**Committee Approval Pending**

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)**

**MEETING MINUTES**

**PAGE 1 OF 11**

**Committee:** Physician Advisory Committee  
**Date / Time:** September 11, 2019 - 7:35 to 9:05 am

### Members Present:

- Jeffrey Bosworth, MD - VC  
- Angela Brennan, DO  
- Shandi Fuller, MD (7:30 – 8:00)  
- Michele Herman, MD  
- Melissa Marshall, MD  
- Mills Matheson, MD – TC  
- Danielle Oryn, DO – TC  
- Mitesh Popat, MD - TC  
- Matthew Symkowick, MD  
- Lisa Ward, MD – VC

### Members Excused:

- Jeffrey Gaborko, MD (Chair)  
- David Gorchoff, MD  
- Steve Gwiazdowski, MD  
- Willard Hunter, MD

### Members Absent:

- Thomas Paukert, MD

### Visitors:

- Michael Ginsberg, MD, NorthBay  
- Suzanne Eidson-Ton, MD, CommuniCare

### PHC Staff Present:

- Liz Gibboney, Chief Executive Officer  
- Patti McFarland, Chief Financial Officer  
- Wendi West, Northern Executive Director - VC  
- Kirt Kemp, Chief Information Officer  
- Margaret Kisiuk, Behavioral Health Admin.  
- Lynn Scuri, Regional Director - VC  
- Mary Kerlin, Senior Dir. Provider Relations  
- Robert Moore, MD, Chief Medical Officer  
- Peggy Hoover, RN, Senior Dir., Health Services  
- Colleen Townsend, MD, Regional Med. Director  
- James Cotter, MD, Associate Medical Director  
- Stan Leung, Pharm.D. Director, Pharmacy Services  
- Debra McAllister, RN, Dir. Utilization Management  
- David Glossbrenner, MD, N. Regional Medical Dir. - VC  
- Marshall Kubota, MD, Regional Medical Director - VC  
- Jeffrey Ribordy, MD, Regional Medical Director - VC  
- Michael Vovakes, MD, Associate Medical Director - VC  
- Bettina Spiller, MD, Associate Medical Director - VC  
- Erika Robinson, Dir., S. Quality & Perf. Improvement  
- Sharon Hoffman-Spector, RN, N. UM Manager – VC  
- John Hunsaker, Manager, Quality Incentive Programs

### AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS / ACTION | TARGET DATE | DATE RESOLVED
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**Public Comments / Introductions** | The Acting Committee Chairperson asked for public comments. None were presented. Attendees introduced themselves. Visiting physician, Dr. Eidson-Ton, shared that she has been the Chief Medical Officer (CMO) at CommuniCare since February of this year. | N/A | N/A |
**Quorum** | | Committee quorum requirements met. | | |
**I. Approval of Minutes** | The Committee’s Acting Chair presented the meeting minutes for approval. | **MOTION:** Dr. Herman moved to approve Agenda Item [I.] as presented, seconded by Dr. Brennan. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions. Motion carried. | 09/11/19 |
**II.A. Status Update Administration** | The HealthPlan’s Chief Executive Officer (CEO), provided the following report on PHC activities.  
- Department of Health Care Services (DHCS) - The Director of DHCS has resigned, effective the end of this month. | For information only, no formal action required. | 09/11/19 |
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<td>II.A. Status Update Administration, Continued</td>
<td>As of now, there is no Interim Director or replacement. PHC staff will monitor carefully, in case there are any policy changes stemming from this transition. - 5-Year State Waiver – The State has announced the dates of the formal stakeholder process, to give feedback to DHCS regarding the components of the Waiver, which is being called CalAIM (California Advancing and Innovating Medi-Cal.) The Waiver is being significantly changed, and is ambitious. For a number of month, the State has been identifying three major objectives for this Waiver: 1) Standardize and reduce complexity across the Medi-Cal system (number of Medi-Cal managed care models, various benefit packages that impacts oversight and rate development) 2) More rigorous and consistent identification and management of population health 3) Improve quality outcomes, and do more system reform with regards to payment and value-based purchasing The State is planning on convening a number of workgroups for public feedback on these initiatives. PHC will participate in these discussions through the Local Health Plans of California Association. Included in the initiatives is more integration on behavioral, physical, and dental health care, implementing value-based purchasing, requiring National Committee for Quality Assurance (NCQA) Accreditation, and other payment strategies to pay for non-traditional, supplemental types of services that have the potential of reducing more mainstream health care costs. - Pharmacy Services – The Governor’s Executive Order (GEO) regarding pharmacy services continues to move on. The State has announced a second public stakeholder meeting in late September, which will focus on how to move these services over. The Administration seems very committed to this concept, and maintains a carve-out date of January 1, 2021. Major pharmacy benefit manager companies have been submitting their proposals, in response to the State’s Request for Proposals (RFPs). An announcement of their selection is expected in November. PHC management still has many questions regarding what will be carved in, and carved out, and how the HealthPlan will function alongside a major PBM, in terms of data exchange, etc., and it will continue to advocate with sister health plans from across the state.</td>
<td>For information only, no formal action required.</td>
<td>09/11/19</td>
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<td>II.A. Status Update Medical</td>
<td>The HealthPlan’s Chief Medical Officer (CMO) presented an overview of some Health Services activities. - Asthma Medication Ratio (AMR) – In recent Medical Director Newsletters, the asthma medication ratio was addressed (i.e. ways providers can improve.) The specifications, per NCQA, are being programmed under PHC’s Quality Dashboard, so the numbers should be more accurate (currently inflated by approximately 25%). There was a large study published in the New England Journal, reviewing use of one long-acting beta agonists (Formoterol), along with a corticosteroid, as a use for primary treatment for mild asthma. Though long-acting, it has a quick onset. The study showed that this treatment was superior for mild asthma (on an intermittent basis), as compared to rescue inhalers, which may lead the patient to the emergency room (thus, impacting the practice site’s rates.)</td>
<td>For information only, no formal action required.</td>
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<td>II.A. Status Update Medical, Continued</td>
<td>Pulmonologists are seeing this as a major game-changer, for the treatment of asthma. The use of Symbicort and Dulera (the two brand names with Formoterol) as an intermittent therapy, will relieve symptoms and is better than a short-acting beta-agonist. The European guidelines have already adopted this recommendation, and the American Thoracic Society is reviewing the same. Within the next few weeks, PHC expects to remove all restrictions on this therapy. Dr. Herman noted that LaClinica has been focusing their provider education on areas of need, and the AMR was not part of that process, thinking their numbers were good. Can there be some adjustments under the Primary Care Provider (PCP) Quality Improvement Program (QIP) bonus, as there is limited resources and time remaining in the year to improve on those rates? PHC’s CMO advised that this will be discussed, but, it is also hoped that providers will interject extra effort, due to this new information. - Proposition (Prop) 56 – Information around Prop 56 is filtering from the State, one of which is significant in terms of configuration, and applies to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal Health Centers. The State released changes to codes for the Adverse Childhood Events (ACEs) screening (one code for a positive screening [G9919], another code for a negative screening [G9920].) Documentation of the screening will not be required with the claim. The State is also requiring training for providers (by DHCS) before payment of service. However, they are delaying the training requirement until July 1, and claims for services until then will be accepted. It was noted that the definition of an ACE is pending from the State. - Patient Satisfaction Survey – This is the first time PHC has done its own Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to prepare for NCQA Accreditation. The State does this survey every three years. PHC staff is in the process of analyzing the information and submitting to committees. However, an initial review shows the biggest issues around access, with specific concern around pediatrics. - NCQA – PHC passed its Interim Survey last month. Staff is preparing for the First Survey, which will be in 18 months. A Mock Survey will be done in the next couple months to see if there are any major gaps that need addressing. There are a number of standards required for the First Survey, which are not required for the Interim Survey. With a 6-month lookback under the First Survey, fixes will need to be put into place quickly. PHC’s Regional Medical Director for Napa and the Southeast (SE) counties presented a brief overview. - Access – There is some shifting of providers in Napa County. The area will be losing a gastrointestinal (GI) physician, Dr. David Freeto, who will be retiring at the end of the year. Harvest Pediatrics is filling one physician position with a locum tenens, as that person goes on a short leave of absence. In Solano County, Dr. Daquioag is retiring. He has worked in Solano and Napa counties in primary care and many skilled nursing facilities for many years. Dr. Karen Tong, Ole Health, has accepted the position of Associate Medical Director for the Fairfield site.</td>
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| II.A. Status Update Medical, Continued | In Yolo County, Sacramento Pediatrics is moving in December. Winters Health Care and Community Medical Centers have started the initial discussions for shifting of some management at the Esparto clinic. It is expected that these negotiations may take several years. PHC’s Regional Medical Director for the Southwestern (SW) counties presented a brief overview. Access and Provider Update –  
- Vista Health Center – Dr. Ward shared that the reopening has been exciting, and challenging, as many staff are reestablishing themselves at the clinic. It was noted that the Center was damaged at the time of the Tubbs Fire, due to the amount of water from their sprinkler system, which ran over 24 hours.  
- Sonoma West Hospital (previously Palm Drive Hospital)  This facility has been sold, with the intent of becoming a Long-Term Care Acute (LTAC) hospital. It is currently in the process of its Medicare assessment.  
- Joint Leadership Initiative (JLI) – A number of the larger health centers have been participating in the JLI. The focus of the leadership teams is to improve quality, along with Hospital and Primary Care Provider (PCP) Quality Improvement Programs (QIPs).  
- Health Officers –  
  • Dr. Celeste Philip is now the Health Officer in Sonoma County (previously Florida’s Surgeon General.) Among the issues she is addressing is working with a contingency planning for power outages, and how to respond to those for the region.  
  • Lake and Mendocino counties are currently recruiting to fill the vacancies.  
PHC’s Regional Medical Director for the Northwestern (NW) counties presented a brief overview.  
- Access – The area continues to struggle with pediatric care. This will impact the work being done around the Healthcare Effectiveness Data and Information Set (HEDIS®) measures (well-child and immunization). Humboldt Pediatrics, started by one of the former partners of Eureka Pediatrics, is closing at the end of November, due to financial reasons. Though the clinic does not take PHC patients, the closure will release 1,800 patients into the community, with little to no options of a new medical home. In addition to those with private insurance, there are a number of Coast Guard families who will be impacted. The region is still down about 5 or 6 pediatricians, as compared to a couple years ago.  
- Opioid Use and Related Deaths – Humboldt County has been in the forefront of opioid use and related deaths in past years, though it has shown improvement. Of good news, recent data from the State places Humboldt County at number 11 in the state, which shows significant progress. The area has a very active opiate coalition, and Open Door Community Health Centers has been a state leader in Medication Assisted Treatment (MAT).  
PHC’s Northern Regional Medical Director presented a brief overview.  
- The Eureka office hosted PHC’s Board meeting in August. Board members and participants had the opportunity to tour a new Open Door facility in Fortuna. | For information only, no formal action required. | 09/11/19 |
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## II.A. Status Update Medical, Continued

### II.A1. – Update County Public Health

- Joint Leadership Initiatives - In conjunction with the tour of the new Open Door facility, the leadership teams were able to hold their JLI meeting. The JLI meeting at Shasta Community Health Center has also been held in Redding. A major topic for both meetings was recruitment and retention of providers, access to care, and HEDIS® measurements.
- Owen’s Pharmacy – As mentioned last month, this independent pharmacy in Redding has closed, though there are continuing challenges with the transition. Chain pharmacies are having some difficulty assimilating the patients and obtaining medication records. There have been some member complaints regarding the discontinuity of medications.
- Northern California Rural Roundtable – This event will be held in Redding at the end of the month.
- Regional Fires – Last year at this time, there were significant fires disrupting the region. Fortunately, current ongoing fires have not impacted major population areas.

### II.A2. – Committee Member Highlight

Dr. Fuller was not available to present a brief epidemiology update to the committee.

Dr. Fuller shared that she is a pediatrician, as well as the Deputy Health Officer for Solano County. There have been some experiences that helped shape her life passions (faith, love for family and children, and her pursuit for equity), and the reason she came to California. Originally from Northern Virginia (outside of Washington, D.C.), she is the youngest of four children, who grew up with chronically ill parents. Her father had severe diabetes, with heart attacks starting in his 30s, and a quadruple bypass surgery in his late 40s. His uncontrolled diabetes led to endstage kidney disease and dialysis, along with amputations that ended with him losing both legs. His health deteriorated quickly after the amputations, losing his life battle when Dr. Fuller was in her third year of medical school. Though not diagnosed properly for 20 to 30 years, her mother suffered from Crohn’s Disease. It was only when an intern stepped up and suggested Crohn’s Disease that her mother was referred to a gastrointestinal physician. In the 1960s/1970s, the condition was most commonly found in Caucasians, not African-Americans.

Having two ill parents definitely shaped who Dr. Fuller is, and gave her a different perspective from many of her peers. A lot of her homework was done in hospital waiting rooms. With her Fisher Price medical bag, Dr. Fuller knew she wanted to be a doctor at a very young age, with a partiality toward babies.

The schools in Fairfax County, Virginia, were excellent at the time, though her family moved around often. Each time they moved, Dr. Fuller was required to retest to prove she could handle accelerated classes. Though not a normal request, she asked to take Algebra in the seventh grade. Unfortunately, at a new school, her test scores were lost and she was placed in the wrong class. Talking to her guidance counselor, she asked to take a summer class in Algebra. He questioned her ability, stating that he thought she was more of a “C” student who just worked hard for the B or A, and said that he did not think she would do well in the class. This was a challenge for Dr. Fuller, who took the summer class and received an A.
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<td>II.A2. – Committee Member Highlight, Continued</td>
<td>That was a defining moment, and made her realize that everyone may not be supportive of her goals. She attended Howard University in Washington, D.C., and continued there for medical school. She moved to Orlando for her residency, and has been followed by her mother with each of her career moves. After Orlando, she moved to Cherokee, North Carolina, working on the Cherokee Reservation. It is there that Dr. Fuller truly learned the definition of historical and generational trauma. This peaked her interest in public health. Though she loved the experience of working there, it was in a very rural area of N. Carolina. Being raised in a suburban / city setting, the abundance of wildlife and minimal population was a bit intimidating. After three and a half years, she wanted to give California a try, and the timing was right. She interviewed over the telephone with Dr. Stacey, and accepted the position, without having seen Fairfield. Everything seemed to come together. When she came out to sign her offer letter and was looking for a place to live, a property manager happened to have a house that had not yet been placed on the Multiple Listing Service (MLS). Two hours before her flight home, Dr. Fuller saw the home and signed the paperwork. She moved to Fairfield with her mom (and her four-legged children), and has never regretted the move. She has since gone back to earn her Master of Public Health (MPH) degree, and is doing what she loves to do (working with children and equity.) Having the experiences she has had, Dr. Fuller believes she can help those who have not been encouraged to follow their dreams, or those who have been given the impression that they do not deserve good health care or decent housing. Giving a voice to those needing some help is part of her life’s purpose. She does a lot with Race Equity Training, and talks about historical / generational trauma.</td>
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<td>II.B. Quality/Utilization Advisory Committee</td>
<td>Dr. Bosworth pulled the Pulmonary Rehabilitation policy, along with the Gender Dysphoria / Surgical Treatment policy for comment. There were significant changes to the Pulmonary Rehabilitation (Rehab) criteria, specifically in terms of someone with Chronic Obstructive Pulmonary Disease (COPD), and the change for Class II to “Dyspnea at rest.” He assumes this was revised based on evidence-based criteria, which he is not familiar with. That change would place a large restriction on the population he would traditionally refer for a pulmonary rehab. PHC’s SW Regional Medical Director offered that he reviewed the policy, and changes were made based upon new recommendations under the American Thoracic Society / European Respiratory Society. The policy is considerably expanded and based less upon the diagnosis and more upon the function, regardless of the type of lung disease, and primarily divides the conditions into restrictive, obstructive, and lung transplant. Previously, authorizations for pulmonary rehab were more limited. Additional discussion by the Committee determined that the removal of the qualifier “Dyspnea at rest” under conditions would be less restrictive, allowing the noted patient population pulmonary rehab, before their illness reached that level of severity. This policy will be pulled and returned for review by the other committees, before returning for approval by the Physician Advisory Committee.</td>
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<td>II.B. Quality/ Utilization Advisory Committee, Continued</td>
<td>Dr. Bosworth asked about the Gender Dysphoria / Surgical Treatment policy, as an informational item. What is the definition of a “qualified mental health professional”, who makes the recommendation for the surgery? What are the qualifications of that person, and, does the person need to be one with experience in gender reassignment surgery, a psychiatrist, or a psychiatric nurse practitioner? PHC’s SW Regional Medical Director shared that the term generally means a licensed behavioral health professional, which spans the entire spectrum of behavioral health practitioners. There were no objections to the policy.</td>
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<td>II.B.1. Physician Advisory Committee (PAC) policy</td>
<td>The Committee’s Acting Chairperson presented the policy for the Physician Advisory Committee. Changes reflect PHC staffing updates, and the frequency of this meeting – at least 10 times per year, versus 9 times. There were no items pulled from the policy for discussion.</td>
<td><strong>MOTION:</strong> Dr. Marshall moved to approve Agenda Item [II.B.1.], as presented, seconded by Dr. Herman. <strong>ACTION SUMMARY:</strong> [9] yes, [0] no, [0] abstentions. Motion carried.</td>
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<td>II.C. Pharmacy &amp; Therapeutics (P&amp;T) Committee</td>
<td>PHC’s Pharmacy Director noted that recommendations by the P&amp;T Committee were presented at the August PAC meeting. The most significant change was opening up PHC’s formulary for asthma inhalers, which should be reflective now. There was also the addition of a couple of generic medications to the formulary. There has been discussion regarding Flovent, which is more difficult for some children to use. Adding Flovent back to the formulary is under consideration, as some providers have advised on the advantages of using Flovent over other alternatives. That will be returned to the P&amp;T Committee for discussion. The other change, as reported earlier in the meeting, is regarding Dulera and Symbicort, based on the new guidelines. PHC will be removing the Step requirement for those two inhalers, which should be reflective before the end of the month.</td>
<td>For information only, no formal action required.</td>
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<td>II.D. Provider Advisory Group, &amp; II.E. Credentialing Committee</td>
<td>There were no items pulled from the reports for the Provider Advisory Group or the Credentialing Committee for additional discussion.</td>
<td>These items will be returned under the Consent Calendar in October for approval purposes.</td>
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<td>II.G. Committee Membership</td>
<td>PHC’s SW Regional Medical Director asked that PAC members consider joining the Credentialing Committee. The committee requires some diversity of specialty types. It would be very beneficial for a specialist to join the committee, which meets the half hour prior to this Committee meeting, and can be attended by phone or in person.</td>
<td>For Credentialing Committee membership consideration, no formal action required.</td>
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<td>It was noted that Dr. Marshall will be resigning from this Committee, while Dr. Eidson-Ton is requesting appointment to fill that vacancy. These changes will be reflected on the Committee’s October agenda.</td>
<td>Noted Committee changes will be included under the Committee’s October agenda.</td>
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<td>II.G. Committee Membership, Continued</td>
<td>Dr. Ginsberg advised that he needed to leave for clinic, and expressed his thanks for the experience on the Physician Advisory Committee. The Committee’s Acting Chairperson presented a plaque to Dr. Ginsberg for his membership and participation on the PAC.</td>
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| IV.A. Perinatal Quality Improvement Program | PHC’s Manager of Quality Incentive Programs (QI Manager) referred to the information included in the meeting packet. An extended pilot of the Perinatal Quality Improvement Program (QIP) is proposed, to start on October 1 of this year and continue through June 30, 2020. There are three measures under this pilot, and, specifications are expected in the next few weeks, which will be posted on-line.  
  - Timely Tdap and Influenza vaccines  
  - Timely Prenatal Care with Depression Screening, and  
  - Timely Postpartum Care  
  
  Program participation is limited to providers who are Comprehensive Perinatal Services Program (CPSP) providers, or those who are non-CPSP perinatal providers, who are otherwise in good standing with PHC and generally perform more than 50 deliveries per year. Providers interested in participating can contact PHC’s Perinatal QIP e-mail perinatalqip@partnershiphp.org, and complete a survey, which gives staff an idea of the services provided.  
  
  Providers eligible for the new DHCS Value-Based Purchasing under Prop 56 can only participate in the Perinatal QIP for the Timely Prenatal Care measure, and the Influenza portion of the vaccine measure. This is due to incentives offered by the State for other aspects of the measurement set.  
  
  Payment is based on direct submissions to the Perinatal QIP, based on attestations that services were provided for prenatal and postpartum visits, along with some additional information about the visit and member. Tdap and influenza data will be extracted through PHC’s claims database. A kick-off webinar is scheduled for September 24 from noon to 1:00pm. Those interested should reach out to the Quality staff.  
  
  Dr. Ward asked about timeliness of prenatal care. Is the criteria based on when the member starts with PHC, or when they started prenatal care with any provider and then transferred over? It was noted that the criteria includes any provider, as long as there is some documentation to that effect. There will also be some presentations of the program to provider groups later this year, or early next year.  
  
  Dr. Brennan advised that, in talking to CommuniCare’s Perinatal Services Director, it sometimes occurs that a non-PHC patient is being care for, obtains PHC membership, and then gets reassigned to another provider. The Director has had difficulty preventing this from happening. PHC’s QI Manager reported that members need to self-select to be assigned to a provider. With the member’s consent, providers can contact PHC’s Member Services department on behalf of the patient. PHC’s Senior Health Services Director noted that, when the member is new to PHC, they are considered a special member for the first month. This gives them 30 days to choose their primary care provider (PCP). If that is not done, then they are auto-assigned. The clinic can reinforce the need for the member to contact PHC, for selecting their PCP. The process of changing a PCP is a bit more involved, if done after 30 days. | | |
| | **MOTION:** Dr. Marshall moved to approve Agenda Item IV.A. as presented, seconded by Dr. Herman.  
  **ACTION SUMMARY:** [9] yes, [0] no, [0] abstentions. Motion carried. | 09/11/19 |

PHC’s Director of Quality & Performance Improvement, South (Quality Director) reported that the Quality Performance and Improvement team are tasked with updating three documents, which reflect past, present and future work. These include:

1) Quality Improvement Program Description
2) QI Work Plan, and
3) Quality Improvement (QI) Program Evaluation

Each document is a regulatory (DHCS) and NCQA Accreditation requirement. This past year, a workgroup was created within the Quality department, to ensure these updates remain timely, and to ensure other departments are included to help support these updates. Approval of the documents started in August at the quality committees, with final approval sought from the Board in October. The review cycle for all now falls on the fiscal year.

1) Quality Improvement Program – This document is a summary of the overall QI Program, and contains related committees, structure, and inter-departmental work that supports improvement efforts. The components of the document include:
   - QI Program structure
   - Behavioral health (BH) care aspects
   - Involvement of designated physician in the QI Program, and BH practitioners
   - BH aspects of the Program
   - Oversight of QI functions
   - Annual Work Plan, and
   - Objectives for serving a culturally and linguistically diverse member population

   The major updates this year focused on the committees (and their structure), outlined time frames of meetings, appropriate participants, physician participation (particularly with the BH leadership), and the relationships between the committees that report up to the Board. Additional information regarding the All Plan Letters (APLs) from DHCS was also included, which help support the initiative work being done.

2) QI Work Plan – This document outlines major activities for the department and the organization as a whole. In addition to QI work, related efforts from other departments is included. These include:

   Yearly planned QI activities and objectives for improving the quality of clinical care, safety of clinical care, quality of service, and members’ experience, in addition to other information that includes timeframe for each activity’s completion, staff members responsible for each activity, the monitoring of previously identified issues, and the evaluation of the Program. Key updates made this year included:
   - Ensuring Smart Goals were “smart” – coordinating deliverables to Smart Goals, to make sure that what is reflected in the Work Plan are truly goals that can be measureable and specific
   - Updates to accountability (more streamlined)
   - More details on the performance initiative information, which was extracted from the main Work Plan and entered into a separate database for reference by the teams overseeing performance improvement, and provider and member engagement work
   - Document reformatted into an Excel database
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| IV.B. Trilogy Documents – 1) Quality Improvement Program, 2) 2019/20 QI Work Plan, 2018/19 QI Work Plan Update & 3) 2018/19 QI Program Evaluation, Continued | 3) QI Evaluation – This document is designed to assess performance on work outlined in the QI Program Description and QI Work Plan, reviewing ongoing QI activities that address quality safety and clinical care, quality of service, trending measures to assess performance, and deeper analysis and evaluation of the overall effectiveness of the QI Program and its progress toward influencing network-wide safe clinical practices. Key updates made this year, which included guidance from PHC’s NCQA consultant, included:  
- Grand Analysis reports, which is a process recommended by NCQA, to help PHC move forward and break down the pieces of work required for Accreditation. As a result, several workgroups and subcommittees presented work and reports, which was assimilated into the Evaluation.  
- Quantitative and qualitative evaluation steps were clarified  
- Documentation of activities, committees, and workgroups, to ensure they met their intent | **MOTION:** Dr. Herman moved to approve Agenda Item IV.B.1 as presented, seconded by Dr. Brennan.  
**ACTION SUMMARY:** [9] yes, [0] no, [0] abstentions. Motion carried. | 09/11/19 |
| IV.C. Primary Care Provider (PCP) Quality Improvement Program (QIP) 2018 Evaluation | 2018/2019 QI Work Plan Update – (As Addendum to Minutes – Please reference the Executive Summary, for major milestones, and to support major updates, which was omitted from the meeting packet.)  
PHC’s Quality Director advised on the update to the 2018/2019 QI Work Plan, which is the conclusion of the previous fiscal year. The document highlights the items completed, still in progress, or if the goals were met, partially met, or not met. Forty-six of the 59 goals were completed, three goals were partially met, and 10 goals were not met. The Executive Summary includes explanations for goals not met. Much of which was due to initiatives and work in progress, and continuing to address the challenges of some QIP measures previously acknowledged, along with work being launched and started this fiscal year.  
The Trilogy Documents will be presented to the Board in October for final approval.  
PHC’s QI Manager presented highlights to the 2018 PCP QIP. This was the first year the PCP QIP was on the calendar year cycle, and the first year that payment and performance were calculated at the site level, as opposed to the organization level.  
- 149 provider organizations participated in 2018, 274 provider sites  
- 26 measures across the three practice types  
- Approximately $27.4 million dollars were distributed (average unweighted points earned were 48.2 out of 100)  
- Overall performance showed steady improvement over previous measurement periods  
- Increase in percent of providers meeting the 90th percentile, as well as the 75th percentile targets  
- Decline in points earned, for both unweighted and weighted, is reflected due to the increase in thresholds, as imposed by the State | **MOTION:** Dr. Brennan moved to approve Agenda Item IV.B.2 as presented, seconded by Dr. Herman.  
**ACTION SUMMARY:** [9] yes, [0] no, [0] abstentions. Motion carried. | 09/11/19 |
| | | **MOTION:** Dr. Herman moved to approve Agenda Item IV.B.3 as presented, seconded by Dr. Brennan.  
**ACTION SUMMARY:** [9] yes, [0] no, [0] abstentions. Motion carried. | 09/11/19 |
### AGENDA ITEM

IV.C. Primary Care Provider (PCP) Quality Improvement Program (QIP) 2018 Evaluation, Continued

<table>
<thead>
<tr>
<th>DISCUSSION / CONCLUSIONS</th>
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<td>• First year that Relative Improvement had a threshold, which was impacted by the higher thresholds from the State</td>
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One of the questions asked for the evaluation is “does it improve care.” There was a plan-wide improvement in 7 of the 10 clinical measures (where baselines were available from previous measurement periods.) There were 7 clinical measures that ended above the 50th percentile. Providers reaching the 90th percentile increased in 7 of 10 measures. For the 75th percentile, there was an increase in 8 of the 10 clinical measures. There was closer alignment between the QIP and HEDIS®, and there was improvement in avoidable emergency department (ED) visits, while other utilization measures remained steady.

An assessment of providers’ participation in the QIP experience is conducted, and PHC received favorable feedback. Ninety-eight percent of providers believe the QIP measures are actionable, 95% believe the QIP measures lead to improved care, and 95% believe the QIP drive the quality agenda.

There was some feedback from providers on areas to improve, which included eReports and the PHC Quality Dashboard (PQD), which will be incorporated into the development for those in the upcoming year. Based on feedback, there were a few recommendations over the next few years:

- Steadily increase the patient experience metric, as that will be more important plan-wide
- Lower Relative Improvement (RI) point earning threshold (the 50th percentile was designated for RI, and providers need to have a 10% RI.) It was noted that, though the minimum threshold to qualify for RI was changed to the 50th percentile, the required RI was reduced from 15% to 10%.

The recommendation is to reduce that level, to allow smaller sites the chance to earn funds through RI. There are some other adjustments being considered for this year. Those specifications are being developed, and should be available for public comment some time in November, with the goal of being finalized and posted on-line in December.

Adjournment

The Committee adjourned at 9:05 AM
Respectfully submitted: Linda Largent

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<tr>
<th>RECOMMENDATIONS / ACTION</th>
<th>DATE RESOLVED</th>
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<tbody>
<tr>
<td>For information only, no formal action required.</td>
<td>09/11/19</td>
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The foregoing minutes were APPROVED AS PRESENTED on: ____________________ ____________________ Jeffrey Gaborko, M.D., Committee Chairman

The foregoing minutes were APPROVED WITH MODIFICATION on: ____________________ ____________________ Jeffrey Gaborko, M.D., Committee Chairman

***See Addendum to Minutes Attached – Executive Summary – QI Work Plan Reporting Period 7/1/2018 – 6/30/2019***
Background: The QI work plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members’ experience. For fiscal year 2018-2019, the decision was made to revise the frequency of status updates on goal completion from three times per year to twice per year. This update includes progress on activities from 7/1/2018 – 6/30/2019.

Results: Of the 59 Goals outlined in the work plan, 46 have a status of “Goal Met”, 3 are “Partially Met” 10 are “Goal Not Met”.

<table>
<thead>
<tr>
<th>Status</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Goal Met</td>
<td>46</td>
<td>77.97%</td>
</tr>
<tr>
<td>Partially Met</td>
<td>3</td>
<td>5.08%</td>
</tr>
<tr>
<td>Goal Not Met</td>
<td>10</td>
<td>16.95%</td>
</tr>
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</table>

QI WORK PLAN STATUS UPDATE
7/1/2018 - 6/31/2019

- 78% Goal Met
- 17% Goal Partially Met
- 5% Goal Not Met
QI Major Milestones and Activities:

- QI trilogy documents (QI Work Plan, QI Program Description, and QI Evaluation) were reviewed and revised by PHC staff.
- The baseline CAHPS survey conducted by PHC was completed. Assessment of performance will be incorporated into the Member Satisfaction Grand Analysis team work.
- PHC began work to outline strategies, revised policies and procedures for the new site review tool required by the state.
- HEDIS 2019 Summary of Performance was drafted and a communication plan created for sharing the results with internal and external stakeholders, including quality committees and the Board.
- The Partnership Quality Dashboard provider and staff evaluation plan was outlined and continued work is being done including drafting of charters, requirements gathering for Managed Care Accountability Set (MCAS) measure incorporation, development of unblinding of quality data visualizations, and Partnership Quality Dashboard (PQD) maintenance and development.
- A workgroup to address new state requirements and further development of initiatives to support perinatal care began in June 2019.
- Initial planning began for the development of the long term care advisory group.
- The initial pilot of the Perinatal QIP program was completed in September 2018 and the pilot was extended for an additional 6 months.
- The Performance Improvement Team completed an evaluation of the cervical cancer screening media campaign and found that media notices in conjunction with outreach calls contributed to an improved rate of Pap test completion.
- Age specific questionnaires and screening tools were added to Essette in preparation for the CCS go-live.
- The Growing Together Perinatal Program (GTPP) was changed to the Growing Together Program (GTP) to better accommodate moms in the postpartum period.
- The NCQA Interim Survey is complete, with an anticipated score of 50/50.
- Grand Analysis teams completed final reports and sustainability plans for ongoing work in preparation for First Survey.
- Gap lists/dose reports for childhood immunizations were shared with providers.
- The PCP Quality Improvement Program (QIP) points distribution was changed to better support key measures of focus.
Final Goal Status

Goal Status: Partially Met

Partially met goals were those where most of the objectives were met, but the goal itself was not fully accomplished, based on a partially met targeted outcome (e.g. 2 of the three targeted outcomes were achieved). This is the case for 3 of the HEDIS measure score improvement related work plan activities. The targets were set to reduce the number of measures <MPL (25<sup>th</sup> percentile) or for a set number of measure rates to increase to a higher percentile.

<table>
<thead>
<tr>
<th>Project or Program</th>
<th>Goal</th>
<th>Status Details</th>
<th>Next Steps</th>
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<tbody>
<tr>
<td>4e - HEDIS Score Improvement – Childhood Immunization Status, Combination 3 (CIS-3)</td>
<td>Reduce number of CIS-3 measures below the Minimum Performance Level across PHC’s regions from 3 to 0</td>
<td>There were 2 CIS measures &lt;MPL across PHC regions (NW and NE)</td>
<td>CIS-3 is a challenging measure. In addition to DHCS changing the measure for which Medi-Cal plans are accountable in April 2019 from CIS-3 to CIS-10, it raised the Minimum Performance Level to the 50&lt;sup&gt;th&lt;/sup&gt; percentile. PHC will continue many of the above activities, as well as increase the focus on well child visits for babies 0-15 months of age, which align with the CIS-10 immunization dose schedule.</td>
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</table>
| 4g - HEDIS Score Improvement – Breast Cancer Screening (BCS) | Decrease the total BCS measures below MPL across PHC’s regions from 2 to 0. Increase BCS rates in the SE and SW regions to the 50<sup>th</sup> percentile | This goal was partially met. The total BCS measures below MPL across PHCs regions decreased from 2 to 1. (NW <MPL, NE increased from <25<sup>th</sup> to 25<sup>th</sup>) | The following activities will be done to continue progress on BCS rate improvement.  
  - Outreach to providers.  
  - Work toward contracting with mobile mammography service that consistently produces images meeting of sufficient quality and is able to consistently meet appointments.  
  - Inform providers which mobile mammography services meet quality standards.  
  - Continue pilots with providers and spread |
Partnership HealthPlan of California
Executive Summary – QI Work Plan
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Goals with a “not met” status include items where the work to complete the goal was set for a timeframe outside of the 2018-19 fiscal year, due to a delay or alternate stakeholder timelines for necessary work. Items with a goal status of “not met/delayed” are tied to an evaluation of the exchange of member information via the member portal and other electronic/digital engagement modalities. The development of these modes of sharing information with members are still in development.

Other goals with a status of “not met” are items where the full goal target was not met, such as with the HEDIS measure score improvement goals where the expected outcome was improvement across all 4 reporting regions or a certain measure to improve in a portion of the regions as part of the expected goal outcome.

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<tr>
<td>2e - Web Based Member Information Assessment</td>
<td>Complete the annual evaluation of the quality and accuracy of information provided to members via the web, e-mail and telephone</td>
<td>Communications channels for the portal were not set for the initial rollout/scope of the launch on 7/1/2018.</td>
<td>These activities (establishing standard member communications via email, the web and telephone) are being addressed during the FY19-20 goals as part of Member Services commitment to completing the remaining 19% first survey requirements.</td>
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<tr>
<td>Project or Program</td>
<td>Goal</td>
<td>Status Details</td>
<td>Next Steps</td>
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<td>4d - HEDIS Score Improvement – Annual Monitoring for Patients on Persistent Medications (MPM-ACE/ARB, MPM-Diuretics)</td>
<td>Reduce number of MPM measures below the Minimum Performance Level across PHC’s regions from 3 to 0. HEDIS 2018 performance below MPL: • NE Region: MPM ACE/ARBs and MPM Diuretics • NW Region: MPM ACE/ARBs</td>
<td>The goal work was completed and there were improvements in the NE region. However, the target was not met of reducing the # of MPM measures across PHC regions below the MPL from 3 to 0. There were still 3 MPM measures &lt;MPL in the NE and NW regions.</td>
<td>Due to NCQA’s proposed retirement of the MPM measures for Medicaid plans and the likelihood that the Department of Health Care Services will retire the measures from the Managed Care Accountability Set (MCAS, formerly EAS), improvement activities specific to MPM have been paused beyond the corrective action plan’s stated activities.</td>
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<td>4f - HEDIS Score Improvement – Comprehensive Diabetes Care, Nephropathy Screening (CDC-N)</td>
<td>Decrease the total CDC-Nephropathy measures below MPL across PHC’s regions from 2 to 0.</td>
<td>There were still 2 PHC Regions (NW and SW) were where the CDC Nephropathy (CDC-N) measure was &lt; MPL.</td>
<td>CDC-N, although being a PCP QIP measure and a measure of potential focus for a PIP in 2018-2019, the required percentile was not met per HEDIS 2019 annual performance results. Due to the new Managed Care Accountability Set, CDC-N is no longer a focus for PHC.</td>
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<tr>
<td>4h - HEDIS Score Improvement – Asthma Medication Ratio (AMR)</td>
<td>Decrease the total AMR measures below MPL across PHC’s regions from 2 to 0. HEDIS 2018 regions below MPL on AMR: NW and NE</td>
<td>The total AMR measures below MPL across PHC regions (NW, NE, SW) is 3 per HEDIS 2019 rates. The goal was not met.</td>
<td>AMR is a challenging measure – it is largely driven by clinical judgment. In April 2019, DHCS raised the Minimum Performance Level to the 50th percentile. PHC will continue many of the above activities. The PHC formulary was designed for it to be easier to order rescue meds (generic) vs. controller (brand name). In July 2019, formulary changes will be made effective to allow prescribing the controller inhaler up to 90 days and</td>
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### Partnership HealthPlan of California
### Executive Summary – QI Work Plan
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| 4i - HEDIS Score Improvement – Comprehensive Diabetes Care, Eye Exam (CDC-Eye) | Improve performance on CDC-Eye measure across PHC regions | This goal was partially met. There was improvement in 2 regions: SW – 50th → 90th percentile NE – 50th → 75th percentile The rate in the SE remained in the same percentile threshold (50th), and declined in the NW region (<25th) | In HEDIS MY2018/RY2019, the NE and SE achieved or exceeded the cited performance goals. The NW suffered a decline, moving to below MPL performance. And, the SW region had no percentile change. 
This measure is not included in the DHCS MCAS for MY2019/RY2020 but it remains as a measure assessed under HEDIS accreditation. As a result, CDC-Eye will remain in the PHC QI Work Plan as we work to further improve performance. |
<p>| 4i - HEDIS Score Improvement – Well Child Visits (W34) | Decrease the total Well Child measures below MPL across PHC’s regions from 1 to 0. Improve performance on Well Child measure across other PHC regions  - SE: Improve from 50th to 75th percentile  - NE: Improve from 25th to 50th percentile  - NW: Raise above MPL | The goal was not met. 2 Regions, NE and NW had rates &lt;MPL. The rates declined in the SE and SW regions. | Plans to continue driving improved performance under W34 and the new MCAS measures, W15 and AWC, are included in the 2019-20 PHC QI Work Plan. |
| 4m - HEDIS Score Improvement – Immunizations for Adolescents (IMA-2) | Decrease the total IMA-2 measures below the MPL across PHC’s regions from 1 to 0. - NE: Raise above MPL | The goal was not met. The rate in the NE region is still &lt;25th percentile and the rate in the NW regions also decreased to &lt;25th percentile. The rate decreased in the SW region from the 90th → 75th percentile | Initiative work tied to the HEDIS tactical plan will continue for this measure during the next fiscal year. This includes expansion of the poster campaign and presenting information to school officials in the southern region, as well as aiming to partner with provider sites to support |</p>
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<tr>
<th>5e - Electronic Member Engagement Solutions</th>
<th>Coordinate the use of Electronic Member Engagement solutions to support improvement for 2 HEDIS measures that are &lt;HPL Delayed</th>
<th>Digital/ electronic member engagement strategies inclusive of texting/ emailing appt. reminders and push notifications are being discussed and a request to continue to carry this work forward as an effort separate from the current team goal structure will be shared at the PHC Project Review Board (PRB) in March.</th>
<th>The member portal is not currently designed to accommodate these types of communications but these changes are planned for future development.</th>
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<tbody>
<tr>
<td>6c - Member Assessments</td>
<td>Assess all new members within 90 days of enrollment with the health plan</td>
<td>The goal is part of the IT department 2019/20 automation projects</td>
<td>This goal has been identified for automation in the IT automation Team Goal, with anticipated completion of 6/30/2020.</td>
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<tr>
<td>7c - Initial Health Assessment</td>
<td>Improve IHA compliance rates from 48.02%, based on administrative data in 2017 MY to 55%, inclusive of hybrid and administrative data collected over 2018-2019.</td>
<td>Although all of the activities to support improvement were completed with success, our final number was 50.55%, which is almost exactly half of the anticipated increase in our IHA compliance.</td>
<td>Work will continue to incorporate IHA completion into provider education sessions.</td>
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