Provider Advisory Group Meeting  
August 16, 2019  
Lunch: 12:00 pm  
Meeting: 12:15 pm – 1:30 pm

1. **Standing Agenda Items**
   1.1 Welcome – Tahereh Daliri Sherafat, *Northern Region Director of Member Services and Provider Relations, Partnership HealthPlan of California*
   1.2 Review of Minutes – Tahereh Daliri Sherafat
   1.3 Review of Agenda – Tahereh Daliri Sherafat

2. **New Business**
   2.1 *PHC Administrative Update* – David Glossbrenner M.D., *Northern Region Medical Director, Partnership HealthPlan of California*
   2.2 *Report from Physician’s Advisory Committee* – David Glossbrenner M.D.
   2.3 *Provider Relations – Training and Events Calendar* - Tahereh Daliri Sherafat
   2.4 *Report from Provider Education Team* – Bianca Veneracion, *Education Specialist, Provider Relations Department, Partnership HealthPlan of California*

3. **Provider Topics of Interest**
   3.1 Topics of Interest, Upcoming Events, Health Fairs and Trainings: *All Attendees*

4. **Presenter: Subject Matter Experts from Partnership HealthPlan of California**
   Topics will include the following HEDIS measures:
   4.1 *Asthma Medication Ratio (AMR)* – Learn best practices to help patients achieve the best outcomes.
   4.2 *Breast Cancer Screening (BCS)* – Focused on helping providers guide women to complete this screening. Hear a success story from a Northern Region primary care physician and learn from a local imaging provider how to simplify mammogram scheduling.
   4.3 *Well Child Visits (W34, W15, AWC)* – Learn best practices on outreach, scheduling, and billing.

5. **Old Business**
   5.1 None

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**Meeting Locations:**

*Video conferencing is available at our PHC regional offices:*
- Main Office: 4665 Business Center Drive, Fairfield
- Southwest Regional Office at 495 Tesconi Circle, Santa Rosa
- Northeast Regional Office at 3688 Avtech Parkway, Redding
- Northwest Regional Office at 1036 5th Street, Suite E, Eureka

*Video conferencing also is available at these non-PHC offices:*
- Fairchild Medical Center at 444 Bruce Street, Yreka, CA (Board Room)
- Banner Lassen Medical Center at 1800 Spring Ridge Drive, Susanville, CA
# Meeting Minutes

**Meeting Name:** Provider Advisory Group  
**Date:** 05/17/2019  
**Time:** 12:30 pm to 1:30 pm  
**Location:** Fairfield (Host), Santa Rosa, Eureka, & Redding via video  
**Guests:**  
**Fairfield:** Scott Perryman, MD, Crystine Lee, MD, Joel Moncado, L.Ac, Summer Summers, Emily Partida, Vita Marks, Maggie Galicia Mendoza, Cozette Pyeatt, Elaine Bryant  
**Santa Rosa:** Teri Ortiz  
**Eureka:**  
**PHC Attendees:**  
**Fairfield:** Liz Gibboney; Lisa O’Connell; Jeanette Camarena; Rebecca Garcia; Mark Aguirre; Ledra Guillory, Takishka Wright, Kristy Woolworth, Celilia Pizano-Damian, Grace Zhang, Jamie Wilborn, Belinda Love  
**Redding:** Tahereh Sherafat, Melissa McCartney, Sharon McFarlin, Nikki Rotherham, Barbara Crandall, Kim Palfini, Jennifer Oakes  
**Santa Rosa:** Mark Netherda, MD, Melissa Perez, Gloria Turner, Stephanie Phipps  
**Eureka:** Jeff Robordy, MD, Nai Chadderdon, Shell Swift, Cindy Aston

<table>
<thead>
<tr>
<th>Agenda Topic</th>
<th>Minutes</th>
<th>Action Items</th>
</tr>
</thead>
</table>
| **Agenda Item #1**  
**Standing Agenda Items** | 1.1. **Introductions:** Guest facilitator Joel Mancada, DACM, L.Ac was introduced.  
1.2 **Review of Agenda** | Presented as information only |
| **Agenda Item #2**  
**Presentations** | 2.1 **PHC Updates – Liz Gibboney, CEO** of Partnership HealthPlan updated the group on recent news:  
- California’s newly elected Governor, Gavin Newsome, promises to focus much more on healthcare, with a particular emphasis on children in the coming months.  
- PHC is looking at a new core Claims system called HealthEdge and will phase in this new system over the next 2 years.  
- DHCS is changing health plan accountability measures and will impose sanctions for all HEDIS measures that fall below the national average for Medicaid plans (effective for activities starting in January 2019).  
- NCQA Accreditation is progressing; we have an Interim Survey date of June 14, 2019  
- PHC turned 25 on May 1!! Activities included an Open House celebration in our new building located at 4605 Business Center Drive in Fairfield. | Presented as information only |
| Agenda Item #3  
Old Business | None |
---|---|
| **Agenda Item #4**  
Presentation | 4.1 Update from Physicians Advisory Group (PAC) – Regional Medical Officer Mark Netherda, MD updated the group on PHC key initiatives:  
- The new Governor is committed to providing healthcare for all children to ensure a “Healthy start”. This includes an emphasis on well-child exams, and immunizations.  
4.2 Report from Quality Department – John Hunsaker, Manager of Quality Incentive Programs updated the group:  
- The Department of Health Care Services (DHCS) has released the new series of measures managed care plans will be held accountable to. This Managed Care Accountability Set (MCAS) has been expanded to include CMS Adult and Child Core Set measures and more measures focused on well care for children.  
- The HEDIS medical record review portion of the annual project has concluded. PHC is completing the validation of collected medical record information for auditor review.  
- The Partnership Improvement Academy is offering webinars in May and June that can assist providers with Quality and Performance Improvement. See Attachment A.  
4.3 Report from Claims – Takishka Wright, Claims Resolution Coordinator gave the group information about CMS 1500 Claims Form  
- PHC has noticed an increase in CMS1500 forms rejected for corrections. This delays provider payments and increases the workload for both the provider office and PHC. Required fields for a “clean” claim form were reviewed.  
4.4 Report from Provider Education Team – Lisa O’Connell, Manager of Provider Education, gave a report on activities on the Provider Education Team:  
- PHC has implemented new eRAF and eTAR modules on the Online Services portal.  
- We are offering webinars and trainings on the new modules: please visit the PHC website for dates and times of upcoming trainings.  
4.3 Report from Provider Relations – Gloria Turner, PR Representative for Lake County presented information to the group:  
- Providers are reminded that they must notify PHC at a minimum of 90 days prior to contract terminations, any site relocation, closure, addition or joining another organization. To do so they may fill out the Provider Change Form available on the PHC Website. |
---|---|
- Annual Provider Satisfaction Surveys were mailed out starting May 3. Providers are asked to please respond to the survey.

<table>
<thead>
<tr>
<th><strong>Agenda Item #5</strong></th>
<th>None</th>
<th>Presented as information only</th>
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<tbody>
<tr>
<td><em>Provider Topics of Interest</em></td>
<td></td>
<td></td>
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<tr>
<td><strong>Next Meeting</strong></td>
<td>August 16, 2019, hosted in Redding</td>
<td>Any suggestions for next agenda</td>
</tr>
</tbody>
</table>
TOPIC: QI Provider Advisory Group Updates

Hello Providers! The Quality and Performance Improvement Department wants to emphasize the following activities and initiatives for the months of May and June:

The Partnership Improvement Academy is offering the following webinars in May and June:

Advanced Access Webinar Series – This series covers resources for improvement and tactics for reducing appointment wait times and pertinent aims and measures. While it is encouraged to sign up for the entire series, registration for separate webinars is allowed. Visit the Partnership Health Plan website to sign up.

The Department of Health Care Services (DHCS) has released the new series of measures managed care plans will be held accountable to for demonstrating the provision of quality care and services. The Managed Care Accountability Set (MCAS) has been expanded to include CMS Adult and Child Core Set measures and more measures focused on well care for infants, children and adolescents.

The HEDIS medical record review portion of the annual project has concluded. PHC is completing the validation of collected medical record information for auditor review.

Quick Tip: EMR templates can used to effectively capture well child visits and related services. Work with your EMR vendor to help maximize your medical record system to the fullest extent possible.
Improving Priority HEDIS Measures

Presenters:

James Devan, MS
NR Manager of Performance Improvement

Nancy Steffen
NR Director of Quality and Performance Improvement

August 16, 2019
Today’s Objectives

• Learn about priority quality measures (HEDIS) and how PHC and its provider partners can improve the quality of care our members receive

• Takeaway tips and tricks for improving the quality of care members receive, as measured by HEDIS

• Learn and discuss the clinical significance of the measures and best practices for patient care
Asthma is a treatable, reversible condition that affects more than 25 million people in the United States. Managing this condition with appropriate medications could save the U.S. billions of dollars in medical costs.

The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication.

Measure: Asthma Medication Ratio (AMR)

Measure Description

The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

\[
\frac{\text{Units of Controller Medications}}{\text{Units of Total Asthma Medications}} = \text{AMR Ratio}
\]
Measure: Asthma Medication Ratio (AMR)

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of members 5-64 years of age who were identified as having persistent asthma during the measurement year and the year prior to the measurement year</td>
<td>Number of members in the eligible population who have a medication ratio of 0.5 or greater during the measurement year</td>
</tr>
</tbody>
</table>
Asthma Medication Ratio (AMR) Rates in PHC

25th percentile: 56.85%, 50th percentile: 62.28%

Partnership Quality Dashboard 04/09/2019
Asthma Medication Ratio (AMR)

Inclusion into the measure can be based on any of the following events:

- Outpatient visit or observation visit where there was a diagnosis of asthma and the patient received two separate asthma dispensing events.
- Acute inpatient visits where the patient received a principal diagnosis of asthma.
- ED visits with a principal diagnosis of asthma.
- At least four asthma medication dispensing events.

Exclusions:

- Members who had any of the following diagnosis at any time in their history...
  - Emphysema
  - COPD
  - Obstructive Chronic Bronchitis
  - Chronic Respiratory Conditions due to fumes/vapor
  - Cystic Fibrosis
  - Acute Respiratory Failure
- Members with no asthma medications dispensed.
- Members in hospice.
Components of Managing Asthma

- Monitoring Symptoms
- Patient Education
- Pharmacologic Interventions
- Asthma Triggers

Asthma Management
Optimize the use of Integrated Primary Care Teams to Optimize use of medications

- Use of Pharmacists, RNs, and students for patient education especially inhaler use

- Follow up phone call to assess frequency and use of Inhalers with Standing Orders to step up therapy as needed

- Use of AMR list to identify patients in need of follow up and education
Tips to improve Asthma Care Performance

- Submit claims and encounter information in a timely manner
- Ensure patients are accurately diagnosed with persistent asthma
- Evaluate members before approving requests for refills of rescue inhalers
- Educate patients on asthma and taking asthma medications correctly, including the proper use of long-term controller medications
- Community pharmacist as part of care team
- If a PCP, use member gap lists in PHC’s eReports to prioritize patients with low AMR (e.g. less than 0.50)
Questions
Updates in the Well-Child Measure

• In March 2019, a scathing report entitled: “Millions of Children in Medi-Cal Not Receiving Preventive Health Services” was released.

• As a result, DHCS is requiring major changes to well child visit measures effective January 2019.

• There are now three Well-Child visit measures:
  • W15: Well-Child Visits in the First 15 Months
  • W34: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years
  • AWC: Adolescent Well-Care Visits
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years

Measure Description

Assess children 3-6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.
Well-Child Visits in the First 15 Months

Measure Description

Assesses children who turned 15 months old during the measurement year and requires six or more well-child visits with a primary care physician during the first 15 months of life.

**This measure is new as of January 2019.**
Adolescent Well-Care Visits

Measure Description

Assesses adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year.

**This measure is new as of January 2019.**
Multiple components are required to meet the well-child/care visit definition. This includes:

- Health History
- Physical Developmental History
- Mental Developmental History
- Physical Exam
- Health Education/Anticipatory Guidance

Follows recommended schedule under Bright Futures.

The goal is to close the gap on well-child visits and simultaneously benefit immunization rates.
Well-Child Annual Rate in PHC

<table>
<thead>
<tr>
<th>PHC Regions</th>
<th>W34 Performance</th>
<th>HEIDS Reporting Year 2018</th>
<th>HEIDS Reporting Year 2019</th>
<th>Percentile Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC NE Region</td>
<td>67.29%</td>
<td>62.02%</td>
<td></td>
<td>-5.27%</td>
</tr>
<tr>
<td>PHC NW Region</td>
<td>63.45%</td>
<td>63.26%</td>
<td></td>
<td>-0.19%</td>
</tr>
<tr>
<td>PHC SE Region</td>
<td>75.00%</td>
<td>68.37%</td>
<td></td>
<td>-6.63%</td>
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<tr>
<td>PHC SW Region</td>
<td>84.03%</td>
<td>74.24%</td>
<td></td>
<td>-9.79%</td>
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<tr>
<td>HEDIS 25th Percentile</td>
<td>66.18%</td>
<td>67.15%</td>
<td></td>
<td>+0.97%</td>
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<tr>
<td>HEDIS 50th Percentile</td>
<td>72.45%</td>
<td>73.89%</td>
<td></td>
<td>+1.44%</td>
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<tr>
<td>HEDIS 75th Percentile</td>
<td>78.51%</td>
<td>79.33%</td>
<td></td>
<td>+0.82%</td>
</tr>
<tr>
<td>HEDIS 90th Percentile</td>
<td>82.77%</td>
<td>83.70%</td>
<td></td>
<td>+0.93%</td>
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</tbody>
</table>

*Measure performance has decreased while HEDIS percentiles have increased.*
# Year-To-Date Well-Child Rates in PHC

<table>
<thead>
<tr>
<th>Measure_Submeasure - FullName</th>
<th>Monthly--YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-19</td>
</tr>
<tr>
<td><strong>Adolescent Well Care (AWC)</strong></td>
<td></td>
</tr>
<tr>
<td>NORTHEAST</td>
<td>6.33</td>
</tr>
<tr>
<td>NORTHWEST</td>
<td>9.29</td>
</tr>
<tr>
<td>SOUTHEAST</td>
<td>14.38</td>
</tr>
<tr>
<td>SOUTHWEST</td>
<td>12.62</td>
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<tr>
<td><strong>Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)</strong></td>
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<tr>
<td>NORTHEAST</td>
<td>17.77</td>
</tr>
<tr>
<td>NORTHWEST</td>
<td>22.89</td>
</tr>
<tr>
<td>SOUTHEAST</td>
<td>26.81</td>
</tr>
<tr>
<td>SOUTHWEST</td>
<td>25.25</td>
</tr>
<tr>
<td><strong>Well-child visits in the first 15 months of life (W15) - Six or more well child visits</strong></td>
<td></td>
</tr>
<tr>
<td>NORTHEAST</td>
<td>6.23</td>
</tr>
<tr>
<td>NORTHWEST</td>
<td>13.07</td>
</tr>
<tr>
<td>SOUTHEAST</td>
<td>13.62</td>
</tr>
<tr>
<td>SOUTHWEST</td>
<td>16.27</td>
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</table>

Preliminary rates: AWC <10th percentile, W15 <5th percentile

Partnership Quality Dashboard as of 08/06/19
Why is it challenging?

- Access is an ongoing challenge, especially in the more rural regions.
- Confusion over periodicity and minimum number of visits.
- Vaccine hesitancy may influence their engagement in completing timely well-child visits.
Tips to Improve

- **Clinical Teams**
  - Create template to use and review at visit.
  - Explore use of group visits.

- **Documentation**
  - Health history can be obtained by documenting at each visit.
  - Use of “development appropriate for age” in the chart, “well developed” is no longer applicable for HEDIS measurement.

- **Outside the Visit**
  - Timely submission of claims and encounter data.
  - Identify and address barriers to Well Child Visits. IE transportation, parent/guardian work schedules, physical capacity, scheduling capacity, etc.
  - Designate a team member to outreach.
Breast Cancer Screening

Measure Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

**Note:** One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Mammograms are the best method to detect early breast cancer, before it is big enough to feel or cause symptoms and is easier to treat. Detecting early breast cancer via mammography can provide women with a greater range of treatment options, such as less aggressive surgery (e.g., lumpectomy vs. mastectomy), less toxic chemotherapy or the option to forego chemotherapy. Mammography can also reduce the risk of dying from breast cancer by 20 percent.

Transportation issues, especially in rural areas.

Misunderstanding of the benefits or risks of radiological imaging compared to other methods like ultrasounds.

Difficult or misunderstood diagnostic ordering processes.
BCS Rate in PHC

Partnership Quality Dashboard as of 08/06/19

PHC REGIONS
- Northwest
- Northeast
- Southwest
- Southeast

Breast Cancer Screening (BCS)

<table>
<thead>
<tr>
<th>Region</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTHEAST</td>
<td>50.67</td>
<td>51.53</td>
<td>53.32</td>
</tr>
<tr>
<td>NORTHWEST</td>
<td>46.04</td>
<td>47.31</td>
<td>47.75</td>
</tr>
<tr>
<td>SOUTHEAST</td>
<td>57.20</td>
<td>56.96</td>
<td>60.33</td>
</tr>
<tr>
<td>SOUTHWEST</td>
<td>52.06</td>
<td>52.85</td>
<td>56.30</td>
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2018 MPL: 51.78%
## Year-To-Date BCS Rates in PHC

<table>
<thead>
<tr>
<th>Measure Submeasure - Full Name</th>
<th>Use Select Breakout</th>
<th>Monthly - YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>May-19</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>NORTHEAST</td>
<td>44.84</td>
</tr>
<tr>
<td></td>
<td>NORTHWEST</td>
<td>38.14</td>
</tr>
<tr>
<td></td>
<td>SOUTHEAST</td>
<td>52.04</td>
</tr>
<tr>
<td></td>
<td>SOUTHWEST</td>
<td>48.03</td>
</tr>
</tbody>
</table>
Joint project with Shasta Community Health Center

- Pilot with SCHC to utilize MD Imaging portal.
- Allows providers to add member information.
- MDI conducts outreach, scheduling, and reminders.
- 91 of the 429 targeted received mammograms.
- Median time from outreach to mammogram completion was 14 days.
Tips to Improve

- Document last mammogram including results.
- Establish system to promote mammography. IE reminder calls, text, post cards.
- Phone call to women who have not made an appointment after 4 – 6 weeks of mail reminder.
- Real time booking.
- Hard stop question during visit.
- Use services provided by local imaging providers.
- Mobile mammography if available.
- Timely submission of claims and encounter data.
Questions
Improving Asthma Medication Rate Quality Measure

The Asthma Medication Ratio (AMR) is a measure that is challenging to stay ahead of and meet the recommended benchmark. In this measure, the goal is to have a dispensing history of asthma medications that reflect a consistent use of controller medications at a higher rate than rescue medications. Often at the beginning of a measurement period, the Asthma Medication Ratio looks great, as the use of controllers may seem higher than the use of rescue inhalers. However, as the measurement year progresses, patients often FORGET to use controller and rely heavily on rescue inhalers as allergies, wildfire smoke, and upper respiratory infections produce more symptoms.

Some key messages to pass on to your clinicians:

1. **Tailor the length of time for prescriptions to the medication type.** Prescribe controllers for three months at a time with three refills; prescribe rescue inhalers one at a time with one refill.

2. **Think twice before refilling a rescue inhaler.** Make it a short-term refill; check for a controller prescription; and evaluate controller medication compliance.

3. **Consider using oral montelukast** for mild-to-moderate asthma. This also helps with allergic rhinitis and has higher adherence than inhaled corticosteroids. Prescribe for three months at a time with three refills.

4. **Intermittent combo agents** for mild asthma. A recent article in the May 28 edition of The New England Journal of Medicine suggested that intermittent use of a combined corticosteroid/long-acting beta agonist worked equally well as continuous use of an inhaled corticosteroid alone. Fluticasone/Salmeterol® (generic Airduo RespiClick®) and Fluticasone/Salmeterol® (generic Advair®) are the preferred formulary ICS/LABA medications for PHC (brand name Airduo® and Advair® are not covered).

5. **Manage the denominator.** Review the charts of those patients you have coded with asthma to see if they have had a good workup to confirm the diagnosis. Consider ordering spirometry or pulmonary function tests if not clear. Coding for COPD, for example, will remove that patient from the denominator.

Recently, PHC posted a webinar that combines technical QIP data analytic information and clinical information that aims to improve the Asthma Medication Ratio and patient care. The link to the webinar is http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

Please encourage providers, nurses, pharmacists, and QI/data analytics staff to log into this webinar to learn more about how to optimize asthma disease management for your patients AND improve your AMR score in QIP. If you have any questions about the Asthma Medication Ratio or any other measure in the PCP QIP, feel free to reach out to us at PCPQIP@partnershiphp.org.
The Department of Health Care Services’ (DHCS) Value-Based Payment (VBP) Program includes a measure for Blood Lead Screening. For Fiscal Year 2019-2020, the governor’s budget proposes a VBP through Medi-Cal managed care plans (MCPs) that will provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations.

These risk-based incentive payments are targeted toward physicians who meet specific achievement on metrics such as early childhood prevention. An incentive payment will be issued to providers for completing a Blood Lead Screening in children up to 2 years of age. DHCS requires all Medi-Cal beneficiaries be screened twice with Blood Lead Screening tests, at approximately ages 12 months and 24 months. The purpose of this measure is to improve the rate of identification and treatment of elevated blood lead levels among children.

To help our providers meet the Blood Lead Screening measure, effective **August 1, 2019**, Blood Lead Screening tests will be reimbursed when provided in the office setting or by a public health laboratory, including counties with Quest capitation. The CPT code used for the Blood Lead Screening test is 83655 and will be reimbursed at the fee-for-service (FFS) rate.

If you would like to add a point of care Blood Lead testing to your office, contact your local health department for details. For questions regarding the Blood Lead Screening, please contact your Provider Relations representative.

**Resources**

https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs.aspx
IMPORTANT INFORMATION

Topical fluoride is an important tool used for tooth decay prevention. The U.S. Preventive Services Task Force recommends fluoride varnish application to teeth of children up to four times per year as standard of care (from the eruption of the first tooth to age 5). This reduces childhood cavities by inhibiting the metabolism of the decay-producing bacteria in plaque. Reducing childhood cavities also lowers the risk and cost of anesthesia for young children.

You can incorporate fluoride varnish applications in well-child visits in one of two ways:
1. The medical assistant applies the varnish (often after the clinician is done with their portion of the visit)
2. The physician applies the varnish, and it can be integrated into the physical exam of the oral cavity. The actual application process takes seconds as the varnish dries and sticks to the teeth almost instantly.

Although once a year application of fluoride varnish reduces risk of caries, optimal prevention of caries requires additional applications of fluoride varnish between scheduled well-child visits. Fluoride varnish application by primary care clinicians is eligible for a “value-based” bonus payment, which started on July 1, 2019. For details on the codes to use to attain this bonus, see the documents found on the DHCS website.

Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Service (IHS) providers/Tribal Health Centers, and other outpatient prospective payment system (PPS) providers are NOT eligible for this bonus but will be paid the usual office visit fees for such visits. Depending on how the visits are structured, FQHCs, RHCs, and IHS providers may be able to apply their PPS rate to fluoride varnish applications between regular health maintenance visits.

Resources:
- https://www.dhcs.ca.gov/services/chdp/Pages/FluorideVarnish.aspx#powerpoint
- https://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx
Important Provider Information
Boosting Pediatric Well Child Visits

Background:
On March 5, the California Department of Healthcare Services (DHCS) ushered in important changes to how Medi-Cal managed care plans provide comprehensive preventive health care to children in the state. In light of these changes, we want to encourage you to support these sweeping reforms by considering the following as you provide care and services to our young members.

**Why it Matters:** Most children with Medi-Cal are missing pediatric well visits.
Closing the gap on well-child visits will likely have a collateral benefit of increasing vaccination rates and helping two additional measures (the child and adolescent immunization rates). Missed periodic visits are a substantial driver of low immunization rates.

**Well-Child Visits – Key Components**
Three major drivers of well-child visits are:
1. Access of children’s health care providers
2. Office systems to ensure scheduling and reminders for these well-child visits

There are three HEDIS measures of adequacy of pediatric preventive care:
1. Six well-child visits before a baby turns 15 months of age (W15)
2. Annual well-child visits for children ages 3 – 6 (W34)
3. Annual adolescent well visits for ages 12 – 21 (AWC)

All three of the well-child measures noted above will be in the Primary Care Provider Quality Improvement Program (PCP QIP) in 2020.

There are a **minimum** of 5 components of a well-child visit, as listed below:

- **A health history.** Health history is an assessment of the member’s history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history.** Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history.** Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam.**
- **Health education/anticipatory guidance.** Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

PHC will be auditing against the Bright Futures recommendations at our regular Medical Records Review visits (visit [https://brightfutures.aap.org/clinical-practice/Pages/default.aspx](https://brightfutures.aap.org/clinical-practice/Pages/default.aspx) for more details).

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**Eureka       |       Fairfield       |       Redding       |       Santa Rosa**
(707) 863-4100 | [www.partnershiphp.org](http://www.partnershiphp.org)
What can your office do?

1. Examine your office practices to be sure pediatric well visits are prioritized in scheduling and a recall system is in place for children due for visits or those who miss scheduled well-child visits.

2. Use pediatric health maintenance codes whenever possible: 99381-99385 for new patients and 99391-99395 for established patients.

3. Ensure a process exists in your office for converting a visit for an acute problem into a health maintenance visit.

We strongly urge all offices caring for children to review their own data and office practices now, so changes that increase the rate of well-child visits can be made this year. This is especially important for your current patients currently under 1 year of age.

If you have any questions about the pediatric health maintenance visits or any other measure in the PCP QIP, reach out to us at PCPQIP@partnershiphp.org.
The Department of Health Care Services (DHCS) has released the new Managed Care Accountability Set (MCAS) aimed at demonstrating the provision of quality care and services for managed care plans. These measures have been expanded to include CMS Adult and Child Core Set and measures focused on well care for infants, children and adolescents.

Partnership HealthPlan of California’s (PHC) Quality and Performance Improvement team is here to help providers with the following tools:

- **Advanced Access Webinar Series** – This series covers resources for improvement and tactics for reducing appointment wait times and pertinent aims and measures. We encourage sign-ups for the entire series, but you can register for separate webinars. Visit PHC’s website at [http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx](http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx)

- **HEDIS® Measures** – You can find information on the HEDIS process, scheduled webinars as well as the Medi-Cal HEDIS annual performance on this PHC webpage, [http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx#](http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx#)

- **Quality Improvement Programs (QIPs)** – To learn more about our QIPs for PCPs, Hospitals, Long Term Care facilities, Palliative Care providers and Perinatal Care providers, please visit [http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Improvement-Programs.aspx](http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Improvement-Programs.aspx)

- **Partnership Quality Dashboard (PQD)** – PQD is an online platform that integrates many sources of quality performance data to enable PCPs to prioritize, inform and evaluate quality improvement efforts. To access the PQD dashboard through eReports contact pqd@partnershiphp.org.

The QI Team is here to help you, so if you have any questions regarding quality and performance improvement, please contact QIOutreach@partnershiphp.org.

*HEDIS® is a registered trademark of the National Committee on Quality Assurance (NCQA)*
### Asthma Medication Ratio (AMR)

**What is it?** The quality of asthma care is measured over patients 5-64 years of age who have persistent asthma.

The goal is to demonstrate a dispensing history of asthma medications that reflects consistent use of controller medications at a higher rate than rescue medications.

**Why is it important?** Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs (i.e. hospitalizations, emergency room visits, missed work and school days).

**Why is it hard?** This measure is challenging because it is highly dependent on how and when patients fill prescribed controllers and rescue inhalers. Patients often FORGET to use controller and rely heavily on rescue inhalers as allergies, wildfire smoke, and upper respiratory infections produce more symptoms.

**Why come to PAG?** Come learn best practices to help patients achieve the best outcomes under this measure!

**Detailed Description of Measure**

HEDIS Rate is defined as:

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Simply put:

\[
\frac{\text{Units of Controller Medications}}{\text{Units of Total Asthma Medications}} = 0.50
\]

Example: Member has 1-month supply of asthma medications including a prescription for 5 refills of controller meds and 5 refills of rescue meds. Claims data shows within 6 months the control meds were filled 2x and rescue meds filled 6x thus the AMR is \(2/(2+6) = 0.25\) so the member does not meet the measure.

**Importance:** Medications for asthma are categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-reliever medications used to treat acute symptoms and exacerbations. Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs.

**Exclusions:** Members who had diagnoses of emphysema, COPD, Obstructive Chronic Bronchitis, Chronic Respiratory Conditions, Cystic Fibrosis, and Acute Respiratory Failure. Members who had no asthma meds dispensed in measurement year and members in hospice.
**Breast Cancer Screening (BCS)**

- **What is it?** The use of imaging to detect early breast cancer in women is a key quality indicator of preventive healthcare in women. It is measured over women 50-74 years of age.
- The goal is to demonstrate women in this age range are completing mammograms consistently within a rolling 2-year time frame.
- **Why is it important?** Mammograms are the best method to detect early breast cancer, before it is big enough to feel or cause symptoms and is easier to treat. Detecting early breast cancer via mammography can provide women with a greater range of treatment options, such as less aggressive surgery, less toxic chemotherapy or the option to forego chemotherapy. Mammography can also reduce the risk of dying from breast cancer by 20 percent. The U.S. Preventive Services Task Force (USPSTF) and the American College of Physicians recommend that women ages 50–74 should have biennial (every two years) screening.
- **Why is it hard?** Women often do not prioritize personal preventive care and some even refuse to complete this screening for personal reasons (i.e. fear of results, discomfort, etc.) Access to local imaging providers can be limited, especially in more rural parts of the PHC service region. There is often lacking consistency in referral practices between PCPs and imaging providers creating delays/missed opportunities.
- **Why come to PAG?** PHC will share benefit details to help providers guide women in completing this screening. And, we’ll share a successful intervention completed by a Northern Region PCP and local imaging provider to simplify mammogram scheduling!

**HEDIS Rate is defined as:**
The percentage of women 50-74 years of age who had at least 1 mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement (calendar) year through December 31 of the measurement year.

Because the measure does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) can be used to demonstrate the patient meets the measure.

Some exclusions apply including: evidence of bilateral mastectomy, instances of unilateral mastectomy, and members in hospice care.

**PCPs** – family practice, internal medicine

**OB/Gyns**

**Imaging Providers** – including those embedded in hospitals and stand alones
| Well Child Visits (W34, W15, AWC) | **What is it?** In March 2019, a scathing report entitled: “Millions of Children in Medi-Cal Not Receiving Preventive Health Services” was released by the California State Auditor. As a result, DHCS is requiring major changes to well child visit measures health plans report each year, effective back to January 2019.  
**The goal of expanding well child visit measures is to address large gaps in pediatric well-visits amongst the Medi-Cal population. Specifically, we look to achieve the following:**  
- 6 well-child visits before a baby turns 15 months of age  
- Annual well-child visits for children ages 3-6 years of age  
- Annual adolescent well visits for members ages 12-21 years of age  
**Why is it important?** These well-children visit measures reflect recommendations of the American Academy of Family Physicians and the American Academy of Pediatrics. Closing the gap on well-child visits will also benefit immunization rates, which are very low across the PHC Northern Region.  
**Why is it hard?** Access has been an ongoing challenge, especially in the more rural regions of PHC’s service area. Confusion over CHDP minimum intervals applicability is a barrier to timely scheduling of visits relative to the measures. Vaccine hesitancy amongst some members may also be influencing their engagement in completing timely well–child visits.  
**Why come to PAG?** PHC will share best practices from outreach to scheduling to billing in an effort to effect change across multiple drivers! |
Updated Information:

Partnership HealthPlan of California’s (PHC) contract with the State of California’s Department of Health Care Services (DHCS) requires PHC members be assigned to a primary care provider (PCP) and/or a local medical home. PHC members with Native American status will continue to be like special members, with no referral authorization form (RAF) required for services, but will be assigned to a PCP/medical home.

Important Information:

- Beginning September 1, 2019, Native American Indian members will be assigned to a primary care provider (PCP)/medical home, but will continue to be like a special member – no referral authorization form (RAF) required.
- All Native American Indian members can choose a NAIHC or a PHC primary care provider with an “Accepting New Patients” status as their PCP.
- If members do not choose a PCP/medical home, one will be assigned based on claims data if available.
- Native American Indians may go to any NAIHC or specialist for services without a RAF.
- Providers will see an indicator on the Provider Portal eligibility screen, which will be located under the CCS indicator. It will display AI – Yes, no RAF required or will display no, if not applicable to member.

If a PHC member has questions regarding assignment or eligibility, they can call Member Services at (800) 863-4155, option 2. For provider questions, please contact your Provider Relations Representative.
## Northern Region Provider Relations Department Schedule of Events

### October 2019

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<tr>
<th>Date</th>
<th>Topic</th>
<th>Provider/Event</th>
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<tbody>
<tr>
<td>10/08/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Provider Networking &amp; Education</td>
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<tr>
<td>10/09/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Provider Networking &amp; Education</td>
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<td>10/22/19</td>
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<td>Provider Networking &amp; Education</td>
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<tr>
<td>10/24/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Provider Networking &amp; Education</td>
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### November 2019

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<tr>
<td>11/15/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Provider Advisory Committee</td>
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<tr>
<td>11/27/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Thanksgiving holiday</td>
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<td>11/28/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
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<td>12/10/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Redding Referral Roundtable</td>
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<tr>
<td>12/12/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>Eureka Referral Roundtable</td>
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<tr>
<td>12/24/19</td>
<td>TOPIC-Grievance/Member Outreach</td>
<td>PHC Office Closed holiday</td>
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<tr>
<td>12/25/19</td>
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