
</table>

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### Potential Quality Issues

#### 2016 Q1 & 2016 Q2, Region: North

<table>
<thead>
<tr>
<th>Region</th>
<th>North</th>
</tr>
</thead>
</table>

**Select Q Multiple values**

**Region**

### PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th></th>
<th>2016 Q1 North</th>
<th>2016 Q2 North</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Count</td>
<td>147</td>
<td>199</td>
<td>346</td>
</tr>
<tr>
<td>Members Months</td>
<td>463,992</td>
<td>469,548</td>
<td>933,540</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>3.80</td>
<td>5.09</td>
<td>4.45</td>
</tr>
</tbody>
</table>

#### Trend of Rate per 1,000 members

![Graph showing trend of rate per 1,000 members](image)

### Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODOC</td>
<td>13</td>
<td>11,729</td>
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</tr>
<tr>
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<td>370,148</td>
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<td>TRINITY</td>
<td>9</td>
<td>27,102</td>
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</tr>
<tr>
<td>HUMBOLDT</td>
<td>60</td>
<td>305,416</td>
<td>2.36</td>
</tr>
</tbody>
</table>

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### Potential Quality Issues

**2016 Q1 & 2016 Q2**

<table>
<thead>
<tr>
<th>Region</th>
<th>All</th>
</tr>
</thead>
</table>

**PQI Counts by Provider Type**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>PQI Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>448</td>
</tr>
<tr>
<td>OTHER</td>
<td>61</td>
</tr>
<tr>
<td>SPEC</td>
<td>13</td>
</tr>
</tbody>
</table>

**PQI Counts by Referral Type**

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>PQI Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Treatment/Diagnosis &amp; ATD</td>
<td>307</td>
</tr>
<tr>
<td>AA &amp; Access &amp; Availability</td>
<td>102</td>
</tr>
<tr>
<td>Communication/Conduct</td>
<td>38</td>
</tr>
<tr>
<td>CC</td>
<td>29</td>
</tr>
<tr>
<td>CCare &amp; Continuity of Care</td>
<td>13</td>
</tr>
<tr>
<td>SS &amp; Surgical Services</td>
<td>9</td>
</tr>
<tr>
<td>OT</td>
<td>8</td>
</tr>
<tr>
<td>Pharmacy &amp; RX</td>
<td>8</td>
</tr>
<tr>
<td>UD</td>
<td>3</td>
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<tr>
<td>UM</td>
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<tr>
<td>Other</td>
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<td>External</td>
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<tr>
<td>RMD</td>
<td>1</td>
</tr>
<tr>
<td>OB</td>
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**PQI Counts by Referral Source**

<table>
<thead>
<tr>
<th>Source</th>
<th>PQI Counts</th>
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<tr>
<td>UM</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>CMO</td>
<td>1</td>
</tr>
<tr>
<td>External</td>
<td>1</td>
</tr>
<tr>
<td>RMD</td>
<td>1</td>
</tr>
<tr>
<td>RX</td>
<td>1</td>
</tr>
</tbody>
</table>

### For questions/suggestions please contact Liat Vaisenberg (L.vaisenberg@partnershiphp.org).
**Potential Quality Issues**

**2016 Q3 & 2016 Q4, Region: All**

Select Q
Multiple values

Region  
North  
South  
All

### PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th></th>
<th>2016 Q3</th>
<th></th>
<th>2016 Q4</th>
<th></th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>North</td>
<td>South</td>
<td>North</td>
<td>South</td>
<td></td>
</tr>
<tr>
<td>PQI Count</td>
<td>160</td>
<td>62</td>
<td>95</td>
<td>75</td>
<td>392</td>
</tr>
<tr>
<td>Members Months</td>
<td>468,630</td>
<td>1,242,228</td>
<td>470,896</td>
<td>1,243,761</td>
<td>3,425,515</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>4.10</td>
<td>0.60</td>
<td>2.42</td>
<td>0.72</td>
<td>1.37</td>
</tr>
</tbody>
</table>

### Trend of Rate per 1,000 members

#### Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODOC</td>
<td>7</td>
<td>18,144</td>
<td>4.63</td>
</tr>
<tr>
<td>SHASTA</td>
<td>140</td>
<td>364,471</td>
<td>4.61</td>
</tr>
<tr>
<td>TRINITY</td>
<td>7</td>
<td>22,911</td>
<td>3.67</td>
</tr>
<tr>
<td>SISKIYOU</td>
<td>25</td>
<td>87,650</td>
<td>3.42</td>
</tr>
<tr>
<td>LASSEN</td>
<td>6</td>
<td>21,655</td>
<td>3.32</td>
</tr>
<tr>
<td>DEL NORTE</td>
<td>12</td>
<td>56,835</td>
<td>2.53</td>
</tr>
<tr>
<td>HUMBOLDT</td>
<td>55</td>
<td>312,463</td>
<td>2.11</td>
</tr>
<tr>
<td>MENDOCINO</td>
<td>11</td>
<td>147,956</td>
<td>0.89</td>
</tr>
<tr>
<td>YOLO</td>
<td>20</td>
<td>269,133</td>
<td>0.89</td>
</tr>
<tr>
<td>NAPA</td>
<td>4</td>
<td>58,128</td>
<td>0.83</td>
</tr>
<tr>
<td>SOLANO</td>
<td>44</td>
<td>684,574</td>
<td>0.77</td>
</tr>
<tr>
<td>LAKE</td>
<td>9</td>
<td>148,542</td>
<td>0.73</td>
</tr>
<tr>
<td>SONOMA</td>
<td>25</td>
<td>677,999</td>
<td>0.44</td>
</tr>
<tr>
<td>MARIN</td>
<td>2</td>
<td>75,382</td>
<td>0.32</td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (L.vaisenberg@partnershiphp.org).
Potential Quality Issues
2016 Q3 & 2016 Q4, Region: South

Select Q
Region South

PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th>Region</th>
<th>2016 Q3 South</th>
<th>2016 Q4 South</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Count</td>
<td>62</td>
<td>75</td>
<td>137</td>
</tr>
<tr>
<td>Members Months</td>
<td>1,242,228</td>
<td>1,243,761</td>
<td>2,485,989</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>0.60</td>
<td>0.72</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>Region</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENDOCINO</td>
<td>11</td>
<td>147,956</td>
<td>0.89</td>
</tr>
<tr>
<td>YOLO</td>
<td>20</td>
<td>269,133</td>
<td>0.89</td>
</tr>
<tr>
<td>NAPA</td>
<td>4</td>
<td>58,128</td>
<td>0.83</td>
</tr>
<tr>
<td>SOLANO</td>
<td>44</td>
<td>684,574</td>
<td>0.77</td>
</tr>
<tr>
<td>LAKE</td>
<td>9</td>
<td>148,542</td>
<td>0.73</td>
</tr>
<tr>
<td>SONOMA</td>
<td>25</td>
<td>677,999</td>
<td>0.44</td>
</tr>
<tr>
<td>MARIN</td>
<td>2</td>
<td>75,382</td>
<td>0.32</td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (L.vaisenberg@partnershiphp.org).
Potential Quality Issues
2016 Q3 & 2016 Q4, Region: North

Select Q
Multiple values

Region North

PQI Rate, Count and Membership

<table>
<thead>
<tr>
<th></th>
<th>2016 Q3 North</th>
<th>2016 Q4 North</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Count</td>
<td>160</td>
<td>95</td>
<td>255</td>
</tr>
<tr>
<td>Members Months</td>
<td>468,630</td>
<td>470,896</td>
<td>939,526</td>
</tr>
<tr>
<td>Rate per 1,000 Members</td>
<td>4.10</td>
<td>2.42</td>
<td>3.26</td>
</tr>
</tbody>
</table>

Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODOC</td>
<td>7</td>
<td>18,144</td>
<td>4.63</td>
</tr>
<tr>
<td>SHASTA</td>
<td>140</td>
<td>364,471</td>
<td>4.61</td>
</tr>
<tr>
<td>TRINITY</td>
<td>7</td>
<td>22,911</td>
<td>3.67</td>
</tr>
<tr>
<td>SISKIYOU</td>
<td>25</td>
<td>87,650</td>
<td>3.42</td>
</tr>
<tr>
<td>LASSEN</td>
<td>6</td>
<td>21,655</td>
<td>3.32</td>
</tr>
<tr>
<td>DEL NORTE</td>
<td>12</td>
<td>56,835</td>
<td>2.53</td>
</tr>
<tr>
<td>HUMBOLDT</td>
<td>55</td>
<td>312,463</td>
<td>2.11</td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (L.vaisenberg@partnershiphp.org).
### Potential Quality Issues

#### 2016 Q3 & 2016 Q4

**Region**
- All

<table>
<thead>
<tr>
<th>POI Counts by Provider Type</th>
<th>PCP</th>
<th>OTHER</th>
<th>SPEC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>448</td>
<td>61</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POI Counts by Referral Source</th>
<th>PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS &amp; Surgical Services</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacy &amp; RX</td>
<td>8</td>
</tr>
<tr>
<td>OT</td>
<td>8</td>
</tr>
<tr>
<td>CMO</td>
<td>2</td>
</tr>
<tr>
<td>CC</td>
<td>1</td>
</tr>
<tr>
<td>CMO</td>
<td>1</td>
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<td>External</td>
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<tr>
<td>RMD</td>
<td>1</td>
</tr>
<tr>
<td>RX</td>
<td>1</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>POI Counts by Referral Type</th>
<th>Assessment/Treatment/ Diagnosis &amp; ATD</th>
<th>AA &amp; Access &amp; Availability</th>
<th>Communication/Conduct</th>
<th>CC</th>
<th>CCare &amp; Continuity of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>307</td>
<td>102</td>
<td>38</td>
<td>29</td>
<td>13</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>POI Counts by Level, Service Type &amp; Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>OTHER</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>PCP</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>SPEC</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (lvaisenberg@partnershiphp.org).
### Potential Quality Issues

2016 Q1, 2016 Q2, 2016 Q3 and 1 more, Region: All

Select Q, Multiple values

<table>
<thead>
<tr>
<th>Region</th>
<th>North</th>
<th>South</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Count</td>
<td>601</td>
<td>314</td>
<td>915</td>
</tr>
<tr>
<td>Members Months</td>
<td>1,873,066</td>
<td>4,951,369</td>
<td>6,824,435</td>
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<tr>
<td>Rate per 1,000 Members</td>
<td>3.85</td>
<td>0.76</td>
<td>1.61</td>
</tr>
</tbody>
</table>

### PQI Rate, Count and Membership

#### Trend of Rate per 1,000 members

#### Count, Membership and Rate per 1,000 Members by County

<table>
<thead>
<tr>
<th>County</th>
<th>PQI Count</th>
<th>Members Months</th>
<th>Rate per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODOC</td>
<td>20</td>
<td>29,873</td>
<td>8.03</td>
</tr>
<tr>
<td>SHASTA</td>
<td>334</td>
<td>734,619</td>
<td>5.46</td>
</tr>
<tr>
<td>LASSEN</td>
<td>20</td>
<td>50,522</td>
<td>4.75</td>
</tr>
<tr>
<td>TRINITY</td>
<td>16</td>
<td>50,013</td>
<td>3.84</td>
</tr>
<tr>
<td>SISKIYOU</td>
<td>60</td>
<td>189,523</td>
<td>3.80</td>
</tr>
<tr>
<td>DEL NORTE</td>
<td>26</td>
<td>113,751</td>
<td>2.74</td>
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<tr>
<td>HUMBOLDT</td>
<td>115</td>
<td>617,879</td>
<td>2.23</td>
</tr>
<tr>
<td>YOLO</td>
<td>49</td>
<td>589,995</td>
<td>1.00</td>
</tr>
<tr>
<td>LAKE</td>
<td>24</td>
<td>323,980</td>
<td>0.89</td>
</tr>
<tr>
<td>NAPA</td>
<td>10</td>
<td>143,668</td>
<td>0.84</td>
</tr>
<tr>
<td>SOLANO</td>
<td>91</td>
<td>1,365,940</td>
<td>0.80</td>
</tr>
<tr>
<td>MENDOCINO</td>
<td>23</td>
<td>372,584</td>
<td>0.74</td>
</tr>
<tr>
<td>MARIN</td>
<td>15</td>
<td>294,357</td>
<td>0.61</td>
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<tr>
<td>SONOMA</td>
<td>55</td>
<td>1,350,969</td>
<td>0.49</td>
</tr>
</tbody>
</table>

For questions/suggestions please contact Liat Vaisenberg (Lvaisenberg@partnershiphp.org).
# Potential Quality Issues

## 2016 Q1, 2016 Q2, 2016 Q3 and 1 more

<table>
<thead>
<tr>
<th>Region</th>
<th>All</th>
<th>Quarter</th>
<th>Multiple values</th>
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</table>

## PQI Counts by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>PCP 785</th>
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</thead>
</table>

## PQI Counts by Referral Type

<table>
<thead>
<tr>
<th>Category</th>
<th>S0</th>
<th>P0</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
<th>Track &amp; Trend</th>
<th>UTD</th>
<th>Grand Total</th>
</tr>
</thead>
</table>

## PQI Counts by Referral Source

<table>
<thead>
<tr>
<th>Source</th>
<th>MS 769</th>
</tr>
</thead>
</table>

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For questions/suggestions please contact Liat Vaisenberg (Lvaisenberg@partnershiphp.org).
<table>
<thead>
<tr>
<th>COMMITTEE:</th>
<th>Pharmacy &amp; Therapeutics Committee Meeting (P&amp;T)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE / TIME:</td>
<td>Thursday, July 27, 2017 / 7:30am-10:00am PT</td>
</tr>
</tbody>
</table>

| MEMBERS PRESENT:     | Thomas Paukert, MD                               |
|                      | Kirsten Balano, Pharm.D.                         |
|                      | Hayley Park, Pharm.D.                            |
|                      | Jay Shubrook, DO                                |
|                      | Robert Moore, MD, MPH, MBA                      |
|                      | Stan Leung, Pharm.D                             |
|                      | Mark Glickstein, MD                             |
|                      | Marshall Kubota, MD                             |
|                      | Scott Endsley, MD                               |
|                      | Jeffery Ribordy, MD, MPH                        |
|                      | James Cotter, MD                                |
|                      | Mark Netherda, MD                               |
|                      | Bettina Spiller, MD                             |
|                      | Diane Wong, Pharm.D                             |
|                      | Ominder Mehta, Pharm.D.                         |
|                      | Peggy Hoover, RN                                |
|                      | Lynette Rey, Pharm.D.                           |
|                      | Jeannie Ngo, Pharm.D.                           |
|                      | Kim Fillette, Pharm.D.                          |
|                      | Erin Montegary, Pharm.D.                        |
|                      | Marlena Ogawa, Pharm.D.                         |
|                      | Jordan Sumodobila, Pharm.D.                     |
|                      | Monika Brunkal, RPH                             |
|                      | Kathleen Vo, Pharm.D.                           |
|                      | Lisa Ooten, Pharm.D.                            |
|                      | Tony Sengdara, CPhT                             |
|                      | Danielle Biasotti, CPhT                         |

| PHC STAFF PRESENT:   | Robert Soper, MD                                |
|                      | David R. Gilliam, MD                            |
|                      | Cristie Pellegrini, Pharm.D.                    |
|                      | Harvey Katzman, Pharm.D.                        |
|                      | Anh Do, Pharm.D.                                |
|                      | Hyejin Lee, Pharm.D.                            |

| VISITORS:            | Michael Vovakes, MD                             |
|                      | Liz Gibboney, CEO, PHC                          |
|                      | Karen Steven, MD                                 |
|                      | Teresa Lugo, CPhT                                |

| MEMBERS ABSENT:      | Moje Moradi, Pharm.D.                           |
|                      | M. Tracy Johnson, MD                             |
|                      | Lynette Rey, Pharm.D.                           |
|                      | Jeannie Ngo, Pharm.D.                           |
|                      | Kim Fillette, Pharm.D.                          |
|                      | Erin Montegary, Pharm.D.                        |
|                      | Marlena Ogawa, Pharm.D.                         |
|                      | Jordan Sumodobila, Pharm.D.                     |
|                      | Monika Brunkal, RPH                             |
|                      | Kathleen Vo, Pharm.D.                           |
|                      | Lisa Ooten, Pharm.D.                            |
|                      | Tony Sengdara, CPhT                             |
|                      | Danielle Biasotti, CPhT                         |

<p>| MEMBERS EXCUSED:     | Moje Moradi, Pharm.D.                           |
|                      | M. Tracy Johnson, MD                             |
|                      | Lynette Rey, Pharm.D.                           |
|                      | Jeannie Ngo, Pharm.D.                           |
|                      | Kim Fillette, Pharm.D.                          |
|                      | Erin Montegary, Pharm.D.                        |
|                      | Marlena Ogawa, Pharm.D.                         |
|                      | Jordan Sumodobila, Pharm.D.                     |
|                      | Monika Brunkal, RPH                             |
|                      | Kathleen Vo, Pharm.D.                           |
|                      | Lisa Ooten, Pharm.D.                            |
|                      | Tony Sengdara, CPhT                             |
|                      | Danielle Biasotti, CPhT                         |</p>
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Approval of minutes</td>
<td>April 6, 2017 Meeting Minutes – approved by committee (Motion to approve: )</td>
<td>Approved – Quorum Reached: Diane Wong Pharm.D., Mark Netherda MD, Mark Glickstein MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Standing Agenda</td>
<td></td>
<td>Presented by: Robert Moore, MD, MPH, MBA PHC Chief Medical Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. PHC Update</td>
<td>1) Will not review the Federal updates because they are continuously changing – 2) California state budget: Not too many changes but a few that effect Medi-Cal: A) Planning to reinstate adult dental benefits in 2018, but they don’t have the funding worked out yet. B) Planning to add adult vision benefits in 2020, but again they have to figure out the funding. This will be nice for PHC, as we have been paying for a vision care benefit for the last several years as an enhancement, and it will be nice if we can start getting reimbursed. C) There is a diabetes prevention program, a new benefit starting in July 2018 (the biggest one that affects us). D) We have 2 sites in Sonoma that have been funded to provide medically tailored meals to individuals with certain medical conditions. This is a pilot program. This has been shown in small studies to have some cost savings, so we’re trying it in a pilot program to see how it works out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEM</td>
<td>DISCUSSION / CONCLUSIONS</td>
<td>RECOMMENDATIONS / ACTION</td>
<td>TARGET DATE</td>
<td>DATE RESOLVED</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>4)</td>
<td>The state legislature has passed a law mandating that members are now eligible for transportation for anything related to medical care that is provided by Partnership, and in October, the state is requiring us to cover transportation for care related to mental health and dental health as well. This benefit has been used already and it’s growing rapidly. The state doesn’t have a good handle on the costs as yet.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>We are in the process of promoting Medication Synchronization. This is where pharmacies try to have all member fills done at the same time, one time a month. In other words, if a member fills 5 prescriptions and needs to make 5 trips to the pharmacy in a month and utilizes their transportation benefit, it would be much less costly to have to cover their transportation only one time per month. This also improves quality and compliance. We seem to have more independent pharmacy interest in this program than commercial pharmacies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td>“Well-Child” visits that are paid for the CHDP (California Health &amp; Development Program) – is removing the fee for service from their site that required using a form called the PM160, which has been used for a number of years. It is not a HIPAA compliant form. The Federal Government was getting increasingly upset that the state was utilizing this form so the state has now figured out how to get fee for service data to get what they need, but the department of the state that figures out how to do that for PHC didn’t get a process implemented as yet, so PM160 is still required for Medi-Cal Managed Care at this time. We are pushing hard to eliminate that requirement for managed care as quickly as possible.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td>“The Final Rule” – this is a CMS collection of regulations regarding Medicare Managed Care which has required a lot of work throughout our health plan. The two big impacts for pharmacy are</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

lot of interest throughout our counties. This is very exciting news for PHC.
2. PHC Formulary:
Proposed
Additions/
Changes,
Including Prior
Authorization
Criteria

The following were presented as formulary maintenance items, no action needed by committee:
Salmeterol succinate DPI (Serevent)
Estradiol tablets (Estrace)
Piperacillin-Tazobactam (Zosyn)
Epinephrine auto-injector (Adrenaclick)
Epinephrine auto-injector (Auvi-Q)
Everolimus (Afinitor, Afinitor Disperz)
Freestyle, InsuLinx, Precision test strips (Abbott)
Clindamycin 1% facial swab (Cleocin-T)
Clariithromycin suspension (Biaxin)
Ursodiol tablets (URSO, URSO Forte)
Sodium Fluoride chewable tablets (Ludent, Fluoritab)
Sodium Polystyrene Sulf/Sorbitol (Kionex) 15g/60ml
Isosorbide Dinitrate (Isordil)
Cyclosporin (Neoral) 100mg/ml
Lorazepam (Ativan) injection
Mirtazapine (Remeron)
Propranolol (Inderal)
Palonosetron (Aloxi)

the 24 hour review requirement, which has resulted in the addition of Saturday hours for some of our pharmacy staff. Additionally, there is some controversy between the state and the federal government as to whether there is an elimination of the ability to do a “pending” status, so we’re erring with the Federal interpretation which means we have to move very quickly to figure out what’s going on if a TAR is not clear or else we’ll have to deny it if we can’t get the information, then it can be resubmitted if need be; so instead of pending it, it would either be approved or denied, and then it would have to be resubmitted instead of being placed in a “pending” status while waiting for pertinent information.

8) PHC Site wide is working on NCQA accreditation. Our goal is to have something called “Interim Accreditation” in the fall of 2019. Many activities in the next 2 years will be focused on achieving this goal. The goal is to not just to be accredited, but to be accredited with a high performance standard when the performance standard rankings come out.

Formulary Maintenance Items, Presented for Information Only (no objections):

<table>
<thead>
<tr>
<th>Drug</th>
<th>Maintenance Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salmeterol succinate DPI (Serevent)</td>
<td>Formulary addition for DHCS compliance</td>
</tr>
<tr>
<td>Estradiol tablets (Estrace)</td>
<td>Removal of quantity limit</td>
</tr>
<tr>
<td>Piperacillin-Tazobactam (Zosyn)</td>
<td>Addition of 13g vial to formulary as line extension</td>
</tr>
<tr>
<td>Epinephrine auto-injector (Adrenaclick)</td>
<td>Addition of new generic GCN as line extension</td>
</tr>
<tr>
<td>Epinephrine auto-injector (Auvi-Q)</td>
<td>Edit to block claims by labeler (Kaleo, Inc)</td>
</tr>
<tr>
<td>Everolimus (Afinitor, Afinitor Disperz)</td>
<td>Formulary addition for DHCS compliance</td>
</tr>
<tr>
<td>Freestyle, InsuLinx, Precision test strips (Abbott)</td>
<td>Change to Code-1 with increased QL to 4-8 per day</td>
</tr>
<tr>
<td>Clindamycin 1% facial swab (Cleocin-T)</td>
<td>Addition to formulary as line extension</td>
</tr>
<tr>
<td>AGENDA ITEM</td>
<td>DISCUSSION / CONCLUSIONS</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Testosterone cypionate (Depo Testosterone) Testosterone undecanoate (Aveed) Testosterone enanthate (Delatestryl) Octreotide (Sandostatin)</td>
<td>Clarithromycin suspension (Biaxin)</td>
</tr>
<tr>
<td></td>
<td>Ursodiol tablets (URSO, URSO Forte)</td>
</tr>
<tr>
<td></td>
<td>Sodium Fluoride chewable tablets (Ludent, Fluoritab)</td>
</tr>
<tr>
<td></td>
<td>Sodium Polystyrene Sulf/Sorbitol (Kionex) 15g/60ml</td>
</tr>
<tr>
<td></td>
<td>Isosorbide Dinitrate (Isordil)</td>
</tr>
<tr>
<td></td>
<td>Cyclosporin (Neoral) 100mg/ml</td>
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<tr>
<td></td>
<td>Lorazepam (Ativan) injection</td>
</tr>
<tr>
<td></td>
<td>Mirtazapine (Remeron)</td>
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<tr>
<td></td>
<td>Propranolol (Inderal)</td>
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<tr>
<td></td>
<td>Palonosetron (Aloxi)</td>
</tr>
<tr>
<td></td>
<td>Testosterone cypionate (Depo Testosterone)</td>
</tr>
<tr>
<td></td>
<td>Testosterone undecanoate (Aveed)</td>
</tr>
<tr>
<td></td>
<td>Testosterone enanthate (Delatestryl)</td>
</tr>
<tr>
<td></td>
<td>Octreotide (Sandostatin)</td>
</tr>
</tbody>
</table>

The following were presented for PHC formulary review for the Medi-Cal Formulary:

- Potassium Citrate ER tablets (Urocit-K)
- Potassium Chloride 20 mEq packets (Klor-Con)
- Potassium Chloride solution (10% & 20%)
- Pentosan Polysulfate Sodium 100mg capsules (Elmiron)
- Desvenlafaxine Succinate ER tab (Pristiq)
- Atomoxetine (Strattera)

<table>
<thead>
<tr>
<th>Added to Formulary:</th>
<th>Drug</th>
<th>Restrictions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Potassium Citrate ER tablets (Urocit-K)</td>
<td>Code 1 and prescriber restriction (urologist, nephrologist)</td>
</tr>
<tr>
<td></td>
<td>Desvenlafaxine Succinate ER tab (Pristiq)</td>
<td>QL 1 per day</td>
</tr>
<tr>
<td></td>
<td>Atomoxetine (Strattera)</td>
<td>QL 1 per day</td>
</tr>
<tr>
<td></td>
<td>Tramadol 37.5 mg-acetaminophen 325 mg tablet</td>
<td>QL per IR initiative (#30 in 90ds, and 8/day dosing).</td>
</tr>
</tbody>
</table>

Minutes: P & T 7/27/2017
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
</table>
| - Varenicline Tartrate (Chantix)  
- Tramadol 37.5 mg-acetaminophen 325 mg tablet  
- Fluticasone/ Salmeterol Xinafoate (AirDuo)  
- Budesonide/ Formoterol Fumarate (Symbicort)  
- Mometasone Furoate/Formoterol (Dulera)  
- Isosorbide Dinitrate ER 40mg Capsules (Dilatrate SR)  
- Isosorbide Dinitrate IR 40mg tab (Isordil Titradose)  
- Podophylox gel (Condylox)  
- Podophylox Sol. (Condylox)  
- Mesalamine, sulfite free 4gm/60ml enema (SFRowasa)  
- Erythromycin 2% (Ery-Pad)  
- Erythromycin/benzoyl peroxide 3%/5% (Benzamycin)  
- clindamycin/benzoyl peroxide 1.2%/5% (Duac)  
- Urea 40% cream (Carmol 40, Rea Lo 40)  
- Adapalene (Differin)–RX product only  
- PEG3350/Sod Sul/NaCl/ASB/C/KCl (MoviPrep)  
- Sod Phosphate MBas/Sod Phos Dibasic oral tablets (OsmoPrep)  
- Sod Pico SO4/Mag Oxide/Cit Ac (Prepopik)  
- Sodium, Potassium & Mag Sulfates (SuPrep)  
- Zinc Acetate Gel (Amerigel)  
- Fexofenadine tablets (Allegra) | Fluticasone/ Salmeterol Xinafoate (AirDuo) | Step, QL | | |
| | Mesalamine, sulfite free 4gm/60ml enema (SFRowasa) | Code 1: Active dz & Rx by (or recommended by) GI. Duration limit: 8 weeks (56 days) | | |
| | Erythromycin 2% pad (ERY PAD) | QL | | |
| | Erythromycin/benzoyl peroxide 3%/5% (Benzamycin) | Step: tretinoin, CLN, ERY or BP QL: 46.6g | | |
| | clindamycin/benzoyl peroxide 1.2%/5% (Duac) | Step: tretinoin, CLN, ERY or BP QL: 45g | | |
| | Urea 40% (Carmol 40, Rea Lo 40) | QL: 85g | | |
| | Zinc Acetate Gel (Amerigel) | Fexofenadine (Allegra) 30mg | QL 2/day | | |
| | Fexofenadine tablets 60 & 180mg (Allegra) | 60 & 180mg: Remove Step edit.  60mg: QL 2 per day  180mg: QL 1 per day | | |

**Changes made to formulary utilization edits:**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Restriction Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentosan Polysulfate Sodium 100mg capsules (Elmiron)</td>
<td>Step, duration limit</td>
</tr>
<tr>
<td>Varenicline Tartrate (Chantix)</td>
<td>Increased duration limit to 24 wks</td>
</tr>
<tr>
<td>Budesonide/ Formoterol Fumarate (Symbicort)</td>
<td>Revise step edit: AirDuo or COPD maintenance tx (removed ability to step from ICS)</td>
</tr>
<tr>
<td>Mometasone Furoate/Formoterol (Dulera)</td>
<td></td>
</tr>
<tr>
<td>Podophylox gel (Condylox)</td>
<td>Code 1 (either anogenital or perianal warts)</td>
</tr>
<tr>
<td>Podophylox Sol. (Condylox)</td>
<td>Code 1 (genital warts only; not indicated for perianal warts).</td>
</tr>
<tr>
<td>Fexofenadine tablets 60 &amp; 180mg (Allegra)</td>
<td>60 &amp; 180mg: Remove Step edit.  60mg: QL 2 per day  180mg: QL 1 per day</td>
</tr>
<tr>
<td>No Action (review purposes only)</td>
<td></td>
</tr>
</tbody>
</table>

Minutes: P & T 7/27/2017
The following were presented as class reviews:

**Parenteral Iron Products (by Marlana Ogawa, PharmD and Kathleen Vo, PharmD)**
- Iron Sucrose (Venofer)
- Iron Dextran, low molecular weight (InFeD)
- Ferrous Gluconate (Ferrlecit)
- Ferric Carboxymaltose (Injectafer)
- Ferumoxytol (Injectafer)
- Ferric Pyrophosphate (Triferic)

**Bone Resorption Inhibitors (by Lynette Rey, PharmD)**
- Alendronate (Fosamax)
- Alendronate effervescent tab (Binosto)
- Alendronate w/ Vit. D (Fosamax Plus D)
- Calcitonin salmon, nasal (Fortical)
- Calcitonin salmon, injection (Miacalcin)
- Pamidronate
- Ibandronate tabs, injection (Boniva)
- Risedronate (Actonel)
- Risedronate DR (Atelvia)

### Removed from Formulary
<table>
<thead>
<tr>
<th>Drug</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEG3350/Sod Sul/NaCl/ASB/C/KCl (MoviPrep)</td>
<td>Remains non-formulary</td>
</tr>
<tr>
<td>Sod Phosphate MBas/Sod Phos Dibasic oral tablets (OsmoPrep)</td>
<td>Remains non-formulary</td>
</tr>
<tr>
<td>Sod Pico SO4/Mag Oxide/Cit Ac (Prepopik)</td>
<td>Remains non-formulary</td>
</tr>
</tbody>
</table>

### Class Review, approved actions

<table>
<thead>
<tr>
<th>Drug or Drug Group</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Sucrose (Venofer)</td>
<td>Added to formulary, with PA required; criteria revised.</td>
</tr>
<tr>
<td>Iron Dextran, low molecular weight (InFeD)</td>
<td></td>
</tr>
<tr>
<td>Ferrous Gluconate (Ferrlecit)</td>
<td></td>
</tr>
<tr>
<td>Alendronate Oral sol 70mg/75ml (Fosamax)</td>
<td>Added to formulary, with Code 1 (swallowing difficulties)</td>
</tr>
<tr>
<td>Ibandronate (Boniva) 150mg tab</td>
<td>Added to formulary, with QL</td>
</tr>
<tr>
<td>Risedronate (Actonel) 35mg tab</td>
<td>Added to formulary, with QL and step edit</td>
</tr>
<tr>
<td>Raloxifene (Evista)</td>
<td>Added to formulary</td>
</tr>
<tr>
<td>Zoledronic Acid (Reclast)</td>
<td>Not a Pharmacy Benefit (remains a medical benefit)</td>
</tr>
<tr>
<td>Zoledronic Acid (Zometa)</td>
<td></td>
</tr>
</tbody>
</table>
### Agenda Item

**AGENDA ITEM**

**DISCUSSION / CONCLUSIONS**

**RECOMMENDATIONS / ACTION**

**TARGET DATE**

**DATE RESOLVED**

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion / Conclusions</th>
<th>Recommendations / Action</th>
<th>Date Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raloxifene (Evista)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoledronic acid 5mg/100ml (Reclast)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoledronic acid 4mg/100ml (Zometa)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denosumab 60mg/ml (Prolia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denosumab 120mg/1.7ml (Xgeva)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. pylori Regimens (by Jordan Sumodobila, PharmD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin (Amoxil)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Metronidazole (Flagyl)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarithromycin (Biaxin)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Omeprazole (Prilosec)</td>
<td></td>
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</tr>
<tr>
<td>Bismuth subsalicylate (Pepto-Bismol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracycline (Sumycin)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levofoxacin (Levaquin)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline monohydrate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amox/Clar/Lansoprazole (Prevpa)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amox/Clar/Omep (Omeclamox-Pak)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bismuth subcitrate potassium/MTN/TCN (Pylera)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarithromycin 500mg tabs (Biaxin)</td>
<td>Added fill limit of 2 fills per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarithromycin 250mg tabs (Biaxin)</td>
<td>Added to formulary to equal the 500mg (QL, C1, FL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracycline 500mg caps (Sumycin)</td>
<td>Added to formulary with C-1 (H. pylori), QL (4/d), DS limit (14) and FL (2 fills/yr)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Class Review, no change in status or edits:

<table>
<thead>
<tr>
<th>Drug or Drug Group</th>
<th>Status remains as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferric Carboxymaltose (Injectafer)</td>
<td>Remains non-formulary</td>
</tr>
<tr>
<td>Ferumoxytol (Feraheme)</td>
<td>Remains non-formulary</td>
</tr>
<tr>
<td>Ferric Pyrophosphate (Triferic)</td>
<td>Remains non-formulary</td>
</tr>
<tr>
<td>Alendronate (Fosamax)</td>
<td>Remains on formulary with QL</td>
</tr>
<tr>
<td>Calcitonin salmon, nasal (Fortical)</td>
<td>Remains on formulary with QL</td>
</tr>
<tr>
<td>Calcitonin salmon, injection (Miacalcin)</td>
<td>Remains NF, no change in criteria.</td>
</tr>
<tr>
<td>Pamidronate</td>
<td>Remains on formulary</td>
</tr>
<tr>
<td>Denosumab (Prolia)</td>
<td>Remains NF: criteria revised, approved as modified.</td>
</tr>
<tr>
<td>Denosumab (Xgeva)</td>
<td></td>
</tr>
<tr>
<td>Ibandronate inj. (Boniva)</td>
<td>Remains NF: criteria added, approved as submitted.</td>
</tr>
<tr>
<td>Risedronate (Actonel) 5, 30 &amp; 150mg</td>
<td></td>
</tr>
<tr>
<td>Risedronate DR 35mg (Atelvia)</td>
<td></td>
</tr>
<tr>
<td>Alendronate effervescent tab (Binosto)</td>
<td></td>
</tr>
<tr>
<td>Alendronate Plus Vitamin D (Fosamax Plus D)</td>
<td></td>
</tr>
<tr>
<td>Amox/Clar/Lans (PrevPak)</td>
<td></td>
</tr>
<tr>
<td>Amox/Clar/Omep (Omeclamox-PAK)</td>
<td>Remains NF, criteria added, approved as submitted</td>
</tr>
<tr>
<td>Bis.subcit/MTN/TCN (Pylera)</td>
<td></td>
</tr>
</tbody>
</table>
The following were presented for clinical criteria review (both new & revised):
- Nitazoxanide (Alinia)
- Tinidazole (Tindamax)
- Fluticasone/Salmeterol (Advair Diskus, HFA)
- Fluticasone/Vilanterol (Breo Ellipta)
- Selexipag oral (Uptravi)
- Treprostinil oral (Orenitram)
- Treprostinil IV inhalation (Tyvaso)
- Treprostinil IV/SQ (Remodulin)
- Sucralfate suspension (Carafate)
- Adalimumab (Humira)
- Etanercept (Enbrel)
- Lifitegrast (Xiidra) (presented as part of New Business)

Diane Wong, Pharm D presented to the committee the Plan’s new formulary status designation, “Formulary, Prior Authorization Required”. The purpose of this designation is to allow the plan to have certain preferred products while still maintaining safety and utilization controls through the use of TAR criteria. This will be a formulary maintenance function of the pharmacy department and such additions to the formulary will be reported to the committee retrospectively as maintenance items.

The following were presented to the committee for addition to PHC Formulary, with Prior Authorization Required (and associated criteria minor updates). In the future, these changes will be reported as part of Formulary Review.

<table>
<thead>
<tr>
<th>Drug or Drug Group</th>
<th>Criteria revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalimumab (Humira)</td>
<td>Clinical update, see PA criteria</td>
</tr>
<tr>
<td>Etanercept (Enbrel)</td>
<td>Clinical update, see PA criteria</td>
</tr>
<tr>
<td>Tofacitinib (Xeljanz)</td>
<td>No change needed</td>
</tr>
<tr>
<td>Fentanyl Patches 50, 75 &amp; 100mcg/24hr (Duragesic)</td>
<td>No change needed</td>
</tr>
<tr>
<td>Zolmitriptan, oral/ODT (Zomig)</td>
<td>No change needed</td>
</tr>
<tr>
<td>Fesoterodine fumarate (Toviaz)</td>
<td>Deleted phrase “PHC’s preferred NF agent” (no longer applies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Criteria (both new &amp; updated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug or Drug Group</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Nitazoxanide (Alinia)</td>
</tr>
<tr>
<td>Tinidazole (Tindamax)</td>
</tr>
<tr>
<td>Fluticasone/Salmeterol (Advair Diskus, HFA)</td>
</tr>
<tr>
<td>Fluticasone/Vilanterol (Breo Ellipta)</td>
</tr>
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<tr>
<td>Treprostinil oral (Orenitram)</td>
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<tr>
<td>Treprostinil IV inhalation (Tyvaso)</td>
</tr>
<tr>
<td>Treprostinil IV/SQ (Remodulin)</td>
</tr>
<tr>
<td>Sucralfate suspension (Carafate)</td>
</tr>
<tr>
<td>Adalimumab (Humira)</td>
</tr>
<tr>
<td>Etanercept (Enbrel)</td>
</tr>
<tr>
<td>Lifitegrast (Xiidra)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formulary Additions, with PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug or Drug Group</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Adalimumab (Humira)</td>
</tr>
<tr>
<td>Etanercept (Enbrel)</td>
</tr>
<tr>
<td>Tofacitinib (Xeljanz)</td>
</tr>
<tr>
<td>Fentanyl Patches 50, 75 &amp; 100mcg/24hr (Duragesic)</td>
</tr>
<tr>
<td>Zolmitriptan, oral/ODT (Zomig)</td>
</tr>
<tr>
<td>Fesoterodine fumarate (Toviaz)</td>
</tr>
</tbody>
</table>
### Agenda Item

**III. Old Business**

- **Policies for Review:**
  - a) HKRP4052 – Continuation of Prescription Drugs – Commercial Lines of Business

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zolmitriptan, oral &amp; ODT (Zomig)</td>
<td>No change needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fesoterodine fumarate (Toviaz)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zolpidem CR (Ambien CR)</td>
<td>Iron Dextran (InFeD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Dextran (InFeD)</td>
<td>Iron Sucrose (Venofer)</td>
<td>Clinical update, see PA criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Sucrose (Venofer)</td>
<td>Sodium Ferric Gluconate Complex (Ferrlecit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium Ferric Gluconate Complex (Ferrlecit)</td>
<td>Alpha hydroxyprogesterone (Makena)</td>
<td>No change needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alpha hydroxyprogesterone (Makena)</td>
<td>Lifitegrast (Xiidra)</td>
<td>Clinical update, see PA criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifitegrast (Xiidra)</td>
<td>Somatropin (Norditropin)</td>
<td>No change needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatropin (Norditropin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Criteria referencing above drugs, with updates to reflect PA Required status**

<table>
<thead>
<tr>
<th>Drug or Drug Group</th>
<th>Approved change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anakinra (Kineret)</td>
<td>Insert “formulary” in reference to Enbrel, Humira.</td>
</tr>
<tr>
<td>Abatacept (Orencia)</td>
<td></td>
</tr>
<tr>
<td>Infliximab (Remicade)</td>
<td></td>
</tr>
<tr>
<td>Golimumab (Simponi)</td>
<td>Added Xeljanz as a preferred 2nd line agent.</td>
</tr>
<tr>
<td>Certolizumab Pegol (Cimzia)</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone ER (Zohydro ER, Hysingla ER)</td>
<td>Changed wording to correctly state methadone is NF and fentanyl patches are F/PA.</td>
</tr>
<tr>
<td>Morphine Sulfate ER (Avinza)</td>
<td></td>
</tr>
<tr>
<td>Morphine Sulfate ER (Kadian)</td>
<td></td>
</tr>
<tr>
<td>Tapentadol (Nucynta ER)</td>
<td></td>
</tr>
<tr>
<td>Oxymorphone ER (Opana ER)</td>
<td></td>
</tr>
<tr>
<td>Zolmitriptan nasal (Zomig Nasal Spray)</td>
<td>Included ODT as a preferred F/PA product.</td>
</tr>
<tr>
<td>Almotriptan (Axert)</td>
<td>Replaced wording of “preferred NF Zolmitriptan” with “Formulary/PA”.</td>
</tr>
<tr>
<td>Frovatriptan (Frova)</td>
<td></td>
</tr>
<tr>
<td>Eletriptan (Relpax)</td>
<td></td>
</tr>
<tr>
<td>Mirabegron (Myrbetriq)</td>
<td>Replaced wording of “preferred NF fesoterodine” with “Formulary/PA”.</td>
</tr>
<tr>
<td>Darifenacin HBr (Enablex)</td>
<td></td>
</tr>
<tr>
<td>Solifenacin (Vesicare)</td>
<td></td>
</tr>
</tbody>
</table>
### AGENDA ITEM

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>b)</td>
<td>HKRP4054 – Prescription Drugs for Non-Approved Uses – Commercial Lines of Business</td>
<td>For Archive – Health Kids Program has ended. <em>(Approved for archive by committee)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>HKRP4057 – Prescription Drug Prior Authorization Procedure for Health Kids</td>
<td>For Archive – Health Kids Program has ended. <em>(Approved for archive by committee)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nothing to report</td>
<td>For Archive – Healthy Kids Program has ended <em>(Approved for archive by committee)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meeting adjourned at 9:56am.</td>
<td><em>All motions approved by the committee as presented or modified.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Effective October 1, 2017, upon PAC approval

Key:
Minor wording revisions due to addition of preferred drugs to Formulary/PA required tier are shown in **redline**
Modifications made/approved by P & T committee are highlighted in **yellow**
NF = Non-formulary
F, PA = Formulary, with prior authorization required

<table>
<thead>
<tr>
<th>PA Group: Biologics for RA (revised)</th>
<th>Approved as submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anakinra (Kineret)</strong></td>
<td>Status: NF</td>
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<tr>
<td><strong>Abatacept (Orencia)</strong></td>
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<tr>
<td><strong>Infliximab (Remicade)</strong></td>
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<tr>
<td><strong>Golimumab (Simponi)</strong></td>
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<thead>
<tr>
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<th>Prescriber Restrictions</th>
<th>Coverage Duration</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of moderate to severe rheumatoid arthritis</td>
<td></td>
<td>Disease Activity Score, lab reports, imaging reports and clinic notes as needed to document severity, disease activity/progression or otherwise support medical necessity.</td>
<td>For members 18 yrs or older</td>
<td>TBD</td>
<td></td>
<td>Trial and failure of at least 3 month trials of formulary Enbrel and Humira (anti-TNF therapies) and Xeljanz (JAK inhibitor). Note that formulary Enbrel, Humira and Xeljanz require prior authorization.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PA Group: Cimzia (revised)</th>
<th>Approved as submitted</th>
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</thead>
<tbody>
<tr>
<td><strong>Certolizumab Pegol (Cimzia)</strong></td>
<td>Status: NF</td>
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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of moderately to severely active rheumatoid arthritis and for the treatment of Crohns disease</td>
<td></td>
<td>Specialist’s clinic notes documenting disease course, previous therapies tried and responses, current evaluation (lab and imaging reports as appropriate), treatment plan. RA: Include Disease Activity Score.</td>
<td></td>
<td>Appropriate specialist</td>
<td>TBD</td>
<td>RHEUMATOID ATHRITIS: Enbrel and Humira and Xeljanz are the preferred anti-TNF agents, second-line agents (on formulary, prior authorization required). Trial and failure of at least 3 month trials of Enbrel, Humira (anti-TNF therapies) and Xeljanz (JAK inhibitor). Requires Disease Activity Score. CROHNS DISEASE: Evaluation by appropriate specialist with inadequate response to conventional therapy. Adalimumab (Humira) is the preferred anti-TNF agent.</td>
</tr>
<tr>
<td>Covered Uses</td>
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<tr>
<td>Treatment of severe pain in opioid tolerant terminal cancer patients when pain requires around-the-clock opioid-level pain control and alternative long-acting opioids are contraindicated or inadequate.</td>
<td>(1) Not opioid tolerant. (2) Not terminally ill. (3) PRN use or any SIG other than routine dosing (dosed every 12 hours, at same dose every day) to maintain steady blood levels ATC. (4) Concurrent use of benzodiazepines or other soporifics. (5) Rx/TAR is for undifferentiated pain. (6) Severe or acute Asthma. (7) Hypercarbia. (8) Known or suspected paralytic ileus. (9) Hypersensitivity to hydrocodone. (10) Significant respiratory depression.</td>
<td>Clinic notes adequately documenting: (1) Previous pain regimens used and member’s response to treatments. (2) Any known contraindications to formulary alternatives. (3) Specialists notes regarding members current health status and prognosis. (4) UTOX within 30 days prior to treatment initiation, and periodically upon PHC request. Additional documentation: (1) Member has agreed to abstain from alcohol during treatment with Zohydro ER. (2) Member will be monitored closely for s/sx respiratory depression during the first 72hrs of initiation and with each dose increase</td>
<td>18 years and over. Ages 18-20 will be referred to CCS if not already enrolled.</td>
<td>Board certified in oncology or pain management.</td>
<td>14 days' supply authorized per fill.</td>
<td>Member is enrolled in PHC Hospice. Members enrolled in a non-PHC Hospice must obtain any comfort meds (including pain medications) from the hospice plan rather than PHC. Must have adequate documentation supporting the medical necessity of the use of this product to treat chronic pain in a terminally ill member and that other long-acting opioids are either contraindicated or have failed. Unless contraindicated, member must have tried/failed formulary methadone and morphine (long-acting) and formulary fentanyl patches (prior authorization required for 50, 75 and 100 mcg; step therapy requirement for 12 and 25 mcg) as well as non-formulary fentanyl patches and methadone and non-formulary OxyContin (TAR required for fentanyl patches and OxyContin, criteria must be met). Duration of TAR auth to be determined on a case-by-case basis, based on prognosis. Ages 20 and younger: Subject to PHC CCS screening and referral for CCS coverage of CCS eligible condition.</td>
</tr>
</tbody>
</table>
### PA Group: Opioid Analgesics – Long Acting  (revised)

- Morphine Sulfate ER capsules 24hr (Avinza)
- Oxymorphone ER tablets 12 hr (Opana ER)
- Morphine Sulfate ER pelleted capsules (Kadian)
- Tapentadol ER tablets (Nucynta ER)

**Approved as submitted**

<table>
<thead>
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<tbody>
<tr>
<td>For the management of moderate to severe pain in patients requiring continuous, around-the-clock opioid therapy for an extended period of time.</td>
<td>Trial and failure or contraindication to use of morphine sulfate sustained-release tablets (generic MS Contin), fentanyl patches (prior authorization required for 50, 75 &amp; 100mcg; step therapy required for 12 &amp; 25mcg), and non-formulary methadone and non-formulary fentanyl patches, at equi-analgesic doses. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with pain management consultant may be required.</td>
<td>Not FDA approved for ages less than 18 years old</td>
<td>TBD</td>
<td>For Avinza: This formulation is a 24h pelleted capsule and the package labeling states it should not be dosed any more often than once every 24 hours. Therefore there will be no exception to the criteria limit of once daily dosing. If multiple daily dosing is required, alternative products should be considered.</td>
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</table>

### PA Group: Triptans – Non-oral   (revised)

- Zolmitriptan nasal spray (Zomig)

**Approved as submitted**

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<thead>
<tr>
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<th>Coverage Duration</th>
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</thead>
<tbody>
<tr>
<td>For the acute treatment of migraine with or without aura</td>
<td>Reasons why member cannot use sumatriptan nasal spray or zolmitriptan oral/ODT. For requests exceeding 1 unit per month (6 doses): neurology consult notes</td>
<td>TBD</td>
<td>Documentation of trial and failure of formulary sumatriptan nasal spray and formulary oral (ODT or tablets) Zolmitriptan ODT (TAR prior authorization required). Request limited to 1 unit per month (6 doses). Requests exceeding 1 per month will require documentation that member has had a consult with a neurologist and is receiving adequate prophylactic therapy.</td>
<td></td>
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</tbody>
</table>
### PA Group: Triptans – Oral (revised)
- Almotriptan (Axert)
- Frovatriptan (Frova)

#### Approved as submitted
Status: NF

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of acute migraine headache attacks with or without aura</td>
<td></td>
<td>Documentation of trial and failure of formulary sumatriptan, and rizatriptan oral tablets, as well as AND preferred Non-Formulary agent Zolmitriptan (TAR-formulary, prior required authorization required).</td>
<td></td>
<td></td>
<td>TBD</td>
<td>Requests are limited to #12/month. Requests exceeding #12 per month will require documentation that member has had a consult with a neurologist and is receiving adequate prophylactic therapy.</td>
</tr>
</tbody>
</table>

### PA Group: Beta-3 Adrenergic Receptor Agonist (revised)
- Mirabegron ER tablets (Myrbetriq)

#### Approved as submitted
Status: NF

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</thead>
<tbody>
<tr>
<td>For the treatment of patients with overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency</td>
<td></td>
<td>Clinic notes documenting a specific contraindication to anticholinergics (e.g., severely decreased GI motility conditions, uncontrolled narrow-angle glaucoma).-or-Documentation of minimum 30 day trial and nature of failure with preferred non-formulary fesoterodine (Toviaz), AND at least 2 other formulary alternatives. (Note: fesoterodine requires prior authorization.)</td>
<td></td>
<td></td>
<td>TBD</td>
<td>Limited to members with: Documented contraindication to anticholinergics (e.g., severely decreased GI motility conditions, uncontrolled narrow-angle glaucoma).-or-Adequate trial (minimum 30 days) of preferred non-formulary fesoterodine (Toviaz (prior authorization required) AND at least 2 of the following: formulary Oxybutynin ER tablets, formulary/step Tolterodine ER tablets, formulary/step Trospium ER tablet.</td>
</tr>
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</table>
**PA Group: OAB Extended Release Agents (revised)**

- Darifenacin (Enablex)
- Solifenacin succinate (Vesicare)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of an overactive bladder (OAB) with symptoms of urinary frequency, urinary urgency, or urge-related urinary incontinence</td>
<td>Documentation of minimum 30 day trial and nature of failure with preferred non-formulary fesoterodine (Toviaz prior authorization required), AND at least 2 other formulary alternatives.</td>
<td>Not indicated for pediatric use.</td>
<td>TBD</td>
<td>Limited to members who have had an adequate trial (minimum 30 days) of at least 2 other formulary alternatives (see Additional Requirements, at right).</td>
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</table>

**PA Group: OAB Extended Release Preferred Agents (revised)**

- Fesoterodine (Toviaz)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of an overactive bladder (OAB) with symptoms of urinary frequency, urinary urgency, or urge-related urinary incontinence</td>
<td>Documentation of adequate trial and nature of failure with at least 2 formulary alternatives (see Additional Requirements, at right).</td>
<td>Not indicated for pediatric use.</td>
<td>TBD</td>
<td>PHC's preferred non-formulary agent. Limited to members who have had an adequate trial (minimum 30 days) of at least 2 of the following: formulary Oxybutynin ER tablets, formulary/step Tolterodine ER tablets, formulary/step Trospium ER tablets.</td>
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<tr>
<td>Covered Uses</td>
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<tr>
<td>LMW Iron Dextran (InFeD): IV/IM for treatment of patients with documented iron deficiency in whom oral administration is unsatisfactory or impossible (with or without CKD).</td>
<td>(1) Documentation of trial and failure to adequate doses of oral iron along with nature of failure. Compliance to be confirmed per pharmacy fill history.</td>
<td>(2) Required laboratory evidence of iron deficiency anemia: hemoglobin/hematocrit, ferritin, serum iron, transferrin/TIBC, percent saturation of transferrin/TIBC.</td>
<td>(3) Appropriate specialist notes, depending on etiology.</td>
<td>(4) Dialysis status.</td>
<td>(5) Requests for non-formulary products must include rationale of why preferred formulary products cannot be used.</td>
<td>TBD</td>
</tr>
<tr>
<td>Iron Sucrose (Venofer): Venofer is indicated for the treatment of iron deficiency anemia in patients with CKD.</td>
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<tr>
<td>Ferric Gluconate (Ferrlecit): Ferrlecit indicated for the treatment of iron deficiency anemia in adult patients and in pediatric patients (6+) with CKD on dialysis who are received supplemental epoetin therapy.</td>
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</table>

**In post-P & T literature search, an evidence-based TSAT goal for maintenance could not be found. KDIDO, NICE, Kidney Supplements, Up To Date, and EU Renal Best Practice Position Statement on KDIGO 2012 did not recommend a target TSAT for maintenance. Other patient factors for consideration were recommended such as Hgb and ferritin. An EU study found that IV iron raised TSAT by only 0.1% per 100mg when starting with TSAT >30 and Hgb values remain unchanged; interpretation was that this suggested targeting to TSAT levels >/=30% does not improve erythropoiesis and exposes patients to the risk of iron overload.**
**PA Group: Prolia (revised)**

- Denosumab 60mg/ml subcutaneous (Prolia, prefilled syringe for subcutaneous injection)

*Approved as modified*

**Status:** NF

<table>
<thead>
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<tbody>
<tr>
<td>Treatment of osteoporosis in men and postmenopausal women at high risk for fracture. Prevention of bone loss in members at high risk for fracture receiving aromatase inhibitor therapy in women with breast cancer or androgen deprivation therapy in men with nonmetastatic prostate cancer.</td>
<td>Documentation of treatment failure with oral bisphosphonates and zoledronic acid OR clinical reason to avoid treatment with bisphosphonates. Treatment failure is defined as a decline in T-score of ≥5% after 2 years of compliant use with bisphosphonate therapy.</td>
<td>18 yrs or older</td>
<td>12 months</td>
<td>Treatment failure to <strong>formulary</strong> bisphosphonates and <strong>zoledronic acid</strong>, or intolerance/contraindication to formulary bisphosphonates; AND must have documented history of one of the following: • osteoporotic vertebral or hip fracture • history of fragility fracture • hip or lumbar spine T-Score of -2.5 or less • If T-score is between -1 and -2.5 must have FRAX score of ≥3% for hip fracture or ≥20% for combined major osteoporotic fracture. For bone loss prevention in breast or prostate cancer, the following will also be required: Currently on aromatase inhibitor therapy for breast cancer, or androgen deprivation therapy for nonmetastatic prostate cancer unless the member has undergone an orchietomy.</td>
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</tr>
<tr>
<td>Covered Uses</td>
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<tr>
<td>1) Prevention of skeletal-related events in patients with bone metastases from solid tumors.</td>
<td></td>
<td>Albumin-corrected serum calcium while member was on prior zoledronic acid therapy.</td>
<td>13 &amp; older when DX is Giant Cell tumor of the bone. 18 &amp; older for other indications.</td>
<td></td>
<td>TBD</td>
<td>1) When used for prevention of skeletal-related events in members with bone metastases from solid tumors: Treatment failure or intolerance /contraindication to zoledronic acid. For consideration outside of PHC criteria, submit additional patient factors that need to be considered along with the reason why zoledronic acid (Zometa) cannot be used in place of Xgeva. 2) When used to treat Giant cell tumor of bone: Limited to use when tumor is unresectable or surgical resection is likely to result in severe morbidity. 3) When used for hypercalcemia of malignancy: Limited to use when hypercalcemia is refractory to zoledronic acid or member has a contraindication zoledronic acid. Refractory is defined as albumin-corrected serum calcium of greater than 12mg/dL.</td>
</tr>
<tr>
<td>2) Giant cell tumor of bone.</td>
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<tr>
<td>3) Hypercalcemia of malignancy refractory to bisphosphonate therapy.</td>
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</tbody>
</table>
### PA Group: Bisphosphonates—Atelvia/Binosto (revised)
- Alendronate effervescent tabs (Binosto)
- Alendronate ER 35mg (Atelvia)
- Alendronate with Vit. D (Fosamax Plus D)
- Risedronate 5mg (Actonel)

**Approved as submitted**

<table>
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<tbody>
<tr>
<td>- Treatment of osteoporosis in men and postmenopausal women. - Treatment of osteoporosis in postmenopausal women. - Treatment of glucocorticoid induced osteoporosis or in postmenopausal women</td>
<td></td>
<td>18 years or older</td>
<td></td>
<td>12 months</td>
<td>Trial and failure, or intolerance/contraindication to formulary oral bisphosphonates (alendronate, ibandronate, risedronate).</td>
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</table>

### PA Group: Bisphosphonates—Actonel 30mg (revised)
- Risedronate 30mg (Actonel)

**Approved as submitted**

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<tbody>
<tr>
<td>Paget’s disease</td>
<td></td>
<td>18 years or older</td>
<td></td>
<td>2 months</td>
<td>Trial and failure, or intolerance/contraindication to alendronate.</td>
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</table>

### PA Group: Bisphosphonates—Ibandronate Injection (revised)
- Ibandronate 3mg/3ml IV syringe (Boniva)

**Approved as submitted**

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<th>Coverage Duration</th>
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<tbody>
<tr>
<td>Treatment of osteoporosis in postmenopausal women.</td>
<td></td>
<td>18 years or older</td>
<td></td>
<td>12 months</td>
<td>Trial and failure, or intolerance/contraindication to zoledronic acid.</td>
<td></td>
</tr>
</tbody>
</table>
### Proposed Additions & Changes: Criteria

**PA Group: H. pylori convenience packs (new)**
- Amoxicillin/Clarithromycin/Omeprazole (Omeclamox-Pak)  
- Bismuth subcitrate K/Metronidazole/Tetracycline (Pylera)  
- Amoxicillin/Clarithromycin/Lansoprazole (Prevpa)

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<tr>
<td><em>Helicobacter pylori</em> (H. pylori) eradication</td>
<td></td>
<td>Medical record confirming diagnosis of <em>H. pylori</em> infection as confirmed by biopsy, stool or urea breath test.</td>
<td></td>
<td></td>
<td>1 treatment course</td>
<td>Must have documented inability (other than non-compliance) to use individual ingredients as separate prescriptions. Formulary single agents: PPI – lansoprazole, omeprazole, pantoprazole, rabeprazole Antiinfective – amoxicillin, clarithromycin, levofloxacin, metronidazole, tetracycline Other – bismuth subsalicylate</td>
</tr>
</tbody>
</table>

**PA Group: Antiprotozoal – Nitazoxanide (new)**
- Nitazoxanide tablets, suspension (Alinia)

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<tbody>
<tr>
<td>Infectious diarrhea caused by <em>Giardia lamblia</em> or <em>Cryptosporidium parvum</em></td>
<td></td>
<td>Clinic notes and labs confirming diagnosis may be required.</td>
<td></td>
<td></td>
<td></td>
<td>Limited to FDA-approved use for treatment of diarrhea caused by <em>Giardia lamblia</em> or <em>Cryptosporidium parvum</em>. For treatment of giardiasis, must have trial and failure with metronidazole (formulary) or tinidazole (non-formulary, TAR required). Requests for any other use will be reviewed on case-by-case basis.</td>
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</table>

**PA Group: Antiprotozoal, nitroimidazole (new)**
- Tinidazole tablets (Tindamax)

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<tbody>
<tr>
<td>Amebiasis, Bacterial vaginosis, Giardiasis, Trichomoniasis</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>Limited to FDA-approved use for treatment of amebiasis, bacterial vaginosis, giardiasis, or trichomoniasis. Requests for any other use will be reviewed on a case-by-case basis. Must have documented trial and failure of, or contraindication to, metronidazole.</td>
</tr>
<tr>
<td>Covered Uses</td>
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<tr>
<td>Asthma</td>
<td></td>
<td>Advair Diskus: 4 and older.</td>
<td>12 mo</td>
<td></td>
<td></td>
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<tr>
<td>COPD</td>
<td></td>
<td>Advair HFA: 12 and older</td>
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<td></td>
<td></td>
<td>Breo Ellipta: 18 and older</td>
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</table>

For COPD:
1. Documentation of trial and failure with preferred formulary/step products, Symbicort AND Dulera (accepted off label use for COPD)
2. Verification of compliance with confirmation of use by PHC claims or fill history submitted.
3. Symptom assessment while on preferred formulary/step products Symbicort and Dulera.
4. PHC may request spirometry results.

For Asthma:
1. Documentation of trial and failure with preferred formulary/step fluticasone/salmeterol (generic AirDuo) AND formulary/step products, Symbicort AND Dulera.
2. Verification of compliance with confirmation of use by PHC claims or fill history submitted.
3. Symptom assessment while on formulary products.
4. PHC may request spirometry results.
**PA Group: PAH – Prostacyclin**

- Selexipag oral tablets (Uptravi) *new*
- Treprostinil oral tablets (Orenitram) *new*
- Treprostinil inhalation (Tyvaso) *revised*
- Treprostinil IV/SQ (Remodulin) *revised*

**Covered Uses**

<table>
<thead>
<tr>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Documentation</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
<th>Coverage Duration</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary Arterial Hypertension, with etiology WHO Group I and functional/symptom WHO Class (or NYHA Class) III or more.</td>
<td>Members with drug-induced PAH: evidence that the offending agent continues to be in use is reason to exclude coverage.</td>
<td>WHO (World Health Organization) Group (identifies etiology), WHO Class or NYHA Class (identifies functional/symptom severity, Cardiologist or Pulmonologist clinic notes which include heart cath, vasoreactivity test if included at time of cath, result of prior use of calcium channel blockers (if vasoreactivity positive). For functional class III, documentation of responses to both a PDE-5 inhibitor (sildenafil or tadalafil) AND an endothelial receptor antagonist (bosentan, ambrisentan or macitentan). For methamphetamine induced PAHT, PHC requires a recent toxicology screen upon TAR renewal.</td>
<td>Ages 0-20: TAR review includes screening for CCS eligibility and referral to CCS when appropriate.</td>
<td>Prescribed or recommended by a Cardiologist or a Pulmonologist</td>
<td>TBD</td>
<td>Must be prescribed by or recommended by a cardiologist or a pulmonologist. Limited to WHO Group I and WHO Class III or greater. For Drug-Induced PAH, a tox-screen may be requested at any time. Right heart cath must be performed prior to initiation of advanced treatment with this drug class. Members who have had a positive vasoreactivity test during heart cath must have a trial of a calcium channel blocker/CCB (include results of CCB use with TAR). WHO/NYHA Class III requires previous trial of a PDE-5 Inhibitor (Sildenafil or Tadalafil) and an Endothelin Receptor Antagonist (Bosentan, Ambrisentan or Macitentan); TAR must include response (or contraindication) to those agents (waived for documented Class IV).</td>
</tr>
</tbody>
</table>

**Approved as submitted**

Status: NF
### Covered Uses
Short term treatment of Duodenal Ulcer, Maintenance therapy for DU (at reduced dosage) in members requiring liquid dosage form due to tube administration.

### Exclusion Criteria
Current guidelines recommend against the use of oral and rectal sucralfate for the prevention of mucositis in patients receiving radiation therapy.

### Required Medical Documentation
- 18 yo
- Safety and Effectiveness in pediatric patients have not been established.

### Age Restrictions
TBD

### Prescriber Restrictions
Approval is limited to members with G-tube with diagnosis of Duodenal Ulcer, documentation of trial and failure to liquid PPIs and H2 blockers with contraindication to oral sucralfate tablets which can be cut in half or dissolved in water. Non-FDA approved indications will be reviewed on a case-by-case basis with preference for first-line (formulary or non-formulary) treatment alternatives. For any submitted off-label indication, Safety and Efficacy must be documented in the clinical literature &/or use of sucralfate recommended for the off-label indication in either nationally recognized treatment guidelines or in a clinical reference source such as [www.uptodate.com](http://www.uptodate.com). Note: criteria applies to both new starts and renewals.

### Coverage Duration
TBD

### Other
Approved is submitted status: NF
<table>
<thead>
<tr>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Documentation</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
<th>Coverage Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humira: Ankylosing spondylitis (AS), Hidradenitis suppurativa (HS), Inflammatory Bowel Disease--Crohn’s (CD) or Ulcerative Colitis (UC), Juvenile idiopathic arthritis (JIA), Plaque psoriasis (PP), Psoriatic arthritis (PA), Rheumatoid arthritis (RA), Uveitis. Enbrel: AS, Plaque Psoriasis, JIA, Psoriatic arthritis, RA.</td>
<td>Active, serious infection, latent (untreated) tuberculosis, demyelinating disease (e.g., MS, optic neuritis), moderate to severe heart failure (NYHA Class III/IV)</td>
<td>Specialist’s clinic notes documenting disease course, previous therapies tried and responses, current evaluation (lab and imaging reports as appropriate), treatment plan. Prescriber is aware of immunosuppression risks specific to latent TB infection and has ordered TST (Tuberculin Skin Test, AKA PPD) or Interferon-Gamma Release Assay (eg, QuantiFERON-TB Gold test).</td>
<td>18 &amp; older: AS, HS, PP, PA, RA, UC and Uveitis. 6 and older: CD 2 and older: JIA TAR review includes referral to CCS when appropriate for ages 0-20.</td>
<td>Rheumatologist: AS, JIA, PA, RA. Dermatologist: HS, PP Gastroenterologist: CD, UC Ophthalmologist or Ocular immunologist: Uveitis</td>
<td>Initial: 3 months approval. Renewal: 12 months with documentation of improvement in symptoms. Subsequent annual approvals with updated specialist’s notes documenting continued benefit</td>
</tr>
<tr>
<td>The following apply to both Humira and Enbrel: AS: Diagnosis of ankylosing spondylitis confirmed with radiographic sacroiliitis on plain radiography, with disease that remains active despite an adequate trial of at least two formulary NSAIDs/COX-2 inhibitors. An adequate trial of NSAIDs would consist of lack of response (or intolerance) to at least 2 different NSAIDs over 1 month, or incomplete response to at least 2 different NSAIDs over 2 months. JIA: Diagnosis of active polyarticular JIA in pediatric patients ≥ 2 years. PP: Diagnosis of moderate to severe chronic (≥ 1 year) plaque psoriasis in adults who are candidates for systemic therapy or phototherapy, and when other systemic therapies are less appropriate. Each of the following criteria must be met: 1.) Patient has documented ≥ 10% BSA affected or &lt; 10% BSA involving sensitive areas that significantly involved quality of life (palms of hands, soles of feet, head/neck, genitalia). 2.) Patient has documented trial and failure of, or contraindication to, at least two preferred therapies (PUVA, UVB phototherapy, acitretin, CyA, MTX). PA: Diagnosis of active psoriatic arthritis in adults with documentation of trial and failure of, or contraindication to, a minimum of a 3 month trial of methotrexate or other oral DMARD if patient is unable to take methotrexate. RA: Limited to established RA (≥6 months duration) with clinical documentation of moderate to high disease despite having a minimum of a 3 month trial to combination conventional oral DMARD therapy (double or triple therapy which would include MTX).</td>
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<tr>
<td>The following apply to Humira only: HS: Diagnosis of moderate to severe hidradenitis suppurativa with documentation of Hurley Stage II or III disease. Documentation of a minimum of a 3 month trial to conventional therapy (oral antibiotics with or without antiandrogenic agents). CD, UC: Diagnosis of active, moderate to severe, CD or UC, with inadequate response to conventional therapy. Documentation of previous trial and failure, or contraindication to, at least two therapies such as corticosteroids, 5-aminosalicylates, immunomodulators (6-MP, azathioprine, MTX, cyclosporine), or other biologic agent. Special consideration for patients dependent on steroids with documented inability to be weaned off of steroids or patients with Crohn’s related fistulas or previous bowel resections. Uveitis: Documentation of non-infectious intermediate, posterior, and pan-uveitis that is chronic, recurrent, treatment refractory or vision threatening disease. Documentation of inadequate response to conventional therapies (e.g., systemic glucocorticoids, immunosuppressive drugs).</td>
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<tr>
<td>Covered Uses</td>
<td>Exclusion Criteria</td>
<td>Required Medical Documentation</td>
<td>Age Restrictions</td>
<td>Prescriber Restrictions</td>
<td>Coverage Duration</td>
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<tr>
<td>Treatment of chronic dry eye syndrome (i.e. keratoconjunctivitis sicca, dry eye disease).</td>
<td>Concurrent use of ophthalmic cyclosporin and lifitegrast, as there are no data to support concomitant use.</td>
<td>Clinical documentation supporting chronic dry eye syndrome (i.e. keratoconjunctivitis sicca, dry eye disease)</td>
<td>18 and older</td>
<td></td>
<td>Initial: 3 months, Renewal: up to 12 months</td>
</tr>
</tbody>
</table>
# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## MEETING MINUTES

**Committee:** Provider Advisory Group (PAG)

**Date/Time:** July 21, 2017 12:30 p.m. – 1:30 p.m.

**Guests Present:**
- Fairfield: Tara Sharifzadeh, David Lopez, Pat Zarate, Flaco Zonatis, Pam Sakamoto, Bridget Oduni, Wendy Wink, Celine Regalia, Christy Grills, Andrea Badillo, Jennifer Adams, Lisa Chin, Minerva Arellano, Cinda Ortega, Maya Sioso, Michelle Rodriguez, Kim Rizzi, Brittany Speer
- Santa Rosa: Claudia Nola, Linda Bohn, Brittany Ruane, Isabel Soriano, Natalie Douglas, Maria Madrigal, Kenneth Chambers, Brittany Curtright, Teri Ortiz, Melinda Medeiros, Elena Pardini, James Hurbin, Robert Powell, April Treble, Laura Andrews
- Eureka: Julie Levy, Kier Flicker, Sandra Jones, Chris Cody, Michael Franklin,
- Redding: Candy Stockton, MD, Jeff Bosworth, Fang Chen, Leanna Williams, Shelly Polink

**PHC Staff Present:**
- Fairfield: Liz Gibboney, Mary Kerlin, Robert Moore, Mark Netherda, Ledra Guillory, Betsy Campbell, Maria Cabrera, Araceli Gutierrez, Rebecca Mannella, Tondenisha Coleman, Denise Surette, Rebecca Garcia, Carol Parker
- Santa Rosa: Mark Netherda, MD, Gloria Turner, Stephanie Phipps, Melissa Perez
- Eureka: Jeff Ribordy, Shell Swift, Sommer Halligan
- Redding: David Ho, MD, Nai Chadderdon, Kris Devan, Kim Palfini, Sharon McFarlin

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION/CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Standing Agenda Items</strong></td>
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<tr>
<td>1.1. Welcome and Introductions</td>
<td>1.1. Meeting called to order by Chairperson Tara Sharifzadeh, NorthBay Home Health &amp; Hospice</td>
<td>1. Presented as information only</td>
<td>07/21/2017</td>
</tr>
<tr>
<td>1.2. Review of Minutes</td>
<td>1.2. Minutes from 05/19/2016 reviewed.</td>
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<tr>
<td>1.3. Review of Agenda</td>
<td>1.3. Agenda was reviewed.</td>
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<tr>
<td><strong>2. Presentations</strong></td>
<td>2.1. Betsy Campbell, Senior Health Educator at Partnership HealthPlan of California gave a presentation on Heat Related Illness.</td>
<td>2. Presented as information only</td>
<td>07/21/2017</td>
</tr>
<tr>
<td></td>
<td>▪ Heat exhaustion causes symptoms such as: excessive thirst, muscle cramps, heavy sweating and weakness. Heat Stroke is more serious, and can cause rapid heartbeat, shortness of breath, and loss of consciousness. Infants and the elderly are particularly at risk.</td>
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<td>▪ It is important to stay hydrated, protected from the sun, and stay cool to avoid both heat exhaustion and heat stroke.</td>
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<td>3. Old Business</td>
<td>3.1. None.</td>
<td>3. Presented as information only.</td>
<td>07/21/2017</td>
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<tr>
<td><strong>4.1. PHC Updates</strong></td>
<td><strong>4.1. Liz Gibboney, CEO at Partnership HealthPlan of California</strong> reported on recent activities at PHC.</td>
<td><strong>4. Presented as information only.</strong></td>
<td><strong>07/21/2017</strong></td>
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<td></td>
<td>▪ The American Health Care Act (AHCA) would repeal or modify many provisions of the Affordable Care Act (ACA). The Congressional Budget Office (CBO) estimates that in 2018, 14 million more people would be uninsured than are currently, and that this number would rise to 24 million by 2026 if the ACA were repealed. There is a great deal of uncertainty surrounding the issue, and PHC continues to monitor the situation.</td>
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<td>▪ The Fiscal Year 2017-18 Budget has been completed. PHC has included a fairly static membership model, and we anticipate very little change in our membership over the next year.</td>
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<td>▪ The 3-year Strategic Plan was approved. Initiatives include NCQA Accreditation and a Substance Use Disorder Treatment &quot;Drug Medi-Cal&quot; Program.</td>
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<td>▪ PHC is working with transportation provider MTM to implement the State-mandated transportation benefit, and asks that our provider network use this benefit judiciously.</td>
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<td><strong>4.2. Report from Claims</strong></td>
<td><strong>4.1.2. Robert Moore, MD, MPH, Medical Director at Partnership HealthPlan of California</strong> reported on the recent Physicians Advisory Committee (PAC) Meeting.</td>
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<td>▪ PHC has expanded its Partners in Palliative Care Benefit program.</td>
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<td>▪ PHC will continue our Intensive Outpatient Care Management Program, but the larger State Health Home pilot program has been put on hold because of anticipated changes to state and federal healthcare programs.</td>
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<td>▪ Pay-for-performance programs such as PHC’s Quality Improvement Program are being re-evaluated at the State level, and changes are anticipated. PHC’s Long Term Care pay for performance program is in its second successful year.</td>
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<td><strong>4.2.1. Rebecca Mannella, Claims Resolution Manager,</strong> spoke to the group regarding Claims issues.</td>
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<td></td>
<td>▪ PM-160 CHDP Claims Conversion: Please refer to Important Provider Notice #277 on the PHC Website.</td>
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<td></td>
<td>▪ Beginning on July 1, 2017, CHDP claims should be billed using the CMS-1500 form, UB04 form or the electronic 837 HIPAA compliant claim format.</td>
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</tbody>
</table>
### 4.3. Reports from Member Services

**4.3.1. Araceli Gutierrez, Member Services Rep Supervisor**, shared information about the recent meeting of the Consumer Advisory Committee.

- The Consumer Advisory Committee (CAC) drafted a letter to our State Senators in regards to their support of the Affordable Care Act.
- La Clinica Vallejo gave a presentation on their Social Determinants of Health Grant recipient, Transitions Clinic, which provides care and support resources for recently incarcerated people returning to society.

### 4.4. Report from Provider Relations

**4.4.1. Denise Surette, Provider Education Specialist**, shared information about the recent Child Health and Disability Prevention (CHDP) Program HIPAA Code Conversion and Claim Form Transition

- The PR Education Team has traveled to all service areas conducting provider trainings regarding the PM-160 Information Only billing form and the 2-digit local procedure codes currently used for CHDP program claims. A webinar training is being held August 9, and will be recorded. More information is available on the Partnership HealthPlan of California website at [www.partnershiphp.org](http://www.partnershiphp.org).

### 5. Provider Questions, Topics of Interest, Announcements, and Upcoming Events

**5.1. None**

5. Presented as information only.  

<table>
<thead>
<tr>
<th>Meeting Adjourned</th>
</tr>
</thead>
</table>

*PHC – Provider Advisory Group – July 21, 2017*

Minutes prepared and submitted by: Carol Parker

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**Tara Sharifzadeh**  
Chairperson

---

7/21/2017  
Date
## AGENDA ITEM

<table>
<thead>
<tr>
<th>I. Meeting called to order</th>
<th>I. PHC Regional Medical Director Marshall Kubota, MD called the meeting to order.</th>
</tr>
</thead>
<tbody>
<tr>
<td>II. Review/Approval of previous minutes</td>
<td>II. A. The Credentialing Committee meeting minutes for April 12, 2017 and Special Meeting Minutes from May 2, 2017 including Summary of Suspension Letter.</td>
</tr>
<tr>
<td>III. Old Business</td>
<td>III. A. Committee requested additional information. Charts have been requested by PHC for chart review. Chart review will be presented upon completion, including additional information at an upcoming meeting.</td>
</tr>
<tr>
<td>B. Family Medicine</td>
<td>B. Provider is requested modification of Agreement with PHC. Modification to include: supervising of Nurse Practitioners</td>
</tr>
<tr>
<td>C. Family Medicine</td>
<td>C. As a stipulation of continued credentialing PHC recommended provider attend UC San Diego PACE Program.</td>
</tr>
<tr>
<td>IV. New Business</td>
<td>A. Please see approved list of Routine Providers on Pages 4-13</td>
</tr>
<tr>
<td>A. Review of Practitioner File</td>
<td>The Committee reviewed and discussed the list of Twenty seven (27) Physicians, thirteen (13) Non-Physician Medical Practitioners, one (1) Chiropractor, nine (9) Behavioral Health Analysts, and one (1) Podiatrist for Initial Credentialing, thirty four (34) Physicians, twelve (12) Non-Physician Medical Practitioners, three (3) Physical Therapists, one (1) Podiatrist, one (1) Speech Language Pathologist, and one (1) Acupuncturist for Re-Credentialing.</td>
</tr>
<tr>
<td>IV. A. The Committee reviewed and discussed the list of Twenty seven (27) Physicians, thirteen (13) Non-Physician Medical Practitioners, one (1) Chiropractor, nine (9) Behavioral Health Analysts, and one (1) Podiatrist for Initial Credentialing, thirty four (34) Physicians, twelve (12) Non-Physician Medical Practitioners, three (3) Physical Therapists, one (1) Podiatrist, one (1) Speech Language Pathologist, and one (1) Acupuncturist for Re-Credentialing.</td>
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</table>

### PRODUCTS

- **TARGET**
- **DATE RESOLVED**

<p>| I. Meeting called to order | 5-10-2017 |
| II. Review/Approval of previous minutes | 5-10-2017 |
| III. Old Business | 5-10-2017 |
| B. Family Medicine | 5-10-2017 |
| C. Family Medicine | 5-10-2017 |
| IV. New Business | 5-10-2017 |</p>
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. New Business (cont.)</td>
<td>IV. New Business (cont.)</td>
<td>VI. Motion made and carried to approve all items in the Consent Calendar.</td>
<td>5-10-2017</td>
<td></td>
</tr>
<tr>
<td>VI. Consent Calendar Items. A. Report of Long Term Care Facility, Hospital, and Ancillary Prov. List</td>
<td>VI. A. Report of Long Term Care Facility, Hospital, and Ancillary provider list</td>
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<td></td>
<td></td>
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<tr>
<td>B. Update of Ongoing Monitoring of Sanctions</td>
<td>B. Update of Ongoing Monitoring of Sanctions</td>
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</tr>
<tr>
<td>C. Kaiser San Rafael: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
<td>C. Kaiser San Rafael: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
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<td>D. Kaiser Santa Rosa: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
<td>D. Kaiser Santa Rosa: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
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<tr>
<td>H. Sutter Medical Foundation: Solano Regional Medical Group 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
<td>H. Sutter Medical Foundation: Solano Regional Medical Group 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
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<td>DISCUSSION / CONCLUSIONS</td>
<td>RECOMMENDATIONS / ACTION</td>
<td>TARGET DATE</td>
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<tr>
<td>VI. Consent Calendar Items (cont.)</td>
<td>VI. Consent Calendar Items (cont.)</td>
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<tr>
<td>I. Sutter Medical Foundation: Sutter Medical Group (Yolo County including Sacramento Specialist) 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
<td>I. Sutter Medical Foundation: Sutter Medical Group (Yolo County including Sacramento Specialist) 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
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<tr>
<td>J. Lucile Packard Children’s Hospital Medical Group: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
<td>J. Lucile Packard Children’s Hospital Medical Group: 1st Quarter 2017 Credentialing/ Re-Credentialing Activities</td>
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<tr>
<td>L. First Quarter Report Showing Credentialing Packet Delivery/Trainings: (Northern Region)</td>
<td>L. First Quarter Report Showing Credentialing Packet Delivery/Trainings: (Northern Region)</td>
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<tr>
<td>M. First Quarter Report Showing Credentialing Packet Delivery/Trainings: (Southern Region)</td>
<td>M. First Quarter Report Showing Credentialing Packet Delivery/Trainings: (Southern Region)</td>
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<tr>
<td>VII. Meeting Adjourned</td>
<td>With No further items for discussion, the meeting was adjourned</td>
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<td>Next Meeting Scheduled for June 14, 2017.</td>
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PAC Summary of Meeting for May 10, 2017, respectfully prepared and submitted by Skyler Bellmore - Credentialing Specialist II

Chairman Signature of Approval ___________________________ Date ___________________________
Marshall Kubota M.D., PHC Credentialing Chairman
<table>
<thead>
<tr>
<th>IC or RC</th>
<th>Provider Name/Provider Group</th>
<th>County</th>
<th>Practice Specialty</th>
<th>Board Certification Board Status</th>
<th>Privileges Criteria Hospital Privileges</th>
<th>Malpractice Claims &amp; Payments (within 7 yrs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 IC</td>
<td>Abercrombie, Melani BCBA</td>
<td>Humboldt</td>
<td>Behavioral Health</td>
<td>Behavioral Analyst - 2017</td>
<td>No Claims History</td>
<td></td>
</tr>
<tr>
<td>2 RC</td>
<td>Ali, Ruby S., MD</td>
<td>Solano</td>
<td>Neurology</td>
<td>Neurology - 2009</td>
<td>NorthBay Medical Center - Active Attending</td>
<td>No Claims History</td>
</tr>
<tr>
<td>3 RC</td>
<td>Ancellotti, Loretta J., FNP</td>
<td>Lake</td>
<td>Family Nurse Practitioner</td>
<td>Family Nurse Practitioner-2005</td>
<td>No Claims History</td>
<td></td>
</tr>
<tr>
<td>4 RC</td>
<td>Arjona, Jose L., MD</td>
<td>Solano</td>
<td>Diagnostic Radiology</td>
<td>Diagnostic Radiology-1992</td>
<td>No Direct Patient Contact</td>
<td>No Claims History</td>
</tr>
<tr>
<td>5 RC</td>
<td>Babenko, Mykhaylo PA</td>
<td>Yolo</td>
<td>Physician Assistant</td>
<td></td>
<td>No Claims History</td>
<td></td>
</tr>
<tr>
<td>6 RC</td>
<td>Balani, Ekta V., DPM</td>
<td>Mendocino</td>
<td>Podiatry</td>
<td>Foot Surgery-2011</td>
<td>Hospitalist Coverage</td>
<td>No Claims History</td>
</tr>
<tr>
<td>7 IC</td>
<td>Beaudoin, Alicia M., BCBA</td>
<td>Sacramento</td>
<td>Behavioral Health</td>
<td>Behavioral Analyst - 2016</td>
<td>No Claims History</td>
<td></td>
</tr>
<tr>
<td>8 RC</td>
<td>Behrens, Paula M., PT</td>
<td>Solano</td>
<td>Physical Therapy</td>
<td></td>
<td>No Claims History</td>
<td></td>
</tr>
<tr>
<td>9 IC</td>
<td>Bonatto, Justin BCBA</td>
<td>San Francisco</td>
<td>Behavioral Health</td>
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<td>Mendocino</td>
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<td>Oechsel, Michael S., MD Mt. Tam Orthopedics</td>
<td>Marin</td>
<td>Orthopaedic Surgery</td>
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<td></td>
<td>Provider Name/Provider Group</td>
<td>County</td>
<td>Practice Specialty</td>
<td>Board Certification Board Status</td>
<td>Privileges Criteria Hospital Privileges</td>
<td>Malpractice Claims &amp; Payments (within 7 yrs.)</td>
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<tr>
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<td>71</td>
<td>Pak, Peter S., MD</td>
<td>Del Norte</td>
<td>Surgery</td>
<td>Surgery - 2016</td>
<td>Sutter Coast Hospital - Locum Tenens</td>
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<tr>
<td>72</td>
<td>Palma, Aura A.F., FNP</td>
<td>Lake</td>
<td>Family Nurse Practitioner</td>
<td>Family Nurse Practitioner - 2016</td>
<td>Shriners Hospitals for Children-Active</td>
<td>No Claims History</td>
</tr>
<tr>
<td>73</td>
<td>Palmieri, Tina L., MD</td>
<td>Sacramento</td>
<td>Surgery</td>
<td>Surgery-1994</td>
<td>Shriners Hospitals for Children-Active</td>
<td>No Claims History</td>
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<tr>
<td>74</td>
<td>Pearson, Chelsea PA-C</td>
<td>Modoc</td>
<td>Physician Assistant Certified</td>
<td>Physician Assistant Certified-2013</td>
<td>No Claims History</td>
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<tr>
<td>75</td>
<td>Portnoff, Jon S., MD</td>
<td>Mendocino</td>
<td>Cardiology</td>
<td></td>
<td>Ukiah Valley Medical Center-Active</td>
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<tr>
<td>76</td>
<td>Press, Marlin B., LAc</td>
<td>Mendocino</td>
<td>Acupuncture</td>
<td></td>
<td>No Claims History</td>
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<tr>
<td>77</td>
<td>Rafie, Shervin MD</td>
<td>Solano</td>
<td>Diagnostic Radiology</td>
<td>Diagnostic Radiology - 2009</td>
<td>No Direct Patient Contact</td>
<td>Open: 1 Closed W/pay: 0 w/o pay: 0 Total Cases: 1</td>
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<tr>
<td>78</td>
<td>Rowley, Kimberly BCBA</td>
<td>Sacramento</td>
<td>Behavioral Health</td>
<td>Behavioral Analyst-2015</td>
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<tr>
<td>79</td>
<td>Santo Domingo, Noel E., MD</td>
<td>Sonoma</td>
<td>Cardiovascular Disease</td>
<td>Cardiovascular Disease - 2000</td>
<td>Santa Rosa Memorial Hospital-Active</td>
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<tr>
<td>80</td>
<td>Schwartz, Andrew I., DO</td>
<td>Lake</td>
<td>Family Medicine</td>
<td>Osteopathic Manipulative Therapy-2006</td>
<td>Sutter Lakeside Hospital-Active</td>
<td>No Claims History</td>
</tr>
<tr>
<td>81</td>
<td>Scipione, Paul J., MD</td>
<td>Shasta</td>
<td>Pain Management Suboxone</td>
<td>Anesthesiology-1989</td>
<td>Mercy Medical Center of Redding-Courtesy</td>
<td>No Claims History</td>
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<td>County</td>
<td>Practice Specialty</td>
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<td>Privileges Criteria Hospital Privileges</td>
<td>Malpractice Claims &amp; Payments (within 7 yrs.)</td>
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<td>82 IC</td>
<td>Scott, Alan B., MD North Bay Eye Associates</td>
<td>Sonoma</td>
<td>Ophthalmology</td>
<td>Ophthalmology-1963</td>
<td>California Pacific Medical Center-Active</td>
<td>No Claims History</td>
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<tr>
<td>83 IC</td>
<td>Shea, Theodore W., MD Dignity Health Medical Group-Northstate</td>
<td>Tehama</td>
<td>Gynecology</td>
<td>Obstetrics &amp; Gynecology-1997</td>
<td>St. Elizabeth Community Hospital-Active</td>
<td>Open: 0 Closed w/pay: 1 w/o pay: 0 Total Cases: 1</td>
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<tr>
<td>84 IC</td>
<td>Smith, Wendy L., MD Humboldt Medical Specialists</td>
<td>Humboldt</td>
<td>Otolaryngology</td>
<td>Otolaryngology - 2002</td>
<td>Group Coverage</td>
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<tr>
<td>85 RC</td>
<td>Song, Samuel S., MD Solano Diagnostic Imaging</td>
<td>Solano</td>
<td>Diagnostic Radiology</td>
<td>Diagnostic Radiology-2011</td>
<td>No Direct Patient Contact</td>
<td>No Claims History</td>
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<tr>
<td>87 RC</td>
<td>Stafford, James M., PA Santa Rosa Community Health Center</td>
<td>Sonoma</td>
<td>Physician Assistant</td>
<td></td>
<td></td>
<td>No Claims History</td>
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<tr>
<td>88 IC</td>
<td>Stevens, Scott K., MD Klamath Eye Center</td>
<td>Oregon</td>
<td>Ophthalmology</td>
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<td>Lake District Hospital-Courtesy</td>
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<tr>
<td>89 IC</td>
<td>Stuart, Pamela L., CNM Dignity Health Medical Group-Northstate</td>
<td>Tehama</td>
<td>Certified Nurse Midwife</td>
<td>Certified Nurse Midwife-1998</td>
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<td>90 RC</td>
<td>Sulzer, Jana L., MD Solano Diagnostic Imaging</td>
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<td>Diagnostic Radiology</td>
<td>Diagnostic Radiology - 1985 Nuclear Radiology - 1986 Pediatric Radiology - 1997</td>
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<td>Shasta</td>
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<td>Group Coverage</td>
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<td>92 IC</td>
<td>Tito, Elizabeth P., MD Annadel Medical Group</td>
<td>Sonoma</td>
<td>Surgery</td>
<td>Surgery-1999</td>
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<td>Provider Name/Provider Group</td>
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<td>Todd, Angela R., FNP Planned Parenthood Northern CA: Napa</td>
<td>Napa</td>
<td>Family Nurse Practitioner</td>
<td>Family Nurse Practitioner-2012</td>
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<td>No Claims History</td>
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<tr>
<td>94 RC</td>
<td>Upadhyaya, Darshna OT NBHG: Northbay Rehab Services OT/PT</td>
<td>Solano</td>
<td>Occupational Therapy</td>
<td></td>
<td></td>
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<td>95 IC</td>
<td>Valdez, Emerson A., DPM Healdsburg District Hospital: Northern California Wound Care</td>
<td>Sonoma</td>
<td>Podiatric Surgery</td>
<td></td>
<td>Healdsburg District Hospital- Provisional Active</td>
<td>No Claims History</td>
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<td>96 RC</td>
<td>Velasquez-Hickerson, Ana M., PA-C Lassen Medical Group</td>
<td>Shasta</td>
<td>Physician Assistant Certified</td>
<td>Physician Assistant Certified-2012</td>
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<td>No Claims History</td>
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<td>97 IC</td>
<td>Wahi, Gaurav DO Dignity Health Medical Group-Northstate</td>
<td>Tehama</td>
<td>Obstetrics &amp; Gynecology</td>
<td>St. Elizabeth Community Hospital-Active</td>
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<td>Walker, Elisabeth A., FNP Camellia Women's Health</td>
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<td>Watters, Laura E., MD Capital OB/GYN, Inc.</td>
<td>Sacramento</td>
<td>Obstetrics &amp; Gynecology</td>
<td>Obstetrics &amp; Gynecology-2015</td>
<td>Methodist Hospital of Sacramento-Active</td>
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<td>100 RC</td>
<td>Weeks, John A., MD Adventist Health: RHC: St. Helena Family Health Center</td>
<td>Lake</td>
<td>Family Medicine</td>
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<td>St. Helena Hospital Clearlake-Affiliate Staff</td>
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<td>101 RC</td>
<td>Weisblum, Lewis S., MD Solano Diagnostic Imaging</td>
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<td>Diagnostic Radiology</td>
<td>Diagnostic Radiology-1987</td>
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<td>102 RC</td>
<td>Williams, John P., DO</td>
<td>Mendocino</td>
<td>Internal Medicine</td>
<td>Meets MP CR #17 - Verified 3 year residency in Internal Medicine per AMA</td>
<td>Frank R. Howard Memorial Hospital - Active</td>
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<tr>
<td>103 RC</td>
<td>Yambao, Annabelle A., PT NBHG: NorthBay Rehab Services</td>
<td>Solano</td>
<td>Physical Therapy</td>
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<td></td>
<td>No Claims History</td>
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<tr>
<td>IC or RC</td>
<td>Provider Name/Provider Group</td>
<td>County</td>
<td>Practice Specialty</td>
<td>Board Certification Board Status</td>
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<td>Malpractice Claims &amp; Payments (within 7 yrs.)</td>
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<td>Yoon, David W., MD</td>
<td>Shasta</td>
<td>Family Medicine</td>
<td>Meets MP CR #17 - Verified completed 2 year residency in Family Medicine per AMA</td>
<td>Hospitalist Coverage</td>
<td>No Claims History</td>
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</table>

Medical Director/Physician Approval of Routine List

Marshall Kubota M.D., PHC Credentialing Chairman
**Objective**

To seek the Physician Advisory Committee’s (PAC) approval on the 2017-18 Palliative Care QIP measures

**Program Overview**

Partnership HealthPlan of California (PHC) has value-based payment programs in the areas of primary care, hospital care, specialty care, long-term care, community pharmacy and mental health. These value-based programs align with PHC’s organizational mission to help our members and the communities we serve be healthy.

In 2015, Partnership HealthPlan of California (PHC) developed a pilot pre-hospice intensive palliative care program, called *Partners in Palliative Care*. The legislature of California passed a bill (SB 1004) in late 2015, requiring the development of a similar program as a state wide benefit for Medicaid. Implementation of this benefit will likely be on or after January 1, 2018. However, Partnership’s board of directors has approved expansion of the pilot program, based on the favorable clinical and financial outcomes of our pilot program.

The expanded pilot implementation began on July 1, 2017, and includes incentives used in the pilot. The incentives in the expanded pilot will be monitored by the PHC Quality Department under the name “Palliative Care Quality Improvement Program (QIP)” consistent with terminology used for other value-based payment programs at PHC. All palliative care providers participating in the expanded pilot will be automatically enrolled in the Palliative Care QIP.

**Timeline**

For 2017-18, there are two measurement periods:

- Measurement Period I: July 1, 2017 – December 31, 2017
  Payment Date: April 30, 2018
- Measurement Period II: January 1, 2018 – June 30, 2018
  Payment Date: October 31, 2018

Performance will be evaluated every six months, and payments will be made four months after the close of the measurement period. This allows time for three months for claims/TAR data lag and one month for validation of data. Information for the measures will be calculated by Finance and Quality Departments. The Quality Department will review preliminary data, validate it and submit to Finance for final approval and payment.

**Assumptions**

Approximately 5-10 provider organizations will be participating in the expanded pilot and the Palliative Care QIP.
Proposed Measures

1. **Avoiding hospitalization and emergency room visits:**
   Rationale: One goal of palliative care is to improve quality of life for both the patient and the family. For members who have serious illnesses and are in the palliative care program, we expect the palliative care team to be the first point of contact, which in turn minimizes unnecessary hospitalizations and emergency room visits. We would like to reinvest the hospital savings resulted from quality palliative care as part of the benefit.
   a. Payment Details: $200 per patient enrolled in the palliative care program per month only if there are no hospital admissions or ED visits that month.
   b. Specifications:
      i. Denominator: Members approved for enrollment in the palliative care program for each month
      ii. Numerator: Approved members who have no claims or TARs for hospitalization (including observation status) or emergency department visits, with dates of service in the same month
   c. Data collected by: Finance/Analytics runs report of hospital admission encounters, ED encounters and inpatient hospital TARs for each patient with an approved TAR to be enrolled in the program, by month of the date of service.
   d. Example: Member enrolled on February 25, seen in the emergency room on March 9 and admitted from April 29 through May 5. Dies on July 17 with no other hospital visits. Number of months with no Hospital encounters or ED visits: 3 (February, June and July). Total payment for avoiding hospitalization and ED visits in this patient: $600

2. **Completion of POLST and use of Palliative Care Quality Network (PCQN) Tool.**
   Rationale: To align best practices the expanded pilot program includes an incentive for 1) completion of the Physician’s Orders for Life Sustaining Treatment (POLST) in conjunction with documentation of POLST and patient encounters in the Palliative Care Quality Network System (PCQN).

   The POSLT was designed for seriously ill patients with the goal of providing a framework for healthcare professionals so they can ensure the patient received the treatments they DO want and avoid those treatments that they DO NOT want.

   The PCQN tool is an online system where palliative care providers share data and from that data can identify possible quality improvement opportunities. This measure will incentivize providers in our program to contribute data, learn about best practices, and capture the key components of care delivery.
   a. Payment Details: $200 per patient enrolled in the program per month
   b. Specifications:
      i. Denominator: Members approved for enrollment in the palliative care program for the month
      ii. Numerator: At least two entries reflecting patient contact into the PCQN quality tool are submitted; encounters must include minimum data elements (see attachment 1: PCQN Data Elements) as well as completion and documentation of POLST in PCQN
   c. Data collected by: QI Department uses the PCQN reporting capability to generate monthly reports on the 15th of each month for the prior months’ encounters of patients who are 1) enrolled in the program and 2) numerator compliant.
   d. Example: Member enrolled on February 25, but the POLST was not completed and entered into PCQN until April 20. PCQN was used for documenting visits each month. Semi-annual payment for April-June: $600.
<table>
<thead>
<tr>
<th>CORE DATASET ITEM</th>
<th>ITEM CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location / Type of Visit</td>
<td>□ Clinic&lt;br&gt; □ Home&lt;br&gt; □ Telehealth&lt;br&gt; □ SNF / Nursing Home</td>
</tr>
<tr>
<td>Visit type</td>
<td>□ Initial consult</td>
</tr>
<tr>
<td>Date of Visit</td>
<td>{YYYY-MM-DD}</td>
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<tr>
<td>Medical Record Number</td>
<td></td>
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<tr>
<td>Encounter #</td>
<td></td>
</tr>
<tr>
<td>First Name, Last Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>□ Male&lt;br&gt; □ Female&lt;br&gt; □ Unknown</td>
</tr>
<tr>
<td>Age at time of visit</td>
<td></td>
</tr>
<tr>
<td>Primary diagnosis leading to PC consult</td>
<td>□ Cancer (solid tumor)&lt;br&gt; □ Cardiovascular&lt;br&gt; □ Pulmonary&lt;br&gt; □ Vascular&lt;br&gt; □ Complex chronic conditions/failure to thrive&lt;br&gt; □ Renal&lt;br&gt; □ Trauma&lt;br&gt; □ Congenital/chromosomal&lt;br&gt; □ Gastrointestinal&lt;br&gt; □ Hepatic&lt;br&gt; □ Hematology&lt;br&gt; □ Infectious/ immunological/HIV&lt;br&gt; □ In-utero complication/condition&lt;br&gt; □ Neurologic/stroke/ neurodegenerative&lt;br&gt; □ Dementia&lt;br&gt; □ Other</td>
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<tr>
<td>Reasons given by referring provider for initial PC consult (check all)</td>
<td>□ Goals of care discussion/Advance Care Planning&lt;br&gt; □ Pain management&lt;br&gt; □ Other symptom management&lt;br&gt; □ Withdrawal of interventions&lt;br&gt; □ Comfort Care&lt;br&gt; □ Hospice referral/discussion&lt;br&gt; □ No reason given&lt;br&gt; □ Support for patient/family&lt;br&gt; □ Other: ____</td>
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<tr>
<td>Referral Source</td>
<td>□ Inpatient Palliative Care</td>
</tr>
<tr>
<td>Core Dataset Item</td>
<td>Item Choices</td>
</tr>
<tr>
<td>--------------------------------------------</td>
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</table>
| **Core Dataset Item**                      | □ Other Inpatient Team  
 □ ED  
 □ Primary care  
 □ Outpatient Palliative Care  
 □ Other Outpatient Specialist  
 □ Self  
 □ Other: ________________________  
 □ Unknown                                                                 |
| Advance directive on chart at the time of consult | □ Yes  
 □ No                                                                 |
| POLST on chart at the time of consult       | □ Yes  
 □ No                                                                 |
| **Patient Symptoms/Status**                 |                                                                                 |
| Palliative Performance Scale (PPS) at time of consult | (0% to 100%)                                                                 |
| ESAS Measures                               |                                                                                 |
| Pain                                        | 0-10 scale (77= pt unable)                                                     |
| Tiredness                                   | 0-10 scale (77= pt unable)                                                     |
| Nausea                                      | 0-10 scale (77= pt unable)                                                     |
| Depression                                  | 0-10 scale (77= pt unable)                                                     |
| Anxiety                                     | 0-10 scale (77= pt unable)                                                     |
| Drowsiness                                  | 0-10 scale (77= pt unable)                                                     |
| Appetite                                    | 0-10 scale (77= pt unable)                                                     |
| Well-being                                  | 0-10 scale (77= pt unable)                                                     |
| Short of breath                             | 0-10 scale (77= pt unable)                                                     |
| Constipation                                | 0-10 scale (77= pt unable)                                                     |
| Composite score                             | Auto calculated                                                               |
| Are you at peace?                           | □ Not at all  
 □ A little bit  
 □ A moderate amount  
 □ Quite a bit  
 □ Completely  
 □ Patient unable to rate                                                                 |
| How much distress have you been experiencing the past week including today? | 0-10 scale (Distress thermometer) (77=pt unable to rate)                       |
| How would you rate your overall quality of life? | □ Very poor  
 □ Poor  
 □ Fair  
 □ Good  
 □ Excellent  
 □ Patient unable to rate                                                                 |
| PC team members involved in visit           | □ Physician  
 □ Clinical Nurse Specialist  
 □ Nurse Practitioner                                                            |
<table>
<thead>
<tr>
<th>CORE DATASET ITEM</th>
<th>ITEM CHOICES</th>
</tr>
</thead>
</table>
| CORE DATASET ITEM                        | □  Physician Assistant  
 □  Nurse  
 □  Social Worker  
 □  Chaplain  
 □  Pharmacist  
 □  Psychologist/Psychiatrist  
 □  Other |
| Screening Status                         |                                                                             |
| Pain                                     | □  Negative  
 □  Positive |
| Non-Pain Symptoms                        | □  Negative  
 □  Positive |
| Psychosocial needs                       | □  Negative  
 □  Positive  
 □  Patient/Family declined  
 □  Patient/Family unable to be screened |
| Spiritual needs                          | □  Negative  
 □  Positive  
 □  Patient/Family declined  
 □  Patient/Family unable to be screened |
| Advance care planning/Goals of care needs| □  Negative  
 □  Positive  
 □  Patient/Family declined  
 □  Patient/Family unable to be screened |
| Intervention                              |                                                                             |
| Pain                                     | □  Yes |
| Non-Pain Symptoms                        | □  Yes |
| Psychosocial needs                       | □  Yes |
| Spiritual needs                          | □  Yes |
| Advance care planning/Goals of care needs| □  Yes |
| Other outcomes                           |                                                                             |
| Preference for life-sustaining treatment clarified | □  Yes |
| Advance directive completed              | □  Yes |
| POLST completed                          | □  Yes |
| Preference for life-sustaining treatment  | □  Full code  
 □  Partial code  
 □  DNR/DNI  
 □  Unknown (default if no code status In system) |
| Surrogate decision maker identified      | □  Surrogate decision maker identified and documented  
 □  Attempted to identify but not confirmed  
 □  Not addressed |
| Support for family/caregiver provided    | □  Yes  
 □  No caregiver present |
## CORE DATASET ITEM

### Services referred to

- Hospice
- Home Health
- Home-Based Palliative Care
- Admission to Hospital
- Emergency Department
- Community Services
- Physical Therapy
- Integrative Therapies
- Social Work
- Mental Health
Documenting Parental Refusal to Have Their Children Vaccinated

All parents and patients should be informed about the risks and benefits of preventive and therapeutic procedures, including vaccination. In the case of vaccination, the American Academy of Pediatrics (AAP) strongly recommends and federal law mandates that this discussion include the provision of the Vaccine Information Statements (VISs). Despite our best efforts to educate parents about the effectiveness of vaccines and the realistic chances of vaccine-associated adverse events, some will decline to have their children vaccinated. This often results from families misinterpreting or misunderstanding information presented by the media and on unmonitored and biased Web sites, causing substantial and often unrealistic fears.

Within a 12-month period, 74% of pediatricians report encountering a parent who refused or delayed one or more vaccines. A 2011 survey of children six months to six years of age reported that 13% of parents followed an alternative vaccination schedule. Of these, 53% refused certain vaccines and 55% delayed some vaccines until the child was older. Seventeen percent reported refusing all vaccines. In a 2009 survey, 11.5% of parents of children 17 years and younger reported refusing at least one vaccine. The use of this or a similar form in concert with direct and non-condescending discussion can demonstrate the importance you place on appropriate immunizations, focuses parents’ attention on the unnecessary risk for which they are accepting responsibility, and may in some instances induce a wavering parent to accept your recommendations.

Providing parents (or guardians) with an opportunity to ask questions about their concerns regarding recommended childhood immunizations, attempting to understand parents’ reasons for refusing one or more vaccines, and maintaining a supportive relationship with the family are all part of a good risk management strategy. The AAP encourages documentation of the health care provider’s discussion with parents about the serious risks of what could happen to an unimmunized or under-immunized child. Provide parents with the appropriate VIS for each vaccine at each immunization visit and answer their questions. For parents who refuse one or more recommended immunizations, document your conversation and the provision of the VIS(s), have a parent sign the Refusal to Vaccinate form, and keep the form in the patient’s medical record. The AAP also recommends that you revisit the immunization discussion at each subsequent appointment and carefully document the discussion, including the benefits to each immunization and the risk of not being age-appropriately immunized. For unimmunized or partially immunized children, some physicians may want to flag the chart to be reminded to revisit the immunization discussion, as well as to alert the provider about missed immunizations when considering the evaluation of future illness, especially young children with fevers of unknown origin.

This form may be used as a template to document that the health care provider had a discussion with the parent signing the form about the risks of failing to immunize the child. It is not intended as a substitute for legal advice from a qualified attorney as differing state laws and factual circumstances will impact the outcome. While it may be modified to reflect the particular circumstances of a patient, family, or medical practice, practices may want to consider obtaining advice from a qualified attorney. If a parent refuses to sign the refusal form such refusal along with the name of a witness to the refusal should be documented in the medical record.

The AAP Section on Infectious Diseases and other contributing sections and committees hope this form will be helpful to you as you deal with parents who refuse immunizations. It is available on the AAP Web site on the Section on Infectious Diseases Web site (http://www2.aap.org/sections/infectdis/resources.cfm), and the Web site for the AAP Childhood Immunization Support Program (http://www2.aap.org/immunization/pediatricians/refusaltovaccinate.html).

Sincerely,
/s/
Tina Tan, MD, FAAP
Chairperson
AAP Section on Infectious Diseases

/s/
Ed Rothstein, MD, FAAP
AAP Section on Infectious Diseases
Refusal to Vaccinate

Child’s Name ____________________________  Child’s ID# ____________________________

Parent’s/Guardian’s Name __________________________________________________________

My child’s doctor/nurse, ________________________________, has advised me that my child (named above) should receive the following vaccines:

<table>
<thead>
<tr>
<th>Recommended</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Diphtheria tetanus (DT or Td) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Pneumococcal conjugate or polysaccharide vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Measles-mumps-rubella (MMR) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Varicella (chickenpox) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Influenza (flu) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Meningococcal conjugate or polysaccharide vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Hepatitis A vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Rotavirus vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) vaccine</td>
<td>x</td>
</tr>
<tr>
<td>Other ____________________________</td>
<td>x</td>
</tr>
</tbody>
</table>

I have been provided with and given the opportunity to read each Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine(s) and the disease(s) it prevents for each of the vaccine(s) checked as recommended and which I have declined, as indicated above. I have had the opportunity to discuss the recommendation and my refusal with my child’s doctor or nurse, who has answered all of my questions about the recommended vaccine(s). A list of reasons for vaccinating, possible health consequences of non-vaccination, and possible side effects of each vaccine is available at www.cdc.gov/vaccines/pubs/vis/default.htm.

I understand the following:

- The purpose of and the need for the recommended vaccine(s).
- The risks and benefits of the recommended vaccine(s).

That some vaccine-preventable diseases are common in other countries and that my unvaccinated child could easily get one of these diseases while traveling or from a traveler.

If my child does not receive the vaccine(s) according to the medically accepted schedule, the consequences may include:
- Contracting the illness the vaccine is designed to prevent (the outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness; other severe and permanent effects from these vaccine-preventable diseases are possible as well).
- Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.

My child’s doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine(s) be given according to recommendations. Nevertheless, I have decided at this time to decline or defer the vaccine(s) recommended for my child, as indicated above, by checking the appropriate box under the column titled “Declined.” I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others with whom my child might come into contact. I therefore agree to tell all health care professionals in all settings what vaccines my child has not received because he or she may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been vaccinated.

I know that I may readress this issue with my child’s doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature: ____________________________ Date: ________________

Witness: __________________________________________ Date: ________________

I have had the opportunity to rediscuss my decision not to vaccinate my child and still decline the recommended immunizations.

Parent’s Initials: ____________________________ Date: ________________  Parent’s Initials: ____________________________ Date: ________________
Parental Refusal to Accept Vaccination: Resources for Pediatricians
The following are some of the resources available to help pediatricians develop a productive dialogue with vaccine-hesitant parents and answer questions about vaccine risks and benefits:

Web Sites
1. AAP Childhood Immunization Support Program (CISP)
   Information for providers and parents.
   www.aap.org/immunization
   www2.aap.org/immunization/pediatricians/refusaltovaccinate.html
2. Immunization Action Coalition (IAC)
   The IAC works to increase immunization rates by creating and distributing educational materials for health professionals and the public that enhance the delivery of safe and effective immunization services. The IAC “Unprotected People Reports” are case reports, personal testimonies, and newspaper and journal articles about people who have suffered or died from vaccine-preventable diseases.
   www.immunize.org/reports
3. Centers for Disease Control and Prevention (CDC) National Immunization Program
   Information about vaccine safety.
   www.cdc.gov/vaccines/hcp.htm
4. National Network for Immunization Information (NNii)
   Includes information to help answer patients’ questions and provide the facts about immunizations.
   http://www.immunizationinfo.org/professionals
5. Vaccine Education Center at Children’s Hospital of Philadelphia
   Information for parents includes “Vaccine Safety FAQs” and “A Look at Each Vaccine.”
   www.vaccine.chop.edu
6. Institute for Vaccine Safety, Johns Hopkins Bloomberg School of Public Health
   Provides an independent assessment of vaccines and vaccine safety to help guide decision-makers and educate physicians, the public, and the media about key issues surrounding the safety of vaccines.
   www.vaccinesafety.edu
7. Immunize Canada
   Immunize Canada aims to meet the goal of eliminating vaccine-preventable disease through education, promotion, advocacy, and media relations. It includes resources for parents and providers.
8. Sample office policy/letter to parents about refusal to vaccinate

Journal Articles

Books

Handout

Reliable Immunization Resources for Parents

Web Sites
1. Centers for Disease Control and Prevention (CDC) Vaccine Information Statements
   Provide possible health consequences of non-vaccination and possible side effects of each vaccine.
   www.cdc.gov/vaccines/pubs/vis/default.htm
2. AAP Childhood Immunization Support Program (CISP)
   Information for providers and parents.
   www.aap.org/immunization
3. Why Immunize?
   A description of the individual diseases and the benefits expected from vaccination.
   www2.aap.org/immunization/families/faq/whyimmunize.pdf
4. Pennsylvania Immunization Education Program of Pennsylvania Chapter, AAP
   Includes answers to common vaccine questions and topics, such as addressing vaccine safety concerns; evaluating anti-vaccine claims; sources of accurate immunization information on the Web; and talking with parents about vaccine safety.
   www.paiep.org
5. CDC For Parents: Vaccines for Your Children
   Information about vaccine safety.
   www.cdc.gov/vaccines/pdfs/parents/index.html
6. National Network for Immunization Information (NNii)
   Includes information to help answer patients’ questions and provide the facts about immunizations.
   www.immunizationinfo.org/parents
7. Vaccine Education Center at Children’s Hospital of Philadelphia
   Information for parents includes “Vaccine Safety FAQs” and “A Look at Each Vaccine.”
   www.vaccine.chop.edu
8. Institute for Vaccine Safety, Johns Hopkins Bloomberg School of Public Health
   Provides an independent assessment of vaccines and vaccine safety to help guide decision-makers and educate physicians, the public, and the media about key issues surrounding the safety of vaccines.
   www.vaccinesafety.edu
9. Immunize Canada
   Immunize Canada aims to meet the goal of eliminating vaccine-preventable disease through education, promotion, advocacy, and media relations. It includes resources for parents and providers.
10. Vaccinate Your Baby
    This Every Child By Two site serves as a central resource of vaccine information for parents. The site links to the latest research and studies about vaccines, an interactive timeline on the benefits of vaccines, information about vaccine safety and ingredients, and the importance of adhering to the recommended schedule.
    www.vaccinateyourbaby.org
Overview of Substance Use Services and Partnership HealthPlan
A Brief History

• For many years, substance use services for Medi-Cal clients were limited for the Medi-Cal population and were administered by counties and the State. These included some outpatient; methadone; limited residential services (perinatal only) and intensive outpatient (perinatal only).

• In 2011 the State’s “realignment” of criminal justice services provided funds which many counties used to expand treatment for those on probation or parole.

• In late 2015, the State received federal approval to provide the full continuum of services to all on Medi-Cal at the option of each county.
• Until the most recent waiver, the tie to primary care and the need for integrated care was not emphasized.

• Throughout these models the roles of clinics and in particular their ability to provide and bill for services was, at best unclear.
Drug Medi-Cal Services Under the Waiver

- Outpatient, including intensive outpatient services
- Residential services (up to 90 days)
- Case management

New

- Withdrawal management (“detox”)
- Recovery services (community support)
- Medication assisted treatment including methadone
- Emphasis on links to primary and mental health care.
- All services are tied to medical necessity criteria from the American Society for Addiction Medicine (ASAM).
• 4 counties (Marin, Yolo, Napa, Sonoma) will administer the benefit separately and coordinate care with PHC for the individuals served.
  • To date, only Marin has “gone live” and is providing the services.
  • The other three expect to be operational by the end of 2017.

• 8 counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, Trinity) are working with PHC to develop a regional benefit administered by the PHC.

• The other 2 counties (Lake and Del Norte) are waiting for the time being.
Current Activities

• PHC submitted its Implementation Plan for the regional model for State review, with a target implementation date of July 1, 2018.

• PHC allocated $2 million for projects to help establish the network.

• Workgroups, including a medical advisory group and technical workgroup are addressing key protocol and planning issues.

• PHC is committed to ensuring a significant role for clinics, even if SB 323 is not enacted.
Other Developments

• The state allocated $90 million (over 2 years) to extend the availability of buprenorphine and methadone, including grants in several PHC counties. The grantees are expected to participate in community coalitions and reach out to the community and providers.

• Other grant opportunities focusing on opiate abuse are pending with applicants from throughout the PHC service area.

• The state will be working on the final phase of waiver implementation with the Native American clinics.
Contact Us

Visit:

Email: DrugMediCalPHC@partnershipphp.org