PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator I, Quality Improvement
DATE: May 10, 2024
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines. Meeting locations (and call-in information for PHC staff only) are below and also listed on the agenda. Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Date: Wednesday, May 15, 2024
Meeting Time: 7:30 – 8:55 a.m.
Meeting Locations: Partnership HealthPlan of California

- **4665 Business Center Drive, Fairfield, CA 94534 |** Napa/Solano Conference Room
- **2525 Airpark Drive, Redding, CA 96002 |** Trinity Alps Conference Room
- **495 Tesconi Circle, Santa Rosa, CA 95401 |** Santa Rosa Huddle Room

Chapa-de Indian Health: 11670 Atwood Road, Auburn, CA 95603
Open Door Community Health Center, 3770 Janes Road, Arcata, CA 95519

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
PHC Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx https://partnershiphp.webex.com/meet/quac | 809114256 (Note: If you need assistance please contact IT a minimum of one (1) day prior to the meeting so that they can provide instructions and testing.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Manager, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Administration
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Associate Medical Director
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director, Southwest
Leung, Stan, PharmD., Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, North
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Bjork, Sonja, JD, Chief Executive Officer
Booth, Garnet, Manager of PR Representatives (NR)
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, Quality Improvement
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Escobar, Nicole, Senior Manager of Behavioral Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Manager of Performance Improvement, QI (SR)
Harrell, Bria, Configuration Specialist, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Manager, Northwest
Matthews, R. Douglas, MD, Regional Medical Director, East
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Nakatani, Stephanie, Manager of Provider Relations Representatives
O'Leary, Hannah, Manager of Population Health, Population Health
Quichocho, Sue, Manager of Quality Improvement, QI
Santos, Rose, RN, BSN, Sprvsr, Member Safety-Quality Investigations
Scuri, Lynn, MPH, Regional Director, Southwest
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, East
Veneracion, Bianca, Supervisor of UM Strategies, UM
Vij, Namita, Sr. Provider Education Specialist, Provider Relations

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: May 15, 2024 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room

PHC Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Other Locations:
Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603
Open Door Community Health Center, 3770 Janes Road, Arcata, 95519

PHC Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape record of this meeting, made by or at the direction of PHC, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Approval/Acceptance of Minutes**			
1	*Approval of* Quality/Utilization Advisory Committee (Q/UAC) Minutes of April 17, 2024	Robert Moore, MD	7:30	5 – 14
2	*Acknowledgment and acceptance of* • Internal Quality Improvement (IQI) Committee Meeting Minutes of April 9, 2024 • Jan. 25, 2024 Substance Use Internal Quality Committee (SUIQI) *draft* Minutes			15 – 54
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:34	55 – 68
2	HealthPlan Update	Robert Moore, MD	7:38	--
III.	**Old Business –** *returning from March 20; see Synopsis of Changes, pp. 69*			
	MCQG1015 – Pediatric Preventive Health Guidelines	Mark Netherda, MD	7:42	69 – 78
IV.	**New Business – Consent Calendar Policies**			
	Consent Calendar	All	7:45	79
	Quality Improvement			
	MCQP1021 – Initial Health Appointment			81 – 89
	MCQP1047 – Advance Directives			90 – 92
	MCQP1052 – Physical Accessibility Review Survey SR Part C			93 – 139
	MPQP1055 – Provider Preventable Condition (PPC) Reporting			140 – 144
	MPXG5003 – Major Depression in Adults Clinical Practice Guidelines			145 – 149
	Care Coordination			
	MCCP2025 – Pediatric Quality Committee Policy			151 – 153
	MCCP2026 – Diabetes Prevention Program			154 – 157

	Item	Lead	Time	Page #
	Utilization Management			
	MCUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults			159 – 162
	MCUG3134 – Hospital Bed / Specialty Mattress Guidelines			163 – 167
	MCUP3136 – Fecal Microbiota Transplant (FMT)			168 – 170
	MCUP3144 – Residential Substance Use Disorder Treatment Authorization			171 – 175
	Provider Relations			
	MPNET100 – Access Standards and Monitoring			177 – 188
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			189 – 201
	Quality Improvement			
	MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	Rachel Newman, RN	7:48	203 – 372
	MPQP1016 – Potential Quality Issue Investigation and Resolution	Mark Netherda, MD	7:51	373 – 383
	Care Coordination			
	MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Shannon Boyle, RN	7:54	384 – 390
	MCCP2034 – Transitional Care Services (TCS) – **NEW POLICY**		7:57	391 – 401
	MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities		8:00	403 – 410
	Utilization Management			
	MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	Tony Hightower, CPhT	8:03	411 – 423
	MCUP3041 – Treatment Authorization Request (TAR) Review Process		8:06	425 – 444
	MCUP3114 – Physical, Occupational and Speech Therapies		8:09	445 – 452
	MCUP3028 – Mental Health Services	Jeff Devido, MD / Mark Bontrager	8:12	453 – 480
	MCUP3101 – Screening and Treatment for Substance Use Disorders *revised Attachment A is now a screening tool grid: clean copy starts on p. 505*		8:15	481 – 509
VI.	**Presentations**			
1	Continuity and Coordination between Medical Care and Behavioral Healthcare	Nicole Escobar	8:18	511 – 532
2	Behavioral Health Overview	Jeff Devido, MD & Mark Bontrager	8:28	533 – 548
3	Inequity Analysis of HEDIS® / PCP QIP	Mohamed Jalloh, Pharm.D	8:38	549 – 572
VII. FYI	QI Initiative: Expanded Mobile Mammography Program – *direct questions to Areli Carrillo*			573 – 593
	Updated 2024 QI Committee Presentations Calendar – *direct questions to Leslie Erickson*			595
	Adjournment scheduled for 8:55 a.m. – Q/UAC next meets 7:30 a.m. Wednesday, June 19, 2024			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, April 17, 2024 / 7:32 a.m. – 8:42 a.m. Napa/Solano Room, 1st Floor

Q/UAC has now returned to in-person meetings governed by Brown Act requirements following the Feb. 28, 2023 lifting of California's Public Health Emergency.

Voting Members Present	Brandy Lane, PHC Consumer Member	Michael Strain, PHC Consumer Member
Sara Choudhry, MD	Brian Montenegro, MD	Chris Swales, MD
Steven Gwiazdowski, MD, FAAP	Meagan Mulligan, FNP-BC	Randolph Thomas, MD
Emma Hackett, MD, FACOG	John Murphy, MD	Jennifer Wilson, MD
Voting Members Absent: Robert Quon, MD, FACP		

Partnership *Ex-Officio* Members Present:	Leung, Stan, Pharm.D, Director of Pharmacy Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Cox, Bradley, DO, Associate Medical Director	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Frankovich, Terry, MD, Associate Medical Director	Ribordy, Jeff, MD, Northern Regional Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination	Ruffin, DeLorean, DrPH, Director of Population Health
Glickstein, Mark, MD, Associate Medical Director	Scuri, Lynn, MPH, Regional Director (Southwest)
Hightower, Tony, CPhT, Associate Director, UM Regulations	Spiller, Bettina, MD, Associate Medical Director
Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Thornton, Aaron, MD, Associate Medical Director
Katz, Dave, MD, Associate Medical Director	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Kubota, Marshall, MD, Regional Medical Director (Southwest)	Watkins, Kory, MBA-HM, Director, Grievance and Appeals
Partnership *Ex-Officio* Members Absent:	Guillory, Ledra, Senior Manager of Provider Relations Representatives
Bontrager, Mark, Sr. Director of Behavioral Health, Administration	Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Cotter, James, MD, Associate Medical Director	Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Devido, Jeff, MD, Behavioral Health Clinical Director	Kerlin, Mary, Senior Director of Provider Relations
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Randhawa, Manleen, Senior Health Educator, Population Health
Guests:	Devan, James, Manager of Performance Improvement (NR)
Armstead, Jay, Program Manager II, QI (NCQA Team)	Erickson, Leslie, Program Coordinator I, QI (scribe)
Booth, Garnet, Manager of Provider Relations Representatives, PR	Garcia-Hernandez, Margarita, Director of Health Analytics
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Matthews, Doug, MD, Regional Medical Director (East)
Brown, Isaac, Director of Quality Management, QI	McCune, Amy, Manager of Quality Incentive Programs, QI
Brunkal, Monika, RPh, Assoc. Director of Population Health	O'Leary, Hannah, Senior Health Educator, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management	Rodriguez, Cindy, Project Coordinator II, Member Safety – Quality Investigations

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Approval of Minutes	Chair Robert Moore, MD, called the meeting to order at 7:32 a.m. The March 20, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft minutes of the* • Internal Quality Improvement (IQI) Committee Meeting Minutes of March 12, 2024 • Feb. 20, 2024 Quality Improvement Health Equity Committee (QIHEC) • Feb. 29, 2024 Member Grievance Review Committee (MGRC) Dr. Moore welcomed two new Partnership employees who are now *ex-officio* members of this committee: • Kermit Jones, MD, JD, Partnership's new Medical Director for Medicare Services, will lead our D-SNP (Dual-eligible Special Needs Plan) preparatory efforts for Jan. 1, 2026 go-live of our new Medicare line of business. Dr. Jones is a board-certified internal medicine physician who once worked at Kaiser and as a health policy advisor at the Department of Health and Human Services. He holds a juris doctorate. • DeLorean Ruffin, DrPH, is the new Director of Population Health Management. She is experienced in the community health sector of Federally Qualified Health Centers (FQHCs) and has a background in clinical research and health education.	Unanimous Approval of Q/UAC Minutes: Steven Gwiazdowski, MD Second: Meagan Mulligan, FNP Unanimous Acceptance of other Minutes: Steven Gwiazdowski, MD Second: John Murphy, MD
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Senior Director of Quality & Performance Improvement*	• We are near to final scoring of and payment on the Measurement Year 2023 Primary Care Provider Quality Improvement Program (PCP QIP). A provider webinar May 8 will launch the MY2024 Partnership Quality Dashboard. Our new core claims system launches this summer. • A new State-mandated collaboration between the Department of Health Care Services (DHCS) and the Institute for Healthcare Improvement (IHI) is running March 2024 through March 2025, focusing on five interventions around child health equity. Partnership's Health Equity Officer and personnel from the CMO's Office, QI, and Pop Health are participating in the effort, which pairs nicely with our quality measure score/measure improvement efforts underway for the pediatric population of focus. Partnership has also collaborated with a rural provider in family practice who serves a varying member population in which we have identified some disparities that we can work on up in Del Norte County. • We are in our second round of offering blood lead point-of-care screening devices to providers to help our members get this care completed before they leave primary care practice sites. We have distributed or reimbursed providers for their purchases of 35 devices. We are hopeful that will improve our rates, particularly in areas where we have had low performance in many of our rural counties. • Our internal presentations at various committees on the Cologuard bulk ordering process has sparked interest from several provider organizations. We currently have 22 POs engaged in varying levels from just starting the process with Partnership and Exact Sciences through being in the midst of a second participation cycle. • Our Performance Improvement Academy on May 1 will offer its first on-site East Region ABCs of Quality Improvement in Chico. • We continue to focus on improving our member experience and our Consumer Assessment of Healthcare	For information only: no formal action required. There were no questions for Nancy. *Meeting postscript:* Staff was informed via email April 30 of the following dates: • 2024 PQD launch: **April 30** • 2024 PQD Kick-Off Webinar: **Wed., May 8** • 2024 Disparity Dashboard launch: **Tues., May 7**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Providers and Systems (CAHPS) scores. We are working with our Northern Region Consortia, the Health Alliance of Northern California, the North Coast Clinics Network and our FHQC partners on how to incorporate or integrate a patient experience component to QI projects. Providers within and without the Northern Region are welcome to enroll in the May 7 webinar. • Work continues to assure ongoing preparation for our next National Committee for Quality Assurance (NCQA) renewal survey. Several teams are engaged in quarterly file reviews. We have a file review audit coming up in May, in addition to ongoing focus in our Health Equity Accreditation. I am happy about our ongoing progress to demonstrate compliance to all of those standards. We are currently sitting at a compliance rate of just over 55 percent. We need to achieve at least 80 percent of applicable element points to obtain this accreditation. We're on track to have a mock HEA survey in August and our first HEA survey in June 2025. Some departments are further along than others because we are building infrastructure around data capture across a variety of demographics and ways to understand where disparities may exist and understand from our members how they represent themselves. These are all new elements and system changes that are underway.	
2. HealthPlan Update *Robert Moore, MD, Chief Medical Officer*	• We are in the midst of our annual regional Medical Directors meetings. Meetings yet to occur are April 19 in Fairfield, April 26 in Eureka, and May 3 in Oroville. Clinician and non-clinician leaders are invited to attend. • A few weeks ago, Partnership met with public health officers from about one-half of our 24 counties. o We shared our comprehensive collection of county-level data to assist the officers with their strategic and public planning health processes. (This data is also being shared at our regional Medical Directors meetings.) We will post this data on our website, along with a form that a county health officer may sign off on to request changes in future years. o There is interest among the public health officers to do a collective maternal/child health planning process. Currently, each county is responsible to do its own plan, perhaps once every five years. The main thing counties now run is the Women, Infants and Children (WIC) program. First Five has taken on the parenting aspects. All the rest of the delivery services, however, now fall under Medi-Cal managed care. It behooves us to come up with a more regional approach, not least because the Comprehensive Perinatal Services Program (CPSP) program has been mostly phased out of the counties. Partnership will be working on this in the next year. o Public health officers are now embracing receiving Partnership data on who has or has not completed latent tuberculosis treatment so that they might better interface with CalREDIE (California Reportable Disease Information Exchange that the California Department of Public Health has implemented for electronic disease reporting and surveillance) and perform case management. o Dr. Tomás Aragón, the director of California Public Health, made some remarks: his main theme was focusing on the public health aspects of substance use disorder, specifically, the consequences of alcohol abuse and, on a more micro public health level, the misuse of the labeling of hemp to introduce high potency marijuana derivatives into foods in an unregulated setting. • Partnership is attempting to get key stakeholders together to address ambulance use for hospital-to-hospital transportation.	For information only: no formal action required. Dr. Moore concluded his Dignity update by thanking Dignity provider Chris Swales, MD, for his continued participation as a voting Q/UAC member. A conversation about how many Partnership members are affected, how FFS Medi-Cal rates compare, and capitation or direct member status ensued between Dr. Moore, Dr. Swales, Brian Montenegro, MD, and John Murphy, MD.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Our Partnership contract with Common Spirit, the parent organization for Dignity, did end the last day of March. For the first time in Partnership history, we were not able to come to an agreement, and we are in the process of dealing with the consequences of that. Clinicians should be aware that both sides really do want to have an agreement, although they remain extremely far apart on the financial rates. (Partnership has publically stated that the rates being asked for as so high that it would put the Health Plan at risk of survival.) o Unlike commercial contract terminations, since Dignity is contracted with Medi-Cal, the hospitals and clinicians will be paid for any services provided to our members. On a commercial termination, the member suddenly becomes responsible if they go to an out-of-network provider. Not the case for Medi-Cal. Emergency care and inpatient care, anything that is provided through Dignity, will be paid through fee-for-service. o Certain conditions are eligible by statute for continuity of care. That includes zero to three-year-olds, pregnant patients who have established care with a Dignity provider, women who have given birth in the last three months, cancer under chemotherapy, dialysis, approved services with a Treatment Authorization Request (TAR) on file and on-going specialty care that is needed. ▪ Most continuity of care is for non-Dignity primary care patients, for patients who are seen by CommuniCare in our Southern Region or by some of the tribal health, Shasta Community Health is a big one up north. Only a small percentage are Dignity patients, and I suspect most of those are zero to three-year-olds and pregnant patients. ▪ As of April 1, all Dignity members this month are direct members, which means they can go to any provider who is willing to see them. In the absence of a contract, we pay fee for service Medi-Cal rates for any bills we get for direct members. No patient is prohibited from going to a Dignity provider. We want to stress that we value our Dignity colleagues and physicians. Trying to find a way to minimize the pain for everyone involved is a key principle. Several PCP organizations have been reaching out to their Dignity colleagues, trying to figure out how best to take care of patients, and I really appreciate that effort to put the patients first. If any patients get stuck in denial of care, we encourage them to reach out to our Care Coordination department. o All medical records for Dignity's patients are in SacValley MedShare, which providers may access online. There is no need to look at paper or send a fax request for records.	
III. Old Business – None		
IV. New Business – Consent (Committee Members as Applicable)		
Consent Calendar	2024-25 Hospital QIP (HQIP) Proposed Measure Set – *direct questions to Troy Foster* 2024-25 Perinatal QIP (PQIP) Proposed Measure Set – *direct questions to Deanna Foster* ***Health Services Policies*** <u>Quality Improvement</u> MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus	Motion to approve consent calendar without MCUP3121: Brian Montenegro, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Motion to approve MCUP3121

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Utilization Management MCUP3014 – Emergency Services MCUP3047 – Tuberculosis Related Treatment MCUP3051 – Long Term Care SSI Regulation (previously Long Term Care Admissions) MCUP3103 – Coordination of Care for Members in Foster Care MCUP3121 – Neonatal Circumcision – ***pulled from consent*** MCUP3146 – Street Medicine MPUG3031 – Nebulizer Guidelines MPUP3026 – Inter-Rater Reliability Policy MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump Dr. Gwiazdowski **pulled MCUP3121 Neonatal Circumcision from consent** to question the proposed deletion of gender-specific nouns and pronouns, saying such deletions may open "Pandora's box," calling into question whether Partnership endorses female circumcision. (Partnership does not.) After some discussion, **Q/UAC agreed to substitute "penile circumcision" for "male circumcision" where appropriate.**	as amended: Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: May 8 Physician's Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions	**Section VI.B.6:** The paragraph on Extensions was deleted as DHCS APL 21-011 *Revised* calls for all appeals to be resolved within 30 days. **Section VII.** Existing References were updated for dates and hyperlinks **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." **Attachments B & C are updated with** Redding's Airpark address. Tony went through the synopsis. Removal of the paragraph on extensions was a balance between the requirements dictated by NCQA and DHCS where we will abide by the more strict standard, which is DHCS's standards that do not allow for an extension of appeals requests. There were no questions.	Motion to approve as presented: Jennifer Wilson, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: May 8 Physician's Advisory Committee (PAC)
MPUD3001 – Utilization Management Program Description	Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 3:** A Program Staff description was added for Medical Director, MD/ DO and for Medical Director of Medicare Services – MD/DO. **Pages 3 and 4:** Assigned responsibilities for the Medical Director of Quality, the Behavioral Health Clinical Director, and the Pharmacy Services Director were all updated to include serving on the Quality Improvement and Health Equity Committee (QIHEC). **Page 5:** The Program Staff description for the Senior Director of Health Services was superseded by new description and responsibilities for the Chief Health Services Officer. This title change was reflected throughout the policy. **Page 5:** Assigned responsibilities for the Director of Health Equity were updated to reflect Co-Chairing the Population Needs Assessment (PNA) committee.	Motion to approve as presented: Steven Gwiazdowski, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: May 8 Physician's Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Page 6: Assigned responsibilities for the Director of Utilization Management were updated to clarify participation in the UM Program and audits of health services programs. **Page 7:** Assigned responsibilities for the Associate Director of Utilization Management were updated to include coordination of activities with Population Health and UM reporting duties. **Page 7:** A Program Staff description was added for Associate Director of Enhanced Care Management Operations. **Page 8:** Assigned responsibilities for the Associate Director of Utilization Management Regulations were updated for report structure and committee presentation responsibilities. **Page 9:** Program Staff descriptions were added for Manager of Long Term Support Services and Clinical Team Manager, CalAIM Justice Liaison, ECM Program. **Page 10:** Program Staff description was added for Senior Programmer Analyst. **Pages 12 and 13:** Program Staff descriptions were added for Supervisor of Utilization Management Strategies and Policy Analyst. **Pages 13 and 14:** Program Staff descriptions for Program Manager I and II as well as Project Coordinator I were modified to apply to both the CalAIM Community Supports or Enhanced Care Management teams. **Page 14:** Program Staff description for Project Coordinator I – Regulatory/ Delegation was deleted as the responsibilities of that position have been absorbed into the Program Manager I – Regulatory/ Delegation position. **Page 14:** Program Staff descriptions were added for Health Services Analyst I and Executive Assistant to the Chief Health Services Officer. **Page 15:** Program Staff descriptions for Health Services Administrative Assistant I and II in UM were clarified. **Pages 15 and 16:** Program Staff descriptions for Coordinator I and II were modified to apply to UM and CalAIM teams. **Page 17:** The Provider Advisory Group (PAG) was deleted from the list of Committees as it has been disbanded. **Page 18:** The description of the Consumer Advisory Committee (CAC) was updated to reflect that there is now one committee for all regions and a new objective of the committee will be to provide feedback on health equity initiatives. **Pages 21-22:** The Mental Health services section was updated to remove references to Kaiser and Beacon. **Page 22:** The SUD treatment services section was clarified for residential treatment and Care Coordination services. **Page 23:** The BHT section was updated to specify that PHC will provide “medically necessary” BHT services “covered under Medicaid” as per new language in APL 23-010 Revised. **Page 25:** The Referral Management section was updated to specify PHC’s Online Services Portal for submission and to clarify that requests for out-of-network referrals are reviewed to determine if services can be provided within PHC’s network. Also on this page, the QUAC committee was added as one of the committees where practitioners with clinical expertise advise PHC on the development and/or adaptation of UM criteria.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Page 29: The phone number for addressing post-stabilization care and inter-facility transfer needs 24/7 was updated. This number was changed due to its prior similarity to our Transportation phone number, which often resulted in member misdials. **Pages 31 - 33:** Much of the Appeals section was deleted from this documents because it is all stated in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions. A summary paragraph remains which directs the reader to the other policy. **Pages 37:** Dates and hyperlinks were updated in for existing References. Tony went through the synopsis, touching only on the major changes to this document. The bulk of the work had to do with updating staff structure and physician descriptions within that staff structure, including Medical Director, Regional Medical Director, Associate Medical Director, Medical Director for Quality, and Medical Director of Medicare Services. Updating the position of Senior Director of Health Services to Chief Health Services Officer was a major change in the UM leadership structure. Within Health Services, there was a major migration of an entire team: our Enhanced Care Management team migrated from Care Coordination to UM Strategies (CalAIM). The entire ECM team now reports to the Director of Utilization Management Strategies. Within UM operations and regulations, we added a manager of long-term support services, a senior program analyst job description and a policy analyst, as well as a health service analyst to work with our data. We made changes to remove references to our contractual arrangement with Kaiser. In the Appeals section, we removed a bulk of the language involving our appeals processes because, as reviewed with our NCQA consultant, we found the language regarding our appeals process duplicative to the language that already exists in MCUP3037 - Appeals of Utilization Management / Pharmacy Decisions. There were no questions for Tony.	
VI. Presentations		
CY 2023 UM Program Evaluation – NCQA UM Standard 1 Element B and Supplemental UM & Pharmacy TAR Report *Tony Hightower, CPhT*	UM annually evaluates a consistent set of areas within its program structure to ensure that the program continues to be aligned with obligations for NCQA accreditation and DHCS regulatory compliance. UM reviews its staffing ratios as well as its TAR-to-staff ratios to ensure staffing is appropriate to conduct the reviews for which UM is responsible. UM reviews its program scope, which includes review/maintenance of policies in accordance with DHCS and NCQA requirements. UM evaluates the timeliness of TAR processing and the consistency of applying medical necessity criteria to TAR reviews; this is accomplished in the monthly and quarterly Inter-Rater Reliability process. Appropriate level of care is assessed via continual over/under utilization monitoring. Senior physician participation within the UM program via medical reviews and participation within our committees, including PAC, Q/UAC and Pharmacy & Therapeutics (P&T), is also evaluated. Quorum was met in each 2023 meeting of each of these advisory committees. For clinical staffing, a 20 percent threshold has been applied in measuring ratios of UM staff nurses and pharmacists to medical directors. This threshold was met in CY 2023. UM's overall CY 2023 TAR volume was 246,234, which represents a 10.74% increase year-over-year from 2022. A major contribution to this uptick was the March and April 2022 system disruption Partnership experienced. Increases in membership also drove the volume increase.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The Pharmacy department processed 7,502 TARs in CY 2023, a 3.21% decrease from 2022 driven by the continuing department scale back as the State via Medi-Cal Rx has taken on more TAR processing responsibilities. Partnership's UM TAR staffing ratios are reviewed on a month-over-month basis to evaluate staffing fluctuations. For UM, the skilled nursing facilities (SNF), inpatient, and long-term care (LTC) groups did exceed thresholds for the months between July and October 2023. This was largely driven by staff turnover and staff's leaves of absence. For Pharmacy, the TAR to Pharmacist ratio exceeded thresholds in July 2023 due to a reduction in pharmacist staffing, again, largely resulting from the transition of the Pharmacy benefit to Medi-Cal Rx. UM's timeliness goals (90% threshold) for urgent, concurrent, and urgent pre-service requests were met. UM did not meet its non-urgent pre-service and post-service request timeliness goals. This was driven by increases in volume and some restructuring that occurred this year. Some of the more veteran staff left the department, leading to some historical knowledge loss. This has been addressed by hiring permanent staff and engaging with temporary staff to address specific gaps with teams, as well as by adjusting approaches to workflows. Where historically UM focused on siloed teams doing specific reviews, UM now cross-trains staff across different review types. Pharmacy's timeliness goal was met for non-urgent pre-service and post-service requests and was not met for urgent pre-service requests. A similar issue occurred with Pharmacy as to turnover and loss of seasoned staff. Pharmacy has worked on workflows. For Inter-Rater Reliability (IRR), UM managed to exceed its 90% concurrence rate for all reviewer types. We are consistent in our application of criteria in our reviews. Level of care/ criteria evaluation through over/under utilization is performed by various groups in Partnership, not just within the UM team. Some of the areas evaluated include, within our QI department, HEDIS® scores via our IQI and Q/UAC committees, Site Review process, and evaluation through our Access/Availability Grand Analysis. Partnership's also maintains a cross-departmental Over/Under Utilization Workgroup, the work of which is summarized in this evaluation by Dr. Moore. Additional analysis and remediation actions for the detection of over/under utilization are accomplished via the QIP programs for both hospitals and providers, as well as through UM review. Annually, UM evaluates its major criteria set, InterQual®. This evaluation will be presented to QI committees in June. UM also leverages additional criteria, including Medi-Cal guidelines, Medicare criteria etc. Pharmacy criteria and pharmaceutical drug class are reviewed in collaboration with internal and external stakeholders during our P&T and PAC committees. Partnership's CMO and Medical Directors participate in the review of our policies via committee as well as participating in clinical rounds and the daily UM review and medical decision-making process. Network PCPs and specialists participate in an annual survey to gauge overall satisfaction with our UM and Pharmacy processes. This year, we had three questions that did not meet our 90% threshold amongst our specialists. The corrective action is that UM is working with Provider Relations on beefing up our provider education for accessing our information online as well as training UM staff on medical necessity denials and what information should be included in denial letters. UM evaluates Partnership's member experience via the Grievance and Appeals PULSE report. The good news is that in CY 2023 there was an overall decrease from CY 2022 in the number of grievances received related to UM processes. To conclude, Partnership's UM Program functions effectively; we have a solid program structure, a comprehensive policy library and robust guidance and support of senior-level physicians and internal and external committees. No significant changes will be required for the 2024 UM Program.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Gwiazdowski said he understood the underpinnings around metrics and audits but said he wondered how initial ratios are determined. Is it via NCQA? DHCS? Internally driven? Tony replied that the structure of this evaluation as a whole is fairly strictly dictated by NCQA. This is good because it sets us up for success with DHCS, which may not require these ratios. Furthermore, having these ratios and standards in place will help as we take on the Medicare D-SNP line of business because the Centers for Medicare and Medicaid Services (CMS) defers to NCQA for these types of measures. Stan Leung, Pharm.D, clarified that NCQA is not proscriptive in terms of a specific number or ratio. The ratios are something Partnership designed to evaluate its processes and to determine that if fluctuations occur, timeliness and other metrics are not adversely affected. Dr. Thomas pointed out that "rapid testing for strep" is misstated under HEDIS/NCQA guidelines in the evaluation for potential under-utilization. After some discussion among doctors Moore, Netherda, and Montenegro, Q/UAC directed Tony to delete the word "rapid." Dr. Murphy motioned and Dr. Gwiazdowski seconded that the UM Evaluation is accepted as amended for Dr. Thomas's suggestion and after Tony does a last search to mitigate for any gender pronouns. Q/UAC unanimously concurred.	
Population Needs Assessment CY 2023 *Hannah O'Leary, MPH, CHES, Manager of Population Health*	The PNA is an opportunity for Partnership to assess the needs of our members, pulling from different data sources. It is also used to fulfill many NCQA requirements. The PNA results can be categorized into four buckets: healthcare access and quality, economic instability, neighborhood and built environment, and social/community context. 1. The PNA found that many of our counties have insufficient access to healthcare services, including primary care, dental care, specialty care, mental health, substance abuse services, and inadequate prenatal care. In 2023, hypertension and tobacco use were the most common conditions diagnosed among our adult population. Pediatric members saw high rates of anxiety, stress and trauma. Breast cancer screening rates and cervical cancer rates in our Northern Region continued to underperform. The white population continues to have some of the highest numbers of mental health visits compared to other groups. 2. Our counties continue to have low income and unemployment as well as unstable housing. The median household incomes in many of Partnership's counties is lower than California's median income. Almost all counties have lack of affordable and quality housing. Many individuals who do qualify for housing assistance are unable to find a place to rent. Homelessness continues as a constant through many of our counties. For context, the most recent homeless count for the state of California was about 181,399 persons. 3. The PNA found many of our counties lack access to healthy foods and opportunities to exercise. There are high rates of violence and unintentional injury. The risk of fire is a big concern. Partnership had 176,443 acres burned in 14 fires last year. Transportation issues continue to be challenging. 4. Many persons within Partnership's counties experience much higher rates of ACEs (adverse childhood experiences) than does the general population. To address some of this, in 2023 Partnership hired a regional lead in the new East Region and one in the Northeast. Partnership continues to build out doula and community health worker (CHW) networks. Partnership will continue to work to leverage State funds, like CalAIM, the Community Support services and Enhanced Care Management. Partnership plans to offer scholarships in 2024 to Sacramento City College's CHW certificate program to help create employment opportunities in our local communities. To support the unhoused, Partnership in early 2024 distributed a total of 6,430 backpacks with essential supplies to members in 23 of our 24 counties. That completed their PIT counts at the beginning of 2024. Population Health has created a fire and disaster reporting email inbox so various Partnership departments can support members in need in real time.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	In the beginning of 2023, Partnership collaborated with providers and community agencies to provide member education and referrals to members recently diagnosed with hypertension. Partnership also supported members living with chronic conditions by conducting telephonic outreach and offering support through Population Health's Healthy Living tool, which is a self-management tool. Some other pilot programs currently underway are the colorectal and cervical cancer screenings and are resulting in increased testing. Partnership continues to contract with Alinea Medical Imaging to bring mobile mammography services to many in our rural communities and health centers that do not have access to these services. Partnership has and will continue to strengthen relationships and collaborative efforts with tribal health providers to address disparities between our American Indian and non-American members, including working with the Better Birthing Coalition.. Partnership has performed outreach to all pregnant members and their offspring from birth through age six, offering incentives to attend well-care visits and vaccinations. These efforts are ongoing into 2024. Ongoing mail-only campaigns target our teenage population to encourage vaccination and wellness visits. Partnership is allocating dollars and staff time to collaborate with local public health officials and schools to promote vaccinations and wellness visits through school-based clinics and other strategies to promote childhood wellness care. Partnership has developed a multi-prong approach to recruitment of providers. Incentive programs are continuing to evolve and expand to recruit and retain high quality health professionals and to preserve institutional knowledge in these provider networks. Partnership will continue to participate in efforts that support members recently diagnosed with diabetes and hypertension and will continue to attend mobile mammography events. Partnership will continue to collaborate with community groups, offering education to members, particularly non-English speaking ones, about available benefits, including vision, mental health services and preventive care. Flyers are being developed. Population Health's Health Education team is working closely with Communications to create member-facing videos to help members with preventive care, vaccine safety, mental health, and women's health. In conclusion, there are multiple planned and ongoing actions to address the four buckets of need, including some improvements in our organizational structure, addressing social and environmental needs, addressing member health and wellness, access to care, health disparities, health education and cultural and linguistics. There were no questions for Hannah.	
VII. FYI	Pharmacy Operations Update – *direct any questions to the Director of Pharmacy Services, Stan Leung. Pharm.D*	
VIII. Adjournment – Before adjourning at 8:43 a.m., those meeting on-site introduced themselves to new Q/UAC *ex-officios* Dr. Jones and DeLorean. Q/UAC next meets at 7:30 a.m. Wednesday, May 15, 2024.		

Respectfully submitted by: Leslie Erickson, Program Coordinator I, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Committee Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, April 9, 2024 / 1:31 – 2:42 PM

Members Present:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, Quality Improvement
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Health Services Policy Analyst, Utilization Management
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance, Administration
Klakken, Vicki, Regional Manager – Northwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Scuri, Lynn, MPH, Regional Director – Southwest
Sharp, Tim, Regional Director – Northeast
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:

Ayala, Priscila, Associate Director of Provider Relations
Bjork, Sonja, JD, Chief Executive Officer
Davis, Wendi, Chief Operating Officer
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Kubota, Marshall, MD, Regional Medical Director – Southwest
Kerlin, Mary, Senior Director, Provider Relations
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Bikla, Dejene, Sr. Health Data Analyst II, Finance
Chebolu, Radha, Senior Health Data Analyst II, Finance
Clark, Kristen, Supervisor of Quality & Training, Member Services
Devido, Jeff, MD, Behavioral Health Clinical Director
Erickson, Leslie, Program Coordinator I, QI (scribe)
Fulgham, Coquise, RN, Manager of Utilization Management, UM
Gaul, Kristine, Manager of Performance Improvement (SR), QI
Harris, Vander, Senior Health Data Analyst I, Finance
Lee, Donna, Manager of Claims, Claims
Matthews, Doug, MD, Regional Medical Director (East)
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, Manager of Population Health
Power, Kathryn, Regional Manager, Communications
Rodekohr, Dianna, Project Manager I, Configuration
Thomas, Penny, Senior Health Data Analyst I, Finance
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Vaisenberg, Liat, Associate Director of Health Analytics, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions – None Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA called the meeting to order at 1:31 p.m. Approval of March 12, 2024 IQI Minutes *Acknowledgement and Acceptance of draft minutes of the* • Feb. 29, 2024 Member Grievance Review Committee (MGRC)	Motion to approve IQI Minutes: Mark Netherda, MD Second: Isaac Brown Motion to accept draft MGRC: Brigid Gast, RN Second: Isaac Brown
II. Old Business – None		
III. New Business (Committee Members as applicable) – Consent Calendar Policies		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Health Services Policies Quality Improvement MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus Utilization Management MCUP3014 – Emergency Services MCUP3047 – Tuberculosis Related Treatment MCUP3051 – Long Term Care SSI Regulation (previously Long Term Care Admissions) MCUP3103 – Coordination of Care for Members in Foster Care MCUP3121 – Neonatal Circumcision MCUP3146 – Street Medicine MPUG3031 – Nebulizer Guidelines MPUP3026 – Inter-Rater Reliability Policy MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump ***Member Services Policy*** MC305 – Distribution of Member Rights and Responsibilities ***Provider Relations Policies*** MPPR203 – Provider Enrollment Status Guidelines Credentialing MPCR4B – Identification of HIV/AIDS Specialists MPCR13 – Credentialing of Pain Management Specialist MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist MPCR102 – Provider Directory Accuracy MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements MPCR600 – Range of Actions to Improve Practitioner Performance MPCR602 – Reporting Actions to Authorities – ***pulled and tabled for further internal discussion*** MPCR809 – Delegation of Credentialing and Re-credentialing Activities Anna Campbell **pulled MPCR602** to ask if "licensed midwives" shouldn't be included in the list of provider types subject to the 805 Report**.** After some discussion, Dr. Moore and **IQI agreed to add licensed midwives in Section III.B.** but took no action on Isaac Brown's query whether to include them under Section VI.A.1 as well. **MPCR500** – Ongoing Monitoring and Interventions **was also added as a Related Policy.**	The Consent Calendar minus the tabled MPCR602 was approved as presented: Isaac Brown Second: Stan Leung, Pharm.D Next Steps: • Health Services policies go to the Quality/Utilization Advisory Committee (Q/UAC) April 17 and to the Physician Advisory Committee (PAC) May 8 MS's MC305 goes to the department director for signature. PR's MPPR203 goes to CEO Sonja Bjork, JD, for signature. *Meeting Postscript:* The Credentials Committee on April 10 approved all credentialing policies but for the tabled MPCR602. Medical Director for Quality Mark Netherda, MD, and Southwest Regional Medical Director Marshall Kubota, MD, together will review MPCR602 to see if other revisions are warranted before the policy is brought back to IQI.
IV. New Business – Discussion Policies		
Utilization Management: *Presenter: Tony Hightower, CPHT, Associate Director, UM Regulations*		
MCUP3037– Appeals of Utilization Management /	**Section VI.B.6:** The paragraph on Extensions was deleted as DHCS APL 21-011 *Revised* calls for all appeals to be resolved within 30 days. **Section VII.** Existing References were updated for dates and hyperlinks **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer."	Motion to **approve as presented**: Mark Netherda, MD Second: Katherine Barresi, RN Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Pharmacy Decisions	Tony remarked that the National Committee for Quality Assurance (NCQA) does grant extensions on some timeframes; however, Partnership has chosen to adapt our policies to the more restrictive DHCS All Plan Letter 21-011. Attachments B&C now reflect a pending change in office address from Redding's Avtech address to its Airpark office. There were no questions.	April 17 Q/UAC May 8 PAC
MPUD3001 – Utilization Management Program Description	Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 3:** A Program Staff description was added for Medical Director, MD/ DO and for Medical Director of Medicare Services – MD/DO. **Pages 3 and 4:** Assigned responsibilities for the Medical Director of Quality, the Behavioral Health Clinical Director, and the Pharmacy Services Director were all updated to include serving on the Quality Improvement and Health Equity Committee (QIHEC). **Page 5:** The Program Staff description for the Senior Director of Health Services was superseded by new description and responsibilities for the Chief Health Services Officer. This title change was reflected throughout the policy. **Page 5:** Assigned responsibilities for the Director of Health Equity were updated to reflect Co-Chairing the Population Needs Assessment (PNA) committee. **Page 6:** Assigned responsibilities for the Director of Utilization Management were updated to clarify participation in the UM Program and audits of health services programs. **Page 7:** Assigned responsibilities for the Associate Director of Utilization Management were updated to include coordination of activities with Population Health and UM reporting duties. **Page 7:** A Program Staff description was added for Associate Director of Enhanced Care Management Operations. **Page 8:** Assigned responsibilities for the Associate Director of Utilization Management Regulations were updated for report structure and committee presentation responsibilities. **Page 9:** Program Staff descriptions were added for Manager of Long Term Support Services and Clinical Team Manager, CalAIM Justice Liaison, ECM Program. **Page 10:** Program Staff description was added for Senior Programmer Analyst. **Pages 12 and 13:** Program Staff descriptions were added for Supervisor of Utilization Management Strategies and Policy Analyst. **Pages 13 and 14:** Program Staff descriptions for Program Manager I and II as well as Project Coordinator I were modified to apply to both the CalAIM Community Supports or Enhanced Care Management teams. **Page 14:** Program Staff description for Project Coordinator I – Regulatory/ Delegation was deleted as the responsibilities of that position have been absorbed into the Program Manager I – Regulatory/ Delegation position. **Page 14:** Program Staff descriptions were added for Health Services Analyst I and Executive Assistant to the Chief Health Services Officer. **Page 15:** Program Staff descriptions for Health Services Administrative Assistant I and II in UM were clarified. **Pages 15 and 16:** Program Staff descriptions for Coordinator I and II were modified to apply to UM and CalAIM teams. **Page 17:** The Provider Advisory Group (PAG) was deleted from the list of Committees as it has been disbanded. **Page 18:** The description of the Consumer Advisory Committee (CAC) was updated to reflect that there is now one committee for all regions and a new objective of the committee will be to provide feedback on health equity initiatives. **Pages 21-22:** The Mental Health services section was updated to remove references to Kaiser and Beacon. **Page 22:** The SUD treatment services section was clarified for residential treatment and Care Coordination services.	Motion to **approve as presented**: Stan Leung, Pharm. D Second: Katherine Barresi, RN Next Steps: April 17 Q/UAC May 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Page 23: The BHT section was updated to specify that PHC will provide "medically necessary" BHT services "covered under Medicaid" as per new language in APL 23-010 Revised. **Page 25:** The Referral Management section was updated to specify PHC's Online Services Portal for submission and to clarify that requests for out-of-network referrals are reviewed to determine if services can be provided within PHC's network. Also on this page, the QUAC committee was added as one of the committees where practitioners with clinical expertise advise PHC on the development and/or adaptation of UM criteria. **Page 29:** The phone number for addressing post-stabilization care and inter-facility transfer needs 24/7 was updated. This number was changed due to its prior similarity to our Transportation phone number which often resulted in member misdials. **Pages 31 - 33:** Much of the Appeals section was deleted from this documents because it is all stated in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions. A summary paragraph remains, which directs the reader to the other policy. **Pages 37:** Dates and hyperlinks were updated in for existing References. Tony went through the synopsis, saying staffing structure, titles and job description updates drove many changes. UM is currently onboarding a new Medical Director for Medicare. Another position has been added for long-term support services. References to Kaiser and Beacon were removed from the Mental Health section as the only delegate now is Carelon (formerly Beacon). The Appeals section is now edited to a high-level description because much of the information was duplicative of our policy MCUP3037 Appeals of Utilization Management/Pharmacy Decisions, which also appears in this packet. Tony mentioned that MCUP3037 was updated to remove a paragraph on extensions which NCQA would allow but DHCS APL 21-011 does not allow. Dr. Moore asked if Treatment Authorization Request (TAR) timeframes are affected? Tony replied No, that the timeframes for TAR processing remain the same and no changes were necessary in this policy. There were no other questions.	
V. Presentations		

1. Quality and Performance Improvement Update
 	
Nancy Steffen, Senior Director of Quality and Performance Improvement
	• The Primary Care Provider Quality Improvement Program (PCP QIP) team is presently processing Measurement Year 2023 payment and is on track to distribute by April 30.
	• Well-child visit gap lists for assigned members turning 15 months of age (W15) can be accessed via the Preventive Care Dashboard, embedded within the eReports interface, beginning in May. A kick-off webinar will occur May 8.
	• Quality Assurance Performance Improvement (QAPI) program research and meetings with a few of our long-term care partners has been completed. Next steps are to formulate a Managed Care Plan (MCP) level QAPI program for increased quality monitoring of our skilled nursing facilities, in response to DHCS' LTC benefit standardization and subsequent APL requirements.
	• DHCS, in partnership with the Institute for Healthcare Improvement (IHI), has announced a 12-month Child Health Equity Collaborative to improve completion if well-child visits for all California MCPs. Partnership will participate in this collaboration running March 2024 through March 2025 on five focused interventions.
	• Two Quality pilots are going well. Partnership
	  ○ Has purchased or reimbursed primary care providers for a total of 10 point-of-care devices to make blood lead testing more accessible to members. A second round will purchase/reimburse up to 25 devices.
	  ○ Has 22 provider organizations (POs) engaged in the Cologuard bulk ordering process. Colorectal cancer screening is not yet a Managed Care Accountability Set (MCAS) measure; however, we expect it soon will become one.
	• This fiscal year's final "ABCS of Quality Improvement" training will be held May 1 in Chico.
		Information only.
		
		There were no questions for Nancy.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

	• The "Incorporating Patient Experience in Quality Improvement Projects and Plans" webinar has been scheduled for May 7. Thank you to our Consumer Advisor Healthcare Providers and Systems (CAHPS) team for putting this forward.
	• The Equity and Practice Transformation (EPT) program work continues.
	  ○ Partnership will be receiving approximately $1.5M in Initial Planning Incentive Payment (IPIP) from DHCS by April 30.
	  ○ The Statewide Learning Collaborative (SLC) is meant to support practices awarded the Provider Directed Payment Program (PDPP) funding in the implementation of practice transformation activities. All PDPP participants are required to participate in the SLC.
	  ○ Partnership has the most (eight) tribal health participants among California's MCPs.
	  ○ Based on the funding criteria, there is a possible draw-down of $45M for Partnership's 27 contracted POs upon meeting the practice transformation activities over the program's five-year timeline ending Dec. 31, 2028.
	• Our National Committee on Quality Assurance (NCQA) team continues to do great work preparing everyone for our upcoming Health Equity and Health Plan accreditations (2025 HEA and 2026 HPA, respectively).	

2. 2024-2025 Hospital QIP Proposed Measure Set
 	
Troy Foster, Project Manager II, Quality Improvement
	Providers have the potential to earn a total of 100 points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set. The recommended 2024 measure set varies from the 2023 by the addition of three new measures and the deletion of one.
	
	• **Remove** Hepatitis B / CAIR Utilization from the Operations/Efficiency Domain because the State now requires all hospitals to record immunizations in the California Immunization Registry (CAIR).
	• **Add** "7-day Follow-up Clinical Visit" to the Risk Adjusted Domain because evidence suggests patients who have follow-up visits within seven days of discharge from hospital do not readmit as frequently as those who follow-up after the seven-day window or who do not follow-up at all. We need to collect baseline data so targets are neither too low or too high. (Unresolved questions are should our age range include pediatrics and newborns, and should stepdown to a SNF be included or excluded from numerators and denominators? Commenting on the first question, Dr. Moore noted that lack of accurate data as it relates to newborns is a major challenge.)
	• Under the Clinical Domain:
	  ○ **Add to or expand** privileges to increase the number of family physicians and midwives who are allowed to perform deliveries in hospital. This would be a two-year incremental measure.
	  ○ **Add** a measure to increase capacity for diagnostics and screening for breast cancer through the HQIP, which may include expanding the available appointment hours and hosting mobile mammography clinics. Increasing access/capacity by five percent would earn the hospital partial points; increasing by 10% or more would earn the hospital full points. We need to look at January – June 2024 data to establish a baseline for our new East Region providers. Kristine Gual noted that small hospitals would need to complete at least 25 exams. She, Nancy, and Dr. Moore agreed these POs should prioritize Partnership members whenever possible. Tiny hospitals could earn full credit by working with nearby clinics to reach the 25-exam threshold.
	
	Meeting Postscript: Troy audibled this small change from "25 exams conducted for PHC members" to "25 exams conducted and *prioritized for* PHC members" at the April 10 PAC. The PAC approved this and the other recommended changes to the 2024 measure set.	

3. 2024-2025 Perinatal QIP Proposed Measure Set	Participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers who provide quality and timely prenatal and postpartum care to PHC members have the option to earn additional financial incentives. The PQIP framework as developed with PCPs and OB/GYNs in mind, includes the following measures: 1) Timely Immunization Status - Tdap and Influenza Vaccine; 2) Timely Prenatal Care; and 3) Timely Postpartum Care.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Amy McCune Manager, Quality Incentive Programs, QI	There are no proposed changes from 2023 to the 2024 PQIP core measure set, which begins July 1; however, there will likely be a shift later this year in the electronic data measure should testing in the new DataLink go well and implementation occurs. DataLink should help for HEDIS® in primary source extraction, Amy said. Dr. Moore noted the contract with DataLink has been signed. Amy noted there are no changes to our incentive amounts.	
4. Annual Utilization Management Program Evaluation (CY 2023) and Supplemental TAR Report to the 2023 UM Program Evaluation: UM & Pharmacy Reports *Andrea Ocampo, Pharm.D, Clinical Pharmacist, Pharmacy Services,* and *Tony Hightower, UM*	This annual evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate. Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program. In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data, which is evaluated under delegation oversight. Staffing ratios within the program structure were analyzed according to NCQA and DHCS standards, Tony noted. Policy library management and the processing/ timeliness of Treatment Authorization Requests (TARs) are also evaluated. UM experienced a 10.7% increase in total TAR volume from CY2022. Part of the increase was attributed to the notable increase in the outpatient TARs processed for the months of March-April between the 2002 and 2023 calendar years. This was because many outpatient services were auto approved in 2022 during the system disruption. There were TAR: Nurse staff ratio variances exceeding the 20% threshold in July through October due to leaves of absence, declines in staffing, and then increases in staffing as temps were hired and new permanent positions were requisitioned. Andrea added that Pharmacy saw no significant changes in its TAR volumes. Tony noted that the Pharmaceutical & Therapeutics (P&T) Committee, Q/UAC, and PAC each met quorum at every 2023 meeting, thereby enabling timely policy discussions and decisions. Both UM and Pharmacy achieved some timeliness goals but missed others, in large part because of staff turnovers and a resulting loss of experienced organizational knowledge. Both permanent and temporary staff has been hired and continues to train, so we are getting back on track, Tony said. As for Inter-Rater Reliability, both UM and Pharmacy achieved 90% or better for all reviewer types. InterQual® remains our primary criteria support. UM also utilizes Medi-Cal and other national guidelines. The 2023 evaluation contains Dr. Moore's summary of Over-/Underutilization Workgroup activities in the assessment of appropriate levels of care. Throughout 2023, PHC's UM Program demonstrated active senior level physician involvement in committee work, policy decisions, clinical rounds, etc.; thus, no changes are expected to occur in 2024. The evaluation found that primary care practitioner and specialist experience with the UM process required no interventions; however, the process could be better for specialists on the following three issues, which did not meet the 90% satisfaction goal: 1. "I know how to determine whether or not a service requires that TAR be submitted to PHC." (89%) 2. "My TARS are approved in a timely manner." (85%) 3. "When a TAR for medical service is denied by the Plan, the basis for denial is clearly specified." (84%) Tony noted that this has largely been remediated through increased staff training, including how much detail is required to write more specific denial letters. Andrea added that we evaluate the member experience via Grievance and Appeals' PULSE report. Despite an increase in PHC's membership and the total number of cases received in 2023, there was a decrease in the number of grievances related to the UM process overall. Because of this decrease, PHC did not exceed the threshold in any category in 2023. Based on the results from the 2023 UM program evaluation, PHC concludes there are no significant program changes required. Activities addressing improvement opportunities will continue to be monitored, measured, and reported in future evaluations.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The Supplemental TAR Report breaks down the 246,234 UM and 7,502 Pharmacy TARs completed across all categories in 2023 against month-to month 2022 numbers. The Pharmacy numbers include all requests for Physician Administered Drugs (PADs).	
5. Population Needs Assessment (PNA) *Hannah O'Leary, MPH, CHES, Manager of Population Health*	The annual PNA's primary focus is helping Partnership better serve its members by utilizing multiple data sources to identify member needs and health disparities. This report categorizes findings into four "buckets": 1. Healthcare Access and Quality 2. Economic instability 3. Neighborhood and built environment 4. Social/community context We continue to see insufficient access to both primary and specialty care areas, particularly in our rural areas. Almost all of our 24 counties lack affordable housing and available places to rent. Partnership members continue to face challenges posed by domestic violence, fires, and lack of transportation. To address these issues, Partnership is beefing up its organizational structure through the hiring of regional leads in the new East Region and in the Northeast Region, and by working to increase the doula and community health worker (CHW) networks. To meet social and environmental needs, Partnership is leveraging state funds (e.g., CalAIM or California Advancing and Improving Med-Cal), and creating scholarships to create and incentivize a CHW workforce. Earlier this year, Partnership completed a PIT Count (point-in-time effort to aid homeless individuals) by distributing thousands of backpacks each filled with essential supplies, and by creating and monitoring a fire and disaster reporting email inbox for members and Partnership's member-facing departments to communicate urgent needs during crises. Member health and wellness activities are ongoing around hypertension diagnoses, colorectal and cervical cancer screenings, breast cancer screenings, tribal engagement efforts and well-child visits/vaccinations. Active, incentivized provider recruitment and retention activities will help access to care. Health disparities in diabetes, hypertension and breast cancer screenings are being addressed. Benefit education in collaboration with community organizations, many of which aid non-English speakers, is occurring, and member-friendly videos on women's health and mental health have been produced or are in the process of development.	
VI. FYI and Adjournment		
FYI: Pharmacy Operations Update – *direct questions to Stan Leung, Pharm.D – The PHC Pharmacy department in 2024 will begin to prepare for operating a Medicare D-SNP (Dual Special Needs Program) by Jan. 1, 2026.*		
Dr. Moore announced that QI committees would not meet in July before adjourning the meeting at 2:42 p.m. IQI will next meet Tuesday, May 7, 2024.		
Respectfully Submitted by Leslie Erickson, Program Coordinator I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD* *Chief Medical Officer and Committee Chair*		

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MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**1/25/2024**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**Webex**

Meeting Objective/s

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services oversight. Activities and progress are reported to the IQIC.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
Welcome and Introductions	Stephanie Wilson	5 Minutes
Review & Approve Minutes from November 11, 2023	Stephanie Wilson	5 Minutes
BH Administrator Update • January Budget • Prop 1	Nicole Escobar in Mark Bontrager's Absence	5 Minutes
Wellness and Recovery Updates • Introduction of New Staff Member • Reconciliation • MOU Updates • Expansion Counties & Meetings • Kaiser Transition • BHIN 24-001	Nicole Escobar	20 Minutes
Auditing Update • ACMA • DMC-ODS • SUBG	Wendy Millis	10 Minutes
Program Enhancements and Highlights • Provider Recruitment • Annual DMC Training • MAT Policy Requirement	Stephanie Wilson	5 Minutes
Monitoring and Oversight A. Monitoring and Oversight • New Providers for Quarter • Credentialed Network Providers • Provider Compliance Summary	Wendy Millis & Josette McKrola	60 Minutes

○ DATAR Reporting ○ Open Admissions CalOMS Reporting ○ Provider CAP Compliance		
B. Utilization Management • SABRIT • TAR & TAR Denials • Member Utilization by Level and County • Timely Access • Transitions of Care	Josette McKrola & Wendy Millis	
C. Claims Processing • Timeliness of Claims Processing for Quarter • Denial Rates • DHCS Short Doyle Acceptance Rate	Stephanie Wilson	
D. Quality Improvement Program Activities • W&R Provider Site Reviews	Rachel Peterson	
E. Grievance & Appeals • FY 23-24 First Quarter Report • FY 23-24 Second Quarter Report	Latrice Innes	
F. Member Services • Beneficiary Access Line/Call Center Statistics • CalOMS Data • Member Correspondence	Wendy Millis	
G. Compliance • BHINs & Policy Updates	Josette McKrola	
Walk On Items	Stephanie Wilson	5 Minutes
Wrap Up and Closing	Stephanie Wilson	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Deanna Bay	Humboldt County	X
Michelle Thomas	Humboldt County	X

Nancy Starck	Humboldt County	X
Tiffany Armstrong	Lassen County	X
Barbie Svendsen	Mendocino County	X
Alicia Kay	PHC	X
Becky Miller	PHC	X
Carina Monroy	PHC	X
Diana Rose	PHC	X
Dr. Jeffrey DeVido	PHC	X
Garnet Booth	PHC	X
Josette McKrola	PHC	X
Kathryn Power	PHC	X
Latrice Innes	PHC	X
Lynn Scuri	PHC	X
Matt Ramsey	PHC	X
Nicole Escobar	PHC	X
Ryan Ciulla	PHC	X
Shawn Porter	PHC	X
Stephanie Wilson	PHC	X
Vicki Klakken	PHC	X
Vivian Agudelo	PHC	X
Wendy Millis	PHC	X
Katie Cassidy	Shasta County	X
Rachel Ibarra	Shasta County	X
Ashley Bray	Siskiyou County	X
Dayan Garcia	Siskiyou County	X
Dee Barton	Siskiyou County	X
Rose Bullock	Siskiyou County	X
Toby Reusze	Siskiyou County	X
Judeth Greco-Gregory	Solano County	X
Rob George	Solano County	X
Ruth Leonard	Solano County	X

Notes, Decisions, Issues

- Welcome and Introductions:
    - Objective of meeting and agenda reviewed along with a few housekeeping items
        - Please stay muted if you are not speaking to cut back on background noise
        - If logged into Webex, PHC can track participation but if not, (calling in or conference room), place name in chat.
- Approval of Minutes:
    - Approved by Nancy Starck & Toby Reusze
- BH Admin Update – Included in packet:
    - Proposition 1:
        - Movement of MHSA to BHSA – still following closely alongside State's webinars on how this will impact Regional Model
    - January Budget:
        - Initiatives under BH programs are continuing to move forward
        - Continuing to watch; so far no money needs to be returned to the State.
    - Free Digital BH Platforms for Children & Families:
        - Two new virtual platforms provided by DHCS
        - Additional information link included in packet
    - PATH Capacity and Infrastructure Program Round 3 Application Opening:
        - Listed two opportunities for technical assistance in packet
            - Weekly office hours from January 22nd through February 12th
            - Grant writing technical assistance webinar
        - Nancy asked if the weekly office hours were DHCS or PHC office hours?
            - Nicole answered with "DHCS office hours"
- W&R Program Updates
    - Introduction of New Staff Member:
        - Vivian Agudelo was introduced – Behavioral Health Quality & Compliance Specialist
    - Reconciliation
        - PHC has shared 3 reconciliation files with DHCS to allow for end testing of the developed process – Processes used three years ago may not work today; using like data against process built to determine if it's still successful
        - State is using month or two to ensure processes are okay before talking to counties about dollars.
        - Updates will be shared once feedback is received
    - MOU Updates
        - PHC will be responsible for counties responsibilities in MOU but PHC will NOT be signing on county's behalf
            - Reach out to Stephanie, Wendy, or Nicole if anyone part of approval process has any questions
            - Send any redlines to Anabel
                - Redlines are okay for ALL MOUs not just SUD
    - Expansion Counties & Mtgs
        - SUIQI Mtgs will continue through this fiscal year
        - PHC will reach out to counties to discuss interest in meeting more often or independently
        - Using this info to gauge what meeting structure looks like for FY 24/25
        - Possibly all 24 counties to meet at once for quarterly meeting – this will check off MOU & State requirements

- Nancy mentioned having to think the all 24-county meeting through as only seven counties are Regional Model counties and they may not need to sit through meetings that do not have relevancy to the Regional Model.
    - Nicole explained a few things that have come to mind as the 24 counties have been meeting on the mental health side. Quarterly meetings are not in lieu of SUIQI meetings, but PHC is looking into seeing if SUIQI meets the needs of the counties. PHC wants to ensure timelines are being met and decide if additional meetings may be needed.
- Counties are encouraged to reach out to Stephanie or Wendy to modify the cadence of oversight and monitoring meetings for the administration of their SUD program

- Kaiser Transition:
    - Direct contract between state & Kaiser
        - No significant issues
        - Kaiser is now an MCP, there will be some data sharing for individuals receiving SUD services
        - Offline conversations are happening between PHC & Kaiser to develop these processes, but one specific issue pertaining to Solano County. DHCS excluded all Kaiser members and they are continuing to work through this issue

- Auditing Update
    - ✳ **Small reminder: If auditing emails are received from the State, PHC does not receive those emails. Please forward those to PHC team if any received.**
    - ACMA
        - Variety of responses received from DHCS – some counties have been cleared for this year. PHC working on solution for those not cleared.
        - Not cleared: 3 or 4 site reviews. These have been sent to the counties.
        - Stephanie or Wendy have sent an email if they have not received a follow-up; please check emails and send any updates
    - DMC-ODS: Email sent for updates
        - Good response from state on this audit
        - One county cap has been closed; hoping to close remaining within 30 days. PHC has not seen a few updates since CAPs were submitted in October. **Counties are being asked to please send over any additional information received.**
        - One outstanding CAP item connected to the access line; PHC awaiting the education documentation from Carelon. PHC will send along to the applicable counties when received.
        - No date for 23-24 audit – **if an email is received with a requested date, please let PHC know**.
        - Stephanie or Wendy have sent an email if they have not received a follow-up; please check emails and send any updates
    - SUBG
        - Stephanie or Wendy have sent an email if they have not received a follow-up; please check emails and send any updates
        - Let PHC know if you need anything to close CAP for 22-23 year
- Program Enhancements and Highlights
    - Provider Recruitment
        - Ongoing endeavor of our program to recruit with providers to expand our network
            - Looking for Medi-Cal providers (and/or providers who are willing to become Medi-Cal certified providers) & Specialty providers (perinatal & youth)
            - Providers going through contracting process:

        - Shasta Day Reporting – IOP Redding
        - Anov – Quartz Valley Indian Reservation in Fort Jones for OP Peri & Non-Peri
        - JCole – Residential Program in Contra Costa County
        - Fourth and Hope – Residential and OP in Yolo County
        - Karuk Indian Valley Services – Yreka, OP and MAT services
    - Providers waiting on Medi-Cal cert.
        - Woman's Recover Services – Peri Res in Santa Rosa
        - MyFamilySpring – Youth OP/Telehealth
        - Pure Vida – Program that provides continuum of services in Santa Rosa
    - Discussions with other providers in various stages
    - Outreached to Medi-Cal certified and non-certified to verify if they meet a specialty need and/or willing to become Medi-Cal certified
- Annual DMC Training
    - Annual training required for all providers, including clinical, administrative & support staff who touch DMC-ODS
    - To be completed and attested by 1/31/24
    - Reminder will be sent to all providers to complete this training.
- MAT Policy Requirement
    - BHIN 23-054 provided new and updated guidance on the required MAT policies for SUD providers
    - Asked providers to share their policies with us and will continue to work with providers to ensure compliance with this requirement
    - PHC generated a MAT policy for monitoring providers and sent to counties 1/11/24

- Monitoring and Oversight

A. Monitoring and Oversight

- New Providers for Quarter
    - No new providers
- Credentialed Network Providers
    - Credentialed providers included in the meeting packet
    - Reach out to PMs if there are any credentialing questions or waiting on anyone to be credentialed
- Provider Compliance Summary
    - DATAR Reporting
        - The new system of requiring DATAR site updates to be completed on or prior to the 5th of the month was instituted starting November 1st for the October 2023 update. The providers have adapted well to the policy change.
            - Program Managers are able to focus on outlying providers if they are in danger of being non-compliant
        - MedMark Vallejo & Genesis House (Solano County) received CAP for late entry
            - Providers will be continued to be monitored
    - Open Admissions CalOMS Reporting
        - Overall percentage has fallen below 95% due to error in CalOMS; IT working on his – CAPs issued related to this are being deferred
    - Provider CAP Compliance

- Archway and Genesis House (Solano County) received CAP due to administrative error

B. Utilization Management
   - SABRIT
     - New data sheet PHC will be providing each meeting showing different demographics of all members with a diagnoses of SUD
     - Sent to specific counties (included in county packet)
       - Nancy asked: What is the other category in service location?
       - Nicole answered: Anything that falls outside of: PCP, OP, Long Term Care.
     - Identifying any characteristics of PHC member demographics who had claims
       - Age, chronic conditions, gender, race/ethnicity, mothers, homeless, etc.
     - Top three substances: Opioids, Alcohol, and stimulants; most services are being provided in an office visit and the ED
     - Solano & Shasta highest #s with mothers in SUD
     - Claims paid by PHC
       - SUD as primary/secondary diagnoses, SUD procedures, service locations
   - TARs & TAR Denials
     - Growth rate month to month
       - Report focuses on 1st six months of Treatment Authorizations during this fiscal year
       - TARs authorized fluctuated between high of 150 authorizations in August and October and low 99 in December
       - Historically, Nov-Feb have been the slowest months
       - Reach out to PHC with questions
     - Residential Treatment Authorization frequency shown
     - Feedback welcome
       - **Katie suggested a different color option as blue is hard to distinct**
   - Member Utilization by Level and County
   - Timely Access
     - Received via email specific to your county
     - Report of fiscal year to date
     - Above 90% meeting non-urgent/urgent episode
     - For the most part, the graph shows all services are being started within 1-3 days of screening
   - Transitions of Care
     - Wendy can provide full list of episode volume by service provider
     - Toby asked what is the difference between urgent and non-urgent?
       - Wendy answered: Urgent is WM/Detox or a youth service; non-urgent captures all the rest.

C. Claims Processing
   - Timeliness of Claims Processing for Quarter
     - Last quarter it was reported all claims were being processed manually, which is no longer the case.
     - All configuration has been completed and claims are now hitting appropriate edits required under the payment reform billing guidelines
     - 99% of claims continue to be paid within 2-weeks of receipt
     - Nancy asked: No claims for recovery services?

- Nicole answered: We have not; some counties still working on their billing systems. Unfortunately, implementation of EHRs has been a bit complicated for counties and providers.

- Denial Rates
  - Continuing to provide education to providers reminding them of the need to include taxonomy codes indicating the rendering provider's specialty
  - Claims not including taxonomy codes where required are being rejected and/or denied depending on the method of billing (paper vs electronic)
  - Technical assistance is being offered to providers who are continuously receiving denials
  - Overall PHC claim denials have increased slightly from 2% to just over 5%
- DHCS Short Doyle Acceptance Rate
  - Denials rates have increased since 7/1/23 due to payment reform code set implementation
  - Prior to 7/1/23, denials averaged 1-2%, Post 7/1/23 denials are averaging 7-8%
  - Taxonomy code mapping, claiming for primary insurance coverage, and rendering vs group NPI submissions continue to be monitored and improvements are applied when identified

D. Quality Improvement Program Activities
- W&R Provider Site Reviews
  - 2 CAPs issued and closed – Genesis House & Shasta County Alcohol and Drug Programs
  - Description for CAPs included in packet.

E. Grievances & Appeals
- FY 23-24 First Quarter Report
- FY 23-24 Second Quarter Report
- Pulse report will be released 3/11
- 3 grievances received: Shasta, Siskiyou, and Lassen
- Closed out 4 cases: Lassen, Siskiyou, and two from Solano
- Trend of unhappy with treatment – unsubstantiated
  - Members were moved to other programs
- Nancy asked if data would be available next meeting?
  - Latrice answered: Yes; the data was just not produced yet.

F. Member Services
- Beneficiary Access Line/Call Center Statistics
- CalOMS Data
  - Most from Shasta, Solano, and Humboldt
  - Self-referral still tops the source of referral list;
  - OP and NTP top the level of care received.
  - Co-Occurring is about a 50/50 ratio.
  - Standard discharges are still received more than administrative.
  - Majority of clients are not reporting housing instability and 50/50 for employed vs unemployed at discharge.
- Member Correspondence
  - None to report

G. Compliance
- BHINs & Policy Updates
  - 11 BHINs included. Highlighting a few more below:

- 23-058: Update to Certification requirement; already in provider contracts. Stephanie assisted providers in getting this submitted by Jan 1st.
- 23-062: Update to GA & GA Reporting; change to reporting due dates. PHC will continue to report this information to the State including reporting the requirements in this BHIN
- 23-068: Updates to Service Documentation requirement; Provider facing changes were included in the annual compliance training now available on the PHC site

  - Katie mentioned having issues with technical assistance on the AOD certification and the $2.000/day fines DHCS may issue due to providers not having the certification, had them worried. If providers are worried, (PHC) please let them know they are not alone in the concern but there have been some challenges in getting this certification completed. Tiffany added that they, too, were facing issues.
  - Toby mentioned receiving an email from DHCS stating the fines would start Jan 2025. Will be sending to Nicole, Wendy, and Stephanie to distribute
  - Katie requested an email for the first three pages or what the guidance was for the initial "first push," as Wendy mentioned, & asked the counties if they had multiple in-county providers, are you doing ONE AOD certification that covers all of the programs? Or do you have to do one application per program?
    - Toby answered: They had two sites and they had to do it for both sides

- Walk On Items
  - Katie: Carelon has told anyone who needs residential treatment to go to county to be authorized. Solano is also facing this same issue
    - Wendy asked for specific info for Carelon to narrow down who provided this information and will follow-up with Carelon
- Wrap Up and Closing
  - Reach out to PHC if anything comes up
  - Next meeting 4/11/2023
  - Dismissal: 11:15 AM

MEETING AGENDA

Meeting / Project Name: Substance Use Internal Quality Improvement Committee Meeting (SUIQI)	
Objective of Meeting: A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.	
Date: January 25, 2024	**Time**: 10:00 am – 12:00 pm
Location: WebEx – virtual	**Facilitator**: Stephanie Wilson

PHC Invited Attendees:

Sonja Bjork	Garnet Booth	Lisa Adams
Wendi West	Jackie Krznarich	Lynn Scuri
Alicia Kay	Jeff DeVido	Nancy McAdoo
Alison French	Joanie Williams	Nancy Steffen
Amy Turnipseed	Josette McKrola	Nicole Curreri
Angela Guevarra	Katherine Power	Nicole Escobar
Becky Miller	Kenzie Hanusiak	Rachel Newman
Carina Monroy	Kevin Spencer	Robert Moore
Cassia Martinez	Kory Watkins	Ruth Hood
Dani Ogren	Lonnie Hemphill	Ryan Ciulla
Danielle Biasotti	Lulu Salinas	Shawn Porter
Dell Coats	Mark Bontrager	Stephanie Wilson
Diana Rose	Mary Kerlin	Tim Sharp
Dolores Plascencia	Matt Ramsey	Wendy Millis
Doreen Crume	Mohamed Jalloh	Vicky Klakken
David Lavine	Latrice Innes	Vivian Agudelo

County Invited Attendees:

Deanna Bay - Humboldt	Barbie Svendsen – Mendocino	Rose Bullock - Siskiyou
Elvira Schwarz- Humboldt	Jenine Miller - Mendocino	Sarah Collard – Siskiyou
Emi Botzler-Roger - Humboldt	Jill Ales - Mendocino	Toby Reusze - Siskiyou
Kaleigh Emry - Humboldt	Dolores Navarro-Turner - Modoc	Emery Cowan - Solano
Michelle Thomas - Humboldt	Michael Traverso - Modoc	Judeth Greco-Gregory - Solano
Nancy Starck - Humboldt	Stacy Sphar - Modoc	Rob George - Solano
Barbara Longo - Lassen	Katie Cassidy - Shasta	Ruth Leonard - Solano
Tiffany Armstrong - Lassen	Melissa Harris - Siskiyou	

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State Behavioral Health Updates

Proposition 1:

The May ballot will include Proposition 1, which purports to do many things. First, if approved, it would direct the state to initiate a general obligation bond of over $6 billion dollars to build and/or modify housing for individuals with behavioral health needs who are housing insecure. Second, it will modify the Mental Health Services Act (MHSA) and rename it the Behavioral Health Services Act. It will also substantially modify the spending categories that MHSA had long ago instituted to include a substantial investment in housing supports. It also allows for the option for broader inclusion of individuals with Substance Use Disorder treatment needs.

January Budget Release & Behavioral Health Priorities

Despite the fact that they release of the January budget anticipates more than a $38 billion state deficit for next fiscal year, the Governor is proposing to maintain nearly all of the substantial investments in behavioral health, including the Child and Youth Behavioral Health Infrastructure (CYBHI) investments, Care Courts and so many more. The budget does include 'delays' in expenditures that include $140 million delay in the Round 6 Behavioral Health Continuum Infrastructure Program (BHCIP), and a delay in $189 million in healthcare workforce education investments for nursing and social workers.

Ultimately, much can change between January and the "May Budget Revise" prior to formal budget approval by the legislature. However, given the size of the deficit, it is encouraging that nearly all of the behavioral health investments and initiatives are moving forward without reductions.

California Launches Free Digital Behavioral Health Platforms for Children and Families

On January 16, DHCS launched the Behavioral Health Virtual Services Platform – two free behavioral health services applications for all families with kids, teens, and young adults ages 0-25. BrightLife Kids, developed by Brightline, is for parents or caregivers and kids 0 -12 years old. Soluna, developed by Kooth, is for teens and young adults ages 13-25. Families with multiple children whose ages span 0-25 can use both platforms to meet their unique needs. Each app will also offer coaching services in English and Spanish, as well as telephone-based coaching in all Medi-Cal threshold languages.

Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion, and Development (CITED) Round 3 Application Opening

On January 15, DHCS opened the PATH CITED Round 3 application window. The PATH CITED initiative provides funding to build the capacity and infrastructure of on-the-ground partners, including community-based organizations, public hospitals, county agencies, tribes, and others, to successfully participate in Medi-Cal. The deadline to apply for PATH CITED Round 3 funding is February 15. The below events will serve to assist prospective applicants:

- Weekly office hours: January 22 through February 12 at 9 a.m. (select a date and register on the PATH CITED website).
- How to Improve Your Grant Application Webinar Part 2: January 23 at 10 a.m. (advance registration required)

Newly Credentialed Wellness and Recovery Providers – November 2023-January 2024

11/8/2023	Elmanawy, Youseef LAADC	Archway Recovery Services IOP W & R
11/8/2023	Lawes, Sally R.,LPCC	GROUPS Recover Together - W & R and MAT
11/8/2023	Lopez, Domasio Y.,SUDCC II	MedMark Treatment Centers Vallejo
11/8/2023	Pena, Sabrina M.,SUDRC	Visions of the Cross/ Women's Residential Treatment
11/8/2023	Renfro, Jasmin J.,SUDRC	Visions of the Cross/ Women's Residential Treatment
12/13/2023	Babb, Amie SUDRC	Empire Recovery
12/13/2023	Crispierri, Dempsey SUDRC	Archway Recovery Services IOP W & R
12/13/2023	Miranda, Steven SUDRC	VOTC
12/13/2023	Cline, Christopher W.,SUDRC	Hilltop Recovery Services - The Ranch
12/13/2023	Gibbs, Matthew SUDCC	Siskiyou County Behavioral Health
12/13/2023	Levin, Tara CADC II	Shasta Day Reporting Center
1/10/2024	Jackson, James SUDRC	VOTC
1/10/2024	Alexander, Sierra RADT	H.O.M.E Tule House
1/10/2024	Enomoto, Charles CADC II	Shasta Day Reporting Center
1/10/2024	Logan, Paige N.,SUDRC	Hilltop Recovery Services - The Ranch
1/10/2024	Reda, Azelarab SUDRC	Visions of the Cross/ Women's Residential Treatment

PARTNERSHIP HEALTHPLAN PROGRAM SUMMARY – Fiscal Year 2023/2024

Open Admissions

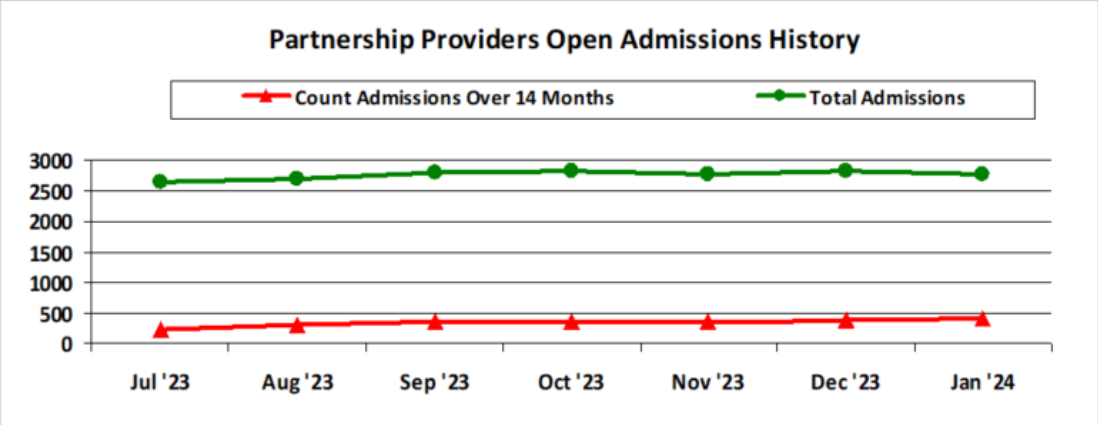
Open Admissions in CalOMS data is monitored to ensure that CalOMS data is kept up to date. Open admissions should have either an annual update at 12 months or a discharge. Admissions not updated/discharged for longer than 14 months are considered out of compliance. A point in time Open Admissions Report is pulled prior to the 20th of each month from DHCS data and shared with providers. The table below shows overall count of records appearing in each Open Admissions Report pulled during the fiscal year. Partnership began a non-clinical PIP focused on working with providers to remedy records that were out of compliance.

The table shows the count of open admissions, the number of those admissions that were over 14 months, and the percent of those open admissions that were in compliance at the time of reporting. Those months with less than 95% of records in compliance are highlighted in red. The chart gives a picture view of the same data.

Table 1 – Compliance tracking across month

FY2023/2024 Report Date	Count of Over 14 Months	Total Record Count	% in Compliance*
07/17/2023	225	2647	91.5%
08/21/2023	305	2700	88.7%
09/20/2023	352	2785	87.4%
10/20/2023	347	2814	87.7%
11/17/2023	366	2767	86.8%
12/19/2023	381	2813	86.5%
01/17/2024	402	2778	85.5%

Chart 1 – Compliance tracking across month



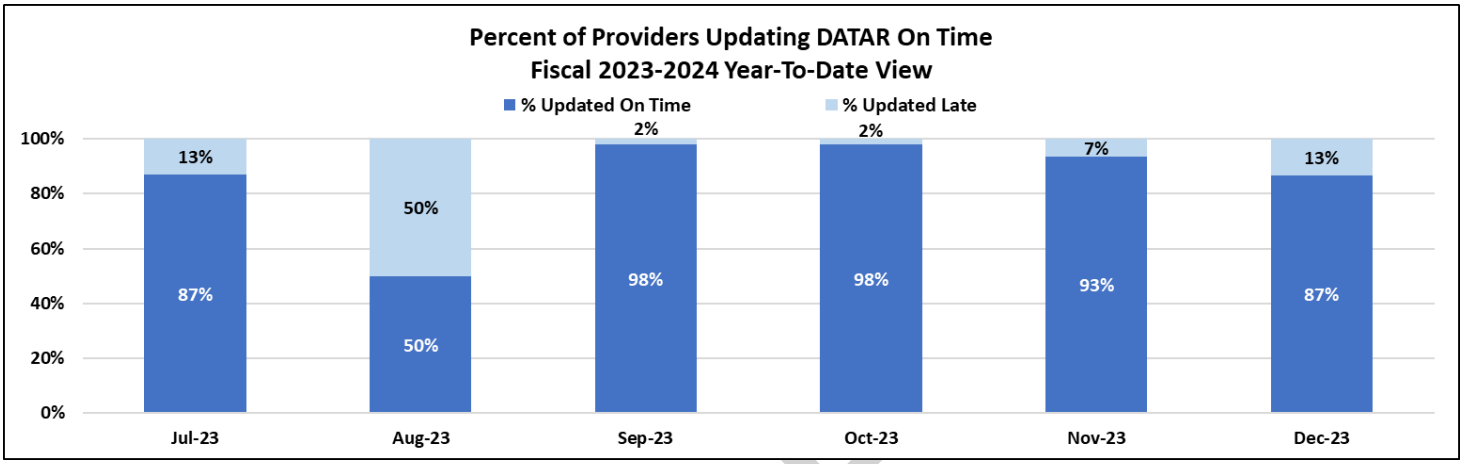
As shown above the provider's rate of compliance, records over 14 months vs. open admissions have fallen since July 2023 and continues to fall now to 85.5%. This is an artifact of an error in Partnership's CalOMS open admissions update system. The error is known and is being repaired. Until this time, CAPs are issued case by case. The compliance rate goal for PHC is 95%.

CAPS: Due to technical issues there have been no Open Admissions CAPs issued during the reported period.

DATAR

DATAR is a State run site to monitor treatment capacity of addiction treatment facilities in California. PHC works with providers, counties, and the State to ensure all providers have access and training to use the site. The chart below shows the percent of providers who have updated their information on time each month. Reporting has now stabilized as all providers have gained access to the site.

Chart 2 - The chart shows the fluctuation of providers updating the website on time, by the 10th of the month.



Partnership has developed a communication process to assist providers with timely update of DATAR system. Partnership has modified the deliverable date to the 5th of the month, with the intent of allowing time to work with the provider before they fall out of compliance. This change is effective November 1, 2023. Starting in 2024 CAPs will be issued as of the 11th of the month to providers out compliance.

CAP(s) Issued: There were 2 providers issued a DATAR CAP. Both have submitted a sufficient CAP. These providers will continue to be monitored.

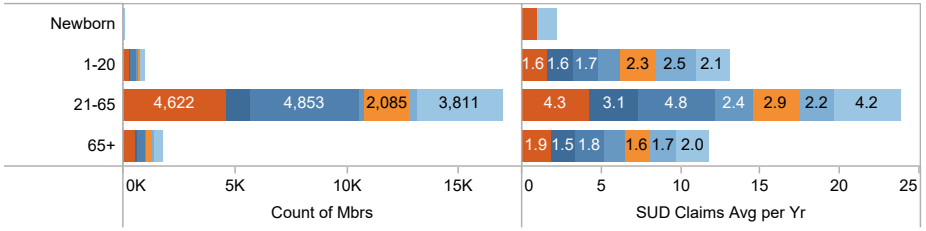
Demographics & Disease Status of Members Diagnosed with Substance Use Disorder

This view describes the demographic characteristics of PHC members who had claims with any substance use disorder diagnosis or procedure, the prevalence of major chronic conditions, diagnosis occurrence during pregnancy, and homelessness status at the time of service for those members.

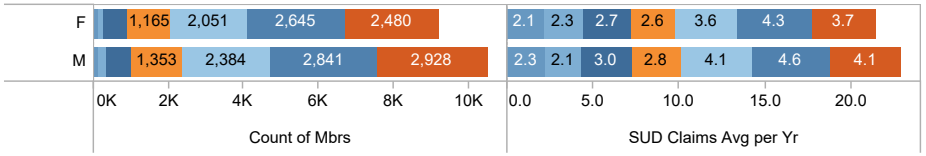
Click on any demographics bar to filter on

Year	Choose Location Level	Choose Location	Homelessness	Risk Class	Kaiser Status
2023	Mbr County	Multiple values	All	All	All

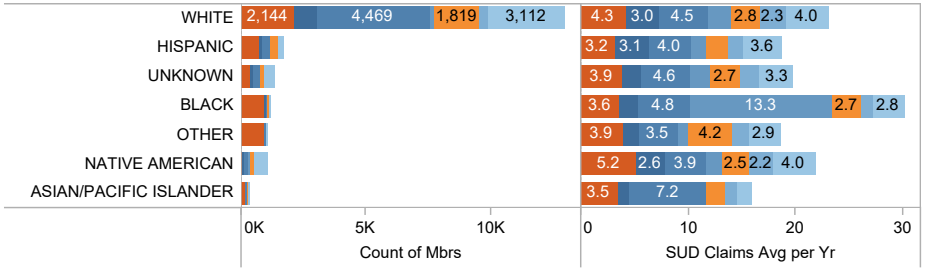
Age Group



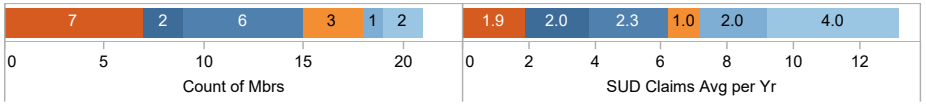
Gender



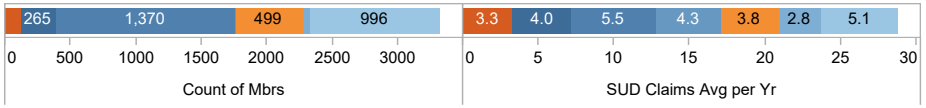
Race / Ethnicity



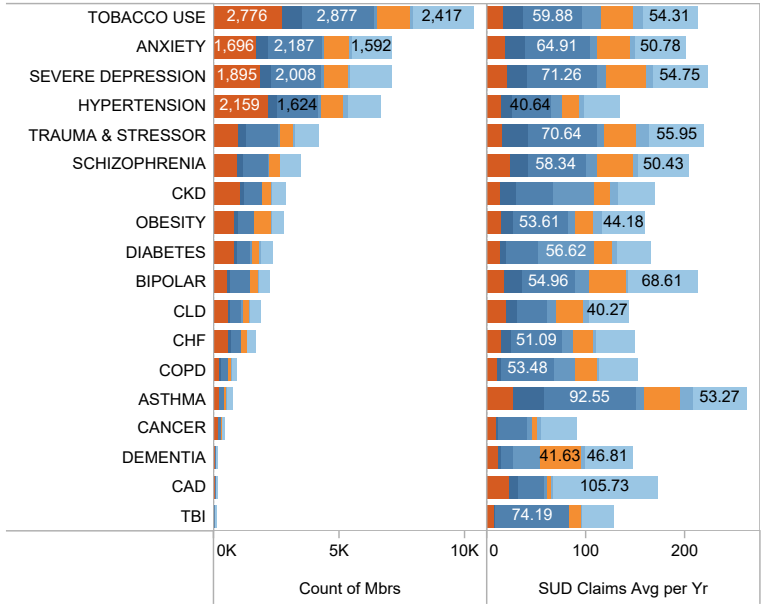
Mothers with SUD Diagnoses During Pregnancy



Homeless Members



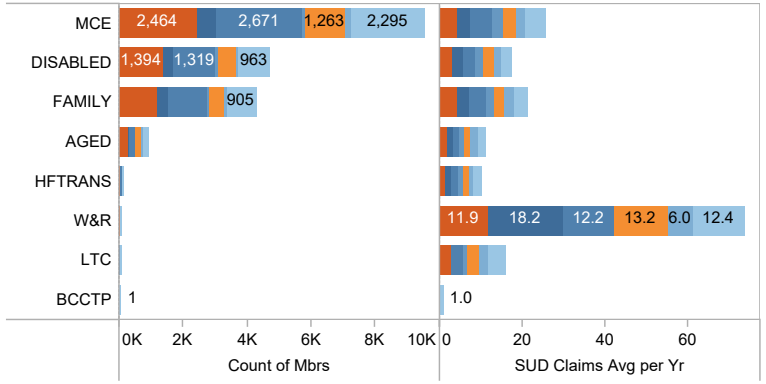
Chronic Conditions



Location Legend

- HUMBOLDT
- LASSEN
- MENDOCINO
- MODOC
- SHASTA
- SISKIYOU
- SOLANO

Aid Code Class



Paid Claims with Substance Use Disorder Diagnoses or Procedures

This view shows information on all the medical claims paid by PHC that had at least one substance use disorder diagnosis or procedure code in any position in the claim summarized by year and substance type, procedure, and service location.

Year of Service
2023

Choose Location Level
Mbr County

Choose Location
Multiple values

Homelessness
All

Age Group
All

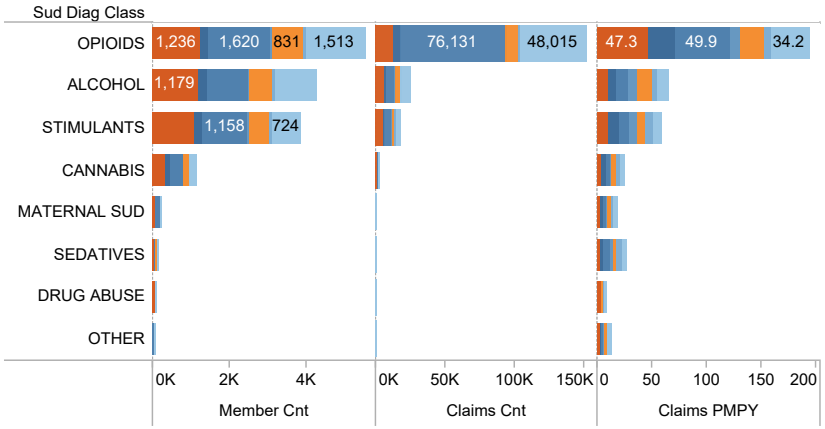
Risk Class
All

Kaiser Status
All

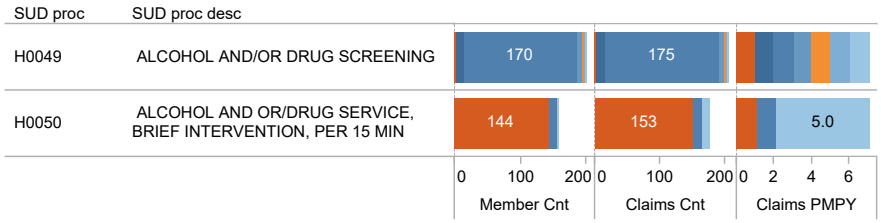
Location Legend
- HUMBOLDT
- LASSEN
- MENDOCINO
- MODOC
- SHASTA
- SISKIYOU
- SOLANO

Click on any bar or header below to filter on.

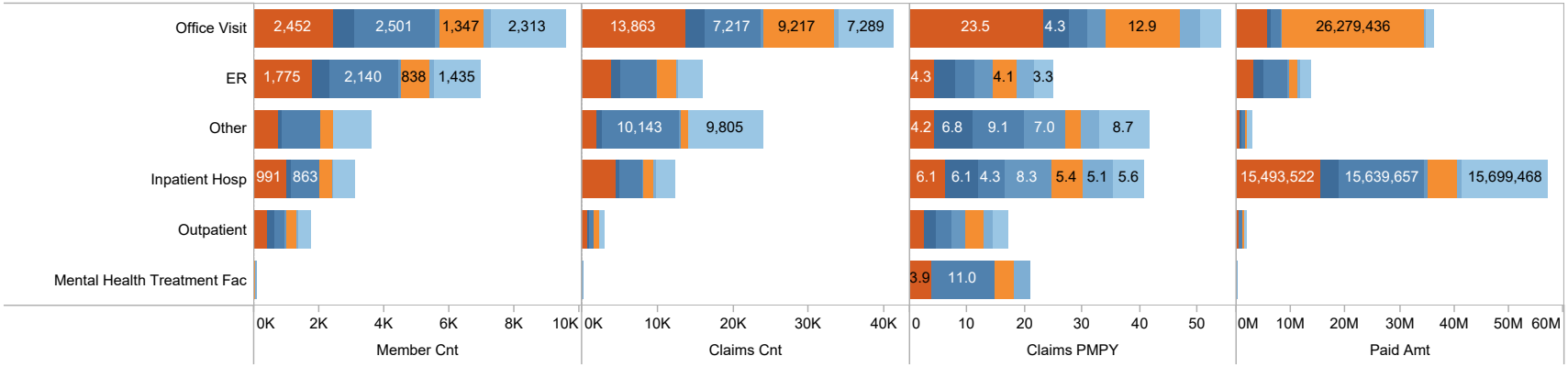
Claims with SUD as Primary or Secondary Diagnosis



Claims with SUD Procedures



Service Location



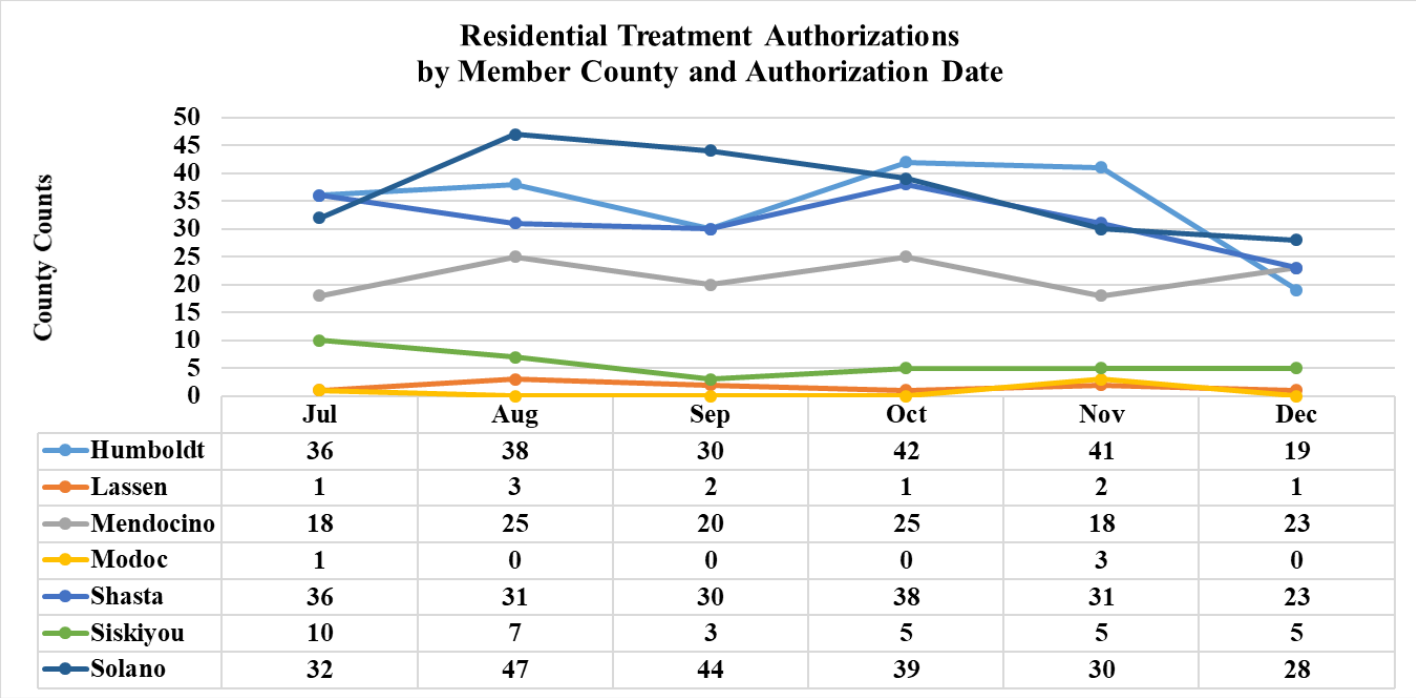
Refreshed: **12/11/2023**

Prepared by: Margarita Garcia (mhernandez@partnershiphp.org)

RESIDENTIAL TREATMENT AUTHORIZATIONS
(by Member County and Providing Facility)

The following study shows the Treatment Authorization Activity between July 1, 2023 and December 31, 2023. The study is presented by Member County and Provider Facility. Authorization Activity had a negative growth of 35% December 2023 compared to July 2023. The average total number of Authorizations approved for the study period was 132 across month.

Chart and Table 1: Shows the total count approved Authorizations by Member County and Month Authorized



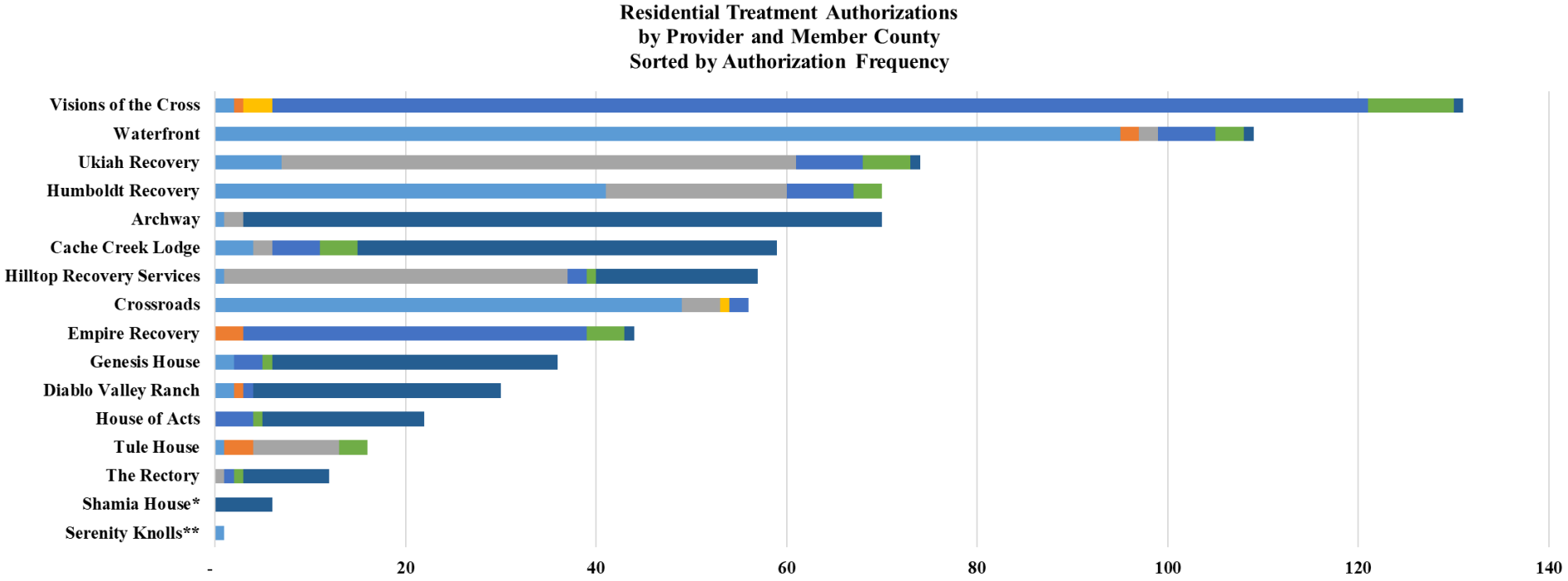
	Jul	Aug	Sep	Oct	Nov	Dec
Humboldt	36	38	30	42	41	19
Lassen	1	3	2	1	2	1
Mendocino	18	25	20	25	18	23
Modoc	1	0	0	0	3	0
Shasta	36	31	30	38	31	23
Siskiyou	10	7	3	5	5	5
Solano	32	47	44	39	30	28

Chart and Table 2: Shows the Treatment Authorizations rate of growth across Authorization month.

Member County	Jul	Aug	Sep	Oct	Nov	Dec
Humboldt		5.3%	-26.7%	28.6%	-2.4%	-115.8%
Lassen		66.7%	-50.0%	-100.0%	50.0%	-100.0%
Mendocino		28.0%	-25.0%	20.0%	-38.9%	21.7%
Modoc		-100.0%	0.0%	0.0%	100.0%	-100.0%
Shasta		-16.1%	-3.3%	21.1%	-22.6%	-34.8%
Siskiyou		-42.9%	-133.3%	40.0%	0.0%	0.0%
Solano		31.9%	-6.8%	-12.8%	-30.0%	-7.1%

RESIDENTIAL TREATMENT AUTHORIZATIONS
(by Member County and Providing Facility)

Chart and Table 3: Shows the FYTD December 2023 count of authorizations by Member County and Provider Facility



	Serenity Knolls**	Shamia House*	The Rectory	Tule House	House of Acts	Diablo Valley Ranch	Genesis House	Empire Recovery	Crossroads	Hilltop Recovery Services	Cache Creek Lodge	Archway	Humboldt Recovery	Ukiah Recovery	Waterfront	Visions of the Cross
Humboldt	1	-	-	1	-	2	2	-	49	1	4	1	41	7	95	2
Lassen	-	-	-	3	-	1	-	3	-	-	-	-	-	-	2	1
Mendocino	-	-	1	9	-	-	-	-	4	36	2	2	19	54	2	-
Modoc	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	3
Shasta	-	-	1	-	4	1	3	36	2	2	5	-	7	7	6	115
Siskiyou	-	-	1	3	1	-	1	4	-	1	4	-	3	5	3	9
Solano	-	6	9	-	17	26	30	1	-	17	44	67	-	1	1	1

*Provider now closed
**Provider not contracted, listed due to coordinated treatment with primary insurance

Timely Access of Substance Use Disorder Treatment

The dashboard shows metrics on how timely substance use disorder (SUD) treatment is received after Level of Care (LOC) Screenings by Beacon and participating Providers. Urgent Episodes have a U9 or UA modifier code. Non-Urgent Episodes are other not Urgent SUD episodes. Regulations are Met if days from screening to treatment is within 3 days for Urgent Episodes and 10 days for Non-Urgent Episodes. View the information (i) icon for more details.

Last Updated 1/5/2024 11:01:05 PM
Data Refreshed Monthly
Episodes up to 12/29/2023
Screenings up to 10/31/2023
Prepared by Jen Kung

Health Analytics

# SUD Treatment Episodes	Episodes that Met Regulations	Walk-In Episodes
1,862	1,720 (92% of Episodes)	1,093 (59% of Episodes)

Service Date
7/1/2023 to 1/1/2024

Provider
All

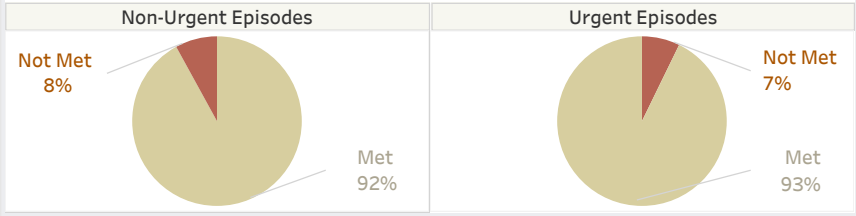
Member County
All

Is Walk-In Episode
- [x] No
- [x] Yes

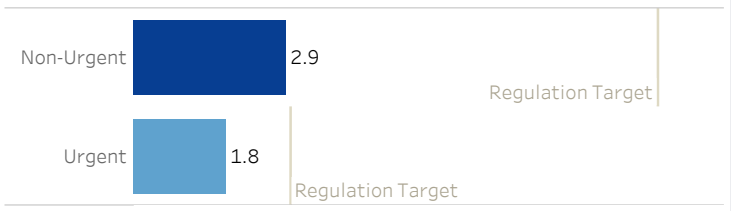
Is Pending Episode
- [x] No
- [ ] Yes

Level of Care
- [x] Non-Urgent
- [x] Urgent

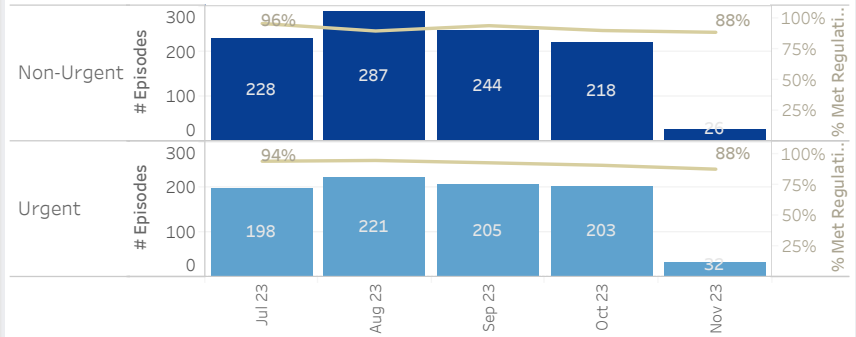
Share of Episodes that Met Regulation by Level of Care



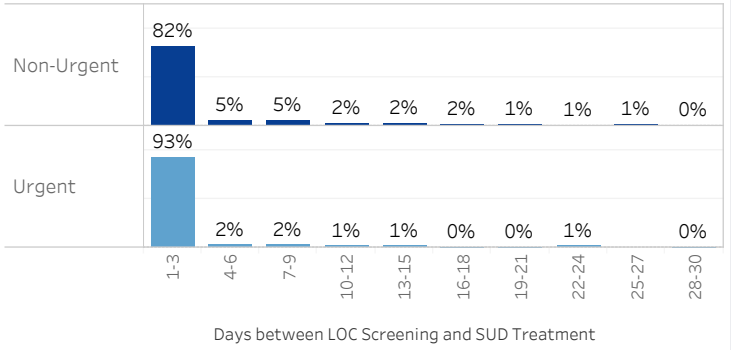
Average Number of Days from LOC Screening to SUD Treatment



Episode Volume and Percent that Met Regulation Criteria by Month



Distribution of Days between LOC Screening and SUD Treatment



Timely Access of Substance Use Disorder Treatment by Location

The dashboard shows the volume of substance use disorder (SUD) treatments and the share of episodes that met timely access regulations by Provider and Member County. Urgent Episodes have a U9 or UA modifier code. Non-Urgent Episodes are other not Urgent SUD episodes. Regulations are Met if days from screening to treatment is within 3 days for Urgent Episodes and 10 days for Non-Urgent Episodes. View the information (i) icon for more details.

Last Updated 1/5/2024 11:01:05 PM
Data Refreshed Monthly
Episodes up to 12/29/2023
Screenings up to 10/31/2023
Prepared by Jen Kung

Health Analytics

# SUD Treatment Episodes	Episodes that Met Regulations	Walk-In Episodes	# Providers with Treatment Episodes
1,848	1,708 (92% of Episodes)	1,083 (59% of Episodes)	34

Service Date
7/1/2023 to 1/1/2024

Provider
All

Member County
~~Multiple values~~

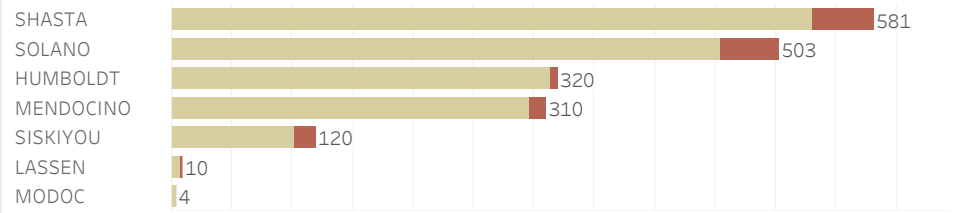
Is Walk-In Episode
- [x] No
- [x] Yes

Is Pending Episode
- [x] No
- [ ] Yes

Level of Care
- [x] Non-Urgent
- [x] Urgent

Episode Volume by Member County

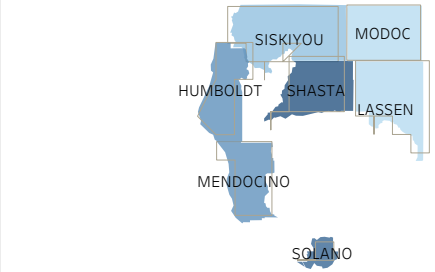
Regulation Met: Met, Not Met



Episode Volume by Service Provider

Number of Episodes by Member County

Displayed Measure
- (●) Number of Episodes
- ( ) Number of Service Providers
- ( ) Percent of Episodes that Met Regulation



Note: PHC counties that do not have values based on selected filters will not appear on the ..

Transitions of Care

This dashboard summarizes the number of days between each level of care for Wellness and Recovery Members over time, by county and service provider (counted after th..

Health Analytics

Service Date from **7/1/2020** to **12/31/2023**
Refreshed on **1/5/2024 11:01:09 PM** Next Refresh on **02/5/2024**
Contact: Shivani Sivasankar (ssivasankar@partenrshiphp.org)

By Transition Type?
- ○ Yes
- ◉ No

Transition Days Measure
- ◉ Average
- ○ Median

Members without transition	Members with transition			Average Transition Days		
		Step Down	Step Up		Step Down	Step Up
1,877	683	526	256	2.08	2.04	12.41

No Change	No Change
132	0.98

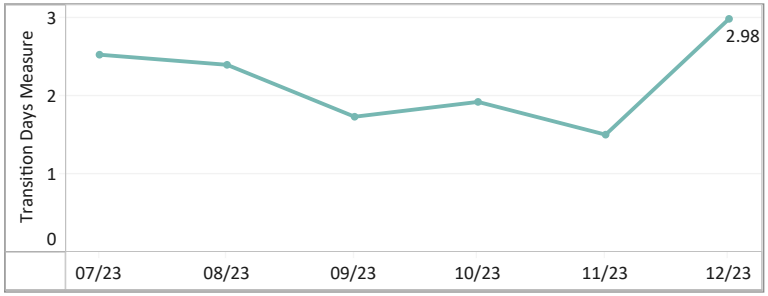
Service date
7/1/2023 to 1/1/2024 and Null values

Transition days > 90 days
No

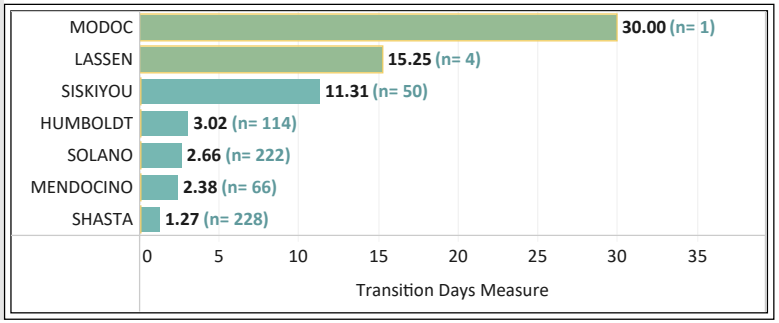
Transition Type
Multiple values

Povider Name
All

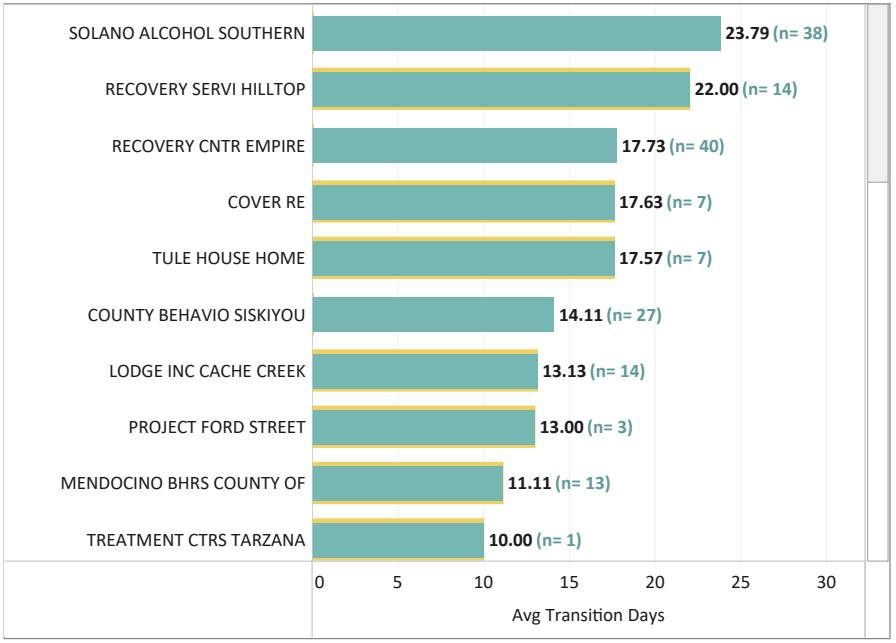
Average Days of Transition over Time



Average Days of Transition by County



Average Days of Transition by Service Provider



Wellness and Recovery Overview of Paid Claims by Member County

This dashboard tracks health services by Wellness and Recovery program across the participating counties. Data gathered from paid claims.

Service date untill 1/8/24

Health Analytics

by: Tiphanie Salehi

7/1/23 to 1/8/24	3,273	233,209
Service Date	Total participating Members	Total Visits

Service date
7/1/2023 to 1/18/2..

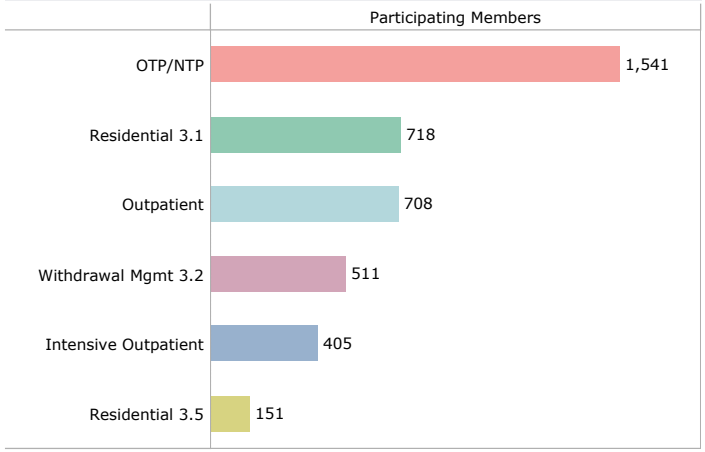
View by Members/ Total Visits
Participating Members

Mbr County
~~Multiple values~~

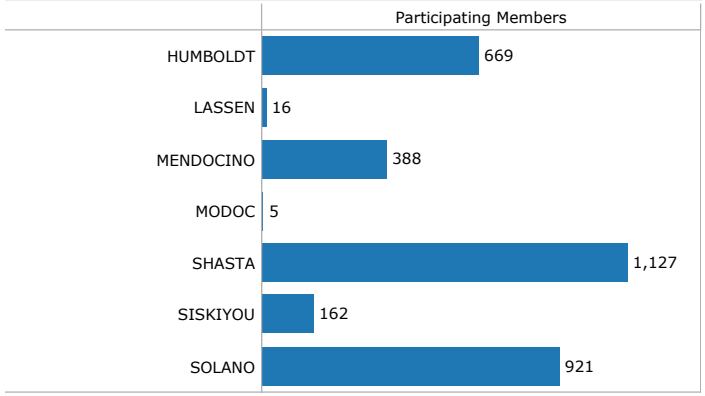
Serv Prov Full Name
All

Level of Care
- Intensive Outpat..
- OTP/NTP
- Outpatient
- Residential 3.1
- Residential 3.5
- Withdrawal Mgm..

Level of Care Overview



By County



Level of Care by County

Mbr County	Level of Care	Participating Members
HUMBOLDT	Intensive Outpatient	2
	None	
	OTP/NTP	385
	Outpatient	34
	Recovery Service	
	Residential 3.1	110
	Residential 3.5	99
	Withdrawal Mgmt 3.2	140
LASSEN	Intensive Outpatient	
	OTP/NTP	1
	Outpatient	1
	Recovery Service	
	Residential 3.1	7
	Residential 3.5	2
	Withdrawal Mgmt 3.2	7
MENDOCINO	Intensive Outpatient	
	OTP/NTP	136
	Outpatient	123
	Recovery Service	
	Residential 3.1	110
	Residential 3.5	22
	Withdrawal Mgmt 3.2	65
MODOC	Intensive Outpatient	
	OTP/NTP	
	Outpatient	
	Recovery Service	
	Residential 3.1	4
	Residential 3.5	1
	Withdrawal Mgmt 3.2	
SHASTA	Intensive Outpatient	127
	None	
	OTP/NTP	602
	Outpatient	342

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Service date untill 1/8/24

Health Analytics

by: Tiphanie Salehi

County Selected:
All

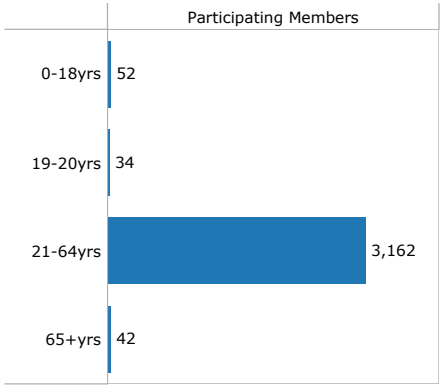
Service date
7/1/2023 to 1/18/2024

View by Members/ Total Visits
Participating Members

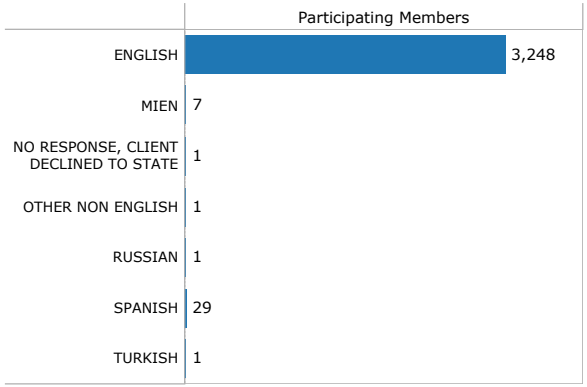
Mbr County
All

Serv Prov Full Name
All

By Age Group



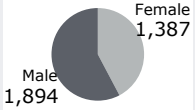
By Language



By Ethnicity

Race and Ethnicity group	
WHITE	2,189
HISPANIC	360
OTHER	534
ASIAN/PACIFIC ISLANDER	48
BLACK	228

By Gender



Division of Rendered Services

Youth/Perinatal Service	Modifiercode1	Modifiercode2	Modifiercode3	
Perinatal Services	U1	HD	Null	4
	U7	HD	Null	27
	U8	HD	Null	7
Youth Services	U1	HA	Null	6
	U3	HA	Null	6
	U7	HA	Null	32
			GT	6
			SC	7
	U8	HA	Null	3
	U9	HA	Null	6
	UA	HA	HG	6
		HG	HA	1

Wellness & Recovery Program
Short Doyle % of Claims (PCCN) Paid by County and FY Payment Month

Report Contact:
Diana Rose, Sr. QI Analyst, 530-351-9015
drose@partnershiphp.org

Fiscal Year
FY24

Report Date
- ○ 8/14/2023
- ○ 9/7/2023
- ○ 10/16/2023
- ○ 11/3/2023
- ○ 12/5/2023
- ◉ 1/8/2024

		Jul '23	Aug '23	Sep '23	Oct '23	Nov '23	Dec '23
12	Humboldt	99.89%	99.93%	90.69%	100.00%	100.00%	92.95%
18	Lassen	100.00%	100.00%	36.36%	70.75%		87.72%
23	Mendocino	92.89%	97.74%	79.01%	79.52%	50.00%	89.44%
25	Modoc	80.00%	100.00%		0.00%		9.09%
45	Shasta	99.81%	97.29%	37.73%	100.00%	89.89%	98.15%
47	Siskiyou	100.00%	98.69%	81.23%	85.41%	95.71%	49.63%
48	Solano	98.12%	70.19%	24.33%	90.37%	100.00%	89.06%

Limit
Top 6 by MAX([Report Date])

		Jul '23	Aug '23	Sep '23	Oct '23	Nov '23	Dec '23
12	Humboldt	99.89%	99.93%	90.69%	100.00%	100.00%	92.95%
18	Lassen	100.00%	100.00%	36.36%	70.75%		87.72%
23	Mendocino	92.89%	97.74%	79.01%	79.52%	50.00%	89.44%
25	Modoc	80.00%	100.00%		0.00%		9.09%
45	Shasta	99.81%	97.29%	37.73%	100.00%	89.89%	98.15%
47	Siskiyou	100.00%	98.69%	81.23%	85.41%	95.71%	49.63%
48	Solano	98.12%	70.19%	24.33%	90.37%	100.00%	89.06%

- Short-Doyle denied this service because this service is not allowed on the same date as the previously-approved service for this beneficiary.
- Short-Doyle denied the claim because it was for a beneficiary with unsatisfactory immigration status and the county is responsible to pay for 100% of the cost of the Medi-Cal services.
- Beneficiary is 21 years of age or more on the service start date and the HA modifier is reported on the claim or beneficiary is less than 21 years of age on the service end date and the HA modifier is not reported on the claim.
- Short-Doyle Medi-Cal denied this service because the NPI of the rendering provider is inactive in NPPES, or the incorrect NPI type for the rendering provider has been entered on the claim.
- Short-Doyle denied the service because the claim level pregnancy indicator is not present for a perinatal service.
- Short-Doyle denied this service because the service that is not methadone dosing was billed with a date range rather than a single date of service.
- Short-Doyle denied this service because too many units of that service were billed.
- Short-Doyle denied the service because the billing county is not the county of responsibility nor the county of residence for the beneficiary.
- Short-Doyle denied this service because the beneficiary is covered by Medicare and Medicare must be billed before billing Short-Doyle. (Medi-Medi)
- Short-Doyle denied the claim because all services in that claim were not provided in the same calendar month.
- Short-Doyle denied this Medi-Medi NTP/OTP Claims, because the coordination of benefits was entered at the Service Line level, or a combination of the Claim Line and Service Line level.
- Short-Doyle denied this service because the rendering provider's taxonomy code shown on the claim is not eligible to perform this outpatient service.
- Short-Doyle denied this service because the claim did not include the rendering provider's taxonomy code.

Wellness Recovery
Completed Site Reviews
FY 7/1/2023-1/19/24

DHCS Site ID	FacilityName	Proper City	COUNTY	REVIEW TYPE	REVIEW DATE	CAP?	CAP Deficiencies	Submitted to DHCS
42200004	MedMark - Vallejo	Vallejo	SOLANO	PERIODIC	07/11/23	No		7/25/2023
42200003	MedMark - Fairfield	Fairfield	SOLANO	PERIODIC	07/19/23	No		7/25/2023
42200013	AK Bean Foundation_Fairfield	Fairfield	SOLANO	PERIODIC	07/25/23	No		8/8/2023
40200001	Bi-Bett - Diablo Valley Ranch	Clayton	CONTRA COSTA	PERIODIC	07/26/23	No		8/8/2023
42200006	Bi-Bett - Shamia Recovery Center	Vallejo	SOLANO	PERIODIC	08/02/23	No		8/8/2023
40200002	Ujima - The Rectory-1901 Church Ln.	San Pablo	CONTRA COSTA	PERIODIC	08/08/23	No		8/11/2023
40200002	Ujima - The Rectory-1916 Church Ln.	San Pablo	CONTRA COSTA	PERIODIC	08/08/23	No		8/11/2023
42200007	Ujima Hope Solano	Vallejo	SOLANO	PERIODIC	08/09/23	No		8/10/2023
42200014	AK Bean Foundation_Vallejo	Vallejo	SOLANO	INITIAL MRR	09/01/23	No		9/23/2023
44000000	Modoc County Health Services	Alturas	MODOC	PERIODIC	09/05/23	No		9/6/2023
40500000	Tarzana Treatment Centers	Lancaster	LOS ANGELES	PERIODIC	09/19/23	No		9/26/2023
40500001	American Indian Changing Spirits	Long Beach	LOS ANGELES	INITIAL MRR	09/20/23	No		9/26/2023
42700000	Cache Creek Lodge	Woodland	YOLO	PERIODIC	10/10/23	No		10/16/2023
43200006	New Life Clinic	Ukiah	MENDOCINO	PERIODIC	10/10/23	No		10/18/2023
43200001	The Arbor Outpatient Drug Free Clinic	Ukiah	MENDOCINO	INITIAL FSR	10/10/23	No		10/18/2023
43200002	Ukiah Recovery Ctr_Ford Street (OP/IOP)	Ukiah	MENDOCINO	PERIODIC	10/11/23	No		10/18/2023
43200003	Ukiah Recovery Ctr - Ford Street (Res)	Ukiah	MENDOCINO	PERIODIC	10/12/23	No		10/18/2023
42200008	House of Acts Substance Abuse Program	Vallejo	SOLANO	PERIODIC	10/18/23	No		10/26/2023
42200005	Genesis House	Vallejo	SOLANO	PERIODIC	10/19/23	Yes	FSR CAP: I AS C1, I AS C2, II P A7, II P A8, III SABG A1e, III SABG A6 III SABG A7, III SABG A8, IV OM C26, IV OM C27, IV OM F2, IV OM G MRR CAP: II IS A, II IS I, II IS L, II IS O, IV DS A, IV DS C1, IV DS C5, IV DS C6, IV DS C7, IV DS C9, IV DS D, VI RES C, VI RES E	10/26/2023
42200010	Archway Recovery Services - OP/IOP	Fairfield	SOLANO	PERIODIC	10/23/23	No		11/7/2023
42200011	Archway Recovery Services - Res	Fairfield	SOLANO	PERIODIC	10/23/23	No		11/7/2023
42200015	Aldea Children & Family Services_Fairfield	Fairfield	SOLANO	INITIAL MRR	11/01/23	No		11/2/2023
42200009	Bi-Bett - Southern Solano Alcohol Council	Vallejo	SOLANO	PERIODIC	11/02/23	No		11/7/2023
42200016	Archway Recovery Services_Res_355 Travis	Fairfield	SOLANO	INITIAL MRR	11/07/23	No		11/14/2023
43200005	Mendocino County BHRS - Fort Bragg	Fort Bragg	MENDOCINO	PERIODIC	11/14/23	No		12/1/2023
43200000	Mendocino County BHRS - Ukiah	Ukiah	MENDOCINO	PERIODIC	11/14/23	No		12/1/2023
43200004	Mendocino County BHRS - Willits	Willits	MENDOCINO	PERIODIC	11/15/23	No		12/1/2023
40900000	Aldea Children & Family Services_Napa	Napa	NAPA	PERIODIC	11/29/23	No		11/29/2023
43600008	Groups Recover Together	Redding	SHASTA	PERIODIC	12/07/23	No		12/11/2023
43600006	Shasta County - Alcohol and Drug Programs	Redding	SHASTA	PERIODIC	12/07/23	Yes	II IS A, II IS B, II IS C, II IS D, II IS E, II IS H, II IS I, II IS L, II IS M, II IS O, III TS M, IV DS C2, IV DS C3, IV DS C4, IV DS C5, IV DS C6, IV DS C7, IV DS C8, IV DS C9, IV DS D.	12/11/2023
43600003	Empire Recovery Center Outpatient	Redding	Shasta	PERIODIC	12/20/2023	No		12/22/2023
43600001	Empire Recovery Center Residential W/M	Redding	Shasta	PERIODIC	12/21/2023	No		12/22/2023
43600007	Aegis Treatment Centers	Redding	Shasta	PERIODIC	1/4/2024	No		1/4/2024

FSR

Criterion	Deficiency
I AS C1	There is evidence that staff has received safety training and/or has safety information available in: Fire safety and prevention
I AS C2	There is evidence that staff has received safety training and/or has safety information available in: Emergency non-medical procedures (e.g. site evacuation, workplace violence)
II P A7	All employees have mandatory training on annual DMC-ODS requirements.
II P A8	All appropriate staff have received regular training on evidence based practices (EBP)
III SABG A1e	Personnel files maintained on all employees and volunteers/interns contain the following:Health records/status as required by program or Title 9
III SABG A6	Staff will receive Cultural and Linguistic training annually.
III SABG A7	Proof that staff have received education on the Trafficking Victims Protection Act of 2000
III SABG A8	All staff will sign confidentiality agreements, and/or have proof of training annually.
IV OM C26	Program has policies and procedures on the following area: Continuing Services
IV OM C27	Program has policies and procedures on the following area: Cultural Competency Program around CLAS standards
IV OM F2	Group sign in sheets include required elements below: Printed name, title and signature of the counselor
IV OM G	Counseling groups consist of between 2 and 12 clients.

MRR

Criterion	Deficiency
II IS A	Medical record does not contain a signed Consent to Release Information document.
II IS B	Medical record does not contain a signed HIPAA notification.
II IS C	Medical record does not contain a signed Client Rights document.
II IS D	Medical record contains signed Consent to Treatment document.
II IS E	Medical record does not contain a signed Program Rules document
II IS H	Medical record does not contain a signed Follow-Up Consent document.
II IS I	Medical record does not contain a documented physical exam.
II IS L	Medical Necessity is not determined appropriately by either a LPHA or Medical Director
II IS M	Missed appointments and outreach efforts are not documented in the client's chart.
II IS O	Medical record does not contain evidence of ASAM criteria used to determine medical necessity.
III TS M	Medical record does not contain evidence of justification for continuation of treatment services exceeding 6 months for OP services and annually for MAT services.
IV DS A	Discharge plan is not present for each client, with the exception of beneficiary with whom the provider loses contact
IV DS C1	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Reason for discharge, including whether the discharge was voluntary or inv
IV DS C2	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Description of treatment episodes

IV DS C3	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Description of recovery services completed.
IV DS C4	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Current alcohol and/or other drug usage.
IV DS C5	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Vocational and educational achievement
IV DS C6	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Client’s discharge summary signed by counselor and client
IV DS C7	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Transfers and referrals
IV DS C8	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Client's comments.
IV DS C9	Discharge summary for clients that terminate services does not include required elements according to AOD7120b: Beneficiary’s prognosis
IV DS D	Discharge plan is not present for each client, with the exception of beneficiary with whom the provider loses contact
VI RES C	Medical record does not contain documentation of TB test and results
VI RES E	Adult beneficiaries in Residential treatment are not re-assessed every 30 days, Youth every 30 days

By County

This dashboard shows data collected for CalOMS about Admissions, Discharges, and Annual Standard data by County for Substance Use Disorder (SUD) treatment services.

Health Analytics

Prepared by, Name

Discharge Date
7/1/2023 to 1/18/2024
and Null values

Admission Date
7/1/2023 to 1/18/2024
and Null values

Report St.. All

Co-occuri.. All

Unemploy.. All

Housing I.. All

Pregnancy All

Primary D.. All

Source Of .. All

Ethnicity .. All

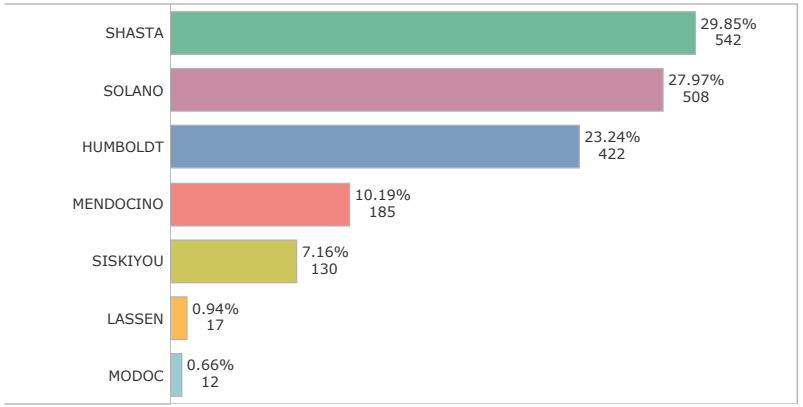
Discharge.. All

Race Desc All

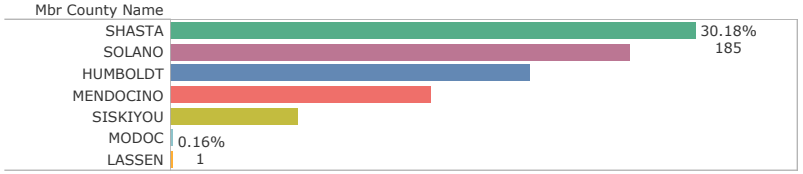
Type of Tr.. All

Out Of Co.. All

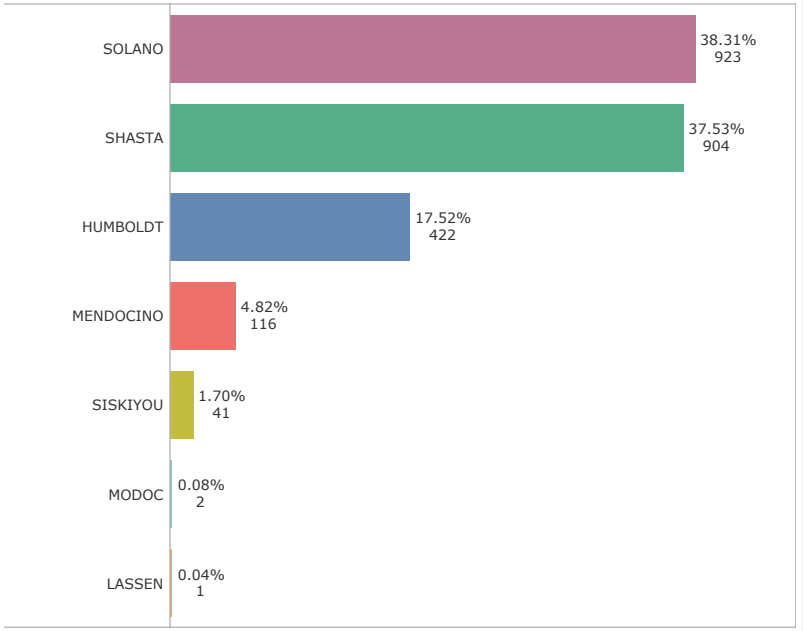
Admissions by County



Discharges by County



Annual Standard by County



CalOMS Workbook

This dashboard shows data collected for CalOMS which is data for Substance Use Disorder (SUD) treatment services

Health Analytics

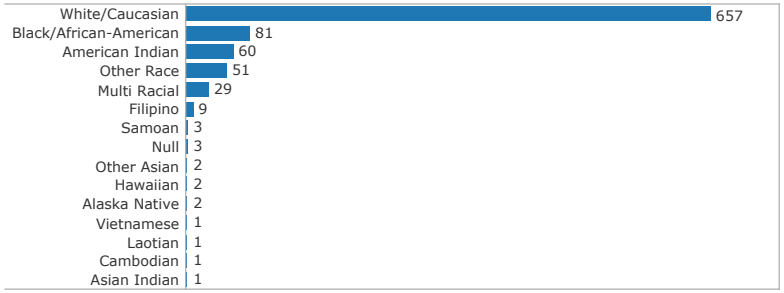
Prepared by, Name

Admission Date
7/1/2023 to 1/18/2024

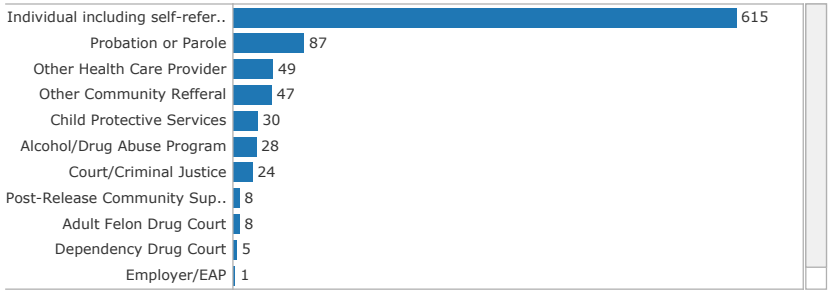
Type of Treatment Service Desc
All

Ethnicity Desc
- [x] Null
- [x] Cuban
- [x] Mexican/Mexican American
- [x] Not Hispanic
- [x] Other Hispanic/Latino
- [x] Puerto Rican

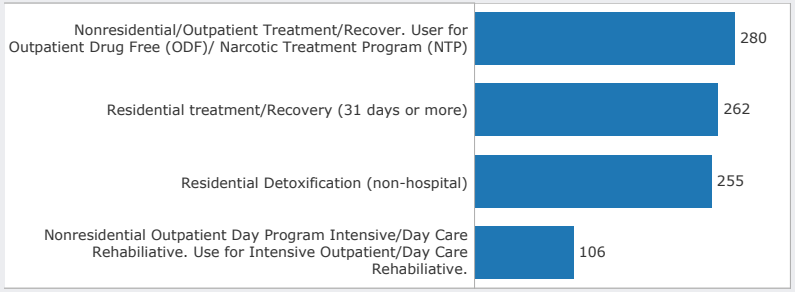
By Race



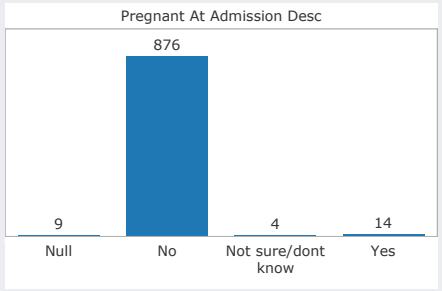
By Source Of Referral



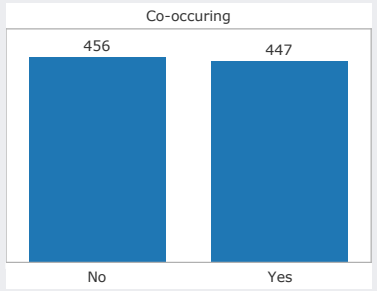
By Level Of Care



Pregnancy



Co-Occuring



CalOMS Workbook

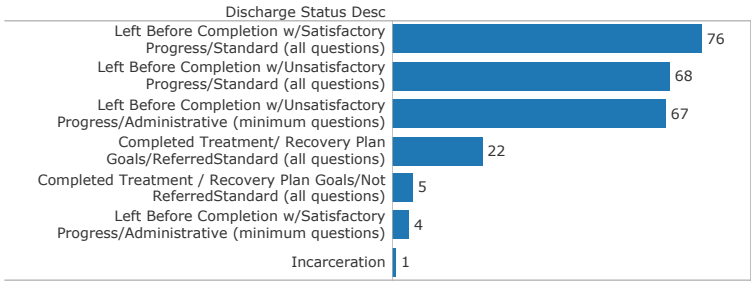
This dashboard shows data collected for CalOMS which is data for Substance Use Disorder (SUD) treatment services

Health Analytics

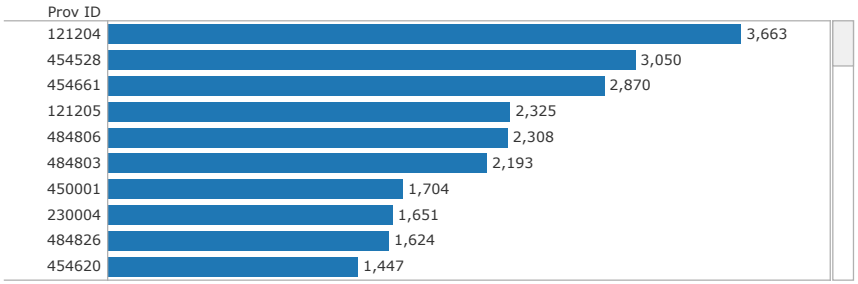
Prepared by, Name

Submitted..	July 1, 2023 to Januar..
Report Ty..	All
Type of Tr..	All
Discharge..	Multiple values
Co-occuri..	All
Housing I..	All
Race Desc	All
Ethnicity ..	Multiple values
Pregnancy	All
Primary D..	All
Source Of ..	All
AgeGroup	All
Prov ID	Multiple values

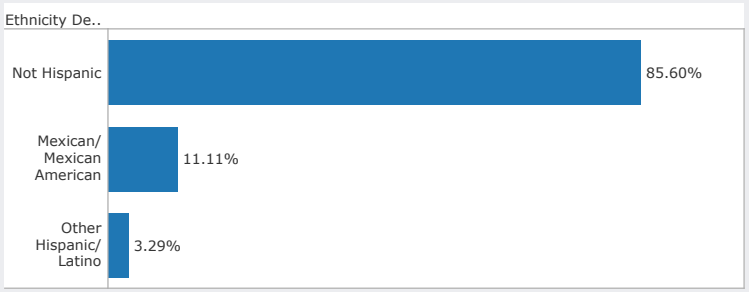
Discharges By Type



Reports by Provider



By Ethnicity



By Race

CalOMS Workbook

This dashboard shows data collected for CalOMS which is data for Substance Use Disorder (SUD) treatment services

Health Analytics

Prepared by, Name

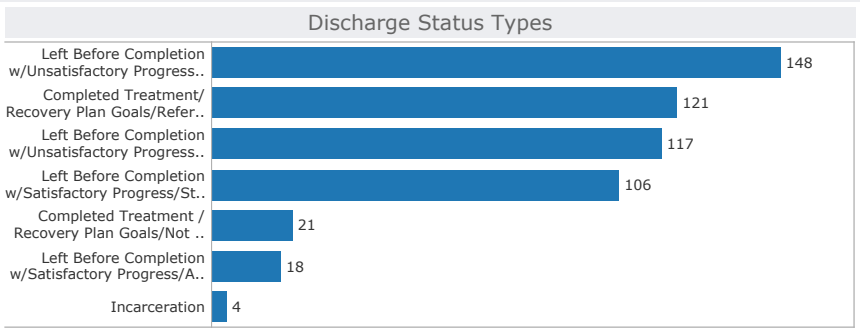
Discharge Date
7/1/2023 to 1/18/2024

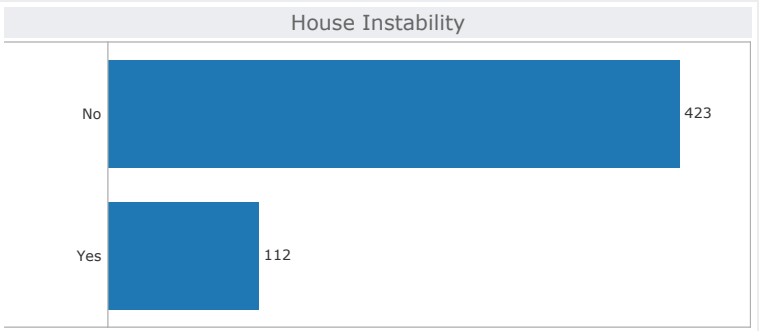
Type of Treatment Service Desc
All

Ethnicity Desc
- [x] Null
- [x] Cuban
- [x] Mexican/Mexican American
- [x] Not Hispanic
- [x] Other Hispanic/Latino
- [x] Puerto Rican

Report Type Desc
- [ ] Admission
- [ ] Annual Standard
- [x] Discharge

Report Status Code Desc
- [x] Deleted
- [x] Draft Not submitted to PHC
- [x] PHC Received
- [x] PHC Rejected
- [x] PHC Submitted to State
- [x] State Accepted
- [x] State Rejected





QI DEPARTMENT UPDATE
MAY 2024
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• Measurement Year (MY) 2023 final payment was distributed on 4/30/2024. • Providers can access their Final MY2023 Payment Statement on the Final Payment Dashboard through the Partnership Quality Dashboard (PQD) when it launches the first week of May. • PQD Kick Off Webinar is scheduled for 05/08/2024, 12 – 1 pm. Providers can notify the QIP team for registration details or materials, if unable to attend, at QIP@partnershiphp.org. • The PCP QIP Team will be hosting an Enhanced Supplemental QIP Webinar for eligible PCP sites taking on former Dignity Members in May. The webinar is planned for 05/09/2024 from 12 – 1 pm. This webinar will detail how provider sites can participate in supplemental targeted quality incentives given these member assignments are too late in the measurement year to qualify for final PCP QIP measure denominators in December. Partnership is designing these new opportunities to mitigate negative impact on HEDIS measures by prioritizing services needing gap closures in coming weeks and months.
LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTC QIP)	• Measurement Year 2023 final payment was mailed out on 4/30/2024.
PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)	• Palliative QIP team is processing July-December 2023 payment, which will be distributed by 05/31/2024.
PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP)	• 3rd Quarter Performance Reports were distributed to perinatal providers last month. • Fiscal Year (FY) 2024-2025 measure changes were reviewed and approved in quality committee meetings last month. • FY 2024-2025 outreach to perinatal providers in expansion counties began last month and continues with onboarding meetings being scheduled through May. • Detailed measure specifications are in progress. This document will be completed and made available for the network by 06/30/2024. • The FY2024/2025 Perinatal QIP Kick Off webinar will be scheduled for June, date still TBD.
ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (ECM QIP)	• A new measure, Timely Follow-up of ED/Admissions, is being proposed for addition to the 2024 measurement set in 3rd or 4th quarter. The details of this proposal are close to being finalized, per internal technical workgroup review and discussion. • The ECM QIP team will present measure set changes to the Physician Advisory Committee (PAC) in June.

HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)	• Hospital Quality Symposium planning is in progress and is on track to occur in two (2) locations: Fairfield, 08/07/2024, and Redding, 08/05/2024. Emails to hospitals with registration links went out in April. Reminders will go out in May and June. Redding Registration Link & Fairfield Registration Link. • FY 2024 – 2025 measurement set specification proposals were presented to IQI and approved by PAC. Detailed measure specifications are in progress. This document will be completed and made available for the network by 06/30/2024. • Our new Expansion County hospitals were spotlighted in both the HQIP Spring Newsletter and at the HQIP Advisory Group meeting. Check out the newsletter for a few highlights. • The FY2024/2025 HQIP Kick Off webinar is scheduled for 07/11/2024 at 1 pm.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• PQD 2024 launches the first week of May. • The PQD Kick-Off Webinar is scheduled to be held on 05/08/2024 from 12-1pm. • 2024 PQD Health Rules Payer – HealthEdge (HRP) User Acceptance Testing (UAT) is in progress, as the QIP team prepares for the HRP cut-over this summer.
EREPORTS	• Final HRP UAT for eReports is in progress, as the QIP team prepares for the HRP cut-over this summer. Exact timing for this cut-over is being finalized with IT and will soon be shared with providers.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	IHI / DHCS Medi-Cal Child Health Equity Collaborative
	• DHCS, in partnership with the Institute for Healthcare Improvement (IHI), has announced a 12-month Child Health Equity Collaborative to improve completion of well-child visits for all California Managed Care Plans (MCPs). More information:
	  ○ Collaborative Framework:
	  ▪ Timeline: March 2024 – March 2025
	  ▪ Implementation of interventions every 1-2 months
	  ▪ Each MCP has designated an internal team who: Meets weekly, participates in 2x monthly collaborative calls, Conducts project work
	  ▪ MCPs will engage a pilot provider partner site who will: Meet with MCPs/Collaborative as requested (at least monthly), plan and execute identified interventions
	  ○ Intervention topics and timelines
	  ▪ April-May 2024: Data - Equity & Transparent, Stratified, and Actionable Data
	  ▪ June-July 2024: Experiences - Understand Provider and Patient/Caregiver Experiences

- August-October 2024: Scheduling - Reliable & Equitable Scheduling Processes
- November-December 2024: Partnership Identification - Asset Mapping & Community Partnerships
- January-March 2025: Developing/Enhancing Partnerships - Partnering for Effective Education & Communication

- Collaborative Teams:
  - The Partnership project team consists of subject matter experts in quality, clinical practice, equity and population health. Ad-hoc team members will be engaged as needed and may include representatives from Health Analytics, Provider Relations, Health Education, Care Coordination, and our Tribal Liaison.
  - The pilot provider partner who has agreed to participate is Stallant Health and Wellness in Crescent City, CA
- Next Steps - The immediate next step in this process is completing the 1st intervention focused on Data. In this intervention phase, all MCPs will:
  - Engage in foundation setting conversations on equity alongside other participants
  - Explore the current state of their pilot clinic's Well Child Visit (WCV) measure data
  - Take at least one step towards improving and stratifying the data
  - Review data with their pilot clinic to agree on a shared priority population and aim for the work

IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative

- DHCS, in partnership with the Institute for Healthcare Improvement (IHI), has also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, in partnership with Nevada County Behavioral Health Department, was selected by DHCS to participate in this collaborative.
- This collaborative will run April 2024 through June 2025 and has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
  - % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)
  - % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)
- Partnership will partner with Nevada County's Behavioral Health Department to form an MCP/BHP "dyad" to plan and implement interventions. Partnership's Collaborative team will be led by Partnership's Behavioral Health Administrator; other team members will be subject matter experts in quality, clinical practice, equity and population health.

Enhanced Provider Engagement (EPE) & Modified PCP QIP Strategies

- All providers assigned to the Modified PCP QIP in 2024 have been assigned coaches and have begun initial steps of engagement for 2024.

	Performance Improvement Projects (PIPs) Update
	• As a contracted MCP, Partnership has been assigned two (2) Performance Improvement Projects (PIPs) by DHCS that will be completed over 2023–2026. Planning activities have begun on both PIP assignments:
	  ○ Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County
	  ○ Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit

QUALITY MEASURE SCORE IMPROVEMENT	• Partnership has completed one (1) round of Blood Lead testing grants for point-of-care (POC) devices for primary care providers and has closed its 2nd grant offering. The first round resulted in 10 POC device awardees along with 2 reimbursements for recently purchased POC devices. The second round is expecting to grant up to 25 devices, with applications currently in the review process.
	• Partnership continued to have growing interest in its Cologuard bulk ordering process pilot. At present, twenty-four (24) provider organizations are now engaged. Since last month's report, several have advanced in this pilot with the current status being:
	  ○ One (1) provider: Sonoma Valley Community Health Center has completed their first cycle and is deployed for a second cycle.
	  ○ One (1) provider: Consolidated Tribal Health Project has completed their first cycle and is in the planning phase for a second cycle.
	  ○ Two (2) providers: Alliance and Mountain Communities have completed their first cycle.
	  ○ Four (4) Providers: Colusa Medical Center, Fairchild Medical Center, Petaluma Health Center, and Southern Humboldt are all currently in the pilot process.
	  ○ Eleven (11) providers: Adventist Health, Ampla Health, Anderson Walk-in Medical, Chapa-De Indian Health, Greenville Rancheria Tribal Health, Lake County Tribal Health Consortium, Long Valley Health Center, River Bend Medical Associates Inc, Redwoods Rural Health Center, Santa Rosa Community Health Centers and Western Sierra Medical Clinic are in the planning phase for their first cycle.
	  ○ Four (4) providers: Families First, Mendocino Community Health Clinic, OLE+Communicare, and Peach Tree Health are pending a meeting with Exact Sciences to start the pilot process.
	  ○ Three (3) providers: Mad River Community, Marin Community Clinics and Shasta Community Health Center have met with Exact Sciences but are unsure if they will engage in a pilot at this time.
	  ○ One (1) providers: West County Health Centers have expressed interest with an outreach attempt being made but no initial meeting with Exact Sciences has been scheduled yet.

	• Partnership has engaged in the 3rd annual planning process for school-based immunization clinics with Evergreen Elementary School District (EESD) and Anderson RX (ARX). There are a total of four (4) planned events for this partnership: ○ One (1) Saturday clinic in early August 2024, just before school. In previous years, this was done at Shasta Community Health Center's (SCHC's) Enterprise location. In 2024, this is planned to be conducted on-site at EESD as a large event with volunteers from Partnership, EESD, ARX and SCHC. ○ Three (3) during school events in April and May of 2024. Framework for these events: ▪ School Nurses identify event days, locations and approximate eligible student population for vaccinations, based on CAIR review. ▪ Pre-event student education is delivered by EESD School Nurses with materials developed by Partnership. ▪ Use of event form developed by CDPH to be sent home and returned to school prior to the event day. School Nurses deliver forms to ARX at least ½ day prior to the event, so that ARX can prepare vaccines needed for the event day. ▪ Two (2) staff from ARX the day of the event, working in coordination with the 2 EESD school nurses to conduct immunizations. ○ First (1st) event day outcome summary: Conducted on 04/18/2024 at Mistletoe Elementary School (part of EESD). Over 50 vaccinations were given to over 20 students in a 1.5 hour timeframe with a high acceptance rate of HPV. This success is attributed to the pre-event education given to students. • Partnership continues working with five (5) providers engaged in the Cervical Cancer Screening Self Swab pilot to use 200 self-swab kits. • Practice Facilitation coaching has begun for 2024. At present, practices are focusing on finalizing SMART Aims and planning initial interventions. The following practices will be participating in Practice Facilitation in 2024: ○ Solano County Family Health Services ○ Consolidated Tribal Health Project ○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties ○ Adventist Health Ukiah Valley ○ Ampla Health ○ Northern Valley Indian Health
IMPROVEMENT ACADEMY	• The 2024 Improving Measure Outcomes (IMO) six part webinar series covering Partnership's Primary Care Provider Quality Incentive Program (PCP QIP) measures concluded in April. Content focused on direct application of measure best practices in clinical workflows, health disparity analysis, and Voices from the Field provider presentations about applications of best practices yielding high performance. ○ The most recent webinars, sessions 4 and 5, focused on Breast/Cervical Cancer Screenings and Perinatal Care/Chlamydia Screening. They were held on 04/10/2024 (63 attendees, representing 36 unique organizations) and 04/24/2024 (42 attendees, representing 25 unique organizations) respectively.

	○ Final program evaluations were sent to those attending two or more webinars. Survey results are being analyzed to measure the impact and effectiveness of trainings. • Other recently completed trainings included the *ABCs of Quality Improvement* on 05/01/2024 in Chico and the *Incorporating Patient Experience in Quality Improvement Projects and Plans* webinar on 05/07/2024.
Joint Leadership Initiative (JLI)	• Spring sessions are underway in the Northern and Southern Regions: ○ Shasta Community Health Center 04/22/2024 ○ OLE Health + Communicare 04/22/2024 ○ Open Door Community Health Clinics 05/6/2024 ○ Solano County Family Health Center 05/28/2024 ○ La Clinica 05/29/2024 ○ Adventist Health 06/05/2024 ○ Fairchild Medical Center 06/06/2024
Regional Improvement Meetings	• No updates

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI Program & Project Management

ACTIVITY	UPDATE
State Mandated Work: *Equity and Practice transformation (EPT) Program*	• The DHCS Equity and Practice Transformation (EPT) Program is a one-time $700 million state-wide initiative. The goals of this initiative are focused on advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; $25M for the Initial Planning Incentives Payments (IPIP), $650M over five (5) years for the Provider Directed Payment Program (PDPP), and $25M over five (5) years for the Statewide Learning Collaborative (SLC). • Partnership awarded $10,000 to twenty-three (23) qualifying provider organizations through the Initial Planning Incentive Payment (IPIP) program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the PDPP. Ten (10) of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023. Two (2) provider organizations who did not initially qualify for the IPIP program have since been approved by DHCS to participate. ○ In March, DHCS distributed IPIP payments to participating Managed Care Plans (MCPs). Partnership received $1,526,085.49 in IPIP funding. ○ The EPT strategy team has begun to explore utilization for the IPIP funds. A subset of funds will be allocated to tribal health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continues to develop.

	• All twenty-seven (27) provider organizations who were invited to participate in the PDPP sent acceptance responses to DHCS by their 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. Based on the funding criteria of the program, there is a possible draw-down of $45M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's five-year (5) timeline (01/01/2024 – 12/31/2028). ○ Milestone #1: As of 04/29/2024, all but one of the EPT practices have submitted their first EPT milestone deliverable. This deliverable requires completion of a Population Health Management Capabilities Assessment Tool (phmCAT) by 04/30/2024 to the Population Health Learning Center (PHLC) through an online platform at https://takethephmcat.com. The practice coach assigned to the remaining EPT practice is in active discussion with this practice to assure timely completion. ▪ The phmCAT is a self-administered survey assessment that is used to understand the current population health management capabilities of primary care practices. It can help organizations identify strengths and opportunities for improving population health management. ○ EPT practices who attested to completing any of the below required activities on their PDPP application need to complete an online form by 05/06/2024 or notify PHLC via e-mail at info@pophealthlc.org of their withdrawal to attestation. ▪ Empanelment & Access Activity ▪ Population Health & Quality Improvement Governance ▪ Dashboards & Business Intelligence ▪ Data & Quality Reporting Gaps • The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. ○ To support EPT practices in completing the first EPT milestone deliverable, PHLC hosted an EPT PhmCAT Webinar on 03/14/2024 and hosted twice weekly office hours and periodic learning labs to help EPT practices complete their PhmCAT. ○ PHLC is hosting additional office hours for EPT practices who attested to completing one (1) or more of the required activities.

<table>
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Partnership has a team of practice coaches dedicated to supporting EPT awardees and may draw on outside experts for specific transformation topics as needed.

Partnership met with PHLC on 04/16/2024 to follow-up on identifying and coordinating efforts between Partnership coaches and the PHLC coaching pool and the PHLC coaching pool.

</td></tr>
<tr><td>Quality Measure Score Improvement Mobile Mammography Program</td><td>

Completed Mobile Mammography Events:

Between 01/01/2024 - 05/01/2024, Partnership sponsored a total of 13 event days, with six (6) provider organizations in the following counties: Del Norte, Humboldt, Mendocino, Shasta and Sonoma.

Upcoming Mobile Mammography events:

14 event days are scheduled for May and June.

Northwest Region: two (2) event days with two (2) provider organizations (POs).
Northeast Region: four (4) event days with four (4) POs.
Southwest Region: three (3) event days with three (3) POs.
Southeast Region: five (5) event day with three (3) POs.

Planning for Mobile Mammography event days for Q3 is underway for Northern, Southern and Eastern region provider organizations. Targeted providers include those who had Breast Cancer Screening HEDIS® rates below the 50th percentile benchmark in MY2023 and remain at risk of being below the benchmark in MY2024; for providers who are located in imaging center deserts with little or no access to local imaging services.

</td></tr>
<tr><td>QI Trilogy Program</td><td>

The FY 2024/25 QI Program Description was finalized on 04/26/2024.
The following QI Trilogy documents are in the process of being updated and will be finalized by July 2024.

2023/24 QI Work Plan (final updates) – submissions due: 05/13/2024
2023/24 QI Program Evaluation – submission due: 05/31/2024

Upcoming deliverables for the remaining QI Trilogy document is as follows:

2024/25 QI Work Plan – submissions due: 06/19/2024

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<tr><td>Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program</td><td>

The regulated Consumer Assessment of Healthcare Providers and Systems® CAHPS survey is currently in the field.

Adult year-over-year respondent rates, are trending higher than last year. This is likely attributed to the increase in sample size for this population.
Child year-over-year respondent rates, are relatively flat to last year.

<table>
<tr><th>Task Name</th><th>Date</th><th>Status</th></tr>
<tr><td>Survey Mailed (1st attempt)</td><td>02/23/2024</td><td>★</td></tr>
<tr><td>First Reminder Letter Mailed</td><td>03/01/2024</td><td>★</td></tr>
<tr><td>Survey Mailed (2nd attempt)</td><td>03/29/2024</td><td>★</td></tr>
<tr><td>Second Reminder Letter Mailed</td><td>04/05/2024</td><td>★</td></tr>
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</td></tr>
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	<table><tr><td>Telephonic Reminders Begin</td><td>04/19/2024</td><td>★</td></tr><tr><td>Survey Concludes</td><td>Week of 05/13/2024</td><td></td></tr></table> • The non-regulated Drill Down survey is realizing strong growth week-over-week, likely due to the $30 gift card incentive offered to members who complete this survey. <table><tr><th>Task Name</th><th>Date</th><th>Status</th></tr><tr><td>Survey Mailed (1st attempt)</td><td>03/18/2024</td><td>★</td></tr><tr><td>Survey Mailed (2nd attempt)</td><td>04/03/2024</td><td>★</td></tr><tr><td>Telephonic Reminders Begin</td><td>04/17/2024</td><td>★</td></tr><tr><td>Drill Down Survey Concludes</td><td>05/29/2024</td><td></td></tr></table> • The CAHPS Score Improvement (CSI) is on track to meet the FY '23/24 department goal of ensuring at least two improvement activities and three interventions are implemented by the end of the fiscal year. This includes two improvement activities the QI CAHPS® Team has been leading this fiscal year. The first activity is the implementation of the Drill Down survey highlighted above. The second activity is a pilot in which in-house data sets are analyzed on a quarterly basis in an attempt to identify themes that point to member dissatisfaction. The goal is to effect change and/or implement steps to address barriers closer to real time. • The Charter and goal development for the FY '24/25, Access to Care and Member Experience Improvement Organizational Goal, is in-process.
GEOGRAPHIC EXPANSION: QI PROGRESS	The Quality Improvement (QI) Project Plan to onboard the East Region Expansion Counties to QI functions and programs began in June 2023 and will continue over the course of 2024. Status updates include: • Resource planning to recruit, hire, and onboard staff dedicated to Expansion Counties is nearly complete. Two (2) Improvement Advisor positions are in active recruitment, one of which will be based out of the Chico area and the other Auburn. Both will report join the Performance Improvement (PI) team. • Provider onboarding events in 2024 are underway with continued planning to build out further offerings, including: ○ PCP QIP focused communications and monthly office hours to assure providers have all the technical assistance needed to make a strong start in the PCP QIP. ▪ In the April office hour session, there were seventeen (17) attendees representing eight (8) East Region organizations. ▪ There are twenty-eight (28) registrants representing thirteen (13) East Region organizations for the May office hour session. ○ Partnering with PCP organizations in Regional Performance Improvement initiatives and interventions, like Mobile Mammography.

	○ As noted earlier in this update, the Perinatal QIP team is scheduling onboarding meetings in May to prepare East Region participants to join this fiscal year program, starting 07/01/2024. ○ Providing in-depth Site Review trainings to address DHCS Site Review changes. ○ Orientation events expected later this year will align with an introduction to topics like: Member Experience Surveys (i.e. CAHPS/CG-CAHPS), participating in Annual HEDIS Medical Record Projects, and Member Safety oriented investigations (i.e. Potential Quality Issues and Peer Review).

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **03/27/2024 TO 02/24/2024**	• There were eight PQI referrals received during this time period which were from Grievance and Appeals (7), and Utilization Management (1). • In total, 18 cases were processed and closed during this period. • There are 39 cases currently open. • Two new cases were presented 04/15/2024 to the Peer Review Committee. • Three cases were sent to Medical Review Institute of America for a subject matter expert review. • Engaged with other Managed Care Plan PQI teams for idea exchange and process improvements. • Conducted an educational virtual meeting regarding Provider Preventable Conditions (PPC) and reporting requirements with the Risk Management/Patient Safety manager at an inpatient acute hospital. • Conducting a focus review on two providers related to concerns identified during a Facility Site Review.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **03/28/2024 TO 04/24/2024**	• As of 04/24/2024, Partnership has a total of 467 PCP and OB Sites, versus a prior total of 482. While Partnership observed an increase of 5 new sites, it also termed 20 sites due to current status of negotiations with Dignity-Common Spirit. **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
North	6	5	1	5
South	5	8	3	4
Expansion	3	0	2	0

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	The MY2023 (i.e. Reporting Year (RY) 2024) Annual Projects continue. Key updates include: • On 04/29/2024, NCQA communicated broadly, in alliance with CMS, that it is offering an extended window to submit HEDIS® MY2023 results in response to the disruption of the Change Healthcare cyberattack on quality reporting efforts. • This means the final rate submission deadline is being extended nationally from 05/31/2024 to 06/28/2024. Partnership, along with several other health plans, formally requested NCQA consider an extension given the impact this disruption has had on over 1600 of our network providers. More specific details on Partnership's updated rate submission deadline and final rate approvals, dependent in part on our HEDIS auditors, will be shared next month. The Medical Record activities are expected to continue as originally planned and outlined below. ▪ 05/03/2024: Medical Record abstraction stops ▪ 05/09/2024: Medical Record Review & Validation (MRRV) Audit Launches • ECDS Data Integration Effort: ○ (8) of the (16) ECDS provider data passed the Supplemental Data Primary Source Verification (PSV) process. This data has been loaded and integrated into the MY2023 Annual Project. ○ Thank you to all participating providers for your collaboration in this very detailed audit process. ○ An initial assessment of the preliminary HEDIS rates for the depression screening measures indicates a positive increase in the rates from prior year. • MY2023 Preliminary Rates were submitted for both the MCAS and HPA required audits. PHC observed a positive increase in several rates from prior year for the Administrative and Hybrid measures across the board.
HEDIS® Program Overall	HRP: Conversion of PHC's core claims system from Amisys to HRP • Completed testing for the transition from PHC's core claims system, Amisys, to the new claims system, Health Rules Payer-HealthEdge (HRP) • If feasible another round of testing will be completed in the next 1-2 months, pending final cut-over deadlines and partnering with IT. Geographic Expansion: • The HEDIS team will be hosting Office Hours targeted to begin in July 2024, please look for a flyer that will soon be distributed with details.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE

NCQA Health Plan Accreditation	• Partnership's next HPA Renewal Survey is scheduled for 09/22/2026. In preparation for the start of the 24-month look-back period, which begins September 2024, Business Owners are asked to:
	  ○ Prepare screenshots of online materials and submit them to the NCQA Program Management Team by 08/08/2024.
	  ○ Ensure all documented processes are in compliance with the 2024 HPA Standards and Guidelines prior to the start of the look-back period (on or before August 2024).
	• Deadlines for policy and desktop revisions may vary based on the type of revision and if committee approval is required:
	  ○ Policy revisions impact NCQA requirements and require committee approval:
	  ▪ 05/09/2024: Deadline to submit redline policies to the NCQA Program Management Team for approval by our consultant.
	  ▪ 05/28/2024: Due date for June IQI. Note: IQI and Q/UAC will not be held in July, therefore policies must go to IQI and Q/UAC by June 2024 at the latest.
	  ○ Policy or desktop procedure revisions impact NCQA requirements but do not require committee approval:
	  ▪ 07/25/2024: Deadline to submit redline policies and desktop procedures to the NCQA Program Management Team for review by our consultant prior to the start of the look-back period.
	  ○ Policy or desktop procedure revisions do not impact NCQA requirements:
	  ▪ 07/25/2024: Deadline for Business Owners to confirm all documented processes are in compliance prior to the start of the look-back period.
	• The plan-wide NCQA-related HPA Department Goal for FY 23-24 focuses on sustaining key NCQA reporting requirements and maintaining up-to-date knowledge of the 2024 HPA Standards and Guidelines. There are three (3) milestones under the department goal.
	  ○ Milestones 1 and 2 are complete.
	  ○ Milestone 3: Selected departments will continue to maintain strict oversight of file review requirements by conducting quarterly file reviews. The next file review audit is due 05/15/2024. In addition, teams have participated in mock file reviews with our NCQA consultant.
	  ▪ Provider Relations completed their mock file review in March 2024, receiving perfect scores on the files reviewed.
	  ▪ Pharmacy completed their mock file review in April 2024; additional follow-up is required based on the assessment outcome.
	  ▪ Utilization Management will hold their mock file review in May 2024.
	  ▪ Business Owners will submit analysis reports for Partnership's NCQA Consultant review and approval.

NCQA Health Equity Accreditation	• Partnership's HEA Mock Initial Survey with our NCQA Consultant, Diane Williams, is scheduled for 08/19/2024-08/21/2024. Evidence preparation and submission

	training was recently held with all teams, which provided guidance and tips on how to prepare and present evidence in a standardized manner. Key upcoming activities for the HEA Mock Initial Survey include: ○ 04/30/2024-06/28/2024: Business Owners to prepare and submit evidence. ○ 05/06/2024-07/22/2024: NCQA Program Management Team to review submitted evidence and provide feedback, as needed. ○ By 07/26/2024: Business Owners to resubmit evidence, as needed, based on feedback received. • The plan-wide NCQA-related HEA Department Goal, Focus Area 2, focuses on NCQA HEA compliance with requirements assigned to a Business Owner within a department to ensure Partnership's readiness for accreditation. There are five (5) milestones under the HEA Focus Area 2 goal: ○ Milestones 1, 2, and 3 are complete. ○ Under Milestone 4, BOs are to achieve 80% compliance with their assigned HEA requirements. Activities by the BOs include: ▪ Submission of all draft reports as indicated in the HEA Report Schedule. ▪ Review their respective Action Items Tracker at least monthly. ▪ For departments below 80% compliance, a detailed strategic plan will be submitted to the NCQA Program Management Team to address the 20% or more non-compliant requirements by 06/14/2024. ○ Milestone 5 is in progress. This milestone is related to the submission of the annotated evidence for the HEA Mock Initial Survey, which began 04/30/2024 and will conclude on 06/28/2024. • The plan-wide NCQA-related HEA Department Goal, Focus Area 3, focuses on addressing compliance with Health Equity Standard HE 2, which is tied to Race/Ethnicity and Language (REaL) Data and Sexual Orientation and Gender Identity (SOGI) Data. The HE 2 Workgroup meets at least biweekly to develop the framework for compliance with HE 2 and includes the following activities: ○ The IT and HE Teams submitted documented processes that outline how Partnership receives, stores, retrieves, reconciles, and collects individual level data on REaL and SOGI. The documented processes explained the receipt of direct data from DHCS for 90% or more of individuals, how Partnership integrates the data into our system, as well as how and why Partnership receives data via other methods such as the annual member mailing, telephone, self-reporting data via the member portal, and other means. These documents will be revised and finalized based on NCQA Consultant feedback, but are on track to be completed by 06/28/2024. ○ The IT Team is exploring the options of generating report(s) to demonstrate how Partnership's data collection methods follow its documented processes. • The HE 2 Workgroup will begin discussion regarding managing access to and use of REaL and SOGI data, as well as notifying members of such policies and procedures.

	The HE 2 Workgroup engaged the Compliance Team to ensure Partnership continues to meet all other requirements per DHCS, etc., as we make updates to meet NCQA HEA requirements.

OLD BUSINESS
Synopsis of Further Changes to MCQG1015 – Pediatric Preventive Health Guidelines

Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement - *Presenter: Mark Netherda, MD. Medical Director for Quality*		
70 - 78	Q/UAC on March 20 approved most of the redline changes but directed Partnership staff to re-define 'Parent." After much internal discussion, "Parent" is now stated as: "For our purposes, a 'parent' is the designated legal guardian for the pediatric member." We are also adding back the definition of the CHDP program as this program does not sunset until July 1, 2024. The Pediatric Quality Committee approved these changes on May 2.	Health Services Claims Member Services Provider Relations

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Pediatric Preventive Health Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~03/08/2024~~ 06/12/2025
Last Review Date: ~~03/08/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td><td>☒ PQC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD MPH, MBA</td><td colspan="3">Approval Date: ~~03/08/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCQP1021 - Initial Health Appointment
B. MCUP3047 – Tuberculosis Related Treatment
C. MPQP1022 - Site Review Requirements and Guidelines
D. MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
F. MCCP2024 – Whole Child Model for California Children's Services (CCS)
G. MCUP3101 – Screening and Treatment for Substance Use Disorders
H. MPCP2002 – California Children's Services
I. CMP-20 Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Adolescent: The American Academy of Pediatrics (AAP) defines adolescents as persons aged 11 up to 21 years of age.
B. Parent: For our purposes, a "parent" is the designated legal guardian for the pediatric member.
~~A.~~C. CHDP: The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. CHDP sunsets July 1, 2024.

IV. ATTACHMENTS:

A. AAP Recommendations for Preventive Pediatric Health Care
B. TB Screening Recommendations (Flow Charts)
C. Blood Lead Testing Refusal Form
~~B.~~D. Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger

Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)		**Lead Department: Health Services**
Guideline/Procedure Title: Pediatric Preventive Health Guidelines		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date:** ~~03/08/2024 05/08/2025~~06/12/2025 **Last Review Date:** ~~03/08/2023~~05/08/2024~~06~~/12/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

~~To specify Partnership HealthPlan of California (PHC) policy for periodic health screening and preventive health services for members up to 21 years of age provided by primary care providers (PCPs). The California Department of Health Services requires that all Medi-Cal managed care health plans, including PHC, utilize the current Child Health and Disability Program (CHDP) and American Academy of Pediatrics (AAP) preventive health care recommendations, as well as the Advisory Committee on Immunization Practices (ACIP)/AAP immunization schedule, in formulating plan specific standards and guidelines. Since all PHC primary care providers who care for children are expected to be enrolled as CHDP providers, all other CHDP policies related to the provision of pediatric preventive services are applicable as well.~~To specify Partnership HealthPlan of California (Partnership) policy for periodic health screening and preventive health services for members up to 21 years of age provided by primary care providers (PCPs). The California Department of Health Care Services (DHCS) requires that all Medi-Cal managed care health plans, including Partnership, utilize the American Academy of Pediatrics (AAP) preventive health care recommendations, as well as the Advisory Committee on Immunization Practices (ACIP)/AAP immunization schedule, in formulating plan specific standards and guidelines. Since all Partnership primary care providers who care for children are expected to be enrolled as CHDP providers, all other CHDP policies related to the provision of pediatric preventive services are applicable as well.

VI. GUIDELINE / PROCEDURE:

A. The following standards and guidelines address periodic health screening and preventive services for low~~-~~risk, asymptomatic children and adolescents. Pediatric preventive care is also addressed in ~~PHC's~~ Partnership's policy MCCP2022 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

1. Individuals identified as being at high risk for a given condition may require screening at more frequent intervals or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those whose risk behaviors, family history, socioeconomic status, life style or disease or genetic condition is associated with a higher tendency to the development of a specific condition or disease.
2. ~~Where the AAP periodicity exam schedule (see Attachment A) is the same as the Child Health and Disability Prevention (CHDP) periodicity examination schedule, T~~the AAP scheduled assessment must include all components required ~~by the CHDP program~~ for the lower age nearest to the current age of the child. A physical examination is completed according to ~~CHDP/~~AAP periodicity exam schedule and each health assessment will include:
   a. Anthropometric measurements of weight, length/height and head circumference of infants up to age 24 months.
   b. Physical examination/body inspection, including screen for sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) on sexually active adolescents.
   c. Follow up care or referral ~~is provided~~ for identified physical and behavioral health problems as appropriate.
   d. Pediatric preventive care visits may take place ~~when medically necessary~~ on a more frequent basis than the AAP periodicity recommendations, when medically necessary. ~~PHC~~ Partnership recommends a 14-day minimum interval between well-child visits.

B. Primary Care Providers (PCPs) must complete an Initial Health Appointment (IHA) on all new M~~m~~embers within 120 days of enrollment to ~~PHC~~ Partnership or assignment to a PCP, or within 12 months prior to Plan enrollment~~.~~; (S~~s~~ee policy MCQP1021~~. - Initial Health Appointment~~). The IHA~~Initial Health Appointment~~ must include a history of the M~~m~~ember's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases (Reference A~~B~~, CalAIM Population Health Management Guide (~~September 2022~~October 2023). PCP office should ~~be requesting~~request and review

previous medical record(s) to show a complete history.

C. PCPs must provide immunizations according to the *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices* (ACIP), AAP, ~~and~~ the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC). ~~See the links in VII.F-I below.~~

1. Specific to ~~Department of Health Care Services (~~DHCS~~)~~ All Plan Letter (APL) 18-004, providers must ensure timely provision of immunizations to M~~m~~embers in accordance with the most recent schedule and recommendations published by ACIP, regardless of ~~a member's~~ age, sex, or medical condition, including pregnancy [as clinically appropriate]. Providers must document each M~~m~~ember's need for ACIP recommended immunizations as part of all regular health visits and enter such into the California Immunization Registry (CAIR2).
2. When immunizations are provided at sites other than the PCP's office, ~~the~~ that provider should ~~notify the PCP's office of the immunization given and the date~~enter the immunizations into CAIR2~~.~~, according to the provisions of AB1797.
   ~~a. If this is not possible, the member or parent/guardian or legal representative of the member must be advised to provide this information to the PCP at the next visit.~~
   ~~3. Provider site utilizes the (CAIR2) or the most current version available.~~
      ~~a. If the provider site does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record and refer member to appropriate facility to receive vaccination.~~

D. Screening for alcohol or drug or tobacco use and/or substance use disorders is considered part of the standard of primary care of Members aged 11 up to age 21. APL 21-014 stipulates that, consistent with United States Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, ~~Managed Care Plans (~~MCPs~~)~~ are required to provide SABIRT (Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment) for all M~~m~~embers aged 11 and older. PCPs must screen via validated screening tools. For more details, see MCUP3101 - Screening and Treatment for Substance Use Disorders.

~~1. PCPs will conduct (SABIRT Services using a validated assessment tool to determine if unhealthy alcohol use or SUD is present.~~
~~2. Brief intervention sessions (three, 15 minute sessions) will be offered. These sessions will be conducted by the member's PCP. Those members with a potential substance use disorder will be referred for treatment.~~
~~3. For more details on the SABIRT benefit, see MCUP3101 - Screening and Treatment for Substance Use Disorders.~~
~~4. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered part of the standard of care for primary care of members between the ages of 11 and under the age of 21.~~

E. Unless the M~~m~~ember has received a ~~periodic~~ health screening visit within the periodicity schedule (Attachment A), the M~~m~~ember, or the M~~m~~ember's parent~~/guardian or legal representative~~, must be informed at the time of **each** non-emergency primary care visit of the availability of services through the PCP's practice. If the Member is not seen as scheduled, the PCP's staff should contact the Member (or parent to reschedule the visit and document that they have done so. Any voluntary refusal by the Member (or parent) to visit their PCP as recommended should be documented in the medical record.

~~1. If the needed exam qualifies for services through the CHDP program, the member's parent/guardian or legal representative should be informed that services are available at the PCP's practice, or at another site offering CHDP services.~~
~~2. Should the member not receive periodic health screening services according to the recommended schedule in Attachment A, either of the following should be documented:~~
~~a. The voluntary refusal of the member (or the parent/guardian or legal representative) regarding the~~

~~use of CHDP services should be documented in the member's medical record, or:~~

~~b. There should be documentation of an outbound phone call or written communication from the provider~~PCP office ~~to the member advising of the need to schedule a periodic health screening appointment.~~

~~3.~~1. ~~In the case where a child scheduled for a periodic health screening visit is not seen as scheduled, the PCP's staff should contact the member (or parent/guardian) to reschedule the visit, and document same in the medical record.~~document all efforts.~~.~~

F. Diagnosis and treatment of any medical conditions identified through the periodic health screening ~~(CHDP) process,~~ either by the PCP or through referral to a specialist, must be initiated as soon as possible but no later than ~~within~~ 60 days ~~of~~ from identification. Justification for delays beyond 60 days must be entered into the M~~m~~ember's medical record.

~~G. Providers must enter their findings in the member's medical record.~~

~~H.~~G. If the PCP determines the Member has a condition making them eligible for the ~~Parents of children found to have conditions that could be eligible~~constitute eligibility for ~~for the~~ California Children's Services (CCS) Program, the PCP or their staff should inform the parent and initiate a referral to the county CCS office for eligibility determination. ~~must be informed of such.~~ (See policies ~~policy~~ MCCP2024 and MPCP2002.) ~~(CCS)). The PCP's staff should initiate a referral to the county CCS office for eligibility determination.~~

~~I.~~H. Monitoring and Quality Management

1. Timeliness and appropriateness of pediatric preventive health will be monitored annually by ~~completing designated~~ Healthcare Effectiveness Data and Information Set (HEDIS®) measures (including but not limited to Childhood Immunization, Adolescent Immunization, Well Child Visits in the third, fourth, fifth and sixth years of life, Adolescent Well Care Visits and Well Child Visits in the First 15 months.

~~1.~~2. Partnership's Site Review team will periodically review PCPs' d~~D~~ocumentation of pediatric preventive services. ~~will be reviewed periodically as a component of the Site Review process.~~ (See ~~policy~~ MPQP1022 ~~Site Review Requirements and Guidelines~~.)

~~J.~~I. Developmental Screening

1. Before age 3, comprehensive developmental screening must be performed at least annually in accordance with the APP/Bright Futures periodicity schedule, using one of the standardized instruments listed below.
   a. Ages and Stages Questionnaire (ASQ) - 2 months to age 5
   b. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
   c. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
   d. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
   e. Brigance Screens-II - Birth to 90 months
   f. Child Development Inventory (CDI) - 18 months to age 6
   g. Infant Development Inventory - Birth to 18 months
   h. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
   i. Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
   j. Or a standardized tool that follows CMS criteria per APL 23-016:
      1) Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
      2) Established Reliability: Reliability scores of approximately 0.70 or above.
      3) Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

i. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above (Reference: APL 23-016, Pg. 4)

~~2. The allowable standardized instruments are specified by CMS pediatric core measure definition: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf~~

3. Comprehensive developmental screening using one of the instruments above must be billed using the Current Procedural Terminology (CPT) code 96110 without a modifier.
4. Additional screening tests, such as focused screening for autism using the Modified Checklist for Autism in Toddlers (M-CHAT) or screening for social and emotional development using the ASQ-SE, may be performed before age 3, but must be billed using the added KX modifier: 96110.KX.
5. Developmental screening may also be performed for children over age 3, and billed with 96110 if one of the standardized instruments in section VI.I~~J~~.1 is used, or 96110.KX if another standardized tool is used.
   a. Up to one 96110 without a modifier is payable per year. Additionally, up to one 96110.KX is payable per year.
6. Providers will be audited for correct use of developmental screening instruments ~~by the Patient Safety team~~ as part of the site review process. ~~at their practice.~~

~~7. Use of the correct billing codes will be audited with intermittent spot audits, performed by the Patient Safety team.~~

7. Providers must document the following:
   a. The tool that was used.
   b. That the completed screen was reviewed.
   c. The results of the screen.
   d. The interpretation of the results.
   e. Any discussions with the Member and/or family; and any appropriate actions taken.
      1) Note, this documentation must remain in the Member's medical record and be available upon request by the Member and/or Member's parent~~(s)/guardian(s)~~.
   f. Completion of the developmental screening with CPT code 96110 without the modifier KX.
   g. Any additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX (Reference: APL 23-016, Pg. 4 & 5).

J. Trauma Screening – Adverse Childhood Experiences (ACEs) APL 23-017
1. PCPs may screen children annually up to age 19 for traumatic life events using the Pediatric ACEs and Related Life-events Screener (PEARLS), which includes screening for several social determinants of health.
   a. Coding results of screening will depend on the result of the screening. Codes will not be reported for non-qualifying ACE screening services or other services. Providers must calculate the Member's ACE screening score using the questions on the 10 original categories of ACE.
      1) G9919: Screening performed and positive and provisions of recommendations (4 and greater)
      2) G9920: Screening performed and negative (0 to 3)
2. ~~The California Department of Health Care Services (~~DHCS~~)~~ develops recommendations for stratifying the risk, based on the screening, and tailoring interventions to this risk stratification. These recommendations are based on consensus of experts and have not yet been studied systematically. DHCS maintains provider resources for administering trauma screenings and

provision of trauma informed care. More information is available on the DHCS website. See also ACESaware.org.

3. Providers must document the following in the Member's medical record and be available upon request by the Member and/or Member's parent~~(s)/guardian(s)~~ in compliance with all relevant state and federal privacy requirements:
   - The tool that was used.
   - The completed screen was reviewed.
   - Results of the screen.
   - The interpretation of results.
   - What was discussed with the Member and/or parent~~family~~.
   - Any appropriate actions that were taken.

   ~~2.~~ (References: APL 23-017, Page 7-8)

~~3. At this time, trauma screening for children is recommended but not required to be performed by primary care providers caring for children.~~

4. Provider attestation of completion of DHCS-approved training (accessible through the ACESaware.org website) by individual clinicians performing the screening is required for payment for billing of trauma screening services.

5 Auditing: U~~The u~~se of an ~~the~~ approved ACE Screening Tool~~s~~ ~~PEARLS in conjunction with use of the correct billing codes (listed above)~~ ~~A~~will be audited ~~intermittently by the Patient Safety team(s) in PHC~~Partnership~~'s Health Services' Quality Improvement department.~~through the s~~S~~ite r~~R~~eview p~~P~~rocess.

K. Blood Lead Level (BLL) ~~Screening~~Testing

1. DHCS APL 20-016 requires that during each well-child visit, ~~network~~ providers shall ensure the provision of oral or written anticipatory guidance to the parent~~/guardian(s)~~ of children between six months and six years of age that, at a minimum, includes:
   a. Information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning.
2. As per state and federal law, California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) guidance and Centers for Disease Control and Prevention (CDC) recommendations, ~~and unless the risk of screening is documented by the PCP as being greater than the benefit of testing~~, all children ~~members~~ should be should be tested and as applicable, treated for elevated blood lead levels (BLL) at intervals as follows:
   a. Ages 12 and 24 months;
   b. For children up to 72 months in age:
      1) Upon identification of missing/undocumented screening;
      2) Upon change in circumstance that may put the child at risk; or
      3) As requested by parent/guardian; and/or
      4) Post-arrival screening of refugees consistent with CLPPB guidance

~~3. Providers are not required to perform a blood lead screening test if the parent, guardian, or legal representative refuses to consent to screening.~~

~~a.~~c. If parent~~(s)/legal guardian(s)~~ refuses BLL ~~testing screening~~, they must sign a refusal form, which the provider will ~~must be signed by the parent/legal guardian and~~ document~~ed~~ in the Member's medical record. (See Attachment C.)

~~b.~~d. If a parent, guardian or legal representative refuses to sign ~~a~~ the refusal form, the provider must note this refusal and reason in the Member's medical record.

~~4.~~3. Communication to Providers

a. Effective January 1, 2021, ~~Managed Care Plans (~~MCPs~~)~~ must identify, at least quarterly and report to respective network providers, all M~~m~~embers under the age of 6 years~~,~~ who do not have a recorded BLL test result.~~.who have no recorded blood lead screening.~~

1) This list will be shared with the PCP site, which is expected to conduct ~~member~~ outreach to arrange ~~screening for elevated blood lead levels.~~for ~~blood lead~~BLL ~~test~~screening/testing.

b. ~~In addition to quarterly communication regarding missed blood level screenings, PHC~~ Partnership will ~~communicate and, as needed,~~ train providers and~~, including~~ laboratories as appropriate, regarding ~~PHC~~Partnership~~'s blood level screening~~testing requirements and related claims ~~policies~~procedures. This includes use of correct billing codes, claims forms, and reporting to ~~PHC~~ Partnership and to the ~~California Department of Public Health's Childhood Lead Poisoning Prevention Branch (~~CLPPB~~)~~ as required.

5. Record Retention and Reporting
   a. Data, documentation, and information related to the processes described under this policy shall be maintained in compliance with ~~PHC~~ Partnership policy ~~and procedure~~ CMP-30 ~~Records Retention and Access Requirements~~.
6. Claims and Validation
   a. ~~Fee-for-service claims and capitated encounters for covered blood lead level screening and treatment services~~Claims shall be submitted to ~~PHC~~ Partnership using appropriate and current claims forms/format (CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I)).
   b. Consistent with DHCS APLs 14-019 and 17-005 and the current DHCS Companion Guide for X12 Standard File Format, capitated encounters shall be validated, by ~~PHC~~Partnership, for completeness, accuracy, reasonableness, and timeliness when making payment and/or submission to DHCS. ~~This includes screening blood lead screening encounters for the use of appropriate indicators.~~

VII. REFERENCES:

A. CalAIM Population Health Management Policy Guide, ~~September 2022~~ October 2023
B. American Academy of Pediatrics (AAP) Practice Management, Preventive Care/Periodicity Schedule Summary of Changes to the ~~2022~~ 2023 Recommendations: https://www.aap.org/periodicityschedule (revised March 1, 2023)
C. AAP. Bright Futures Guidelines and Pocket Guide, 4th Edition. https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/ (April 26, 2022)
D. Centers for Disease Control and Prevention (CDC). 2024 Immunization Schedules at https://www.cc.gov/vaccines/index.html and https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
E. American Academy of Family Physicians (AAFP) Immunization Schedules: http:www.aafp.org/immunization
~~G.~~F. AAP publications on Health Supervision for Children with (disease/genetic condition) https://www.aappublications.org/search/policy/%20subject_collection_code%3A100 (Search should be done under the Policy tab)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-017 Directed Payments for Adverse Childhood Experiences Screening Services (June 13, 2023 supersedes APL 19-018)
H. DHCS APL 23-016 Directed Payments for Developmental Screening Services (June 9, 2023 supersedes APL 19-016)
I. DHCS APL 22-030 Initial Health Appointment (Dec. 27, 2022 supersedes APL 13-017)
~~H.~~J. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)
~~I.~~K. DHCS APL 20-016 *Revised:* Blood Lead Screening of Young Children (Nov. 2, 2020 supersedes APL 18-017)
~~J.~~L. DHCS APL 18-004 Immunization Requirements (Jan. 31, 2018 supersedes APL 07-015)

~~K.~~M. DHCS APL 17-005 Reminder Regarding Requirement to Submit Specialty Referrals Report (July 28, 2017)
N. DHCS APL 14-019 Encounter Data Submission Requirements (Dec. 19, 2014 supersedes APL 13-006)
O. DHCS Child Health and Disability Prevention Program (CHDP) https://www.dhcs.ca.gov/services/chdp/Pages/CHDP-Transition.aspx
P. United State Preventive Services Task Force (USPSTF) A & B Recommendations
Q. Title 17 CCR section 37100
R. California Assembly Bill 1797 Immunization Registry. (9/27/22).
~~L.~~S. CHDP Provider Notice 23-04 Child Health and Disability Prevention Program Activities in Fiscal Year 2023-2024 (12/14/23)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer (CMO)

X. REVISION DATES:
Medi-Cal
10/13/95; 10/10/97 (name change only); 03/11/98; 5/17/00; 02/20/02; 10/30/02 vs. 10/16/02; 10/20/04; 04/20/05; 10/19/05; 06/21/06; 09/19/07; 03/18/09; 02/17/10; 03/16/11; 10/17/12; 10/16/13; 11/19/14; 11/18/15; 10/19/16; 09/20/17; *06/13/18; 06/12/19; 02/12/20; 02/10/21; 05/12/21; 02/09/22; 03/08/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee (Q/UAC) meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee (PAC) meeting date.

PREVIOUSLY APPLIED TO:
PartnershipAdvantage:
MPQG1015 - 09/19/2007 to 10/16/2013

****

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

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

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

~~PHC's~~ Partnership's authorization requirements comply with the requirements for parity in mental health and

substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALIY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
Consent Calendar
May 15, 2024

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1021 (previously QP100121)				**Lead Department: Health Services**	
Policy/Procedure Title: Initial Health Appointment				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/18/2000			**Next Review Date:** ~~03/13/2025~~06/12/2025 **Last Review Date:** ~~03/13/2024~~06/12/2024		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~03/13/2024~~06/12/2024	

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MPQG1015 – Pediatric Preventive Health Guidelines
C. MCUP3101 – Screening and Treatment for Substance Use Disorders
D. MCUG3118 – Prenatal and Perinatal Care
E. MPQP1022 – Site Review Requirements and Guidelines
F. CMP36 – Delegation Oversight and Monitoring
G. MCUP3039 – Direct Members
~~G.~~H. MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services

III. DEFINITIONS:

A. An Initial Health Appointment (IHA) is defined as a member's visit to his or her Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
B. ~~PHC~~ Partnership HealthPlan of California (Partnership) defines newly assigned members as those individuals never before enrolled to the health plan or a previously enrolled member's first month back to the plan, who was not continuously enrolled for 120 days in the past eight months, prior to the new member month.
C. Direct Members are those whose service needs are such that ~~Primary Care Provider (~~PCP~~)~~ assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership~~PHC~~ network providers and/or certified Medi-Cal providers willing to bill Partnership~~PHC~~ for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

IV. ATTACHMENTS:

A. PCP New Member Letter MC
B. IHA Applicable Visit Codes
C. Two- Attempt Outreach Tracker Template

Policy/Procedure Number: MCQP1021 (previously QP100121)		**Lead Department: Health Services**
Policy/Procedure Title: Initial Health Appointment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/18/2000	**Next Review Date:** ~~03/13/2025~~06/12/2025 **Last Review Date:** ~~03/13/2024~~06/12/2024	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

V. PURPOSE:

To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members.

VI. POLICY / PROCEDURE:

A. To meet the Department of Health Care Services (DHCS) contractual requirements, an IHA is to be performed:
   1. Within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership~~PHC~~) or within 120 days of a member's assignment to a PCP (whichever is most recent).
      a. Refer to Medi-Cal Managed Care Division policy letter APL22-030 (Dec. 22, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003).
      b. Exceptions to this requirement are specified in Section E of this policy.

B. An IHA must be performed by a Provider within the primary care medical setting and must be provided in a way that is culturally and linguistically appropriate for the member.

C. An IHA must include all of the following:
   1. A history of the member's physical and mental health;
      a. History of present illness
      b. Past medical history
      c. Social history
      ~~1.~~d. Review of organ systems (ROS) including dental assessment
   2. An identification of risks;
   3. An assessment of need for preventive screens or services; see Section D
   4. Health education
      a. The provider should assure documentation, at initial and subsequent visits, of health education interventions including risk factors addressed, intervention codes, date and PCP's signature or initials. More extensive documentation in the progress notes is encouraged.
   5. The diagnosis and plan for treatment of any diseases.
   ~~5.~~6. A member Risk Assessment

D. Preventive Services
   1. The IHA must bring members up to date with all currently recommended preventive services, including immunizations, or arrange to have the member brought up-to-date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.
   2. For members under the age of 21 years, the IHA shall follow these requirements:
      a. The IHA shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et seq., and Title 17, CCR, Sections 6l842 through l6852, except that the PCP shall follow the most recent periodicity schedule (*aka* Bright Futures Recommendations for Periodic Preventive Health Care) recommended by the American Academy of Pediatrics (AAP) as noted in Reference D of this document and in MPQG1015, the Pediatric Preventative Health Guidelines. This supersedes any contradicting information found within the Child Health and Disability Prevention (CHDP) Program guidelines, as the CHDP sunsets July 1, 2024. ~~Although American Academy of Pediatrics (AAP) guidelines/periodicity must be followed, the preventive visits must also include age specific assessments and services required by the Child Health and Disability Prevention Program (CHDP).~~
      ~~a.~~1) All active CHDP providers as of June 30, 2024 will be automatically enrolled as CPE (Children's Presumptive Eligibility Program) providers on July 1, 2024.
      b. For asymptomatic members 21 years and older, the IHA shall follow these guidelines:
         1) The IHA shall include a history and physical examination sufficient to assess and manage

the acute, chronic, behavioral, and preventive health needs of the member.

2) The PCP shall provide the core set of preventive services for adult screening of asymptomatic health members over the age of 21years consistent with MCQG1005, Adult Preventive Health Guidelines and the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF).

3. Perinatal Services
   a. Perinatal services for pregnant members will be provided according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG). Refer to the policy MCUG3118, Prenatal and Perinatal Care. For members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, an IHA must be performed by the member's PCP, or other provider of primary care services (i.e., OB/GYN). The pregnancy must be noted and the Initial Prenatal Assessment for pregnant women completed, or referral made to another ~~PHC~~ Partnership provider for initiation of pregnancy-related services, including the required prenatal assessment. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.
   b. Pregnant and breastfeeding members must be referred to the Women, Infants, and Children (WIC) program. Infant feeding plans should be documented during the prenatal period, and infant/breastfeeding status is documented during the postpartum period. See MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program.
4. Members with Chronic and/or Complex Conditions
   a. For members who have been receiving services for chronic and/or complex conditions prior to enrollment in ~~PHC~~Partnership, the clinician conducting the IHA must ask specific questions to identify services being provided to members by Local Education Agencies, Regional Centers, early intervention programs, the Whole Child Model (WCM) and other special programs outside of the ~~PHC~~ Partnership network, including those serving aged and/or disabled members, to allow the PCP and ~~PHC~~ Partnership to most effectively accomplish necessary coordination, continuity of care and case management functions.

E. Excluded Members
1. Individual members may be excluded from the IHA requirement under the following circumstances:
   a. The medical records contain documentation of prior health assessments within the 12 months prior to enrollment, and which the member's primary care services provider determines meets the requirements for documentation of the IHA.
   b. Members under 2 years of age upon enrollment generally require a periodic health examination in less than 120 days given AAP periodicity requirements and related contractual requirements.
   c. Members who are not continuously enrolled in ~~PHC~~ Partnership for 120 days.
   d. Members, including emancipated minors, or a member's parent(s) or guardian, who refuses an IHA. In this case, a statement signed by the member must be documented in the member's medical record. If the member or the party legally responsible for the member refuses to sign a refusal statement, the verbal refusal of services will be noted in the medical record.
   e. Members with certain restricted aid codes, except pregnancy, which limit the services to which members are entitled, or to members who are share-of-cost (SOC) Medi-Cal beneficiaries are exempted from the IHA.
   f. The member was dis-enrolled from the plan before an IHA could be performed.
   g. The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least the following:
      1) One attempt to contact member by phone

2) One attempt to contact member by letter or postcard
3) ~~PHC's~~ Partnership's good faith effort to update the member's contact information
4) Attempts to perform the IHA at subsequent member office visit(s)

F. IHA Training
1. Site Review:
   a. ~~PHC~~ Partnership will provide training for our network providers and staff during the Site Review (SR) and via the Providers' Newsletter on an annual basis. Information includes:
      1) Adequate documentation,
      2) Timelines for performing IHAs, and
      3) Procedures to assure the visit(s) for the IHA are scheduled and that members are contacted for missed IHA appointments.
2. Provider Relations
   a. New member lists, with address labels, are distributed to providers. Providers may use these lists to document contact attempts. This documentation should be kept for three years.

G. Informing Members
1. Members will be informed of IHA requirements via the Member's Newsletter and ~~PHC's~~ Partnership's website regarding:
   a. Instructions on arranging IHA appointments with appropriate timelines
   b. Importance of scheduling and keeping the IHA appointment

H. IHA Monitoring
1. ~~PHC~~ Partnership will monitor compliance to the timely provision of IHAs during the regularly scheduled Medical Record Review (MRR~~MMR~~), as part of the Site Review. Reviewers provide PCPs with a list of members that claims data identifies as needing an IHA. Reviewers also provide templates for PCPs to document outreach attempts to bring members in for an IHA visit. PCPs or other providers of primary care services must document the performance of an IHA in the member's medical record or state that equivalent information is part of the medical record. All counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted during the IHA should be documented in the medical record. Exemptions from the IHA requirement must be appropriately documented in the medical record or on the PCP member list.
2. On an annual basis, ~~PHC~~ Partnership pulls claims and encounters with specific visit codes (Attachment B – IHA Applicable Visit Codes) for primary care providers to identify the percentage of their newly assigned members who had a visit within 120 days of being newly assigned.

I. Direct Members: Since Direct Members are not generally assigned to a PCP, providers primarily responsible for their care should perform the IHA per the requirements outlined in this policy. For more information on Direct Members, see MCUP3039 – Direct Members.

J. Delegation of IHA monitoring functions
1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at ~~PHC~~ Partnership discretion, to perform IHA monitoring functions as part of the Site Review Process. An organization or groups will perform these functions under a formal delegation agreement.
2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both ~~PHC~~ Partnership and the delegated entity.
3. Delegated entities will perform IHA monitoring functions for all Primary Care Physician (PCP) sites no less than every three years.
4. ~~PHC~~ Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
5. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

Policy/Procedure Number: MCQP1021 (previously QP100121)		**Lead Department: Health Services**
Policy/Procedure Title: Initial Health Appointment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/18/2000	**Next Review Date:** ~~03/13/2025~~06/12/2025 **Last Review Date:** ~~03/13/2024~~06/12/2024	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (-APL) 22-030 Initial Health Appointment (Dec. 22, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
B. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021)
C. DHCS APL 18-004 Immunization Requirements (Jan. 31, 2018)
D. American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
E. DHCS APL 23-005 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21 (March 16, 2023 supersedes 19-010)
F. DHCS CHDP Provider Notice 22-06 Child Health and Disability Prevention Program Discontinuance (Oct. 21, 2022)

~~E.~~

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer (CMO)

X. REVISION DATES: 05/15/02; 04/20/05; 06/21/06; 06/20/07; 07/16/08; 10/21/09 11/17/10; 10/16/13; 02/19/14; 02/17/16; 02/15/17; *03/14/18; 06/13/18; 06/12/19; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 03/13/24; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

To: Primary Care Providers

From: Partnership HealthPlan of California
Provider Relations Department

RE: Mailing Labels/List of New Patients to your Practice

Attached is a list and address labels for members recently assigned to your practice. We are providing this information to assist you in welcoming new patients to your practice and to remind you of the importance of conducting an Initial Health Appointment (IHA) within 90 days of the member's enrollment into ~~PHC~~Partnership. If the member had a health history and physical exam completed by you or a previous provider within 1 year of joining Partnership, you do not have to complete another initial health appointment, provided that you have a copy in the member's chart. Conducting IHAs is a regulatory requirement by the Department of Healthcare Care Services (DHCS) and is therefore contractually required by ~~PHC~~Partnership.

The initial health appointment must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screenings or services, health education, and the diagnosis and treatment plan for any diseases. For children and youth (i.e., individuals under age 21) screenings should be conducted according to the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care: Bright Futures periodicity schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). For adults screenings should be conducted according to U.S. Preventive Services Task Force (USPSTF) guidelines.

We've attached sample letters in English, Spanish, Russian and Tagalog that you can use to welcome new members to your practice and to encourage them to make an appointment with you so that they can timely receive an IHA.

You should retain documentation of your efforts as Partnership will look for this documentation during your facility site review and sometimes, DHCS audits providers directly to ensure this requirement is met.

Please contact your Provider Relations Representative at (707) 863-4100 if you have any questions. We hope this information is helpful to your practice.

Thank you.

www.partnershiphp.org

SAMPLE WELCOME LETTER MEDI-CAL

Dear Partnership HealthPlan Member,

Welcome to our practice. As your primary care provider, I am looking forward to meeting you and would like to ask that you call the office to schedule a check-up. Both the Partnership HealthPlan and state Medi-Cal program ask that you have this visit within 3 months of becoming Medi-Cal eligible. During this check-up, we will review your past and current medical needs. I would also be happy to answer any questions that you have about your health.

Please take the time to schedule your appointment by calling (___) ___-____. Check-ups are a great way for you to know that you are in good health and also, a good time for your doctor to explain how you can prevent health problems.

Let's work together for your health.

Sincerely,

Estimado miembro del Partnership HealthPlan:

Bienvenido a nuestro consultorio. Como somos su proveedor medico principal, nos encantaría conocerle, y por eso le pedimos que nos llame para hacer una cita con su medico regular. Tanto el Partnership HealthPlan, como el Medi-Cal del Estado de California, requieren que usted haga cita con su médico antes de que pasen tres meses desde la fecha en que le dijeron que era elegible para Medi-Cal. Cuando venga a su cita para que le hagan un examen general, vamos a platicare de su cuidado medico del pasado, y del cuidado medico que necesita en estos momentos. También tendremos el gusto de darle respuesta a cualquier pregunta que tenga sobre su salud.

Por favor, llame al numero (___) ___-____ para hacer su cita para un examen general con el medico. Los exámenes generales son la mejor manera de saber si su salud es buena, y también es la mejor oportunidad de que su doctor le explique en que forma puede prevenir ciertos problemas médicos que pueda tener.

Vamos a colaborar juntos para mantenerlo sano.

Atentamente,

ОБРАЗЕЦ ПРИВЕТСТВЕННОГО ПИСЬМА MEDI-CAL

Уважаемый участник плана Partnership HealthPlan,

Добро пожаловать в нашу организацию. Как ваш основной поставщик медицинских услуг я жду знакомства с вами и прошу вас позвонить администратору, чтобы запланировать проверку здоровья. Правила плана Partnership HealthPlan и программы штата Medi-Cal требуют, чтобы вы посетили нас в течение 3 месяцев с момента получения права на Medi-Cal. Во время этой плановой проверки мы оценим ваши текущие и прошлые потребности в медицинском обслуживании. Я также с удовольствием отвечу на все ваши вопросы о вашем здоровье.

Запишитесь на прием по телефону (___) ___-____. Плановые проверки помогут установить состояние вашего здоровья и обсудить с врачом способы профилактики проблем со здоровьем.

Вместе мы сможем позаботиться о вашем здоровье.

С уважением,

HALIMBAWA NG WELCOME LETTER SA MEDI-CAL

Minamahal na Miyembro ng Partnership HealthPlan,

Welcome sa aming panunungkulan. Bilang inyong tagapagbigay ng pangunahing pangangalaga, inaabangan ko ang ating pagkikilala at gusto kong hilingin sa inyo na tawagan ang opisina para magtakda ng check-up. Hinihingi ng kapwa Partnership HealthPlan at programang Medi-Cal ng estado na pumunta kayo para sa pagbisitang ito sa loob ng 3 na buwan matapos maging kwalipikado para sa Medi-Cal. Sa check-up na ito, rerepasuhin namin ang inyong mga medikal na pangangailangan sa nakaraan at sa kasalukuyan. Ikagagalak ko ring sagutin ang anumang mga tanong ninyo tungkol sa inyong kalusugan.

Maglaan sana ng oras para itakda ang inyong appointment sa pamamagitan ng pagtawag sa (___) ___-____. Ang mga check-up ay magandang paraan para malaman ninyo na nasa mabuting kalusugan kayo at mabuti ring panahon para ipaliwanag ng doktor ninyo kung paano ninyo maiiwasan ang mga problema sa kalusugan.

Magtulungan tayo para sa inyong kalusugan.

Taos-pusong sumasainyo,

PCP ID	Patient Name:	CIN:	DOB:	Date of Enrollment	Date of Attempt 1: How was attempt made?	Date of Attempt 2: How was attempt made?

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCQP1047 (previously MPQP1047)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Advance Directives</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/17/2009</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1038 – Physician Orders for Life-Sustaining Treatment
B. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define member rights to have an Advance Health Care Directive (aka Advance Directive), and define practitioner and health plan responsibility to provide Advance Directive information to Partnership HealthPlan of California (Partnership) members who are adults or emancipated minors.

VI. POLICY / PROCEDURE:

A. Regarding Members

1. ~~PHC~~ Partnership advises members about Advance Health Care Directives and their right to execute one. The Advance Directive form enables the individual to express his or her preferences for life-sustaining treatment and to elect an individual to make health care decisions in a situation where the individual is unable to make decisions for ~~himself or herself~~themselves. Members receive this information from ~~PHC~~ Partnership in the Evidence of Coverage document on enrollment and information about Advance Directives is available on the ~~PHC~~ Partnership website. ~~PHC~~ Partnership will notify members within 90 days if there are changes in state law regarding Advance Directives. ~~PHC~~ Partnership acknowledges that members have the right to not fill out part or all of the Advance Directive form as a matter of conscience. ~~PHC~~ Partnership will not discriminate in any way against a member who chooses to not fill out part or all of an Advance Directive form. If a member is incapacitated at the time of initial enrollment and unable to receive information (due to the incapacitating condition or to a mental disorder) or articulate whether ~~he or she has~~they have executed an Advance Directive, ~~PHC~~ Partnership will give Advance Directive information to the member's family or surrogate in the same manner that we issue other materials about policies and procedures. When the incapacity has resolved, ~~PHC~~ Partnership Care Coordination staff ~~identify~~

~~any adult member whose incapacity has resolved, Care Coordination staff~~ will discuss advance care planning with the member, including the recommendation to complete an Advance Directive.

B. Regarding Practitioners
   1. ~~PHC~~ Partnership regularly provides education on Advance Directives to all contracted providers for whom advance care planning is an appropriate part of their scope of practice. ~~PHC~~ Partnership encourages its clinicians to discuss the right to execute an Advance Directive and to honor the Advance Directive of any individual who completes the form. The primary care provider (PCP) and/or specialist should periodically review the Advance Directive with the patient to ensure the elections made on the form continue to reflect the current wishes of the individual. The PCP should keep a copy of an executed Advance Directive in the medical record. PCPs should not condition the provision of care or discriminate against an individual based on whether the patient has executed an Advance Directive or on the contents of that Advance Directive. ~~PHC~~ Partnership acknowledges that health care providing organizations, and individual clinicians practicing in each organization, may conscientiously object to implementing parts of executed Advance Directives. In such cases, it is expected that the organization and/or individual practitioner will inform the member that they cannot implement those portions of the Advance Directive to which there is conscientious objection. The member should be offered the right to switch their care to an organization or practitioner who will follow the requests in their Advance Directive.
   2. ~~PHC~~ Partnership Facility Site and Medical Record Review (see MPQP1022) on primary care provider sites determines if providers offer Advance Directive information. Documentation in the medical record should indicate if the PCP discussed Advance Directives with the patient and/or if the patient executed or refused an Advance Directive. Evidence of a discussion of the Advance Directive is sufficient to meet site review requirements.

C. Regarding ~~PHC~~ Partnership Staff
   1. ~~PHC~~ Partnership provides education of its staff regarding our policies and procedures about Advance Directives.

D. Regarding the Community
   1. ~~PHC~~Partnership, in partnership with various community organizations, encourages community education regarding Advance Directives, emphasizing that they are designed to enhance individual's control over their medical treatment plans.

VII. REFERENCES:

A. Title 42, Code of Federal Regulations, Sections 422.128 and 489.100
B. California Probate Code, Sections 4670 through 4743
C. Medi-Cal Handbook / Evidence of Coverage
D. Medicare Managed Care Manual
E. ~~PHC~~ Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/California-Advance-Health-Care-Directive.aspx
F. Multiple Advanced Directive options can be found on the California Coalition for Compassionate Care website: https://coalitionccc.org/CCCC/Resources/ACP-Tools-Resource-List.aspx

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

Policy/Procedure Number: MCQP1047 (previously MPQP1047)		**Lead Department: Health Services**
Policy/Procedure Title: Advance Directives		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/17/2009	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: 06/14/202306/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

X. REVISION DATES:

Medi-Cal

08/18/10; 05/21/08; 05/20/09; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 10/19/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 6/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Partnership*Advantage*:

PAQI 101 – 06/21/2006 to 05/21/2008

PAQP1036 – 05/21/2008 to 10/17/2012

MPQP1047 – 10/17/2012 to 01/01/2015

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCQP1052</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/20/2013</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1022 - Site Review Requirements and Guidelines
B. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Provider Relations
B. Quality Improvement

III. DEFINITIONS:

A. The Physical Accessibility Review Survey (PARS) is an on-site review of a provider office site's structural amenities vis-a-vis the potential for an adverse effect on seniors or persons with disabilities.
B. Primary Care Provider (PCP): the PCP is a general practitioner, internist, pediatrician, family physician, ~~or~~ obstetrician/gynecologist (OB/GYN), nurse practitioner or physician assistant.
C. High Volume Specialist: a provider in Partnership HealthPlan of California's (~~PHC's~~Partnership's) Southern Region that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year or a provider in ~~PHC's~~ Partnership's Northern Region that has billed at least 350 visits during the prior calendar year and who saw a minimum of 150 unique members during the prior calendar year. Specialist types are those recommended by the American Board of Medical Specialties (ABMS). A specialist is defined as: A physician specialist, Board Certified by an ABMS Member Board is a licensed physician who focuses ~~his or her~~their practice in a particular area of medicine or patient care and may concentrate on certain body systems, specific age groups or complex scientific techniques to diagnose or treat particular medical conditions.
D. High Volume Ancillary Provider: a provider in ~~PHC's~~ Partnership's Southern Region that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year or a provider in ~~PHC's~~ Partnership's Northern Region that has billed at least 350 visits during the prior calendar year and who saw a minimum of 150 unique members during the prior calendar year. ~~Examples of~~ A~~a~~ncillary providers may provide ~~are:~~ audiology, community based adult services (CBAS), dialysis, occupational/speech/physical therapy, nutritional education, and home infusion or other such services.
E. Hospitals: Since hospitals represent a unique group of ancillary providers, ~~PHC~~ Partnership will collaborate with our network hospitals to assess whether they meet the elements in the ~~Physical Accessibility Review Survey (~~PARS~~)~~ tool and will make the findings available on the ~~PHC~~ Partnership website and provider directories. See Attachment B.
F. Excluded Providers: Certain provider types are excluded from the ~~PHC~~ Partnership assessment of accessibility for Seniors and Persons with Disabilities (SPDs). They include licensed and certified

facilities, dental and vision providers, Long Term Care (LTC) facilities, imaging centers, pharmacies and labs, medical transportation, medical supplies, and Durable Medical Equipment (DME) sites. Non-contracted providers are excluded from ~~PHC~~ Partnership assessment of accessibility for SPDs.

IV. ATTACHMENTS:

A. Physical Accessibility Review Survey Guidelines/Tool
B. Hospital Letter
C. PARS ~~Close_Letter~~Close Letter Template

V. PURPOSE:

To define the scope and frequency of performing the Physical Accessibility Review Survey (PARS) for PCPs and High Volume Ancillary and Specialist Providers (HVASP). The PARS tool was developed by a collaborative coalition made up of staff from the California Department of Health Care Services (DHCS) and Medi-Cal Managed Care Health Plans and meets DHCS standards. The purpose of the PARS is to assess the physical accessibility of provider sites using a set of standards mindful of the needs of seniors or persons with disabilities. Results of the PARS will be made available through the ~~PHC~~ Partnership website and provider directories.

VI. POLICY / PROCEDURE:

~~PHC~~ Partnership will conduct a PARS at the time of the initial site review for newly credentialed PCPs and at least once every three years thereafter. Providers determined to be HVSAPs will be reviewed every three years following their initial PARS assessment. ~~PHC~~ Partnership will notify DHCS of any changes made to the HVASP methodology by January 31st of each year in accordance with MMCD Policy Letter 12-006 (see references below.) Annually, no later than April 15th, ~~PHC~~ Partnership will apply the methodology approved by DHCS to identify any new HVASP that meet the criteria described in Section III. Providers that no longer meet the HVASP definition, will be deleted from the list to survey. Newly identified HVASP providers will receive a PARS assessment within six (6) months of such identification.

A. Requirements
   1. PARS is an on-site review of the office site and covers critical elements across~~-~~:
      a. Parking
      b. Exterior Building
      c. Interior Building
      d. Restroom
      e. Exam Room
      f. Exam Table/Scale

B. Scheduling - ~~Non-clinical staff may~~A member of the Quality Improvement department's ~~Patient Safety~~ Quality Inspections ~~Investigations~~ team or designee (aka the PARS Reviewer) conducts the PARS. (Refer to Section VI.E. for delegation criteria.) ~~Scheduling~~
   1. The Quality ~~Improvement (QI) Coordinator~~ Inspections team schedules the physical accessibility reviews and provides information to the provider on preparing for the review in the following situations:
      a. Providers who change~~d~~ site locations subsequent to receiving a PARS assessment must receive a new review. A Provider Relations' Credentialing Specialist will notify the ~~QI department~~Inspections team of relocating/relocated providers so that the ~~QI Coordinator~~team can schedule the review within sixty (60) days of the notification date or the date the site opened.
      b. Newly identified providers based on the annual HVASP methodology will be assessed within six months of being identified.

c. PCPs and existing HVASPs that continue to meet the High Volume methodology will be assessed every three years.

C. Review
1. The PARS Reviewer will conduct the review, using the most recent DHCS PARS tool.
   a. Review Criteria
      1) Criteria are scored as Yes, No, or Not Applicable
      2) Access is identified as Basic or Limited, as well as Medical Equipment Access (if applicable)
      3) There is no Corrective Action Plan (CAP) required when elements of the review do not meet the standards
2. Results Notification:
   a. ~~PHC~~ Partnership Contracted Provider
      1) The ~~PHC~~ Partnership contracted provider will receive a final close letter within sixty (60) days of the review, which will indicate the level of access and the appropriate accessibility indicator. – See Attachment C.
   b. Provider Relations
      1) The results of the PARS will be forwarded to the ~~PHC~~ Partnership Provider Relations department on a quarterly basis. Provider Relations staff will make the information available on the ~~PHC~~ Partnership website and in the provider directories in accordance with MMCD Policy Letter 12-006.

D. Physical Access Designation
1. Access designations are documented in the Partnership HealthPlan Provider Directory as required by MMCD 12-006.
   a. Basic Access: Demonstrates access for SPDs meet the Basic Access requirements, for all Critical Elements (CE) in the following areas: parking, building, elevator, doctor's office, exam room and restroom.
   b. Limited Access: Demonstrates access for SPDs where one or more of the Critical Elements (CE) are missing or incomplete in the following areas: parking, building, elevator, doctor's office, exam room, and restroom.
   c. Medical Equipment Access: Demonstrates the PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of basic or limited access as appropriate.
   d. Provider Directory Indicators noted:
      In addition to identifying the locations' accessibility level, the following should be identified (where applicable) such;
      P = Parking EB = Exterior Building IB = Interior Building
      R = Restroom E = Exam Room T = Exam Table/Scale

E. Delegation of PARS functions
1. Organizations or groups who have one or more DHCS Certified Site Reviewers or appropriately trained personnel may be determined eligible, at ~~PHC~~ Partnership discretion, to perform PARS functions. An organization or group will perform these functions under a formal delegation agreement.
2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both ~~PHC~~ Partnership and the delegated entity.
3. Delegated entities will perform PARS functions for all PCP sites no less than once every three years.
4. Delegated organizations and/or groups will provide timely copies of all PARS reviews conducted at the site level, within ~~PHC's~~ Partnership's service area, when requested.
5. ~~PHC's~~ Partnership's ~~QI department~~Patient Safety – Quality Inspections team will track all PARS

~~reviews~~ conducted by the delegated entities.

6. For organizations and groups that are ~~over~~ more than one year past due for PARS at the site level or otherwise missing a PARS, the ~~QI department~~Inspections team will refer to ~~PHC's~~ Partnership's Delegation Oversight Reporting Sub-Committee (DORS), which is managed by ~~PHC's~~ Partnership's C~~c~~ompliance unit within the Administration department, for action.
7. As part of the oversight process, ~~PHC~~ Partnership may perform one or more repeat PARS on sites that have had the PARS performed by a delegated entity.

VII. REFERENCES:

A. MMCD Policy Letter 12-006 Revised Facility Site Review Tool (Aug. 12, 2012)
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017~~20-006~~ Primary Care Provider Site Review~~s~~: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006~~March 4, 2020~~)
C. DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-based Adult Service Providers (Oct. 28, 2015)

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 02/19/14; 02/18/15; 02/17/16, 02/15/17; *03/14/18; 03/11/20; 3/10/21; 05/12/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

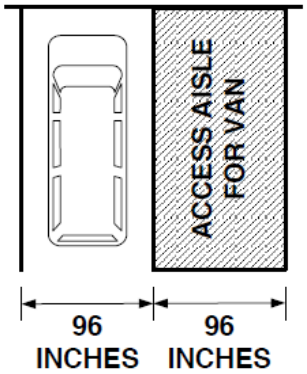
I certify that there have been no changes since the last physical accessibility review:

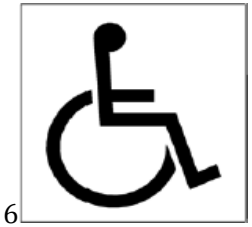
Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

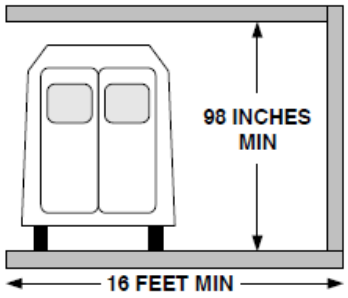
Name: _____ Signature: _____ Date: _____

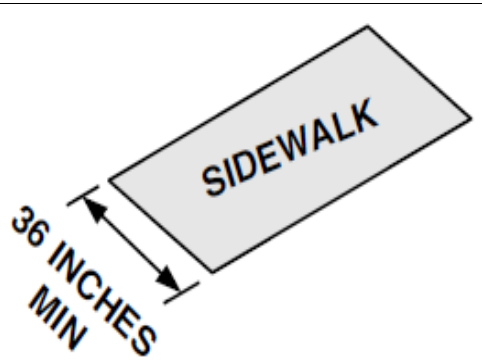
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

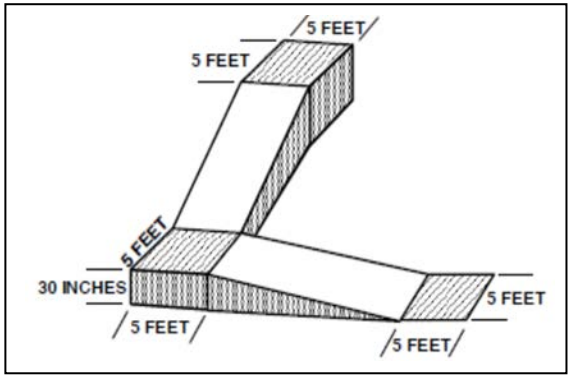
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

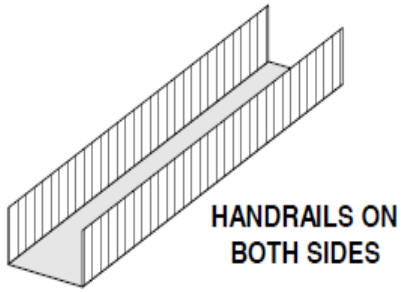
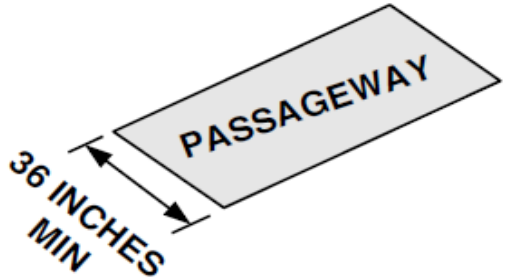
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

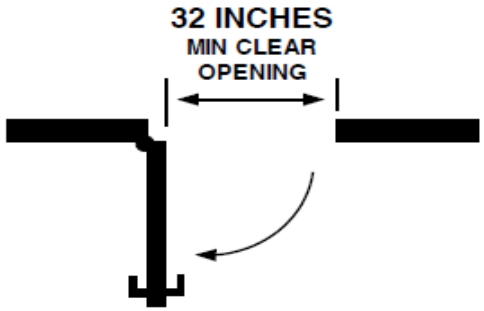
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

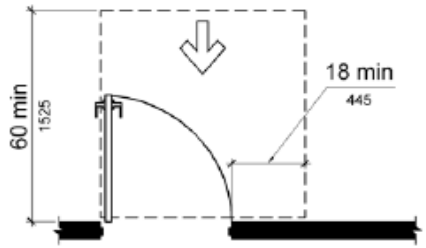
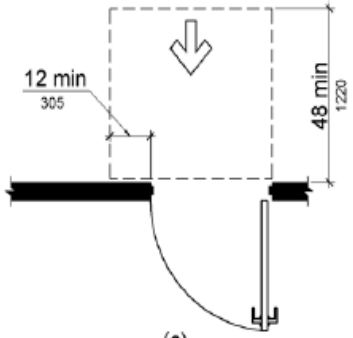
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

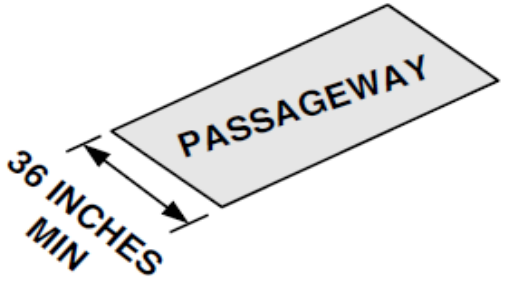
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

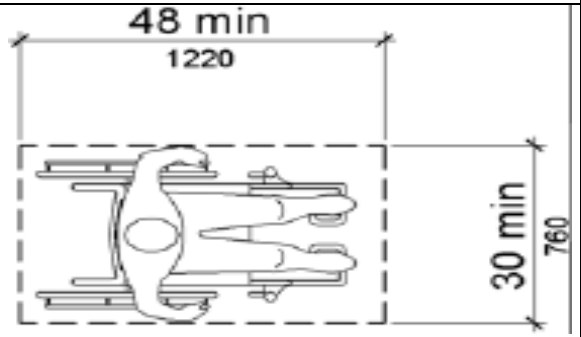
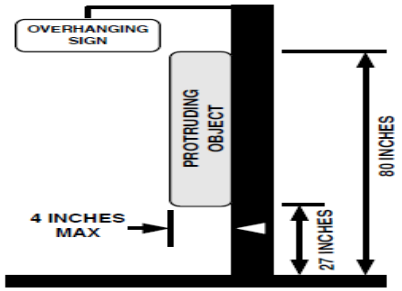
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

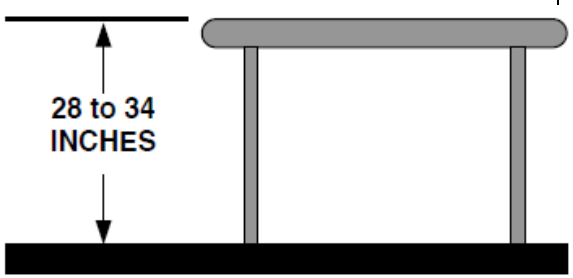
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

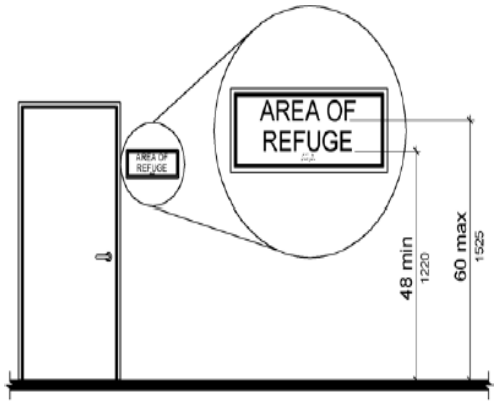
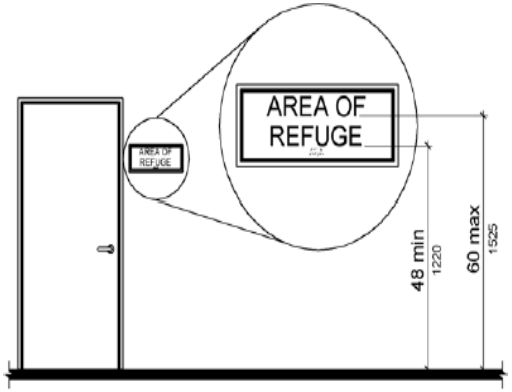
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

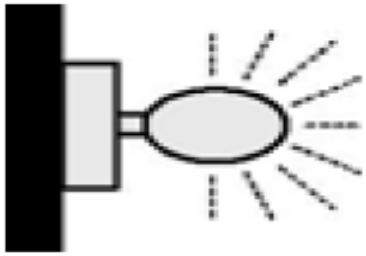
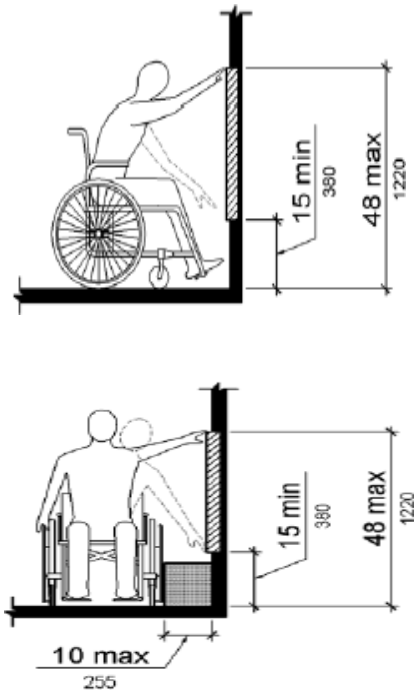
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

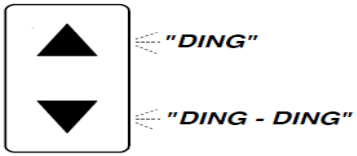
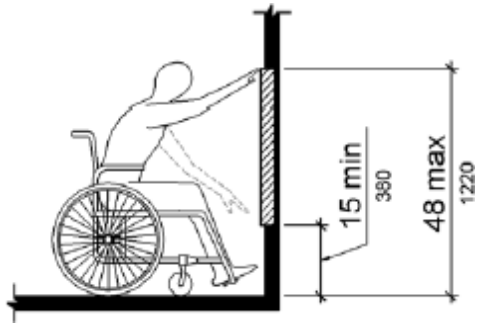
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

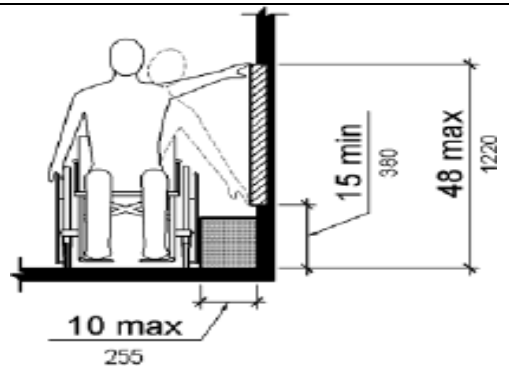
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

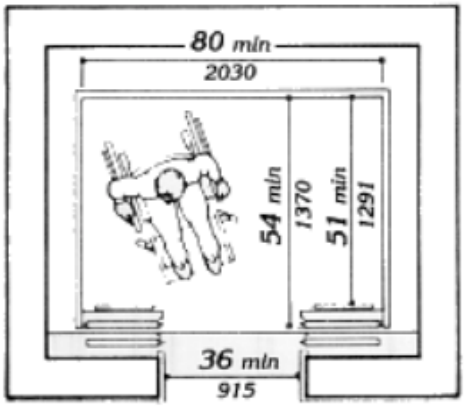
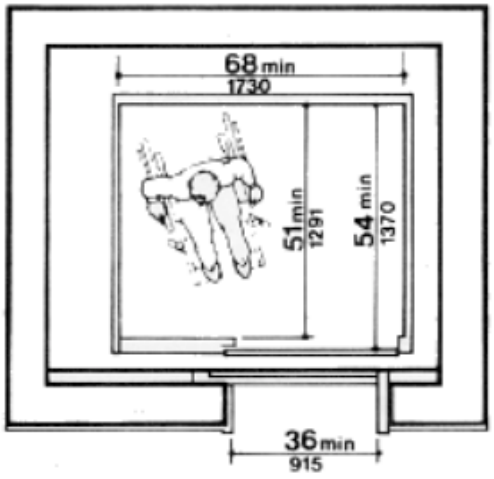
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

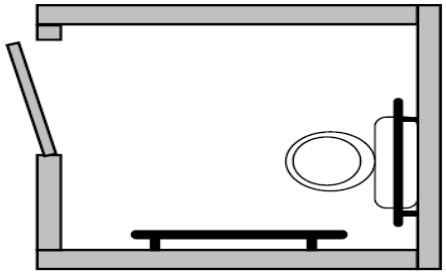
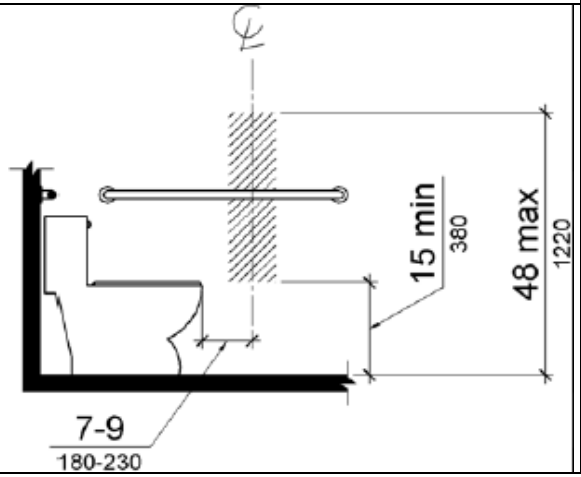
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

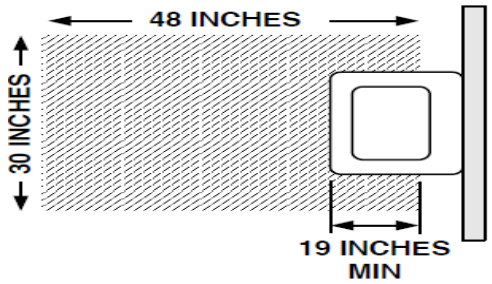
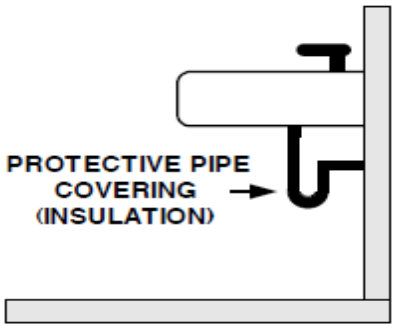
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

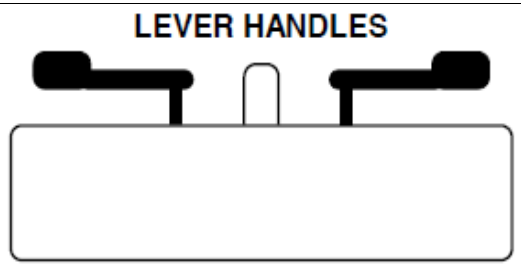
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				

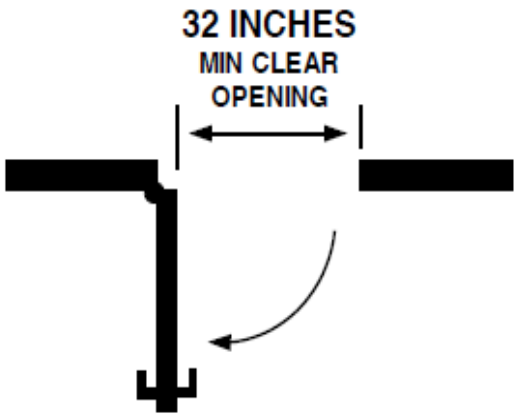
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

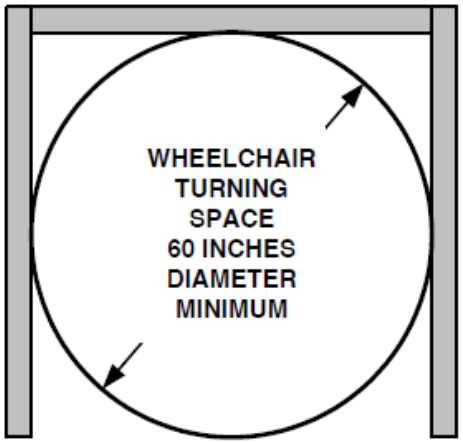
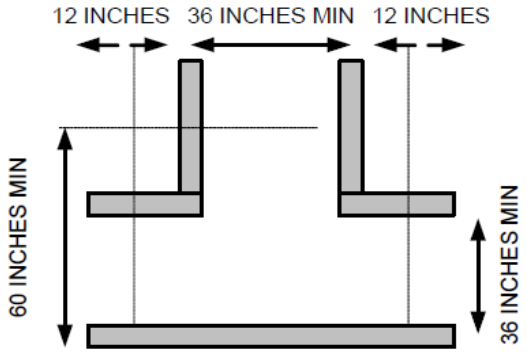
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

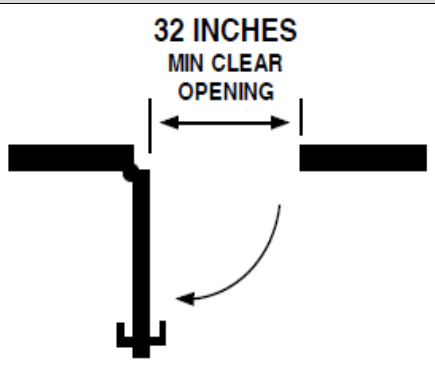
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

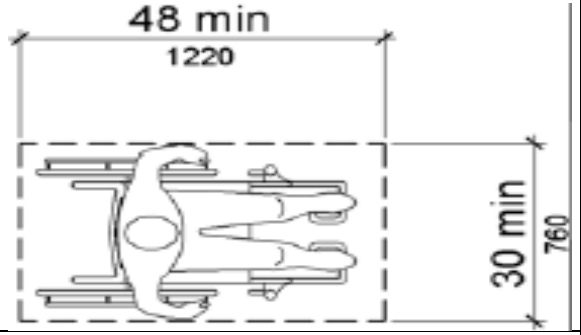
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

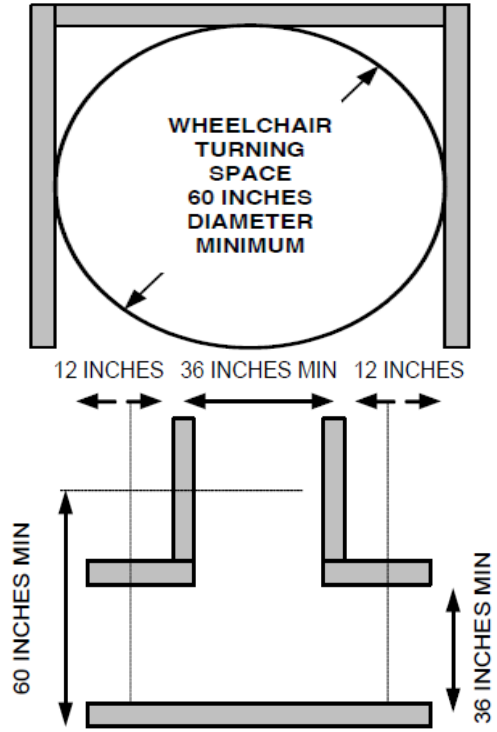
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.  				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Date

Hospital Name
Hospital Contact person name
Address
City State Zip

Dear:

The Department of Health Care Services (DHCS) requires hospitals to complete a Physical Accessibility Review Survey (PARS). Partnership HealthPlan of California (~~PHC~~Partnership) requests your assistance in answering the questions on the enclosed PARS and signing the attestation.

Please have your facility-designated staff complete and submit the PARS and the accompanying attestation by xxxxx to:

Email: fsr@partnershiphp.org
Fax: 530-999-6950

In addition to hospitals, the PARS is required for all primary care providers, high-volume specialists, and ancillary providers that serve the seniors and persons with disabilities (SPD) population. The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). The PARS tool consists of critical access elements to assist members in selecting the facility that can best serve them. Based on the outcome of the PARS evaluation, each hospital site and the above-noted providers are designated as having either Basic Access or Limited Access, along with specific accessibility indicator designations for parking, external building, interior building, restrooms, examination rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables). We appreciate your assistance in completing the attached attestation.

If you have questions about the PARS, please contact the above email for further guidance. We are also available to visit your site and complete the PARS form for your site if requested.

Sincerely,

Manager of Clinical ~~Quality and Patient Safety~~Compliance Inspections Team

Enclosures:
Policy Letter 12-006

PARS Survey and Guidelines
Attestation Page

Hospital Physical Accessibility Review Survey 2012 (Attachment C)

California Department of Health Care Services Medi-Cal Managed Care Division

Physical Accessibility Review Survey Completion Attestation

I have completed the Physical Accessibility Review Survey (PARS) for the _____ review performed
(Hospital Name)

on _____.
(Date of Review)

I affirm the PARS was conducted and completed as indicated on the attached tool. I hereby authorize the health plan to furnish to all collaborative health plans, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the PARS results this facility.

_____	_____	_____
Hospital Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please return completed PARS along with this signed attestation via email or fax:

Partnership HealthPlan of California
Email: FSR@partnershiphp.org
Fax: (530) 999-6950

2525 Airpark Drive~~3688 Avtech Parkway~~
Redding, California 96002

May 8, 2024~~March 25, 2024~~

Site Name
Attn: Contact name, Title
Address
City, State, Zip

RE: Physical Accessibility Review Survey (PARS) / FSR-Attachment C

Dear Ms. / Mr. last name of contact,

In compliance with the Department of Health Care Services (DHCS), Medi-Cal Managed Care Division Policy Letter 12-006, Partnership HealthPlan of California (~~PHC~~Partnership) has been conducting assessments of our network providers' offices to determine the level of physical accessibility of provider sites, including primary care physician, and specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

The information gathered will allow PHC to provide information to assist ~~PHC~~ Partnership members in choosing provider sites that will be able to meet their needs.

The access level below will be denoted in the ~~PHC~~ Partnership Provider Directory and on the ~~PHC~~ Partnership website, as well as the Accessibility Indicators next to your individual information.

Accessibility Levels:

☐ Basic Access	Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
☐ Limited Access	Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
☐ Medical Equipment Access	The site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.

Accessibility categories: (checked boxes indicate what will be identified in the directory):

- ☐ **P**-Parking and pedestrian walkways
- ☐ **EB**-Exterior entrance to medical office buildings or office complexes
- ☐ **IB**-Interior entrance to medical office buildings or office complexes
- ☐ **R**- Restroom accessibility
- ☐ **E**- Maneuverability and access to waiting rooms and exam/treatment rooms
- ☐ **T***- Adjustable exam table and a weight scale that can accommodate a wheelchair or scooter.

*Please note that this is in addition to the other Accessibility Indicators and will not affect the level of basic accessibility.

A copy of the survey tool was provided to you at the time the site visit was scheduled. Please let us know if you need another copy.

Deficiencies for each category are:

- **P (Parking)**: The guidelines state:
  - There must be at least 1 ADA parking space for every 25 regular spaces.
  - Curbs on the route from off-street public parking must have curb ramps at the parking locations.
  - Curbs on the route from off-street public parking must have curb ramps at the drop off locations
  - There must be at least 1 VAN accessible parking space provided. To qualify, the parking space and access aisle must be at least 92" each or at least a total of 192" overall.
- **EB (Exterior Building):** The guidelines state:
  - If accessible route crosses a curb, there must be a curb ramp provided to the building entrance from: Parking, Public Transpiration, and Public Sidewalk.
  - If ramp is present, each run (leg) of the ramp should be no longer than 30' between landings.
  - If ramp is over 6' long, handrails must be provided on both sides of the ramp and be mounted between 34" and 38" above the ramp surface.
  - Handrails must be at least 36" wide.
  - If the main entrance is not accessible, there must be another accessible entrance.
  - The entrance doors must have a minimum opening of at least 32" when opened at 90 degrees.
  - There must be space available for a wheelchair user to approach, maneuver, and open the door (Pull doors requires a clear space of 60" perpendicular X 18" parallel to the doorway; Push doors require 48" perpendicular to the doorway).
  - Entrance doors must have handles that can be opened without grasping, pinching or twisting the wrist.
- **IB (Interior Building):** The guidelines state:
  - All interior paths of travel must be at least 36" wide.
  - If there are stairs on the accessible route, handrails must be on each side.
  - If a platform lift is used, it must be available without assistance.
  - If there is an elevator, is available for public/patient use during business hours?
  - The elevator equipped with both visible and audible door opening/closing and floor indicators.
  - The elevator must have raised letter and Braille signs on each site of each elevator jamb.
  - The elevator hall call buttons must be no higher than 48" from the floor.
  - The elevator car must be large enough for a wheelchair or scooter user to enter, turn to reach the controls, & exit (Must be 36" wide doorway with: centered doorway-51" long X 80" wide care, side doorway-54" long X 68" wide.

- The buttons on the control panel inside the elevator must have Braille and raised characters/symbols.

- **R (Restroom)**: The guidelines state:
  - Grab bars must be provided, one on the wall behind the toilet and one on the wall next to the toilet (must be mounted in a horizontal position between 33" and 36" above the floor).
  - The toilet paper dispenser must be mounted below the side grab bar with the centerline of dispenser between 7" and 9" in front of the toilet, and at least 15" high.
  - There must be space which is at least 30" wide and 48" deep to allow wheelchair user to park in front of the sink (space must extend at least 17" under the sink from the front edge, although it can extend up to 19" underneath).
  - Faucet handles must be operable with one hand and without grasping, pinching, or twisting.
  - Doorways must have a minimum opening of 32" with the door open at 90 degree.
  - For toilet rooms with stalls, there must be a 60" diameter turning circle or 60" x 60" "t"-shaped space inside the stall to allow a turnaround for wheelchair and scooter users.
- **E (Exam room):**
  - The exam room doorways must have a minimum clear opening of 32" with the door open at 90 degrees.
  - There must be a 60" diameter or a 60" x 60" "t"-shaped space for 180 degree turns.
- **T (Exam Table/Scale):**
  - There must be a height adjustable exam table that lowers to between 17" and 19" from the floor to the top of the cushion.
  - There must be space next to height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table (30" wide x 48" long).
  - There must be a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient.

Although these are considered a critical element, corrective action is not required as the assessment is for informational purposes only at this time.

Please contact me if you have any questions.

Thank you for your assistance with the review.

Sincerely,

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPQP1055 (previously CMP-36)			**Lead Department: Health Services**	
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/03/2013 (CMP-36)		**Next Review Date:** ~~06/14/2024~~06/12/2025 **Last Review Date:** ~~06/14/2023~~06/12/2024		
Applies to:	☒ **Medi-Cal**		☒ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/14/2023~~06/12/2024	

I. RELATED POLICIES:

A. MPQP1016 – Potential Quality Issue Investigation and Resolution
B. FIN 405 – Treatment of Recoveries of Overpayments to Providers
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS.:

A. Health Services
B. Claims
C. Finance
D. Provider Relations
E. Compliance

III. DEFINITIONS:

A. Provider Preventable Condition (PPC): specified and defined Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (OPPC), which is a medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. See Title 42 of the Code of Federal Regulations Sections§447.26, 434.6, 438.3 and Welfare and Institutions Code Section 14131.11 for original documentation related to these terms.
B. Potential PPC: An incident or activity reported to Partnership HealthPlan of California (~~PHC~~Partnership), or flagged during internal ~~PHC~~ Partnership encounter data audits, as a possible PPC, before it has been investigated and confirmed.
C. OPPC and HCAC definitions, according to the Department of Health Care Services (DHCS), can be found here: (http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx)
D. Other Provider Preventable Conditions (OPPC) for purposes of Medicaid include the following (may occur in any health care settings):
    1. Wrong surgery or wrong invasive procedure
    2. Surgery or invasive procedure on the wrong body part
    3. Surgery or invasive procedure on the wrong patient
E. Health Care Acquired Condition (HCAC or HAC) for purposes of Medicaid include the following (for inpatient hospital settings only):
    1. Air embolism
    2. Blood incompatibility transfusion
    3. Catheter-associated urinary tract infection (UTI)
    4. Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
    5. Foreign object retained after surgery

6. Iatrogenic pneumothorax with venous catheterization
7. Manifestations of poor glycemic control
   a. Diabetic ketoacidosis
   b. Nonketotic hyperosmolar coma
   c. Hypoglycemic coma
   d. Secondary diabetes with ketoacidosis
   e. Secondary diabetes with hyperosmolarity
8. Stage III and IV pressure ulcers that developed during the patient's hospital stay
9. Surgical site infection following:
   a. Mediastinitis following coronary artery bypass graft (CABG)
   b. Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
   c. Orthopedic procedures for spine, neck, shoulder, and elbow
   d. Cardiac implantable electronic device (CIED) procedures
10. Vascular catheter-associated infection
11. Deep vein thrombosis (DVT)/pulmonary embolism (PE) (excluding pregnant women and children under 21 years of age) resulting from:
    a. Total knee replacement
    b. Hip replacement

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Title 42 of the Code of Federal Regulations, Sections 447.26, 434.6 and 438.3 and Welfare and Institutions Code Section 14131.11 prohibit the payment of Medicaid/Medi-Cal funds to a provider for the treatment of a PPC except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider. Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specified that managed care organizations must participate in reporting PPC-related encounters.

This policy serves to define the mechanism for screening, investigating, processing and reporting of PPCs.

VI. POLICY / PROCEDURE:

A. Reporting Requirements
   1. Providers must report potential PPCs directly to the DHCS Audits & Investigations (A&I) Unit after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. Online reporting guidance at: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx. Reporting is required for all Medi-Cal beneficiaries, including those eligible for Medicare or other insurance coverage.
   2. Any potential PPC pertaining to a ~~PHC~~ Partnership member must also be reported directly to ~~PHC~~Partnership. Providers should forward potential PPCs to the Quality Improvement (QI) d~~D~~epartment via a secure email at PQI@partnershiphp.org. The email must be encrypted through a secure messaging system.
   3. ~~PHC~~ Partnership follows-up on all provider self-reported potential PPCs to ensure that appropriate notification has also been sent by the provider to DHCS A&I.
   4. Potential PPCs may also be reported to the ~~Quality Improvement~~ (QI~~)~~ department by ~~PHC~~ Partnership staff or community members, per the ~~Potential Quality Issue~~PQI identification methods identified in MPQP1016 Potential Quality Issue Investigation and Resolution.
   5. Request for information about the PPC process or how to report a PPC may be referred to the QI department's Member Safety & Clinical Investigations t~~T~~eam via PQI@partnershiphp.org.

B. ~~PHC~~ Partnership Screening for PPCs
   1. ~~PHC~~ Partnership Claims department screens encounter data on a monthly basis, including data received from network providers, for the presence of PPC-specific billing codes. Encounters identified are forwarded by the Claims department to PQI@partnershiphp.org on a monthly basis in a report format, and are reviewed by ~~QI department staff~~the Clinical Investigations team.

C. Clinical Review of Potential PPCs
   1. Potential PPCs are investigated according to the ~~Potential Quality Issue (~~PQI~~)~~ investigation processes outlined in MPQP1016 Potential Quality Issue Investigation and Resolution.
   2. The scope of review includes both a medical record and claims history review.
   3. All potential PPCs are forwarded to the Chief Medical Officer (CMO) or physician designee for secondary review.
   4. Potential PPC cases may be reviewed by the ~~PHC~~ Partnership Peer Review Committee for additional potential actions/remedies, as noted in MPQP1016.

D. Reporting Confirmed PPCs
   1. The QI department reports all confirmed PPCs previously unreported to the DHCS A&I unit via the online reporting module: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.
   2. Notification of the reported incident is also sent to ~~PHC's~~ Partnership's internal Compliance Oversight Department (RAC_Inbox@partnershiphp.org.)

E. Payment Recoupment for Confirmed PPCs
   1. If the case is determined to be a PPC, the medical record will be reviewed to determine which, if any extra procedures, length of hospitalization, medications or other items/ actions were provided to the member exclusively because of the PPC. Documentation of this review will be placed in the QI department PQI case file.
   2. The CMO or physician designee will discuss the case with a representative of Claims, Finance – Cost Avoidance Unit, Provider Relations and Utilization Management departments who are well versed in provider reimbursement. Using the results of the PPC clinical review, and a review of the federal code, this group will recommend which, if any, charges are recommended for recoupment. ~~PHC's~~ Partnership's CMO and Chief Financial Officer (CFO) will review and act upon this recommendation.
   3. The Finance – Cost Avoidance Unit will process any recoupment in accordance with ~~PHC~~ Partnership Policy FIN-405 – Treatment of Recoveries of Overpayments to Providers.
   4. Contractor, Subcontractor, Downstream Subcontractor, or Network Provider shall not pay any Provider claims nor reimburse a Provider for a PPC in accordance with 42 CFR section 438.3(g)

F. Communication
   1. The QI department will notify the provider of the results of the potential PPC clinical investigation.
   2. For confirmed PPCs, the Finance – Cost Avoidance Unit will communicate with the provider the recommendations of the PPC financial review and the mechanism of recoupment proposed, if indicated.
   3. Any objections raised by the provider regarding final case determinations will be escalated to the CFO and CMO for review.

G. Training
   1. Provider training: The Provider Relations department provides routine education of the contracted provider network through provider newsletters and bulletins on the requirement to report PPCs for ~~PHC~~ Partnership members directly to DHCS and ~~PHC~~Partnership.
   2. Employee training: ~~PHC~~ Partnership staff that review hospital records and hospital inpatient quality issues will be trained on this policy. This includes the QI staff involved in medical record review, Claims staff reviewing hospital claims, and Utilization Management and Care Coordination staff reviewing hospital care. These trainings will be conducted at the department level during the orientation process, and when the policy is updated.

Policy/Procedure Number: MPQP1055 (previously CMP-36)		**Lead Department: Health Services**
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting		☒**External Policy** ☐**Internal Policy**
Original Date: 09/03/2013 (CMP-36)	**Next Review Date:** ~~06/14/2024~~06/12/2025 **Last Review Date:** ~~06/14/2023~~06/12/2024	
Applies to:	☒ **Medi-Cal**	☒ **Employees**

3. Delegate notification: Each year, as part of the delegate oversight process, each delegated health care provider will be notified of their responsibility to report PPCs to ~~PHC~~ Partnership when they occur.

Policy/Procedure Number: MPQP1055 (previously CMP-36)		**Lead Department: Health Services**
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting		**☒External Policy** **☐Internal Policy**
Original Date: 09/03/2013 (CMP-36)	**Next Review Date: ~~06/14/2024~~06/12/2025** **Last Review Date: ~~06/14/2023~~06/12/2024**	
Applies to:	**☒ Medi-Cal**	**☒ Employees**

H. Document Retention
   1. Copies of all PPC submissions to DHCS by ~~PHC~~ Partnership or ~~PHC~~ Partnership providers, and supporting medical record evidence, will be maintained by ~~PHC~~ Partnership in accordance with ~~PHC~~ Partnership document retention policy CMP30.

I. Oversight
   1. An annual summary PPC report will be presented to the ~~PHC's~~ Partnership's Internal Quality Improvement Committee (IQI), the Quality and Utilization Advisory Committee (Q/UAC) and the Compliance Committee.

VII. REFERENCES:

A. Department of Health Care Services All Plan Letter 17-009 (DHCS APL 17-009): Reporting Requirements Related to Provider Preventable Conditions (05/23/2017)
B. DHCS Medi-Cal Guidance on Reporting PPCs (last modified 03/23/2021)
C. DHCS PPC Frequently Asked Questions (last modified 03/23/2021)
D. DHCS PPC Online Reporting System
E. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 434, 438, and 447 - Medicaid Program; Payment Adjustment for Provider Preventable Conditions including Health Care-Acquired Conditions, effective July 1, 2011 https://www.govinfo.gov/content/pkg/FR-2011-06-06/pdf/2011-13819.pdf,
F. Centers for Medicare & Medicaid Services, Hospital-Acquired Conditions https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond?redirect=/hospitalacqcond/

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Chief Medical Officer

X. REVISION DATES:

10/19/16, 06/14/17, *03/14/18; 03/13/19; 03/11/20; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
CMP 36, Provider Preventable Conditions – 09/03/2013 to 10/19/2016, now archived.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPXG5003</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/19/2000</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:
MPCP2017 – Scope of Primary Care – Behavioral Health and Indication for Referral Guidelines

II. IMPACTED DEPTS:
A. Health Services
B. Provider Relations

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. Clinical Decision Flow Chart

V. PURPOSE:
To define the appropriate diagnostic criteria and therapy for patients with major depression.

This guideline is meant to be a basic guideline, not an enforceable standard, and is intended to assist the primary care professional in caring for Partnership HealthPlan of California (Partnership) adult members with major depression. Recommendations are not intended to replace sound clinical judgment in caring for individual patients.

VI. POLICY / PROCEDURE:
A. Overview
Nationally accepted clinical practice guidelines for depression are created and updated regularly. Pharmacologic choices for depression also continually change as new products enter the market. For these reasons, and upon the recommendation of ~~the Partnership Health Plan of California (PHC)~~ Partnership's Physician Advisory Committee, this clinical practice guideline (CPG) will be annually updated with the appropriate internet references, which will provide timely guidelines for the management of major depression in adults.

VII. REFERENCES:
A. From the American Psychiatric Association (2010):
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
~~B. From the MacArthur Initiative on Depression and Primary Care~~
~~https://www.depression-primarycare.org/clinicians/toolkits~~

B. From the American Psychological Association Treatment of Depression Across Three Age Cohorts https://www.apa.org/depression-guideline/guideline.pdf (February 2019)

C. From the US Preventive Services Task Force (USPSTF) Final Recommendation Statement (June 20, 2023)~~: Screening for~~ Depression and Suicide Risk in Adults: Screening (2023): ~~D.~~ https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults ~~https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening~~

~~E.~~D. National Institute of Mental Health: Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study (2006): https://www.nimh.nih.gov/funding/clinical-research/practical/stard/index.shtml

~~F.~~E. U.S. Department of Veteran Affairs. VA/DoD Clinical Practice Guidelines: Assessment and Management of Patients at Risk for Suicide (2019): https://www.healthquality.va.gov/guidelines/mh/srb/index.asp

~~G.~~F. VA/DoD Clinical Practice Guidelines: Management of Major Depressive Disorder (2022) https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual

B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

09/18/02; 10/20/04; 11/15/06; 05/18/11; 06/19/13; 7/27/15; 08/19/15; 08/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 04/14/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Families

05/18/11

Partnership*Advantage*

11/15/06; 05/18/11

Healthy Kids

11/15/06; 05/18/11; 08/19/15, 08/19/16 (Healthy Kids Program ended 12/01/2016)

Depression Treatment Flow Diagram

(MPXG5003 Policy Attachment A)

By: Kim Fillette, Pharm. D. 4/27/2023

PROVIDERS PLEASE NOTE:

As of January 1, 2022, the pharmacy benefit for *all Medi-Cal enrollees (including Partnership members)* is administered through DHCS State Medi-Cal Fee-for-Service. Check the State Medi-Cal Provider Manuals for information on covered drugs and how to submit TARS on/after 1/1/2022. Web links are provided for your convenience (see references).

ADULT WITH DEPRESSION (no psychosis)

Mild to Moderate

Partnership Note on Antidepressants: Antidepressant medications may not be as effective in treating depressed mood tied to external factors (i.e. adjustment disorder with depressed mood) or depressed mood resulting from medical illness (i.e., anemia) or substance use. It is important to carefully assess depressive symptoms via thorough history, physical examination and laboratory work up as indicated.If PHQ9 <15 and no hx of benefit from an AD, refer to a BH specialist for help with diagnostic clarification, as medication may not be appropriate. Important to evaluate for current or past history of manic episodes, as monotherapy antidepressant medication treatment can rarely precipitate mania in those with latent bipolar disorder.

Consider referral to a psychotherapist for help and possible further assessment for appropriateness of medication

Pharmacotherapy is *not* appropriate

Continue psychotherapy or other non-pharmacologic therapy.

Severe

ABSENCE of risks for: Cardiovascular issues, Seizures, CYP40 interactions?

No

Prescriber selects agent which has acceptable risk/benefit ratio.

All medication treatment decisions should be made alongside the patient through a shared decision making (SDM) model.

State CDL agents are not appropriate

Submit TAR to MEDI-CALRx with patient-specific contraindications or interactions

State Medi-Cal CDL (Covered Drug List) agent is appropriate

Yes

Min 6-12 wk (6 if no response, 12 if partial response) trial, max. dosing of a covered first-line agent

If patient with depression and have had a previous positive response to a particular medication, then trialing that medication preferentially initially is reasonable.

If pharmacotherapy *is* appropriate

Remission?

No

Progress through treatment levels per STAR-D study w/ 6-12wk min. trials, maximized dosing, adjunctive tx & CBT (cognitive behavioral therapy) as appropriate & available.

Yes

Remission?

No

T/F 3 first-line agents such as: SSRI, SNRI, TCA, mirtazapine, trazodone, vortioxetine, vilzazdone, bupropion, SR or ER, alone &/or in combination with adjunctive therapies; CBT, Li, T3, aripiprazole or other pharmacologic agent indicated for adjunctive management.

STATE TAR may be required for treatment of Treatment Resistant Depression, including use of adjunctive agents or progressing to other 2nd/3rd/4th line pharmacotherapies

Continue treatment

Individuals who answer "yes" to PHQ-9 question pertaining to thoughts about self harm require further evaluation and suicide risk stratification. See VA/DoD Clinical Practice Guidelines (refer to Partnership Policy MPXG5003 Reference section or this attachment's References & Resources page for the web address).

NOTE: This document is **not** intended to provide or infer DHCS TAR requirements for a drug that is not on the State CDL. State TAR criteria are not available publically at this time. However, it is reasonable to consider that documentation of adequate trials of State-covered antidepressants would be the MINIMUM that should be included on a TAR, together with any additional patient-specific justification.

Treatment Algorithm based on STAR*D prospective trial, through 4 treatment changes

Pt w/ non-psychotic depression, no bipolar d/o, no OCD, no eating d/o, no seizure d/o, no CYP interaction considerations, no cardiovascular dx.

STAR-D Treatment Level 1: Citalopram was used as representative of SSRI class. Those who could not tolerate it or did not remit progressed to Level 2. STAR-D discussions have said that any first-line antidepressant (SSRI, SNRI or other) could be used in lieu of citalopram and the theory of this algorithm would still pertain, as main objective is to give adequate trial of single agent during pharmacologic initiation.

Following min. 8 wk trial @ max tolerated dosing

Remission Achieved? — No → STAR-D Treatment Level 2: Trial participants were given the option of either changing medications or adding on to existing citalopram. The "switch group" were randomly assigned to sertraline, bupropion-SR, or venlafaxine-ER. The "add on group" were given either bupropion SR or buspirone. Cognitive psychotherapy was also offered as either add-on or switch.

Yes → Continue treatment

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved? — No → STAR-D Treatment Level 3: "Switch Group" assigned to either mirtazapine or nortriptyline. "Add on group" assigned to either lithium or triiodothyronine (T3).

Yes → Continue treatment

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved? — No → STAR-D Treatment Level 4: Taken off all other medications and randomly switched to either tranylcypromine (MAOI) or combination of mirtazapine with venlafaxine-ER.

Yes → Continue treatment

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved? — No

Yes → Continue treatment

STAR*D study is now 15 years old but the algorithm for the treatment of depression remains largely consistent with subsequent guidelines, notably the recently published (2022) VA DoD clinical practice guidelines (see MPGX5003). The general approach remains, stepwise: routine screening for depression for all patients; if screen positive, assess for severity using standardized depression severity tools (i.e., PHQ-9), assess for medical or substance-related etiologies (i.e., anemia, hypothyroidism) and assess for significant medical or psychiatric comorbidities (i.e., seizure disorder, med-med interactions (CYP interactions), cardiovascular disease (especially cardiac arrhythmias), CKD, pregnancy, GI bleeding, bipolar disorder, OCD, psychosis, suicidal or homicidal thinking, ADHD, PTSD) as the presence of these may impact medication selection; initiate first line antidepressant medication trial at adequate dose and of adequate duration (i.e., SSRI, SNRI, bupropion, trazodone, vortioxetine, vilazadone, mirtazapine); if first line medication is ineffective or only partially effective then consider switching to another first line medication and/or adding an augmenting agent (i.e., lithium, atypical antipsychotic, T3); if patient depression continues to not resolve after several (3+), consider specialty referral and/or discontinuing medications and trialing second line agents (i.e., MAOi, TCAs, esketamine, ketamine, nefazodone).

Notable differences/updates from STAR*D with VA DoD Clinical Practice Guidelines (CPG) include the following:

-First-line medication options include (no rank order): bupropion, mirtazapine, SSRI, SNRI, trazodone, vortioxetine, vilazodone

-Insufficient evidence to support pharmacogenetic testing

-TMS can be considered after 3+ failed adequate medication trials (requires specialty mental health referral)

-ECT can be considered for individuals with severe depression (i.e., severe suicidality, catatonia, need for rapid depression reversal for medical or other reasons, psychosis)--requires specialty mental health referral

Note regarding adequate trial durations:
STAR-D recommends a minimum 8 wk trial once pt is at max tolerated dose. PHC Subcommittee recommends that 6 wk is adequate to determine failure if no response present; if partial response, should continue tx x 12 wks before considering changing.

Note on discontinuation of drug therapy:
Pharmacotherapy discontinuation can be considered when symptoms have resolved and patient is fully re-evaluated. Abrupt discontinuations of medications are to be avoided, with several-week tapers usually preferable. Monitor closely for symptom recurrence during taper and for several months after discontinuation.

Multidrug Resistance: If depression does not remit satisfactorily, it may be necessary to refer to psychiatric specialist &/or consider other treatments not included in the STAR*D study may need to be considered, such as esketamine nasal spray (Spravato™), which is a consideration for severe depression. Spravato™, like other drug therapies, would be the responsibility of State Medi-Cal regardless of whether billed as a pharmacy or medical clinic as a medical claim, because treatment of severe depression is carved out to State (PHC is responsible only for mild to moderate behavioral health treatment).

References & Resources:

1. Thase, Michael, MD, Connolly, K Ryan, M, MS; Unipolar depression in adults: *Choosing treatment for resistant depression* UpToDate May 10, 2019
2. Gaynes, Bradley N., et al. *The STAR*D Study: Treating Depression in the Real World. Cleveland Clinic Journal of Medicine*, 2008, vol 75, no 1, pp 57-66.
3. Kirsch, I, et al. *Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration,* PLoS Medicaine, 2008; vol 5, no 2, pp 260-268.
4. PL Detail-Document, Treatment Resistant Depression: An Update. Pharmacist's Letter/Prescriber's Letter 2009; 25(5):250510.
5. Weber, J, et al. *Aripiprazole: In Major Depressive Disorder.* CNS Drugs, 2008, 22(10):807-13; http://www.ncbi.nlm.nih.gov/pubmed/18788833
6. Trintellix® (Vortioxetine) [prescribing information]. Takeda Pharmaceuticals America, Inc., Deerfield, IL. October 2018.
7. Fetzima® (Levomilnacipran) [prescribing information]. Allergan USA, Inc., Irvine, CA. January 2017.
8. Viibryd® (Vilazodone) [prescribing information]. Allergan USA, Inc., Madison, NJ. May 2018.
9. Spravato® (Esketamine) [prescribing information]. Janssen Pharmaceuticals, Inc. Titusville, NJ. March 2019.
10. ClinicalTrials.gov [Internet]. Bethesda, MD: National Library of Medicine (US). 2000 Feb 29 – Identifier: NCT02418585, A study to evaluate the efficacy, safety, and tolerability of flexible doses of intranasal esketamine plus an oral antidepressant in adult participants with treatment-resistant depression (TRANSFORM-2); 2018 May 31. Available from: https://clinicaltrials.gov/ct2/show/NCT02418585
11. ClinicalTrials.gov [Internet]. Bethesda, MD: National Library of Medicine (US). 2000 Feb 29 – Identifier: NCT02493868, A study of intranasal esketamine plus an oral antidepressant for relapse prevention in adult with treatment-resistant depression (SUSTAIN-1); 2019 February 15. Available from: https://clinicaltrials.gov/ct2/show/NCT02493868
12. ClinicalTrials.gov [Internet]. Bethesda, MD: National Library of Medicine (US). 2000 Feb 29 – Identifier: NCT02497287, A long-term, safety and efficacy study of intranasal esketamine in treatment-resistant depression (SUSTAIN-2); 2018 October 26. Available from: https://clinicaltrials.gov/ct2/show/NCT02493868
13. Saef MA, Saadabadi A. Protriptyline. [Updated 2019 Jan 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2019 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499828/
14. Rush AJ et al. "Acute and longer-term outcomes in depressed outpatient requiring one or several treatment steps: A STAR*D report". The American Journal of Psychiatry. 2006. 163(11):1905-1917.
15. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder. Arlington, VA: American Psychiatric Association, 2010. Available online at https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
17. NIH: Questions & Answers about the NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study – all medication levels. November 2006. www.nimh.nih.gov/funding/clinical-research/practical/stard/allmedicationlevels.shtml
18. VA/DoD Clinical Practice Guidelines: Assessment and Mangement of Patients at Risk for Suicide (2019). Available online at: https://www.healthquality.va.gov/guidelines/mh/srb/index.asp
19. VA/DoD Clinical Practice Guidelines:Management of Major Depressive Disorder (2022) Available online at: https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf

Medi-Cal Rx Pharmacy Benefit Resources:
Pharmacy Communications (News, Bulletins, Manuals): https://medi-calrx.dhcs.gove/provider/pharmacy-news
Pharmacy Manual: https://medi-calrx.dhcs.ca.gov/home/provider-manual
State Medi-Cal Contract Drug Lists (aka pharmacy formulary) – *note that drugs are listed in State CDL by generic name only*
Contract Drugs List Online Search Tool: https://medi-calrx.dhcs.ca.gov/member/drug-lookup/
Medi-Cal Rx Contract Drugs List (May 1, 2023) https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf
Medi-Cal Rx Contract Drugs List - Therapeutic Classifications (May 1, 2023) https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_CDL_Therapeutic_Classifications_FINAL.pdf
Medi-Cal Rx Contract Drugs List - OTC (May 1, 2023) https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_OTC_FINAL.pdf

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2025			**Lead Department: Health Services**	
Policy/Procedure Title: Pediatric Quality Committee Policy			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/10/2019		**Next Review Date:** ~~06/14/2024~~06/12/2025 **Last Review Date:** ~~06/14/2023~~06/12/2024		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	☒ **PQC**
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD MPH MBA*			**Approval Date:** ~~06/14/2023~~06/12/2024	

I. RELATED POLICIES:

A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1002 – Quality/Utilization Advisory Committee
C. MCCP2024 – Whole Child Model For California Children's Services (CCS)
D. MPCP2002 – California Children's Services
~~C.~~E. ADM21 – Stipends for Committee Members Serving on Partnership~~HC~~'s CAC, FAC, PQC, Provider Grievance Review, and Q/UAC Committees

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. California Children's Services (CCS): The CCS program is a program of the State of California, established under the Health and Safety Code, Section 123800 et seq. which is administered by the Department of Health Care Services (DHCS). It provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.
B. Whole Child Model (WCM): A program of the California Department of Health Care Services (DHCS) established under the authority of Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016), which allowed designated County Organized Health Systems (COHS) or Regional Health Authority Counties to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. [1]

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

The Partnership HealthPlan of California (Partnership~~PHC~~) Pediatric Quality Committee (PQC) was

[1] For Members under age 21 with a CCS-eligible condition(s), services and supplies for the CCS-eligible condition(s) will either be authorized by Partnership~~PHC~~ under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In Partnership~~PHC~~'s service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership~~PHC~~'s service area are participants in the State's CCS program and are not participants in Partnership~~PHC~~'s Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

established by the Chief Medical Officer (CMO) to provide Partnership~~PHC~~ with advice on clinical issues related to CCS conditions. It reports its findings to the Partnership~~PHC~~ Physician Advisory Committee (PAC) and the Family Advisory Committee (FAC). ~~-~~The PAC has the ultimate authority over clinical policies for Partnership~~PHC~~, so recommendations of the PQC are subject to the approval of PAC.

VI. POLICY / PROCEDURE:

A. ~~COMMITTEE STRUCTURE~~Committee Structure

1. Membership:
   a. The PQC is comprised of the Partnership~~PHC~~ Chief Medical Officer, the Partnership~~PHC~~ Whole Child Model Medical Director, the ~~Senior Director of~~Chief Health Services Officer, the Pharmacy Director, at least four CCS-paneled clinician providers, the CCS Medical Directors designated by each Partnership~~PHC~~ county, ~~-~~and the Nurse Director/Manager designated by each County CCS program.
   b. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from the committee chair or designee.
2. Minutes: Minutes of all meetings are maintained.
3. Chair: The Partnership~~PHC~~ Whole Child Model Medical Director chairs the committee; the Partnership~~PHC~~ Chief Medical Officer is the vice chair.
4. Meetings: The Committee meets at least four (4) times a year, with the option to add additional meetings if needed. ~~-~~The meeting agenda will be sent out at least one week prior to meeting date.
5. Advisory Recommendations: Only non-Partnership~~PHC~~ clinical members (physicians and nurses) may reach a consensus on recommendations to be submitted to the PAC. ~~-~~The committee chair may lead and participate in the discussion and serves in a tie breaking capacity as necessary. ~~-~~A quorum needed to recommend action items shall be at least 4 non-Partnership~~PHC~~ members. ~~-~~Any action items pass with a simple majority of members present.
6. Compensation: Physician members who are not Partnership~~PHC~~ staff are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by their county CCS agency for attendance at PQC or by Partnership~~PHC~~ for management responsibilities.) ~~-~~This stipend may be in addition to other compensation when the member serves as a clinical consultant/physician adviser. (Please see policy ADM21 – Stipends for Committee Members Serving on Partnership~~PHC~~'s CAC, FAC, PQC, Provider Grievance Review, and Q/UAC Committees for stipend form and instructions.)

B. ~~COMMITTEE RESPONSIBILITIES~~Committee Responsibilities

1. Discuss clinical issues relating to CCS conditions, as brought to the committee by committee members, by Partnership~~PHC~~ staff or by referral from the Family Advisory Committee.
2. Make recommendations to the PAC on CCS/WCM related clinical policies. ~~-~~These recommendations may first flow through the Internal Quality Improvement (IQI)/ Quality Utilization Advisory Committee (QUAC) policy flow, if applicable, before going to the PAC.
3. Upon approval by the committee, an ad hoc subcommittee may be formed as needed.

VII. REFERENCES:

DHCS All Plan Letter (APL) 23-034 – California Children's Services Whole Child Model Program (12/27/2023)

~~DHCS All Plan Letter (APL) 21-005 California Children's Services Whole Child Model Program (*Revised* 12/10/2021)~~

VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Department Directors
B. Partnership~~PHC~~ Provider Manual

Policy/Procedure Number: MCCP2025		**Lead Department: Health Services**
Policy/Procedure Title: Pediatric Quality Committee Policy		☒**External Policy** ☐**Internal Policy**
Original Date: 04/10/2019	**Next Review Date: ~~06/14/2024~~06/12/2025** **Last Review Date: ~~05/11/2022~~06/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 05/13/20; 05/12/21; 05/11/22; 06/14/23; 06/12/24

PREVIOUSLY APPLIED TO:
N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2026			**Lead Department: Health Services**	
Policy/Procedure Title: Diabetes Prevention Program			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/13/2019 **Effective Date:** 01/01/2019 per DHCS		**Next Review Date:** ~~06/14/2024~~06/12/2025 **Last Review Date:** ~~06/14/2023~~06/12/2024		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD MPH MBA*			**Approval Date:** ~~06/14/2023~~06/12/2024	

I. RELATED POLICIES:

A. MCUP3052 - Medical Nutrition Services

B. MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements~~CMP36 - Delegation Oversight and Monitoring~~

II. IMPACTED DEPTS:

A. Health Services

B. Claims

C. Member Services

III. DEFINITIONS:

A. Diabetes Prevention Program (DPP): An evidence-based lifestyle change program, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.

B. Lifestyle Coach (also known as Peer Coaches): A person formally trained in Centers for Disease Control and Prevention (CDC) approved curriculum for a minimum of 12 hours or approximately two days.

A lifestyle coach may have credentials [e.g. Physician, Registered Dietician (RD), and Registered Nurse (RN)], but they are not required. –The CDC approved training may be provided by one of the following:

1. A training entity listed on the CDC website
2. A private organization with a national network of CDC recognized program sites
3. A CDC recognized virtual organization with national reach or
4. A Master Trainer, as designated by the CDC recognized program, who has delivered that lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity listed on the CDC website.

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

To describe the Diabetes Prevention Program and provide eligibility requirements and processes for participation.

Policy/Procedure Number: MCCP2026		Lead Department: Health Services
Policy/Procedure Title: Diabetes Prevention Program		☒External Policy ☐Internal Policy
Original Date: 03/13/2019 **Effective Date:** 01/01/2019 per DHCS	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: ~~06/14/2023~~06/12/2024**	
Applies to:	☒ Medi-Cal	☐ Employees

VI. POLICY / PROCEDURE:

A. Program Description

The Diabetes Prevention Program is an evidence-based lifestyle change program established by the CDC, taught by lifestyle coaches and designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.

B. Eligibility Criteria

1. Members must meet the CDC Diabetes Prevention Program eligibility requirements to qualify for participation in the DPP benefit. The requirements are as follows:
   a. Must be 18 years or older
   b. Must not be pregnant at the time of enrollment. (A participant who becomes pregnant during the program may continue at the discretion of their health care provider and the program delivery organization.)
   c. Must have a body mass index (BMI) of ≥ 25 kg/m^2 (≥ 23 kg/m^2 if Asian American)
   d. Must have a positive screening for pre-diabetes based on the CDC Prediabetes Screening Test https://www.cdc.gov/diabetes/prevention/pdf/Prediabetes-Risk-Test-Final.pdf
   e. All program participants must be considered eligible based on either:
      1) A blood test within the past year meeting one of the following specifications:
         a) Fasting glucose of 100 to 125 mg/dl
         b) Plasma glucose measured 2 hours after a 75 g glucose load of 140 to 199 mg/dl
         c) A1c of 5.7 to 6.4
         d) Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy (may be self-reported)
2. Participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment.
3. A health care professional may refer potential participants to the program, but a referral is not required for participation. Members meeting the eligibility criteria may self-refer.

C. Provider Requirements

1. Diabetes Prevention Program providers must comply with the most current CDC Diabetes Prevention Recognition Program (DPRP) guidelines and obtain pending, preliminary or full CDC recognition.
2. DPP Providers must use a CDC approved lifestyle change curriculum that includes all of the following;
   a. Emphasizes self-monitoring, self-efficiency and problem solving
   b. Provides for coach feedback
   c. Includes participant materials to support program goals
   d. Requires participant weigh-ins to track and achieve program goals

D. Program Structure

1. The core DPP benefit includes a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. These visits are typically once a week for the first 6 months.
2. The core benefit is followed by maintenance sessions once a month for the next 6 months.
3. Thereafter, Partnership~~PHC~~ will ~~provide~~ cover 12 months of ongoing maintenance sessions to qualified members to promote continued healthy behavior. A member qualifies for the ongoing maintenance sessions if:
   a. The member achieves and/or maintains a minimum weight loss of 5% from the first core session, and
   b. The member meets the attendance requirement as outlined in the Medi-Cal Manual in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018).

4. Weigh-ins are required, but may be obtained in these ways:
   a. In person at a DPP Session or DPP Provider location
   b. Remote weigh-in at the member's home using scales with digital or Bluetooth communications ability
   c. Self-reported weigh-ins with or without confirmatory documentation
   ~~c.~~

E. Delivery Methods for DPP Sessions

Partnership~~PHC~~ will cover the following methods for DPP sessions as deemed clinically appropriate:

1. In-Person: Members must be physically present in a classroom or classroom-like setting with a lifestyle coach.
2. Distance Learning: Distance learning occurs when lifestyle coaches deliver sessions via remote classroom or telehealth. The lifestyle coach is present in one location while participants call in or participate by video-conference from another location.
3. Online: Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication.
4. Combination: Members may use a combination of in-person, distance learning or online delivery methods.

F. Frequency

The benefit may be offered as often as necessary, but the member's medical record must indicate that the member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit. Examples of circumstance that may warrant repeat or additional participation include:

1. Member switched enrollment from one Managed Care Plan (MCP) to a different MCP
2. Member transitioned from Fee for Service Medi-Cal into an MCP
3. Member moved to a different county
4. Member experienced a lapse in Medi-Cal enrollment
5. Member has or had medical conditions that hinder DPP session attendance

G. Curriculum and Translations

1. Partnership~~PHC~~ will ensure that DPP providers use a CDC approved curriculum. DPP Providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC.
2. Partnership~~PHC~~ will monitor the DPP providers to ensure that the DPP services are provided in a culturally and linguistically appropriate manner and that the curriculum materials are translated and made available to members in a timely manner and meet all the requirements per Welfare and Institutions Code (WIC) Section 14029.91, Part 92 of Title 45 of the Code of Federal Regulations (CFR) and Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116].

H. Documentation of Performance-Based Codes

Partnership~~PHC~~ will ensure that any DPP providers are informed and comply with all applicable state and federal laws and regulations, contract requirements and other Department of Health Care Services (DHCS) guidance, including All Plan Letters (APLs) and Policy Letters.

~~I. Delegation of Diabetes Prevention Program (DPP)~~

~~J. PHC delegates the administration of the diabetes prevention program to a contracted globally capitated health plan for its assigned members and may contract with other entities as appropriate to provide this benefit. For any services delegated, the following procedures apply:~~

~~K. A formal agreement will be issued, inclusive of all delegated functions required for the provision of DPP, pursuant to DHCS .~~

~~L. Oversight/Regular monitoring of activities will be performed which includes, but is not limited to, an~~

~~audit conducted no less than annually.~~

I. ~~Results from the annual delegation oversight audit shall be presented to PHC's Delegation Oversight Review Sub-Committee (DORS) for review and approval and approved by the Chief Medical Officer (CMO) or physician designee.~~Ancillary Care Services Provider
PartnershipPHC credentials and re-credentials all of the types of ancillary care service providers which includes DPP, refer to PartnershipPHC Policy MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements for more details.

J. PartnershipPHC Medical Equipment Distribution Services (PMEDS) Program
Members may be able to obtain certain medical devices (scales, etc.) through the PMEDS program when they meet medical criteria and their Provider submits a request form on their behalf. Forms can be found on the PartnershipPHC website at www.partnershiphp.org in the Provider Section. Keywords: Medical Equipment Distribution Services Request Form.

VII. REFERENCES:

A. DHCS All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018)
B. Welfare and Institutions Code (WIC) Section 14029.91
C. Part 92 of Title 45 of the Code of Federal Regulations (CFR)
D. Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116]
E. Centers for Disease Control and Prevention, Diabetes Prevention Recognition Program Standards and Operating Procedures, http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf May 1, 2021

VIII. DISTRIBUTION:

A. PartnershipPHC Department Directors
B. PartnershipPHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Chief ~~Senior Director,~~ Health Services Officer

X. REVISION DATES:

06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24

PREVIOUSLY APPLIED TO:
N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3110 (previously MPUG3110)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/18/2009</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF)
C. MCUP3013 – Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Obstructive Sleep Apnea (OSA) is a disorder that is characterized by obstructive apneas, obstructive hypopneas, and/or respiratory related arousals caused by repetitive collapse of the upper airway during sleep.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The following guideline discusses the current recommendations for the evaluation and management of obstructive sleep apnea (OSA) in adults.

VI. GUIDELINE / PROCEDURE:

A. OSA is an important disorder because it is common and patients with OSA are at increased risk for poor neurocognitive performance and organ system dysfunction due to repeated arousals or hypoxemia during sleep over months to years. The severity and duration of OSA necessary for these sequelae likely varies among individuals. Despite its importance, medical practitioners often under-recognize OSA. Cardinal features of obstructive sleep apnea (OSA) in adults include:
   1. Perturbations of a regular respiratory pattern during sleep, including obstructive apneas, hypopneas, or respiratory effort related arousals.
   2. Daytime symptoms attributable to disrupted sleep, such as sleepiness, fatigue, or poor concentration.
   3. Signs of disturbed sleep, such as snoring with restlessness. Simple snoring alone does not require a work up. If patients who have significant snoring have additional findings, such as obesity, daytime sleepiness, witnessed apneas, or morning headaches, further evaluation for obstructive sleep apnea should be considered.

B. RISK FACTORS
1. Risk factors for OSA include obesity and craniofacial or upper airway soft tissue abnormalities, while potential risk factors include heredity, smoking, and nasal congestion.
   a. Obesity is the best documented risk factor for OSA.
   b. Craniofacial or upper airway soft tissue abnormalities increase the likelihood of having or developing OSA.
   c. A family history of OSA
   d. Current smoking
   e. Nasal congestion
   f. Diabetes or insulin resistance
   g. Older age

C. DIAGNOSIS
1. If patients are suspected of having sleep apnea based on the history or if the patient is at high risk for the condition, evaluation with a sleep study should be considered.
2. Overnight pulse oximetry study (Current Procedural Terminology [CPT] 94762) is not a Medi-Cal benefit, and is not covered by Partnership HealthPlan of California (PHC).
3. A Treatment Authorization Request (TAR) is not required for CPT 95782 (polysomnography for members younger than 6 years of age).
4. Unattended Sleep Study:
   a. A home unattended portable multimodal monitoring (CPT codes 95800, 95801, and 95806 or HCPCS codes G0398, G0399, and G0400) is required prior to having a facility-based attended diagnostic sleep study in the following circumstances:
      1) When there is a high pre-test probability of moderate to severe obstructive sleep apnea on clinical grounds (excessive daytime drowsiness AND at least one of the following: habitual loud snoring, hypertension, nocturnal gasping or choking, witnessed apnea, or frequent awakenings) OR
      2) The patient has had a screening overnight pulse ox study which showed likely OSA, AND
      3) If there are no co-morbid conditions that would impact the accuracy of the sleep study (e.g. neuromuscular disease, history of stroke, significant cardiopulmonary disease, chronic opioid use, severe insomnia, impaired dexterity or mobility, cognitive impairment),
   b. This diagnostic evaluation should only be interpreted by a specialist with experience in administering and interpreting this test.
   c. No prior authorization is required for home sleep studies. Unattended sleep studies are not covered for diagnoses other than OSA. Reimbursement for home sleep studies is limited to one per year. Reimbursement for home sleep studies beyond 1 per year requires a TAR for medical necessity.
5. An attended diagnostic sleep study (CPT 95808, 95810 or 95811) is generally indicated when one or more of the following conditions are diagnosed or suspected:
   a. Narcolepsy
   b. Idiopathic CNS Hypersomnia
   c. Sleep disordered breathing due to central sleep apnea
   d. Parasomnia
   e. Nocturnal Oxygen Desaturation
   f. Disorders of REM Sleep
   g. Suspicion of OSA in mission critical workers such as airline pilots, bus drivers, truck drivers, taxi drivers, rideshare service company drivers, and others in whom falling asleep at work could have a major negative impact
6. Attended sleep studies must be ordered by the primary care provider (PCP) or by the specialist who is treating the member. For Direct Members, the study must be ordered by the physician who is

currently managing the medical care for the member. Prior authorization is required by PHC for an attended sleep study, and PHC utilizes InterQual® criteria to determine the medical necessity of this service.

7. The use of polysomnography for a complaint of insomnia is not considered medically necessary and is not covered because there is no convincing evidence that polysomnography is useful or improves outcome results for this symptom.
8. If there is some question about the need for sleep study, a specialist consultation should be obtained.

D. TREATMENT: Correct diagnosis is the foundation for a treatment plan for sleep disorders. This section focuses on the treatment of obstructive sleep apnea.
   1. Many options exist for treatment of obstructive sleep apnea. These include behavior modification (including weight loss, exercise, sleep position, alcohol avoidance), surgical options, pharmacologic treatment and Continuous Positive Airway Pressure (CPAP).
   2. For the initial approval of CPAP, InterQual® Criteria (*noninvasive airway assistive devices*) must be met and a sleep study performed within the past 12 months and documented OSA is required. When CPAP is selected as the treatment modality, it may be titrated in a sleep study laboratory (CPT 95810) or at home, with a self-titrating CPAP device (Healthcare Common Procedure Coding System [HCPCS] code: E0601). Determination of which titration method is needed is made by the treating physicians. Both titration methods require prior diagnosis of OSA and should only be done under the supervision of a clinician with experience coaching a patient on the use of CPAP.
   3. For approval of renewal of CPAP authorization, InterQual® Criteria *(noninvasive airway assistive devices*) apply.

E. EQUIPMENT REQUIREMENTS: PHC follows Centers for Medicare and Medicaid Services (CMS) standards for specifications for equipment permissible for diagnosis of obstructive sleep apnea, interpretation of sleep studies, and titration of CPAP (CAG#0093R2, March, 13 2008, or any subsequent updates published by CMS) including Local Coverage Determinations (LCDs).

F. No TAR is required for CPAP supplies for a CPAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).

VII. REFERENCES:

A. Centers for Medicare & Medicaid Services (CMS) Standards: CAG#0093R2, March, 13 2008, or any subsequent updates published by CMS
B. Medi-Cal Provider Manual/ Guidelines including Medicine: Neurology and Neuromuscular (*medne neu*)
C. InterQual® criteria: Durable Medical Equipment: Non-invasive airway assistive devices, ~~10/15/2022~~July 2023 Release
D. InterQual® criteria: Procedures: Sleep studies, ~~7/23/2022~~July 2023 Release
E. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults; UpToDate: published online ~~06/03/2021~~10/05/2023.

VIII. DISTRIBUTION:

A. PHC Departmental Directors
B. PHC Provider Manual

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

X. REVISION DATES:

Medi-Cal
10/01/10; 04/18/12; 02/20/13; 10/15/14; 01/20/16; 11/16/16; 11/15/17; *02/13/19; 02/12/20; 01/13/21; 02/09/22; 05/11/22; 06/14/23; 06/12/24

Guideline/Procedure Number: MCUG3110 (previously MPUG3110)		**Lead Department: Health Services**
Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2009	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: 06/14/202306/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
Healthy Kids
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013

PartnershipAdvantage:
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013
PAUG3123 – 02/20/13 to 01/01/15 (PA program ended 01/01/2015)

Healthy Families:
MPUG3110 - 10/01/10; 04/18/12 to 02/20/2013

****

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

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3134</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 01/20/2016</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
~~C.~~D. MCUP3039 – Direct Members

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. The stages of decubitus ulcer severity are follows:
   1. Stage I - a reddened area, skin unbroken
   2. Stage II - a superficial blister or open area involving the epidermis
   3. Stage III - a deeper lesion that invades the dermis and subcutaneous tissue
   4. Stage IV - an extension lesion that may involve muscle and bone
B. Prevention of decubitus ulcers includes the following:
   1. Elimination of moisture
   2. Proper patient positioning with hourly changes
   3. Relief of spasticity
   4. Reduction of shear force
   5. Weight dispersion

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for a hospital bed or a specialty (antidecubitus) bed or mattress.

VI. GUIDELINE / PROCEDURE:

A. HOSPITAL BEDS
   1. A hospital bed must be ordered by the Primary Care Provider (PCP) or specialist who is treating the member through a referral from the PCP. For Direct Members, the hospital bed must be ordered by the provider who is currently managing the medical care for the member.

2. Bariatric beds for a member weighing greater than 350 pounds will be considered for authorization on a case by case basis. These requests will require:
   a. Documentation from a specialist provider delineating the member's medical need for this equipment.
   b. Evaluation of the member's home, documenting the compliance of the structure to safely install the bed in this home.
   c. Documentation of member/caretaker's ability to use the equipment safely.
   d. A recent weight measurement of the patient within the last 12 months.
3. A hospital bed can be ordered for a member with a medical condition that requires positioning of the body not feasible in a non-hospital bed; promotion of body alignment to prevent contractures in a patient with history of contractures or a documented medical condition that causes risk of contractures; recipient needs elevation of the head of the bed more than 30 degrees due to conditions such as congestive heart failure, chronic obstructive lung disease or history of aspiration; or recipient need use of special attachments or traction equipment. Hospital beds are not covered if elevation of the head/upper body is less than 30 degrees. Pillows and wedges must be ruled out as an option.
4. The TAR must include documentation of medical necessity for the use of the hospital bed that includes the following information related to the condition:
   a. Description of the severity and frequency of the symptoms
   b. Description of need for any attachments for the bed
   c. Evaluation of the member's functional abilities
   d. Length of time member will need the equipment
   e. Care giver status
5. The TAR must include information regarding the member or caretaker's ability to properly use the hospital bed.
6. For semi-electrical beds, the TAR must include documentation that the electric feature is medically necessary for one of the following reasons:
   a. Condition requires the electric feature to allow the patient independent transfer to chair or standing position by enabling the patient to sit up unassisted.
   b. Condition requires frequent change in body position and/or an immediate need for a change in position and the patient can operate the controls to cause the required position changes.
7. Requests for full electric hospital beds will be reviewed on a case by case basis.
8. Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability but not necessarily to restore the member to previous function.
9. The UM staff will compare the cost of purchase versus rental of the equipment and authorize the most cost effective.

B. SPECIALTY BEDS/ MATTRESSES
1. A specialty bed or mattress must be ordered by the PCP or specialist who is treating the member through a referral from the PCP. For Direct Members, the specialty bed or mattress must be ordered by the provider who is currently managing the medical care for the member.
2. Documentation required for the initial TAR includes the following:
   a. Diagnosis
   b. Prescription signed by a prescribing clinician
   c. Documentation of bed-bound status and wound history
   d. Whether wound(s) are currently present or not
   e. If wounds are present at time of TAR submission, the following clinical documentation must also be submitted with the TAR:
      1) Number of wounds
      2) The stage and size of each wound

3) Description of each wound
4) Location of each wound
5) Relevant wound history, including any prior pressure sore(s)
6) Relevant history of patient's use of pressure sore equipment

3. TARs will be reviewed in 3 month increments. Documentation requirements for reauthorization of a TAR include the following:
   a. Updated treatment & care plans, as indicated
   b. Re-evaluation of healing status of the pressure sore(s), including update of size, number and location of wounds
4. A specialty bed or mattress may be ordered for a member with a history of pressure decubitus ulcers unresponsive to conservative therapy.
   a. Requests for specialty beds (e.g., Clinitron, Mediscus, Hydrofloat, Hydrothermic, KinAir, Flexicair, etc.) are generally authorized only for a member with the following conditions:
      1) Severe decubitus ulcers (Stage III or IV)
      2) History of recurrent Stage II or higher decubitus ulcers on the trunk or pelvis that are unresponsive to conservative therapy
5. There are three levels of bed support surfaces which may be authorized as appropriate:
   a. Group 1 includes gel overlays, foam mattresses and alternating pressure pads with pump which are appropriate for:
      1) Current Stage I or II pressure sore(s) on trunk of body
      2) History of stage III or IV pressure sore(s) on trunk of body, OR
      3) Member is bed bound & requires support surface for pressure sore prevention
   b. Group II includes Alternating Pressure Pump and Pad System (APP) mattresses and low air loss mattresses which are appropriate for current Stage III or IV pressure sore(s) on trunk of the body
   c. Group III includes complete bed systems also known as air-fluidized beds and requests will be reviewed on a case by case basis.
6. Requests for decubitus wheelchair pads and cushions may be authorized for members with the following conditions;
   a. Stage I or II ulcer
   b. Bed or wheelchair bound member to prevent development of ulcers (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components for wheelchair specifics).
7. The TAR must include information regarding the member or caretaker's ability to properly use the specialty bed and the type of care currently being provided for the ulcer.
8. Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability but not necessarily to restore the member to previous function.
9. The UM staff evaluates all options for care of the decubitus ulcer and authorize the most appropriate modality that will assist in healing of the ulcer. Specialty beds/mattresses are initially approved for 3 months with reauthorization dependent upon documentation of significant improvement in the decubitus ulcers and prognosis of further healing that requires the continued use of the specialty bed. Re-evaluation for the continued need of a specialty mattress will occur in 3 month authorization periods until the item capitates to purchase at the end of 12 months. Once a decubitus ulcer is healed, a Group 3 Low Air Loss Mattress should be downsized to a lesser product (i.e. gel overlay) for prevention of skin breakdown.
10. Decubitus Pads, Cushions and Mattress
    a. Pads, cushions, mattresses, alternating pressure pads, etc., require at least 3 to 4 inches thickness to be effective in the treatment of pressure sores.

b. Gel foam mattresses and other special mattresses are useful in the care of a decubitus and may be authorized as appropriate. Other options include alternating pressure mattresses and dry flotation mattresses.

11. Specialty Beds
    a. An anti-decubitus ulcer bed is generally authorized for use in long-term care facilities, or for home use, where it can be documented that appropriate nursing care and the use of more conservative treatments have failed, or would fail, to prevent or treat the patient's pressure sores.
    b. The use of the bed permits care for a chronically ill patient at a lower level of care than acute hospital level and may prevent or reduce recurrent hospitalization for treatment of decubiti.

VII. REFERENCES:
Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products *(dura ~~bil~~ thp)*

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

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

X. REVISION DATES: 02/17/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 02/10/21; 05/11/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUG3021 (previously UG100321) **Hospital Bed Guidelines**
Original date: 05/30/1995
Revision Dates: 04/28/00; 11/28/01; 10/16/02; 04/16/03; 10/20/04; 10/19/05; 08/20/08; 01/19/11; 02/20/13; 02/18/15 ARCHIVED 01/20/2016

MCUG3040 (previously UG100340) **Specialty Bed/Mattress Guidelines**
Original date: 05/30/1995
Revision Dates: 04/28/00; 10/17/01; 10/16/02, 04/16/03; 10/20/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 03/18/15 ARCHIVED 01/20/2016

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

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually

- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3136</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Fecal Microbiota Transplant (FMT)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/17/2017</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Review (TAR) Review Process
B. MCUP3142 – Technology Assessment

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Fecal microbiota transplantation (FMT) – the transfer of a processed stool specimen from a healthy donor to a diseased recipient for the purpose of restoring a normal population of bacteria to the colon of the recipient. Also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.
B. *Clostridioides* (formerly *Clostridium*) *difficile* infection (CDI) - confirmed stool test positive for toxigenic *C. difficile* and patient currently has symptoms of watery diarrhea.
C. Non-severe CDI – CDI with documented White Blood Cell Count ≤15,000 cells/ml and serum creatinine <1.5 mg/dL. [E]
D. Severe CDI - CDI with WBC >15,000 cells/mL and/or serum creatinine ≥1.5 mg/dL. [E]
E. Complicated/fulminant CDI – CDI associated with hypotension or shock, ileus or megacolon. [E]
F. Recurrent or relapsing CDI (RCDI) – a second or greater episode of documented CDI.
~~G. Initial treatment of non-severe or severe CDI* Preferred: Fidaxomicin 200 mg orally 2X per day for 10 days. Alternative: Vancomycin 125mg orally 4X per day for 10 days. [E]~~
~~H. Alternate initial treatment of non-severe CDI* Metronidazole 500 mg orally 3X per day for 10 - 14 days if vancomycin and fidaxomicin are unavailable. [E]~~
~~I. Initial Treatment of Complicated/Fulminant CDI* Vancomycin 500mg orally 4X per day + Metronidazole 500mg IV every 8 hours (Vancomycin delivery by mouth or by nasogastric tube. If ileus, consider adding rectal instillation of vancomycin.). [E]~~
~~J. Initial Treatment of RCDI* For treatment of RCDI occurring within 6 months, IDSA guidelines favor the use of adjunctive treatment with standard-of-care (SOC) antibiotics, either fidaxomicin or vancomycin in standard or tapered and pulsed dosing, along with adjunctive therapy with the monoclonal antibody bezlotoxumab 10mg/ kg given intravenously once. Second or more recurrences (third episodes or more) may include the addition of rifaximin to SOC or consideration for FMT. [E]~~

~~*Listed medications may require prior authorization for coverage. Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal Rx/ Magellan DHCS contracted pharmacy administrator instead of PHC.~~

Policy/Procedure Number: MCUP3136		Lead Department: Health Services
Policy/Procedure Title: Fecal Microbiota Transplant (FMT)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/17/2017	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: 06/14/202306/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the FMT policy is to assist Utilization Management (UM) staff with decision making when reviewing Treatment Authorization Requests (TARs) for FMT to treat confirmed recurrent CDI that has failed standard CDI treatment.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all FMT procedures.

B. Partnership HealthPlan of California (PHC) considers FMT medically indicated in cases of recurrent CDI as follows:

1. Eligibility Criteria - Must meet ALL criteria below:
   a. Member must be 18 years of age or older.
   b. Documentation of current symptomatic recurrent CDI.
   c. Documentation of at least a moderate **second or more** episode of RCDI (as defined above) which is a third episode or more of CDI, unresponsive to standard AND alternate treatments.
      1) ~~(~~FMT is no longer recommended as first line treatment for fulminant CDI~~)~~.[E]
   ~~c.~~d. Patient is not immunocompromised (including neutropenia).
   ~~d.~~e. All other uses of FMT are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.
2. Methodology
   a. FMT is limited to centers of expertise.
   b. FMT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
   c. The provider performing the FMT and facility providing the transplant materials must comply with the U.S. Food and Drug Administration's regulations regarding FMT[A].

VII. REFERENCES:

A. U.S. FDA Vaccines, Blood and Biologics Bulletin- Guidance for Industry: Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat *Clostridium difficile* Infection Not Responsive to Standard Therapies November 2022

B. TJ Borody, MD et al. Fecal microbiota transplantation ~~in the~~ for treatment of ~~recurrent Clostridium~~ *Clostridioides difficile* infection; UpToDate. Accessed ~~04/28/2023~~04/12/2024

C. Moore T, et al. Fecal Microbiota Transplantation: A Practical Update for the Infectious Disease Specialist; Clin Infect Dis (2014) 58 (4) 541-545; doi.org/10.1093/CID/cit950. Accessed March 24, 2017

D. Cho, Janice M. *et al*. Update on Treatment of *Clostridioides difficile* Infection; Mayo Clin Proc. April 2020; 95(4): 758-769. https://www.mayoclinicproceedings.org/ Accessed March 23, 2021.

E. Johnson, Stuart et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of *Clostridioides difficile* Infection in Adults *Clinical Infectious Diseases*, Volume 73, Issue 5, 1 September 2021, Pages e1029–e1044, https://doi.org/10.1093/cid/ciab549 Accessed March 30, 2022.

~~F. DHCS All Plan Letter (APL) 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)~~

VIII. DISTRIBUTION:

A. PHC Provider Manual

B. PHC Department Directors

Policy/Procedure Number: MCUP3136		**Lead Department: Health Services**
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Original Date: 05/17/2017	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: 06/14/202306/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

X. REVISION DATES: *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3144 (previously MCCP2028)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/13/2019 (MCCP2028)
Effective Date: 07/01/2020 (MCCP2028)</td><td colspan="3">Next Review Date: ~~06/14/2024~~06/12/2025
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I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

A. Administration
B. Behavioral Health
C. Claims
D. Health Services
E. Member Services
F. Provider Relations

III. DEFINITIONS

~~A. Adolescents – As defined for Drug Medi-Cal (DMC) purposes, adolescents are eligible beneficiaries from the twelfth (12th) birthday up to the twenty-first (21st) birthday.~~

~~B.~~A. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

~~C.~~B. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

~~D.~~C. Behavioral Health Clinical Director – The Partnership HealthPlan of California (PHC) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of PHC activities. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use disorder treatment related services.

~~E.~~D. Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

~~F.~~E. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with Title 42 Code of Federal Regulations (CFR) 438.210 (a) (4). ~~or, in the case of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), services that meet the criteria specified in Title 22, Code of California Regulations (CCR) Sections 51303 and 51340.1~~

F. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: (California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

G. Non-Urgent Request – A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

H. Program Beneficiary – A person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

I. Residential Treatment – As defined for DMC purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

J. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
   2. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (PHC) to process Treatment Authorization Requests (TARs) for residential substance use disorder treatment services.

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)
   1. Partnership HealthPlan of California (PHC) authorizes residential treatment services for substance

use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:

a. Adults (Age 21 or older)
   1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco Related Disorders and Non-Substance Related Disorders).
   2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM Criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to PHC.

b. Adolescents ~~(From the twelfth [12th] birthday~~ up to the twenty-first [21st] birthday)
   1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.
   2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to PHC.

2. PHC utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. PHC shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview
1. When the Medi-Cal eligible beneficiary presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary of the assessment findings and a treatment plan to the PHC Health Services Department for review.
   a. TAR determinations cannot be made by PHC until all required documents and information are received.
   b. TARs should be submitted electronically via PHC's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to PHC's Health Services Department for review.
3. PHC's Utilization Management (UM) staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within 5 business days of receipt of the request.
   a. PHC's UM staff includes nurse coordinators who are Registered Nurses (RNs) with specialized ASAM training who can approve and defer (pend) the TAR, or deny the TAR for administrative reasons (e.g. TAR not required, duplicate request, or invalid code). Any decision requiring medical necessity determination will be referred to a Physician as per 3.b. below. The nurse coordinator reviews the information received from the residential treatment provider utilizing

the approved review guidelines as described in section VI.A. above.

b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.CE. above) or Physician Designee for further evaluation. When a TAR requires clinician review, the nurse coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.

c. Notification of approved TARs will be provided to the provider at the time of decision, but no later than 24 hours from the date of decision.

4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process

1. PHC will review the program beneficiary's progress periodically throughout their length oCf stay as appropriate.
2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to PHC no later than five business days prior to the expiration of the previous authorization.
   a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and PHC will review and notify the provider of the determination (approved, modified, deferred/pended, or denied) within 5 business days of receipt of the request.
2. Adults (Age 21 or older)
   a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from PHC.
   b. After completing 90 days of treatment, PHC may approve extensions of the stay based upon medical necessity and the treatment plan.
3. Adolescents ~~(From the twelfth [12th] birthday~~ up to the twenty-first [21st] birthday)
   a. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
   b. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
4. Pregnant/Post-Partum Beneficiaries
   a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy). Extension beyond 60 days will require prior approval from PHC and must be to a non-perinatal level of care.
   b. Providers will be required to provide proof of pregnancy or delivery date for each new TAR submitted to PHC.

D. Notification of Denials/Modifications/Appeals Process

1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Medi-Cal eligible beneficiary within two (2) business days of the decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

B. Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage

C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
D. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
E. Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-021 Drug Medi-Cal Organized Delivery System – Updated Policy on Residential Treatment Limitations (May 14, 2021)
F. InterQual® Behavioral Health Criteria
G. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, ~~2023~~2024) UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A
H. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:
MCUP3144 (05/11/2022):
06/14/23; 06/12/24

PREVIOUSLY APPLIED TO:
MCCP2028
04/08/20, 04/14/21; 09/08/2021 – 05/10/2022

****

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

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Access Standards and Monitoring</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/19/2003</td><td colspan="4">Next Review Date: ~~8/8/2024~~06/11/2025
Last Review Date: ~~08/09/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/09/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services
D. Finance
E. Compliance

III. DEFINITIONS:

A. High-Impact Specialist: Partnership HealthPlan of California (~~PHC~~Partnership) shall annually identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources. ~~PHC~~Partnership will include oncology/hematology as a high impact specialty type every year.

B. High-Volume Behavioral Healthcare Practitioner: ~~PHC~~Partnership shall identify high volume behavioral healthcare practitioner types by assessing the number of unique members seen by a given practitioner type within a calendar year. ~~PHC~~Partnership annually selects the top four practitioner types with the largest numbers of unique members seen.

C. High-Volume Specialist (Non-Hospital Specialist): ~~PHC~~Partnership shall identify high-volume specialists by using available claim and encounter data to identify the number of unique members seen by a given specialty type within a calendar year. ~~PHC~~Partnership will select the top six specialty types with the largest numbers of unique members seen. ~~PHC~~Partnership will include obstetrics/gynecology as a high-volume specialty type every year.

D. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards) include Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity.

E. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards) include Lake, Napa and Yolo.

F. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards) include Marin, Solano and Sonoma.

G. Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

H. Triage or Screening Wait Time: The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.
I. Urgent Care: Health care for a condition that requires prompt attention.

IV. ATTACHMENTS:

A. Standards for Core Specialists

V. PURPOSE:

To define access standards and the framework for monitoring compliance with those standards across primary care, specialty care and mental health care.

VI. POLICY / PROCEDURE:

Partnership HealthPlan of California is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. ~~PHC~~Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone availability. ~~PHC~~Partnership monitors provider availability and accessibility on an annual basis ~~PHC~~Partnership will monitor and ensure sufficient providers are in the network and service areas for provider types that include but are not limited to: CalAIM, Enhanced Care Management, Community Supports, Community Health Workers, and the Department of Health Care Services (DHCS)-mandated benefits or services. ~~PHC~~Partnership will collaborate with network hospitals and birthing centers to eliminate barriers to doula access when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits, regardless of outcome: stillbirth, abortion, miscarriage, or live birth.

A. Availability of Practitioners

~~PHC~~Partnership maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners and monitors how effectively this network meets the needs and preferences of our members.

1. ~~PHC~~Partnership maintains an overall ratio of total network physicians to members of 1 FTE physician to every 1,200 members (DHCS standard).
2. Cultural Needs and Preferences:
   a. ~~PHC~~Partnership assesses the cultural, ethnic, racial and linguistic needs of its members annually and adjusts the availability of practitioners within the network, if necessary (National Committee for Quality Assurance [NCQA] requirement).
3. Practitioners Providing Primary Care: To evaluate the availability of practitioners who provide primary care services, including general medicine or family medicine, internal medicine and pediatrics, ~~PHC~~Partnership:
   a. Establishes measureable standards for the number of each type of practitioner providing primary care.

NUMBER OF PRACTITIONERS, PRIMARY CARE [1]		
Practitioner Type	**Measure: Ratio**	**Standard/Performance Goal**
Primary Care Provider overall	Primary care provider to member (adult and children)	1:≤ 2,000
Family Practice/General Practice	Family or General practice practitioner to member (adult and children)	1:≤ 2,000
Pediatrics	Pediatricians to members (children)	1:≤ 2,000
Internist	Internists to members (adult)	1:≤ 3,000

b. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, PRIMARY CARE [2]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Primary Care Physician overall	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%
Family Medicine /General Practitioner	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Pediatrics	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Internist	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Obstetrics/Gynecology	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%

c. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care (NCQA requirement).
d. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care (NCQA requirement).

4. Practitioners Providing Specialty Care: To evaluate the availability of specialists in ~~PHC~~Partnership's delivery system, ~~PHC~~Partnership:
   a. Identifies high-volume specialists (NCQA requirement) by assessing the number of unique members seen by a given specialty type within a calendar year. ~~PHC~~Partnership annually selects the top six specialty types with the largest numbers of unique members seen. Ratios for identified high- volume specialists that are also an identified core specialist will be the same as the core specialty standard. (See Attachment A.)
   b. Identifies high-impact specialists (NCQA requirement) by identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or identifying practitioner types

[1] DHCS requires an overall PCP-to-member ratio of 1 FTE PCP to every 2,000 members. NCQA requires health plans to set ratio goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact performance goals are internally determined by ~~PHC~~Partnership.

[2] DHCS requires member access to primary care overall within 10 miles and 30 minutes from member's residence. NCQA requires health plans to set geographic distribution goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact standards and performance goals are internally determined by ~~PHC~~Partnership.

where treatment requires significant resources. ~~PHC~~Partnership's current high-impact specialty type is:

1) Oncology/Hematology

c. Monitors geographic availability for additional specialty types defined by DHCS as "Core Specialists."

DHCS ADULT AND PEDIATRIC CORE SPECIALISTS			
Cardiology/Interventional Cardiology*	Gastroenterology	Nephrology	Orthopedic Surgery*
Dermatology*	General Surgery*	Neurology	Physical Medicine and Rehabilitation
Endocrinology	Oncology/ Hematology **		Psychiatry
ENT/Otolaryngology	HIV/AIDS Specialists/Infectious Diseases	Ophthalmology*	Pulmonology
*High-volume specialty type; **High-impact specialty type			

NUMBER OF PRACTITONERS, HIGH IMPACT		
Practitioner Type	Measure Ratio	Standard Performance Goal (Ratio of specialists to members)
Oncology/Hematology	Oncology Hematology to Member	1: ≤ 25,000

d. Establishes measureable standards for the geographic distribution of each type of specialist (high-volume, high-impact, and DHCS Core).

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, SPECIALTY CARE [3]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
• Cardiology*+ • Dermatology*+ • Endocrinology+ • ENT/Otolaryngology+ • Gastroenterology+ • General Surgery*+ • HIV/AIDS Specialists/Infectious Diseases+ • Nephrology+ • Neurology+ • Obstetrics/Gynecology (as specialist)* • Ophthalmology*+ • Orthopedics*+ • Physical Medicine and Rehabilitation+ • Pulmonology+	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%
Oncology/Hematology **+		≥ 80%
*High-volume specialty type; **High-impact specialty type; +DHCS Core Specialists		

e. Analyzes performance against the established specialty care availability standards at least annually (NCQA requirement).

5. Practitioners Providing Behavioral Healthcare: To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, ~~PHC~~Partnership:
   a. Identifies high volume behavioral healthcare practitioners (NCQA requirement) by assessing the number of unique members seen by a given practitioner type within a calendar year. ~~PHC~~Partnership annually selects the top four practitioner types with the largest numbers of unique members seen. ~~PHC~~Partnership's current high-volume practitioner types are:
      i. Psychiatrist
      ii. Clinical psychologist
      iii. Licensed clinical social worker
      iv. Marriage and family counselor
   b. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.

[3] DHCS sets geographic distribution requirements for all DHCS Core Specialty types. NCQA requires geographic distribution standards for all high-volume and high-impact specialty types but does not dictate the exact standards or performance goals. ~~PHC~~Partnership has adopted the DHCS geographic distribution standard across all monitored specialty types; the performance goal is internally determined by ~~PHC~~Partnership.

NUMBER OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [4]		
Practitioner Type	**Measure: Ratio**	**Standard/ Performance Goal**
Psychiatrist	Psychiatrist to members	1: ≤50,000
Clinical psychologist	Clinical psychologist to member	1: ≤30,000
Licensed clinical social	Licensed clinical social worker to member	1: ≤10,000
Marriage and family counselor	Marriage and family counselors to members	1: ≤10,000

c. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [5]		
Practitioner Type	**Standard: Geographic Distance**	**Performance Goal**
• Psychiatrist[+] • Clinical psychologist • Licensed clinical social • Marriage and family counselor [+]DHCS Core Specialist	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%

d. Analyzes performance against the established behavioral healthcare availability standards annually (NCQA requirement).

6. Pharmacy: To evaluate the availability of pharmacy services, ~~PHC~~Partnership establishes measureable standards for the geographic distribution of pharmacies.

GEOGRAPHIC DISTRIBUTION OF PHARMACIES	
Practitioner Type	**Standard: Geographic Distance**
Pharmacy	One within 10 miles and 30 minutes from member's residence (DHCS standard)

7. Hospitals: To evaluate the availability of hospital services, ~~PHC~~Partnership establishes measureable standards for the geographic distribution of hospitals.

GEOGRAPHIC DISTRIBUTION OF HOSPITALS	
Practitioner Type	**Standard: Geographic Distance**
Hospital	One within 15 miles and 30 minutes from member's residence (DHCS standard)

[4] NCQA requires ~~PHC~~Partnership to establish measurable standards for the number of each type of high-volume behavioral healthcare practitioners; however, the exact standards are internally determined by ~~PHC~~Partnership.
[5] DHCS sets geographic distribution requirements for psychiatrists (DHCS Core Specialty). NCQA requires geographic distribution standards for all high-volume behavioral health care practitioner types, but does not dictate the exact standards. ~~PHC~~Partnership has adopted the DHCS geographic distribution standards across all monitored behavioral health care practitioner types; the performance goal is internally determined by ~~PHC~~Partnership.

B. Accessibility of Services
~~PHC~~Partnership provides and maintains appropriate access to primary care, specialty care and behavioral healthcare services. These timeframes will only be extended if it is determined by the treating health provider that waiting will not have a detrimental impact on the member's health and it must be noted in the member's medical record.

1. Access to Primary Care
   a. Regular and Routine Care Appointments:
      1) Non-Urgent Primary Care Appointments: These appointments include preventive visits and follow-up visits. Appointments should be provided within 10 business days of request.
      2) Prenatal Care Appointments: Pregnant members should be provided an initial prenatal care appointment within 10 business days of request.
      3) Newborn Appointments: Infants discharged from hospital in less than 48 hours of life after delivery should be seen within 48 hours of discharge. The follow-up visit can take place in a home or clinic setting as long as the health care professionals examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician or his or her designees on the day of the visit where the PCP is not examining the infant. (~~PHC~~Partnership standard)
   b. Urgent Care Appointments
      1) Appointments that do not require prior authorization- within 48 hours of a request.

ACCESSIBILITY TO PRIMARY CARE PRACTITIONERS [6]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care primary care appointments within 10 business days of request (DHCS standard)	≥ 90%
Prenatal Care appointments within 10 business days of request (DHCS standard)	≥ 90%
Newborn appointments within 48 hours of discharge (~~PHC~~Partnership standard)	≥ 90%
Urgent Care appointments without prior authorization within 48 hours of request (DHCS standard)	≥ 90%

2. Access to Specialty Care
   a. Appointments for non-urgent specialty care shall be provided within 15 business days of member's referral. (This standard applies to all Specialty type referenced in section A.4.e.)

ACCESSIBILITY TO SPECIALTY CARE PRACTITIONERS [7]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care specialty appointments within 15 business days of request (DHCS standard)	≥ 80%

3. Access to Behavioral Healthcare
   a. Routine office visits (initial and follow-up care) within 10 business days of member's request (DHCS and NCQA standard).
   b. Urgent and Emergency care: Coverage for moderate to severe behavioral health is a carved out

[6] NCQA requires that ~~PHC~~Partnership set primary care appointment accessibility standards for regular and routine care appointments and urgent care appointments, but does not dictate what the standards should be. Where indicated, ~~PHC~~Partnership has adopted the DHCS appointment access standard.

[7] NCQA requires that ~~PHC~~Partnership set specialty care appointment accessibility standards for high-volume and high-impact specialty care but does not dictate what the standards should be. Where indicated, ~~PHC~~Partnership has adopted the DHCS appointment access standard.

benefit and members are referred out to county emergency services. Members who contact ~~PHC~~Partnership or contact our delegated providers, Beacon Health Options and Kaiser Permanente, with a psychiatric emergency are immediately redirected to county mental health providers for appropriate psychiatric crises intervention and follow-up care. Both ~~PHC~~Partnership and our delegated providers have policies and protocols in place to ensure the member's safety and well-being during such redirection.

ACCESSIBILITY TO BEHAVIORAL HEALTHCARE	
Timely Access Standard	**Performance Goal**
Routine office visits (initial and follow-up care) within 10 business days of request (DHCS standard)	≥ 80%

4. Access to Long Term Services and Support (LTSS)
    a. Access to LTSS services within 14 calendar days of request for rural and small counties
    b. Access to LTSS services within 7 business days of request for medium counties
    c. Access to LTSS services within 5 business days of request for dense counties

ACCESSIBILITY TO LONG TERM SERVICES AND SUPPORT Standards effective post PAC approval – June 2019			
Timely Access Standard by County Size			
	Rural/Small	Medium	**Performance Goal**
Skilled Nursing Facility Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 7 business days of request	≥ 80%

5. Access to Emergency Care
    a. Emergency treatment must be available immediately to all members 24 hours a day. During hours when PCP offices are closed, members should be directed to an after-hours or emergency care location depending on the nature of the problem.

C. Primary Care Practitioner and Specialty Care Office Hours and Telephone Access Standards
1. Regular Business Hours
    a. PCP practices must be open and staffed by a clinician(s) who is available to members for a minimum of 20 hours per week. PCPs with multiple sites less than ten (10) miles apart that see members at either site may combine open hours to meet the requirements. Exceptions to this requirement can be made by the ~~PHC~~Partnership Chief Medical Officer (CMO) based on need for access to primary care services. PCP sites granted this exception must assist members with coordination of care when the assigned PCP office is not open and submit a referral authorization to another PCP site.
    b. Office hours and an emergency 24-hour number must be displayed in a clearly visible area, window, or door.
    c. Hours of operation must be adequate and convenient for members to schedule appointments and should not in any way discriminate against Partnership HealthPlan members.

d. When calling the provider's office:
   1) Phone calls are answered within 5 rings
   2) Maximum time on hold is 5 minutes
   3) Phone messages left for provider during regular business hours should be responded to within 30 minutes of the call.
   4) Number of minutes waiting from scheduled appointment time to being seen must not exceed 30 minutes unless practitioner unexpectedly delayed.
   5) Emergency calls must be immediately reviewed by a qualified clinician who will determine urgency of the appointment or referral as indicated.

2. After Hours[8]
   a. Provider practices must be available or arrange for services 24 hours/7 days per week.
   b. The telephone triage or screening services must be provided in a timely manner appropriate for the member's condition; the member's wait time for screening or triage services must not exceed 30 minutes.
   c. Medically unlicensed persons handling member calls may ask questions on behalf of a licensed person to help ascertain the condition of the member so that the member can be referred to licensed staff. Unlicensed persons cannot use the answers to those questions to assess or make any decisions regarding the condition of a member, or to determine when a member needs to be seen by a licensed medical professional.
   d. After-hours advice must be provided by a licensed or registered professional whose scope of practice includes making assessments and recommending interventions.
      1) Provider must make best efforts to ensure a Member's existing Mental Health Provider is notified during an Urgent Care situation.
   e. Provider offices may use the ~~PHC~~Partnership Advice Nurse line, which is available to members 24 hours a day, 7 days a week. Providers who use ~~PHC~~Partnership Advice Nurse Line for after-hours support must actively promote the service to ~~PHC~~Partnership members.
   f. Provider offices must communicate their after-hours procedure to members. At a minimum, this communication should include:
      1) Clear communication to patients via answering machine or on call service:
         a) To call 911 or go to the nearest Emergency Room for medical emergencies.
         b) How to access after-hours medical advice
      2) Posted after hour procedure on provider site door and communicated verbally or by informational packets.

After Hours Access	
Timely Access Standard	**Performance Goal**
Answering machine or answering services	≥ 90%
Instructions to call 911/ER	≥ 90%
Instructions to reach MD/Advice Nurse	≥ 90%
Wait times for screening or triage services must not exceed 30 minutes	≥ 90%

D. Assessment of Network Adequacy
   1. On an annual basis, ~~PHC~~Partnership analyzes access and availability performance against the standards set forth in this policy. Additionally, ~~PHC~~Partnership annually assesses member experience with network adequacy by analyzing patient experience survey results, data from network adequacy grievances and appeals, and requests for/utilization of out-of-network services (NCQA requirement). This analysis informs ~~PHC~~Partnership of any access issues specific to geographic areas and/or types of providers. Where applicable, ~~PHC~~Partnership implements

[8] NCQA requires that ~~PHC~~Partnership set primary care after-hours care standards.

interventions to address opportunities for improvement and measures the effectiveness of those interventions (NCQA requirement). Analysis results and related interventions are reviewed by ~~PHC~~Partnership's Quality Improvement committees.

2. ~~PHC~~Partnership conducts additional assessment of network language and cultural deficits that may exist. Analysis results and related interventions are reviewed by ~~PHC~~Partnership's Director of Health Equity ~~Director~~ and the Population Health t~~T~~eam. Actions will be taken to address any identified gaps which may include, but not limited to, additional telephone or video interpretation services; resources for culturally and linguistically appropriate health education materials; lists of ancillary providers who offer services in non-English languages; community resources that focus on specific cultural or linguistic services; and practitioner training for diversity, equity, and language services.

~~2.~~3. Network adequacy for organizations delegated for primary care, specialty care, or behavioral healthcare: ~~PHC~~Partnership annually reviews its delegate's network management procedures and evaluates delegate's performance against NCQA and DHCS standards for delegated activities. ~~PHC~~Partnership also semiannually evaluates regular reports, as specified in the delegation agreement.

E. Communication
   1. ~~PHC~~Partnership communicates access standards to:
      a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
      b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VII. REFERENCES:

A. DHCS Contract
B. 2024~~3~~ NCQA Network Adequacy Standards:
   1. NET 1:
      a. Element A – Factors 1-2
      b. Element B – Factors 1-4
      c. Element C – Factors 1-5
      d. Element D – Factors 1-4
   2. NET 2:
      a. Element A – Factors 1-3
      b. Element B – Factors 1-4
      c. Element C – Factors 1-2
   3. NET 3:
      a. Element A – Factors 1-4
      b. Element B – Factors 1-3
      c. Element C – Factors 1-3
C. DHCS All Plan Letter (APL) 20-003, Network Certification Requirements (Feb. 27, 2020)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Provider Relations

Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)	**Lead Department: Provider Relations**
Policy/Procedure Title: Access Standards and Monitoring	☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/19/2003	**Next Review Date:** ~~**08/08/2024**~~**06/11/2025** **Last Review Date:** ~~**08/09/2023**~~**06/12/2024**
Applies to: ☒ **Medi-Cal**	☐ **Employees**

X. REVISION DATES:

Medi-Cal
09/15/04; 03/15/06; 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15; 09/20/17; *03/14/18; 08/08/18; 06/12/19; 04/08/20; 5/12/21, 10/13/21, 06/08/22, 08/09/23, 06/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Medi-Cal
MPQP1023 – 02/19/2003 to 04/08/2020

PartnershipAdvantage:
QP10012 - 06/21/2006 to 12/21/2006
MPQP1023 – 12/21/2006 to 01/01/2015

Healthy Families:
MPQP1023 - 02/16/2011 to 03/01/2013

Healthy Kids
KK QI 205 - 11/15/2005 to 06/21/06
MPQP1023 – 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15 to 12/01/16 (Healthy Kids program ended 12/01/2016)

STANDARDS FOR CORE SPECIALISTS

Standards for Core Specialists are established by PHC Chief Medical Officer and the Quality Utilization Advisory Committee (QUAC).

Specialty	**Physician to Member Ratio**
Cardiology	1:10,000
Opthalmology	1:10,000
OB/Gyn	1:5,000
Pulmonology	1:25,000
Podiatry	1:20,000
Orthopedic	1:10,000
Gastroenterology	1:10,000
General Surgery	1:10,000
Dermatology	1:15,000
Neurology	1:15,000
Otolaryngology	1:25,000
Urology	1:15,000
Oncology / Hematology	1:25,000
Endocrinology	1:25,000
Nephrology	1:25,000
Pain Management	1:25,000
Physical Medicine/Rehab	1:50,000

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the May 15, 2024 Quality/Utilization Advisory Committee (Q/UAC).
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager of Clinical Compliance*				
MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	203 – 372	**Related Policies: Added** MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline. **III. Definitions C.** Expansion counties Nevada and Placer are added to the list of Partnership counties that have their own Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, over which Partnership has no regulatory oversight responsibilities. **III. D&E Definitions added:** D. Non- Physician Medical Practitioners (NPMP) are defined as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNM) and licensed midwives (LM). See MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines. E. Licensed Practitioner of the Healing Arts (LPHA) includes physicians, NPs, PAs, registered nurses (RNs), registered pharmacists, licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor, licensed marriage and family therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. See MCUP3144 - Residential Substance Use Disorder Treatment Authorization. **IV. Attachments:** The former Attachment A is split into Attachments A and B, respectively renamed SUD FSR Tool and SUD FSR Guidelines. **V.B.** DMC-ODS and Substance Abuse Block Grant (SABG) monitoring language is eliminated from the Purpose Statement. **VI.B.1-2.** The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by Partnership personnel. At a minimum, Partnership's Site Review team will consist of one of the following staff: a physician, a registered nurse (RN), or other Non-Physician Medical Practitioner (NPMP).	Health Services Behavioral Health Provider Relations External and Regulatory Affairs Claims Member Services Grievance and Appeals Compliance

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			Licensed physicians, RNs, NPMPs, and Certified Counselors, are eligible to act as Site Reviewers and may perform a site review (SR) independently and sign off on the FSR and MRR tools. Partnership will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. **Reviews of survey elements will be completed by the appropriate category of reviewer, as noted by survey labels (e.g., LPHA or RN/Physician/NPMP only).** **VI.C.1-2.** now outlines the 10 sections of both the SUD FSR Tool and the Guidelines (new Attachments A & B), as well as the new nine sections of the SUD MRR (re-lettered Attachment C). **VI.D.2:** An initial SUD MRR must now be completed within **11** months of the SUD FSR assuming services have been rendered. This may be deferred on claims. **New References G & H** supersede earlier Behavioral Health Information Notices (BHINs).	
Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*				
MPQP1016	Potential Quality Issue Investigation and Resolution	373 – 383	Staff titles are changed throughout the document as appropriate: "Quality Investigator" replaces "Performance Improvement Clinical Specialty (PICS)" and "Manager, Member Safety – Quality Investigations" replaces "Manager, Quality Assurance and Patient Safety." **VI.B.3.a revised**: Cases occurring more than two years before reporting involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee. **VI.C.1.c.i added**: Notification that another Peer Review Organization (PRO) is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process. **VI.C.2.b added**: Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions. **VI.C.2.f added:** Upon determination that a PQI case is out of Partnership's jurisdiction (e.g., serious mental health cases) the	Health Services Provider Relations Grievance & Appeals

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			case will be referred to the appropriate oversight body (e.g., County Mental Health). **VI.C.3. Tertiary Review**: the Peer Review Committee's specific responsibilities are outlined in greater detail. **Section VI.C.3.b added**: "The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any letters to and responses from POCs and all other relevant documentation and correspondence related to the case. i. Following review and discussion of the case, the PRC may uphold the original scoring determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review. ii. If a score is leveled, the PRC will direct the Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid." **VI.C.3.d.iv is added:** For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the Provider of Concern (POC) to verify that the deployed corrective action is effective and eliminates the noted deficiencies. **VI.C.7.** on reporting per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities clarifies that "a similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency." **Attachment A:** The Practitioner Performance and Systems Scores Grid clarifies discrete practitioner score (P) and system score (S) definitions and actions/follow-ups. • P2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • P3 – Action/Follow-up strengthened: ASAP communication to provider of concern requesting a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentialing Committee with recommendations from the PRC. • PUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to Peer Review	

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			Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated. • S2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • S3 – Action/Follow-up strengthened: ASAP communication to FOC/POC requesting a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentials Committee with recommendations for PRC. • SUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to the PRO of the FOC or the system of concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*				
MCCP2022	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	384 – 390	Changes made to Policy based on APL 23-023 ICF/DD Language **Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities **Definitions added:** B. California Children's Services F. ICF/DD G. ICF/DD-H H. ICF/DD-N O. Whole Child Model (WCM) **VI.R added:** Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) 1. For more information, refer to Partnership Policy MPCP2006 Coordination of Services for Members with Special Health Care Needs	Health Services Claims Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			(MSHCNs) and Persons with Developmental Disabilities **VII. Reference added:** DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) **IX.** Updated to Chief Health Services Officer	
MCCP2034	Transitional Care Services (TCS)- **NEW POLICY**	391 – 401	This policy describes and defines Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings. Partnership members identified as 'high risk' must be offered TCS services beginning Jan. 1, 2023. Partnership must offer support for TCS for lower-risk transitioning members effective Jan. 1, 2024. This policy outlines that Partnership shall ensure TCS are provided to members transferring from one setting, or level of care, to another. TCS includes the following: 1. Ensuring collaboration and partnership with discharging facilities 2. Closed loop referrals 3. Ensuring medication reconciliation is conducted pre- and post-transition 4. Ensuring all necessary prior authorizations required are completed 5. Coordination to ensure appropriate post-discharge appointment attendance and follow ups 6. Follow up with member and/or guardian/caregiver/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met 7. Members may choose to have limited to no contact with the identified TCS care manager, in these cases TCS care manager must act as a	Health Services Behavioral Health Claims Member Services Provider Relations

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			liaison 8. Coordination and verification that the member is receiving all appropriate services regardless of setting 9. Ensuring collaboration, communication and coordination with the member, their caregiver(s)/guardian/authorized representatives and their care team 10. Care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member 11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy level-appropriate, and be shared with the member.	
MPCP2006	Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities	403 – 410	Changes made to Policy based on APL 23-023 ICF/DD language and Child Health Disabilities Prevention (CHDP) Program sunsetting July 1, 2024. **Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities MCUG3038- Review Guidelines for Member Placement in Long Term Care (LTC) Facilities MCCP2014- Continuity of Care MCCP2034- Transitional Care Services (TCS) MPCD2013- Care Coordination Program Description MCCP2007- Complex Case Management MCCP2032- CalAIM ECM **Definitions added:** A. California Children's Services (CCS) B. Direct Member C. ICF/DD D. ICF/DD-H E. ICF/DD-N F. Medical Home G. Whole Child Model **VI.B.1 added:**	Health Services Claims Member Services Provider Relations

			a. In participating counties, Partnership members who have a CCS-eligible condition participate in the Whole Child Model (WCM). As part of this model, Partnership provides the case management and utilization management services for these members. For more information, refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS). b. Partnership members who have a CCS eligible condition and participate in the CCS Program, refer to policy MPCP2002- California Children's Services for more details. **VI.B.2 is revised and added:** High Risk Infant Follow-Up (HRIF) Services- Birth to age 3 years a. In accordance with APL 23-034 California Children's Services Whole Child Model Program (12/27/2023), for members in counties that participate in the WCM program, Partnership is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services. b. For members who live in a county that participates in the State CCS Program, this would be the responsibility of the CCS offices and providers, Partnership may work in collaboration if necessary. **VI.B.3.c. added** under Medicaid per APL 23-010 revisions **VI.B.5.a revised due to APL 23-010 and to reference BHT Policy:** a. Partnership is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, Partnership must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]). Please see Partnership policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details. **VI.B.6 added:** Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) a. Services are offered to members with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system b. Partnership ensures that members in ICF/DD Homes have access to a	

Synopsis of Changes to Discussion Policies

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			comprehensive set of services based on their needs and preferences across the continuum of care c. TCS: High-risk individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability. d. CCM: Members may need extra support to avoid adverse outcomes but who are not in the highest risk group e. COC: MCPs must provide 12 months of continuity of care for the ICF/DD Home placement of any member who is mandatorily enrolled into Partnership after January 1, 2024. Members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care of Medi-Cal Beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal Fee-For Service, on or after January 1, 2023. f. ECM: If a member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the member must be assessed to determine need/eligibility for ECM services g. Utilization Review: Refer to Partnership policy MCUG3058 **VI.B.7.b added language CHDP superseding** 10) This supersedes any contradicting information found within CHDP Program guidelines, as the CHDP sunsets July 1, 2024. **References updated:** A. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III, Section 4.3.9 D. DHCS All Plan Letter (APL) 23-034 – California Children's Services Whole Child Model Program (12/27/2023) F. National Committee for Quality Assurance (NCQA) Health Plan Standards 2024. Population Health Management 5 Complex Case Management **Reference added:** H. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*				

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
MCUG3038	Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	411 – 423	The annual review of this policy includes updates made for the 2024 contract and the CalAIM PHM Policy Guide as well as APL 23-004. **I. Related Policies:** Add two Related Policies: A. MCUP3142 – CalAIM Community Supports B. MCCP2032 – CalAIM Enhanced Care Management (ECM) **IV. Attachments** Deleted Attachments A. "BedHold/ TAR Process flow chart" and Attachment B. "Admissions for Short Term Rehab or Short Term Skilled Nursing," as both of these attachments are better suited to be desktop procedures. Attachment C. "Bed Hold & Change of Status Report Form" is now Attachment A but there were no changes otherwise. **VI.A.2.** This statement was deleted in light of 2024 DHCS contract requirements and the CalAIM PHM Policy Guide requirements for Transitional Care Services: "Partnership assists with finding a facility for the appropriate level of care upon request although primary responsibility remains with the hospital discharge planning staff." **VI.C.2.a.** Added information regarding "the Preadmission Screening and Resident Review (PASRR) form" indicating appropriateness for placement. **VI.C.j.** Deleted paragraph on Kaiser Capitated Members. Clarified language for Medicare denial letters. **VI.F.4.** Updated COC APL from 18-008 to 22-032 **VI.G.** Updated description of process for referring potential quality of care issues that may be identified during routine case review to Partnership's Member Safety Quality Investigations team. **VI.K.3** Added new paragraph describing ECM and CS services for which members in a SNF or LTC setting may be eligible. **VII. References** C. Updated DHCS Contract sections H. Updated APL 22-018 to APL 23-004 I. Updated APL 18-008 to APL 23-002 **IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer."	Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
MCUP3041	Treatment Authorization Request (TAR) Review Process	425 – 444	With the annual review of this policy, we include changes in TAR requirements as per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process. **VI.A.2.b.** We deleted the phone number and reference to Partnership's Eligibility and Interactive Voice Response (IVR) System as this system will cease to operate on 05/01/24. Instead, we refer the reader to Partnership's Online Services (OLS) portal to verify Member eligibility for services and PCP assignment. **VI.A.5.** Updated paragraph on storage of UM records to specify they are not archived electronically. **VI.B.1.b.** Added that we include a few HCPCS codes on our TAR Requirements list. **VI.C.4.** Clarified in two places that 90 days is 90 "calendar" days. **VI.D.3.b.** Specified that the Associate Director of UM Regulations is responsible for monitoring the UM activities of delegate entities (instead of the Senior Health Services Director.) **IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." **Attachment A:** The Partnership TAR Requirements list was updated as follows: **H: Diagnostic Studies** In this section a change was made to specify that certain CT scans and MRIs no longer require a TAR. <u>For CT Scans:</u> A TAR is required for chest, abdomen, and/or pelvis CT. No TAR is required for other CT scans of extremities, Head/Neck/Spine, CT colonogram - effective 7/1/2024. <u>For MRI:</u> A TAR is required for chest, abdomen, and/or pelvis, including Cardiac MRI 05561. No TAR is required for other MRI scans of extremities, Head/Neck/Spine, MRI Breast - effective 7/1/2024. **W: Medical Supplies** A change was made to clarify TAR requirements for Wound Care Supplies. An additional resource was added for the reader to find detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, by referencing the Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits.	Health Services Claims Member Services

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			Information was also added in the Nutritional Supplements section at W.7. to update the name of Partnership's "Medical Drug List Navigator" instead of Partnership's "Covered Medical Drug List." **W: Medications Provided by a Pharmacy:** The name "Magellan" was removed in this section and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan. **AA: Occupational Therapy, FF: Physical Therapy, and HH: Speech Therapy:** All of these sections were updated to match new TAR requirements in policy MCUP3114 Physical, Occupational and Speech Therapies. For both PT and OT, it was specified that Members under age 21 still require a TAR for services; however, no TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.) For speech therapy, it was specified that Members age 21 and over still require a TAR for services; no TAR is required for Members under age 21 for up to 12 visits (limit one visit per day) in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.)	
MCUP3114	Physical, Occupational and Speech Therapies	445 – 452	Per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process, this policy was updated to adjust TAR requirements for certain PT, OT, and ST services. **VI.B. and B.1.** Heading of this section updated to reflect "General Guidelines for Authorization" of services instead of "Submission of TARS" and the information regarding no RAF required but written prescription required for PT/OT/ST services, was moved to the beginning of this section. **VI.B.2.** This section was updated to specify PT/OT/ST services that will now have No TAR requirement which includes PT and OT services for Members age 21 and over and ST services for Members under age 21. **VI.B.3.** This section was updated to specify PT/OT/ST services that continue to have a TAR requirement, which includes PT and OT services for Members under age 21, ST services for Members age 21 and over, any PT/OT/ST services prescribed by a non-contracted provider, and services provided through home health. **VI.B.4.e.4)** This section was moved up from below for continuity in explaining which services are generally not considered medically necessary or are not covered.	Provider Relations Provider Notification Member Services Configuration

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			VI.C. This section was rearranged to better explain ESPDT services as they relate to PT/OT/ST services. Some EPSDT details were deleted with a statement added to refer the reader to Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services instead.	
Policy Owner: Utilization Management – *Presenters: Jeffrey Devido, MD, Behavioral Health Clinical Director*, and *Mark Bontrager, Senior Director, Behavioral Health*				
MCUP3028	Mental Health Services	453 – 480	Policy Reviewed for Annual update. **III.A.** Partnership definition of "closed loop referral" was added. **III.F.** Definition of Medical Necessity for EPSDT services was updated to specify that California now refers to the EPSDT benefit as "Medi-Cal for Kids & Teens." **III.I.** Definition was added for Partnership's Wellness & Recovery Program. **VI.A.3.a.e)** Added that Members residing in participating Partnership Wellness & Recovery counties will be directed to Partnership for SUD assessment. **VI.A.4.d.** Specified that Carelon Behavioral Health is Partnership's delegate. **VI.A.4.d.4) and 5)** Added language to explain how a closed loop referral process will work when there is a need to refer a member between levels of care (SMHS and NSMHS). **VI.G.** Clarified that Partnership provides or arranges for NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network. **VI.G.2.** Clarified Medi-Cal Rx information. Removed the name "Magellan" and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan.	Behavioral Health
MCUP3101	Screening and Treatment for Substance Use Disorders	481 – 509	Policy Reviewed for Annual update. **IQI suggested May 7 that the accepted screening tools language be in large part eliminated from the policy itself and turned into a grid. That new grid is now included in a revised Attachment A.** **IV.E.** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders.	Behavioral Health Providers

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			VI.A.3.a. Medications for Addiction Treatment (MAT) was updated to include acamprosate and disulfiram for treatment of alcohol use disorder and naltrexone extended release injection for treatment of opioid use disorder (OUD). A statement was also added to specify that special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of OUD. **VI.C.3.c.** Statement added to say that PCPs may utilize Partnership's delegated managed behavioral health organization through the process described in Partnership policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines when there are barriers in the primary care setting to making Brief Behavioral Counseling Intervention possible. **VI.C.6.d.1)** Screening tools for Unhealthy Alcohol Use were updated. NIAAA SASQ replaces prior NIDA Quick Screen. **VI.C.6.d.2)c)** ASSIST was added as a USPSTF validated screening tool for Unhealthy Drug Use. **VI.C.6.d.3)** CAGE was removed as a recommended screening tool for Unhealthy Drug Use as advised by NIAAA and USPSTF because it does not identify all patients who could benefit from a brief intervention. **VI.C.6.e.1) and 2)** NIAAA SASQ replaces prior NIDA Quick Screen question and the Prenatal Risk Overview PRO was removed as a brief assessment tool because we can no longer locate this tool online. A statement was added to recommend other tools validated for pregnant members and recommended by ACOG as follows: The 4Ps Plus, NIDA Quick Screen (superseded by TAPS), or the CRAFFT **VII. References:** Updated as follows: **C.** Added reference for NIH Quick reference guide for screening for drug use in general medical settings **G.** Removed reference to Prenatal Risk Overview (PRO), which can no longer be accessed. Replaced with reference to CRAFFT instead. **O.** Added reference to APL 23-029 and the two MOU templates attached to the APL for Specialty Mental Health Services and SUD Treatment services. **Attachment A:** The revised attachment now contains a new grid outlining which tool is approved for what screening. **Attachment E:** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders.	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)			**Lead Department: Health Services**	
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/18/2004		**Next Review Date:** ~~05/10/2025~~ ~~4~~ 06/12/2025 **Last Review Date:** ~~05/10/2024~~3 06/12/2024		
Applies to:	☒ **Medi-Cal**	☐ **Employees**		
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*		**Approval Date:** ~~05/10/2023~~ 06/12/2024		

I. RELATED POLICIES:

A. MPQP1022 - Site Review (SR) Requirements and Guidelines
B. MPQP1016 - Potential Quality Issue Investigation & Resolution
C. MPQP1053 - Peer Review Committee
D. CMP36 - Delegation Oversight and Monitoring
E. ~~MCCP2028~~ MCUP3144 - Residential Substance Use Disorder Treatment Authorization
F. MCUG3118 - Prenatal and Perinatal Care
G. MCUP3101 - Screening and Treatment for Substance Use Disorders
H. CMP41 - Wellness and Recovery Program Records
I. MPCR601 - Fair Hearings Process for Adverse Credentialing Decisions
J. MPCR300 – Physician Credentialing and Re-credentialing Requirements
K. MPQP1052 Physical Accessibility Review Survey – SR Part C
~~K.~~L. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline

II. IMPACTED DEPTS:

A. Behavioral Health
B. Health Services
C. Provider Relations
   1. Credentialing
D. External and Regulatory Affairs
E. Claims
F. Member Services
G. Grievance and Appeals
H. Compliance

III. DEFINITIONS:

A. Substance Use Disorder Treatment Provider: Person or entity that provides direct alcohol and other drug treatment services and has been certified by the State as meeting the certification requirements for participation in the Drug Medi-Cal (DMC) program set forth in the DMC certification Standards for Substance Abuse Clinics and Standards for Drug Treatment Programs in California.
B. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with "addiction." According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky

use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as "non-medical use" of prescription medications). The most common substance use disorders in the United States include the following:

1. Alcohol Use Disorder
2. Tobacco Use Disorder
3. Cannabis Use Disorder
4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
5. Opioid Use Disorder

C. Drug Medi-Cal Organized Delivery System (DMC-ODS):an opt-in 1115 waiver program available in California since 2015 that provides for the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. Of ~~PHC~~Partnership's ~~14~~ 24 counties, seven~~7~~ participate in a ~~PHC~~Partnership-organized DMC-ODS program ("Wellness and Recovery Program"): Humboldt, Mendocino, Shasta, Siskiyou, Solano, Modoc, and Lassen counties. ~~3~~Five other counties have organized their own county-managed DMC-ODS programs (over which ~~PHC~~ Partnership has no regulatory oversight responsibilities): Marin, Yolo, Napa, Nevada and Placer counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "state plan" DMC program.

D. Non- Physician Medical Practitioners (NPMP) are defined as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNM) and licensed midwives (LM). See MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines.

~~C.~~E. Licensed Practitioner of the Healing Arts (LPHA) includes physicians, NPs, PAs, registered nurses (RNs), registered pharmacists, licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor, licensed marriage and family therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. See MCUP3144 - Residential Substance Use Disorder Treatment Authorization.

IV. ATTACHMENTS:

A. ~~Substance Use Disorder Facility Site Review Tool~~SUD Facility Site Review (FSR) Tool

~~A.~~B. SUD Facility Site Review (FSR) Guidelines

~~B.~~C. ~~Substance Use Disorder (SUD) Medical Record Review Tool & Guidelines (SUD MRR)~~SUD Medical Record Review (MRR) Tool and Guidelines

~~C.~~D. Physical Accessibility Review Survey (PARS)

V. PURPOSE:

A. To provide Substance Use Disorder (SUD) Service providers a ~~comprehensive~~ guideline for Substance Use Disorder Facility Site Review (SUD FSR) and Substance Use Disorder Medical Record Review (SUD MRR) requirements and processes. This policy will apply to DMC-ODS certified providers contracted with Partnership HealthPlan of California (~~PHC~~Partnership).

B. The purpose of the SUD FSR and SUD MRR is to ensure that practice sites have sufficient capacity to:
   1. Provide appropriate SUD services
   2. Carry out processes that support continuity and coordination of care
   3. Operate in compliance with industry documentation standards of format and legal protocols

4. Maintain patient safety standards and practices, and
5. Operate in compliance with applicable federal, state, and local laws and regulations. Findings of the Site Review are used to:
   a. Provide information for credentialing/re-credentialing decisions
   b. Identify areas where education and technical assistance is needed
   c. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

~~6. Align SUD FSR with DMC-ODS and Substance Abuse Block Grant (SABG) monitoring requirements.~~

~~a. ODS~~
~~1) Availability of DMC-ODS services~~
~~2) Coordination of Care~~
~~3) Quality Assurance and Performance Improvement~~
~~4) Access and Information Requirements~~
~~5) Beneficiary Rights and Protections~~
~~6) Program Integrity~~
~~b. Substance Abuse Block Grant (SABG):~~
~~1) Administration~~
~~2) Perinatal (where applicable)~~
~~3) Adolescent/ Youth Treatment (where applicable)~~
~~4) Program Integrity~~

VI. POLICY / PROCEDURE:

A. Requirements
1. ~~PHC~~ Partnership will conduct annual (~~PHC~~Partnership ~~Fiscal Year~~fiscal year July 1- June 30 calendar) onsite ~~or virtual~~ monitoring reviews of services and subcontracted services ~~for programmatic and fiscal requirements~~, and submit a secure copy of their monitoring and audit reports to the Department of Health Care Services (DHCS) within two weeks of issuance.

B. Review Personnel
1. The Partnership HealthPlan of California (~~PHC~~Partnership) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by ~~PHC~~ Partnership personnel. At a minimum, ~~PHC~~ Partnership's Site Review team~~s~~ will consist of one of the following staff: a physician, a registered nurse (RN), or other Non-Physician Medical Practitioner (NPMP).
2. Licensed physicians, RNs, NPMPs, ~~and~~ Certified Counselors, are eligible to act as Site Reviewers and may perform a site review (SR) independently and sign off on the FSR and MRR tools. ~~PHC~~ Partnership will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. ~~**Only RNs, PAs, LPHAs or physicians may review survey elements labeled "E - RN/MD/LPHA Review only or RN/MD Review only".**~~**Reviews of survey elements will be completed by the appropriate category of reviewer, as noted by survey labels (e.g., LPHA or RN/Physician/NPMP only).**
3. Site reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer reviews procedures.

C. **Site Review (SUD SR)** – A Substance Use Disorder Site Review consists of two basic components: the Substance Use Disorder Facility Site Review (SUD FSR) and the Substance Use Disorder Medical Record Review (SUD MRR). (See Attachments A, B, and C. ~~and B~~) ~~PHC's Credentialing Department~~ Provider Relations' Credentials staff assesses the accreditation status of Substance Use Disorder Treatment Providers as part of the credentialing process.
1. A SUD FSR is required to be completed prior to final credentialing of the site. The SUD FSR ~~Tool~~ consists of the following ~~6 3 Domains~~ 10 sections. (See Attachments A and B.)
   a. Access/Safety
   b. Office Management
   c. Policy/Procedures
   d. Program Policy Booklet
   e. Intake Packet
   f. Interpreter Services
   g. Staff Requirements
   h. Detox Facility

i. Perinatal Services
~~a.~~j. Pharmaceutical/Laboratory
~~b. Personnel~~
~~c. SABG requirements~~
~~d.~~k. ~~Office Management~~
~~e. Perinatal Services~~
~~f. Pharmaceutical/Laboratory~~

2. A SUD MRR consists of up to 10 randomly selected member medical records and consists of the following ~~6 Domains~~nine sections (See Attachment ~~B~~ C.)
   a. Format Criteria

b. Intake Services
c. Care Planning Guidelines~~-treatment plans- NTP Only~~
d. ~~Treatment Services~~Care Planning Guidelines- Problem Lists- All LOC (except NTP)
~~c. Treatment Services~~ Treatment Services
~~d. Residential (if applicable)~~ Discharge Services
~~e. Discharge Services~~
e. ~~Recovery Services~~Care Coordination Services
f. Residential Services
~~f.~~g. Perinatal/Family Services

3. Physical Accessibility Review Survey (PARS) (See Attachment D.)
   a. During the Initial SUD SSR and subsequent annual SUD SRs, a PARS will be addressed every year at all Substance Use Disorder practice sites within the ~~PHC~~ Partnership Medi-Cal network.

D. Initial SUD SR
1. An initial SUD SR includes a SUD FSR~~ and SUD MRR.~~
   a. The SUD FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Credentialing is not completed until the site has received a passing score and Corrective Action Plan (CAP) items are signed off. An initial SUD FSR is not required when a new provider joins a site that has a current passing SUD FSR score.
2. An initial SUD MRR must be completed within 11 ~~6~~ months of the SUD FSR assuming services have been rendered. This may be deferred based on claims. ~~If PHC is unable to generate a list of 7-10 medical records due to a lack of claims, PHC will plan to conduct the medical record review 6 months later when the subsequent SUD SR is due. (see E3)~~
3. Additional scenarios that require an Initial SUD SR, but are not limited to, instances when:
   a. A new site is added to the ~~PHC~~ Partnership network.
   b. The site relocates.

E. Subsequent SUD SRs
1. Subsequent SUD SRs consist of a SUD FSR and SUD MRR conducted annually ~~on~~ during ~~PHC's~~ Partnership's fiscal calendar year. The SUD FSR and SUD MRR are scored separately by the Site Reviewer.
2. Site reviews may be conducted more frequently based on monitoring, evaluation, or follow up related to an applied CAP.
3. The SUD MRR score is based on a review of randomly selected records based off ~~of~~ the ~~timeframe from the last review to the most current available medical record at the site~~prior fiscal year. ~~(July-June).~~ Up to ~~ten~~10 medical records will be reviewed unless there are not enough member claims to support this. If ~~PHC~~ Partnership is unable to generate a list of ~~7~~10 medical records, due to a lack of claims, ~~PHC~~ Partnership will ~~plan to~~ conduct the medical records review ~~6 months later~~with the ~~how many~~ records ~~are~~ available. ~~At that point if PHC is still unable to generate a list of 7-10 medical records to review, PHC will conduct the SUD FSR portion of the review only. PHC will continue to check for claims every 6 months and will document attempts to complete the SUD MRR.~~
4. The site reviewer will advise the practice site of any deficiencies in high priority elements during the SUD SR. Compliance level categories include: Exempted Pass, Conditional pass, and Not Pass.
5. The total points on the SUD FSR or SUD MRR will differ from site to site because the "not applicable" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" (non-applicable) or "No" shall include an explanation regarding the exemption.
~~determinations result in a "N/A" (non-applicable) or "No" shall include an explanation regarding the exemption.~~
6. The reviewer will advise the practice site of any deficiencies during the Site Review.

a. The reviewer conducting the site review is responsible for providing the site with the CAP requirements, including the CAP template and appropriate documentation as listed below:
   1) The specific deficiency~~.~~
   2) Recommended corrective actions~~.~~
   3) CAP due dates
   4) Instructions for CAP submission to ~~PHC~~Partnership

7. Compliance level categories for SUD F~~S~~SR include:

Compliance Category	FSR~~FSSR~~ Score	MRR Score
Exempted Pass (No CAP required)	90% or above without deficiencies in High Priority Elements related to ASAM, SABG, Perinatal and Pharmaceutical/Laboratory	90% or above and all section scores above 80%/
Conditional Pass (CAP required)	80-89% **OR** 90% or above with deficiencies in High Priority Elements related to ASAM, SABG, Perinatal and Pharmaceutical/Laboratory	80-89% **OR** 90% or above with one or more section scores below 80%.
Not Pass (CAP required)	79% and below	79% and below

F. Outside Entity Reviews
   1. ~~PHC~~ Partnership will determine whether to conduct a SUD SR or accept review findings from an outside entity that performed the most recent review if the collaboration processes is defined in detail and meets and/or exceeds the standards according to this policy. A copy of the annual reviews will be provided by the entity or ~~PHC~~ Partnership will conduct the review. If ~~PHC~~ Partnership accepts these reviews, ~~PHC~~ Partnership will still do a complete on site SUD Site Review at a minimum of every three years. ~~PHC~~ Partnership will submit a copy of outside entity reviews to DHCS as proof of annual monitoring.

G. Focused Review
   1. A focused review is a targeted review of one or more specific areas of the SUD FSR or SUD MRR. ~~PHC~~ Partnership must not substitute a focused review for the SUD SR. Focused reviews may be used to monitor providers between SUD SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
   2. Site Reviewers utilize the appropriate sections of the SUD FSR and SUD MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
   3. All deficiencies identified in a focused review must require the completion and verification of the corrective action plan (CAP) according to the CAP timelines.

H. Requirements for New Practitioners at a Site
   1. A SUD SR will not be repeated if a new provider is added to a provider site that has a current passing SUD SR score. If a Substance Use Disorder Treatment provider moves to a site that has not undergone a previous SUD SR, ~~PHC~~ Partnership performs a SUD SR at this site.

I. Corrective Action Plan (CAP) Requirements and Timelines
   1. A CAP is required for SUD sites that have a SUD FSR / SUD MRR conditional pass or not pass score, on a focused review, or for deficiencies identified by ~~PHC~~ Partnership through oversight and monitoring activities. ~~PHC~~ Partnership may require a CAP for other findings identified during the survey that require correction, regardless of the score.
   2. Conditional Pass

      ~~PHC~~ Partnership will provide the practice site with a review findings report and a formal written request for corrections of all deficiencies within 10 calendar days after the site visit. The practice site must submit a CAP to ~~PHC~~ Partnership addressing deficiencies within 30 calendar days of the written initial CAP request date. ~~PHC~~ Partnership will then review/revise/approve the CAP. Under extenuating circumstances, an extension will be given

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)		**Lead Department: Health Services**
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)		☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004	**Next Review Date:** ~~05/10/2024~~06/12/2025 **Last Review Date:** ~~05/10/2023~~06/12/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

in 30-day increments to complete deficiencies that have not been addressed may be granted.

3. Not Pass
   a. Survey deficiencies must be corrected by the provider and verified by ~~PHC~~ Partnership within the CAP timelines. ~~PHC~~ Partnership reserves the right to remove any provider with a not pass score from the provider network.
4. CAP Documentation
   a. CAPs will be completed using a standard format and form. The minimum elements to be included on a CAP:
      1) CAP Documentation
      2) Correction Date
      3) Practitioner Comments
      4) Signature and Title of Responsible Practitioner or Designee
      5) Evidence of the Corrections
      6) Completion and Closure Dates

J. Non-Compliance with Corrective Action Process
1. Providers who do not correct survey deficiencies, or do not cooperate with the CAP process within the established CAP timelines may result in referral to the ~~PHC~~ Partnership ~~Chief Medical Officer~~CMO; Provider Relations s~~S~~taff and/or the Credential~~s~~ing Committee. Actions taken by the Credential~~s~~ing Committee may include termination of the site from the provider network.

~~1.~~2. If ~~PHC~~ Partnership chooses to remove the site from the network, per IGA, Exhibit A: ~~PHC~~ Partnership shall make a good faith effort to give written notice of termination of a network provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

K. Organizational Provider Appeals
1. See ~~PHC~~ Partnership Policy MPCR601 "Fair Hearings Process for Adverse Credentialing Decisions" for appeal procedures.
2. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and ~~PHC~~ Partnership will complete a new site review upon approval.

L. Systematic Monitoring
1. Monitoring following the SUD SR will include, but is not limited to, data gathered through the following sources in order to coincide with ODS monitoring requirement 4.2.2:
   a. Potential Quality Issue information (reviewed when identified)
   b. Focused review or other on-site visit

M. Delegation of Site Reviews
1. Delegation Agreement
   a. Prior to delegating Site Review to an outside entity, ~~PHC~~ Partnership will establish a formal, mutually agreed upon Delegation Agreement that will:
      1) Identify specific delegated functions
      2) Specify policies/procedures to be used for delegated functions
      3) Specify reporting requirements of the delegate
      4) Specify ~~PHC~~ Partnership training, communication, and oversight activities
2. Potential Quality of Care Issues
   a. Potential quality of care issues identified during the course of the Site Review will be conducted in accordance with the ~~PHC~~ Partnership policy for Potential Quality Issue Investigation and Resolution. The clinical reviewer will complete a PQI Report Form, and submit it ~~PHC's~~ Partnership's Quality Improvement d~~D~~epartment for follow up review.

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)		**Lead Department: Health Services**
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)		**☒External Policy** **☐Internal Policy**
Original Date: 02/18/2004	**Next Review Date: ~~05/10/2024~~06/12/2025** **Last Review Date: ~~05/10/2023~~06/12/2024**	
Applies to:	**☒ Medi-Cal**	**☐ Employees**

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (Sept. 22, 2022) supersedes APL 20-006
B. MMCD Policy Letter (PL) 12-006 Revised Facility Site Review Tool (Aug. 9, 2012)
C. DHCS All Plan Letter (APL) 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers (Oct. 8, 2015)
D. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)
E. ~~Department of Health Care Services (~~DHCS~~)~~ Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
F. DHCS Behavioral Health Information Notice (BHIN) 21-056 Ongoing-Compliance-Monitoring-FY-2021-22 (Sept. 14, 2021)
G. BHIN 24-001 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026 (Dec. 21~~17~~, 202~~3~~1) supersedes BHIN 23-001
~~G.~~ BHIN 23-068 Updates to Documentation Requirements for all Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS Services (Nov. 20, 2023) supersedes BHIN 22-019

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
05/18/05; 04/19/06; 06/20/07; 06/18/08; 07/15/09; 09/15/10; 02/20/13; 05/15/13; 05/21/14; 09/20/17; *10/10/18; 11/13/19; 04/08/20; 04/14/21; 05/11/22; 01/11/23; 05/10/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Partnership*Advantage*:
MPQP1025 - 06/20/2007 to 02/20/2013
Healthy Families:
MPQP1025 - 10/01/2010 to 02/20/2013
Healthy Kids
MPQP1025 - 06/20/2007 to 02/20/2013

Facility Site Review Survey
Substance Use Disorder (SUD) Treatment Services

Site ID	Phone:	Fax:	Review Date:
Facility Name:	Contact Name/Title:		
Full Address:			
Reviewer Name/Title:			
Staff on site: ___CADC I/II/III ___ LAADC ___ SUDCC ___LCSW ___LMFT ___ASW ___MFTI ___RADT ___RADT II ___MD ___NP ___RN ___LVN ___Clerical Other_____			

Visit Purpose	Certifications	Clinic type
☐ Initial Full Scope ☐ Monitoring ☐ Periodic Full Scope ☐ Follow-up ☐ Focused Review ☐ Ed/TA ☐Other _____	Most current DMC Certification Number _____ Issuance Date: _____	☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 Perinatal Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 ☐ OTP/NTP ☐ Withdrawal Management (3.2)

Site Review Scores

		Pts. poss.	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Access/Safety**	163				
II.	**Office Management~~Personnel~~**	512				
III.	**~~SABG Requirements~~Policy/ Procedures**	2143				
IV.	**~~Office Management~~Program Policy Booklet**	2760				
V.	**Intake Packet**	9				
VI.	**Interpreter Services**	7				
VII.	**Staff Requirements**	30				
VIII.	**Detox Facility**	7				
~~V.~~IX.	**Perinatal Services**	199				
~~VI.~~X.	**Pharmaceutical/ Laboratory**	87				

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all ten~~six~~ sections.
3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%
Points given / Total/ Adjusted points / Decimal Score / Compliance Rate

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire FSR, regardless of the Total FSR score. ***Any deficiency in SABG or ASAM requirements requires a CAP.***

_____**Exempted Pass: 90% or above:**
(Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:**
(Total FSR is 80-89% *OR* *any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

	14905 3						
	Total Pts. Poss.	**Total Yes Pts.**	**Total No Pts.**	**Total N/A Pts.**			

Facility Site Review Guidelines for Substance Use Disorder (SUD) Treatment Services

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions."

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include: 1) Exempted Pass: 90% or above, 2) Conditional Pass: 80-89%, and 3) Not Pass: below 80%. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all 10tensix (106) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all stenix (106) sections.
	(16) Access/Safety (5) Office Management (21) Policy/Procedures (27) Program Policy Booklet (9) Intake Packet (7) Interpreter Services (30) Staff Requirements (7) Detox Facility (19) Perinatal Services

	(8) Pharmaceutical/Laboratory~~13 (Access/safety)~~ ~~12 (Personnel)~~ ~~43 (SABG Requirements)~~ ~~60 (Office Management)~~ ~~19 (Perinatal Services)~~ ~~7 (Pharmaceutical/Laboratory)~~ **14~~95~~3 (POINTS)**
Step 3: Subtract "N/A" points from ~~154~~ 149 total points possible. 14~~95~~4 (Total points possible) – 6 (N/A points) 14~~34~~8 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 14~~34~~8 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / 12~~1~~6 or "adjusted" total or 126~~137~~ / 14~~34~~8 =. ~~9256~~ 8811 = ~~93~~88%

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Criteria	Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	**A1. ADA Regulations**: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. **Exit doors**: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Additionally:** communication shall be at a maximum 6th grade level. Reading materials available in large print. **AOD 12000,** "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **A2. Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

~~I. Access/Safety~~

~~RN/MD/LPHA Review only~~

Criteria	I. Access/Safety Reviewer Guidelines (Continued)
~~A.~~B. Site environment is maintained in a clean and sanitary condition.	**B1.** The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. **B2.** Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition. **B3. AOD 12000, "**Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **B4.** **B5.** **B6.**
~~B.~~C. Site environment is safe for all patients, visitors, and personnel.	**Ordinances**: Sites must meet city, county, and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **C.1) Fire safety and prevention: T**here is evidence staff has received safety training and/or has safety information ~~**C6. Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.~~ **C2. Non-medical emergency procedures:** Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. **C3. Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **C4. Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. **C5. Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. **C6. Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. **C7. Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **C1. C8. Fire Fighting/Protection Equipment**: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devises. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. Specific information for handling fire emergency procedures is available on site to staff.

	<u>Note</u>: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

Criteria	II. Office Management Reviewer Guidelines
A. Confidentiality of personal medical information is protected according to State and federal guidelines.	**A1. Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **A2. Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. **A3. Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. **A4.** **A5. Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761). PER THE **INTERGOVERNMENTAL AGREEMENT**: **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.
Criteria	**III. Policy/Procedure Reviewer Guidelines**
A. Site has a policy/procedure that addresses each of the following:	**AOD 12010** Program Policies Site has a policy/procedure that addresses each of the following: (each policy in this section should be obtained for evidence) The policies and procedures shall contain, but not be limited to, the following: **1. Obtaining appropriate documentation of admission and readmission criteria-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **2. Determining appropriate Medical Necessity-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **3. Proof of Managed Care eligibility as payment-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **4. Completing ASAM, how is criteria used to determine medical necessity-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **5. Completion of all appropriate and required documentation during intake-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **6. Completion of initial Problem list and/or Treatment plan-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.

7. **Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program**- Program notify clients of their right to services from an alternative service provider if they object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year.
8. **Does the program adhere to priority administration requirements and provides interim services when required**- (a) Pregnant injecting drug users (b) Pregnant substance abusers (c) Injecting drug users (d) All Others. The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days. Interim Services. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s) •Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission
9. **Maintaining confidentiality**- Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
10. **Missed appointments**- If a client fails to keep a scheduled appointment, the program shall discuss the missed appointment with the client and shall document the discussion and any action taken in the client's file.
11. **Progress note requirements**- MC-ODS Progress Notes (1) Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).11 (i) Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service. (2) Progress notes for all non-group services shall include: (I) The type of service rendered. (ii) (iii) The date that the service was provided to the member. Duration of direct patient care for the service.12 (iv) Location/place of service. (v) A typed or legibly printed name, signature of the service provider, and date of signature. (vi) A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).13- (vii) A brief summary of next steps.14 (3) For group services: (i) When a group service is rendered, a list of participants is required to be documented and maintained by the provider. (ii) (iii) Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (2)(i-v) above.15 The progress note for the group service encounter shall also include a brief description of the member's response to the service.16 (4) Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in (2) or (3) above, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others.17 If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note. (5) Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis

services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0). (6) Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC/DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation).18 If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

12. **Process for self-administered medications**- The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational- 1. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone. 2. Care coordination shall be provided to a beneficiary in conjunction

13. with all levels of treatment. Care coordination may also be delivered and claimed as a standalone service. Through executed memoranda of understanding, the Contractor shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a beneficiary-centered and whole-person approach to wellness.3. Care coordination services shall be provided by an LPHA or a registered/certified counselor.4. Care coordination services shall include one or more of the following components:

i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.

ii. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

iii. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

14. **Clients to obtain or have access to MAT**- The Contractor shall require that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for beneficiaries while they are receiving treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not they seek reimbursement through DMC-ODS. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to be tapered off medications as a condition of entering or remaining in the program. The Contractor shall monitor the referral process or provision of MAT services. 6. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g.,telehealth), different staff, and/or different services (e.g., Medi-Cal Peer Support Services). If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider shall

assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

15. **Fraud, Waste and Abuse-** Program must have a policy addressing definition of FWA and procedure for reporting.
    5. Program Integrity Requirements (42 CFR §438.608). i. The Contractor, and its subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, or abuse. A compliance program that includes, at a minimum, all the following elements:1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
16. **Medical record release procedures are compliant with State and federal guidelines**- Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.
17. **All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen-** Hospitals, acute psychiatric hospitals, skilled nursing facilities, primary care clinics, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761).
18. **Serving Native Americans**- The Program shall ensure the availability of culturally competent AOD prevention, treatment, and recovery services to the sites American Indian/American Native population
19. **Serving Co-Occurring clients**- Does the Program provide Co-occurring disorder clients with coordinated/integrated care for both their mental health and substance abuse conditions? If yes, what mechanisms are used to provide this service?
    i. MOU with mental health Program(s)
    ii. Referral to COD Program
    iii. Co-case management with mental health Program
    iv. Provide both mental health and substance abuse treatment at a substance abuse program
20. **Program policy on group counseling -** The Program provides documented curriculum that includes individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.
21. **Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment-** They are as follows: Motivational Interviewing, Cognitive- Behavioral Therapy, Trauma-Informed Treatment, Psycho-Education, ~~Relapse~~and Relapse Prevention.
    - A policy that states what Curriculum are used in counseling. These should coincide to the trainings the providers have taken.

Criteria	IV. Program Policy Booklet Reviewer Guidelines
A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted)	**AOD 12010** Program Policies All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following: 1. Program mission and philosophy statement(s). 2. Program description, objectives, and evaluation plan 3. Admission and readmission; including client assignment to counselor and contact information 4. Intake Services 5. Discharge Services 6. Recovery Services 7. Individual and group sessions 8. Alumni involvement and use of volunteers 9. Recreational activities 10. Detoxification services, if applicable 11. Program administration and personnel practices 12. Client grievances/complaints 13. Fiscal practices and budget mechanisms 14. Continuous quality improvement 15. Client rights 16. Medical Policies 17. Nondiscrimination in provision of employment and services 18. Community relations 19. Confidentiality 20. Maintenance of program in a clean, safe and sanitary physical environment 21. Maintenance and disposal of client files 22. Drug screening 23. Staff code of conduct as specified in section 13020 of these Standards 24. Client code of conduct 25. Care Coordination/Case Management 26. Continuing Services 27. Cultural Competency Program around CLAS standards (includes **all** of the 15 Standards)- The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.(42 C.F.R. § 438.206(c)(2).

Criteria	V. Intake Packet Reviewer Guidelines
B. A copy of a complete admissions/intake packet should be provided (A copy of this packet should be obtained, if posted photo should be taken)	**A1.** At a minimum, the following shall be included during the intake process IV. OM E1-E4 (A-D). These formally stated copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries. 1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay 2) Complaint process and grievance procedures 3) Appeal process for involuntary discharge 4) Program rules and expectations 5) Client rights and responsibilities 6) Consent to release information 7) HIPAA notification 8) Consent to treat 9) Admission agreement

Criteria	VI. Interpreter Services Reviewer Guidelines
A. Interpreter Services	**D1.** All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. ***Note:*** https://lep.gov/commonly-asked-questions **D2.** • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member. • ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record.

~~I. Access/Safety~~

~~RN/MD/LPHA Review only~~

<table>
<tr><th>Criteria</th><th>VII. Staff Requirements Reviewer Guidelines ~~II. Personnel Reviewer Guidelines~~</th></tr>
<tr><td>A. Personnel Files maintained on all employees, LPHA, Medical Director and Volunteers/interns contain the following:</td><td>A1.-A12. Personnel files must contain the following:
1) Application for employment and/or resume
2) Signed employment confirmation statement/duty statement
3) Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position
4) Performance evaluations
5) Health records/status as required by program or Title 9
6) Other personnel actions (e.g. Commendations, disciplines, status change, employment incidents and/or injuries)
7) Training documentation relative to substance use disorders and treatment
8) Current registration, certification, intern status, or licensure:</td></tr>
<tr><td>~~A.~~
~~1) Professional health care personnel have current California licenses and certifications.~~</td><td>
<table>
<tr><th>Medical Professional</th><th>License/Certification</th><th>Issuing Agency</th></tr>
<tr><td>Doctor of Medicine</td><td>Physician’s & Surgeon’s Certificate
DEA Registration</td><td>Medical Board of CA
Drug Enforcement Administration</td></tr>
<tr><td>Psychiatrist/Psychologist</td><td>Physician’s & Surgeon’s Certificate with specialty training</td><td>Medical Board of California</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>RN License w/NP Certification and Furnishing Number</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Registered Pharmacist</td><td>Pharmacist License</td><td>CA State Board of Pharmacy</td></tr>
<tr><td>Physicians’ Assistant (PA)</td><td>PA License.
DEA Registration</td><td>Medical Board of CA
DEA</td></tr>
<tr><td>Licensed Practitioner Healing Arts</td><td>LPHA</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Marriage and Family Therapist</td><td>MFT</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Licensed Clinical Social Worker</td><td>LCSW</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Licensed Professional Clinical Counselor</td><td>LPCC</td><td>Board of Behavioral science</td></tr>
<tr><td>Psychiatric Technician</td><td>Psychiatric Technician</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
<tr><td>Licensed Vocational Nurse (LVN):</td><td>LVN License</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
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	Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers. 1) Proof of continuing education required by licensing or certifying agency and program; 2) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well. 3) Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement) For registered and certified counselors, a copy of registration or certification According to AOD 8000 b., "Counseling services may only be provided by individuals registered or certified pursuant to California Code of Regulations, Title 9, Division 4, and Chapter 8 or by a licensed professional acting within their scope of practice." 8 Hour class at hire should be done on day one (Reviewer to Obtain copies of licenses)
~~**2)** The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.~~	~~Per **Title 22, E.IV.A,** it is mandatory to have a Licensed Physician designated as Medical Director of the Substance Abuse Clinic.~~
~~**3)** The program/facility has a written plan for training staff that is updated annually.~~	~~**Title 22, C 19020** The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.~~
~~**4)** Professional staff (LPHA's) receive a minimum of 5 hours continuing education related to addiction medicine each year.~~	~~Professional staff (LPHA's) receive a minimum of **5 hours** continuing education related to addiction medicine each year.~~
~~**5)** At least 30% of staff providing counseling, are licensed or certified as Drug & Alcohol Counselors.~~	~~**Title 22, D 13010** There has to be at minimum 30% of staff who are certified or licensed to be providing Drug/Alcohol Counseling.~~

B. Program/Facility has a written plan for training that is updated annually (Proof of training should be readily available)	**B1. Title 22, C-19020-** The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information. **B2**.Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3,ii, a The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. • Applies to all providers who co-sign or conduct medical necessity assessments. **B3.** All Employees must complete mandatory DMC-ODS training, provided by PHC on an annual basis. **B4**. Providers will implement and train appropriate staff on at least two of the following EBPs based on the timeline established in the county implementation plan. The required EBP's include: Motivational Interviewing, Cognitive-Behavior Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education. Note: Proof of appropriate staff training related to the Evidence Base Practices (EBP's) currently being used on site. **B5.** New staff are trained in the CalOMS Tx data collection and reporting methods: • CalOMS Tx data is reported in a manner consistent with their county contract as well as within the timelines outlines in the State-County contract • a client admission record is uploaded when the participants have been admitted into treatment, and treatment services have started • admission information is gathered within seven days of a person's entry into treatment • annual update is completed for program participants in treatment for a period of 12 months or more, had no break in service exceeding 30 days and participated continuously in the same modality and program • administrative discharges are used only when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview either in person or by phone • a client is discharged if there has been no contact with the client for 30 days **B6.** The Program shall have policies, procedures and practices in place to ensure DATAR is reported in a manner consistent with their county contract as well within the timelines outlined in the State-County contract **B7.** The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. **B8.** Title 22, C-19020- The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information. **B9.** Staff shall be trained on the Trafficking Victims Protection Act of 2000. Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702" **B10.** All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training. **B11**. Proof of continuing education required by licensing or certifying agency and program. (pg 169 IGA)

	B12. Professional staff (LPHA's) receive a minimum of **5 hours** continuing education related to addiction medicine each year. **B13.** All staff and volunteers whose functions require or necessitate contact with clients or food preparation shall be tested for tuberculosis. The tuberculosis test shall be conducted under licensed medical supervision not more than 45 working days prior to or 5 working days after employment and renewed annually from the date of the last tuberculosis test. Staff and volunteers with a known record of tuberculosis or a record of positive testing shall not be required to obtain a tuberculosis skin test. Unless there is documentation that the staff or volunteer completed at least 6 months of preventive therapy, the staff or volunteer shall be required to obtain, within 30 working days of employment, a chest x-ray result and a physician's statement that he/she does not have communicable tuberculosis and has been under regular care and monitoring for tuberculosis. A chest x-ray within the prior 6 months is acceptable. The physician's statement shall be renewed annually. Any staff or volunteer who has the symptoms of tuberculosis or an abnormal chest x-ray consistent with tuberculosis shall be temporarily barred from contact with clients and other program staff until a written physician's clearance is obtained. At the discretion of the program director, tuberculosis testing need not be required for support or ancillary staff whose functions do not necessitate contact with clients or food preparation, and who are not headquartered at the program. **B14**. Written code of conduct addresses at least the following: a) Use of drugs and/or alcohol; b) Prohibition of social/business relationship with clients or their family members for personal gain; c) Prohibition of sexual contact with clients; d) Conflict of interest; e) Providing services beyond scope; f) Discrimination against clients or staff; g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff; h) Protection of client confidentiality; i) The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under; j) Cooperation with compliant investigations.
C. Professional health care personnel have current California Licenses and Certification.	**C1**. Cross reference with credentialing team **C2. Title 22, D-13010-** There has to be at minimum 30% of staff who are certified or licensed to be providing Drug/Alcohol Counseling. **C3.** Make sure there is proof that this is occurring. Make note of any verbal communication **C4.** NTPs shall comply with all federal and state NTP licensing requirements (Likely has a policy)

~~II. Personnel~~

~~RN/MD/LPHA Review only~~

Site Personnel Survey Criteria	Wt	Yes	No	NA	Score
A. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
1. All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1	1)____	1)____	1)____	
2. The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.	1	2)____	2)____	2)____	
3. The program/facility has a written plan for training staff that is updated annually.	1	3)____	3)____	3)____	
4. Professional staff (LPHA's) receive a minimum of 5 hours continuing education related to addiction medicine each year	1	4)____	4)____	4)____	
5. At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.	1	5)____	5)____	5)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
5 points possible this page

Criteria	VIII. DetoxII. Personnel Reviewer Guidelines
A. All providers and staff conducting ASAM assessments/medical necessity have completed the two e-Trainings. **(Automatic CAP if "no")**	Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3,ii, a The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. • Applies to all providers who co-sign or conduct medical necessity assessments.
B. All employees have mandatory training on annual DMC-ODS requirements.	All Employees must complete mandatory DMC-ODS training, provided by PHC on an annual basis.
C. All appropriate staff have received regular training on evidence based practices (EBP)	Providers will implement and train appropriate staff on at least two of the following EBPs based on the timeline established in the county implementation plan. The required EBP's include: Motivational Interviewing, Cognitive-Behavior Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education. **Note:** Proof of appropriate staff training related to the Evidence Base Practices (EBP's) currently being used on site .
D. A. During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)Tuberculosis (TB) Testing is offered and performed for all staff.	**AOD 11040-** During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: **A1**. In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training. **A2.** In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training. **Clients shall not be used to fulfill the requirements of this section.Tuberculosis testing must be offered to all staff onsite, and documented.**
B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.	A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.

C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k). ~~**E.** For Residential Detoxification there is adequate staff on duty at all times with CPR certificate and current first aid training.~~	~~**AOD 11040 During the provision of detoxification services, the minimum staffing or volunteer ratios and health related requirements shall be as follows:**~~ **C1**. Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files. **C2**. Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files. **C3.** Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services • **C4.** Naloxone training policy and completion of naloxone training~~**In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.**~~ • ~~**In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training.**~~ • ~~**Clients shall not be used to fulfill the requirements of this section.**~~
~~**F.** Staff files maintained for required length of time.~~	~~Site must maintain staff files for 6 years.~~
~~**B.** Counseling services are only provided by registered or certified individuals.~~	~~According to **AOD 8000 b.,** "Counseling services may only be provided by individuals registered or certified pursuant to California Code of Regulations, Title 9, Division 4, and Chapter 8 or by a licensed professional acting within their scope of practice." 8 Hour class at hire should be done on **day one** (Reviewer to Obtain copies of licenses)~~

II. Personnel continued

RN/MD/LPHA Review only

Site Personnel Survey Criteria	Wt	Yes	No	NA	Score
A. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
	1	6)____	6)____	6)____	
.All providers and staff conducting ASAM assessments have completed the two e-Trainings.	1	7)____	7)____	7)____	
.All employees have mandatory training on annual DMC-ODS requirements.	1	8)____	8)____	8)____	
.All appropriate staff have received regular training on evidence based practices (EBP)	1	9)____	9)____	9)____	
.Tuberculosis (TB) Testing is offered and performed onsite for all staff.	1	10)____	10)____	10)____	
.There is adequate staff on duty at all times with CPR certificate and current first aid training.	1	11)____	11)____	11)____	
.Staff files are maintained for the required length of time.					
B. Counseling services are only provided by registered or certified individuals.	1	1)____	1)____	1)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 points possible this page 12 points possible this section.
Total

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
1. Personnel files maintained on all employees and volunteers/interns contain the following:	1	1a) ____	1a) ____	1a) ____	
a) Application for employment and/or resume	1	1b) ____	1b) ____	1b) ____	
b) Signed employment confirmation statement/duty statement	1	1c) ____	1c) ____	1c) ____	
c) Job description	1	1d) ____	1d) ____	1d) ____	
d) Performance evaluations	1	1e) ____	1e) ____	1e) ____	
e) Health records/status as required by program or Title 9	1	1f) ____	1f) ____	1f) ____	
f) Other personnel actions	1	1g) ____	1g) ____	1g) ____	
g) Training documentation relative to substance use disorders and treatment	1	1h) ____	1h) ____	1h) ____	
h) Current registration, certification, intern status, or licensure	1	1i) ____	1i) ____	1i) ____	
i) Proof of continuing education required by licensing or certifying agency and program	1	1j) ____	1j) ____	1j) ____	
j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.					
2. Job descriptions shall be developed, revised as needed, approved by the program's governing body, and include:	1	2a) ____	2a) ____	2a) ____	
	1	2b) ____	2b) ____	2b) ____	
a) Position title and classification;	1	2c) ____	2c) ____	2c) ____	
b) Duties and responsibilities;	1	2d) ____	2d) ____	2d) ____	
c) Lines of supervision;					
d) Education, training, work experience, and other qualifications for the position.					
3. Written code of conduct for employees and volunteers/interns shall be established, which address at least the following:	1	3a) ____	3a) ____	3a) ____	
	1	3b) ____	3b) ____	3b) ____	
a) Use of drugs and/or alcohol;	1	3c) ____	3c) ____	3c) ____	
b) Prohibition of social/business relationship with clients or their family members for personal gain;	1	3d) ____	3d) ____	3d) ____	
c) Prohibition of sexual contact with clients;	1	3e) ____	3e) ____	3e) ____	
d) Conflict of interest;	1	3f) ____	3f) ____	3f) ____	
e) Providing services beyond scope;	1	3g) ____	3g) ____	3g) ____	
f) Discrimination against clients or staff;	1	3h) ____	3h) ____	3h) ____	
g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff;	1	3i) ____	3i) ____	3i) ____	
	1	3j) ____	3j) ____	3j) ____	
h) Protection of client confidentiality;					
i) The element found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under					
j) Cooperation with compliant investigations.					

Comments: Write comments for all "No" (0 points) and "N/A" scores. 13 points possible this page

III. SABG Requirements Reviewer Guidelines

Personnel Files:

If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:

a) Recruitment;
b) Screening;
c) Selection;
d) Training and orientation;
e) Duties and assignments;
f) Scope of practice;
g) Supervision;
h) Evaluation;
i) Protection of client confidentiality.

Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director.

a) All Staff
b) Certified Staff
c) Medical Director
d) Volunteers/Interns

The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

(Notate the topic of trainings conducted, including if they are in-house, outside or PHC)

Staff shall be trained on the Trafficking Victims Protection Act of 2000.

Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702"

All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training.

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
1. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:	1	4a)____	4a)____	4a)____	
a) Recruitment;	1	4b)____	4b)____	4b)____	
b) Screening;	1	4c)____	4c)____	4c)____	
c) Selection;	1	4d)____	4d)____	4d)____	
d) Training and orientation;	1	4e)____	4e)____	4e)____	
e) Duties and assignments;	1	4f)____	4f)____	4f)____	
f) Scope of practice;	1	4g)____	4g)____	4g)____	
g) Supervision;	1	4h)____	4h)____	4h)____	
h) Evaluation;	1	4i)____	4i)____	4i)____	
i) Protection of client confidentiality.	1	5a)____	5a)____	5a)____	
	1	5b)____	5b)____	5b)____	
2. Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director.	1	5c)____	5c)____	5c)____	
a) All Staff	1	5d)____	5d)____	5d)____	
b) Certified Staff					
c) Medical Director	1	6)____	6)____	6)____	
d) Volunteers/Intern		7)____	7)____	7)____	
	1				
3. Staff will receive Cultural and Linguistic training annually.		8)____	8)____	8)____	
	1				
4. Proof that staff have received education on the Trafficking Victims Protection Act of 2000					
5. All staff will sign confidentiality agreements, and/or have proof of training annually					

Comments: Write comments for all "No" (0 points) and "N/A" scores.
16 points possible this page

~~Criteria~~	~~III. SABG Requirements Reviewer Guidelines~~

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
B. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
6. Staff are trained in the CalOMS treatment data collection and reporting methods	**1**	9)_____	9)_____	9)_____	
7. Staff are trained in the DATAR reporting methods	**1**	10)_____	10)_____	10)_____	
8. CalOMS information is submitted on a timely basis	**1**	11)_____	11)_____	11)_____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 3 points possible this page 43 points possible this section. Total					

Criteria	IV. Office Management Reviewer Guidelines

A. Medical records are available for the Provider at each scheduled patient encounter.	**A1.** The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. **A2.** Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055). **A3/4. Adequacy of Medical Record/treatment record keeping:** The reviewers must discuss office documentation practices with the practitioner or practitioner staff. This discussion must include the forms and methods used to keep the information in a consistent manner. It must also include how the practice insures the confidentiality of records. The reviewers must assess the record for orderliness of the record and documentation practices. To ensure member confidentiality the reviewer may review "blinded" medical/treatment records or a model instead of an actual record.
B. Site shall discuss the following processes and provide supporting policies:	Site shall be able to thoroughly discuss the following processes and provide supporting policies: B1-6- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. B7. Program notify clients of their right to services from an alternative service provider if they object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. • Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year. B8. Does the Program adhere to priority admission requirements as follows: (a) Pregnant injecting drug users (b) Pregnant substance abusers (c) Injecting drug users (d) All Others The program shall admit IV drug users within **14 days** of request or provide interim services and admit within **120 days** Interim Services: The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s): •Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within **48 hours** for those individuals who are in need of treatment and who cannot be admitted within **14 days** of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A) Medical records are available for the Provider at each scheduled patient encounter. 22 CCR §75055; 27 CCR §1300.70					
1) Medical records are readily retrievable for scheduled patient encounters.	1	1)	1)	1)	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	1	2)	2)	2)	
3) Site has a system in place to ensure medical records are maintained in a consistent manner.	1	3)	3)	3)	
4) There is an individual medical record is established for each member	1	4)	4)	4)	
5) Medical record contains signed HIPAA notification	1	5)	5)	5)	
B) Site shall discuss the following processes and provide supporting policies:					
1) What is your process for obtaining appropriate documentation of admission and readmission criteria.	1	1)	1)	1)	
2) How do you determine appropriate Medical Necessity	1	2)	2)	2)	
3) How do you show proof of eligibility as payment.	1	3)	3)	3)	
4) Process for completing ASAM, how is criteria used to determine medical necessity. (visualize copy)	1	4)	4)	4)	
5) Process for completing all appropriate and required documentation during intake. (Visualize intake packet and make site "walk" you through process start to finish) adapt to LOC	1	5)	5)	5)	
6) Process for completing initial Treatment plan and/or Problem list (Visualize blank form/ how generated in computer)	1	6)	6)	6)	
7) How do you notify clients of their right to services from an alternative service provider if they object to the religious character of the program	1	7)	7)	7)	
8) Does the program adhere to priority administration requirements and provides interim services when required	1	8)	8)	8)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
13 points possible this page

Criteria	IV. Office Management Reviewer Guidelines

C. Medical record confidentiality is maintained according to State and Federal guidelines.	**B1. Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **B2. Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. **B4. Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **B3. Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. **B5. Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761). PER THE **INTERGOVERNMENTAL AGREEMENT**: **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.

IV. Office Management

RN/MD/LPHA Review only

Wt	Yes	No	NA	Score
1	1)	1)	1)	
1	2)	2)	2)	
1	3)	3)	3)	
1	4)	4)	4)	
1	5)	5)	5)	

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
C. All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following:					
1) Program Mission and Philosophy Statement	1	1)___	1)___	1)___	
2) Program Description, objectives, and evaluation plan.	1	2)___	2)___	2)___	
3) Admission and Re-admission	1	3)___	3)___	3)___	
4) Intake Services	1	4)___	4)___	4)___	
5) Discharge Services	1	5)___	5)___	5)___	
6) Recovery Services	1	6)___	6)___	6)___	
7) Individual and Group Sessions	1	7)___	7)___	7)___	
8) Alumni involvement and Use of volunteers	1	8)___	8)___	8)___	
9) Recreational activities	1	9)___	9)___	9)___	
10) Detoxification Services (if applicable)	1	10)___	10)___	10)___	
11) Program administration and personnel practices	1	11)___	11)___	11)___	
12) Client grievances/complaints	1	12)___	12)___	12)___	
13) Evidence of fiscal practices and budget mechanisms	1	13)___	13)___	13)___	
14) Continuous quality improvement	1	14)___	14)___	14)___	
15) Client rights	1	15)___	15)___	15)___	
16) Medical policies	1	16)___	16)___	16)___	
17) Nondiscrimination in provision of employment and services;	1	17)___	17)___	17)___	
18) Community Relations	1	18)___	18)___	18)___	
19) Confidentiality	1	19)___	19)___	19)___	
20) Maintenance of program in a clean, safe, and sanitary physical environment;	1	20)___	20)___	20)___	
21) Maintenance and disposal of client files	1	21)___	21)___	21)___	
22) Drug screening	1	22)___	22)___	22)___	
23) Staff code of conduct as specified in section 13020 of these Standards	1	23)___	23)___	23)___	
24) Client code of conduct	1	24)___	24)___	24)___	
25) Care Coordination/Case Management	1	25)___	25)___	25)___	
26) Continuing Services	1	26)___	26)___	26)___	
27) Cultural Competency Program around CLAS standards	1	27)___	27)___	27)___	
28) All NTP/OTP medical policies shall conform to CCR, Title 9, Division 4, Chapter 4 with regard to medication practices	1	28)___	28)___	28)___	

~~**Comments:** Write comments for all "No" (0 points) and "N/A" scores. 28 points possible this page~~

IV. Office Management

RN/MD/LPHA Review only

Criteria	IXV. Perinatal Services Reviewer Guidelines
A. These standards apply to programs who provide SUD treatment to pregnant and parenting women, which includes: Pregnant women; Women with dependent children; Women attempting to regain custody of their children; Postpartum women and their children; or Women with substance exposed infants	**A1.** The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them. The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided interim Services are: HIV and TB education and counseling and testing; Referrals for prenatal care; Education on the effects of AOD use on the fetus. **A2.** The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them. **A3**. The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided. Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus
B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s) ~~**A.** Relevant services offered to perinatal patients.~~	**B1.** The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them. **B2.** ~~**Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include:**~~ ~~1) Mother/child rehabilitative services.~~ ~~2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant.~~ ~~Evidence of coordination of ancillary services in the case management note.~~ The Program shall ensure that Pregnant women are referred for interim services within 48 hours if a treatment slot is not available (To assist in making appropriate referrals, the County must make available a current directory of community resources.) and if placed on waiting list, pregnant women are at top of waiting list. **B3.** **B4.** The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided. Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus ~~3)~~
~~B.~~C. ~~Daycare facilities are available to Outpatient Perinatal Patients.~~Programs shall:	**C1.** The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services. **C2.** Child care may be provided on-site or off-site for participants' children who are between 37 months and 12 years of age. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children. In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment. The Pro-Children Act of 1994 prohibits smoking in any indoor facility where services for children are federally funded

	C3. The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect. **C4.** Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her. **C5.** The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services **C6.** Provide or arrange for primary medical care for women in treatment **C7.** The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment. **C8.** The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services or women in need of transportation. **C9.** The Program shall ensure a vehicle log is maintained **C10.** The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect. **C11.** The Program shall provide or arrange for the following services: (a) Educational/vocational training and life skills resources (b) TB and HIV education and counseling (c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information~~**In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment.**~~
~~**C.** Perinatal/Pediatric Patient Care~~	~~Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.~~

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
A. Relevant services offered to perinatal patients. Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include: 1) Mother/child rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Evidence of coordination of ancillary services in the case management note.	 1 1 1	 1)____ 2)____ 3)____	 1)____ 2)____ 3)____	 1)____ 2)____ 3)____	
B. Daycare facilities are available to Outpatient Perinatal Patients.	1	1)____	1)____	1)____	
C. Perinatal/Pediatric Patient Care	1	1)____	1)____	1)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
5 points possible this page

Criteria	V. Perinatal Services Reviewer Guidelines

D. Pregnant women are given preference in admission to recovery and treatment programs	The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them
E. Pregnant women are referred for interim services within 48 hours if a treatment slot is not available	The Program shall ensure that Pregnant women are referred for interim services within **48 hours** if a treatment slot is not available (To assist in making appropriate referrals, the County must make available a current directory of community resources.) and if placed on waiting list, pregnant women are at top of waiting list.
F. Pregnant women who are waitlisted are referred to other programs	Does the Program have a system in place to refer women to other county programs if there is a waitlist.
G. Injection drug using pregnant women are admitted or interim services are provided	The Program shall ensure that Injection drug-using women must be admitted within **14 days** after request or within **120 days** if interim services are provided Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus
H. Child care is provided on site for participants' children	The Program shall ensure that child care is provided on-site for participants' children between **birth and 36 months** while the mothers are participating in the program . Child care may be provided on-site or off-site for participants' children who are between **37 months and 12 years of age**. Child care for children between **13 and 17 years of age**, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children. The Pro-Children Act of 1994 prohibits smoking in any indoor facility where services for children are federally funded.
I. Referrals are made based on individual assessments	The Program shall make referrals based on individual assessments, such as 12-step groups, housing support, food and legal aid, case management, children's services, medical service and social services

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
D.) Pregnant women are given preference in admission to recovery and treatment programs	1	1)____	1)____	1)____	
E.) Pregnant women are referred for interim services within 48 hours if a treatment slot is not available	1	2)____	2)____	2)____	
F.) Pregnant women who are waitlisted are referred to other programs	1	3)____	3)____	3)____	
G.) Injection drug using pregnant women are admitted or interim services are provided	1	4)____	4)____	4)____	
H.) Child care is provided on site for participants' children	1	5)____	5)____	5)____	
I.) Referrals are made based on individual assessments	1	6)____	6)____	6)____	
		7)____	7)____	7)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 points possible this page

Criteria	V. Perinatal Reviewer Guidelines

J. Provide or arrange for sufficient case management	The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services
K. Provide or arrange for primary medical care for women in treatment	The Program shall provide or arrange for primary medical care for women in treatment, including referrals for prenatal care.
L. Provide or arrange for primary pediatric care	The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment.
M. Provide or arrange for transportation	The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services or women in need of transportation.
N. Vehicle log is maintained	The Program shall ensure a vehicle log is maintained
O. Provide or arrange therapeutic interventions for children	The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
P. Program shall provide or arrange for required services	The Program shall provide or arrange for the following services: (a) Educational/vocational training and life skills resources (b) TB and HIV education and counseling (c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
J.) Provide or arrange for sufficient case management	1	1)	1)	1)	
K.) Provide or arrange for primary medical care for women in treatment	1	2)	2)	2)	
L.) Provide or arrange for primary pediatric care	1	3)	3)	3)	
M.) Provide or arrange for transportation	1	4)	4)	4)	
N.) Vehicle log is maintained	1	5)	5)	5)	
O.) Provide or arrange therapeutic interventions for children	1	6)	6)	6)	
P.) Program shall provide or arrange for required services	1	7)	7)	7)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 points possible this page
19 points possible for this section
Total

Criteria	VI. Pharmaceutical/Laboratory: Pharmaceutical/Laboratory Services Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3) • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs (22 CCR §75032 and §75033) **IV.A.2) Controlled substances** Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11057, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses, and pharmacists. **IV.A.3)** Written records are maintained including all medications (inclusive of controlled substances) and include inventory list(s) that have: provider's name, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. **Note**: During business hours, the drawer, cabinet, or room containing drugs, medication supplies, or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies, or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times. **IV.A.4** There must not be any expired medications on site. **IV.A.5** Site has a procedure to check expiration date and a method to dispose of expired medications. **IV.A.6** Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. IV. A.7. Site has a procedure to dispose of Sharps materials **IV.A.8~~7~~** For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.

VI. Pharmaceutical/Laboratory

RN/MD Review only

Pharmaceutical/Laboratory Services Survey Criteria	Wt	Yes	No	NA	Score
A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22					
1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	1	1)____	1)____	1)____	
2) Controlled drugs are stored in a locked space accessible only to authorized personnel.	1	2)____	2)____	2)____	
3) A dose-by-dose medication log is maintained.	1	3)____	3)____	3)____	
4) There are no expired medications on site.	1	4)____	4)____	4)____	
5) Site has a procedure to check expiration date and a method to dispose of expired medications.	1	5)____	5)____	5)____	
6) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	1	6)____	6)____	6)____	
7) For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.	1	7)____	7)____	7)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 Points possible for this section

Total

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Facility Site Review Survey
Substance Use Disorder (SUD) Treatment Services

Site ID	Phone:	Fax:	Review Date:
Facility Name:	Contact Name/Title:		
Full Address:			
Reviewer Name/Title:			
Staff on site: ___CADC I/II/III ___ LAADC ___ SUDCC ___LCSW ___LMFT ___ASW ___MFTI ___RADT ___RADT II ___MD ___NP ___RN ___LVN ___Clerical Other_____			

Visit Purpose	Certifications	Clinic type
☐ Initial Full Scope ☐ Monitoring ☐ Periodic Full Scope ☐ Follow-up ☐ Focused Review ☐ Ed/TA ☐Other _____	Most Current:~~Most current~~ DMC Certification Number _____ Issuance Date: _____	☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent_____ Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 Perinatal Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 ☐ OTP/NTP ☐ Withdrawal Management (3.2)

Site Review Scores

		Pts. poss.	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Access/Safety**	163				
II.	**~~Personnel~~Office Management**	~~12~~5				
III.	**~~SABG~~ ~~Requirements~~Policy/ Procedures**	~~43~~21				
IV.	**~~Office~~ ~~Management~~Program Policy Booklet**	~~60~~27				
V.	**Intake Packet**	9				
VI.	**Interpreter Services**	7				
VII.	**Staff Requirements**	30				
VIII.	**Detox Facility**	7				
~~V.~~IX.	**Perinatal Services**	19~~9~~				
~~VI.~~X.	**Pharmaceutical/ Laboratory**	~~8~~7				
		14~~95~~3				

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all ten~~six~~ sections.
3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%
Points given / Total/ Adjusted points / Decimal Score / Compliance Rate

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire FSR, regardless of the Total FSR score. ***Any deficiency in ~~SABG~~ ~~or~~ ASAM requirements requires a CAP.***

_____**Exempted~~-~~ Pass: 90%~~-~~ or above:**
(Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:**
(Total FSR is 80-89% *OR* *any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

	Total Pts. Poss.	Total Yes Pts.	Total No Pts.	Total N/A Pts.	

Facility Site Review Guidelines for Substance Use Disorder (SUD) Treatment Services

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions."

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include: 1) Exempted Pass: 90% or above, 2) Conditional Pass: 80-89%, and 3) Not Pass: below 80%. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all 10~~tensix~~ (10~~6~~) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all 10 ~~tensix~~ (10~~6~~) sections.
	(16) Access/Safety (5) Office Management (21) Policy/Procedures (27) Program Policy Booklet (9) Intake Packet (7) Interpreter Services (30) Staff Requirements (7) Detox Facility

	(19) Perinatal Services (8) Pharmaceutical/Laboratory ~~13 (Access/safety)~~ ~~12 (Personnel)~~ ~~43 (SABG Requirements)~~ ~~60 (Office Management)~~ ~~19 (Perinatal Services)~~ ~~7 (Pharmaceutical/Laboratory)~~ **~~153~~ 149 (POINTS)**
Step 3: Subtract "N/A" points from 149~~54~~ total points possible. 149~~54~~ (Total points possible) – 6 (N/A points) 143~~48~~ ("Adjusted" total points possible)	**Step 4**: Divide total points given by 143~~48~~ or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / 12~~1~~6 or "adjusted" total or 126~~137~~ / 143~~48~~ =. ~~9256~~ 88111 = 88~~93~~%

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Access/Safety Reviewer Guidelines

A1. ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).

Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities.

Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1 foot rise in 20 feet of horizontal run.

Exit doors: The width of exit doorways (at least 32 in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway.

Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well lit, neat, and clean.

Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30 in. x 48 in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60 in. diameter or square area is needed to turn a wheelchair.

Sanitary Facilities: Restroom and hand washing facilities are accessible to able bodied and physically disabled persons. A wheel chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel.

Additionally: communication shall be at a maximum 6th grade level. Reading materials available in large print.

AOD 12000, "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug free environment."

A2. Note: A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety

RN/MD/LPHA Review only

Site Access/Safety Survey Criteria	Wt	Yes	No	NA	Score
A. Site is accessible and useable by individuals with physical disabilities CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)					
1) Site is accessible and useable by individual with physical disabilities	**1**	1)____	1)____	1)____	
2) If the site is NOT accessible, are reasonable alternatives available?	**1**	2)____	2)____	2)____	

Site Access/Safety Survey Criteria	Wt	Yes	No	NA	Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	**1**	1)	1)	1)	
2) Restrooms are clean and contain appropriate sanitary supplies	**1**			2)	
3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.	**1**	2)	2)	3)	
4) The Program is free from all of the following (AOD 20000) a. Broken glass, filth, litter, or debris b. Flies, insects, or other vermin c. Toxic chemicals or noxious fumes and odors d. Exposed electrical wiring e. Other health or safety hazards	**1**	3) 4)	3) 4)	4)	
5) Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities	**1**	5)	5)		
6) The program shall safely dispose if contaminated water and chemicals used for cleaning purposes	**1**	6)	6)	5)	
				6)	

~~Comments: Write comments for all "No" (0 points) and "N/A" scores.~~
~~2 points possible this page~~

I. Access/Safety Reviewer Guidelines (Continued)

B1. The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained.
B2. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
B3. AOD 12000, "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment."

Ordinances: Sites must meet city, county, and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews.
C6. Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.
C2. Non-medical emergency procedures: Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.
C3. Illumination: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.
C4. Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.
C5. Exits: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.
C7. Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.
C1. C8. Fire Fighting/Protection Equipment: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devises. At least one of the following types of fire safety equipment is on site:
1) Smoke Detector with intact, working batteries
2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances
3) Automatic Sprinkler System with sufficient clearance (10 in.) between sprinkler heads and stored materials.
4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag.
Specific information for handling fire emergency procedures is available on site to staff.
Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

Comments: Write comments for all "No" (0 points) and "N/A" scores.
8 points possible this page

I. Access/Safety

RN/MD/LPHA Review only ~~I. Access/Safety~~

~~RN/MD/LPHA Review only~~

Site Access/Safety Survey Criteria (Continued)	Wt	Yes	No	NA	Score
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34 **There is evidence that staff has received safety training and/or has safety information available in the following:**					
1) Fire safety and prevention	1	1)	1)	1)	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	1				
3) Lighting is adequate in all areas to ensure safety.	1	2)	2)	2)	
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	1	3)	3)	3)	
5) Exit doors are clearly marked with "Exit" signs.	1	4)	4)	4)	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	1	5)	5)	5)	
7) Electrical cords and outlets are in good working condition.	1	6)	6)	6)	
8) At least one type of firefighting/protection equipment is accessible at all times.	1	7)	7)	7)	
~~B. Site environment is maintained in a clean and sanitary condition.~~ ~~8 CCR §5193; 28 CCR §1300.80~~		8)	8)	8)	
~~1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.~~	~~1~~				
~~2) Restrooms are clean and contain appropriate sanitary supplies~~	~~1~~	~~1)~~	~~1)~~	~~1)~~	
~~3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.~~	~~1~~	~~2)~~ ~~3)~~	~~2)~~ ~~3)~~	~~2)~~ ~~3)~~	

C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34 **There is evidence that staff has received safety training and/or has safety information available in the following:**					
1) Fire safety and prevention	1	1)____	1)____	1)____	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	1	2)____	2)____	2)____	
3) Lighting is adequate in all areas to ensure safety.	1	3)____	3)____	3)____	
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	1	4)____	4)____	4)____	
5) Exit doors are clearly marked with "Exit" signs.	1	5)____	5)____	5)____	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	1	6)____	6)____	6)____	
7) Electrical cords and outlets are in good working condition.	1	7)____	7)____	7)____	
8) At least one type of firefighting/protection equipment is accessible at all times.	1	8)____	8)____	8)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 8 points possible this page 16 points possible in this section **Comments:** Write comments for all "No" (0 points) and "N/A" scores. 11 points possible this page 13 points possible in this section Total Total					

~~Medical Board of CA~~ ~~Drug Enforcement Administration~~
~~Medical Board of California~~
~~CA Board of Registered Nursing~~
~~CA Board of Registered Nursing~~
~~CA State Board of Pharmacy~~
~~Medical Board of CA~~ ~~DEA~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral science~~
~~CA Board of Vocational Nursing and Psychiatric Technicians~~
~~CA Board of Vocational Nursing and Psychiatric Technicians~~

RN/MD/LPHA Review only

II. Office Management

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR					
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	**1**	1)	1)	1)	
2) Procedures are followed to maintain the confidentiality of personal patient information.	**1**	2)	2)	2)	
3) Medical record release procedures are compliant with State and federal guidelines.	**1**	3)	3)	3)	
4) Copies of the following shall be posted in a prominent place accessible to all beneficiaries: a. Statement of non-Discrimination b. PHC grievance policy and phone number c. Appeal process for involuntary discharge d. Program rules and expectations	**1**	4)	4)	4)	
5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	**1**	5)	5)	5)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 5 points possible in this section Total					

III. ~~Personnel~~Policy/Procedure

RN/MD/LPHA Review only

Site Specific Policy/ProcedureSite Personnel Survey Survey Criteria	Wt	Yes	No	NA	Score

A. Site has a policy/procedure that addresses each of the following: ~~**A.** (each policy in this section should be obtained for evidence)Professional health care personnel have current California Licenses and Certifications.~~ ~~CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110~~		1)____ 2)____			
1) Obtaining appropriate documentation of admission and readmission criteria ~~All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.~~	**1**	3)____	1)____	1)____	
2) Determining appropriate Medical Necessity ~~The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.~~	**1**	4)____	2)____	2)____	
3) Proof of MediCal eligibility as payment~~The program/facility has a written plan for training staff that is updated annually.~~	**1**	5)____	3)____	3)____	
4) Completing ASAM, how is criteria used to determine medical necessity	**1**	6)____	4)____	4)____	
5) Completion of all appropriate and required documentation during intake	**1**	7)____	5)____	5)____	
6) Completion of initial Problem list and/or Treatment plan	**1**	8)____	6)____	6)____	
7) Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program	**1**	9)____	7)____	7)____	
8) Does the program adhere to priority administration requirements and provides interim services when required	**1**	10)____		8)____	
9) Maintaining confidentiality	**1**	11)____	8)____	9)____	
10) Missed appointments	**1**	12)____	9)____	10)____	
11) Progress note requirements	**1**	13)____	10)____	11)____	
12) Process for self-administered medications	**1**	14)____	11)____	12)____	
13) Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational	**1**	15)____	12)____	13)____	
14) Clients to obtain or have access to MAT	**1**	16)____	13)____	14)____	
15) Fraud, Waste and Abuse	**1**	17)____	14)____	15)____	
16) Medical record release procedures are compliant with State and federal guidelines	**1**	18)____	15)____	16)____	
17) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen	**1**	19)____	16)____	17)____	
18) Serving Native Americans	**1**	20)____	17)____	18)____	
19) Serving Co-Occurring clients.	**1**	21)____	18)____	19)____	
20) Program policy on group counseling- List EBPs used: _____, _____	~~1~~	~~2~~)____	19)____	20)____	
~~4)~~ Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment~~Professional staff (LPHA's) receive a minimum of 5 hours continuing~~	~~1~~ ~~1~~	~~3)____~~ ~~4)____~~ ~~5)____~~	20)____ 21)____ ~~1~~ ~~)____~~	~~1)____~~ ~~2)____~~ ~~3)____~~	

Site Specific Policy/Procedure~~Site Personnel Survey~~ Survey Criteria	Wt	Yes	No	NA	Score
~~education related to addiction medicine each year~~ ~~5)~~21) ~~At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.~~	~~1~~ ~~1~~		~~2)~~ ~~3)~~ ~~4)~~ ~~5)~~	~~4)~~ ~~5)~~	
Comments: Write comments for all "NO" (0 Points) and "N/A" scores 21 points in this section Total					

~~**Comments:** Write comments for all "No" (0 points) and "N/A" scores.~~
~~5 points possible this page~~

IV. Program Policy Booklet

RN/MD/LPHA Review only

Program Policy Booklet Survey Criteria	Wt	Yes	No	NA	Score
A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted)					
1) Program Mission and Philosophy Statement	1	1)	1)	1)	
2) Program Description, objectives, and evaluation plan.	1	2)	2)	2)	
3) Admission and Re-admission; including client assignment to counselor and contact information	1	3)	3)	3)	
4) Intake Services	1	4)	4)	4)	
5) Discharge Services	1	5)	5)	5)	
6) Recovery Services	1	6)	6)	6)	
7) Individual and Group Sessions	1	7)	7)	7)	
8) Alumni involvement and Use of volunteers	1	8)	8)	8)	
9) Recreational activities	1	9)	9)	9)	
10) Detoxification Services (if applicable)	1	10)	10)	10)	
11) Program administration and personnel practices	1	11)	11)	11)	
12) Client grievances/complaints	1	12)	12)	12)	
13) Fiscal practices and budget mechanisms	1	13)	13)	13)	
14) Continuous quality improvement	1	14)	14)	14)	
15) Client rights	1	15)	15)	15)	
16) Medical policies	1	16)	16)	16)	
17) Nondiscrimination in provision of employment and services	1	17)	17)	17)	
18) Community Relations	1	18)	18)	18)	
19) Confidentiality	1	19)	19)	19)	
20) Maintenance of program in a clean, safe, and sanitary physical environment	1	20)	20)	20)	
21) Maintenance and disposal of client files	1	21)	21)	21)	
22) Drug screening	1	22)	22)	22)	
23) Staff code of conduct as specified in section 13020 of these Standards	1	23)	23)	23)	
24) Client code of conduct	1	24)	24)	24)	
25) Care Coordination/Case Management	1	25)	25)	25)	
26) Continuing Services	1	26)	26)	26)	
27) Cultural Competency Program around CLAS standards (inclusive of all 15 standards)	1	27)	27)	27)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 27 points possible in this section Total					

V. Intake Packet

RN/MD/LPHA Review only

Intake Packet Survey Criteria	Wt	Yes	No	NA	Score
A. A copy of a complete admissions/intake packet should be provided (A copy of this packet should be obtained, if posted photo should be taken)					
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	1	1)	1)	1)	
2) Complaint process and grievance procedures	1	2)	2)	2)	
3) Appeal process for involuntary discharge	1	3)	3)	3)	
4) Program rules and expectations	1	4)	4)	4)	
5) Client rights and responsibilities	1	5)	5)	5)	
6) Consent to release information	1	6)	6)	6)	
7) HIPAA notification	1	7)	7)	7)	
8) Consent to treat	1	8)	8)	8)	
9) Admission agreement	1	9)	9)	9)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 9 points possible in this section Total					

VI. Interpreter Services

RN/MD/LPHA Review only

Interpreter Services Survey Criteria	Wt	Yes	No	NA	Score
A. Interpreter services (a copy of policy should be obtained)					
1) All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities.	1	1)	1) –	1) –	
2) Note: https://lep.gov/commonly-asked-questions D2.	1	2) –	2)	2)	
3) If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.	1	3)	3)	3)	
4) Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients.	1	4) –	4)	4)	
5) Family or friends should not be used as interpreters, unless specifically requested by the member.	1		5)	5)	
6) ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.	1	5)	6) –	6) –	
7) A request for or refusal of language/interpreter services must be documented in the member's medical record.	1	6)	7)	7)	
		7)			
Comments: Write comments for all "No" (0 points) and "N/A" scores. 7 points possible in this section Total					

VII. Staff Requirements

RN/MD/LPHA Review only

Staff Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Personnel files maintained on all employees, LPHA, Medical Director and volunteers/interns contain the following: CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 (Obtain a complete copy of all documents)					
1) Application for employment and/or resume	1	1)	1)	1)	
2) Signed employment confirmation statement/duty statement	1	2)	2)	2)	
3) Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position.	1	3)	3)	3)	
4) Performance evaluations	1	4)	4)	4)	
5) Health records/status as required by program or Title 9	1	5)	5)	5)	
6) Other personnel actions	1	6)	6)	6)	
7) Training documentation relative to substance use disorders and treatment	1	7)	7)	7)	
8) Current registration, certification, intern status, or licensure	1	8)	8)	8)	
9) Proof of continuing education required by licensing or certifying agency and program	1	9)	9)	9)	
10) Program Code of Conduct and for registered, certified, and licensed staff	1	10)	10)	10)	
11) Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement)	1	11)	11)	11)	
12) For registered and certified counselors, a copy of registration or certification	1	12)	12)	12)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
12 points possible this page

VII. Staff Requirements continued

RN/MD/LPHA Review only

Staff Requirements Survey Criteria Continued	Wt	Yes	No	NA	Score

B. Program/Facility has a written plan for training staff that is updated annually (Proof of training should be readily available) 1) The program/facility has a written plan for training staff that is updated annually 2) All providers and staff conducting, reviewing, using ASAM assessments have completed the two e-Trainings. 3) All employees have mandatory training on annual DMC-ODS requirements 4) All appropriate staff have received regular training on evidence based practices (EBP) 5) Staff are trained in the CalOMS treatment data collection and reporting methods 6) Staff are trained in the DATAR reporting methods 7) Cultural and Linguistic training annually 8) Title 22 training 9) Education on the Trafficking Victims Protection Act of 2000 10) Annual confidentiality training 11) ONLY MEDICAL DIRECTOR minimum of five hours of continuing medical education related to addiction medicine each year for medical director 12) ONLY LPHA minimum of five hours of continuing medical education related to addiction medicine each year for LPHA 13) Tuberculosis (TB) Testing is offered and performed onsite for all staff who have contact with food preparation and/or any clients. 14) A code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.	**1** **1** **1** **1** **1** **1** **1** **1** **1** **1** **1** **1** **1**	1) 2) 3) 4) 5) 6) 7) 8) 9) 10) 11) 12) 13) 14)	1) 2) 3) 4) 5) 6) 7) 8) 9) 10) 11) 12) 13) 14)	1) 2) 3) 4) 5) 6) 7) 8) 9) 10) 11) 12) 13) 14)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
14 points possible this page

VII. Staff Requirements continued

RN/MD/LPHA Review only

Staff Requirements Survey Criteria Continued	Wt	Yes	No	NA	Score
C. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
1) All staff have received appropriate credentialing	1	1)	1)	1)	
2) At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.	1	2)	2)	2)	
3) Staff files are maintained for the required length of time. (6 years current)	1	3)	3)	3)	
4) NTP/OTP program only Facility must provide policy showing conforming to CCR, Title 9, and Division 4 with regard to medication practices	1	4)	4)	4)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

4 points possible this page

30 points possible this section. Total

VIII. Personnel continuedDetox

RN/MD/LPHA Review only

Site PersonnelDetox Survey Criteria	Wt	Yes	No	NA	Score
A. During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)**Professional health care personnel have current California Licenses and Certifications.** CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 1) In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training. 6) All providers and staff conducting ASAM assessments have completed the two e-Trainings. 2) In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training. 7) All employees have mandatory training on annual DMC-ODS requirements. 8) All appropriate staff have received regular training on evidence based practices (EBP) 9) Tuberculosis (TB) Testing is offered and performed onsite for all staff. 10) There is adequate staff on duty at all times with CPR certificate and current first aid training. 11) Staff files are maintained for the required length of time.	1 1 1 1 1 1 1 1	1)____ 2)____ 6)____ 7)____ 8)____ 9)____ 10)____ 11)____	1)____ 2)____ 6)____ 7)____ 8)____ 9)____ 10)____ 11)____	1)____ 2)____ 6)____ 7)____ 8)____ 9)____ 10)____ 11)____	
B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. **B. Counseling services are only provided by registered or certified individuals.**	1	1)____	1)____	1)____	

Site PersonnelDetox Survey Criteria	Wt	Yes	No	NA	Score
C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).					
1) Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files.	**1**	1)____	1)____	1)____	
2) Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files.	**1**	2)____	2)____	2)____	
3) Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services	**1**	3)____	3)____	3)____	
4) Naloxone training policy and completion of naloxone training	**1**	4)____	4)____	4)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 77 points possible in this pagesection 12 points possible this section. Total	Total				

Criteria	III. SABG Requirements Reviewer Guidelines
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs	
1. Personnel files are maintained on all employees, volunteers/interns and contain the following required documentation:	Personnel files must contain the following: a) Application for employment and/or resume; b) Signed employment confirmation statement/duty statement; c) Job description; d) Performance evaluations; e) Health records/status as required by program or Title 9; f) Other personnel actions (e.g. Commendations, disciplines, status change, employment incidents and/or injuries); g) Training documentation relative to substance use disorders and treatment; h) Current registration, certification, intern status, or licensure; i) Proof of continuing education required by licensing or certifying agency and program; j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.
2. Job descriptions are developed, revised as needed, and are approved by the program's governing body.	The job descriptions shall include: a) Position title and classification; b) Duties and responsibilities; c) Lines of supervision; d) Education, training, work experience, and other qualifications for the position.
3. Written code of conduct for employees, volunteers/interns is established; and addresses the required topics.	Written code of conduct addresses at least the following: a) Use of drugs and/or alcohol; b) Prohibition of social/business relationship with clients or their family members for personal gain; c) Prohibition of sexual contact with clients; d) Conflict of interest; e) Providing services beyond scope; f) Discrimination against clients or staff; g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff; h) Protection of client confidentiality; i) The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under; j) Cooperation with compliant investigations.

~~III. SABG Requirements~~

~~RN/MD/LPHA Review only~~

~~SABG Requirements Survey Criteria~~	~~Wt~~	~~Yes~~	~~No~~	~~NA~~	~~Score~~
~~**A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).**~~					
~~**1.** Personnel files maintained on all employees and volunteers/interns contain the following:~~	~~**1**~~	~~1a) ____~~	~~1a) ____~~	~~1a) ____~~	
~~a) Application for employment and/or resume~~	~~**1**~~	~~1b) ____~~	~~1b) ____~~	~~1b) ____~~	
~~b) Signed employment confirmation statement/duty statement~~	~~**1**~~	~~1c) ____~~	~~1c) ____~~	~~1c) ____~~	
~~c) Job description~~	~~**1**~~	~~1d) ____~~	~~1d) ____~~	~~1d) ____~~	
~~d) Performance evaluations~~	~~**1**~~	~~1e) ____~~	~~1e) ____~~	~~1e) ____~~	
~~e) Health records/status as required by program or Title 9~~	~~**1**~~	~~1f) ____~~	~~1f) ____~~	~~1f) ____~~	
~~f) Other personnel actions~~	~~**1**~~	~~1g) ____~~	~~1g) ____~~	~~1g) ____~~	
~~g) Training documentation relative to substance use disorders and treatment~~	~~**1**~~	~~1h) ____~~	~~1h) ____~~	~~1h) ____~~	
~~h) Current registration, certification, intern status, or licensure~~	~~**1**~~	~~1i) ____~~	~~1i) ____~~	~~1i) ____~~	
~~i) Proof of continuing education required by licensing or certifying agency and program~~	~~**1**~~	~~1j) ____~~	~~1j) ____~~	~~1j) ____~~	
~~j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.~~					
~~**2.** Job descriptions shall be developed, revised as needed, approved by the program's governing body, and include:~~	~~**1**~~	~~2a) ____~~	~~2a) ____~~	~~2a) ____~~	
	~~**1**~~	~~2b) ____~~	~~2b) ____~~	~~2b) ____~~	
~~a) Position title and classification;~~	~~**1**~~	~~2c) ____~~	~~2c) ____~~	~~2c) ____~~	
~~b) Duties and responsibilities;~~	~~**1**~~	~~2d) ____~~	~~2d) ____~~	~~2d) ____~~	
~~c) Lines of supervision;~~					
~~d) Education, training, work experience, and other qualifications for the position.~~					
~~**3.** Written code of conduct for employees and volunteers/interns shall be established, which address at least the following:~~	~~**1**~~	~~3a) ____~~	~~3a) ____~~	~~3a) ____~~	
	~~**1**~~	~~3b) ____~~	~~3b) ____~~	~~3b) ____~~	
~~a) Use of drugs and/or alcohol;~~	~~**1**~~	~~3c) ____~~	~~3c) ____~~	~~3c) ____~~	
~~b) Prohibition of social/business relationship with clients or their family members for personal gain;~~	~~**1**~~	~~3d) ____~~	~~3d) ____~~	~~3d) ____~~	
~~c) Prohibition of sexual contact with clients;~~	~~**1**~~	~~3e) ____~~	~~3e) ____~~	~~3e) ____~~	
~~d) Conflict of interest;~~	~~**1**~~	~~3f) ____~~	~~3f) ____~~	~~3f) ____~~	
~~e) Providing services beyond scope;~~	~~**1**~~	~~3g) ____~~	~~3g) ____~~	~~3g) ____~~	
~~f) Discrimination against clients or staff;~~	~~**1**~~	~~3h) ____~~	~~3h) ____~~	~~3h) ____~~	
~~g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff;~~	~~**1**~~	~~3i) ____~~	~~3i) ____~~	~~3i) ____~~	
~~h) Protection of client confidentiality;~~	~~**1**~~	~~3j) ____~~	~~3j) ____~~	~~3j) ____~~	
~~i) The element found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under~~					
~~j) Cooperation with compliant investigations.~~					

~~**Comments:** Write comments for all "No" (0 points) and "N/A" scores. 13 points possible this page~~

Criteria	III. SABG Requirements Reviewer Guidelines
4. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	Personnel Files: If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address: a) Recruitment; b) Screening; c) Selection; d) Training and orientation; e) Duties and assignments; f) Scope of practice; g) Supervision; h) Evaluation; i) Protection of client confidentiality.
5. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director. a) All Staff b) Certified Staff c) Medical Director d) Volunteers/Interns
6. Staff will receive Cultural and Linguistic training. Annually	The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (Notate the topic of trainings conducted, including if they are in-house, outside or PHC)
7. Proof that staff have received education on the Trafficking Victims Protection Act of 2000	Staff shall be trained on the Trafficking Victims Protection Act of 2000. Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702"
8. All staff will sign confidentiality agreements and/or have proof of training annually.	All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training.

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:	1	4a)____	4a)____	4a)____	
a) Recruitment;	1	4b)____	4b)____	4b)____	
b) Screening;	1	4c)____	4c)____	4c)____	
c) Selection;	1	4d)____	4d)____	4d)____	
d) Training and orientation;	1	4e)____	4e)____	4e)____	
e) Duties and assignments;	1	4f)____	4f)____	4f)____	
f) Scope of practice;	1	4g)____	4g)____	4g)____	
g) Supervision;	1	4h)____	4h)____	4h)____	
h) Evaluation;	1	4i)____	4i)____	4i)____	
i) Protection of client confidentiality.	1	5a)____	5a)____	5a)____	
	1	5b)____	5b)____	5b)____	
5. Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director.	1	5c)____	5c)____	5c)____	
a) All Staff	1	5d)____	5d)____	5d)____	
b) Certified Staff					
c) Medical Director	1	6)____	6)____	6)____	
d) Volunteers/Intern		7)____	7)____	7)____	
	1				
6. Staff will receive Cultural and Linguistic training annually.		8)____	8)____	8)____	
	1				
7. Proof that staff have received education on the Trafficking Victims Protection Act of 2000					
8. All staff will sign confidentiality agreements, and/or have proof of training annually					

Comments: Write comments for all "No" (0 points) and "N/A" scores.
16 points possible this page

Criteria	III. SABG Requirements Reviewer Guidelines
9. Staff are trained in the CalOMS treatment data collection and reporting methods	•The Program shall have policies, procedures and practices in place to ensure: • new staff are trained in the CalOMS Tx data collection and reporting methods • CalOMS Tx data is reported in a manner consistent with their county contract as well as within the timelines outlines in the State-County contract • a client admission record is uploaded when the participants have been admitted into treatment, and treatment services have started • admission information is gathered within seven days of a person's entry into treatment • annual update is completed for program participants in treatment for a period of 12 months or more, had no break in service exceeding 30 days and participated continuously in the same modality and program • administrative discharges are used only when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview either in person or by phone • a client is discharged if there has been no contact with the client for 30 days
10. Staff are trained in the DATAR reporting methods	The Program shall have policies, procedures and practices in place to ensure DATAR is reported in a manner consistent with their county contract as well within the timelines outlined in the State-County contract
11. CalOMS information is submitted on a timely basis	The program shall submit CalOMS information on a timely basis

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
B. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
9. Staff are trained in the CalOMS treatment data collection and reporting methods	**1**	9)_____	9)_____	9)_____	
10. Staff are trained in the DATAR reporting methods	**1**	10)_____	10)_____ 11)_____	10)_____	
11. CalOMS information is submitted on a timely basis	**1**	11)_____		11)_____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 3 points possible this page 43 points possible this section. Total					

Criteria	IV. Office Management Reviewer Guidelines

A. Medical records are available for the Provider at each scheduled patient encounter.	**A1.** The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. **A2.** Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055). **A3/4. Adequacy of Medical Record/treatment record keeping:** The reviewers must discuss office documentation practices with the practitioner or practitioner staff. This discussion must include the forms and methods used to keep the information in a consistent manner. It must also include how the practice insures the confidentiality of records. The reviewers must assess the record for orderliness of the record and documentation practices. To ensure member confidentiality the reviewer may review "blinded" medical/treatment records or a model instead of an actual record.
B. Site shall discuss the following processes and provide supporting policies:	Site shall be able to thoroughly discuss the following processes and provide supporting policies: B1-6- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. B7. Program notify clients of their right to services from an alternative service provider if they object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. • Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year. B8. Does the Program adhere to priority admission requirements as follows: (a) Pregnant injecting drug users (b) Pregnant substance abusers (c) Injecting drug users (d) All Others The program shall admit IV drug users within **14 days** of request or provide interim services and admit within **120 days** Interim Services: The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s): •Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within **48 hours** for those individuals who are in need of treatment and who cannot be admitted within **14 days** of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A) Medical records are available for the Provider at each scheduled patient encounter. 22 CCR §75055; 27 CCR §1300.70					
1) Medical records are readily retrievable for scheduled patient encounters.	1	1)	1)	1)	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	1	2)	2)	2)	
3) Site has a system in place to ensure medical records are maintained in a consistent manner.	1	3)	3)	3)	
4) There is an individual medical record is established for each member	1	4)	4)	4)	
5) Medical record contains signed HIPAA notification	1	5)	5)	5)	
B) Site shall discuss the following processes and provide supporting policies:					
1) What is your process for obtaining appropriate documentation of admission and readmission criteria.	1	1)	1)	1)	
2) How do you determine appropriate Medical Necessity	1	2)	2)	2)	
3) How do you show proof of eligibility as payment.	1	3)	3)	3)	
4) Process for completing ASAM, how is criteria used to determine medical necessity. (visualize copy)	1	4)	4)	4)	
5) Process for completing all appropriate and required documentation during intake. (Visualize intake packet and make site "walk" you through process start to finish) adapt to LOC	1	5)	5)	5)	
6) Process for completing initial Treatment plan and/or Problem list (Visualize blank form/ how generated in computer)	1	6)	6)	6)	
7) How do you notify clients of their right to services from an alternative service provider if they object to the religious character of the program	1	7)	7)	7)	
8) Does the program adhere to priority administration requirements and provides interim services when required	1	8)	8)	8)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
13 points possible this page

Criteria	IV. Office Management Reviewer Guidelines

C. Medical record confidentiality is maintained according to State and Federal guidelines.	**B1. Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **B2. Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. **B4. Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **B3. Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. **B5. Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761). PER THE **INTERGOVERNMENTAL AGREEMENT**: **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
B. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR					
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	1	1) ____	1) ____	1) ____	
2) Procedures are followed to maintain the confidentiality of personal patient information.	1	2) ____	2) ____	2) ____	
3) Medical record release procedures are compliant with State and federal guidelines.	1	3) ____	3) ____	3) ____	
4) Storage and transmittal of medical records preserves confidentiality and security.	1	4) ____	4) ____	4) ____	
5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	1	5) ____	5) ____	5) ____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
5points possible this page

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
C. All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following:					
1) Program Mission and Philosophy Statement	1	1)	1)	1)	
2) Program Description, objectives, and evaluation plan.	1	2)	2)	2)	
3) Admission and Re-admission	1	3)	3)	3)	
4) Intake Services	1	4)	4)	4)	
5) Discharge Services	1	5)	5)	5)	
6) Recovery Services	1	6)	6)	6)	
7) Individual and Group Sessions	1	7)	7)	7)	
8) Alumni involvement and Use of volunteers	1	8)	8)	8)	
9) Recreational activities	1	9)	9)	9)	
10) Detoxification Services (if applicable)	1	10)	10)	10)	
11) Program administration and personnel practices	1	11)	11)	11)	
12) Client grievances/complaints	1	12)	12)	12)	
13) Evidence of fiscal practices and budget mechanisms	1	13)	13)	13)	
14) Continuous quality improvement	1	14)	14)	14)	
15) Client rights	1	15)	15)	15)	
16) Medical policies	1	16)	16)	16)	
17) Nondiscrimination in provision of employment and services;	1	17)	17)	17)	
18) Community Relations	1	18)	18)	18)	
19) Confidentiality	1	19)	19)	19)	
20) Maintenance of program in a clean, safe, and sanitary physical environment;	1	20)	20)	20)	
21) Maintenance and disposal of client files	1	21)	21)	21)	
22) Drug screening	1	22)	22)	22)	
23) Staff code of conduct as specified in section 13020 of these Standards	1	23)	23)	23)	
24) Client code of conduct	1	24)	24)	24)	
25) Care Coordination/Case Management	1	25)	25)	25)	
26) Continuing Services	1	26)	26)	26)	
27) Cultural Competency Program around CLAS standards	1	27)	27)	27)	
28) All NTP/OTP medical policies shall conform to CCR, Title 9, Division 4, Chapter 4 with regard to medication practices	1	28)	28)	28)	

Comments: Write comments for all "No" (0 points) and "N/A" scores. 28 points possible this page

Criteria	IV. Office Management Reviewer Guidelines (Continued)

~~**D.** There is 24-hour access to interpreter services for non-or limited-English proficient (LEP) members.~~	~~**D1.** All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities.~~ ~~***Note:*** https://lep.gov/commonly-asked-questions~~ ~~**D2.**~~ ~~• If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.~~ ~~• Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients.~~ ~~• Family or friends should not be used as interpreters, unless specifically requested by the member.~~ ~~• ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.~~ ~~• A request for or refusal of language/interpreter services must be documented in the member's medical record.~~
~~**E.** Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.~~	~~Copies of the following should be available to beneficiaries:~~ ~~1) Statement of nondiscrimination,~~ ~~2) PHC grievance phone number and packet,~~ ~~3) Appeal process for involuntary discharge,~~ ~~4) Program rules and expectations~~
~~**F.** Group sign in sheets include the printed names, signatures, dates, start and end times and topic of discussion.~~	~~Sign in sheets MUST include all of these components:~~ ~~1) Printed name and signature of the client~~ ~~2) Printed name, title and signature of the counselor~~ ~~3) Date of session~~ ~~4) Start and end times~~ ~~5) Topic~~
~~**G.** Counseling Groups consist of between 2 and 12 clients.~~	~~The Counseling Group must consist of between 2 and 12 clients per Title 22:~~ ~~"(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary."~~
~~**H.** Services offered to the American Indian/ American Native population~~	~~The Program shall ensure the availability of culturally competent AOD prevention, treatment, and recovery services to the sites American Indian/American Native population~~
~~**I.** Services offered/members referred to Mental Health Programs for Co-occurring disorder clients~~	~~Does the Program provide Co-occurring disorder clients with coordinated/integrated care for both their mental health and substance abuse conditions? If yes, what mechanisms are used to provide this service?~~ ~~o (a) MOU with mental health Program(s)~~ ~~o (b) Referral to COD Program~~ ~~o (c) Co-case management with mental health Program~~ ~~o (d) Provide both mental health and substance abuse treatment at a substance abuse program~~

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53751; 27 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1	1)	1)	1)	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	1	2)	2)	2)	
E. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.					
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	1	1)	1)	1)	
2) Complaint process and grievance procedures	1	2)	2)	2)	
3) Appeal process for involuntary discharge	1	3)	3)	3)	
4) Program rules and expectations	1	4)	4)	4)	
F. Group sign in sheets include required elements below:	1				
1) Printed name and signature of the client	1				
2) Printed name, title and signature of the counselor	1	1)	1)	1)	
3) Date of session	1	2)	2)	2)	
4) Start and end times	1	3)	3)	3)	
5) Topic		4)	4)	4)	
		5)	5)	5)	
G. Counseling Groups consist of between 2 and 12 clients.	1	1)	1)	1)	
H. Program offers services to the American Indian/ American Native population	1	1)	1)	1)	
I. Services offered/members referred to Mental Health Programs for Co-occurring disorder clients	1	1)	1)	1)	

Office Management Survey Criteria	Wt	Yes	No	NA	Score
Comments: Write comments for all "No" (0 points) and "N/A" scores. 14 points possible for this page 60 points possible for section Total					

Criteria	V. Perinatal Services Reviewer Guidelines
A. Relevant services offered to perinatal patients.	Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include: 1) Mother/child rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Evidence of coordination of ancillary services in the case management note.
B. Daycare facilities are available to Outpatient Perinatal Patients.	In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment.
C. Perinatal/Pediatric Patient Care	Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.

IXV. Perinatal Services

RN/MD/LPHA Review only

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
A. These standards apply to programs who provide SUD treatment to pregnant and parenting women, which includes: Pregnant women; Women with dependent children; Women attempting to regain custody of their children; Postpartum women and their children; or Women with substance exposed infants					
~~A. Relevant services offered to perinatal patients.~~ ~~Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include:~~	1	1)____	1)____	1)____	
1) The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them ~~Mother/child rehabilitative services.~~	1	2)____	2)____	2)____	
2) Does the Program adhere to priority admission requirements as follows: a. Pregnant injecting drug users b. Pregnant substance abusers c. Injecting drug users d. All Others	1	3)____	3)____	3)____	
3) The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days~~Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant.~~ ~~3) Evidence of coordination of ancillary services in the case management note.~~					

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s)					
1) Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission	**1**	1)____	1)____	1)____	
2) The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment	**1**	2)____	2)____	2)____	
3) The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission	**1**	3)____	3)____	3)____	
4) The Program shall maintain contact with individuals awaiting treatment admission	**1**	4)____	4)____	4)____	
~~B.~~5) The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided~~Daycare facilities are available to Outpatient Perinatal Patients.~~	**1**	5)____	5)____	5)____	

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
C. The Program shall:					
1) The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services	**1**	1)____	1)____	1)____	
2) The Program shall ensure that child care is provided on-site for participants' children between birth and 36 months while the mothers are participating in the program.	**1**	2)____	2)____	2)____	
3) Program has a policy that addresses therapeutic intervention for children of the women receiving SUD treatment services to address the child's: Developmental needs, Sexual Abuse, physical abuse and neglect.	**1**	3)____	3)____	3)____	
4) Program shall ensure Perinatal /Pediatric Patient Care is available	**1**	4)____	4)____	4)____	
5) Program shall provide or arrange for sufficient case management	**1**	5)____	5)____	5)____	
6) Program shall provide or arrange for primary medical care for women in treatment	**1**	6)____	6)____	6)____	
7) Program shall provide or arrange for primary pediatric care	**1**	7)____	7)____	7)____	
8) Program shall provide or arrange for transportation	**1**	____	____	____	
9) Program shall maintain a vehicle log	**1**	8)____	8)____	8)____	
10) Program shall provide or arrange therapeutic interventions for children	**1**	9)____	9)____	9)____	
11) Program shall program shall provide or arrange for required services	**1**	10)____	10)____	10)____	
~~**C.** Perinatal/Pediatric Patient Care~~		11)____	11)____	11)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 11 points possible this page 19 points possible for this section Total					

~~**Comments:** Write comments for all "No" (0 points) and "N/A" scores.~~
~~5 points possible this page~~

~~V. Perinatal Services~~

~~RN/MD/LPHA Review only~~

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
D.) Pregnant women are given preference in admission to recovery and treatment programs	1	1)____	1)____	1)____	
E.) Pregnant women are referred for interim services within 48 hours if a treatment slot is not available	1	2)____	2)____	2)____	
F.) Pregnant women who are waitlisted are referred to other programs	1	3)____	3)____	3)____	
G.) Injection drug-using pregnant women are admitted or interim services are provided	1	4)____	4)____	4)____	
H.) Child care is provided on-site for participants' children	1	5)____	5)____	5)____	
I.) Referrals are made based on individual assessments	1	6)____	6)____	6)____	
	1	7)____	7)____	7)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 points possible this page

Criteria	V. Perinatal Reviewer Guidelines
D. Provide or arrange for sufficient case management	The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services

~~**K. Provide or arrange for primary medical care for women in treatment**~~	~~The Program shall provide or arrange for primary medical care for women in treatment, including referrals for prenatal care.~~
~~**L. Provide or arrange for primary pediatric care**~~	~~The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children.~~ ~~Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds.~~ ~~Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment.~~
~~**M. Provide or arrange for transportation**~~	~~The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services or women in need of transportation.~~
~~**N. Vehicle log is maintained**~~	~~The Program shall ensure a vehicle log is maintained~~
~~**O. Provide or arrange therapeutic interventions for children**~~	~~The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.~~
~~**P. Program shall provide or arrange for required services**~~	~~The Program shall provide or arrange for the following services:~~ ~~(a) Educational/vocational training and life skills resources~~ ~~(b) TB and HIV education and counseling~~ ~~(c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding~~ ~~(d) Parenting skills-building and child development information~~

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
J.) Provide or arrange for sufficient case management	1	1)	1)	1)	
K.) Provide or arrange for primary medical care for women in treatment	1	2)	2)	2)	
L.) Provide or arrange for primary pediatric care	1	3)	3)	3)	
M.) Provide or arrange for transportation	1	4)	4)	4)	
N.) Vehicle log is maintained	1	5)	5)	5)	
O.) Provide or arrange therapeutic interventions for children	1	6)	6)	6)	
P.) Program shall provide or arrange for required services	1	7)	7)	7)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

7 points possible this page

19 points possible for this section

Total

VI. Pharmaceutical/Laboratory

RN/MD Review only

Pharmaceutical/Laboratory Services Survey Criteria	Wt	Yes	No	NA	Score
A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22					
1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	**1**	1)____	1)____	1)____	
2) Controlled drugs are stored in a locked space accessible only to authorized personnel.	**1**	2)____	2)____	2)____	
3) A dose-by-dose medication log is maintained.	**1**	3)____	3)____	3)____	
4) There are no expired medications on site.	**1**	4)____	4)____	4)____	
5) Site has a procedure to check expiration date and a method to dispose of expired medications.	**1**	5)____	5)____	5)____	
6) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	**1**	6)____	6)____	6)____	
~~6)~~7) Site has appropriate process for handling Sharps	**1**	7)____	7)____	7)____	
~~7)~~8) For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.	**1**	8)____	8)____	8)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 Points possible for this section

Total

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Medical Record Review Survey
Substance Use Disorder (SUD) Treatment Services

No. of Records: ____ ~~No. of LPHA/MD~~ _____

Facility Name		**Site ID**		**Date of Review**	
Full Address		**Phone**		**Fax**	
Contact Name/Title			**Email**		
Reviewer Name/Title					

Visit Purpose	~~Site-Specific Certification(s)~~	Clinic Type/Level of Care	
☐ **Initial Full Scope** ☐**Monitoring** ☐ **Periodic Full Scope** ☐**Follow-up** ☐ **Focused Review** ☐**Ed/TA** ☐ **Other** _____ **(type)**	~~Most current~~ ~~DMC Certification Number~~ _____ ~~Issuance Date:~~ _____	☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent ~~☐~~ If Youth services are offered in conjunction with regular services, at least 50% of charts must be that modality	Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 Perinatal Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 ☐ Withdrawal Management. (3.2) ☐ OTP/NTP ~~☐~~ If Perinatal services are offered in conjunction with regular services, at least 50% of charts must be that modality

~~CAP Issuance~~

~~If a singular record is missing 3 or more elements – a CAP shall be issued for those elements. Behavioral Health shall be notified in order to conduct a focused fiscal review.~~

~~If an element is missing across 2 or more records - a CAP shall be issued for those elements.~~

~~Scoring Procedure~~

~~Medical Record Scores~~

~~Purpose: Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey; and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.Compliance Rate~~

Purpose: Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey; and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Medical Record Review for Substance Use Disorder (SUD) Treatment Services

California Department of Health Care Services
Medi-Cal Managed Care Division

~~**Purpose:** Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey; and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.~~

Scoring: Survey score is based on a review standard of 10 records per Licensed Practitioner of the Healing Arts (LPHA). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each LPHA. Sites where documentation of patient care by all LPHA on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each LPHA sharing the records. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "□ □ **RN/MD/LPHA Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single LPHA. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all ~~six (6)~~ nine (9) sections. (Format points given) (Intake Services points given) (Care Planning Guidelines – treatment plans – NTP Only points given) (Care Planning Guidelines – Problem Lists – All LOC *except NTP* points given) (Treatment Services points given) (Discharge Services points given) (Care Coordination Services points given) (~~Recovery~~ Residential Services points given) (~~Residential~~ Perinatal/Family Services points given) **= (Total points given)**
Step 3: Subtract the "N/A" points from total points possible. (Total points possible) – (N/A points) = ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate. Total points given "Adjusted" total points possible Example: 267 305 = 0.875 X 100 = **88%**

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~~**Rationale**: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes~~

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	**AOD 12020**, "A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies."
B. Chart contents are securely fastened and consistently organized.	Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per PHC requirements.
~~**C.** ASAM Assessment for Adolescent Services~~	~~Clients age 12-21 years have received ASAM assessment and meet the adolescent treatment criteria for care that is being provided.~~ ~~ASAM – The 5 Levels of Addiction Treatment~~ ~~According to the widely used ASAM adolescent placement criteria, there are 5 basic levels of teen addiction treatment.~~ ~~**The 5 levels of care are:**~~ ~~Level 0.5 – Early intervention~~ ~~Level 1 – Outpatient~~ ~~Level 2 – Intensive outpatient treatment or partial hospitalization~~ ~~Level 3 – Residential or intensive inpatient treatment~~ ~~Level 4 – Medically managed intensive inpatient treatment~~ ~~To determine an appropriate level of care, professionals look at the situation across 6 assessment dimensions, which are:~~ ~~**Acute intoxication and withdrawal** – looking at how much medical management of withdrawal might be needed, for example.~~ ~~**Biomedical complications** – assessing for other health conditions that might complicate the recovery process.~~ ~~**Emotional, behavioral and cognitive conditions or complications** – looking for other mental health, developmental or behavioral conditions that might complicate the recovery process and lead to a higher level of care requirement.~~ ~~**Readiness to change** – the more ready and motivated for change the lower the treatment intensity that is required.~~ ~~**Relapse or continued use potential** – teens able to control use and maintain abstinence for moderate periods require less intensive treatment than teens unable to stop for even short periods of time.~~ ~~**Recovery environment** – Teens without a safe and stable recovery environment may require higher intensity care, such as residential treatment, to make lasting gains.~~ ~~**The ASAM shall be completed within 30 days of the first face-to-face interaction for youth.**~~

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

☐ ☐ RN/MD/LPHA Review only

Criteria Met=Yes Criteria not Met=No Criteria met: Give one (1) point. Criteria not met: 0 points Criteria Nnot applicable= : N/A Age/ Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age/Gender												
Admission Date												
Discharge Date												
A. An individual medical record is established for each member.	1											
B. Chart contents are securely fastened and consistently organized.	1											
C. ASAM Assessment for Adolescent Services												

Comments:

Criteria	II. Intake Services Reviewer Guidelines
A. Medical record contains a signed Consent to Release Information document.	There is evidence of a Consent to Release Information document signed and in the client file for review. This is per **42 CFR.** A signed release of information (ROI) is present and includes Partnership HealthPlan~~HC~~, the C~~c~~ounty, and entities ~~included in~~that assist in the ~~-~~coordination of care ~~to address needs~~ indicated in the treatment plan.
B. Medical record contains signed HIPAA notification.	There is evidence of a HIPAA (Health Information Portability and Accountability Act) notification signed and in the client file for review.
C. Medical record contains signed Client Rights document.	There is evidence of a Client's Rights document available in the client file for review.
D. Medical record contains signed Consent to Treatment document.	The beneficiary shall sign a consent for treatment form.
E. Medical record contains signed Program Rules document.	There is evidence of a Program Rules document signed and in the client file for review.
F. Medical record contains signed admission agreement.	There is evidence of an Admission Agreement and in the client file for review.
G. Medical record contains evidence of Medi-Cal/Partnership~~HC~~ eligibility verification.	There is evidence of Partnership~~HC~~ or Medi-Cal eligibility in the client file for review.
~~**H. Medical record contains signed Follow-Up Consent document.**~~	~~There is evidence of a Follow-Up Consent signed and in the client file for review.~~
~~H~~**I.** Medical record contains a documented physical exam.	A physical exam must be in documented in the patient's chart within 30 days of admission into program. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician, PA, or Nurse Practitioner (N.P.). ~~a.~~b. ~~Physician.~~ **OR** ~~b.~~c. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). ~~c. Put in Treatment Plan goals.~~ d. Contact Partnerships Care Coordination (CC) team ~~in Partnership Health Plan~~ to ~~help set up~~assist the ~~unestablished~~ member ~~with a network~~ with establishing a PCP provider ~~to perform a~~that will be able to perform the ~~physical~~necessary physical exam. • Perinatal Patients ○ Physician shall review the most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12 month period prior to the admission date. • Alternatively, a physician or non-physician medical practitioner may perform a physical examination within 30 calendar days of admission. 22 CCR § 51303, 42 CFR § 438.210(a)(4) **~~NOTE: This must be done within *30 days* of admission into program.~~** **PHC contract states if client has not been seen in longer than 6 months, client will be referred to Partnerhsip~~HC~~ Care Coordination department to aid in receiving medical care.**

I. Medical Record indicates MAT services were offered or member was referred	
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	
~~**J.** Medical record contains proof of pregnancy and/or delivery for perinatal patients.~~	~~Per Title 22 (page 11-12 Documentation, Modalities, and Services) for services offered to perinatal patients under DMC-ODS services the medical record must contain proof of pregnancy and/or delivery.~~

II. ~~I~~Intake Services

~~**Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.**~~

~~☐ ☐ **RN/MD/LPHA Review only**~~

Criteria Met=Yes **Criteria not Met=No** **Not applicable= N/A** **Criteria met: Give one (1) point.** **Criteria not met: 0 points** **Criteria not applicable: N/A** ~~Age/Gender~~		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score** ~~Score~~
A. Medical record contains a signed Consent to Release Information document.	1											
B. Medical record contains signed HIPAA notification.	1											
C. Medical record contains signed Client Rights document.	1											
D. Medical record contains signed Consent to Treatment document.	1											
E. Medical record contains signed Program Rules document.	1											
F. Medical record contains signed Admission Agreement.	1											
G. Medical record contains evidence of Medi-Cal/Partnership~~HC~~ eligibility verification.	1											
~~**H. Medical record contains signed Follow-Up Consent document.**~~												
~~H~~**I.** Medical record contains a documented physical exam within 30 days of admission.	1											
IJ. Medical Record indicates MAT services were offered or member was ~~/~~referred	1											
JK. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	1											
~~**J. Medical record contains proof of pregnancy and/or delivery for perinatal patients.**~~												

~~(10)~~

Comments:

Criteria	II. Intake Services Reviewer Guidelines (Continued)
KK. Appropriate documentation of admission and readmission criteria.	Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
LL. Medical Necessity determined appropriately.	Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. For beneficiaries 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. For beneficiaries under 21 years of age, a service is deemed medically necessary if the service can improve or correct a screened health condition, such as SUD. The service does not have to correct the issue. It can sustain, support, improve or make the condition more tolerable to be necessary. These services are covered under Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. **The diagnosis and medical necessity determination shall be completed within 30 calendar days of the first face-to-face interaction. Medical necessity determination for homeless patients shall be completed within 60 days.**
MM. Missed appointments and outreach efforts are consistently documented in the client's chart.	There must be documentation from the facility to the client for engagement in treatment. Medical record contains documentation of missed/excused group sessions and/or individual counseling sessions.
NN. Medical record contains evidence the provider accepts proof of eligibility as payment.	**Per Title 22,** providers must accept proof of Medi-Cal/Partnershhsip~~HC~~ eligibility as payment in full for treatment services rendered upon intake and monthly. **NOTE**: This is ***except*** when there is a share of cost (SOC).
OO. Medical record contains evidence of ASAM criteria used to determine medical necessity.	• ~~Adult clients must meet the ASAM criteria definition of medical necessity for services based on the ASAM criteria.~~ • American Society of Addiction Medicine (ASAM) Criteria shall be documented~~applied~~ by the diagnosing individual (Medical Director or LPHA) and used to determine placement ~~into the level of assessed services.~~and level of services needed. • Adults must meet the ASAM criteria definition of medical necessity for services. • Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. • The assessment shall include a typed or legibly printed name of the service provider, provider signature ~~of the service provider~~, provider title (or credentials), and date of signature. • Assessments shall be updated as clinically appropriate, ~~such as where the~~or as needed if the member's condition changes • For adolescent clients, a developmentally appropriate ASAM tool shall be used • ~~*Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.*~~ ~~• ASAM level of Care data shall be entered into the designated system for each assessment or re-assessment and within 7 days of the assessment/re-assessment.~~ ~~• The medical director or LPHA shall review each beneficiary's personal, medical and substance use history if completed by a counselor.~~ ~~• ALL LOC (except Residential)~~

	~~For beneficiaries 21 and over, the ASAM assessment shall be completed within 30 days of the client's first visit with an LPHA or registered/certified counselor~~ ~~For beneficiaries under 21, the ASAM Criteria assessment shall be completed within 60 days of the client's first visit with an LPHA or registered/certified counselor~~ ~~A full ASAM assessment shall not be required to begin receiving DMC-ODS services.~~ ~~The ASAM Assessment does not need to be repeated unless the client's condition changes.~~ ~~For homeless individuals: DMC-ODS services are reimbursable for up to 60 days if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.~~ • RESIDENTIAL ASAM Criteria Assessment is required before a ~~county~~ DMC-ODS plan authorizes a residential treatment level of care. **AUTOMATIC CAP IF ASAM IS NOT COMPLETED
PP. Medical record contains evidence of appropriate documentation during intake.	The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.

II. Intake Services (Continued)

~~Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.~~

~~☐ ☐ RN/MD/LPHA Review only~~

~~Criteria met: Give one (1) point.~~ ~~Criteria not met: 0 points~~ ~~Criteria not applicable: N/A~~ Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
K. Appropriate documentation of admission and readmission criteria.	1											
L. Medical Necessity is determined appropriately.	1											
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	1											
N. Medical record contains evidence the provider accepts proof of eligibility as payment.	1											
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	1											
P. Medical record contains evidence of appropriate documentation during intake.	1											

Comments:

~~**Rationale**: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.~~

Criteria	III. Care Planning Guidelines – Treatment Plans – NTP ONLY~~III. Treatment Services Reviewer Guidelines~~
A. Medical record contains the most recent Treatment Plan.	The most recent treatment plan must be in the file.
B. Medical record contains ~~treatment plan~~a legibly signed treatment plan during appropriate timeframe.	**Signature:** If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within ***15 calendar days*** of being signed by the counselor. Withdrawal Management within one business day of admission. • It must be signed by the beneficiary (client) and the counselor within ***30 days*** of admission to treatment. • IF the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. **Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment.** **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.

C. Treatment plan is client specific and AOD 7110 compliant.	Per **Title 22**, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished.
	• Statement of problems
	• Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed
	• Action steps ~~with~~should include:
	  ◦ Target dates
	  ◦ Type and frequency of counseling/services
	  ◦ Diagnosis as documented by the Medical Director or LPHA
	  ◦ Assignment of primary therapist or counselor
	  ◦ ~~If the beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination is required~~Documentation of physical exam requirements
	  ◦ ~~If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.~~
	  ◦ Documentation demonstrates the client played an active role in creating the treatment plan.
	  ◦ Recovery/discharge plan is part of ongoing treatment plan goals.
	• **Timeframe:** Within 30 calendar days from beneficiary's admission to treatment
	~~**NOTE: ALL elements need to be present in order to receive points for this criteria.**~~

A. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	The Ongoing Treatment Plan must be: • Completed ~~at MOST~~with 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per Title 22, It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment. Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.

III. Care Planning Guidelines – Treatment Plans – NTP ONLY

III. Treatment Services

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

☐ ☐ **RN/MD/LPHA Review only**

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Medical record contains the most recent Treatment Plan.	1											
B. Medical record contains a- legibly signed treatment plan during appropriate timeframe.~~Medical record contains treatment plan legibly signed during appropriate timeframe.~~	1											
C. Treatment plan is client specific and AOD 7110 compliant.	1											
D. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	1											

~~(3)~~ **Comments:**

Criteria	III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)
A. A problem list is established for each ~~client~~patient	The problem list supports the medical necessity of each service provided.
B. Problem list includes all the required elements	The problem list includes a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through the assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include all of the following, but is not limited to: A diagnosis given by a LPHA. Should include specifiers from the DSM, if applicable. Problems identified by provider acting within their scope of practice, if any. Problems or illness provided by client or significant support person, if any. Name and title of provider who identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
C. Problem list is updated in a reasonable time frame	Any problems identified during a subsequent intervention may be added to the problem list. Problems should be updated on an ongoing basis when there is a relevant change. Provider is required to update when problems change and in a reasonable time.

III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. A problem list is established for each client	1											
B. Problem list includes all the required elements	1											
C. Problem list is updated in a reasonable time frame	1											

Comments:

~~**Rationale**: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.~~

Criteria	I~~V~~H. Treatment Services Reviewer Guidelines~~s (Continued)~~
~~D. Medical record contains evidence that ongoing treatment plan meets Title 22 requirements.~~	~~The Ongoing Treatment Plan must be:~~ ~~• Completed at MOST 90 days after the signing of the initial Treatment Plan.~~ ~~• Signed by the counselor within 90 days after the initial Treatment plan.~~ ~~• Signed by the client within 30 days of being signed by the counselor.~~ ~~The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client.~~ ~~Per Title 22, It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client.~~ ~~• If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment.~~ ~~Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.~~
A~~E~~. ~~Attendance at~~ Ceounseling session attendance is~~s~~ ~~are~~ appropriately documented in the chart.	According to **AOD 8000 c. 1-4,** "The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals". This is also illustrated in **§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.**22 CA ADC § 51341.1
B~~F~~. Progress notes contain the minimum required documentation according to Tittle 22 and AOD 7100b.	For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b. Per **Title 22 and AOD 7100 b**, LPHA or Counselor must have these elements in their progress notes for **all** patients enrolled in outpatient services: 1) Topic of the session 2) Description of beneficiary's progress toward treatment plan goals 3) Date of each treatment service 4) Start and end time of each treatment service 5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within ~~7~~ 3 days of the session** 6) Identifies~~y~~ if the service was in-person, telephone or telehealth 7) ~~Document l~~Location of service and how confidentiality was maintained (if provided in the community) is clearly documented 8) If case management services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral. ~~8)~~9) For Crisis services, documentation must be completed within 24-hours of incidence. ~~**NOTE: ALL elements need to be present in order to receive points for this criteria.**~~
C~~G~~. There is evidence of at least two Evidence Based Practices (EBPs) being used and documented in the progress notes ~~.~~	Intergovernmental Agreement Exhibit A, Attachment ~~I~~I, ~~III, AA, 3, iii~~ Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • **Motivational Interviewing**: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • **Cognitive- Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. ~~• **Seeking Safety:** teaches present-focused coping skills to help clients attain safety in their lives.~~ • **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice, and control.

	• **Psycho-Education:** Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. • **Relapse Prevention:** A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment. • ~~**Living in Balance:** helps address issues in lifestyle areas that may have been neglected during addiction.~~

~~III.~~IV. Treatment Services (Continued)

~~Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.~~

~~☐ ☐ RN/MD/LPHA Review only~~

Age/Gender~~Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A~~ ~~Age/Gender~~	~~Wt~~	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score ~~Score~~
~~D. Medical record contains evidence that ongoing treatment plan meets Title 22 requirements.~~	~~1~~											
~~—~~Counseling session attendance is appropriately documented in the c **A.** ~~chart~~hart.**~~AE.~~** ~~Attendance at counseling sessions are appropriately documented in the chart.~~	**1**											
~~BF~~. Progress notes contain the minimum required documentation according to Ti~~t~~tle 22 and AOD 7100b.BHIN 23-068												
1) Topic of the session	**1**											
2) Description of beneficiary's progress toward treatment plan goals.	**1**											
3) Date of each treatment service.	**1**											
4) Start and end time of each treatment service.	**1**											
5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within ~~7~~3 days of the session**	**1**											
6) Identifi~~es~~ if the service was in-person, telephone or telehealth	**1**											
7) ~~Document l~~Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented	**1**											
~~8) If case management services are provided: additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral.~~	~~1~~											
~~CG~~. There is evidence of at least two Evidence Based Practices (EBPs) being used.	**1**											

~~(11)~~ Comments:

Criteria	IVH. Treatment Services Reviewer Guidelines (Continued)
H. Medical record contains evidence of the required number of monthly counseling sessions.	Per **Title 22 and AOD standards:** Outpatient - two individual or group counseling sessions each month Intensive Outpatient – minimum of one progress note per calendar weekprogress note for each session Residential – minimum of one progress note per calendar week daily When applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within the week 3 days There is evidence of the required number of counseling hours for each LOC. (OP 9 hours or less a week, IOP more than 9 hours a week, Residential: WM: NTPfollowing the calendar week when the counseling sessions were provided.
I. Progress notes contain a narrative of treatment plan progress, goals, and action steps.	Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps. The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.
J. Program provides individual and group counseling sessions to clients.	According to AOD 8000 a., "The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client's treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients' needs."
K. Medical record contains evidence of provision or offer of services outlined under Title 22.	There are services provided, and documented directly by the treatment facility, or there are referrals made for the following services: educational, vocational, counseling, job referral, legal services, medical and dental services, social and recreational services. Under Title 22, services must be provided or offered to the client receiving Substance Use Disorder Treatment Services for- education, vocation, counseling, job referral, legal, medical, and dental, social and recreational. Case management
KL. Medical record contains evidence of provider coordination of care./Case Management	Both the discharging and admitting PROVIDER agencies shall shall ensure the transition of the beneficiaries to appropriate LOC. This may include a step-up or step-down in covered DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary. Provider Agencies shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in the beneficiary record. Performance Standard: Transitions between levels of care shall occur within five (5) and no longer than ten (10) business days from the time of re-assessment indicating the need for a different level of care. The PROVIDER shall screen for and link clients with mental and physical health, as indicated. Also ensure that beneficiaries have access to recovery supports immediately after discharge or upon completion of an acute stay. A warm hand off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

~~**M.** Medical record contains evidence of justification for continuation of treatment services exceeding 6 months.~~	~~Identifying the DSM diagnostic code and establishing the medical necessity for treatment and services, and justifying the need to continue services must include documentation.~~

IV~~H~~. Treatment Services (Continued)

~~**Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.**~~

~~☐ ☐ RN/MD/LPHA Review only~~

~~Criteria met: Give one (1) point.~~ ~~Criteria not met: 0 points~~ ~~Criteria not applicable: N/A~~ Age/Gender	~~Wt~~	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score ~~Score~~
H. Medical record contains evidence of the required number of monthly counseling sessions.	**1**											
I. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	**1**											
J. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	**1**											
~~**K.** Medical record contains evidence of provision or offer of services outlined under Title 22.~~	~~**1**~~											
K.~~L~~. Medical record contains evidence of provider coordination of care to ensure smooth transitions between LOCs~~.~~	**1~~1~~**											
~~**M.** Medical record contains evidence of justification for continuation of treatment services exceeding 6 months.~~	~~**1**~~											

Comments:

~~**Rationale**: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment.~~

Criteria	~~I~~V. Discharge Services Reviewer Criteria
A. ~~A~~ Discharge ~~plan~~ plan or Discharge Summary ~~present for each client.~~is documented in the chart	Per **Title 22:** "A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact." If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: • A description of each of the beneficiary's relapse triggers. • A plan to assist the beneficiary to avoid relapse when confronted with a trigger • A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the ~~client~~ patient and the counselor	During the LPHA's or counselor's last face-to-face treatment with the beneficiary~~.~~, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the ~~beneficiary~~ patient and shall be documented in the ~~beneficiary~~ patient's record. **This is N/A if the provider loses contact with the client.**
C. ~~Discharge summary for clients~~ Discharge plan or summary shall include the following elements~~who terminate services include required elements according to AOD7120b~~.	This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit. According to **AOD 7120 b. ,** A discharge summary ~~that includes~~shall include the following elements: 1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program; 2) Description of treatment episodes; 3) Description of recovery services completed 4) Current alcohol and/or other drug usage 5) Vocational and educational achievement 6) Client's continuing recovery or discharge plan signed by counselor and client 7) Transfers and referrals 8) Client's comments 9) Beneficiary's prognosis 10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode. ~~11)~~ ~~**Note: Must meet all of this criteria in order to receive the point.**~~
~~**D.** If client was unavailable to complete a Discharge Plan, the *Discharge Summary* was completed within 30 days of the last face-to-face contact with the client.~~	~~This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit.~~

IV. Discharge Services

Note: A Discharge Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

☐ ☐ **RN/MD/LPHA Review** only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score** **Score**
A. A Discharge plan or Discharge Summary is documented in the chartDischarge plan or summary is present for each client and signed by both client and counselor..	**1**											
B. The discharge plan is signed by both the patient and the counselor	**1**											
B. The discharge plan is signed by both the client and the counselor.The discharge plan is signed by the patient and the counselor	**1**											
C. Discharge plan or summary for clients that terminate services shall include the following elements: required elements according to AOD7120b.												
1) 1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;	**1**											
2) 2) Description of treatment episodes;	**1**											
3) 3) Description of recovery services completed	**1**											
4) 4) Current alcohol and/or other drug usage	**1**											
5) 5) Vocational and educational achievement	**1**											
6) 6) Client's discharge summary signed by counselor and client	**1**											
7) 7) Transfers and referrals	**1**											
8) 8) Client's comments	**1**											
9) 9) Beneficiary's prognosis	**1**											
10) 10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	**1**											
11) Medication needs have beenwere addressed in the discharge planning	**1**											
D. If client was unavailable to complete a Discharge Plan, the Discharge Summary was completed within 30 days of the last face-to-face contact with the client.	**1**											

Comments:

~~**Rationale**: Medical records support coordination and continuity of care with documentation of past and present health status, medical treatment and future plans of care.~~

Criteria	VI. ~~Recovery Services~~Care Coordination Reviewer Criteria
A. Care coordination shall be provided ~~to a beneficiary~~ in conjunction with all levels of treatment.deemed necessary~~Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.~~	Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.~~Beneficiary concerns are identified (triggers, relapse, preventative measures to prevent relapse). There needs to be clear evidence that there is a focus on coordination of care for the identified individual needs of the beneficiary.~~
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services) ~~Care coordination services shall include one or more of the following components:~~~~Recovery Discharge is appropriately documented.~~	- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. - Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.~~Recovery Discharge summary must be completed within 30 days of the last face-to-face client contact.~~
C. Clinical Peer to Peer Consultation must be documented with a progress note	Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction Psychiatrists, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to beneficiaries. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.
~~C. The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.~~	~~**Per AOD 7100 a**, Support plan, proposed coping strategies and information on relapse triggers need to be included in the Recovery Plan.~~ ~~"a. If a program develops a recovery plan, it shall include the following:~~ ~~1. A statement of challenges the client expects to encounter during recovery.~~ ~~2. A statement detailing methods of handling the challenges of recovery.~~ ~~3. A statement of actions that will be taken by the program and/or client to prepare for the challenges of recovery."~~

VI. ~~Recovery Services~~Care Coordination Automatic CAP if no or N/A ~~V.~~

~~**Note: A Recovery Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.**~~

~~☐ ☐ **RN/MD/LPHA Review only**~~

Age/Gender~~Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A~~ ~~Age/Gender~~	~~Wt~~	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score ~~Score~~
A. ~~Care coordination shall be provided to a beneficiary in conjunction with all levels of treatment.~~ Care coordination shall be provided in conjunction with all levels of treatment deemed necessary ~~Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.~~	1~~1~~											
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services) ~~Recovery Discharge is appropriately documented.~~	1~~1~~											
C. Clinical Peer to Peer Consultation must be documented with a progress note ~~Clinical Consultation must be documented with a progress note The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.~~	1~~1~~											

Comments:

~~**Rationale**: These guidelines are pulled from the DHCS website http://www.dhcs.ca.gov/provgovpart/Pages/Incidental-Medical-Services.aspx.~~

Criteria	VI. Residential Reviewer Criteria Only if Applicable
A. Medical record contains evidence of prior authorization for services.	Residential Treatment requires a Prior Authorization for services.
B. ~~B.~~Evidence of multidimensional LOC assessment within 72 hours of admission is present	Evidence of multidimensional LOC assessment is completed within 72 hours of admission is present
CB. There is oversight of self-administered medications.	There is documentation present in the chart that illustrates oversight of patient's taking their medication.
DC. Medical record contains documentation of a TB test, ~~and~~ results, and services offered.	A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client. There has been Tuberculosis (TB) testing done and care received based on results. It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
~~**D.** Medical record contains evidence that TB services are provided or offered to clients receiving SUD treatment.~~	~~It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).~~
E. Adult beneficiaries in Residential ~~treatment~~Treatment shall be re-assessed every 30 days, Youth every 30 days.	Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments.

~~VI.~~V. Residential

~~Note: A Residential Treatment section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.~~

~~☐ ☐ RN/MD/LPHA Review only~~

~~Criteria met: Give one (1) point.~~ ~~Criteria not met: 0 points~~ ~~Criteria not applicable: N/A~~ Age/Gender	~~Wt~~	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score ~~Score~~
A. Medical record contains evidence of prior authorization for services.	1~~1~~											
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	1											
C~~B~~**.** There is oversight of self- administered medications.	1~~1~~											
~~C~~D**.** Medical record contains documentation of a TB test performed, ~~and~~ results, and services offered ~~.~~with a diagnosis of TB	1~~1~~											
~~**D.** Medical record contains evidence that TB services are provided or offered to clients receiving SUD treatment.~~	~~1~~											
E. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days	1~~1~~											

Comments:

Criteria	VII. Perinatal/Family Criteria – Only if Applicable
A. Relevant services offered to perinatal patients or clients with families.	1) Mother/child/ family rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Educational/vocational training and life skills resources 4) TB and HIV education and counseling 5) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information 6) Child care is offered for women- to receive primary medical care services gender-specific treatment services.
B. Daycare facilities are available to Outpatient Perinatal Patients-.	In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment Program provides/-arranges for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's: i. Developmental needs; ii. Sexual abuse; iii. Physical abuse; and Neglect
C. Perinatal/Pediatric Patient Care	Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
E. Interim services have been offered	If client waited more than 48 hours for treatment, indication of the offering of interim services ~~as well as~~and the outcome of that offering is included in the ~~client's~~ patients chart
F. IVDU Interim services have been offered	If the patient~~client~~ uses needles, documentation that ~~the~~~~The Program documented either~~the patient received expedited admission within 14 days after the request or within 120 days if interim services were~~are~~ provided. ~~within the client's chart (IVDU)~~
G. Transportation have been offered/provided	Evidence of transportation provided to perinatal, postnatal, or well child appointments indicated within chart

H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	

VII. Perinatal/Family Criteria – Only if Applicable

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Relevant services offered to perinatal patients or clients with families.	1											
B. Daycare facilities are available to Outpatient Perinatal Patients.	1											
C. Perinatal/Pediatric Patient Care	1											
E. Interim services have been offered	1											
F. IVDU Interim services have been offered	1											
G. Transportation have been offered/provided	1											

H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	1											

Comments:

If more than one Reviewer, both must sign here.

Reviewer 1 Signature: _____ Reviewer 2 Signature: _____

Reviewer 1 Name: _____ Reviewer 2 Name: _____

Reviewer 1 Title: _____ Reviewer 2 Title: _____

Reviewer Comments/Notes:

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

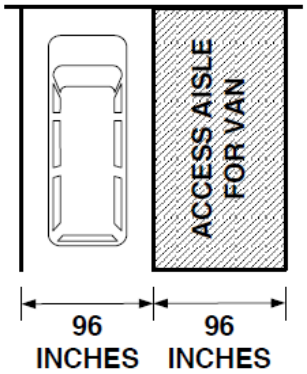
I certify that there have been no changes since the last physical accessibility review:

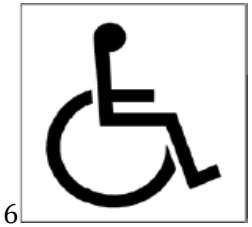
Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

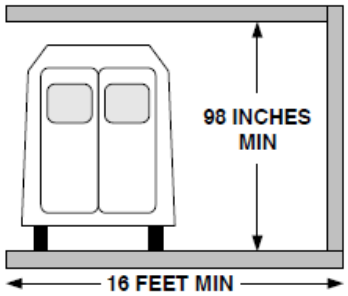
Name: _____ Signature: _____ Date: _____

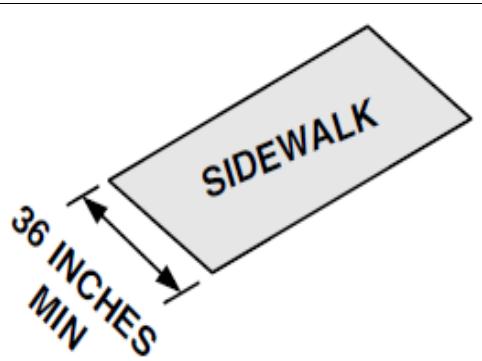
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

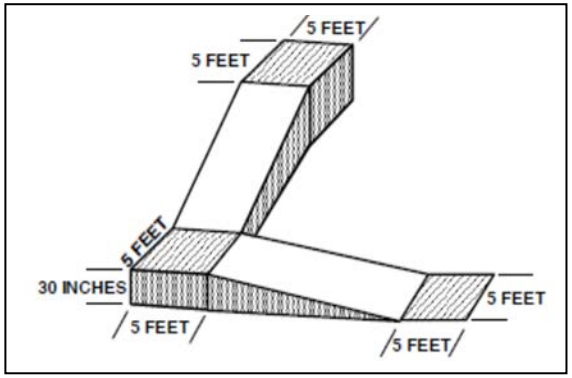
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

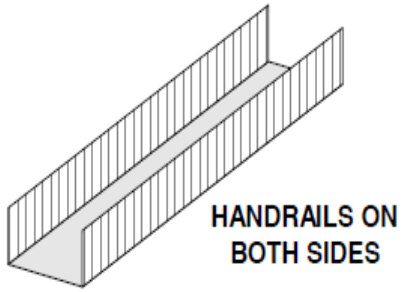
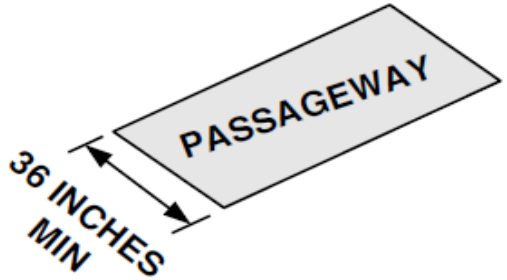
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

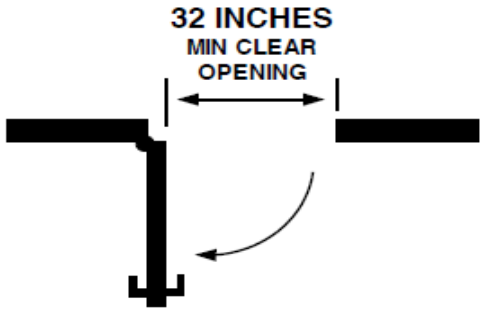
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

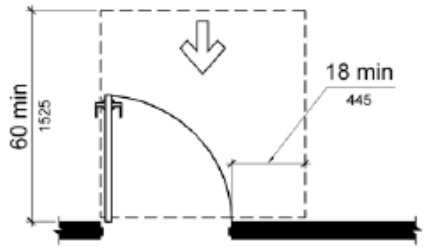
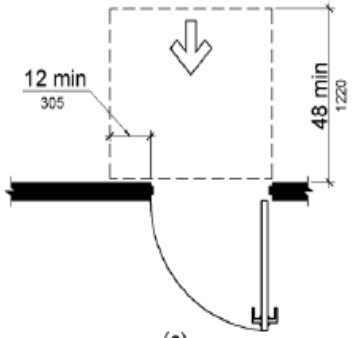
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

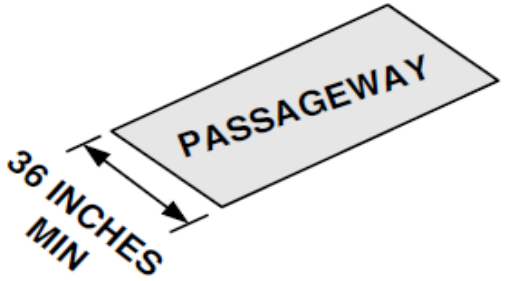
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

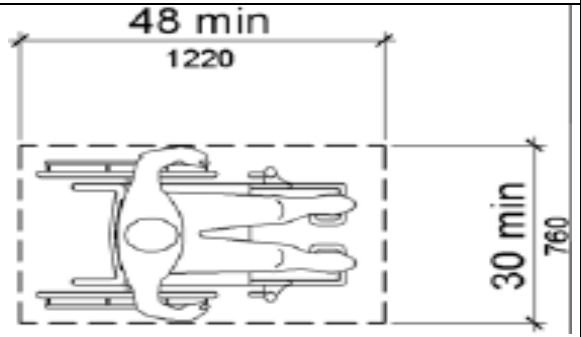
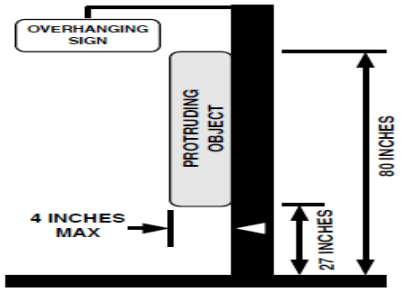
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

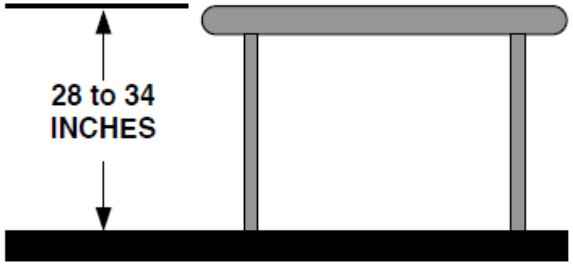
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

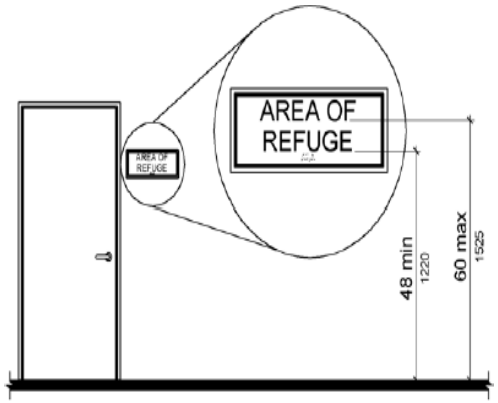
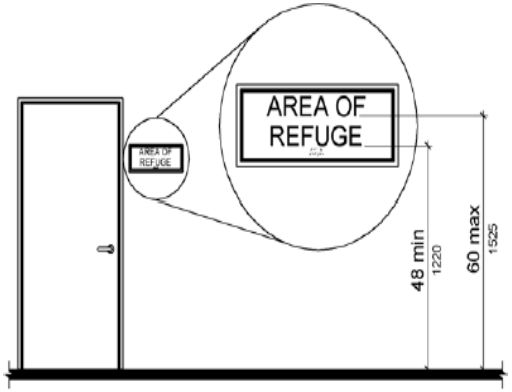
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

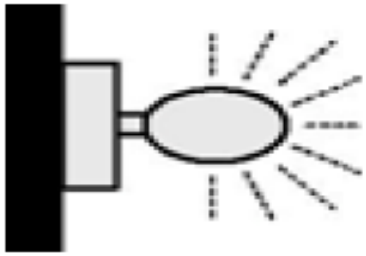
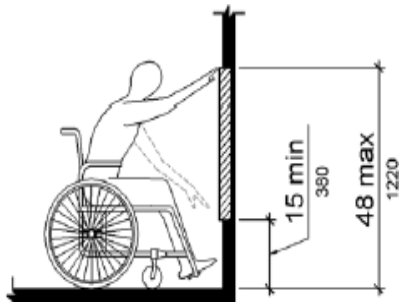
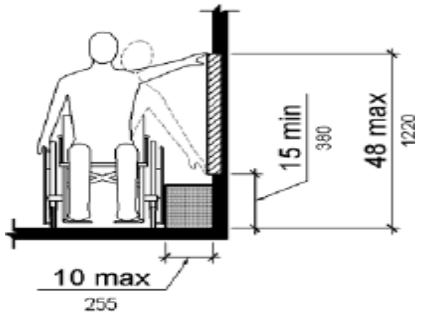
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

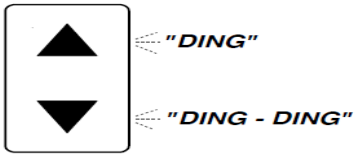
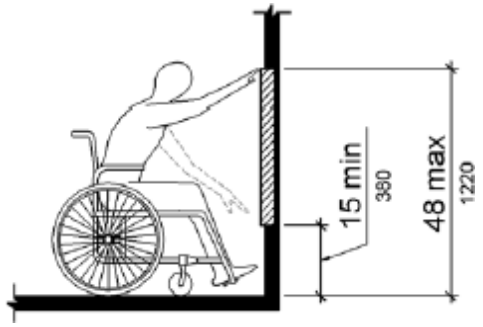
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

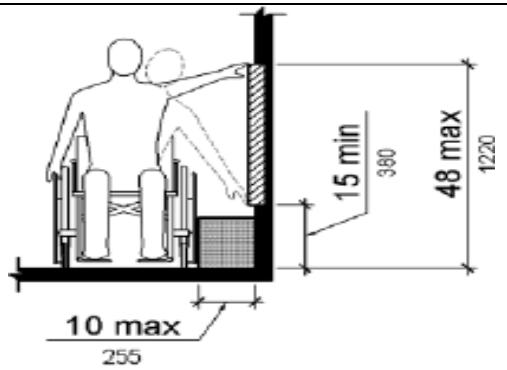
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

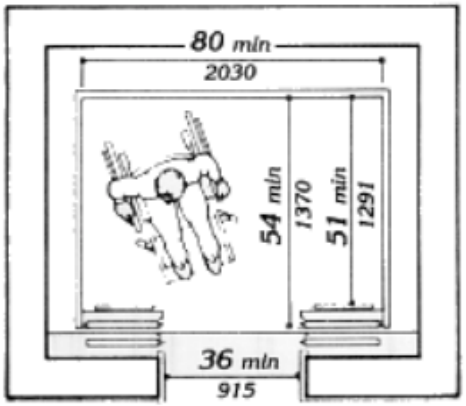
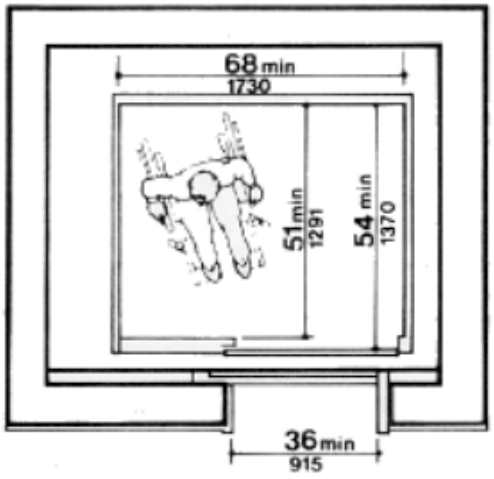
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

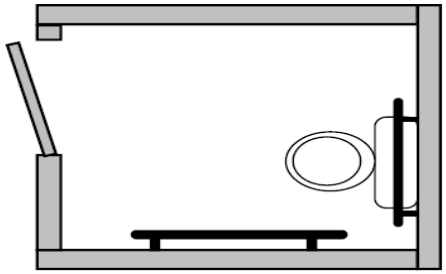
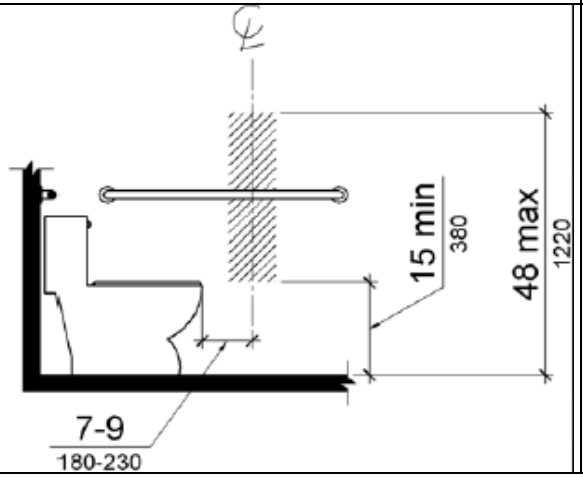
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

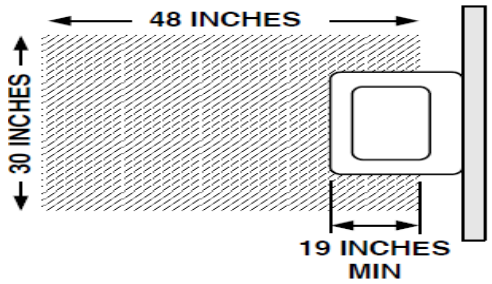
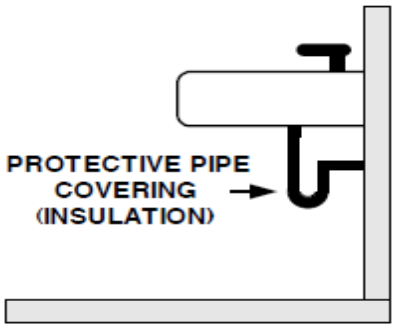
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

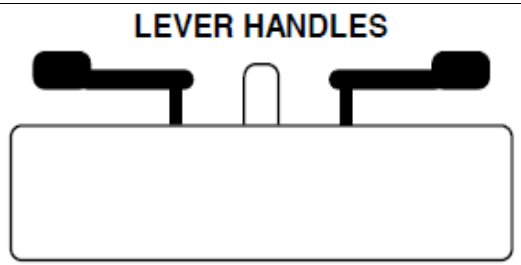
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				

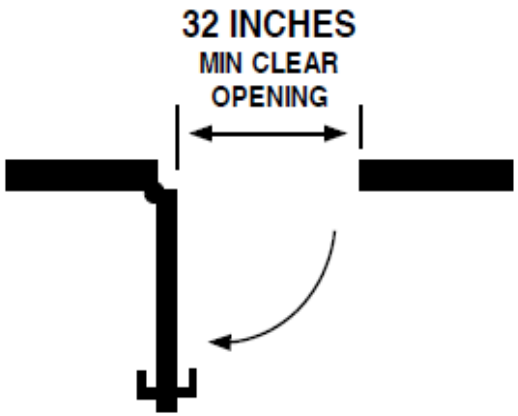
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

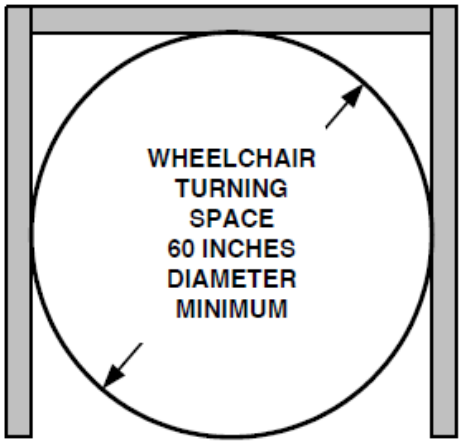
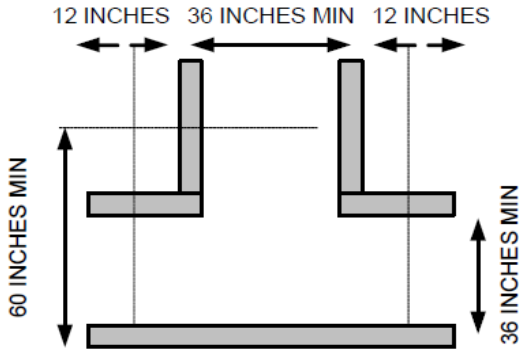
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

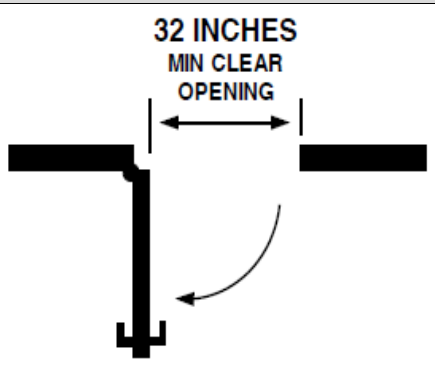
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

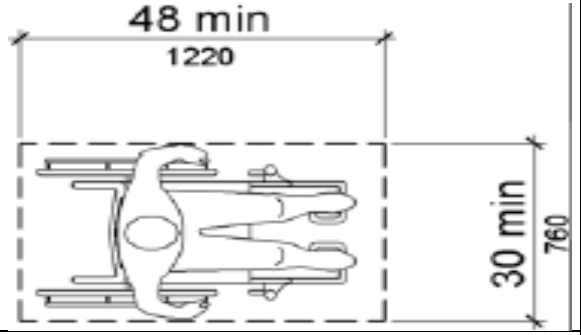
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

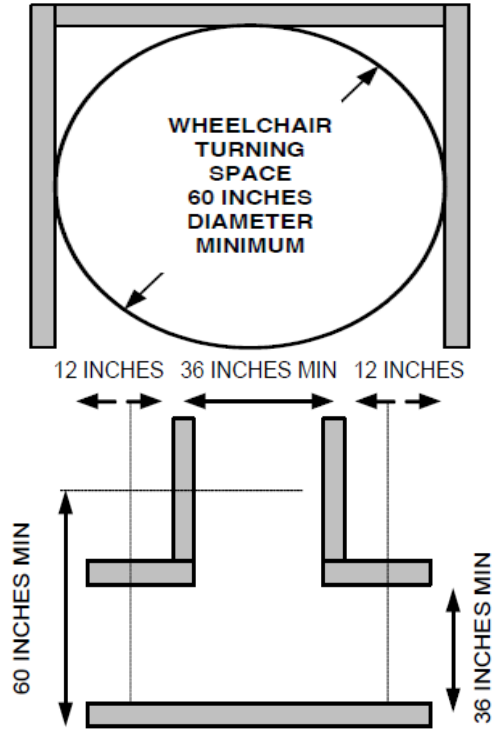
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.  				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="5">Policy/Procedure Number: MPQP1016 (previously QP100116)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="5">Policy/Procedure Title: Potential Quality Issue Investigation and Resolution</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 01/20/1996</td><td colspan="5">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="5">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. CMP30 - Records Retention and Access Requirements
B. CMP36 - Delegation Oversight and Monitoring
C. MPCR200 - Credentialing Committee and CMO Credentialing Program Responsibilities
D. MPCR600 - Range of Actions to Improve Practitioner Performance
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPCR602 – Reporting Actions to Authorities
G. MPQD1002 – Quality and Performance Improvement Program Description
H. MPQP1053 – Peer Review Committee

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Grievance and Appeals

III. DEFINITIONS:

A. ~~A~~ Potential Quality Issue (PQI)~~: is defined as a~~ A possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
B. ~~A~~ Q~~q~~uality I~~i~~ssue ~~: is defined as a~~ A confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
C. C~~A c~~linician or P~~p~~rovider ~~: A is a~~ny individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.
D. ~~A~~ Corrective Action Plan (CAP)~~: A is a~~ plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and time~~-~~frames for completion.
E. Severity Level: Refer to Attachment A: Practitioner Performance and Systems Scores Grid
F. Egregious Lapse: Where the quality of care was significantly outside accepted and common standards of practice and/or where the adverse outcome of the care provided was especially serious.
G. ~~Performance Improvement Clinical Specialist (PICS) Nurse~~Quality Investigator: ~~a~~A Registered Nurse (RN) responsible for assessing and improving the quality of care provided by the providers serving Partnership HealthPlan of California (~~PHC~~ Partnership) members. These nurses perform the PQI Investigations and prepare the files for review by the CMO/ physician designee.

H. Provider of Concern (POC): ~~—~~ T ~~t~~he clinician, service provider, vendor, agency, facility or organization under review during a PQI investigation.

IV. ATTACHMENTS:

A. Practitioner Performance and Systems Scores Grid

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES

1. PQIs are identified through the systematic review of a variety of ~~data~~ sources, including but not limited to:
   a. Information gathered through concurrent, prospective, and retrospective utilization review;
   b. Referrals from any health plan staff;
   c. Facility Site Reviews;
   d. Claims and encounter data;
   e. Pharmacy utilization data;
   f. Health Effectiveness Data Information Set (HEDIS®) medical record abstraction process;
   g. Medical record audits;
   h. Grievances and Appeals
2. PQI reviews shall be conducted on services provided by:
   a. Contracted clinicians or providers, including subcontractors and pharmacists, who provide inpatient and/or outpatient services;
   b. Non-contracted providers: complaints involving non-contracted providers will be discussed with the Chief Medical Officer (CMO)/designee to determine next steps prior to ordering medical records;
   c. Durable Medical Equipment (DME), medical transportation and respiratory supply vendors;
   d. ~~Home Health vendors; skilled nursing facilities; long term care and rehabilitation facilities;~~ Hospitals, skilled nursing facilities, long-term care and rehabilitation facilities, and Home Health agencies.
   e. Ancillary service providers including, but not limited to~~,~~ laboratory and radiology, physical therapy, acupuncturists. ~~;~~
   f. Behavioral Health: the Behavioral Health Clinical Director reviews complaints regarding behavioral health ~~are reviewed by the Clinical Director, Behavioral Health~~ for investigation, intervention, and resolution as part of the general PQI review process.

B. PQI REFERRAL

1. A PQI may be reported by any of the following:
   a. Any ~~PHC~~ Partnership staff member;
   b. Anonymously using the ~~PHC~~ Partnership "confidential line" which is available 24 hours a day, 7 days a week (1-800-601-2146);
   c. Any member of the community; ~~or~~
   d. Any contracted or non-contracted clinician or provider.
2. A PQI is referred internally to the Quality Improvement (QI) department via the PQI Referral Intake System found on PHC4ME. For external PQI referrals and general PQI inquiries, send a secure email via PQI@Partnershiphp.org. The email must be encrypted through a secure messaging system.

3. Time-frame limitations: ~~PHC~~ Partnership will not routinely investigate a PQI which occurred more than two years prior to the notification of the ~~complaint~~ concern to the QI department.

~~3.~~a. Cases occurring more than two years before reporting ~~that may have~~involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee.

C. PQI REVIEW PROCESS

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

1. PRIMARY REVIEW BY ~~PERFORMANCE IMPROVEMENT CLINICAL SPECIALIST (PICS~~QUALITY INVESTIGATOR~~)~~ REGISTERED NURSE (RN) – Upon receipt of a PQI referral, the Patient Safety-Quality Investigations team's ~~QI~~ Project Coordinator opens a new case file in the PQI database, and assigns the case to a ~~PICS~~ Quality Investigator-RN (Investigator) to conduct the primary review and manage the case to completion.
   a. The Investigator conducts a thorough internal investigation on all potential quality issues (provider performance and/or system issues), including a review of the incident as reported or alleged, as well as relevant medical records, and gathers responses from providers or other Partnership~~PHC~~ departments, when appropriate. The Investigator then presents a summary of the case at the internal PQI team rounds for a secondary review and assignment of the severity level by the CMO/physician designee. (S~~s~~ee Attachment A ~~-~~ Practitioner Performance and Systems Scores Grid.)~~.~~
   b. If the issue is urgent or the potential severity may represent an egregious lapse in the quality of care, the Investigator will immediately contact the CMO/physician designee for resolution and next steps. The CMO/physician designee may refer to an outside Peer Review Organization (PRO) depending on the case and availability of an appropriate PRO.
   c. If the PQI occurred at an organization with an accredited PRO responsible for oversight of the care provided by the Clinician or Providers of Concern (POC), the PQI is found to be urgent, and the potential severity of the PQI has been determined by the CMO/physician designee to reflect an egregious lapse in quality, the PQI will be referred to the outside PRO. A response will be required from the PRO acknowledging receipt of the letter of concern. When a referral is sent to the outside PRO, a copy will be sent to the Chief of Quality and Quality Director at the outside organization and the POC will be notified of the PRO referral. If the severity score is not determined prior to the referral, the case will be leveled ~~as:~~as Provider, Unable to Determine (PUTD) or System, UTD.
      i. Notification that another PRO is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process.
   d. If ~~the PICS RN~~Investigator~~the~~ Investigator determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other ~~involved~~ appropriate departments for action and follow-up (e.g., Member Services or Care Coordination).
2. SECONDARY REVIEW BY CMO/PHYSICIAN DESIGNEE – The CMO/physician designee review includes assessment of, but not limited to: appropriate level of care; appropriate diagnostics; therapy and treatment; technical expertise; referral; consultation; timeliness; and adequate documentation. During the CMO/physician designee review, the CMO/physician designee may:
   a. Generate a letter to the provider of concern describing the issue and requesting investigational response and may also request additional documentation including related to system issues. If no response is received within the requested timeline (usually 14 days,

although providers may request extensions), an attempt to contact the provider will be made via any or all of the following methods: a second letter, telephone call, fax, or secure email. A ~~a rate severity~~severity level ~~is~~may be ~~given~~ determined based upon available documentation.

b. Assign a severity level ~~and instruct the PICS RN to close the case~~ (see Attachment A - Practitioner Performance and Systems Scores) and instruct the Investigator to close the case or prepare the case for presentation to the Peer Review Committee (PRC) depending on the ~~significance~~ severity level of the findings. Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions.

c. Generate a letter to the provider of concern (see Attachment A - Practitioner Performance and Systems Scores) for the action/follow-up recommended or required, based upon ~~for~~ the severity level assigned and as determined by the reviewing physician(s).

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

e. Emergency action: If the CMO/physician designee determines that a situation exists where immediate action is required to protect the life or well-being of a Partnership~~PHC~~ member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life or safety of any patient or person, the CMO (or, if the CMO is unreachable, the Partnership Physician Chair of the Credentials Committee or other ~~/~~physician designee) may summarily suspend ~~or terminate~~ the POC's credentialed status. See policy MPCR601 – Fair Hearing and Appeal Process for Adverse Decisions.

~~e.~~f. Upon determination that a PQI case is out of ~~Partnerships'~~sPartnership's jurisdiction (~~i.e.~~ e.g., ~~acute~~serious mental health cases) ~~a referral will be made~~the case will be referred to the appropriate oversi~~te~~eight body (~~i.e.~~e.g., County Mental Health).

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

a. All PQI cases designated a severity level P2 or S2 ~~or P2~~or higher (see Attachment A for descriptions) by the CMO/ physician designee must be referred to the PRC for review and determination of next steps.

b. The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any letters to and responses from POCs and all other relevant documentation and correspondence related to the case.

i. Following review and discussion of the case, the PRC may uphold the original scoring determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review.

~~a.~~ii. If a score is leveled, the PRC will direct the ~~Patient~~ Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid

~~b.~~c. PRC recommendations for cases determined to be S3/P3 may be forwarded to the Credentials Committee for possible action.

~~c.~~d. In cases where the PRC recommends ~~that the Credentials Committee request~~ a Corrective Action Plan (CAP):

i. ~~A notice~~Notice shall be given to the POC within seven calendar days of the recommendation of a CAP being required. Grounds for recommending a CAP include but are not limited to:

a) failure to provide professional services of acceptable quality;

b) failure to follow Partnership ~~PHC~~ utilization review policies;
c) failure to follow Partnership ~~PHC~~ quality improvement policies;
d) failure to treat patients for whom the provider is responsible;
e) failure to adhere to the provider contract or Partnership ~~PHC~~ policies;
f) acts constituting disruptive behavior or an inability to work collaboratively with others;
g) failure to report adverse action by another peer review body or a hospital

ii. If a CAP is recommended, it is included in the PQI case file. A CAP includes the goals, objectives, desired outcomes, time~~-~~frames, persons responsible, follow-up, and CAP evaluation. The time~~-~~frame for clinicians to respond to a CAP is 30 calendar days. The POC will be sent a reminder notice on day 15. If the CAP is not received by Partnership ~~PHC~~ by day 31, the ~~PICS RN~~Investigator will contact the POC. A 15-days extension may be granted for reasonable concerns. If the CAP has not been received by day 46, the case is forwarded to the CMO/physician designee for further determination, including possible review by the Credentials Committee. Upon completion, the ~~CAP will be reviewed~~ CMO/ physician designee reviews the CAP~~and the results reported to the PRC.~~ and either sends a letter to the POC ~~an~~ acknowledging completion with no further action required, or sends a ~~ement~~ letter ~~will be sent to the POC stating that the CAP meets all requirement or a letter~~outlining ~~advising~~ what areas ~~do not meet the requirement, needs~~still need to be addressed~~,~~ and ~~to resubmit~~submitted, again ~~a revised CAP~~ within 14 days of receipt of the follow-up letter. ~~The~~ CAP results ~~will be~~are reported to the PRC.

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

iv. For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the POC to verify that the deployed corrective action is effective and eliminates the noted deficiencies.

~~e)~~

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

5. In the following situations, in addition to the other measures applicable to S3/P3 cases, immediate referral will be made to the CMO for consideration of the need for immediate follow-up and potential rapid escalation to the Credentials Committee, Board of Commissioners, Medical Board of California~~, and~~ or other regulatory agency, ~~and/or~~ and/or law enforcement agencies, depending the severity of the concern:
   a. actions or omissions constituting unethical or unprofessional conduct;
   b. sexual misconduct with or sexual harassment of a patient;
   c. ~~sexual harassment of a patient and~~ discriminatory actions or behavior towards a patient based on rac~~ial~~, gender, gender identity, religious beliefs, disability status, socioeconomic status, or other factors generally viewed as constituting unfair bias.
6. Any POC has the right to request a Fair Hearing for certain adverse actions as outlined in Partnership ~~PHC~~ policy~~. Please refer to~~ MPCR601 Fair Hearing Process for Adverse Actions. This policy also describes reporting requirements to the ~~PHC~~ Partnership Board of Commissioners.
7. A report is filed per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities as required by Section 805.01 of the California Business and Professions Code. Pursuant to Section 805.01, when a peer review body makes a final decision following a formal investigation of one of the categories of misconduct identified below, it must file a report with the Medical Board of California and proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision. A similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency. The investigation findings trigger reporting obligations when the following "may" have occurred:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
   b. The use of, or prescribing for or administering to ~~himself or herself~~themselves of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use;
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.
8. All PRC/Credentials Committee recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action. If a quality issue has multiple clinicians or providers involved in care who are separately evaluated by a clinical reviewer or the PRC, determinations of severity ratings will not be final until all involved clinicians have been assigned final severity ratings. If any data is pending before making a final determination for one involved clinician, the others clinicians' determinations will be pending and notifications will not be made until all determinations are complete.
9. For contracted providers who are not individuals (e.g., hospitals, skilled nursing facilities, community clinics), where a final determination is an S1, S2, or S3, the case will be referred in writing to the quality assurance committee, Medical Director or other designated authority of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has or will be taken to prevent similar system issues in the future. These system issues will be tracked and reviewed at the time of the facility's re-contracting. If

the CMO or PRC determines that the system issue at a facility places ~~our~~ Partnership members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.

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

D. OPPORTUNTITIES FOR DISCUSSION BY THE CLINICIAN OR PROVIDER OF CONCERN (POC)

1. The POC will be sent a letter of concern depending on the severity level assigned. The letter will include the following:
   a. patient name and demographics;
   b. brief statement explaining the purpose of quality review activities;
   c. brief summary of the background of the case;
   d. confidentiality statement; and
   e. CMO/~~ or~~ physician designee signature.
2. The POC will be given an opportunity to discuss the case by one of these methods: written, telephonic, in-person, or by encrypted e-mail. The POC will have 14 calendar days to respond.
3. If the POC fails to provide additional information within the required time-frame, the ~~PICS RN~~Investigator will send a reminder letter with an immediate response required. If no response is received, the CMO or designee may choose to level the case using the information on hand. If an individual clinician is a member of a contracted medical group, the Director of the Quality Assurance (QA) department and/or Medical Director of the group will also be sent a copy of the request for additional information. In addition to the content in the original letter, the following will be included:
   a. A reminder that the organization's Partnership ~~PHC~~ contract requires them to adhere to Partnership ~~PHC~~ policies and procedures, which includes timely response to potential quality incidents; and
   b. An additional 14 calendar days deadline for response.
4. If there is no response from the POC ~~for a second time~~following the second request, the CMO or designee may contact the POC to ensure the letter was received and request a response.
5. When additional information is received from the POC, the CMO or designee may refer the case to the PRC, a physician on the PRC with the same or a similar specialty, or to an outside physician with the same specialty. The original reviewer should be among those who review the additional information. In all such cases, the initial physician reviewer will conduct final review and recommend a level, which is then presented to the PRC for final ~~approval~~determination.
6. The POC will receive a final determination letter that will include the following:
   a. a summary of the case findings, including a preferred or required course of action;
   b. final severity level and any actions to be taken;
   c. a statement of ~~any~~ opportunity to provide any additional information;
   ~~c.~~d. confidentiality statement; and,
   ~~d.~~e. CMO/physician designee signature.
7. Phone conversations between a POC and a peer reviewer or the CMO/physician designee will be documented with written notes, which will be entered into the peer review file and sent to the clinician in a subsequent peer review letter, to offer the opportunity to make corrections.

E. TRACK AND TREND REPORTS

1. Track and trend reports by provider and by level of severity are reported to CMO or physician designee every six months. This includes adverse event trend analysis to assess providers and site rates of adverse events over time.
2. The CMO or physician designee may consider a focused review, or other actions as outlined in section

VI.C.4 when any practitioner demonstrates performance below acceptable standards of care or if there is evidence of poor quality that could affect the health and safety of ~~its~~ Partnership members. The CMO or physician designee will implement a Practice Improvement Plan as needed. This will include specifics regarding the area of focus that requires improvement, timeframes and required documentation of completion.

3. Thresholds for consideration of a focused review:
   a. Two or more P2 or above quality of care scores in the last 24 months; or
   b. Significant trend of service or quality complaints exceeding the established threshold.

F. MEDICAL RECORD REQUESTS
1. Upon determination that medical records and other related documents are required for the case review, the POC is requested to submit documents to the Partnership ~~PHC~~ QI department within 30 calendar days from the date of the request.
2. If ~~medical records~~the information requested is ~~are~~ not received within ~~the requested~~that timeframe, attempts to contact the facility will be made to follow up on the request. T~~t~~he CMO/physician designee will use all available information to rate the PQI. If the PQI cannot be rated due to the lack of medical records, the PQI may be referred to the licensing body that oversees the clinician or facility for investigation and disposition. A letter will be sent to the CMO of the POC or facility of concern informing them of the lack of response to the information request ~~for medical records~~.

G. CASE COMPLETION
1. All PQI cases will be processed and closed with a final severity level within 120 days from the date the case is received by the QI department. If a PQI investigation cannot be completed within the time-frame, a 30- days extension may be granted with the approval of the CMO/physician designee. The rationale for the extension approval shall be documented in the case file.
2. If the reviews are not completed in a timely manner, the CMO/physician designee will institute plans for compliance with standards for completion and timeliness.
3. While under review, all PQI cases and related documentation, when not in electronic form, are kept in a secure file cabinet in the QI department and only designated personnel have access to these files. Access to the electronic files is password protected and limited only to staff directly involved in the PQI process.

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

I. INTER-RATER RELIABILITY (IRR)
1. Inter-rater reliability studies will be performed at least twice a year by the CMO or physician designee to ensure cases are appropriately reviewed, ~~and~~ to ensure that the reliability of the PQI case scoring process can be evaluated, and, for cases reviewed in PRC, review actions are appropriate and implemented. ~~.~~

J. RECORD RETENTION
1. Please refer to Policy CMP30 Records Retention and Access Requirements.

K. CONFIDENTIALITY
1. Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality department and are not released to anyone for purposes other than peer review. Records are maintained in secure electronic format or in a locked file cabinet with access restricted to the CMO, Medical Director for Quality, Manager of~~,~~ Member~~Patient~~ Safety & Quality Investigations, the RN Investigators, ~~of Quality Assurance & Member Safety PICS RNs and~~ the QI Project Coordinator. While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. If a subpoena is served to Partnership ~~PHC~~ regarding a peer review case, the Manager of Member Safety & Quality Investigations ~~Quality Assurance & Patient Safety~~ may act as the "certifier of the medical records" being requested.

L. SUBCOMMITTEES
1. Refer to policy MPQP1053 Peer Review Committee.

M. DELEGATION OVERSIGHT AND MONITORING
1. Partnership may ~~PHC~~ delegate~~s~~ Potential Quality Issue (PQI) investigation including Peer Review Committee activities oversight.
2. A formal agreement ~~is~~ will be maintained and inclusive of all delegated functions.
3. Partnership ~~PHC~~ will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership~~PHC~~ annual oversight audit.
4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:
Exhibit A, Attachment III, Section 2.2 ~~9 Quality Improvement System from~~ in the 2024 DHCS C~~c~~ontract

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

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

X. REVISION DATES:
Medi-Cal 07/01/96; 06/02/97; 10/10/97 (name change only); 01/13/99; 06/16/99; 06/21/00; 05/16/01; 05/15/02; 08/20/03; 04/20/05; 07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16; 06/21/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee~~'s~~ meeting date.

Policy/Procedure Number: MPQP1016 (previously QP100116)		**Lead Department: Health Services**
Policy/Procedure Title: Potential Quality Issue Investigation and Resolution		☒**External Policy** ☐**Internal Policy**
Original Date: 01/20/1996	**Next Review Date:** ~~06/14/2024~~06/12/2025 **Last Review Date:** ~~06/14/2023~~06/12/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:
Healthy Families
MPQP1016 - 10/19/2011 to 03/01/2013

Healthy Kids (Healthy Kids Program ended 12/01/2016)
07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16 to 12/01/16

PRACTITIONER PERFORMANCE AND SYSTEMS SCORES

P Score	Definition	Action/Follow-up
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual~~,~~ minor adverse outcome to member.	An informal letter to the provider may be sent at reviewer's discretion. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member.	Certified l~~L~~etter to provider of concern, r~~R~~e~~questing~~quiring a response. May r~~R~~ecommend CAP and/or other i~~i~~nterventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	~~Immediate~~ ASAP communication to provider of concern requesting a response. May be by certified letter, email or direct phone call. ~~May r~~Require~~ecommend~~ CAP and/or other interventions. May be referred to Credentialing Committee with recommendations ~~for~~ from the PRC.
PUTD	Use whenever the PQI cannot be ~~leveled prior to referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC).~~scored through the usual process.	Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

S Score	Definition	Action/Follow-up
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual~~,~~ minor adverse outcome to member.	An informal letter to the provider may be sent at reviewer's discretion. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member.	Certified l~~L~~etter to provider of concern, ~~Requesting~~ requiring a response. May ~~Recommend~~ recommend CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	~~Immediate~~ ASAP communication to ~~provider~~ FOC/POC~~of concern~~ requesting a response. May be by certified letter, email or direct phone call. ~~May~~ Require~~recommend~~ CAP and/or other interventions. May be referred to Credentials Committee with recommendations for PRC.
SUTD	Use whenever the PQI cannot be scored through the usual process.~~Use whenever the PQI cannot be leveled prior to referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).~~	Referral to the PRO of the FOC or the system of concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.~~Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).~~

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2022 (previously MCUP3065; UP100365)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/16/2005 (MCUP3065)</td><td colspan="4">Next Review Date: ~~10/11/2024~~02/14/202506/12/2025
Last Review Date: ~~10/11/2023~~02/14/202406/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date:
~~10/11/2023~~02/14/202406/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MPUP3126 – Behavioral Health Therapy (BHT) for Members Under the Age of 21
D. MCCP2016 – Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
G. MPUP3048 – Dental Services (including Dental Anesthesia)
H. MCUG3019 – Hearing Aid Guidelines
I. MCCP2031 – Private Duty Nursing Under EPSDT
J. MCUP3028 – Mental Health Services
K. MCND9002 – Cultural & Linguistic Program Description
L. MPCP2002 – California Children's Services
M. MCCP2035 - Local Health Department (LHD) Coordination
~~K.~~N. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Ameliorate: To make more tolerable or to make better
B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
~~B. CCS: California Children's Services~~
C. DHCS: Department of Health Care Services
D. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
E. FFS: Fee-for-Service
F. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
G. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
~~E.~~H. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing

~~F.~~I. LEA: Local Education Agency
~~G.~~J. Maintenance Services: Services that sustain or support rather than cure or improve health problems
~~H.~~K. Medi-Cal for Kids and Teens: DHCS refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of Preven~~ta~~tive Care and also a "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.
~~I.~~ Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services
~~J.~~L. ~~PHC: Partnership HealthPlan of California~~
~~K.~~ TCM: Targeted Case Management
M.
N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by Partnership~~PHC~~.
~~WCM: Whole Child Model~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To define Partnership HealthPlan of California's (PHC's) responsibility to cover medically necessary services not covered under the Medi-Cal Program for individuals under the age of 21 under the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) supplemental services benefit, also referred to as "Medi-Cal for Kids and Teens."~~To define Partnership HealthPlan of California's (Partnership's) responsibility to cover medically necessary services not covered under the Medi-Cal Program for individuals under the age of 21 under the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) supplemental services benefit, also referred to as "Medi-Cal for Kids and Teens."

VI. POLICY / PROCEDURE:

A. Partnership~~PHC~~ covers and ensures the provision of screenings and preventive and medically necessary diagnostic and treatment services for members under the age of 21 in accordance with the EPDST program benefit.
B. Partnership~~PHC~~ provides information regarding EPSDT services for members which can be found in the Partnership~~PHC~~ Medi-Cal Member Handbook and in the "Medi-Cal for Kids and Teens" letter and education materials provided by DHCS and available on their website: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx . In addition, Partnership~~PHC~~ annually provides information to all members, their families and/or caregivers about available EPSDT services through Partnership~~HC~~'s website at http://www.partnershiphp.org/ and also through Member Newsletters which are mailed twice a year (summer and winter) and can also be accessed from this Partnership~~PHC~~ webpage: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Newsletter.aspx .
    1. Partnership~~PHC~~ provides member information in accordance with all language and accessibility standards as described in Partnership~~PHC~~ policy MCND9002 Cultural & Linguistic Program Description.

C. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21. Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. Early and Periodic Screening, Diagnostic and Treatment services: These are services that are provided at intervals, which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services, at a minimum~~,~~ must include a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed exam; appropriate immunizations (according to Title 42 of USC Section 1396s(c)(2)(B)(i) for pediatric vaccines for age and health history); laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).
2. Vision services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.
3. Dental services provided at intervals, which meet reasonable standards of dental practice, as determined by the S~~s~~tate after consultation with recognized dental organizations involved in child health care, and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services are carved out to the State, with the exception of medically necessary dental anesthesia.
4. Hearing services provided at intervals, which meet reasonable standards of medical practice, as determined by the S~~s~~tate after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids. For more information, see Partnership~~PHC~~ policy MCUG3019 Hearing Aid Guidelines.
5. Other necessary health care, diagnostic services, treatment and other measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
6. Partnership~~PHC~~ ensures that members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventative screening or other visit that identifies a need for follow-up.

D. The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that "Early and periodic screening, diagnosis and treatment for any individual under the age of 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."

E. For members under the age of 21, Partnership~~PHC~~ will provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule. For more information, see Partnership~~PHC~~ policy MCQG1015 - Pediatric Preventive Health Guidelines.

F. For ~~PHC~~ members under the age of 21, Partnership~~PHC~~ will provide and cover all medically necessary

EPSDT service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of Partnership~~PHC~~'s contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

G. An EPSDT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are also covered under EPSDT because they 'ameliorate' a condition. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.

H. Additional services must be provided if determined to be m~~M~~edically n~~N~~ecessary for an individual child (as per III.E above). Medical necessity determinations for services requested under EPSDT are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and are not permitted. Requests are reviewed on a case-by-case basis and take into account the particular needs of the member:
   1. Children with mild to moderate mental health issues or conditions are the responsibility of Partnership~~PHC~~ and services for them are available through Carelon Behavioral Health (formerly known as Beacon Health Options) as Partnership~~PHC~~'s subcontractor. ~~If a member is assigned to Kaiser Permanente as his/her Primary Care Provider (PCP), mental health services are available through Kaiser Permanente.~~
   2. The supplies, items or equipment to be provided are medical in nature.
   3. The services are not requested solely for the convenience of the member, family, physician or other provider of service(s).
   4. The services are not unsafe for the individual, and are not experimental.
   5. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the member's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the member's appearance.
   6. Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

I. EPSDT services must meet all of the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Available scientific evidence demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.
   5. The total cost of providing services and all other medically necessary Medi-Cal services to the beneficiary is not greater than the costs incurred in providing medically necessary equivalent services at the appropriate institutional level of care as outlined by State and Federal law.

J. Upon adequate evidence that a member has a California Children's Services (CCS) eligible condition, Partnership~~PHC~~ will refer the member to the local county CCS office for determination of CCS program eligibility. If the local CCS program does not approve eligibility, Partnership~~PHC~~ remains responsible for the provision of all medically necessary covered services for the member. For more information, see Partnership~~PHC~~ policy MCCP2024 Whole Child Model for California Children's Services (CCS).

K. Partnership~~PHC~~ is responsible for providing medically necessary Behavioral Health Treatment (BHT) under EPSDT. For more information, see Partnership~~PHC~~ policy MPUP3126 Behavioral Health Therapy (BHT) for Members Under the Age of 21.

L. Partnership~~PHC~~ has the primary responsibility to provide medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agency (LEA) programs, Regional Centers (RCs), CCS, or local governmental health programs, and will not rely on these or other entities as the primary provider. Where another entity, such as an LEA, RC, or local governmental health program has overlapping responsibility for providing services to a member under the age of 21, Partnership~~PHC~~ will:
   1. Assess what level of EPSDT medically necessary services the member requires
   2. Determine what level of service (if any) is being provided by the other entities, and
   3. Coordinate the provision of services with the other entities to ensure that Partnership~~PHC~~ and the other entities are not providing duplicative services, and that the member is receiving all medically necessary services in a timely manner.

M. ~~TARGETED CASE MANAGEMENT~~Targeted Case Management (TCM)
The EPSDT benefit includes case management and care coordination for all medically necessary EPSDT services. Partnership~~PHC~~ ensures the coverage of ~~Targeted Case Management (~~TCM~~)~~ services designed to assist the member in gaining access to necessary medical, social and educational and other services. When the need for TCM services is identified, Partnership~~PHC~~ shall:
   1. Determine whether a member requires Case Management (CM) or Targeted Case Management (TCM) services under EPSDT.
   2. For members who are eligible for CM or TCM services, Partnership~~PHC~~ will either provide services or refer and collaborate with the appropriate agency, RC or local government health program where applicable.
   3. If a member is currently receiving TCM services, Partnership~~PHC~~ will coordinate the member's health care needs and EPSDT services with the TCM provider.
   4. If Partnership~~PHC~~ determines that an eligible member is not accepted for TCM services, Partnership~~PHC~~ will ensure that the member has access to services comparable to EPSDT TCM services.

N. ~~TRANSPORTATION~~Transportation
   1. Under the EPSDT benefit, for members under the age of 21, Partnership~~PHC~~:
      a. May provide medical (NEMT) and non-medical (NMT) transportation, meals and/or lodging to and from any medically necessary covered EPSDT appointment as outlined by Title 42 Code of Federal Regulations (CFR) Section 440.17 (a)(3).
      b. Shall provide appointment scheduling assistance to and from medical appointments for the medically necessary EPSDT services covered by Partnership~~PHC~~.
   2. For more information, see Partnership~~PHC~~ policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).

O. ~~DENTAL SERVICES~~Dental Services
   1. Most dental services are carved-out of Partnership~~PHC~~'s contract with DHCS. Under EPSDT, for member under the age of 21 Partnership~~PHC~~ will:
      a. Cover and ensure that dental screenings/oral health assessments for all members are included as part of the initial health assessment.
      b. Ensure p~~P~~roviders perform a dental screening/oral health assessment as part of every periodic assessment
      c. Encourage providers to make annual dental referrals no later than 12 months of age or when referral is indicated.

d. Cover and ensure that fluoride varnish and oral fluoride supplementation assessment and provision is consistent with AAP/Bright Futures periodicity schedule and anticipatory guidance.
e. Cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.
f. Ensure that providers refer members to appropriate Medi-Cal dental providers.

2. For more information, see Partnership~~PHC~~ policy MPUP3048 Dental Services (including Dental Anesthesia).

P. ~~EXCLUDED SERVICES~~Excluded Services
For members under the age of 21, Partnership~~PHC~~ is required to cover all medically necessary EPSDT services except those services that are specifically carved out of Partnership~~PHC~~'s contract with DHCS. Carved-out services vary and can include, but are not limited to, dental services, specialty mental health services, non-medical services provided by the Regional Center(s), etc. In addition, Partnership~~PHC~~ does not reimburse families or caregivers for care.

Q. For services to be considered under the EPSDT benefit, a Treatment Authorization Request (TAR) must be accompanied by the following information:
1. The principal~~e~~ diagnosis and significant associated diagnoses
2. Prognosis
3. Date of onset of the illness or condition; and etiology if known
4. Clinical significance or functional impairment caused by the illness or condition
5. Specific types of services to be rendered by each discipline, and anticipated time for achievement of the goals
6. The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
7. Any other documentation available ~~which~~ that may assist Partnership~~PHC~~ in making determinations related to medical necessity.

R. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)
1. For more information, refer to Partnership~~PHC~~ Policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities.

VII. REFERENCES:

A. Title 42 United States Code (USC) Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
B. Title 22 California Code of Regulation (CCR) Section51340(e)
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Welfare and Institutions Code (WIC) Section 14132(v)
E. Mental Health Parity and Addiction Equity Act
F. Social Security Act Section 1905 (a) and (r)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
H. DHCS webpage with resources for "Medi-Cal for Kids and Teens": https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx
~~H.~~I. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)

Policy/Procedure Number: MCCP2022 (previously MCUP3065, UP100365)		**Lead Department: Health Services**
Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services ~~Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities~~		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/16/2005 (MCUP3065)	**Next Review Date:** ~~10/11/2024~~02/14/2025~~06~~/12/2025 **Last Review Date:** ~~10/11/2023~~02/14/2024~~06~~/12/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Provider Manual

B. Partnership~~PHC~~ Department Directors

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

X. REVISION DATES:

MCCP2022 - (as of 02/15/17)

08/16/17; *06/13/18; 02/13/19; 11/13/19; 02/12/20; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 02/14/24; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3065 (03/16/2005 to 02/15/2017)

10/18/06; 07/15/09; 01/18/12; 02/18/15; 02/17/16 to 02/15/2017

****

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

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

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

Partnership~~PHC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2034</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Transitional Care Services (TCS)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/12/2024
Effective Date: 01/01/2023</td><td colspan="4">Next Review Date: 06/12/2025
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MCCP2007 – Complex Case Management
D. MCCP2032 – CalAIM: Enhanced Care Management (ECM)
E. MCUP3142 – CalAIM Community Supports (CS)
F. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MCND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MCUG3011 – Criteria for Home Health Services
L. MCUP3028 – Mental Health Services
M. MCUP3101 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O. MCUP3064 – Communications Services
P. MCCP2018 – Advice Nurse Program
Q. MCCP2033 – Community Health Worker (CHW) Services Benefit

II. IMPACTED DEPTS:

A. Health Services
B. Behavioral Health
C. Claims
D. Member Services
E. Provider Relations

III. DEFINITIONS:

A. Accountable Care Organizations (ACO): These are groups of hospitals, doctors, and other health care providers that come together voluntarily to provide coordinated high-quality care to assigned groups of patients.
B. Admission, Discharge, and Transfer (ADT) data: Feeds for timely notification of member needs at time of hospital discharge, and reducing inefficiencies by sharing member information in standard formats.
C. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The

frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

D. PointClickCare (PCC) formerly Collective Medical Technologies (CMT): A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s data sharing and information exchange system. This platform allows Partnership's Care Coordination staff or other member-facing teams to collaborate with community partners and external case management leads without duplicating services.

E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

G. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

H. Complex Case Management (CCM): The process of applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being.

I. Drug Medi-Cal Organized Delivery System (DMC-ODS): An opt-in 1115 waiver program available in California since 2015 that provides the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In the DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services which enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use treatment, and coordinates with other systems of care. Of Partnership's 24 counties, 7 participate in Partnership's Regional DMC-ODS program (aka as Partnership's "Wellness and Recovery Program" see III.Q.): Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. Five other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Marin, Napa, Nevada, Placer, and Yolo counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "State Plan" DMC program.

J. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

K. Longitudinal Support: This means that a single relationship must span the whole transition.

L. Long-Term Services & Supports (LTSS): These include services and supports designed to allow a

member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS, and includes carved-in and carved-out services.

M. Population Health Management (PHM) Service: A State-wide service that collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and risk-tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.

N. Risk Stratification and Segmentation (RSS)**:** Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process leverages data from multiple data sources to separate its member populations into different risk groups and/or meaningful subsets using information collected through a proprietary algorithm and other data sources that include population and member assessments, demographic data, and utilization data. Partnership's RSS results in the categorization of members with care needs at all levels and intensities. When available, Partnership will also incorporate the standardized risk tier criteria provided through DHCS's PHM Service (defined in III.M. above), which will include a single, statewide, open-source RSS methodology for risk stratification that will place all Medi-Cal members into high, medium-rising, and low-risk tiers.

O. Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services County Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.

P. Transitional Care Services (TCS): A set of activities and interventions provided to members transferring from one institutional care setting or level of care to another institution or lower level of care, including home settings.

Q. TCS Care Manager: Regardless of organizational setting or job title, an individual who shall serve as the identified single point of contact who is responsible for the provision of transitional care services for a member.

R. Wellness & Recovery Program (W&R): Partnership's regional Drug Medi-Cal Organized Delivery System waivered program in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe and define Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings.

This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities.

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members transferring from one

setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Across these settings, TCS shall prioritize member-centered care by:

a. Ensuring members are supported with discharge planning until they have been successfully connected to all needed services and supports.
b. Ensuring that a single point of contact, herein referred to as a TCS care manager, can assist throughout all high-risk members' transitions, providing longitudinal support, and ensuring all required services are completed.
c. Ensuring that a dedicated TCS Team and a phone number is available to support lower-risk transitioning members telephonically when needed.
d. Ensuring members receive timely follow-up care after emergency department (ED) visits for mental health or Substance Use Disorder (SUD) issues.
e. Ensuring members receive timely follow-up after ED visits for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.

B. Transitional Care Services shall include the following:
1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:
    a. Engages the member/caregiver(s)/legal guardian/authorized representative, as appropriate, when being discharged from a hospital, institution, or facility.
    b. Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
    c. Uses a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
        1) For high-risk members, Partnership must ensure the discharging facility shares this information with Partnership's TCS care manager and that the discharging facilities have processes in place to refer to members to Enhanced Care Management (ECM) or CS, as needed.
        2) For members not already classified as high risk by Partnership per Section VI.C.1, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to Partnership for:
            a) Any member who has a special mental health need or SUD.
            b) Any member who is eligible for an ECM Population of Focus
            c) Any member whom the clinical team feels is high risk and may benefit from more intensive transitional care support upon discharge.
    d. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS), Long Term Support

Services (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.

3. Ensuring that medication reconciliation is conducted pre- and post-transition that includes education and counseling about the member's medications.
4. Ensuring all necessary prior authorizations required for a member's discharge are completed in timeframes consistent with the member's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:
    a. Therapy
    b. Home care / Home Health
    c. Medical supplies
    d. Prescription medications
    e. Durable Medical Equipment (DME)
5. Coordination to ensure appropriate post-discharge appointment attendance and follow up as follows:
    a. Ensure the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
    b. Confirm hospital has secured necessary follow-up appointments prior to discharge
    c. Assist with scheduling/arranging transportation when necessary for follow-up appointments
    d. Ensure needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health treatment initiation
6. Follow-up with member and/or their guardian/caregiver/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited to no contact with the identified TCS care manager. In these cases, at a minimum, the TCS care manager must act as a liaison coordinating care among the discharging facility, the primary care provider (PCP), and Partnership.
8. Coordination and verification that the member is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the member, their caregiver(s)/guardian/authorized representative and the care team including, but not limited to, hospitals, physicians (including the member's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:
    a. Risk Assessment: The TCS care manager must assess member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS care manager may supplement this risk assessment as needed through member engagement. During this process, the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM), and/or Community Supports and make appropriate referrals.
    b. Discharge Instructions: The TCS care manager must receive and review a copy of the discharging facility's discharge instructions given to the member, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon member engagement, the TCS care manager must review the discharge instructions with the member and ensure that member can have any questions answered. A best practice (not required) is for the TCS care manager to work with the facility to ensure that the TCS care

manager's name and contact information are integrated into the discharge documents.

c. Discharge Summary and Clinical Information Sharing: The TCS Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.
d. Preadmission status which includes living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission
e. Pre-discharge support needs which include the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge
f. Discharge location, which is the hospital, institution, or facility to which the member was admitted
g. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences
h. Specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling
i. Summary of the nature and outcome of participation of the member/caregiver(s)/legal guardian/authorized representative in the discharge planning process
j. Anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record
k. Information regarding available care, services, and supports that are in the member's community once the member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the member.
l. TCS Care manager's name and contact information and a description of TCS should also be included

11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy-level appropriate, and be shared with the member, their caregiver(s)/legal guardian/authorized representative, treating providers, primary care providers, discharging facility and the receiving provider.

C. TCS Member Eligibility & Identification:
1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership members shall be proactively identified for TCS services.
a. Pursuant to the DHCS Population Health Management (PHM) policy guide, Partnership members identified as 'high risk' must be offered TCS services beginning January 1, 2023. Partnership must offer support for TCS for lower-risk transitioning members effective January 1, 2024.
b. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MCND9001 Population Health Management Strategy & Program Description.
c. High-risk transitioning members means all member that meets criteria under MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other members assessed as high risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
d. In addition to these groups, and in recognition of high risk of poor outcomes in transition for Partnership members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured in criteria mentioned in section VI.C.1.c, Partnership

must also consider the following members high-risk for the purpose of TCS:

1) Any member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
2) Any member transitioning to or from a SNF
3) Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS

e. Lower-risk transition members are defined as those not included in the high-risk transitioning members noted above.

2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a member's admission, transfer or discharge.
   a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

D. TCS Care Manager, Care Manager Assignment, & TCS Team
   1. Once a high-risk member has been admitted, Partnership shall identify a TCS care manager who shall serve as the single point of contact for the member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.
      a. For members enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS care manager and perform all TCS services for the member.
      b. For members enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS care manager and perform all ECM services for the member. For more information regarding the ECM benefit, see Partnership Policy MCCP2032 CalAIM Enhanced Care Management (ECM).
   2. For high-risk members identified for TCS, the member shall be referred to Partnership's CCM program or ECM benefit as appropriate.
   3. For lower-risk members identified for TCS, Partnership is required:
      a. To ensure member has access to a specialized TCS Team (at Partnership or a delegate) for a period of at least 30 days from discharge.
      b. To ensure member can outreach to a dedicated telephonic support service. See Partnership Policy MCUP3046 Communication Services and MCCP2018 Advice Nurse Program for more details.
      c. To facilitate as needed members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service.
   4. For all other members identified for TCS, Partnership shall evaluate and identify an appropriate TCS care manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, primary care providers, and/or other contracted agencies.
      a. Facility staff who help with discharge planning should work with, but not take the place of the

responsible TCS care manager, unless Partnership has formally assigned the facility to act as the TCS care manager.

5. The ADT notification platform, PCC formerly CMT, shall be used to notify the TCS case manager of the member's admission, discharge and/or transfer status including the location of admission and facility contact information.
6. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS care manager in the discharge planning document.
7. Partnership will provide the TCS care manager's contact information to the member, member's parents, legal guardians, or authorized representative, as part of the discharge planning document.
8. The TCS case manager must obtain permission from the member, members' parents, legal guardians, or authorized representatives, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
9. The TCS care manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, Targeted Case Management, etc.
10. The assigned TCS care manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post discharge.
11. High-Risk Member Outreach: The identified TCS care manager is responsible for contacting the member within 7 days of discharge and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
12. Low-Risk Member Outreach: Direct communication about the dedicated TCS team and phone line and how to access it. Partnership must make best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of notification can be utilized.

E. End of TCS
   1. High-Risk Members
      a. TCS will end once the member has been connected to needed services as identified in the discharge risk assessment or in the discharge planning document. TCS should extend at least 30 days post-discharge.
      b. If Partnership has delegated TCS to another contracted entity (e.g. hospital, PCP), Partnership will ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. A monitoring plan would be in place to ensure all required TCS are completed.
         1) This arrangement for managed care plan (MCP) contracted entities to provide TCS is not considered formal delegation and therefore, Partnership is not subject to requirements outlined in APL 23-006 "Delegation and Subcontractor Network Certification."
      c. For those members who have ongoing unmet needs post-TCS, eligibility for ECM or CCM should be reconsidered.
      d. If the member is enrolled in ECM or CCM, and if the TCS care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager, the member should be connected to their new TCS care manager through a referral.
      e. For members who are unresponsive to Partnership's outreach attempts or did not attend scheduled follow-up ambulatory visits, Partnership must make reasonable effort to ensure members:
         1) Are aware that TCS support is available for at least 30 days.

2) Are engaged and that follow-up ambulatory visits are completed.

f. For members with multiple care transitions within a 30-day period, Partnership must ensure the same TCS care manager is assigned to support the member through all these transitions. If the second transition is within 7 days of the first transition, then the TCS care manager must facilitate as needed a follow up visit to be completed within 7-days post discharge after the last transition. The TCS care manager must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or CS eligibility.

2. Lower-Risk Members
   a. Partnership must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge.
   b. In addition to accepting referrals to longer term care management at any point during the transition, Partnership will use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or CS.
3. Partnership may utilize Community Health Worker's (CHW's) when available through the CHW benefit to facilitate member outreach and engagement. Refer to Partnership policy MCCP2033 Community Health Worker (CHW) Services Benefit for details.

F. Prior Authorization and Timely Discharge
1. Partnership adheres to regulatory prior authorization processing timeframes. The timely processing of authorizations supports Partnership's contracted providers in discharge planning and ensuring necessary services and supports are in place prior to discharge. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process describes how Partnership monitors performance and complies with regulatory prior authorization processing timeframes and standards as well as APL 21-011 "Grievance and Appeal Requirements, Notice and "Your Rights" Templates".
2. As described in Partnership policy MPUD3001 Utilization Management Program Description, members are evaluated for appropriateness of care setting pursuant to medical necessity and the documented discharge plan. The discharge plan shall take into account the continuing care needs and initiation of arrangements for services or placement needed after discharge.
   a. Partnership shall collaborate with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.
3. To support effective discharge planning practices, Partnership shall ensure all network providers (e.g. hospitals, acute care facilities, institutions, etc.) educate their discharge staff on the services, supplies, medications, and DME that require a Treatment Authorization Request (TAR). A list of items that require prior authorization is attached to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A. The policy is made available on Partnership's website for further education and to support the provider network and discharge planning staff.
4. Partnership maintains mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services that apply to each of our Network Providers and Out-of-Network Provider hospitals within our Service Area.

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
1. Partnership is responsible for providing TCS to Partnership assigned members even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible member, in-patient acute psychiatric admissions, etc.)
2. For members who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these members, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.

3. For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the member's care upon discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023).
    a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
    b. Partnership shall identify a TCS care manager for these members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM or CS are addressed.
    c. TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
    d. After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.
4. For Partnership members who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
    a. The member's Medicare Medi-Cal Plan (MMP) or the member's Dual-Eligible Special Needs Program (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership shall not provide TCS or assign a transitional care manager for member enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).
        1) If the member is enrolled in ECM or Partnership's CCM Program, Partnership shall notify the care manager of the admission, discharge or transfer status.
    b. For Partnership members who are enrolled in Medicare FFS or Medicare Advantage plans that are not a D-SNP, Partnership shall ensure and provide TCS.
5. Drug Medi-Cal Organized Delivery System (DMC-ODS) or Partnership's Wellness and Recovery services:
    a. For members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
    b. For members needing SUD services in the counties not participating in Partnership's Wellness & Recovery program, Partnership shall identify a TCS care manager for these members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM or Community Supports are addressed.
    c. TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
    d. After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

H. DHCS Monitoring of TCS
1. If Partnership contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, Partership must have robust monitoring and enforcement process in place to hold facilities or providers accountable for providing all required TCS outlined above.

2. For more details on what DHCS will monitor with Partnerships' TCS implementation through specific PHM Monitoring Key Performance Indicators (KPIs), refer to the CalAIM Population Health Management Policy Guide for more details.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. CalAIM Population Health Management Policy Guide January 2024
C. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
D. DHCS APL 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
E. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
F. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
   1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)
G. Title 42 Code of Federal Regulations (CFR) Section 438.208

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: N/A

PREVIOUSLY APPLIED TO:

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

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

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

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPCP2006 (previously CP100206)			**Lead Department: Health Services**	
Policy/Procedure Title: Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/20/2001		**Next Review Date:** ~~09/14/2023~~09/13/202406/12/2025 **Last Review Date:** ~~09/14/2022~~09/13/202306/12/2024		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~09/14/2022~~09/13/202306/12/2024	

I. RELATED POLICIES:

A. MCCP2024 – Whole Child Model for California Children's Services
B. MPCP2002 – California Children's Services
~~B.~~C. MCQG1015 – Pediatric Preventive Health Guidelines
~~C.~~D. MPUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
~~D.~~E. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
~~E.~~F. MCUP3039 – Direct Members
G. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
~~A. MPCP2002 – California Children's Services~~
H. MCCP2035 – Local Health Department (LHD) Coordination
I. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
J. MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
K. MCCP2014 – Continuity of Care
L. MCCP2034 – Transitional Care Services (TCS)
M. MPCD2013 – Care Coordination Program Description
N. MCCP2007 – Complex Case Management
~~F.~~O. MCCP2032 – CalAIM ECM

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status ~~may be~~is based on the member's ~~medical condition~~aid code, prime insurance, demographics, or administrative approval based on qualified circumstances~~eligibility status~~. ~~Direct Members do not require a~~ A Referral Authorization Form (RAF) is not required for Direct Members to see ~~a specialist~~Partnership~~PHC~~ network providers and/or certified Medi-Cal providers willing to bill Partnership~~PHC~~ for covered services. However, many

specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.~~.~~

C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
F. Medical Home: The provider identified as the member's medical home or primary care provider (PCP) is responsible for managing the member's primary care needs.
G. Members with Special Health Care Needs (MSHCNs) are those who have, or are at increased risk for, chronic physical, developmental, behavioral or emotional conditions.
H. Whole Child Model (WCM): In participating counties, this~~A comprehensive~~ program provides comprehensive treatment for the whole child ~~encompassing~~and care coordination in the areas of primary, specialty, and behavioral health for ~~any~~Partnership HealthPlan of California (Partnership~~PHC~~) pediatric members ~~insured by PHC.~~with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To outline a process for the identification, assessment, case management and coordination of care for Members with Special Health Care Needs and Persons with Developmental Disabilities that encourages access to specialties, sub specialties, ancillary providers, and community resources.

VI. POLICY / PROCEDURE:

Partnership HealthPlan of California (Partnership~~PHC~~) has a process for the identification, assessment, case management and coordination of care for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities. ~~-~~Partnership~~PHC~~ encourages timely access to specialties, sub specialties, ancillary providers, and community resources. ~~-~~The effectiveness of Partnership~~PHC~~'s processes in serving MSHCNs is monitored on an annual basis to ensure best practices and identify opportunities for improvement. This quality review may be accomplished by utilizing Healthcare Effectiveness Data and Information Set (HEDIS®) measures, member satisfaction surveys, member grievances, inputs from community agencies, and data-driven measures that analyze clinical trends, access to care and specific utilization questions.

A. Identification
   1. Partnership~~PHC~~ identifies MSHCNs in multiple ways including, but not limited to, the following:
      a. Primary Care Providers (PCP) may identify children with special needs, including California Children's Services (CCS) eligible conditions, and facilitate timely referrals to appropriate services/agencies.
      b. Partnership~~PHC~~ Health Services staff screen Treatment Authorization Requests (TARs) routinely to assess and identify members with potential special needs/conditions; collaborating when necessary with providers, Partnership~~PHC~~ Case Managers (CMs), CCS, and/or other community agencies to ensure members are connected and referred appropriately.
      c. Nurse Coordinators (NCs) review all hospitalizations concurrently for early interventional opportunities.
      d. Health Services Care Coordination (CC) staff respond to requests from providers, families, and other agencies for case coordination assistance, and/or other intended departments.
      e. Partnership~~PHC~~ downloads the list of Regional Center (RC) enrollees from the California Department of Health Care Services (DHCS) monthly.
      f. Risk stratification reports include protocols for both adult and pediatric members whereby

Partnership~~PHC~~'s membership is screened monthly for emergence of new conditions that may qualify for these benefits.

2. Assessment
   Primary Care Providers (PCPs) are trained by Partnership~~PHC~~'s Provider Relations department for the identification of MSHCN when they contract with Partnership~~PHC~~. ~~-~~Our review concerns the following assessment:
   a. A History & Physical (H&P) is completed within 120 calendar days of the member's effective date of enrollment into the HealthPlan, or documented within the 12 months prior to the plan enrollment. ~~-~~The H&P will assess and diagnose acute and chronic conditions.
   b. Health assessments containing Child Health and Disability Program (CHDP) age-appropriate content requirements are provided according to the most recent American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventive health care. ~~-~~Assessments and identified problems are documented in the progress notes. ~~-~~Follow-up care or referral is provided for identified physical health problems as appropriate.
3. Direct Access to Specialists
   Partnership~~PHC~~ allows certain populations of MSHCNs to be placed in a Direct Member category, which allows direct access to care without requiring a referral from a primary care provider. These populations include, but are not limited to, ~~clients of CCS~~CCS-eligible members, youth in Foster Care and members in the Genetically Handicapped Persons Program (GHPP).

B. Case Management and Care Coordination
   Partnership~~PHC~~ coordinates care with other agencies that provide services for MSHCNs as follows:
   1. California Children Services (~~CCS) –~~CCS) ~~-~~ Birth to age 21 years
      ~~a.~~ In participating counties[1], Partnership~~PHC~~ members who have a CCS ~~–~~eligible condition participate in the Whole Child Model (WCM). As part of this model, Partnership~~PHC~~ provides the case management and utilization management services for these members. ~~–~~For more information, ~~please see~~refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS).
      a.
      b. Partnership~~PHC~~ members who have a CCS eligible condition and participate in the CCS Program, refer to policy MPCP2002- California Children's Services for more details.
   2. High Risk Infant Follow-Up (HRIF) Services – Birth to age 3 years~~.~~
      a. In accordance with APL 2~~1~~-0~~3~~405 ~~*Revised* :~~ California Children's Services Whole Child Model Program (12/27/2023~~12/10/2021~~), for members in counties that participate in the WCM program, Partnership~~PHC~~ is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services. Refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS) for more details.
      b. For members who live in a county that participates~~pating~~ in the State CCS Program, this would be the responsibility of the CCS offices and providers, Partnership~~PHC~~ may work in

[1]For Members under age 21 with a CCS-eligible condition(s), services and supplies for the CCS-eligible condition(s) will either be authorized by Partnership~~PHC~~ under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In Partnership~~PHC~~'s service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). ~~-~~As of January 1, 2024, the following 10 counties in Partnership~~PHC~~'s service area are participants in the State's CCS program and are not participants in Partnership~~PHC~~'s Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

collaboration if necessary. Refer to policy MPCP2002- California Children's Services for more details.

~~0) Members who are identified through the HRIF program as potentially eligible for CCS benefits will be directed to county CCS eligibility programs for CCS eligibility determination.~~

~~4.~~3. Early Intervention (EI) Services - Birth to age 3 years

a. The Partnership~~PHC~~ provider network has primary responsibility for the identification of children less than 3 years of age who may be eligible to receive services from the Early Start Program and to make the referral to the RC, which coordinates those services. ~~-~~These include children where a developmental delay in either cognitive, communication, social, emotional, adaptive, physical or motor development is suspected, or whose early health history places them at risk for delay.

b. Partnership~~PHC~~ HS staff assist in identifying and referring children who may qualify for the Early Start Program.

c. Partnership~~PHC~~ HS staff collaborate with providers, RC(s), and/~~-~~or the Early Start Program in resolving problems, determining medically necessary services, including diagnostic and preventive services and provide input to be considered in the treatment plans for members participating in the Early Start Program. Children under age 21 who may benefit from Behavioral Health Treatment (BHT) services can be referred for screening and services. BHT services must be determined to be medically necessary to correct or ameliorate any physical or behavioral conditions and ~~based on medical necessity~~covered under Medicaid. P~~P~~lease see Partnership~~PHC~~ policy MPUP3126 Behavioral Health Treatment for Members Under the Age of 21 for details.

d. Partnership~~PHC~~'s Care Coordination department and primary care providers provide case management (CM) and care coordination (CC) to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services that are identified in the Individual Family Service Plan (IFSP) developed by the Early Start Program.

~~5.~~4. Services for Persons with Developmental Disabilities

a. Partnership~~PHC~~ provides all screening, preventive, medically necessary, and therapeutic covered Medi-Cal services to members with developmental disabilities. ~~-~~Children under 21 may be eligible for BHT services. Please see Partnership~~PHC~~ policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details.

b. Partnership~~PHC~~ members who are also clients of a RC are ~~advised~~ referred to ~~contact~~ the RC for evaluation and access to non-Medi-Cal services provided through the RC(s) including, but not limited to, respite, day care, out-of-home placement, vocational training, financial management and supportive living.

c. Partnership~~PHC~~ members who are not clients of a RC but who may meet their eligibility criteria for developmental disability, are advised to contact the RC for assessment and evaluation. Partnership ~~-~~PHC is not able to make a direct referral to a RC without written consent of the member or legal representative.

d. Upon request to Partnership~~PHC~~ by the member, RC staff or other entities, Partnership~~PHC~~ HS staff will assist with identification and coordination of appropriate services for the member.

~~6.~~5. Local Education Agency Services (LEA)

a. Partnership~~PHC~~ is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, Partnership~~PHC~~ must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]). Please

see Partnership~~PHC~~ policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details.~~has the primary responsibility to provide all carved-in medically necessary services that exceed the amount provided by the Local Education Agency (LEA), RC(s) or local government health programs. However, these entities must continue to meet their own requirements regarding provision of services.~~

b. Partnership~~PHC~~ assures a PCP is available to provide primary care management and care coordination to the member to ensure the provision of all medically necessary Medi-Cal covered diagnostic, preventive and treatment services. Partnership~~PHC~~ encourages the member's PCP to collaborate and share pertinent medical and treatment information with the LEA to assist in the development of the Individual Education Plan (IEP) or Individual Family Service Plan (IFSP). For more information, see Partnership~~PHC~~ policy MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

c. LEA assessment services are services provided by the LEA as specified in Title 22 CCR Section 51360(b) and are provided to students who qualify based on Title 22 CCR Section 51190.1 and are provided pursuant to an IEP as set forth in Education Code, Section 56340 et seq. or an ISFP as set forth in Government Code, Section 95020.

6. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)
   a. ICF/DD, ICF/DD-H, and ICF/DD-N are services offered to members with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system in accordance with APL 23-023 *Revised* Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care. For CCS-eligible members under the age of 21, please refer to Partnership~~PHC~~ policy MCCP2024 and MPCP2002 for more details.
   b. Partnership~~PHC~~ ensures that members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to Partnership~~PHC~~ policy MPCD2013 Care Coordination Program Description for more details.
   c. Transitional Care Services (TCS): High-risk individuals include individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability. For more information on high-risk transitioning members' criteria, refer to MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1. TCS is available when members are in need of transitional support;~~,~~ refer to Partnership~~PHC~~ Policy MCCP2034 Transitional Care Services (TCS) for more details.
   d. Complex Case Management (CCM): Members may need extra support to avoid adverse outcomes but who are not in the highest risk group. Refer to Partnership~~PHC~~ Policy MCCP2007 Complex Case Management for more details.
   e. Continuity of Care (COC) Requirements: During the continuity of care period, MCPs must provide 12 months of continuity of care for the ICF/DD Home placement of any member residing in an ICF/DD Home who is mandatorily enrolled into Partnership~~PHC~~ after January 1, 2024. Following their initial 12-month continuity of care period, members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or after January 1, 2023.

Refer to Partnership~~PHC~~ policy MCCP2014 Continuity of Care and MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities for more details.

f. Enhanced Care Management (ECM): Members living in ICF/DD are not currently eligible for ECM, if there are other individual care needs or concerns, their needs can be reviewed for consideration. If a member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the member must be assessed to determine need/eligibility for ECM services. Refer to Partnership~~PHC~~ Policy - MCCP2032 CalAIM ECM for more details.

~~e.~~g. Utilization Review for ICF/DD, ICF/DD-H, and ICF/DD-N facilities: Refer to Partnership~~PHC~~ policy MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.

7. School Linked Children's Health and Disability Prevention (CHDP) Services.
Partnership~~PHC~~ does not currently have a school linked CHDP program in its county service area. If a school linked CHDP program site establishes within its county service area, Partnership~~PHC~~ will do the following:
   a. Maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain CHDP services through the local school districts or school sites.
   b. Establish guidelines for the following:
      1) Sharing of critical medical information
      2) Coordination of services
      3) Reporting requirements
      4) Quality standards
      5) Processes to ensure services are not duplicated
      6) Processes for notification to member/student /parent/guardian on where to receive initial and follow-up services
      7) Referral protocols/guidelines for the school sites which conduct CHDP screening only, to assure those members who are identified at the school site as being in need of CHDP services receive those services within the required state and federal time frames
      8) Assure processes for appropriate follow-up and documentation of services provided to the member
      9) Provide resources to support the provision of school linked CHDP services
      10) This supersedes any contradicting information found within the Child Health and Disability Prevention (CHDP) Program guidelines, as the CHDP sunsets July 1, 2024.

~~" – "~~*~~Revised~~*

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III, Section 4.3.9~~2009 Section A11.7-11.11~~
B. Title 22, California Code of Regulations (CCR) Sections 51360(b) and 51190.1
C. Department of Health Care Services All Plan Letter (APL) 23-010: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (*Revised* ~~05/04/2023~~11/22/2023)
~~C. DHCS All Plan Letter (APL) 19-014 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (11/12/2019)~~
D. DHCS All Plan Letter (APL) 23-034 – California Children's Services Whole Child Model Program (12/27/2023)~~DHCS APL 21-005 *Revised:* California Children's Services Whole Child Model Program (12/10/2021)~~
E. Department of Health Care Services All Plan Letter (APL) 23-005: Requirements for Coverage of

Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)

E. ~~DHCS APL 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic and Treatment Services for Medi-Cal Members Under the Age of 21 (08/14/2019)~~

F. National Committee for Quality Assurance (NCQA) Health Plan Standards ~~2022~~20243. Population Health Management 5 Complex Case Management

G. DHCS High Risk Infant Follow Up https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx

H. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)

VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Department Directors

B. Partnership~~PHC~~ Provider Manual

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

X. REVISION DATES:

Medi-Cal

08/20/03; 04/20/05; 01/16/08; 05/19/10; 10/01/10; 09/19/12; 10/15/14; 09/16/15; 09/21/16; 09/20/17; *06/13/18; 11/14/18; 03/13/19; 11/13/19; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 06/12/2024

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids MPCP2006 (Healthy Kids program ended 12/01/2016)

01/16/08; 05/19/10; 10/01/10; 09/19/12; 10/15/14; 09/16/15; 09/21/16 to 12/01/16

Healthy Families:

MPCP2006 - 10/01/2010 to 03/01/2013

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

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

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

Partnership~~PHC~~'s authorization requirements comply with the requirements for parity in mental health and

substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~04/12/2024~~06/12/2025
Last Review Date: ~~04/12/2023~~06/12/2024</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~04/12/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3051 – Long Term Care SSI Regulation
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
E. MCCP2016 – Transportation Guidelines for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
F. MPQP1016 – Potential Quality Issue Investigation and Resolution
G. MCRP4068 – Medical Benefit Medication TAR Policy
H. MCUP3142 – CalAIM Community Supports
~~G.~~I. MCCP2032 – CalAIM Enhanced Care Management (ECM)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Custodial Care: Non-medical care that helps members with their daily basic care such as eating, bathing, and/or mobility.
B. Intermediate Care Facilities (ICF): A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
C. Long Term Care (LTC) Facility: A health facility that provides rehabilitative, restorative and/or on-going skilled nursing care to patients in need of assistance with activities of daily living (ADLs).
D. Skilled Nursing Facilities (SNFs): A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.
E. Sub-acute Facilities: Facilities with a level of care that is less intensive than acute care, but is more intensive than skilled nursing care (e.g. ventilator dependent members).

IV. ATTACHMENTS:

~~A. BedHold / TAR Process After Acute Hospitalization Flowchart~~
~~B. Admissions for Short Term Rehabilitation or Short Term Skilled Nursing~~
~~C.~~A. Bed Hold & Change of Status Report form

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)		**Lead Department: Health Services**
Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: ~~04/12/2024~~06/12/2025** **Last Review Date: ~~04/12/2023~~06/12/2024**	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Long Term Care (LTC) facilities for Partnership HealthPlan of California (PHC) members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Long Term Care Facilities

1. PHC ensures access to licensed long-term care facilities, irrespective of location in or out-of-network, to members in need of long-term care services. These facilities may include:
   a. Skilled Nursing Facilities
   b. Sub-acute Facilities (pediatric and adult)
   c. Intermediate Care Facilities

~~2.~~ A member in need of long term care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the member to the appropriate type of facility.

~~3.~~2. ~~PHC assists with finding a facility for the appropriate level of care upon request although primary responsibility remains with the hospital discharge planning staff.~~

~~4.~~3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and PHC Utilization Management (UM) team identifies the most appropriate level of care for the member and assures that the member is placed in a health care facility that provides the level of care most appropriate to the member's medical needs. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e). These Title 22 Medi-Cal guidelines are used to determine the medical necessity for continued placement in a long-term care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended. Classification categories include the following:
   a. Subacute Care: The member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care either can be short term, where there is potential for the member eventually being transferred to a lower level of care; or long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these members are authorized for time intervals based on the characteristics of the member's medical condition.
   b. Short Term Care: The member may need a short term stay for a skilled nursing care need or short term rehab services and expected to return to his/her previous living arrangement or alternate level of care.
   c. Long Term Care: When a member is admitted for custodial care, the TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments.

~~5.~~4. The choice of a long term care facility for a patient is a decision that should include consideration of the following:
   a. If the facility is a licensed Medi-Cal provider
   b. If the facility is contracted with PHC
   c. If there are beds available
   d. If more than one choice is available, the family's choice of facility
   e. Benefit coverage limitations

~~6.~~5. A Long Term Care (LTC) facility must be a licensed institution (other than a hospital) which meets all of the following requirements:
   a. It must be qualified as a provider of services under Medi-Cal

b. It must maintain on the premises all facilities necessary for medical care and treatment
c. It must provide such services under the supervision of physicians
d. It must provide services given by or supervised by a registered nurse AND
e. It must keep medical records on all patients

B. Short Term Skilled Nursing and Rehab Programs ~~(Refer to Attachment B)~~
1. Skilled level nursing is a covered level of care for PHC's members. Usually this level of care is short term and follows hospitalization at an acute care facility during the acute rehabilitation stage of treatment for an illness or injury.
   a. Admission to a skilled nursing facility must be coordinated with a contracted, Medi-Cal licensed facility by the discharge planner. If the member is not currently confined, or the hospital discharge planner is unavailable, the PHC Nurse Coordinator is the appropriate contact for referral to a skilled nursing level facility.
   b. The attending physician should also be aware that a history and physical are needed by the skilled nursing facility that is accepting the member. Orders are generally accepted over the telephone for an immediate placement and a written history and physical must then be completed and sent to the accepting facility.
2. Specialized Rehabilitative Services
   a. Specialized rehabilitative services in skilled nursing facilities shall be covered in accordance with the standards of medical necessity. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either:
      1) A sustained higher level of self-care and discharge to home or
      2) A lower level of care
   b. Specialized rehabilitation service shall be covered contingent upon compliance with the following requirements:
      1) The services shall be ordered by the beneficiary's attending physician.
      2) The physician's signed order, specifying the care to be given, shall be on the beneficiary's chart.
      3) A copy of the order shall be made available for departmental review upon request.
   c. The services require prior authorization by the PHC Nurse Coordinator prior to admission to a skilled nursing facility. The authorization request shall be accompanied by a treatment plan, signed by the attending physician, which shall include the following:
      1) Principal and significant diagnoses
      2) Prognosis
      3) Date of onset of illness or injury
      4) Specific type, number, and frequency of services to be performed by each discipline
      5) Therapeutic goals of the service provided by each discipline and anticipated duration of treatment
      6) Extent of and benefits or improvements demonstrated by any previous provision of physical therapy, occupational therapy, speech pathology or respiratory services
   d. Professional therapy necessary to establish maintenance program services under treatment programs not requiring the skills of a qualified therapist shall not be separately payable or authorized.

C. Admission to a LTC Facility
1. A LTC Treatment Authorization Request (TAR) is required when the member:
   a. Is a new admission to the facility
   b. Has exhausted his/her Medicare benefits
   c. Medicare or other insurance denies LTC
   d. Is readmitted to LTC from an acute care hospital or did not return to the LTC facility on or

before day eight (8) of "bed hold days"

e. Returns to the LTC facility from an approved leave of absence beyond the approved return date
f. Is newly eligible with PHC while residing in the LTC facility
g. Changes level of care (e.g. ICF level to SNF level, SNF to ICF level of care)

2. The physician/ facility submits the TAR to PHC UM Department with the following documentation:
   a. A completed Pre-admission Screening and/or a Preadmission Screening and Resident Review (PASRR) form indicating appropriateness for placement
   b. The Minimum Data Set (MDS) and relevant medical record documentation supporting the medical necessity for the level of care requested which must have been completed within the last 90 calendar days to request for custodial care or re-authorization
   c. A Medicare or other insurance denial, if applicable
3. A UM Nurse Coordinator reviews the request for medical necessity and level of care.
   a. Cases not meeting criteria for medical necessity are referred to one of the Medical Directors for review and determination.
   b. Upon determination of medical necessity, an approval will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
   c. PHC reserves the right to modify a request; it is the facility's responsibility to review their request against what PHC actually approves.
   d. The facility is responsible for verifying the member's eligibility using PHC eEligibilty on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a PHC member loses eligibility, the authorization will no longer be valid.
   e. Acute Care to Long Term Care Facility
      The transfer must be coordinated by the hospital discharge planner or case worker to PHC inpatient concurrent review nurse prior to admission to the ~~skilled~~ LTC facility. The hospital discharge planner or case worker will notify the PHC inpatient concurrent review nurse when the member needs to be transferred to a LTC facility.
      1) The PHC inpatient concurrent review nurse will discuss the case with the PHC Nurse Coordinator. If the transfer meets the PHC guidelines, verbal approval is given for admission to the skilled nursing facility.
      2) If a member is capped to a hospital, the discharge planner at the hospital will directly notify the PHC Nurse Coordinator to initiate a referral to a skilled facility.
   f. Admission from Home to Long Term Care Facility
      1) A LTC facility is required to notify PHC before any elective admission. Prior authorization is required for all elective admissions from home.
      2) The following information must be submitted with the prior authorization request via TAR:
         a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in a long term care facility and the physician's certification that placement in the long term care facility is the appropriate level of care for the member.
         b) If placement follows an acute hospital stay within the past 30 calendar days, please submit the hospital history and physical and discharge summary.
         c) If the member has not been confined in an acute care hospital within the past 30 calendar days, please submit the Primary Care Provider's progress notes for the past six (6) months.
         d) Please Note: If the admission from home occurs without prior approval from PHC and the member's condition and services do not meet criteria, PHC will issue a denial to the facility.
   g. Admissions on Weekends and Outside normal business hours
      1) For an admission to LTC facility on the weekend or outside normal business hours, facility

is to contact PHC as soon as possible to identify the PHC member, reason for admission, and name of facility.

2) Upon review, if PHC determines the member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.

h. Transfer to an Acute Care Facility

1) The transfer of a member to an acute care facility must be reported through the Bed Hold & Change of Status Report form (Attachment A~~C~~) weekly. When appropriate, the PHC Nurse Coordinator places the member in a "bed hold" status for up to 7 calendar days. (see VI.G.4)

2) The LTC facility must notify PHC when the member is readmitted to the LTC facility. Claims will not be paid if the readmission is not appropriately reported to PHC.

i. Discharge or Death

1) All discharges or deaths must be reported on a weekly basis. (Attachment A "~~by using the~~ Bed Hold & Change of Status Report" form is recommended for reporting.) ~~(Attachment C).~~

2) Notification of a member's death should include whether the death occurred within the LTC or in an acute care facility.

~~j. Kaiser Capitated Members~~

~~0) LTC facility fees for members capitated to Kaiser are Kaiser's financial responsibility for the month of admission and the month immediately following the admission. Services after that time period are PHC's responsibility.~~

~~0) Disenrollment from Kaiser must be requested prior to the end of the second month of financial responsibility. At that time, the LTC facility must submit a completed TAR with the required medical documentation. PHC will review the case to determine if continued authorization is medically indicated.~~

~~m.~~j. Medicare/Medi-Cal Members

1) Members with both Medi-Cal and Medicare coverage become the financial responsibility of PHC when the M~~m~~ember has exhausted ~~his/her~~their Medicare skilled days benefit.

2) The ~~LTC facility~~SNF must submit the Medicare denial letter ~~when Medicare benefit or~~ showing non-coverage of services to PHC along with a completed TAR and required medical documentation for review. PHC's Nurse Coordinator reviews the case to determine the medical necessity of continued authorization.

3) Note: PHC follows Title 22 criteria for admission and continuing care for LTC facilities. ~~(See Attachment A)~~

D. Denials and Coordination of Care

1. Cases determined to not meet LTC guidelines based on Title 22 Medi-Cal Guidelines and the information available at the time of review, are managed as follows:
   a. If the Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
   b. The Nurse Coordinator contacts the attending physician to discuss concerns regarding patient's acuity, treatment plan or length of stay (LOS), or to obtain any additional pertinent information that might assist with the level of care determination.
   c. Denials of medical necessity are determined only by the PHC Chief Medical Officer (CMO) or Physician Designee.
   d. UM staff ensures the member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights.

E. Continuing Care Determinations

1. Extensions of stay in long term care facilities for Medi-Cal members require re-authorization by

PHC on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6 for newly admitted members who may be eligible to return home.

2. When a member is admitted for custodial care, a TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

F. Continuity of Care Requirements

1. Effective January 1, 2023, and through July 1, 2023, for Members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, PHC will automatically provide 12 months of continuity of care for the SNF placement. Automatic continuity of care means that if the member is currently residing in a SNF, they do not have to request continuity of care to continue to reside in that SNF. While members must meet medical necessity criteria for SNF services, continuity of care must be automatically applied.
   a. Consistent with Health and Safety Code section 1373.96, application of automatic continuity of care allows for the completion of covered services provided by a nonparticipating provider to a newly covered PHC member who, at the time that coverage became effective, was receiving services from that provider, irrespective of contracting status with PHC.
2. Members are allowed to stay in the same SNF, irrespective of location in or out-of-network, under continuity of care only if all of the following applies:
   a. The facility is enrolled and licensed by the California Department of Public Health (CDPH)
   b. The facility is enrolled as a provider in Medi-Cal
   c. The SNF and PHC agree to payment rates that meet state statutory requirements; and
   d. The facility meets PHC's applicable professional standards and has no disqualifying quality-of-care issues.
3. PHC will determine if members are eligible for automatic continuity of care before the transition by identifying the Member's SNF residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the member or provider. A pre-existing relationship means that the Member has resided in the SNF at some point during the 12 months prior to the date of the member's enrollment with PHC.
4. Following their initial 12-month automatic continuity of care period, members may request an additional 12 months of continuity of care, following the process established by APL ~~18-008~~22-032 ~~*Revised*~~, Continuity of Care for Medi-Cal ~~Members~~ Beneficiaries Who ~~Transition~~ Newly Enroll in~~to~~ Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members Who Transition into a New Medi-Cal Managed Care Health Plan On or After January 1, 2023.
5. A member newly enrolling with PHC and residing in a SNF on or after July 1, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL ~~18-008 *Revised*~~22-032 .

G. Monitoring and Review

1. If, in the course of routine case review, t~~T~~he Nurse Coordinator finds a ~~reviews each member's case for~~ potential quality of care issue~~s~~, the case is referred ~~according~~ to PHC's Member Safety Investigations Team for investigation through the Potential Q~~q~~uality Issue referral process. ~~improvement guidelines. Areas of concern are reported to the Quality Improvement (QI) Coordinator.~~ See policy MPQP1016~~–~~ Potential Quality Issue Investigation and Resolution.
2. The Nurse Coordinator also assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies.

H. TAR Submission Requirements:

The authorization request shall be initiated by the facility with all required attachments as noted below. TAR should be submitted within 15 business days from the date of service. (Note that the TAR must

also be submitted within 60 calendar days from the date that the member established eligibility with PHC.)

1. Initial TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
   c. Medicare or other Insurance denial letter (if applicable)
   d. MDS (Minimum Data Set)
2. Continued Care with a new TAR must include the following:
   a. Completed new TAR form
   b. Current MDS (or most recent quarterly MDS)
   c. Social Services notes and evaluation
3. Post-service Retrospective TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal LTC Facility Admission and Discharge Notification form)
   c. PASSR (Preadmission Screening and Resident Review Medicaid form)
   d. MDS
   e. Medicare or other health coverage denial letter (as applicable)
   f. Social Services notes and evaluation
4. Bed hold TAR (When a member is transferred to acute hospital)
   a. Bed hold TARs must include the following:
      1) Doctor's order
      2) Completed new TAR
   b. Maximum bed hold is 7 calendar days
   c. When member returns to facility on the 8th calendar day current TAR is still valid.
   d. If a PHC member returns to a Long Term Care facility after 8 calendar days, a new TAR and all required attachments must be submitted (see VI.G.1. TAR Submission Requirements, Initial TAR).
5. Short Term TAR (Less than 90 calendar days in a LTC facility) must include the following:
   a. Doctor's order
   b. Completed new TAR form
   c. Medicare or other health coverage denial letter (as applicable)
   d. Eligibility must be No Other Insurance

I. Criteria for Ending or Modifying an Existing TAR

With written or electronic (via PHC ePortal) notification, PHC staff will end or modify an existing valid TAR in the system under the following circumstances:

1. Member's death
2. Exhausted 7 calendar day bed hold
3. Discharge to Medicare, Health Maintenance Organization (HMO) or other insurance bed
4. Discharge to hospice care
5. Discharged to home or transfer to other LTC facility

J. Procedures for Discharge from LTC Facilities

1. Discharge summary should be sent to the member's PCP upon discharge.
2. Day of Discharge or Death Same as Day of Admission Reimbursement Policy
   a. When a patient receiving skilled nursing or intermediate care expires or is discharged from a LTC facility, the facility must notify PHC via the Bed Hold & Change of Status Report form (Attachment A~~C~~).
   b. If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable.

3. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in a LTC facility, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, regarding provision of wheel chairs for patients residing in a skilled nursing facility.
   b. The LTC facility is responsible for providing wheelchairs that are properly maintained at all times unless the member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to PHC for consideration.

K. Policies for Other Services or Supports
1. Facility Therapy Services
   Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.
   a. Therapy services provide to the recipient that are covered by the per diem rate include, but are not limited to:
      1) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
      2) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
      3) Care to prevent formation and progression of decubiti, contractures and deformities, including:
         a) Changing position of bedfast and chairfast recipients
         b) Encouraging and assisting in self-care and activities of daily living
         c) Maintaining proper body alignment and joint movement to prevent contractures and deformities
2. Transportation
   a. For all transportation needs, please refer to PHC's policy MCCP2016 Transportation Guidelines for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
3. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to PHC policy MCCP2032 CalAIM Enhanced Care Management (ECM) for further details.
   ~~a.~~b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For members currently in a LTC setting who may benefit from Community Supports, please refer to PHC policy MCUP3142 CalAIM Community Supports (CS)

VII. REFERENCES:

A. Medi-Cal Guidelines including "Leave of Absence, Bed Hold, and Room and Board" *(leave)*
B. InterQual® criteria
C. DHCS Contract~~ual~~: Exhibit A, Attachment ~~11~~III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services~~Provision 9, Exhibit E, Attachment 1, Definitions, "Covered Services"~~

D. Title 22 California Code of Regulations (CCR) Sections 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51134, 51335, 51335.5, 51335.6, 51321(h)
E. Health and Safety Code (HSC) § 1373.96
F. DHCS APL 15-018 dated 07/09/2015 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components
G. All County Welfare Director's Letter ACWD 97-07 1997 Statewide Average Private Pay Rate (APPR) for Nursing Facility Services (02/27/1997)
H. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~22-018 *(Revised)*~~23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care ~~(October 25, 2022~~(03/14/2023)
I. DHCS APL ~~18-008 *Revised*~~23-022: Continuity of Care for Medi-Cal ~~Managed Care Members~~Beneficiaries Who ~~Transition~~ Newly Enroll in~~to~~ Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023. (~~12/07/2018~~08/15/2023)

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

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

X. REVISION DATES: 06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

****

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

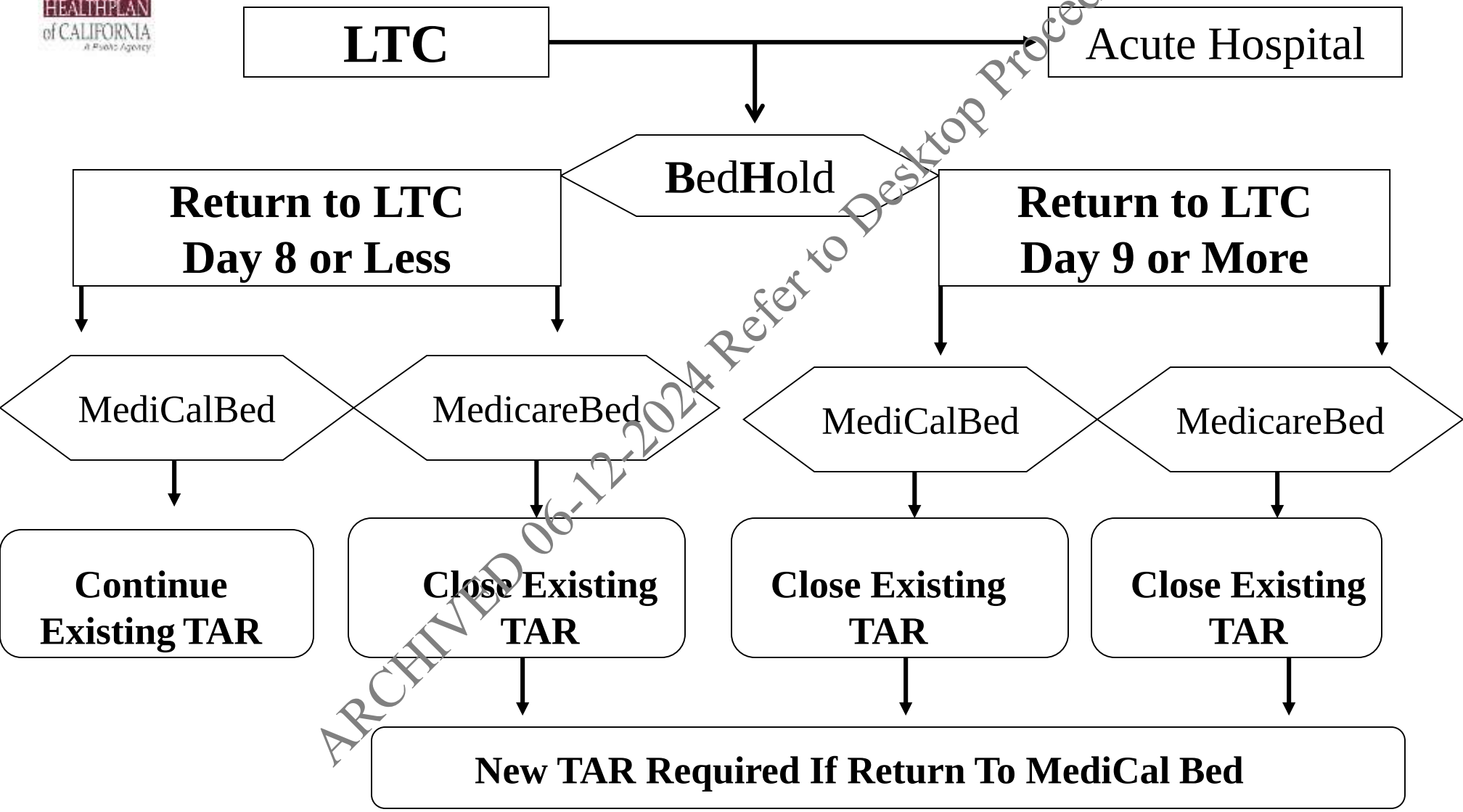
- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

BedHold / TAR Process After Acute Hospitalization

MCUG3038-A



Partnership HealthPlan of California
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

BEDHOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

NO.	MONTH -	DAY OF THE WEEK																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	NAME: TAR NUMBER:																															

Please note, member discharge /transfer to acute requires a MD order.

Fax weekly to **707 - 863 - 4118**

REMARKS:

NO.	

LEGEND:

A - Discharge to Acute (use after 7 day BH)
B - Discharge to B & C
B/H - - Bed Hold
E - Expired
E/A - Expired in Acute
TL - Therapeutic Leave
H - Discharge to Home
I - Discharge to ICF
M - Discharge to Medicare Bed
P - Discharge to Private Pay
R - Return to MediCal Bed
S - Discharge to Other SNF
X - Discharge to Hospice

Prepared By: _____

Telephone #: _____

Fax #: _____

Date Prepared: _____

Please note, report will not be processed without a signed Physician's order

Partnership HealthPlan of California
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

BEDHOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

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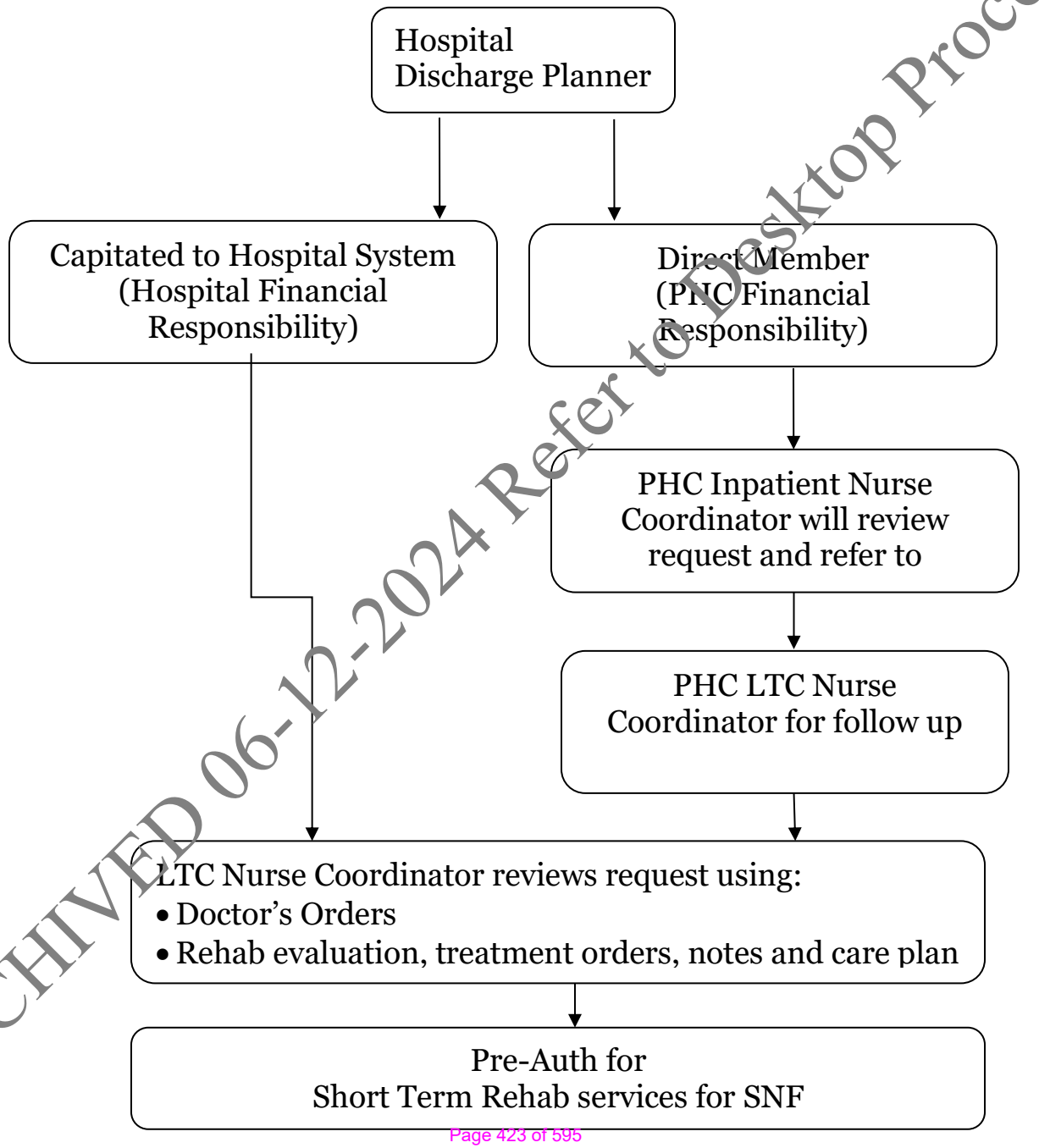
X - Discharge to Hospice

Prepared By: _____
Telephone #: _____
Fax #: _____

Admissions for Short Term Rehabilitation or Short Term Skilled Nursing



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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="5">Policy/Procedure Number: MCUP3041 (previously UP100341)</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="5">Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: (UM-2) 04/25/1994
(Effective 06/19/2013 - TAR/RAF Review Policy split)</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MPUP3026 – Inter-Rater Reliability Policy
C. MCUP3141 – Delegation of Inpatient Utilization Management
D. MPUD3001 – Utilization Management Program Description
E. MCRP4068 – Medical Benefit Medication TAR Policy
F. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
G. CGA-024 – Medi-Cal Member Grievance System
H. CMP36 – Delegation Oversight and Monitoring
I. CMP26 – Verification of Caller Identity and Release of Information
J. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Mmember with making medical decisions. The Mmember will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (PHC) for review prior to releasing PHI. Until the form has been submitted and validated by PHC staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Mmember can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
C. Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
D. Urgent Request: A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Mmember or others, due to the Mmember's psychological state, ***or***

2. In the opinion of a practitioner with knowledge of the M~~m~~ember's medical or behavioral condition, would subject the M~~m~~ember to adverse health consequences without the care or treatment that is the subject of the request.

E. Non-urgent Request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the M~~m~~ember or the M~~m~~ember's ability to regain maximum function and would not subject the M~~m~~ember to severe pain.

F. Concurrent Request: A request for coverage of medical care or services made while a M~~m~~ember is in the process of receiving the requested medical care or services, even if PHC did not previously approve the earlier care.

G. Pre-service Request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

H. Post-service Request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

IV. ATTACHMENTS:

A. PHC TAR Requirements list (including Outpatient Surgical Procedures CPTs Requiring TAR list and Pain Management CPTs Requiring TAR list

V. PURPOSE:

To describe the procedures used by the Partnership HealthPlan of California (PHC) Utilization Management (UM) Department to process Referral Authorization Forms (RAFs) and Treatment Authorization Requests (TARs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. GENERAL PROCEDURES

1. ~~Partnership HealthPlan of California~~PHC pays for authorized services according to the specific terms of each physician, hospital, or other provider contract. PHC will reimburse only if individuals are eligible at the time the service is rendered.
2. Resources necessary to help in determining review decisions, include, but are not limited to the published, current, InterQual® criteria; Medi-Cal (State of California) criteria, Medicare criteria, and PHC internally developed and approved guidelines. Determinations also take into account individual member needs and characteristics of the local delivery system.
   a. The Provider of service must verify eligibility of the M~~m~~ember via PHC systems at the time of service. This verification is necessary for all service authorizations.
   b. PHC's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx ~~Eligibility and Interactive Voice Response (IVR) System~~ is available ~~at this direct phone number (800) 557-5471~~ to verify eligibility and determine the M~~m~~ember's assigned primary care provider (PCP). Information required to verify the eligibility of an individual is as follows:
      1) Provider NPI (National Provider Identifier)
      2) Member Social Security number or PHC Member ID number
      3) Date of Service
3. TARs are not processed by PHC until the TAR form is complete and includes all member information and all attachments noted on the TAR are received. When completing information fields for the provider of service and service(s) being requested, the correct and valid codes must be utilized.
4. Authorizations are only valid for the timeframe approved by PHC. If the timeframe is exceeded due to an unforeseen delay, the Provider may submit a request for an extension of the time period, noting the reason for the delay.

5. Since 2014, a~~A~~ll TARs and related materials including worksheets, letters, and other documentation, are scanned and stored electronically. Electronic files are maintained and archived with appropriate backup both on and ~~on site for 12 months and then archived~~ off~~-~~site. Paper records prior to 2014 are archived and stored offsite. Records are maintained ~~-~~as noted:
   a. For M~~m~~embers ~~over the~~ age ~~of~~ twenty-one (21) and over, archived materials are kept for a minimum of 10 years.
   b. For M~~m~~embers under the age of twenty-one (21), archived materials are kept until the M~~m~~ember reaches the age of twenty-one (21) or for ten (10) years, whichever is longer.

B. SERVICES REQUIRING TREATMENT AUTHORIZATION
1. Certain procedures, services, and medications require prior authorization from PHC before reimbursement is made. Those services requiring a Treatment Authorization Request (TAR) are listed as attachments to this policy. The attachment consists of:
   a. PHC TAR Requirements List
   b. HCPCS Codes Requiring a TAR
   ~~b.~~c. Outpatient Surgical Procedures Requiring TAR
   ~~c.~~d. Pain Management CPTs Requiring TAR
2. For those providers contracting with PHC, if a M~~m~~ember has primary coverage through Medicare Part A, a TAR is not required until the M~~m~~ember exhausts the benefits available under Medicare. Once benefits have been exhausted, the TAR must be submitted along with written verification from Medicare that the benefits have been exhausted. The TAR must be submitted within 15 business days of the date the benefits exhausted or within 60 calendar days of retrospective eligibility.
   a. Exception: If the provider receives a denial from Medicare or any other primary payor source, they must submit a TAR to PHC's Health Services Department, along with a copy of the Medicare denial and the medical record documentation. The TAR must be received by PHC within 60 calendar days of the issue date of the denial from Medicare or the other payor source.
3. TARs are not required for services related to emergency services, minor consent, family planning and preventive services, basic prenatal care, sexually transmitted disease services and human immunodeficiency virus (HIV) testing.
4. Authorizations granted for single-encounter, outpatient medical services (diagnostic imaging, dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) will be limited to a 6-month authorization period. Services excluded from this limit will include: Transplants, Dialysis, Palliative Care, Cardiac Rehabilitation, and Pulmonary Rehabilitation. Please note this limit is only applicable to single-encounter, outpatient medical services requiring a TAR. Requests for extension of authorization when a service is not rendered within the authorization period should continue to be submitted as a correction (as described in VI.C.8 below) and will be reviewed on a case by case basis.

C. TAR SUBMISSION PROCESS

TARs for M~~m~~embers who require services should be submitted electronically via PHC's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx. TARs must be received by PHC within fifteen (15) business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) Electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax (707) 863 - 4118 or mail to PHC's Health Services Department for review.

1. Urgent TAR Requests

   Urgent TAR submission is available for requests in which the provider indicates, or PHC determines, that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Requests for an urgent determination should be

submitted by the provider and clearly marked "Urgent" or "Expedited" and should indicate reason there is an urgent need for authorization. A TAR for an elective (non-emergent) surgery submitted urgently due only to an imminent date of service is NOT considered to be urgent. TARs submitted under these circumstances will be reviewed as a non-urgent pre-service request.

2. Non-urgent Elective Requests
   a. All elective inpatient hospital admissions require prior authorization EXCEPT anticipated two (2) day post vaginal delivery stays and four (4) day post C-Section stay. Obstetrical admissions do not require a TAR prior to admission, for obstetrical delivery. The hospital must notify PHC if the mother and/or baby require additional days of acute care. The Nurse Coordinator concurrently reviews the case within 24 hours (1 calendar day) of receipt of clinical information.
   b. A service being provided that is not pregnancy related requires the admitting physician to submit the TAR for the elective procedure prior to the actual hospital admission. Although an approved TAR will assign a specified number of initial days approved, the hospital is required to notify PHC within one business day of the actual date of admission. Please note that PHC will assign a number of initially approved days, however, it is the hospital's responsibility to notify PHC within one business day of the date of the actual admission. If the patient's condition necessitates hospitalization beyond the pre-approved timeframe, PHC will perform concurrent review on the remainder of the stay.
   c. Authorization for non-obstetric elective hospital admissions must be submitted by the admitting physician and include the following:
      1) Procedure code or service being performed
      2) Facility where procedure will be performed
      3) Anticipated date of procedure
      4) Number of days being requested if inpatient admission
      5) Diagnosis
   d. Managed care plans are not required to cover cosmetic surgery (see definition in III.C).
3. Emergency Admissions
   a. For all emergency and obstetrical admissions, the hospital or long term care (LTC) facility must notify PHC and the M~~m~~ember's PCP of the admission as soon as possible, but not later than the first business day following the date of admission.
   b. The case is reviewed by the Nurse Coordinator and a decision on length of stay is authorized based on PHC established criteria within 24 hours (1 calendar day).
4. Dialysis Services
   a. Initial TAR requests for Dialysis services for M~~m~~embers who have no other insurance will be authorized for a 90 calendar day period only.
   b. Per CCR Title 22 section 50763, "Medi-Cal beneficiaries must apply for any available health care coverage when no cost is involved." All M~~m~~embers receiving dialysis must submit an application to Social Security for Medicare benefits.
   c. The provider must submit a denial from Medicare for PHC to approve services beyond the initial 90 calendar days.
   d. Once a Medicare determination of denial of coverage is received, PHC will issue a TAR that will remain valid for the M~~m~~ember's lifetime or until the M~~m~~ember receives a kidney transplant.
5. Hospice Services
   Hospice services require a TAR ONLY for inpatient services (i.e. acute or ~~[~~skilled nursing facility~~]~~ [SNF]/LTC facility.) However, a Hospice election form signed by the M~~m~~ember or ~~his/her~~their legal representative must accompany any initial claim for hospice services (all outpatient and

inpatient services).

6. Long Term Care/Skilled Nursing Services
   All Skilled Nursing or Long Term Care facility admissions require approval prior to the admission, and throughout the length of stay.
   a. When a M~~m~~ember is admitted for custodial care, a TAR submission may be approved for an initial six (6) month period and the M~~m~~ember's condition will be re-evaluated at six (6) month increments.
   b. For continued custodial care, a new TAR must be submitted within 15 calendar days of the expiration date of the original TAR.
7. Post-service (Retrospective) Requests
   Retrospective (Retro) TARs must be received by PHC within fifteen (15) business days of the date of service or within 60 calendar days of a denial from the primary insurance carrier. (Note that if a provider incorrectly submits a TAR for a PHC member to the State Medi-Cal field office, PHC will apply these timeliness requirements beginning on the date the request is received in our office.) Retro TARs received after that timeframe are considered for review only under the following conditions:
   a. When a M~~m~~ember does not identify ~~himself/herself~~theirself ~~-~~to the provider as a PHC M~~m~~ember by deliberate concealment or because of physical or mental incapacity to so identify ~~himself/herself~~theirself.
   b. If a M~~m~~ember has obtained retroactive eligibility. The TAR must be received by PHC within 60 calendar days of the M~~m~~ember havings~~-~~ obtained~~ing~~ Medi-Cal eligibility.
8. Correction TAR Requests
   a. The provider has up to 12 months from the approved date of the ORIGINAL authorized TAR to submit modifications of approved services. A new TAR must be submitted with the requested modifications and MUST reference the ORIGINAL TAR number and code(s) or date(s) to be modified. Modifications will be accepted or made only on approved TARS for the following:
      1) Types of service. For example, only similar items or procedures may be modified (e.g. micropore tape versus paper tape, right wheels versus left wheels, etc.).
      2) Minor extension or change of dates may be requested (e.g. start of service May 15 versus May 20).
      3) Units of service (e.g. 9 visits versus 6 visits). This usually coincides with a change of, or extension of, dates of service requested.
9. Note that if a provider incorrectly submits a TAR for a PHC M~~m~~ember to the State Medi-Cal field office, PHC applies timeliness requirements to that request. If the M~~m~~ember was eligible with PHC at the time of the request, TARs submitted beyond the 15 business day requirement are considered late but will still be reviewed for medical necessity.

D. UM REVIEW PROCESS
1. Nurse Coordinator Review
   A Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity determinations. The Nurse Coordinator reviews the information received from the provider utilizing PHC approved review guidelines. The Nurse Coordinator approves the request if it meets medical necessity criteria. Requests that do not meet review guidelines and require clinician review due to questions of medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for further evaluation. ~~. TARs that require clinician review due to questions of medical necessity are pended to the Chief Medical Officer/ Physician Designee.~~ The Nurse Coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet. ONLY the Chief Medical Officer or Physician Designee can deny TARs for reasons of medical necessity.

2. Chief Medical Officer / Physician Designee Review
   a. The Chief Medical Officer or Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.
   b. The Chief Medical Officer or Physician Designee review is done in all cases of potential denial due to medical necessity, interpretation issues, or other issues as requested by the UM staff. PHC's Chief Medical Officer or Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate.
   c. The Chief Medical Officer or Physician Designee may contact involved providers or consultants for additional information as required to assist them in rendering a decision about the case. They may contact the requesting provider for further information. The Chief Medical Officer or Physician Designee documents the rationale for any decision on the Medical Director Worksheet. Once the Chief Medical Officer or Physician Designee approves or modifies the request, the TAR will be returned to the Nurse Coordinator for completion.
   d. The Chief Medical Officer or Physician Designee is the only person authorized to sign denials for medical necessity or to make any exceptions or modifications to the established PHC medical criteria. Denials for medical necessity are made only by the Chief Medical Officer or Physician Designee.
   e. PHC makes a physician reviewer available (Chief Medical Officer or Physician Designee) to discuss medical necessity determinations with providers by telephone (peer to peer review).
   f. For information on the process for a Mmember, Mmember's authorized representative, or a provider on behalf of a Mmember, to appeal PHC UM decisions, see PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.
3. Delegated Entity Review
   a. PHC uses delegated entities to perform some aspects of utilization management. They make determinations on service requests for their assigned Mmembers. All delegates will follow the decision making and notification timeframes set out below in section VI.D.6. for medical and behavioral health services.
   b. PHC's Associate Director of UM Regulations ~~Senior Health Services Director~~ is responsible for monitoring the Utilization Management activities of delegated entities. On a daily basis (during business days), the UM Associate Director of UM Regulations and the Delegation Program Manager monitor authorizations performed by delegated entities through PHC's electronic authorization system. On a weekly basis, they generate timeliness reports for all delegated entities and analyze trends. Delegated entities are notified immediately of any areas of concern. On a quarterly basis, timeliness data reports are prepared for review and audit with each delegated entity. Reports are also reviewed by the CMO or physician designee at least annually or more often as needed if areas of concern are noted.
   c. Multi-specialty medical groups do not require pre-authorization from PHC for services for which they are delegated. All elective hospital admissions must be pre-authorized by the medical group and reported to PHC at the time of admission.
4. Non-Contracted Hospital Review
   a. Elective admissions to non-contracted hospitals require approval of a TAR, which is subject to PHC's timeline policies. When the admission is elective and has been given prior authorization, no further communication is required until the approved number of days is nearing expiration and the Mmember is expected to remain hospitalized beyond the days previously approved. The facility is required to provide to the Nurse Coordinator appropriate clinical information supporting the medical necessity of continued stay.
   b. As most admissions to non-contracted hospitals are for emergency conditions, the procedure for non-contracting hospital review is as follows:

1) If the admission does not meet admission criteria, it is referred to the Chief Medical Officer (CMO) or Physician Designee for review. The Nurse Coordinator notifies the non-contracting hospital of the Chief Medical Officer or Physician Designee's decision and provides the process for appeal or the opportunity to discuss the determination with the CMO/Physician Designee (peer to peer review).
2) Until the M~~m~~ember is medically stable for discharge or transfer to a lower level of care, clinical review should be sent to PHC's Nurse Coordinator.
3) For a M~~m~~ember capitated to an in-plan hospital who is admitted to a non-capitated hospital, please refer to policy MCUP3141 Delegation of Inpatient Utilization Management.

5. Post Stabilization Services
   Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 42 CFR section 438.114 and Title 28 CCR Section 1300.71.4.
6. UM Decision and Notification Timelines
   a. Urgent Concurrent Review
      1) For urgent concurrent review, PHC will render a decision (approve, modify, defer/pend, deny) within 72 hours.
      2) If the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the authorized period of time or number of treatments, the request will be reviewed as an urgent pre-service and a decision will be rendered within 72 hours from the original date of receipt.
      3) If the request to approve additional days for urgent concurrent care is related to care not approved by PHC previously, PHC will attempt to obtain necessary information related to the request within 24 hours. The decision will be rendered no later than 72 hours from the original date of receipt of the request. For urgent concurrent denials, PHC may inform the hospital Utilization Review (UR) department staff of the decision, with the understanding that staff will inform the attending/treating prescriber.
      4) If it is determined that additional information is required, or if a M~~m~~ember requests an extension, PHC will extend the time frame one time by up to 14 calendar days. PHC will document the specific reason for the extension in PHC's electronic authorization system. The provider is then notified immediately in writing of the extension and what specific additional information is required to complete the review.
      5) Electronic or written notification of the decision is communicated to the provider within 24 hours of the decision, and no later than 72 hours after receipt of the request. If the time frame was extended, the provider will be notified at the time of decision, but no longer than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. PHC is not required to notify the M~~m~~ember of an urgent concurrent decision as the M~~m~~ember is not at financial risk for the services being requested.
   b. Urgent Pre-service Review
      1) For urgent pre-service review, PHC will render a decision (approve, modify, defer/pend, deny) within 72 hours.
      2) If it is determined that additional information is required, or if a M~~m~~ember requests an extension, PHC will extend the time frame one time by up to 14 calendar days. PHC will document the specific reason for the extension in PHC's electronic authorization system. The M~~m~~ember and the provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of

medical necessity. PHC will re-review the request if the clinical information requested is received after a decision has been made.

3) Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and no later than 72 hours from the receipt of the request. Written notification is mailed to the M~~m~~ember within two (2) business days of the decision. If the time frame was extended, the notification is communicated at the time of decision, but no later than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request.

c. Non-urgent Pre-service Review and Non-urgent Concurrent and Review

1) For non-urgent pre-service review, PHC will render a decision (approve, modify, defer/pend, deny) within five (5) business days from the receipt of the request, but no later than 14 calendar days from the receipt of the request.
2) For non-urgent concurrent review (inpatient care e.g. LTC/SNF), PHC will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of the request and will continue concurrently reviewing the authorization within one (1) business day of receipt each time clinical information is received.
3) If the request is received during non-business hours, PHC will process the request the next business day.
4) If the TAR lacks clinical information necessary to render a decision, the TAR may be deferred/pended up to 14 calendar days from the date of the original receipt of the request. PHC will document the specific reason for the extension in PHC's electronic authorization system. The M~~m~~ember and the P~~p~~rovider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. In addition to electronic or written notification, the UM Staff will contact the Provider and/or designated office staff member to remind them of the specific information requested and the regulatory timeframe for submission. In the event that a M~~m~~ember requests an extension on a deferred/pended TAR with PHC's grievance department, or if PHC determines an extension of the pended request is in the best interest of the M~~m~~ember after the initial 14 calendar days are exhausted, PHC may extend the deferred/pended period up to an additional 14 calendar days, for a total of 28 calendar days from the original date of receipt of the request. Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. PHC will re-review the request if the specified clinical information requested is received after a decision has been made.
5) Notification of Decision:
    a) Non-urgent pre-service review: Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the M~~m~~ember within two (2) business days of the decision. If the time frame for the review was extended, the notification will be provided at the time of decision, but no longer than five (5) business days from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request or 28 calendar days if a second extension is applied.
    b) For a non-urgent concurrent review, electronic or written notification of the decision is communicated to the provider within 24 hours of the decision and no later than 72 hours after receipt of the request. PHC is not required to notify M~~m~~embers of non-urgent concurrent review decisions as the M~~m~~ember is not at financial risk for the services being requested.

d. Post-service (Retrospective) Review
   1) For post-service review, PHC will render a decision (approve, modify, defer/pend, deny) no longer than 30 calendar days from the receipt of the request.
   2) Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Mmember within two (2) business days of the decision.

E. MONITORING OF THE TAR PROCESS
1. Aggregate TAR data is subject to retrospective analysis by PHC's UM Department. This review is designed to:
   a. Identify individual provider practice patterns relative to standards of medical practice.
   b. Evaluate over and under-utilization of services.
2. PHC monitors turnaround times of internal processing for compliance with standards.
3. Denials or modifications for medical necessity are monitored weekly to ensure accuracy in regulatory requirements, review processes, and correspondence.
4. PHC performs inter-rater reliability audits as outlined in policy MPUP3026 Inter-Rater Reliability Policy, at least biannually on both physician and nurse reviewers.
5. Member & provider grievances, as well as PHC's member and provider satisfaction survey responses, serve as an evaluation tool.
6. Administrative denials (as defined in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions) are reviewed monthly by the Chief Medical Officer. A summary is presented to the Internal Quality Improvement Committee (IQI) at least annually or more often as needed.
7. In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:
   a. Consistent with sound clinical principles and processes
   b. Evaluated and updated at least annually
   c. If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request
   d. The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
   e. PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

F. COMMUNICATION SERVICES
1. PHC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:
   a. Calls from Mmembers are triaged through Mmember Sservices staff who are accessible to practitioners and Mmembers to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
   b. Members and Providers may contact the PHC voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
   c. After normal business hours, Mmembers may contact the advice nurse line at (866) 778-8873 for clinical concerns.
   d. Practitioners both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after

normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.

1) PHC has a dedicated after-hours local phone number (707) 430-4808 or toll free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. PHC's Chief Medical ~~Director~~ Officer or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. PHC clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a M~~m~~ember whose emergency medical condition is stabilized.
2) For information on utilization management procedures (prior authorization requirements, Clinical Protocols and Practice Guidelines) refer to PHC's Provider Manual, Section 5: Health Services at www.partnershiphp.org. For information on how to submit claims, refer to PHC's Provider Manual, Section 3: Claims at www.partnershiphp.org.

e. PHC has a toll free number (800) 863-4155 that is available to either members or practitioners.
f. UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.

2. Linguistic services to discuss UM issues are provided by PHC to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These services include the following:
   a. No cost linguistic services
      1) Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
      2) Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated into threshold languages in accordance with regulatory timeframes and into other languages or alternative formats as indicated in the M~~m~~ember's record or upon request. Material formats include audio, large print and electronically for M~~m~~embers with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of PHC, such as when the materials were previously translated or when translation may address Health Equity concerns.
      3) Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711] .
3. PHC regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management
B. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
C. DHCS All Plan Letter (APL) 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (12/30/2022)

D. California Health and Safety Code (HSC) Sections 1363.5 and 1367.01(h)(3)
E. Title 42 Code of Federal Regulations (CFR) section 438.114 and Title 28 California Code of Regulations (CCR) Section 1300.71.4
F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2024~~3~~) UM 5 Timeliness of UM Decisions Elements A and E

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

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

X. REVISION DATES: TAR Procedure [UM-2]: 11/19/96; 12/15/99; 01/12/00 – RAF Procedure [UM-1]: 12/27/95; 05/27/99); (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 05/19/10; 07/20/11); 06/19/13; 06/17/15; 09/16/15; 05/18/16; 04/19/17; *06/13/18; 02/13/19; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 04/14/21; 08/11/21; 05/11/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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Administrative denials are reviewed monthly by the Chief Medical Officer and monitored quarterly to identify trends and/or the need for additional provider education, outreach, or other intervention. A summary is presented to the Internal Quality Improvement Committee every six months. In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PHC TAR REQUIREMENTS

MCUP3041 - Attachment A
MCUP3049 - Attachment A
MCUG3007 -Attachment B
Revised

~~06/14/2023~~06/12/2024

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

A. **Acupuncture** *(see policy MCUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)

C. **Cardiac Rehabilitation** – Phase II and pediatric *(see policy MCUP3128 Cardiac Rehabilitation)*

D. **Chiropractic Services** *(see policy MCUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MCCP2033 Community Health Worker (CHW) Services Benefit)* PHC does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

G. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

H. **Diagnostic Studies**
1. CT Scans: chest, abdomen, and/or pelvis (*No TAR is required for other CT scans of- extremities, Head/Neck/Spine, CT colonogram - effective 7/1/2024)*
2. MRI: chest, abdomen, and/or pelvis, including Cardiac MRI 05561. *(No TAR is required for other MRI scans of~~, including~~ extremities, Head/Neck/Spine~~-~~, MRI ~~of~~ Breast~~.~~ - ~~(~~effective 7/1/2024)*

~~1. Cardiac MRI - 75561 only (effective 08/01/2017)~~
~~2.~~3. MRA (MR Angiogram)
~~3.~~4. MSI
~~4.~~5. MEG
~~5.~~6. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
~~6.~~7. Transcranial Doppler
~~7.~~8. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
~~8.~~9. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit)*
A TAR is required for additional visits (beyond eight) during the postpartum period

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)
1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted /***

miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)

3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MCUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
5. Oxygen and related supplies - No TAR is required for CPAP supplies for a CPAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
6. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
7. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
8. Purchase of any wheelchairs for Medi-Medi members
9. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MCUP3136 Fecal Microbiota Transplant)*

N. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

O. **Genetic Testing and Screening** – A TAR is required for certain genetic testing and screening as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

P. **Home Health Care** *(see policy MCUG3011 Criteria for Home Health Services)*

Q. **Home Infusion Therapy**

R. **Hysterectomy**

S. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

T. **Hospitalization**
1. The hospital must notify PHC of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician prior to the admission.

U. **Hyperbaric Oxygen Pressurization**

V. **Long Term Care**
The LTC facilities must notify PHC of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits/ hospice election.) *See policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities.*

W. **Medical Supplies***
1. Nebulizers – When the billed price including tax is $200 or more *(see policy MPUG3031 Nebulizer Guidelines*)
2. Ostomy Supplies+ (Note: NU modifier may not be used for "disposable" ostomy supplies)
3. Urological Supplies+ (Note: NU modifier may not be used for "disposable" urological supplies)
4. Tracheostomy Supplies+
~~4.~~5. Wound Care Supplies+ TAR requirements vary. ~~detailedregarding Medi-Cal requirements for ostomy, urological, tracheostomy and wound care supplies, please ree Provider Manual/ Guidelines section~~
~~5.~~6. Negative Pressure Wound Therapy ~~Care Supplies~~Devices [*see policy MPUP3059 Negative Pressure Wound Therapy (NPWT) Device/Pump]*
~~6.~~7. Nutritional Supplements - *(see policy MCUP3052 Medical Nutrition Services*) Physician administered nutritional supplements require a TAR to be submitted to PHC when the item is billed to PHC's medical benefit and is not included ~~on~~ in PHC's ~~Covered~~ Medical Drug L~~l~~ist (MDL) Navigator, or when the PHC ~~Covered Medical Drug List~~MDL indicates a prior authorization is required. Nutritional supplements provided by a Pharmacy must be submitted through Medi-Cal Rx TAR processes* when not on the Medi-Cal Rx Contract Drugs List (CDL). Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to PHC for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*

+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-

012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator ~~Magellan~~ instead of PHC.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:** PHC requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

Z. **Non-Emergency Medical Transportation:** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

AA. **Occupational Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)* PHC M~~m~~embers under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. PHC's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services. No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for OT services in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.)

BB. **Outpatient Hemo / Peritoneal Dialysis** Initial authorization will be limited to 90 days and a lifetime authorization may be granted with annual certification, only after submission of Medicare determination.)

CC. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 5)

DD. **Pain Management** – see **Pain Management CPTs Requiring TAR** list (page 8) and policy *MCUP3049 Pain Management Specialty Services*

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)* PHC M~~m~~embers under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. PHC's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services. No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.)

GG. **Pulmonary Rehabilitation** *(see policy MCUP3111 Pulmonary Rehabilitation)*

HH. **Speech Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)* PHC members age 21 and over can be referred by a licensed clinician for one consultation visit through a physician order. PHC's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services. No TAR is required for Members under age 21 to receive speech therapy services for up to 12 visits (limit one visit per day) for ST services in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.)

II. **Transplants** (*see policy MCUP3104 Transplant Authorization Process)*

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28291, 28296, 28292, 28899	Correction Of Bunion
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
36522	Photopheresis, extracorporeal
37700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins From Saphenofemoral Junction To Knee Or Below
37735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins With Radical Excision Of Ulcer And Skin Graft And/or Interruption Of Communicating Veins Of Lower Leg, With Excision Of Deep Fascia
37760	Ligation Of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation Of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division Of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC ‘s
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal Of Tube(S), With Or Without Removal Of Ovary(S) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62290 thru 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685,	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
22510 thru 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy, percutaneous laser discectomy)
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62360 thru 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63661 thru 63664, 63685, 63688	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3114</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Physical, Occupational and Speech Therapies</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/20/2012</td><td colspan="4">Next Review Date: ~~03/13/2025~~06/12/2025
Last Review Date: ~~03/13/2024~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)
D. MPCP2002 – California Children's Services
E. MCUP3125 – Gender Dysphoria/ Surgical Treatment
F. MCUG3011 – Criteria for Home Health Services
G. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity for members age 21 years and over as defined per Partnership HealthPlan of California (PHC) contract with the Department of Health Care Services (DHCS). Medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. Medical Necessity for members under 21 years of age: In addition to the definition noted in III. A~~D~~, medical necessity for members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
E. Physical and Occupational therapy services are designed to:
    1. Assess the existence or extent of a medical condition;
    2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
    3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.

4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and PHC policy MCUP3113 Telehealth Services).

B. General Guidelines for ~~Submission of Treatment~~ Authorization of ~~Requests (TARs) for~~ PT, OT and ST.

1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).
2. PHC does *not* require Treatment Authorization Requests (TARs) from~~from Partnership~~ contracted providers for PT, OT, or ST for the following circumstances:~~for~~
   a. Members age 21 and over for PT or OT services: No TAR required for up to 12 visits (limit one visit per day) for PT or OT services in a rolling 3~~-~~month period of time.
      1) A TAR will be required for services in excess of 12 visits~~. in a rolling 3 month period of time.~~
   b. Members under age 21 for ST services: No TAR required for up to 12 visits (limit one visit per day) for ~~PT, OT, or~~ ST services in a rolling 3 month period of time.
      ~~.~~
      1) A TAR will be required for services in excess of 12 visits~~ in a rolling 3 month period of time~~.
      2) If services for a member under age 21 are being requested under the EPSDT supplemental benefits, please see section VI.C.1.a. for those requirements.
3. ~~In addition, no RAF is required, but services must be ordered through a writer prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).~~PHC *requires* a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21 for PT or OT : PT~~,~~ and OT ~~, and ST~~ services require a TAR for this age group.
      1) ~~The following general guidelines apply to members age 21 years and over or those under age 21 who are not requesting services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits.~~ If services for a member under age 21 are

being requested under the EPSDT supplemental benefits, please see section VI. C.1~~D~~.a.-d. for that process.

b. Members age 21 and over for ST services.
c. Non-contracted Providers: Must submit a TAR f~~F~~or all PT, OT, ST services.
d. Home Health Services: A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MCUG3011 Criteria for Home Health Services. ~~for non-contracted providers.~~

~~1.~~4. ~~TAR~~Submission Guidelines ~~requirements: Here are the requirements,~~ W~~w~~hen a TAR is R~~r~~equired

a. PHC members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner) for one consultation visit through written prescription of licensed practitioners acting within the scope of their practice.
b. No TAR or ~~Referral Authorization Form (~~RAF~~)~~ is required for the initial evaluation.
c. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
    1) Medical diagnosis necessitating the service with a summary of medical condition
    2) Related medical conditions
    3) Functional limitations
    4) Dates and length of treatment
    5) Therapeutic goals of treatment and current functional status of the patient with respect to these goals
    6) Dates of planned progress review
    7) Specific services to be rendered (e.g. evaluation, treatment, modalities)
d. PHC authorizes ancillary services on a case by case basis, provided that medical necessity has been demonstrated in the submitted documentation.
e. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of PHC's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.
    1) Occupational and physical therapy may be considered medically necessary when:
        a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
        b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
        c) The services are used to assess the existence or extent of impairment due to a medical condition.
        d) A "reasonable expectation" referenced above shall be based upon evidence based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
        e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
    2) Speech Therapy services for members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the member and services meet the following criteria:
        a) Speech Pathologists are reimbursed for services only if the services are performed in

response to the written referral of licensed practitioners, acting within the scope of their practice.

b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.

c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.

d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the member's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.

e) A "reasonable expectation" referenced above shall be based upon evidence based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:

a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.

b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.

c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.

d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.

e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.

f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family

g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.

4) The following services are generally not considered "medically" necessary or are not covered:

a) Recreational therapy

b) Activities that provide diversion or general motivation

~~h)~~c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking

~~i)~~d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health

e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities. ~~Note:~~

i. For members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

~~For physical therapy, occupational therapy or speech therapy services provided through a home health agency, refer to policy MCUG3011 Criteria for Home Health Services.~~

~~Submission of Treatment Authorization Request (TAR)~~

f. ~~Any TAR submitted will state the number of treatment visits approved.~~ If therapy is required beyond the visits initially approved, a new TAR must be submitted.

g. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to PHC.

~~1) The following services are generally not considered "medically" necessary or are not covered:~~

~~2)~~1) ~~Recreational therapy~~

~~3)~~1) ~~Activities that provide diversion or general motivation~~

~~4)~~1) ~~Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking~~

~~5)~~1) ~~Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health~~

~~6)~~ ~~Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities. Note: For members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.~~

~~7)~~1) Continued therapy will not be approved ~~When~~ once a member has met established treatment

goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating ~~physical or occupational therapist~~PT or OT in conjunction with the patient's referring physician.~~, continued therapy will not be approved.~~

C. Guidelines for Physical, Occupational and Speech Therapy for Members Under 21 Years of Age

1. Additional therapy benefits are available for eligible members under the age of 21. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, the definition is expanded to include the definition in III.B~~E.~~- above. These Members may also be eligible to receive PT, OT and ST under a supplemental benefit program called "Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits program.
   a. ~~-~~EPSDT diagnosis and treatment services are covered through PHC, subject to the standards set forth in Section 1905(r) of the Social Security Act (SSA) and Title 42 of the United States Code (USC) Section 1396d(r)(5). Members are only eligible for the EPSDT benefit if they are under 21 years of age and qualify for the full scope of Medi-Cal benefits.
   b. Requests submitted for review under the EPSDT program must state explicitly that the request is for EPSDT supplemental services and must be accompanied by the following information:
      1) The principal diagnosis and significant associated diagnoses
      2) Prognosis
      3) Date of onset of the illness or condition, and etiology if known
      4) Clinical significance or functional impairment caused by the illness or condition
      5) Specific types of services to be rendered by each discipline with physician's prescription when applicable
      6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals
      7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
      8) Any other documentation available which may assist PHC in making the required determinations
   c. PHC will review the documents submitted to confirm that the requirements of Title 22, Section 51340(e) have been met.
   d. Additional information on EPSDT services is included in PHC policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services~~See VI. D. below.~~

~~1.~~ Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age: ~~General Guidelines~~

2. The medical condition of hearing loss is covered for hearing tests~~;~~, evaluations by audiologists, and~~;~~ medical evaluations by head and neck surgeons and physicians in other clinical specialties. ~~,~~ H~~h~~owever, speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators, is the responsibility of California Children's Services (CCS) and the member should be referred to ~~California Children's Services~~CCS in the county of residence or the state where applicable, to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will either be provided by State CCS or by PHC under the Whole Child Model program in participating counties. See policies MPCP2002 California Children's Services and MCCP2024 Whole Child Model for California Children's Services (CCS)[1].

[1] In PHC's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in PHC's service area are participants in the State's CCS program and are not participants in PHC's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

~~a. Additional therapy benefits are available for eligible members under the age of 21. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21 the definition is expanded to include the definition in III.E. above. These Members may also be eligible to receive PT, OT and ST under a supplemental benefit program called "Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits program. See VI. D. below.~~

~~b.~~a. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.

~~c.~~ A member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under PHC. If a member is receiving medically necessary services through the Local Educational Agency (LEA), PHC will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, PHC will approve the additional two visits per week if criteria is met.

~~d. Requests for PT, OT and ST under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)~~

~~EPSDT diagnosis and treatment services are covered through PHC, subject to the standards set forth in Section 1905(r) of the Social Security Act (SSA) and Title 42 of the United States Code (USC) Section 1396d(r)(5). Members are only eligible for the EPSDT benefit if they are under 21 years of age and qualify for the full scope of Medi-Cal benefits.~~

~~Requests for review under this program must state explicitly that the request is for EPSDT supplemental services and must be accompanied by the following information:~~

~~The principal diagnosis and significant associated diagnoses~~

~~Prognosis~~

~~Date of onset of the illness or condition, and etiology if known~~

~~Clinical significance or functional impairment caused by the illness or condition~~

~~Specific types of services to be rendered by each discipline with physician's prescription when applicable~~

~~The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals~~

~~The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care~~

~~Any other documentation available which may assist PHC in making the required determinations~~

~~The service to be provided must meet the following:~~

~~Are necessary to correct or ameliorate defects in physical and mental illnesses and conditions discovered by the screening services under EPSDT~~

~~The supplies, items or equipment to be provided are medical in nature~~

~~The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of service~~

~~The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental~~

~~The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of a severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.~~

~~Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well-designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.~~

~~Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the~~

~~health condition of the beneficiary~~
~~The predicted beneficial outcome of the services outweighs potential harmful effects.~~
~~The available scientific evidence demonstrates that the services improve overall health outcomes as much as, or more than, established alternatives.~~
~~Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.~~

~~e.~~b. ~~PHC will review the documents submitted to confirm that the requirements of Title 22, Section 51340(e) have been met.~~

VII. REFERENCES:

A. Title 22 California Code of Regulation (CCR) Section 51340(e)
B. Title 42 United States Code (USC) Sections 1396d(r)(5)
C. Social Security Act Section 1905(r)
D. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; ~~(~~Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
E. Department of Health Care Services All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
F. 2023 Consolidated Appropriations Act HR2617 Section 4113 Advancing Telehealth Beyond Covid-19

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3028 (previously UP100328)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Mental Health Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1995</td><td colspan="4">Next Review Date: ~~04/10/2025~~06/12/2025
Last Review Date: ~~04/10/2024~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~04/10/2024~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
B. ADM52 – Dispute Resolution Between PHC and MHPs in Delivery of Mental Health Services
C. CMP36 – Delegation Oversight and Monitoring
D. MCUG3024 – Inpatient Utilization Management
E. MCUP3014 – Emergency Services
F. MCUP3101 – Screening and Treatment for Substance Use Disorders
G. MCUG3118 – Prenatal & Perinatal Care
H. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Behavioral Health

III. DEFINITIONS:

A. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

~~A.~~B. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's (PHC's) delegated managed behavioral healthcare organization is Carelon Behavioral Health.

~~B.~~C. (MCP) Managed Care Plan: Partnership HealthPlan of California (PHC) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.

~~C.~~D. (MHP) Mental Health Plan: A county Mental Health Plan in PHCs' service area. MHPs are required to provide and cover all medically necessary SMHS in accordance with their contracts with DHCS.

~~D.~~E. Medical Necessity: Medically necessary services are reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

~~E.~~F. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

(California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

~~F.~~G. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*

Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

~~G.~~H. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*

County Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.

I. Wellness & Recovery Program: PHC's regional Drug Medi-Cal Organized Delivery System waivered program in seven counties within PHC's service area.

IV. ATTACHMENTS:

A. Adult Screening Tool
B. Youth Screening Tool
C. Transitions of Care Tool

V. PURPOSE:

To describe the means for providing mental health services to members of Partnership HealthPlan of California (PHC).

VI. POLICY / PROCEDURE:

A. Mental health services for members with Medi-Cal as their primary insurance are provided as follows:
   1. Members determined to require Non-Specialty Mental Health Services (NSMHS) are served by PHC's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health at (855) 765-9703.
   2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County Mental Health Plan in the member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
   3. DHCS requires MCPs and MHPs to use the Screening and Transition of Care Tools (Attachments A, B & C) for members under age 21 (youth) and for members age 21 and over (adults) to determine the appropriate mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The contents, including the specific wording and order of fields in the Adult and Youth Screening Tools and Transition of Care Tool, must remain intact and unchanged

[1] As per APL 22-012 *Revised*, this does not include medications dispensed from pharmacies and covered under Medi-Cal Rx. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: *https://medi-calrx.dhcs.ca.gov/home/education/*

a. The Screening Tools (Attachments A & B) identify initial indicators of member needs in order to make a determination for referral to either the member's MCP (PHC) for a clinical assessment and medically necessary NSMHS or the MHP for a clinical assessment and medically necessary SMHS.
   1) The Adult Screening Tool includes screening questions that are intended to elicit information about the following topics:
      a) Safety: Information about whether the member needs immediate attention and the reason(s) a member is seeking services
      b) Clinical Experiences: Information about whether the member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
      c) Life Circumstances: Information about challenges the member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
      d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
      e) Questions related to substance use disorders (SUD): If a member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan or ~~Carelon~~PHC (for members residing in one of the 7 counties participating in the Wellness and Recovery regional DMC-ODS program administered by PHC) for SUD assessment. (*See also policy MCUP3101 Screening and Treatment for Substance Use Disorders*) The member may decline this referral without impacting their mental health delivery system referral.
   2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
      a) Safety: Information about whether the member needs immediate attention and the reason(s) a member is seeking services
      b) System Involvement: Information about whether the member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
      c) Life Circumstances: Information about challenges the member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
      d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
      e) SMHS access and referral of other services

b. Adult and Youth Screening Tool questions must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the member is able to respond.

c. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the member must be referred to the MCP or the MHP for clinical assessment and medically necessary services.
   1) Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.
   2) MCPs must use the scoring methodology and follow the referral determination generated by the score.
      a) For all referrals, the member must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.
      b) Referral coordination must include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the Member.
      c) The MCP must coordinate member referrals with MHPs or directly to MHP providers delivering SMHS. MCPs may only refer directly to an MHP provider of SMHS if policies

and procedures have been established and MOUs are in place with the MHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the member.

d. The Adult and Youth Screening Tools are administered by PHC's MBHO, Carelon Behavioral Health, and may be administered in a variety of ways, including in person, by telephone, or by video conference.
   1) The Screening Tools can be administered by clinicians or non-clinicians.

e. The Screening Tools are not required or intended for use with members who are currently receiving mental health services.

f. The Screening Tools are also not required for use with members who contact mental health providers directly to seek mental health services. Contracted mental health providers who are contacted directly by members seeking mental health services may begin the assessment process and provide services during the assessment period without using the Screening Tools.

g. The Adult and Youth Screening Tools do not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations and service recommendations.
   4) MCP requirements to provide EPSDT services.

h. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a member is referred to the MCP or MHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.

i. During the assessment period for both youth and adult members, provision of and payment for NSMHS remain the responsibility of PHC, even if member is found to meet criteria for SMHS.

4. MCPs are required to administer the Transition of Care Tool (Attachment C) to facilitate transitions of care to MHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change. When there is a need to refer a member between levels of care (SMHS and NSMHS), the Transition of Care Tool shall be completed by the treating clinical provider and submitted as part of the referral.
   a. The Transition of Care Tool is used for both adults and youth and is intended to document the member's information and provide information from the entity making the referral to the receiving delivery system to begin the member's care transition.
   b. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.
   c. The Transition of Care Tool includes specific fields to document the following elements:
      1) Referring plan contact information and care team
      2) Member demographics and contact information
      3) Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications
      4) Requested services and plan contact information
   d. Following the completion of the Transition of Care Tool, PHC or its delegate, Carelon Behavioral Health, ~~MCPs~~ shall:
      1) Refer the member to the MHP, or directly to an MHP provider delivering SMHS if appropriate processes have been established in coordination with MHPs.

2) Coordinate member care services with MHPs to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the member has been connected with a provider in the new system, the new provider accepts the care of the member, and medically necessary services have been made available to the member.
3) All appropriate consents must be obtained in accordance with accepted standards of clinical practice.
4) The referring party will ensure the transition follows closed loop referral guidelines as defined in III.A.
5) Outcomes of referrals are monitored through monthly referral trackers between PHC and each MHP.

e. The determination to transition services to and/or add services from the MHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols?
1) Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician.
2) Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice

f. The Transition of Care Tool is not considered an assessment and does not replace:
1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
2) MCP protocols that address clinically appropriate, timely, and equitable access to care
3) MCP clinical assessments, level of care determinations, and service recommendations
4) MCP requirements to provide EPSDT services

B. Members may self-refer for mental health services to an appropriate mental health provider. Members do not need a referral from their Primary Care Provider (PCP) to receive mental health services.

C. In an effort to coordinate medical and mental health care, providers should ask members to sign a release of information so that the member's providers can best coordinate care. However, the release of information is not a condition for services to be provided.

D. The County Mental Health Plan's (MHP's) role in providing mental health services:
1. County MHPs provide crisis assessments, SMHS and authorizations for acute in-patient psychiatric care for members in their counties who meet access criteria as described in Behavioral Health Information Notice (BHIN) 21-073.
a. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider.
b. The County crisis stabilization service acts as a backup after hours and on weekends as well as at other times of provider unavailability.
c. Members may call the County crisis line directly, without a referral.
d. Members eligible for mental health services from PHC delegated managed behavioral health organizations will be re-directed to appropriate County crisis services as needed.
e. Should services be rendered concurrently in both the NSMHS and SMHS systems for both members who are under the age of 21 and those 21 years and older, PHC and County Mental Health Plans shall coordinate care as mutually agreed upon, while ensuring member's choice is considered. This collaboration shall continue through transitions between systems of care.

E. The PCP's role in providing mental health services:
1. A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or PHC's delegated managed behavioral health organization, Carelon Behavioral Health ~~(formerly Beacon Health Options)~~, for telephone consultation. For detailed screening, referral and consultation procedures, PCPs can refer to PHC Policy MPCP2017 Scope

of Primary Care - Behavioral Health and Indications for Referral Guidelines.

a. If a member's screening is positive and indicates further assessment, the assessment may be performed either by the PCP or by referral to a network mental health provider.
b. If the member's PCP cannot perform the mental health assessment, they must refer the member to the appropriate provider and ensure referral to the appropriate delivery system for mental health services, either in the MCPs provider network or the county MHP's network
c. Members may then be treated by the PCP within the PCP's scope of practice; or
d. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the MCP network
e. At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCPs provider network.

F. Managed Care Plan's responsibility for providing NSMHS:
1. PHC is responsible for the delivery of NSMHS (as defined in III.F.) for the following populations:
   a. Members who are 21 year of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
   b. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;
   c. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy; and
   d. Members of any age with potential mental health disorders not yet diagnosed.
2. NSMHS may be delivered~~,~~ by PCPs within their scope of practice, or through PHC's provider network which shall provide a full range of covered NSMHS to its pediatric and adult members.
3. In accordance with California Welfare and Institutions Code (WIC) sections 14059.5 and 14184.402, services that are "medically necessary" or a "medical necessity" (see III.F~~E~~.) to correct or ameliorate health conditions for members under the age of 21 shall be in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS. These services are covered by PHC as Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services (per policy MCCP2022) regardless of whether the services are covered in the state's Medicaid State Plan.
   a. Consistent with federal guidance from Centers for Medicare & Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.
4. Consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS are covered by PHC even when:
   a. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
   b. Services are not included in an individual treatment plan;
   c. The member has a co-occurring mental health condition and substance use disorder (SUD); OR
   d. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

G. PHC provides or arranges for the provision of NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs as follows:
1. PHC covers physician administered drugs administered by a health care professional in a clinic,

physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions

2. PHC does not cover pharmacy benefits and services pursuant to APL 22-012 *Revised* ~~Executive Order N-01-19~~ and the Medi-Cal Rx program. ~~Medications covered under the Medi-Cal Rx Contract Drug List can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/.~~ All medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/~~Magellan~~ DHCS contracted pharmacy administrator instead of PHC. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/

H. PHC covers up to 20 individual and/or group counseling sessions for pregnant and postpartum members with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. (*see also policy MCUP3118 Prenatal & Perinatal Care*)

~~I.~~

~~J.~~I. PHC provides medical case management and covers and pays for all medically necessary Medi-Cal-covered physical health care services, not otherwise excluded by contract, for PHC beneficiaries receiving SMHS. PHC coordinates care with the MHP, and is responsible for the appropriate management of a member's mental and physical health which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health services, both within and outside the MCPs provider network.

~~K.~~J. PHC is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

~~L.~~K. PHC is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as well as for emergency services necessary to stabilize the member. *(see also policy MCUP3101 Screening and Treatment for Substance Use Disorders)*

~~M.~~L. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers whether delivered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) model or the DMC State Plan model are covered by the counties respectively, whether or not the member has a co-occurring mental health condition. *(S~~s~~ee also policy MCUP3101 Screening and Treatment for Substance Use Disorders.)*

~~N.~~M. The Parity in Mental Health and Substance Use Disorder Benefits requirements of Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) stipulate that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Therefore, PHC ensures direct access to an initial mental health assessment by a licensed mental health provider within the PHC provider network, and no referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

1. PHC provides information regarding mental health services for members in the PHC Medi-Cal Member Handbook as well as through PHC's website www.partnershiphp.org. Applicable member informing materials state that referral and prior authorization are not required for a member to seek an initial mental health assessment from a network mental health provider.
2. PHC covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.

~~O.~~N. Dispute Resolution

1. If a dispute occurs between the local County Mental Health Plan (MHP) and Partnership HealthPlan of California (PHC) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the MHP and PHC will participate in a dispute resolution process as defined in PHC Policy ADM52 Dispute Resolution Between PHC and MHPs in Delivery of Mental Health Services.
    a. PHC does not delegate the responsibility of MCP and MHP dispute resolution to any Subcontractor.

~~P.~~O. Delegation Oversight and Monitoring

1. PHC delegates the administration of certain mental health services to a managed behavioral health organization.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to PHC's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 10, Section 10.8.D
B. Medi-Cal Provider Manual/ Guidelines: Non-Specialty Mental Health Services: Psychiatric and Psychological Services *(non spec mental)*
C. Title 9 of the California Code of Regulations (CCR) Chapter 11
D. Title 9 CCR Sections 1820.205, 1830.205, 1830.210, 1850.505, 1850.515, 1850.525, 1850.535
E. Title 22 CCR Section 53855
F. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)
G. Title 42 United States Code (USC) § 1396d(r)(5)
H. Welfare and Institutions Codes (WIC) § 14059.5, 14132.03, 14184.402 § 14189
I. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
    a. Specialty Mental Health Services Memorandum of Understanding Template
    b. Substance Use Disorder Treatment Services Memorandum of Understanding Template
J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (04/08/2022)
M. DHCS APL 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)
N. Behavioral Health Information Notice (BHIN) 21-073
O. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
P. County specific Mental Health Plan Memoranda of Understanding (MOUs)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

Policy/Procedure Number:		Lead Department: Health Services
Policy/Procedure Title: Mental Health Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1995	**Next Review Date: 04/10/202506/12/2025** **Last Review Date: 06/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

X. **REVISION DATES:** 08/11/95; 10/10/97 (name change only); 06/21/00; 12/19/2001; 08/20/03, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 04/21/10; 03/16/11; 08/15/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 10/12/22; 06/14/23; 04/10/24; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

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

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Adult Screening Tool for Medi-Cal Mental Health Services

The Adult Screening Tool for Medi-Cal Mental Health Services is required for use when an individual age 21 or older, who is not currently receiving mental health services, contacts the Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Adult Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. Each scored question is a "Yes" or "No" question. Not every question is scored.
2. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
3. Select/mark the number in the "Yes" or "No" column based on the response provided.
4. If the individual is unable or chooses not to answer a question, skip the question and score it as "0."
5. If the individual responds "Yes" to question 11, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality after the screening is completed. Referral coordination should include sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
6. A response of "Yes" to question 13 or 14 does not impact the screening score. If the individual responds "Yes" to question 13 or question 14, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
7. Once responses to questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

8. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

Adult Screening Tool for Medi-Cal Mental Health Services

Name:	Date of Birth:
Age:	***NOTE:*** *If age 20 or younger, switch to the "Youth Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No
2. Can you tell me the reason you are seeking mental health services today?	
3. Are you currently receiving mental health treatment? • If yes, where are you receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

Question	Yes	No
4. Have you ever sought help before today for your mental health needs?	☐ 1	☐ 0
5. Are you currently taking, or have you ever taken, any prescription mental health medication?	☐ 1	☐ 0
6. Are you without housing or a safe place to sleep?	☐ 1	☐ 0
7. Are you having difficulties in important areas of your life like school, work, relationships, or housing, because of how you are feeling or due to your mental health?	☐ 1	☐ 0
8. Have you recently had any changes or challenges with areas of your life, such as personal hygiene, sleep, energy level, appetite, weight, sexual activity, concentration, or motivation?	☐ 1	☐ 0
9. Have you completely withdrawn from all or almost all of your relationships, such as family, friends, or other important people?	☐ 1	☐ 0
10. Have you sought emergency treatment for emotional distress or been admitted to a psychiatric hospital in the past year?	☐ 1	☐ 0
a. If yes, have you had more than one hospitalization?	☐ 1	☐ 0
b. If yes, was your last hospitalization within the last six months?	☐ 1	☐ 0
11. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and not wake up?[1] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
12. Have you recently engaged in any self-harming behavior like cutting or hurting yourself?	☐ 2	☐ 0

Question	Yes	No
13. Are you concerned about your current level of alcohol or drug use?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –
14. Has alcohol or any other drug or medication caused you to behave in a way that was dangerous to yourself or others (e.g., impaired driving, overdose, aggression, loss of memory, being arrested, etc.)?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #8

If score is 6 or above, refer to the MHP per instruction #8

[1] A response of "yes" to question 11 results in immediate coordination of a referral to a clinician for further evaluation of suicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

[2] Questions 13 and 14 are not scored. A response of "yes" results in a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

Clear Form

Youth Screening Tool for Medi-Cal Mental Health Services

The Youth Screening Tool for Medi-Cal Mental Health Services is required for use when an individual under age 21, or a person on behalf of an individual under age 21, who is not currently receiving mental health services, contacts their Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Youth Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. There are two versions of the Youth Screening Tool for Medi-Cal Mental Health Services:
    - One version of the tool is used when a youth is responding on their own behalf: ***Youth Screening Tool for Medi-Cal Mental Health Services: Youth Respondent.***
    - One version of the tool is used when a person is responding on behalf of the youth: ***Youth Screening Tool for Medi-Cal Mental Health Services: Respondent on Behalf of Youth***.
2. The answer to screening question 2 determines which version of the tool is used.
3. Each scored question is a “Yes” or “No” question. Not every question is scored.
4. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
5. Select/mark the number in the “Yes” or “No” column based on the response provided.
6. If the youth, or the person responding on their behalf, is unable or chooses not to answer a question, skip the question and score it as “0.”

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

7. If a response to question 5 indicates that a child who is age 3 or younger has not seen a pediatrician in the last 6 months, or that a child/youth age 4 or older has not seen a pediatrician or primary care physician (PCP) in the last year, the screener must offer to connect them to their MCP for a pediatrician/PCP visit in addition to the mental health delivery system referral generated by the screening score.[2]
8. If the youth, or the person responding on their behalf, responds "Yes" to question 6, 7, or 9, they meet criteria for specialty mental health services per BHIN 21-073. In these cases, the screening is not required, and the screener must offer and coordinate a referral for clinical assessment by the MHP. Referral coordination must include follow up to ensure an assessment has been made available to the individual. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.
9. If the youth, or the person responding on their behalf, responds "Yes" to question 19, 20, or 21, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. Referral coordination should include sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
10. A response of "Yes" to question 17 does not impact the screening score. If the youth, or the person responding on their behalf, responds "Yes" to question 17, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
11. Once responses to all questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.
12. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

[2] Bright Futures well-child visit guidelines indicate a child age 4 and older should be seen by a pediatrician annually, and a child age 3 and under should be seen by a pediatrician every 1, 3, or 6 months depending on their age.

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

Name:	Date of Birth:
Age:	***NOTE:** If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ***NOTE:** If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

***NOTE:** If someone else, please switch to the "Respondent on Behalf of Youth" version of the tool.*

3. Can you tell me the reason you are seeking mental health services today?

4. Are you currently receiving mental health treatment? • If yes, where are you receiving those services? ***NOTE:** If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

5. When was the last time you saw your pediatrician or primary care doctor?

***NOTE:** If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Are you currently or have you ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Are you currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Have you ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Are you currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Have you ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Are you having thoughts, feelings or behaviors that make it hard for you at home, school, or work?	☐ 1	☐ 0
12. Are you having thoughts, feelings, or behaviors that make it hard to be with your friends or have fun?	☐ 1	☐ 0
13. Are you often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the person who takes care of you often not around or unable to take care of you?	☐ 1	☐ 0
15. Do you feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting you?	☐ 1	☐ 0
17. Are you having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —

Question	Yes	No
18. Is anyone in your family or who lives with you having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Do you hurt yourself on purpose?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Do you have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of your family told you that you need help with anxiety, depression, or your behaviors?	☐ 2	☐ 0
23. Have you been seen in the hospital to get help for a mental health condition within the last six months?	☐ 2	☐ 0

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #11

If score is 6 or above, refer to the MHP per instruction #11

1 Questions 6, 7, and 9 are not scored. A response of "Yes" results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of "Yes" results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of "Yes" to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Youth Screening Tool for Medi-Cal Mental Health Services

Respondent on Behalf of Youth

Name:	Date of Birth:
Age:	***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If calling about themself, switch to the "Youth Respondent" version of the tool.*

3. Can you tell me the reason you are seeking mental health services for the child/youth today?

4. Is the child/youth currently receiving mental health treatment? • If yes, where are they receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP or MCP do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

5. When was the last time the child/youth saw their pediatrician or primary care provider?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Is the child/youth currently or have they ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Is the child/youth currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Has the child/youth ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Is the child/youth currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Has the child/youth ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Is the child/youth having thoughts, feelings or behaviors that make it hard for them at home, school, or work?	☐ 1	☐ 0
12. Is the child/youth having thoughts, feelings, or behaviors that make it hard to be with their friends or have fun?	☐ 1	☐ 0
13. Is the child/youth often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the primary caretaker for the child/youth often not around or unable to take care of the child/youth?	☐ 1	☐ 0
15. Does the child/youth feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting the child/youth?	☐ 1	☐ 0

Question	Yes	No
17. Is the child/youth having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —
18. Is anyone in the child/youth's family or who lives with them having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Does the child/youth self-harm or behave in a manner that may cause harm to themselves?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, has the child/youth had thoughts about ending their life, wished they were dead, or wished they could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Does the child/youth have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of the child/youth's family said that the child/youth needs help with anxiety, depression, or their behaviors?	☐ 2	☐ 0
23. Has the child/youth been seen in a hospital for a mental health condition within the last six months?	☐ 2	☐ 0

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #11

If score is 6 or above, refer to the MHP per instruction #11

1 Questions 6, 7, and 9 are not scored. A response of “Yes” results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of “Yes” results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of “Yes” to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Transition of Care Tool for Medi-Cal Mental Health Services

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Instructions: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the plan the beneficiary is being referred to.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:

BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐	
	Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐	
Address:		
City:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

BENEFICIARY INFORMATION

Behavioral Health Diagnosis or Diagnoses, if known:

Supporting Clinical Documents Included:

Cultural and Linguistic Requests:

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

☐ Additional Pages Attached

BENEFICIARY INFORMATION

Current Environmental Factors (including changes in caregiver relationships, living environment, and/or educational considerations):

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors and/or traumatic experiences):

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Additional Pages Attached

BENEFICIARY INFORMATION	
Referring Provider/Current Care Team:	Phone:

SERVICES REQUESTED: ☐ Transition of Care ☐ Addition of Service(s)

What service(s) is the beneficiary being referred for?

TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION

☐ Managed Care Plan:

Managed Care Plan Contact Information

Fax: Phone: Toll Free: TTY:

☐ County Mental Health Plan:

County Mental Health Plan Contact Information

Fax: Phone: Toll Free: TTY:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3101</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Screening and Treatment for Substance Use Disorders</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/21/2012</td><td colspan="4">Next Review Date: ~~06/14/2024~~06/12/2025
Last Review Date: ~~06/14/2023~~06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td><td></td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~06/12/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
B. MCUP3028 – Mental Health Services
C. MCQP1021 – Initial Health Appointment
D. MPQP1022 – Site Review Requirements and Guidelines
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MCQG1005 – Adult Preventive Health Guidelines
G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
H. CMP26 – Verification of Caller Identity and Release of Information.

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims
D. Member Services

III. DEFINITIONS:

A. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with "addiction." According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as "non-medical use" of prescription medications). The most common substance use disorders in the United States include the following:
   1. Alcohol Use Disorder
   2. Tobacco Use Disorder
   3. Cannabis Use Disorder
   4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
   5. Opioid Use Disorder
B. Unhealthy Alcohol Use (UAU): Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder

(e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:

1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks for adult men over a 2-hour period.
2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.

C. Standard Alcohol Drink (US definition): 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz "shot" of hard liquor (about 40% alcohol)

D. Unhealthy Drug Use (UDU): The United States Preventive Services Taskforce (USPSTF) defines UDU as "the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual." Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, PHC expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.

E. Unhealthy Drug Use Screening (UDUS): According to USPSTF, UDUS is defined as "asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format." It does not refer to body fluid substance screening.

F. **SABIRT**: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment: An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:

1. Screening - a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
2. Brief intervention - a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
3. Referral to treatment - a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

SABIRT represents an expansion of SBIRT with the addition of "brief assessment" (e.g., use of a validated assessment tool to determine if unhealthy alcohol of drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.

G. Covered Program: pursuant to 42 CFR Part 2 §2.11, means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.

H. Records: pursuant to 42 CFR Part 2 §2.11, means any information, whether recorded or not, created by,

received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

IV. ATTACHMENTS:

A. Recommended Tools and Training Resources for SABIRT
B. [AC1]Pocket Screening and Brief Intervention for Alcohol Use Disorders
C. Application to be a Contracted Brief Behavioral Counseling Intervention/Referral to Treatment Provider
D. Review Documentation for Applicants to become a Contracted Behavioral Counseling Intervention/ Referral to Treatment Provider
~~D.~~ Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders
E.

V. PURPOSE:

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

VI. POLICY / PROCEDURE:

A. Covered Services:
   1. Alcohol and Other Drug Treatment Services covered through the Counties:
      Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California's (PHC's) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
   2. Wellness and Recovery Benefit through PHC:
      Effective July 1, 2020, PHC members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
      a. Member has been determined eligible for full scope Medi-Cal
      b. Member is not institutionalized
      c. Member has a substance-related and addictive disorder per the current "Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition" (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
      d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND
      e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County
   3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by PHC medical providers should be billed to PHC as any other encounter, using appropriate encounter and management CPT codes.
      a. Many of the medications used to treat addictions (often referred to as Medications for Addiction

Treatment, or [MAT]) require no special or additional training or certification.

1) Primary care clinicians may prescribe ~~(e.g.,~~ naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder~~)~~.
2) ~~Methadone for the treatment of opioid use disorder is, howeverhowever, relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with somewith some exceptions for acute care hospitals and emergency department settings. However, while~~T ~~t~~reating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection ~~(Vivitrol) are~~is ~~is fully~~ [AC2]within the scope of primary care practice.
   a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
   ~~a)~~b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings. ~~.~~

b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists providing office visits for substance use disorder treatment may use the ICD 10 code F11.2x or F10.2x to avoid the requirement for a Referral Authorization normally required for assigned patients.
c. Adjunctive counseling for SUD by non-licensed providers is not covered by PHC, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the member is a qualifying member for SUD services through the Wellness and Recovery Program.

4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter (APL) 21-014. These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all members aged 11 years and older, including pregnant members.
   a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § 2.14 and may be released in compliance with PHC policy CMP-26 Verification of Caller Identity and Release of Information.
5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy MCQG1005 Adult Preventive Health Guidelines.

B. PHC Responsibility, Related to SUD Services
1. Identification
   a. PHC may identify a member in need of SUD services through one of the following:
      1) Telephone inquiries from Member or Provider
      2) During Prior Authorization and/or Concurrent Review Processes
      3) Through Care Coordination programs activity
      4) Through call center activities performed by PHC's delegated managed behavioral health organization
2. Referral
   a. PHC, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the PHC website (see VI.C.8.c. below for details). If a placement within the Member's service area is not available, the member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from PHC is required for referral to outpatient substance use services. (Please note, in PHC's Wellness & Recovery

benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MCUP3144 Residential Substance Use Disorder Treatment Authorization for further information.)

3. Coordination of Care
   a. PHC will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of members entering treatment for outpatient Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the member's Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient's consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.
   b. Wherever possible, PHC will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.

C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
   1. Overview.
      a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act's requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
      b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.
      c. Unhealthy Drug Use: Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as

cocaine and heroin. However, studies have demonstrated significantly positive benefits from various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

2. Non-Covered Services
   a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is "Have you consumed **any** beer, wine or other alcoholic beverage in the past year."
3. Covered Services
   a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to PHC members via the evidence of coverage and via PHC's external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
      1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
      2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
      3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
   b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant members, primary care includes clinicians caring for the pregnant member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
   c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, PHC contracted medical specialists and credentialed SUD counselors. PCPs may also utilize PHC's delegated managed behavioral health organization using the referral forms and process described in PHC policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting. Any non-PCP provider or organization wanting to provide Brief Behavioral Counseling Intervention services needs to apply to PHC, and be approved by the Chief Medical Officer (CMO) or Medical Director designee. Attachment C is an application form "Application to be a Contracted Brief Behavioral

Counseling Intervention/Referral to Treatment Provider." Attachment D is the review documentation for applicants, with a checklist of review criteria. Each application will be reviewed by a Performance Improvement Clinical Specialist (PICS) who conducts site reviews in the Quality and Performance Improvement Department at PHC, whose findings and recommendations will be provided to the CMO or Medical Director Designee for final decision upon approval. Once a Provider or organization is approved as a subcontractor, no prior authorization for SABIRT services is required.

4. Training and Proficiency - Primary Care Providers
   Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:
   a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
      1) Licensed Physician
      2) Physician Assistant
      3) Nurse Practitioner
      4) Psychologist
   b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
      1) Licensed Marriage and Family Therapist
      2) Registered Nurse
      3) Certified Nurse Midwife
      4) Licensed Midwife
      5) Licensed Clinical Social Worker
      6) Licensed Professional Clinical Counselor
   c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.
   d. Other members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
      1) They have at least 100 hours of clinical experience in their current role.
      2) They are trained to provide the services they are providing
      3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
   e. Providers must develop policies and procedures for SABIRT services. These should include:
      1) The PCP site will maintain a list of licensed and registered professionals and non-licensed members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
      2) A quality assurance process for SABIRT services
      3) PHC and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
   f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health Services at PHC.
5. Training and Proficiency – Contracted Brief Behavioral Counseling Intervention/Referral to

Treatment Providers

a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
   1) Licensed Physician
   2) Physician Assistant
   3) Nurse Practitioner
   4) Psychologist

b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
   1) Licensed Marriage and Family Therapist
   2) Registered Nurse
   3) Certified Nurse Midwife
   4) Licensed Midwife
   5) Licensed Clinical Social Worker
   6) Licensed Professional Clinical Counselor

c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.

d. Other members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
   1) They have at least 100 hours of clinical experience in their current role.
   2) They are trained to provide the services they are providing
   3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.

e. Contracted Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services, which will be submitted and approved by PHC prior to providing services. These should include:
   1) The Contracted Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
   2) A quality assurance process for SABIRT services
   3) PHC and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.

6. Screening and Brief Assessment
   a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
   b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
   c. The screening and brief assessment process does not diagnose a disorder, but it does determine whether a problem exists. Providers should consider risks and benefits of administration of screening and assessment tools, including discussion of these as part of informed consent, as

well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.

d. Screening and Brief Assessment Tools

1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.

~~1) Screening Tools for Unhealthy Alcohol Use~~

2) Note that a~~A~~ validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:

a) ~~for alcohol use must include the~~ AUDIT (10 question screening and assessment)~~,~~

b) AUDIT-C (3 question screening also validated in pregnant individuals)~~, or the~~

~~a)~~c) ~~NIDA Quick Screen for Adults-Single Question~~NIAAA Single Alcohol Screening Question (~~Single Question~~SASQ) ~~Screener, or TAPS as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures. Validated screening tools include the following:~~[AC3]

~~a) The Alcohol Use Disorder Identification Test - Consumption (AUDIT-C) is considered validated by the United States National Institute on Drug Abuse (NIDA)~~

~~b) The NIDA Quick Screen for Adults-Single Question is acceptable by USPSTF as a form of expanded screening, however NIDA discontinued the Quick Screen and now recommends using the TAPS tool per c) below.~~

~~i. Non-Senior Adults:~~

~~ii. Men under age 65: In the past year, have you had 5 or more drinks in one day?~~

~~iii. Women under age 65: In the past year, have you had 4 or more drinks in one day?~~

~~iv. Seniors (aged 65 and older): In the past year, have you had 4 or more alcohol drinks in one day?~~

~~c) Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool~~

~~i. A self or clinician-administered tool available in online platform, TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component, TAPS-2 as described in VI.C.6.e.2) below.~~

~~2) Screening Tools for Unhealthy Drug Use considered validated and highlighted by the :~~

~~a) 4 Questions: A four-question screen that inquires about alcohol use, tobacco use, prescription medication use for non-medical reasons, and illegal drug use. (This may be feasible for implementation in busy clinic settings, but alone may be limited in scope of information obtained.) Note that while USPSTF still recommends this screening tool, discontinued the Quick Screen and now recommends using the TAPS tool per b) below.~~

~~b) Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS-1)~~

~~c) A self or clinician-administered tool available in online platform, TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component, TAPS-2 as described in VI.C.6.e.2) below.~~

~~3) Other Tools for Screening for Unhealthy Drug Use deemed acceptable by DHCS include:~~

~~a) Cut Down - Annoyed - Guilty - Eye Opener Adapted to Include Drugs (CAGE-AID)~~

~~b) Drug Abuse Screening Test (DAST-10)~~

~~c) Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents~~

~~d) Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents~~
~~e) Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population~~

~~e. Brief Assessment Tools~~
~~1) Brief Assessment Tool for Unhealthy Alcohol Use:~~
~~a) The Alcohol Use Disorder Identification Test (AUDIT)~~
~~i. Regardless of the drug screening and assessment tools used, at least one screening or assessment tool for alcohol use must include the AUDIT, AUDIT-C (also validated in pregnant individuals) or the NIDA Quick Screen for Adults-Single Question as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures (see above re: NIDA transition from Quick Screen to TAPS).~~
~~2) Brief Assessment Tools for Unhealthy Drug Use:~~
~~a) : After a positive screen on TAPS-1, TAPS-2 guides clinicians through brief substance-specific assessment questions to arrive at a risk level for that substance. ranging in severity from "problem use" to the more severe substance use disorder (previously "Dependence" from earlier editions of the DSM).~~
~~b) Drug Abuse Screening Test 20 (DAST-20)~~
~~c) Prenatal Risk Overview (PRO)~~
~~i. A multi-dimensional assessment of 12 domains of psychosocial risk in pregnancy, of which one domain (3 questions) addresses Drug Use.~~
~~For Pregnant individuals, consider using any of the validated tools recommended by ACOG: The 4Ps Plus, NIDA Quick Screen (TAPS – see above), or the CRAFFT.~~

7. Brief Intervention:
   i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to members who are identified as having risky or hazardous alcohol use.
   b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
      1) Personalized feedback
      2) Education and resources
      3) Negotiated action plans
      4) Drinking use diaries, and
      5) Stress management.
   c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
      1) Feedback to the patient regarding screening and assessment results
      2) Discussion of negative consequences that have occurred and the overall severity of the problem
      3) Supporting the patient in making behavior changes
      4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
         a) Providers must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment.

8. SABIRT Referral to Treatment
   a. No prior authorization is required for SABIRT services or for referral to outpatient services related to substance use or abuse.
   b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5, or those whose diagnoses are uncertain, should be referred for further evaluation and treatment.
   ~~c.~~ PCPs in counties without PHC Wellness and Recovery coverage should refer members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California county contacts for local substance use disorder treatment information and referrals can be found on the PHC website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx under the heading "Alcohol and Drug Treatment ~~(Substance Use Services)~~." In PHC Wellness and Recovery counties, the referral process is outlined on the PHC website at this page: https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx~~http://www.partnershiphp.org/Providers/HealthServices/Pages/Drug%20Medi-Cal/Drug-Medi-Cal-Benefit.aspx~~
   ~~d.~~c. Referrals to treatment must be documented in the medical record.
9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the member and the time spent with the member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
   a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
   b. Documentation should also include:
      1) The service provided (e.g., screen and brief intervention)
      2) The name of the screening instrument and the score on the electronic health record
      3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
      4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
    a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
       1) Review member's response to an age-appropriate, validated alcohol or drug use screening question
       2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
       3) Conduct Brief Behavioral Counseling Intervention sessions
       4) Refer members with potential unhealthy alcohol or drug use and/or SUD for treatment
    b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
    c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
    a. The following billing codes should be used for billing SABIRT services to patients with:
       1) Medi-Cal and no other primary insurance coverage (such as Medicare):
          a) Annual alcohol misuse screening: G0442
          b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)

c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050

2) Medicare/Medi-Cal members should have SABIRT billed through Medicare, using approved Medicare codes.

VII. REFERENCES:

A. For clinician support: NIAAA's Clinician Guide "Helping Patients Who Drink Too Much" provides two methods for screening: a "single question" to use during a clinical interview and a written self-report instrument (AUDIT). http://www.niaaa.nih.gov/guide

B. The AUDIT and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions https://www.samhsa.gov/national-coe-integrated-health-solutions~~https://www.thenationalcouncil.org/integrated-health-coe/resources/~~

~~B.~~C. Quick reference guide for screening for drug use in general medical settings: screening_qr.pdf (nih.gov)

~~C.~~

D. NIDA Quick Screen and NIDA Modified ASSIST: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings: https://www.who.int/publications/i/item/978924159938-2

F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: https://www.drugabuse.gov/taps/#/

~~G. Prenatal Risk Overview (PRO): Harrison, P.A. & Sidebottom, A.C. (2008). Systematic prenatal screening for psychosocial risks. Journal for Health Care for Poor and Underserved, 19, 258-276.~~

~~2. Available online: https://www.prenatalrisk.org/Login.aspx (no cost, but requires registration)~~

G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification. J Addict Med. 2011 Sep;5(3):221-6.

H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a

~~H.~~I. Information on the Medicare SBIRT benefit and requirements: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf

~~I.~~J. Substance Abuse and Mental Health Services Administration (SAMHSA) website: https://www.samhsa.gov/disorders/substance-use

~~J.~~K. Operational Instructional Letter (OIL) 398-13

~~K.~~L. DHCS: All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)

~~L.~~M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

N. Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage

O. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)

1. Specialty Mental Health Services Memorandum of Understanding Template
2. Substance Use Disorder Treatment Services Memorandum of Understanding Template

P. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)

Q. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4), Part 2 §2.11 and § 2.14

R. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1

S. InterQual® Behavioral Health Criteria

Policy/Procedure Number: MCUP3101		Lead Department: Health Services
Policy/Procedure Title: Screening and Treatment for Substance Use Disorders		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/21/2012	**Next Review Date: 06/14/202406/12/2025** **Last Review Date: 06/14/202306/12/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 03/21/12; 02/19/14; 06/18/14; 06/17/15; 04/20/16; 03/15/17; 08/16/17; *02/14/18; 08/08/18; 11/14/18; 11/13/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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

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

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

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

~~**TRAINING RESOURCES FOR**~~

~~**Alcohol and Drug Screening, Assessment, Brief Interventions,**~~

~~**and Referral to Treatment (SABIRT)**~~

~~A list of trainings and resources is included below. Additional resources are available on the DHCS website.~~

~~NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities~~

- ~~Underage and College Drinking Research~~
- ~~Treatment Navigator tool~~
- ~~Surveillance Reports and Epidemiologic Resources~~
- ~~Additional Reports and Resources~~

~~SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2)~~

~~https://sbirt.clinicalencounters.com/activity/sbirt-core/~~

- ~~Four hour training: $49 per individual; group rates are available~~
- ~~CME/CE NYS OASAS Credit approved~~

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

~~SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings~~ https://www.samhsa.gov/brss-tacs/video-trainings

- ~~Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:~~

~~USPSTF Recommendation: Screening for Unhealthy Drug Use~~

~~Podcast Describing the Taskforce's 2020 Recommendation~~

- ~~https://edhub.ama-assn.org/jn-learning/audio-player/18514824~~

~~NIDA Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool~~

~~https://nida.nih.gov/taps2/#/~~

~~NIDA Quick Screen and NIDA Modified ASSIST~~

- ~~https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf~~

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	Screening Tools	Brief Assessment Tools	Recommending Agencies	Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
AUDIT	X	X	NIDA				X		

Partnership HealthPlan of California

Recommended Tools and Training Resources for

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	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	Screening Tools	Brief Assessment Tools	Recommending Agencies	Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
NIDA - The Alcohol Use Disorders Identification Test (10 questions) **Meets* **HEDIS** *measure for IHA*			DHCS NCQA						
AUDIT-C NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) **Meets* **HEDIS** *measure for IHA*	X		NIDA NIAAA USPSTF DHCS	X			X		
SASQ NIAAA Single Alcohol Screening Question **Meets* **HEDIS** *measure for IHA*	X		NIAAA USPSTF	X			X		
TAPS-1 Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
TAPS-2 Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
NIDA Quick Screen (4 questions) *(Recommended by DHCS,ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)*	X		NIDA DHCS USPSTF ACOG	X			X	X	X
NIDA-Modified ASSIST NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) *(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)*		X	NIDA DHCS USPSTF				X	X	X
DAST-10	X	X	DHCS		X			X	

Partnership HealthPlan of California

Recommended Tools and Training Resources for

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	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)			NIDA						
DAST-20 Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
4P's Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
4 P's Plus *(Plus includes additional questions about depression and domestic violence)*		X	ACOG	X			X	X	X
CRAFFT Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X *(Appropriate for non-pregnant adolescents)*		X	X	
MAST-G Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
PRO (Prenatal Risk Overview) *(Recommended by USPSTF but official website is no longer available)*			USPSTF	X			X	X	X

*As per VI.C.6.d.2) of policy MCUP3101, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
ACOG	The American College of Obstetricians and Gynecologists	Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
NCQA/ HEDIS	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH)	NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities • Underage and College Drinking Research • Treatment Navigator tool • Surveillance Reports and Epidemiologic Resources • Additional Reports and Resources
NIDA	National Institute on Drug Abuse	Screening and Assessment Tools: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2) https://sbirt.clinicalencounters.com/activity/sbirt-core/ • Four hour training: $49 per individual; group rates are available • CME/CE NYS OASAS Credit approved

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
SAMHSA	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings https://www.samhsa.gov/brss-tacs/video-trainings • Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:
USPSTF	United States Preventive Services Task Force	• Alcohol screening and intervention tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions • Unhealthy Drug Use Screening Tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening • USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation https://edhub.ama-assn.org/jn-learning/audio-player/18514824

Updated

A POCKET GUIDE FOR

Alcohol Screening and Brief Intervention

Updated 2005 Edition

This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide.*

Visit ***www.niaaa.nih.gov/guide*** for related professional support resources, including:

- patient education handouts
- preformatted progress notes
- animated slide show for training
- materials in Spanish

Or contact:

NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
(301) 443–3860
www.niaaa.nih.gov

NIAAA National Institute on Alcohol Abuse and Alcoholism

NATIONAL INSTITUTES OF HEALTH

HOW TO SCREEN FOR HEAVY DRINKING

STEP 1 Ask About Alcohol Use

Ask: Do you sometimes drink beer, wine, or other alcoholic beverages?

NO → Screening complete.

YES → **Ask the screening question about heavy drinking days:**

How many times in the past year have you had . . .

5 or more drinks in a day? *(for men)*

4 or more drinks in a day? *(for women)*

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

Is the answer 1 or more times?

NO →

- **Advise staying within these limits:**

  Maximum Drinking Limits

  For healthy **men up to age 65**—
  - no more than **4** drinks in a **day** AND
  - no more than **14** drinks in a **week**

  For healthy **women** (and healthy **men over age 65**)—
  - no more than **3** drinks in a **day** AND
  - no more than **7** drinks in a **week**
- **Recommend lower limits or abstinence** as indicated: for example, for patients who take **medications** that interact with alcohol, have a **health condition** exacerbated by alcohol, or are **pregnant** (advise abstinence)
- **Rescreen** annually

→

- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average:**
  - On average, how many **days** a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many **drinks** do you have? ☐

  Weekly average ☐
- **Record** heavy drinking days in past year and weekly average in chart.

→ **GO TO STEP 2**

HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess For Alcohol Use Disorders

Next, determine if there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **relationship** trouble (family or friends)
- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **run-ins** with the law (arrests or other legal problems)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)

If yes to **three or more** → your patient has **alcohol dependence**.

Does patient meet criteria for abuse or dependence?

NO → **GO TO STEPS 3 & 4 for AT-RISK DRINKING**

YES → **GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS**

HOW TO CONDUCT A BRIEF INTERVENTION

FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Gauge readiness to change drinking habits.**

Is patient ready to commit to change?

NO →
- **Restate your concern.**
- **Encourage reflection.**
- **Address barriers to change.**
- **Reaffirm your willingness to help.**

YES →
- **Help set a goal.**
- **Agree on a plan.**
- **Provide educational materials.** (See *www.niaaa.nih.gov/guide.*)

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support positive change** and address barriers.
- **Renegotiate goal and plan;** consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess diagnosis** if patient is unable to either cut down or abstain.

YES →
- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage to return** if unable to maintain adherence.
- **Rescreen** at least annually.

FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Negotiate a drinking goal.**
- **Consider evaluation by an addiction specialist.**
- **Consider recommending a mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly.
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal.
- **Arrange followup appointments**, including medication management support if needed.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain.
- **Relate drinking to ongoing problems** as appropriate.
- **Consider** (if not yet done):
  - consulting with an **addiction specialist.**
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol-dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES →
- **Reinforce and support continued adherence.**
- **Coordinate care** with specialists as appropriate.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence.**
- **Address coexisting disorders**—medical and psychiatric—as needed.

WHAT'S A STANDARD DRINK?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  5% alcohol	• 12 oz. = 1 • 16 oz. = 1.3 • 22 oz. = 2 • 40 oz. = 3.3
MALT LIQUOR	
8–9 oz.  7% alcohol	• 12 oz. = 1.5 • 16 oz. = 2 • 22 oz. = 2.5 • 40 oz. = 4.5
TABLE WINE	
5 oz.  12% alcohol	• a 750-mL (25-oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  40% alcohol	• a mixed drink = 1 or more* • a pint (16 oz.) = 11 • a fifth (25 oz.) = 17 • 1.75 L (59 oz.) = 39

***Note:** Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

DRINKING PATTERNS

WHAT'S YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) **– and –** In a typical **WEEK**—No more than **14** (men) or **7** (women)	**Percentage of U.S. adults aged 18 or older***	**Combined prevalence of alcohol abuse and dependence**
Never exceed the daily or weekly limits (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	 **72%**	fewer than **1 in 100**
Exceed only the daily limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	 **16%**	**1 in 5**
Exceed both daily and weekly limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	**10%**	almost **1 in 2**

*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Source: 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide NIAAA survey of 43,093 U.S. adults aged 18 or older.

PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 16 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit *http://medlineplus.gov*.

	Naltrexone (Depade®, ReVia®)	**Extended-Release Injectable Naltrexone** (Vivitrol®)	**Acamprosate** (Campral®)	**Disulfiram** (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required, and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea; vomiting; decreased appetite; headache; dizziness; fatigue; somnolence; anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea; somnolence.	Metallic after-taste; dermatitis; transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, a naloxone challenge test should be employed. Evaluate liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or* for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

Note: Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

Application to be a Contracted
Brief Behavioral Counseling Intervention/ Referral to Treatment Provider
For Partnership HealthPlan of California

Name of Organization:_____

Address and Phone Number of Organization: _____

_____

Organizational Contact for Questions: Name: _____

Email:_____

- Primary Care Organization(s) that will be referring patients for Brief Behavioral Counseling Intervention/Referral to Treatment:

  Name of Organization(s) (or individual clinicians if in solo/small group practice)

  _____

  City and County where organization(s) located:

  _____

- List of clinicians who will be performing Brief Behavioral Counseling Intervention and Referral to Therapy services
  - Name
  - Licensure Type
  - SABIRT-related Training [description of training, length of training related to Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)]
- Submit Organizational Policy/Procedures describing how Brief Behavioral Counseling Intervention and Referral to Treatment will be performed, including training requirements, flow of patients, and Quality Assurance related to SABIRT services.
- Submit 3 samples (with patient identifying details redacted) of clinical documentation for Brief Behavioral Counseling Intervention.

<u>Attestation of Supervising Physician or Psychologist</u>:

I attest that I oversee Brief Behavioral Counseling Intervention and Referral to Treatment services for alcohol misuse/use disorder or substance use disorder for adults, performed at my institution for patients referred by local Primary Care Providers. I will assure that the staff above are well trained and competent at performing these services. I certify that the above application is accurate.

Name of Supervising Clinician:_____

Title of Supervising Clinician:_____

Date of Signature:_____

Review Documentation for Applicants to Become a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider

To be completed by PHC staff:

Name of Organization:_____Date submitted:_____

Criteria (Internal Checklist)

_____Licensed Clinicians need to be Credentialed with PHC or Carelon Behavioral Health (formerly known as Beacon)

_____Must be a Medi-Cal Provider, in good standing

_____Must set up electronic billing with PHC

_____Must fulfill all parts of the MCUP3101 policy regarding training, proficiency, standards, quality assurance processes etc. for the Brief Behavioral Counseling Intervention benefit

_____Must have referral relationship with PHC PCPs performing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) services

_____Confirm adequacy of documentation of SABIRT

_____Application Complete

_____Attestation signed

Reviewed by Name:_____

Title:_____Date:_____

Signature: _____

Opportunities & Indications for Screening Youth for Alcohol Use

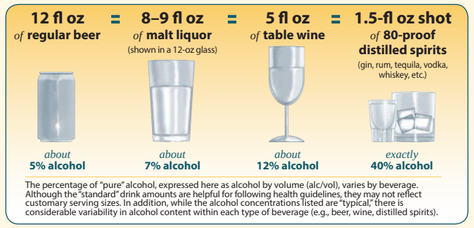
- As part of an **annual examination**
- As part of an **acute care visit**
- In the **emergency department** or urgent care center
- **When seeing patients who:**
  - you **have not seen in a while**
  - are likely to drink, such as youth who **smoke cigarettes**
  - have **conditions associated with increased risk** for substance abuse, such as:
    - depression
    - anxiety
    - ADD/ADHD
    - conduct problems
  - have **health problems that might be alcohol related**, such as:
    - accidents or injury
    - sexually transmitted infections or unintended pregnancy
    - changes in eating or sleeping patterns
    - gastrointestinal disturbances
    - chronic pain
  - show **substantial behavioral changes**, such as:
    - increased oppositional behavior
    - significant mood changes
    - loss of interest in activities
    - change of friends
    - a drop in grade point average
    - large number of unexcused absences in school

1 in 3 children start drinking by the end of 8th grade. Of them, half report having been drunk.

You are in a prime position to help your patients avoid alcohol related harm.

What Counts as a Drink? A Binge?

The drinks shown below are different sizes, but each one has about the same amount of pure alcohol (14 grams or 0.6 fluid ounce) and counts as a single "standard" drink. These serve as examples; alcohol content can vary greatly across different types of beer, malt liquor, and wine.



The percentage of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage. Although the "standard" drink amounts are helpful for following health guidelines, they may not reflect customary serving sizes. In addition, while the alcohol concentrations listed are "typical," there is considerable variability in alcohol content within each type of beverage (e.g., beer, wine, distilled spirits).

Below is the approximate number of standard drinks in different-sized containers of:

regular beer	malt liquor	table wine	80-proof distilled spirits
12 fl oz = **1**	12 fl oz = **1.5**	5-fl oz glass = **1**	a shot *(1.5 oz)* = **1**
16 fl oz = **1.3**	16 fl oz = **2**	25 fl oz = **5**	750 ml *(a "fifth")* = **17**
40 fl oz = **3.3**	40 fl oz = **4.5**	*(a regular 750-ml bottle)*	1.75 L *(a "handle")* = **39**

What kinds of alcohol are kids drinking these days?

All kinds, with variations by region and fad. In many areas, distilled spirits appear to be gaining on or overtaking beer and "flavored alcohol beverages" in popularity among youth, whereas wine appears less preferred. Young people are also mixing alcohol with caffeine, either in premixed drinks or by adding liquor to energy drinks. With this dangerous combination, drinkers may feel somewhat less drunk than if they'd had alcohol alone, but they are just as impaired and more likely to take risks.

What's a "child-sized" or "teen-sized" binge?

Boys		Girls	
Ages **9–13**	3 drinks	Ages **9–17**	3 drinks
Ages **14–15**	4 drinks		
Ages **16+**	5 drinks		

See the full Guide, page 15, for details about these estimates.

Brief Intervention & Referral Resources

Four Basic Principles of Motivational Interviewing:

- **Express Empathy** with a warm, nonjudgmental stance, active listening, and reflecting back what is said.
- **Develop Discrepancy** between the patient's choice to drink and his or her goals, values, or beliefs.
- **Roll with Resistance** by acknowledging the patient's viewpoint, avoiding a debate, and affirming autonomy.
- **Support Self-efficacy** by expressing confidence and pointing to strengths and past successes.

For more information, see the full Guide, page 29, or visit:

- www.motivationalinterview.org
- www.motivationalinterview.net

To Find Local Specialty Treatment Options:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospitals and mental health service organizations.
- Contact the Substance Abuse Facility Treatment Locator (seek centers specializing in adolescents) at 1–800–662–HELP or visit www.findtreatment.samhsa.gov.
- For more suggestions, see the full Guide, p. 34.

List your local resources below.

Questions About Providing Confidential Health Care to Youth?

All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol. See the full Guide, page 25, for more information.

For details specific to your specialty and State:

- See confidentiality policy statements from professional organization(s):
  - American Academy of Pediatrics
  - American Academy of Family Physicians
  - Society for Adolescent Health and Medicine
  - American Medical Association
- Contact your State medical society for information on your State's laws.
- Visit the Center for Adolescent Health and the Law for monographs on minor consent laws professional association policies: www.cahl.org.

This Pocket Guide was produced by the National Institute on Alcohol Abuse and Alcoholism in collaboration with the American Academy of Pediatrics.

NIH National Institute on Alcohol Abuse and Alcoholism

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Order copies of this Pocket Guide, along with the full 40-page Guide, from **www.niaaa.nih.gov/YouthGuide** or call 1-888-MY-NIAAA (888-696-4222)

A POCKET GUIDE FOR

ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH

2011 Edition

This pocket guide is condensed from the NIAAA Guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide.* It was produced in collaboration with the American Academy of Pediatrics.

To order more copies of this Pocket Guide, or sets with the full 40-page Guide and the Pocket Guide, and for related professional support resources, visit **www.niaaa.nih.gov/YouthGuide** or contact the NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
301–443–3860

NIH National Institute on Alcohol Abuse and Alcoholism

NIH Publication No. 11-7806
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Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
AUDIT NIDA - The Alcohol Use Disorders Identification Test (10 questions) ******Meets* **HEDIS** *measure for IHA*	X	X	NIDA DHCS NCQA				X		
AUDIT-C NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) ******Meets* **HEDIS** *measure for IHA*	X		NIDA NIAAA USPSTF DHCS	X			X		
SASQ NIAAA Single Alcohol Screening Question ******Meets* **HEDIS** *measure for IHA*	X		NIAAA USPSTF	X			X		
TAPS-1 Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
TAPS-2 Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
NIDA Quick Screen (4 questions) *(Recommended by DHCS,ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)*	X		NIDA DHCS USPSTF ACOG	X			X	X	X
NIDA-Modified ASSIST NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) *(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)*		X	NIDA DHCS USPSTF				X	X	X

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
DAST-10 Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
DAST-20 Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
4P's Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
4 P's Plus *(Plus includes additional questions about depression and domestic violence)*		X	ACOG	X			X	X	X
CRAFFT Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X *(Appropriate for non-pregnant adolescents)*		X	X	
MAST-G Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
PRO (Prenatal Risk Overview) *(Recommended by USPSTF but official website is no longer available)*			USPSTF	X			X	X	X

*As per VI.C.6.d.2) of policy MCUP3101, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

Partnership HealthPlan of California

Recommended Tools and Training Resources for
Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
ACOG	The American College of Obstetricians and Gynecologists	Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
NCQA/ HEDIS	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH)	NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities • Underage and College Drinking Research • Treatment Navigator tool • Surveillance Reports and Epidemiologic Resources • Additional Reports and Resources
NIDA	National Institute on Drug Abuse	Screening and Assessment Tools: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2) https://sbirt.clinicalencounters.com/activity/sbirt-core/ • Four hour training: $49 per individual; group rates are available • CME/CE NYS OASAS Credit approved

Partnership HealthPlan of California

Recommended Tools and Training Resources for
Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
SAMHSA	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings https://www.samhsa.gov/brss-tacs/video-trainings • Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:
USPSTF	United States Preventive Services Task Force	• Alcohol screening and intervention tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions • Unhealthy Drug Use Screening Tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening • USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation https://edhub.ama-assn.org/jn-learning/audio-player/18514824

*For **ALL** Patients…*

STEP 1: Ask the Two Screening Questions

For elementary and middle school patients, start with the friends' question. Choose the questions that align with the patient's school level, as opposed to age, for patients ages 11 or 14. Exclude alcohol use for religious purposes.

Elementary School (ages 9–11)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: Any drinking?
"How about you—have you ***ever*** had more than a few sips of any drink containing alcohol?"

ANY drinking:
Highest Risk

Middle School (ages 11–14)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: How many days?
"How about you—in the ***past year***, **on how many days** have you had more than a few sips of any drink containing alcohol?"

ANY drinking:
Moderate or **Highest Risk**
(depending on age and frequency)

High School (ages 14–18)

Patient: How many days?
"In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"

Lower, **Moderate**, or **Highest Risk**
(depending on age and frequency)

Friends: How much?
"If your friends drink, **how many drinks** do they usually drink on an occasion?"

Binge drinking by friends heightens concern.
(See "What Counts as a Drink? A Binge?" on reverse)

*For Patients Who **DO NOT** Drink…*

STEP 2: Guide Patient

Do friends drink?

NO

Neither patient nor patient's friends drink

- **Praise choices** of not drinking and of having nondrinking friends.

YES

Patient does not drink, but friends do

- **Praise choice** of not drinking.
- **Consider probing a little** using a neutral tone: "When your friends were drinking, you didn't drink. Tell me more about about that." If the patient admits to drinking, go to Step 2 for Patients Who Do Drink; otherwise, see below.

- **Reinforce healthy choices** with praise and encouragement.
- **Elicit and affirm reasons** to stay alcohol free.
- **Educate**, if the patient is open, about drinking risks related to brain development and later alcohol dependence.

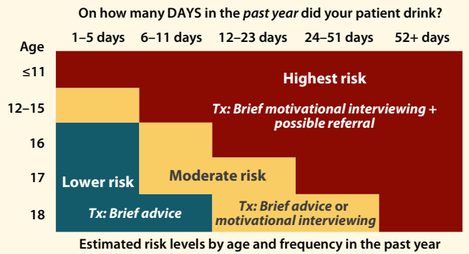
- **Rescreen next year** at the latest.

- **Explore** how your patient plans to stay alcohol free when friends drink.
- **Advise** against riding in car with driver who has been drinking or using drugs.
- **Rescreen** at next visit.

ASSESSMENT COMPLETE for patients who do not drink.

*For Patients Who **DO** Drink…*

STEP 2: Assess Risk



Estimated risk levels by age and frequency in the past year

Factor in friends:

- **For elementary and middle school students:** Having friends who drink heightens concern.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender (see "What Counts as a Drink? A Binge?" on reverse).

Include what you already know about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- **Ask about the drinking pattern:** *"How much do you usually have? What's the most you've had at any one time?"* If patient reports bingeing, ask: *"How often do you drink that much?"*
- **Ask about problems experienced or risks taken:** Examples include getting lower grades or missing classes; drinking and driving or riding in a car driven by someone who has been drinking; having unplanned, unsafe sex; getting into fights; getting injured; having memory blackouts; and passing out.
- **Ask whether the patient has used anything else to get high in the past year**, and consider using other formal tools to help gauge risk.

STEP 3: Advise and Assist

Lower Risk:

- **Provide brief advice** to stop drinking.
- **Notice the good:** Reinforce strengths and healthy decisions.
- **Explore and troubleshoot** influence of friends who drink.

Moderate Risk:

- **Does patient have alcohol-related problems**?
  - **If no**, provide beefed-up brief advice.
  - **If yes**, conduct brief motivational interviewing.
- **Ask if parents know** (see Highest Risk, below, for suggestions).
- **Arrange for followup**, ideally within a month.

Highest Risk:

- **Conduct brief motivational interviewing.**
- **Ask if parents know …**
  - **If no**, consider breaking confidentiality to engage parent.
  - **If yes**, ask patient permission to speak with parent.
- **Consider referral** for further evaluation or treatment.
- **If you observe signs of acute danger** (e.g., drinking and driving, binge drinking, or using alcohol with other drugs) **take immediate steps to ensure safety**.
- **Arrange for followup** within a month.

FOR ALL PATIENTS WHO DRINK

- **Collaborate on a personal goal and action plan** for your patient. Refer to page 31 in the full Guide for sample abstinence, cutting back, and contingency plans. For some patients, the goal will be accepting a referral to specialized treatment.
- **Advise your patient not to drink and drive or ride in a car with an impaired driver.**
- **Plan a full psychosocial interview** for the next visit if needed.

STEP 4: At Followup, Continue Support

Was patient able to meet and sustain goal(s)?

Patients may not return for an alcohol-specific followup, but they may do so for other reasons. In either case, **ask about alcohol use and any associated problems**. Review the patient's goal(s) and assess whether he or she was able to meet and sustain them.

No, patient was not able to meet/sustain goal(s):

- **Reassess** the risk level (see Step 2 for drinkers).
- **Acknowledge** that change is difficult, that it's normal not to be successful on the first try, and that reaching a goal is a learning process.
- **Notice the good by:**
  - **praising** honesty and efforts.
  - **reinforcing** strengths.
  - **supporting** any positive change.
- **Relate drinking to associated consequences or problems** to enhance motivation.
- **Identify and address challenges and opportunities** in reaching the goal.
- If the following measures are not already under way, **consider**:
  - **engaging** parents.
  - **referring** for further evaluation.
- **Reinforce** the importance of the goal(s) and plan and **renegotiate** specific steps, as needed.
- **Conduct, complete, or update** the comprehensive psychosocial interview.

Yes, patient was able to meet/sustain goal(s):

- **Reinforce and support** continued adherence to recommendations.
- **Notice the good:** Praise progress and reinforce strengths and healthy decisions.
- **Elicit future goals** to build on prior ones.
- **Conduct, complete, or update** the comprehensive psychosocial interview.
- **Rescreen** at least annually.

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Continuity and Coordination between Medical Care and Behavioral Healthcare

May 2024

TABLE OF CONTENTS

Objective

This report summarizes Partnership HealthPlan (PHC) work to analyze, improve and build upon efforts to promote the continuity and coordination of medical and behavioral health care services. This work uses established goals for the range of measures and applied interventions and evaluations of effectiveness to improve Plan performance for two of the measures. The measures address the sharing of information; promotion of treatment of the whole person, and adherence to standard diagnosis and treatment guidelines.

In 2019 PHC convened a multidisciplinary team to identify appropriate measures for this analysis, to gather and review the data, recommend interventions and select opportunities for improvement, which is then reported to PHC's Quality & Utilization Advisory Committee. The focus and membership of the team was subsequently narrowed as the specifications, measures and interventions were identified. The current team has members represented from the following departments: Behavioral Health, Health Analytics, the Office of the Chief Medical Officer, Pharmacy, and Carelon Behavioral Health, the Plan's delegated administrator of mental health services. See appendix for further detail on participation. See appendix for list of participants and applicable licensure.

Data sources included in this analysis are:

Data Type	*Data Source*
Medi-Cal Rx pharmaceutical claims data	State data exchange
Medical claims and encounter data	Amisys
PHC HEDIS scores	HEDIS Team
National Incidence Data	Evidence Based Research
Annual Provider Survey	PHC Annual Provider Survey
Annual Provider Survey	Carelon Annual Provider Survey
Meeting minutes	Behavioral Health and other PHC documentation (Appendix)

Results and Analysis

Factor 1: Exchange of Information between Primary Care and Behavioral Health Providers

Measurement

Determination of the extent of effective exchange of information between primary care and behavioral health providers will be determined by a provider survey with a goal of at least 50% of providers will routinely share information that confirms referral is addressing the patient's needs, and that information sharing is bidirectional. Surveys were sent to 274 primary care providers and to 1250 behavioral health providers, encompassing all primary care providers (PCPs) and Behavioral Health (BH) provider sites.

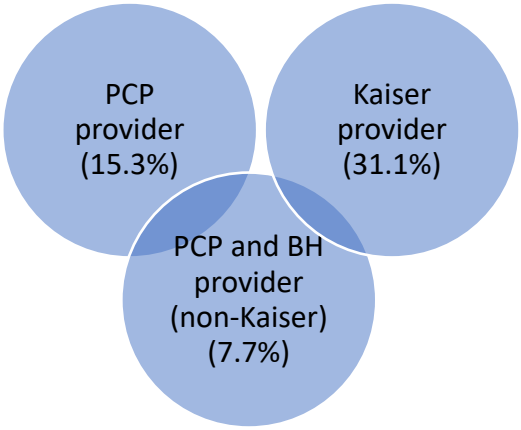
Note that the definition of this factor changed in the HPA 2021 Standards and Guidelines, so the data cannot be trended from years prior to 2021.

Relevance

PHC members receive primary care treatment from a range of primary care site types including federally funded clinics (Federally Qualified Health Centers, Indian Health Service Centers, Rural Health Clinics), from clinics associated with hospital networks, and from private practitioners. Many members address their mental health needs with both a mental health practitioner and with their PCP, emphasizing the need for effective coordination among behavioral and primary care providers.

In 2023, about 15.3% of primary care visits included a mental health diagnosis indicating that the members' mental health was addressed during the visit. This was down 7% from calendar year 2022. During the same period of 2023, 44,845 of non-Kaiser PHC members had at least one visit with a mental health practitioner, which was nearly half, and 6.06% of those who had a mental health-related visit with their PCP also saw a mild-to-moderate mental health practitioner[1].

Sources of Mental Health Care for PHC Members, 2023



In other words, coordination among providers could be an important element of health care for many members; there is a significant need for PCPs and mental health providers to effectively exchange information to ensure the coordination of care and effectively work collaboratively to address patient needs.

Goal

[1] In 2023, 89,249 unique members, or 15.3%% of the average non-Kaiser membership of 580,857 members had a PCP visit that involved a mental health diagnosis. 44,845 unique members, or 6.7% had a visit with a mental health practitioner for mild to moderate treatment needs. Additionally, 12,920 or 2.2% of PHC members were treated in the county-administered mental health system for those with severe and persistent mental health needs. 39,209 members had both a PCP visit for mental health needs *and* a visit with a mild-to-moderate mental health practitioner.

At least 50% of providers will routinely share information that is sufficient; accurate and clear; provided on a timely basis and with sufficient frequency.

Methodology

Primary care providers in particular are asked to participate in a large number of surveys, many of them required by regulations. PHC Provider Relations and other staff often hear concerns regarding the clinic resources needed to respond to these surveys. PHC opted to survey providers through three surveys; directly to providers through a focused survey link, through the Carelon Annual Provider Survey as well as the PHC Annual Provider Survey. By modifying the mode and combining with the annual provider surveys, the pool of respondents grew from 96 in 2022 to 1057 in 2023.

Consequently, the survey was distributed to all PCP sites (274) and to all Carelon[2] mental health provider sites (1250) via a multi-mode survey approach, allowing respondents to complete via email or web. The large disparity in the number of sites for each area of practice is because most PCP sites have a number of clinicians providing care at a site, while a large number of mental health providers are solo practitioners with one provider per site.

Results

929 providers (847 behavioral health providers and 82 primary care providers) responded to the surveys, acknowledging duplication could not be linked as a unique identifier such as a Tax ID or NPI was not included. Overall behavioral health providers had a response rate of 67.76% while PCPs had a 29.9% rate.

Sharing of Information- PHC Independent Survey Responses (10 total responses):

Sharing Information with Other Providers of 10 total responses: Primary care providers reported that they are more likely to routinely share patient information:	BH Providers	PCPs	Total
Info routinely shared	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Info routinely shared w/ release of information	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Information not routinely shared	66.67% (4 of 6)	75% (3 of 4)	70% (7 of 10)

Reported Problems with Receiving Information from Other Providers When Information is Shared (10 total responses):

[2] PHC mental health services are administered by Carelon Behavioral Health, which contracts directly with the providers on PHC's behalf.

	BH Providers	PCPs	Total
Info not generally sufficient	66.7% (4 of 6)	50% (2 of 4)	66.7% (6 of 10)
Info not generally accurate/clear	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Info not timely or provided with sufficient frequency	66.67% (4 of 6)	75% (3 of 4)	70% (7 of 10)
Info was generally sufficient, accurate/clear, timely and sufficiently frequent	33.3% (1 of 6)	25% (0 of 4)	10% (1 of 10)

Sharing of Information- PHC PCP Responses (250 total responses):

Sharing Information with Other Providers of 208 total responses: Primary care providers reported that they are more likely to routinely share patient information:	PCPs
I routinely receive reports after my PHC patients have accessed Mental Health Care and Services	44% (110 of 205)
Once a referral has been issued to Carelon, I routinely receive confirmation that my patient's mental health referral is being addressed	43% (107 of 250)

Sharing of Information- Carelon Mental Health Responses (847 Total responses):

	BH Providers
If my patient has a Primary Care Physician: I communicate (verbal and/or written) about our mutual patient's care	28.8% (244 of 846)
If my patient has a Primary Care Physician: I receive communication (verbal and/or written) about our mutual patient's care	18.5% (157 of 847)
If my patient is currently treated by another behavioral health practitioner: I communicate (verbal and/or written) about our mutual patient's care	44.9% (315 of 701)
If my patient is currently treated by another behavioral health practitioner: I receive communication (verbal and/or written) about our mutual patient's care	29.9% (180 of 607)

Quantitative Analysis

The goal was not met as less than 50% of providers expressed they receive or share information regarding mutual patient's care.

Qualitative Analysis

When examining the quality of the data shared, the 50% goal was not met. Overall, 33.3% of respondents reported they share or communicate regarding the mutual patients are receiving. Previously PCPs had been more likely to answer the survey, indicating a potential need to modify the

communication strategy used to retrieve this information as only 10 of 106 (9.4%) of the survey #1 recipients responding to the survey questions regarding the sufficiency, accuracy, or timeliness of the information.

The survey demonstrated that 33.3% of behavioral health providers feel they receive verbal or written information from primary care providers, indicating information sharing is often one sided. Consequently, PCPs indicated mental health referrals are only addressed 25% of the time, indicating the need to address closed loop referrals.

Appropriate Diagnosis, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care

Measurement

Primary care providers are required to screen/diagnose and provide brief treatment or referral to services for individuals with alcohol use disorder[3]. For several years, PHC's value based incentive program for PCPs, the PCP Quality Improvement Program (QIP) has included alcohol screening and brief intervention among the factors that will allow for PCP-QIP payments to the site. Specifically, primary care sites with at least 50 assigned members will have screened 5% of their assigned members over 18 years of age, and billed or provided encounter data for this screening which can take place every six months.

Analysis through 2020 showed the need to persuade PCPs to more aggressively screen adults and provide brief interventions for those with excessive alcohol use, and to report these activities. It is unclear if the data supports conclusions regarding the prevalence of excessive alcohol use among PHC members or even the prevalence of screenings for these conditions that may occur during a visit. PHC sought to improve this rate in 2021, partnering with regional staff to promote the use of Screening, Brief Intervention, and Referral to Treatment (SABIRT) in primary care settings.

Relevance

Excessive use of alcohol is associated with a range of poor health conditions as well as a variety of adverse social outcomes.

According to the Centers for Disease Control and Prevention January 2014 Vital Signs Report:

- At least 38 million adults (15.5% of the total population)[4] in the US drink too much although most are not alcoholics;
- Only 1 in 6 adults talk with their doctor, nurse, or other health professional about their drinking; and
- Alcohol screening and brief intervention has been shown to reduce drinking by as much as 25% for those who drink too much. (CDC Vital Signs, 2014).

[3] See California Department of Health Services All Plan Letter 18-014, in the Appendix.
[4] According to the U.S. Census there were 244.7 million adults over 18 in 2014

Drinking too much causes about 88,000 deaths in the US each year, and costs the economy about $224 billion (CDC Vital Signs, 2014). These numbers may be significantly higher for recent years; data show increased unhealthy alcohol use in 2020 associated with the Covid-19 pandemic and related social and economic effects.[5]

Information regarding excessive alcohol use is especially important in the primary care setting; as noted, many conditions are associated with or exacerbated by excessive alcohol use and primary care providers are in the best position to identify this problem early.

Talking with a patient about their drinking is part of the screening and brief counseling process, which involves:

- Using a set of questions to screen all patients for how much and how often they drink; counseling patients about the health dangers of drinking too much, including women who are (or might be) pregnant; and
- Providing a brief intervention/counseling; and
- Referring some patients to specialized treatment.

Goal

As noted above, it is estimated that nationally about 15.5 % of those 18 and older drink too much. Ideally, PHC providers will identify all of the individuals who drink too much and provide them with a brief intervention. Thus, the goal is that PHC providers will screen and identify excessive alcohol use in 15% of their adult patients.

Methodology

PHC members receiving services during measurement year 2022 will be screened and connected to treatment for unhealthy alcohol use.

Data Source	Claims data
Denominator	SABIRT screenings conducted as identified by claims with H0049
Numerator	SABIRT screenings found to require follow-up for excessive alcohol use as identified by claims with H0050
Measurement Period	CY 2021-2023

Results

Adult Members Screened for Alcohol Misuse

2021	2022	2023

[5] See for instance, Pollard MS, Tucker JS, Gree HD, Changes in Adult Alcohol Use and Consequences During the Covid-19 Pandemic in the US, JAMA Netw Open 2020;3(9):e2022942.doi:10.1001/jamanetworkopen.2020.2294

Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use	Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use	Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use
785	331	42%	989	605	61%	1695	597	35%

Quantitative Analysis

In 2021 over 40% of those screened were determined to have excessive alcohol use, well above the expectation. Conversely in 2022 further increase in excessive use was apparent with 61% of those screened requiring intervention. In 2023 the goal was met with 706 more screenings than the previous year, with only 35% positive for excessive use of alcohol.

Qualitative Analysis

The data shows that while previously only a small proportion of PHC adult members are reported as being screened, incentive has influenced the integration of behavioral health screenings and referrals within non-behavioral health settings. While the study indicates the presence of need for screening and intervention for alcohol misuse in members being seen in primary care settings the opportunity remains to further study the efficacy of the intervention.

Appropriate Use of Psychotropic Medications

Measurement

This analysis used the HEDIS measure, Follow Up Care for Children Prescribed ADHD Medication – Initiation Phase indicator: members 6-12 years of age with a newly prescribed and dispensed attention-deficit/hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Relevance

Children who require medication to treat attention deficit disorder (with or without hyperactivity) have varying responses to treatment. While some respond well to first-line drug choices, there are many who may either require additional medication therapies or completely different therapeutic modalities. To improve the coordination and efficacy of the care to these children, PHC sought to improve PCPs' understanding and application of these medications and to promote timely follow-up after the initial diagnosis and prescription. Follow-up visits are an essential part of an effective treatment plan in order to assess the efficacy of the medications and to modify the interventions according to the child's needs. The HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication tracks the success of these efforts.

Goal

Each of PHC's four regions will be at or above the 50th percentile of the National Medicaid Benchmark for the ADD-Initiation Phase HEDIS measure indicator.

Methodology

HEDIS measure description	Follow Up Care for Children Prescribed ADHD Medication (ADD); Initiation Phase indicator: Percent of members ages 6 to 12 prescribed ADHD medication with a follow-up visit to a prescribing provider 30 days after initiating treatment.
Measurement Periods	Measurement Year (MY) 2022

Results

Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase

Region	MY 2020 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks			
				25th	50th	75th	90th
Northwest	33.62%	39/116	<25th	36.56	42.95	48.05	55.33
Northeast	28.99%	60/207	<25th				
Southwest	29.08%	114/392	<25th				
Southeast	24.84%	118/475	<25th				
Composite	27.82%	331/1190	<25th				

Region	MY 2021 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks			
				25th	50th	75th	90th
Northwest	33.79%	49/145	<25th	36.56	42.95	48.05	55.33
Northeast	33.33%	75/225	<25th				
Southwest	39.44%	127/322	<50th				
Southeast	34.29%	120/350	<25th				
Composite	35.61%	371/1042	<25th				

Region	MY 2022 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks				Goal Met?
				25th	50th	75th	90th	>50th
Northwest	36.92%	48/130	<25th	38.37	44.51	49.12	55.99	No
Northeast	31.67%	70/221	<25th					No
Southwest	45.37%	147/324	<75th					Yes
Southeast	41.58%	158/380	<50th					No
Composite	40.09%	423/1055	<50th					No

Quantitative Analysis

The goal was not met. The Plan continues to rank below the 50th percentile. However, there is improvement seen in MY 2022 performance in comparison to both preceding measurement years. The Southwest region showed a marked improvement, meeting the 50th percentile goal. There is a slight increase in the ADD measure denominator (eligible population) compared to MY 2021.

Qualitative Analysis

The ADD measure is designed to monitor the follow-up care that children receive over the first 10 months of starting their ADHD medication. Members are included in the ADD eligible population based on their follow-up care timeframe rather than their medication start date; therefore, they are included in the measure 10 months after starting their medication. The ADD measure MY 2022 population reflects members who began their medications between March 1, 2021 and February 28, 2022.

The slight increase in total number of children who started a new ADHD medication in MY 2022 may be attributed to the return of in-person instruction in schools. Notable trends include a slight decrease in children newly started on ADHD medication in the Northern Region while there is an uptick in children newly started on ADHD medication in the Southern Region. The Northern Region continues to perform lower when compared to the Southern Region. Some barriers to care may include access to fewer health care providers and transportation challenges in rural communities.

Collaborative Activities

This was one of the two measures selected for further study and engagement. In 2020, several PHC departments (Pharmacy, Quality Improvement, Behavioral Health, and Health Analytics) developed a process to send prescribers letters to alert them of their patient filling a new ADHD medication at the

pharmacy, and to inform them of the importance of follow-up care when initiating ADHD treatment for pediatric patients between the ages of 6-12 years. This intervention began in July 2020 and continued through 2021.

Methodology

From March 2021 through December 2021, letters were sent to individual prescribers with a patient (6-12 years of age) whom first filled an ADHD medication within the preceding week. The letter included member-specific details, such as medication name and prescription fill date. The letter reminded the prescriber to have a follow-up appointment within 30 days of starting ADHD medication treatment based on the pharmacy prescription claim record.

A total of 188 letters were sent on behalf of individual members newly starting ADHD medication. All 188 members count toward MY 2022 because they started their ADHD medication between March 1, 2021 through February 28, 2022 (the end of the Index period for the ADD measure).

Measuring Effectiveness

Measurement Year	Cohort	Denominator	Numerator	ADD-Initiation Phase Score
2021 (IPSD 03/01/2020 – 02/28/2021)	ADD Composite	1,042	371	35.61%
	Control (i.e. no letter) (control = ADD composite – intervention group)	995	348	34.97%
	Intervention (letter recipients)	47	23	48.94%
2022 (IPSD 03/01/2021 – 02/28/2022)	ADD Composite	1,055	423	40.09%
	Control (i.e. no letter) (control = ADD composite – intervention group)	867	333	38.41%
	Intervention (letter recipients)	188	90	47.87%

IPSD = Index Prescription State Date, date of newly starting ADHD medication

After allowing sufficient time for the members to receive appropriate follow-up care (i.e. 10 months), letter recipient members were identified in the ADD measure MY 2022 eligible population and scores were extracted from the ADD measure data accordingly. The letter recipient cohort included 188 individual members, with 90 of those members receiving appropriate follow-up care with their prescriber within 30 days of starting their new ADHD medication, which translates to an ADD-Initiation Phase score of 47.87% for the intervention group. With a contrasting score of 38.41% for the ADD

eligible population who received no intervention, the results suggest that continual communications with providers through these letters may be beneficial in ensuring appropriate and timely follow-up care for these children.

The 188 letters impacting MY 2022 were sent to 98 individual prescribers. Unfortunately, the ADD measure is not stratified by prescriber, therefore further details or conclusions regarding prescribing habits of individual providers in relation to the impact of these letters cannot be drawn.

Next Steps

As the Plan still has not reached the >50th percentile goal, there is significant room for improvement with the ADD measure – Initiation Phase indicator. This intervention began MY 2021 and based on the continued increase in ADD – Initiation Phase score each year it appears that the prescriber letter notification has had a positive impact. Based on these findings, it is favorable to continue the prescriber letter intervention. Continuing this intervention may open doors to collaborate with prescribers we communicate with, and perhaps identify additional opportunities to improve access to appropriate care for these children.

Due to the transition of pharmacy services from Partnership HealthPlan to Medi-Cal Rx, timely pharmacy data availability was disrupted after December 2021. As a result of this transition combined with the late Q1/Q2 2022 PHC system outage, there was a prolonged delay in receiving timely weekly ADHD new start reports. Timely pharmacy claim data reports were not made available until August 2022. Due to time constraints and competing priorities, the intervention was put on hold until March 2023. To build upon the current intervention, Pharmacy planned the following changes to the intervention:

- Sending individual prescribers faxes instead of U.S. mail for faster turnaround.
- Providing the date that the follow-up appointment must be completed by based on the pharmacy prescription claim record (30 days from fill date).
- Targeting lower performing providers: Providers that had at least five members that newly started ADHD medication within a 6-month lookback period (7/2022-1/2023) and performed below the MPL based on claims data.
- Performing follow-up calls to confirm fax receipt.

Fax communications to providers began March 2023 and the impact of the changes to the intervention will not be fully realized until MY 2024 results are reported.

Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnosis

Measurement

This analysis focused on data on the frequency and follow-up for members diagnosed with a substance use diagnosis.

Relevance

According to the 2020 National Survey on Drug Use and Health (NSDUH), 40.3 million Americans, aged 12 or older, had a substance use disorder (SUD) in the past year.[6] Further, nine percent of Californians met the criteria for a substance use disorder (SUD) in the last year. The health care system is moving toward acknowledging substance use disorders as chronic illnesses, yet only about 10% of people with an SUD in the last year received treatment.[7]

Goal

At least 50% of members with a co-occurring diagnosis (medical and SUD) will be connected to SUD treatment within 10 days, and at least 50% will remain in treatment for 30 days.

Methodology

Data Source:	Claims and encounter data
Denominator:	Members diagnosed with an substance use disorder for the first time within the calendar year, who initially presented with a medical diagnosis
Numerator:	Of those diagnosed, number of days between new diagnosis and first SUD encounter
Numerator #2:	Of those diagnosed, number of days between first and last SUD encounter
Measurement Period:	2021-2023 Calendar Years

Results

2021		2022		2023	
Region	Days from new diagnosis to first SUD encounter	Region	Days from new diagnosis to first SUD encounter	Region	Days from new diagnosis to first SUD encounter

[6] Substance Use Disorders (SUDs) | Feature Topics | Drug Overdose (cdc.gov)
[7] https://www.chcf.org/wp-content/uploads/2022/01/SubstanceUseDisorderAlmanac2022.pdf

Northeast	15.73	Northeast	34.41	Northeast	8.54
Northwest	14	Northwest	35.69	Northwest	8.53
Southeast	13.47	Southeast	28.83	Southeast	6.82
Southwest	11.57	Southwest	28.83	Southwest	6.97

Region	SUD Diagnosis	Average Days Remaining in Treatment
Northeast	Alcohol use and dependency	131.94
	Opioid Use	148.9
	Stimulant use and dependency	148.95
Northwest	Alcohol use and dependency	139.27
	Opioid Use	95.84
	Stimulant use and dependency	91.29
Southeast	Alcohol use and dependency	136.33
	Opioid Use	147.42
	Stimulant use and dependency	151.75
Southwest	Alcohol use and dependency	63.88
	Opioid Use	302
	Stimulant use and dependency	113.07

Service location	Claims PMPY	Member Count
Outpatient	2.6	3109
ER	3.9	11513
Inpatient Hosp	5.5	5666
Office Visit	6.3	18366

Quantitative Analysis

The goal was met with 42% of members with co-occurring diagnosis resulting in a subsequent SUD encounter. Of the individuals who connected to treatment, 79% participated in treatment for a minimum of 7 days, and 63% remained in treatment for at least 30 days.

Members waited to enter treatment an average of 7.71 days after their initial SUD diagnosis. Subsequently, there was an average of 139.22 days in treatment amongst the 3 most common SUD diagnosis with a median of 14.02 treatment episodes monthly.

Qualitative Analysis

Timeliness to first SUD encounter was important to measure whether providers can accommodate subsequent visits after admitting into treatment. While the days to treatment were under the 10-day requirement, hospitals reported admitted members often have delays in discharge due to lack of capacity within substance use facilities. This led to review of the highest utilized locations of service for newly diagnosed which presented as primary care which aligns with the prescribing of medication for addiction treatment. Outpatient and emergency room visits with new SUD diagnosis had decreased from 33,667 in 2022 and 14,622 in 2023 with the utilization of substance use navigators deemed to be a significant factor. Further review drew attention to inpatient stays with over 5 claims per utilizing member with co-occurring diagnosis, higher readmission rates, and longer length of stays.

Collaborative Activities

Throughout the analysis it was apparent substance use navigation supports members in connecting to treatment. With the sun-setting of funding, sustainability of the program with hospitals became a priority.

- Barriers:
    - CA Bridge projects ended July 2023 and many existing substance use navigator (SUN) positions embedded within hospitals were going to be lost or repurposed due to lack of funding.
- Actions:
    - PHC included a substance use disorder referral metric into the Hospital Quality Improvement Program (HQIP) intended to incentivize hospitals for including dedicated staff and/ or referring members for substance use disorder services. Many hospitals have utilized the incentive funding for on-going employment of their SUNs. In 2023, 26 hospitals opted into the HQIP and 19 met the measurement target of at least 10 members referred from larger hospitals and 3 within small hospitals.
- Barriers:
    - Hospitals have expressed a need for SUD screenings to be conducted prior to members discharging from an acute facility.
- Actions:
    - Partnered with Shasta Regional Medical Center to support with discharging members in need of SUD connections from acute setting through offering of screenings and care coordination to support the transition of care.
    - Mercy Medical Center was connected to a local SUD provider to participate in joint discharge planning for those requiring a transition to a SUD setting.
- Barriers:
    - Hospitals report wait listing amongst substance providers due to capacity issues, leading to lengthy time between diagnosis and engagement.
- Actions:
    - Efforts were made to recruit additional SUD providers to accommodate need within service areas. Seven providers have agreed to contract and 3 have executed agreements.
- Barriers:

    - Members and community partners have shared SUD providers rarely answer the phone, resulting in an inability to schedule or participate in treatment.
- Actions:
    - Developed a process for sharing of data to identify individuals who have failed to connect to a provider. As a result, 217 members were connected to treatment after failing during initial engagement.
- Barriers:
    - In July of 2023 DHCS implemented the Behavioral Health Quality Improvement Program, incentivizing counties for meeting deliverables intended to improve HEDIS measures. Counties expressed an inability to identify when a member is admitted into an acute setting therefore limiting the ability to conduct screenings and interventions for multiple measures.
- Actions:
    - PHC and counties executed data sharing agreements and partnered to implement SacValley HIE, prioritizing real time exchange of behavioral health encounters in acute settings. To date 12 of 24 counties have signed participation agreements with Sac Valley, while 4 others are in early participation phases.

Measuring Effectiveness

As shared, our work in year primarily focused on the sustainability of the CA Bridge substance use navigation program. While the one-year funding provided by PHC seems to have improved by decreasing utilization within emergency departments by 57%, a longer term solution needs to be identified and implemented. DHCS has identified community health workers as a new version of substance use navigators and PHC will partner with hospitals to bridge the two programs.

The analysis presented an opportunity for further review of co-morbidities. Members with dementia averaged 15.2 claims per year, and 11.5 for members with TBI, both substantially lower than plan wide average. Questions loom regarding potential correlations and/ or the need to target recruiting of SUD providers who specialize in cognitive behavioral therapy.

Next Steps

- Implement new community health worker program within hospitals
- Gather additional data regarding admissions, readmissions, and acute length of stay, specifically with alcohol use disorder diagnosis
- Partner with counties to identify operational strategies for the use of data provided through SacValley HIE
- Continue work to identify and implement opportunities to bring services to the beneficiary whenever possible as to decrease limitations in engagement

Primary or Secondary Prevention Behavioral Healthcare Program Implementation

Measurement

The prevalence of eating disorder diagnoses and follow-up treatment within 90 days.

Relevance

Eating disorders are among the most difficult behavioral health disorders, with significant healthcare consequences and potential lifelong struggles. Without effective diagnosis and treatment of eating disorders:

- There is a demonstrated adverse effect on the quality of life that is greater, in many cases, than the effects of other severe behavioral health disorders such as schizophrenia or bipolar disorder.
- Anorexia nervosa has been linked to severe cardiac complications, with a mortality rate of 10%. These effects "include profound bradycardia, hypotension, decreased size of the cardiac silhouette and decreased left ventricular mass associated with abnormal systolic function. Patients with anorexia report fatigue and attenuated blood pressure response to exercise and reduction in maximal work capacity. An increased incidence of mitral valve prolapse without significant mitral regurgitation is also observed. Low potassium-dependent QT prolongation increases the risk of ventricular arrhythmia". (Facchini, 2006).
- "Malnutrition subsequent to self-starvation leads to protein deficiency and disruption of multiple organ systems, including the cardiovascular, renal, gastrointestinal, neurologic, endocrine, integumentary, hematologic, and reproductive systems". (Facchini, 2006).
- The physical consequences of bulimia nervosa are myriad, including loss of dental enamel and bowel irregularities, fertility problems, esophageal rupture, dehydration and metabolic disarray, heart failure and cardia dysrhythmias.
- National data shows that 95% of eating disorders start in individuals from 12 to 25. (In 2021, PHC had 161,572 members in this age range, representing 81,244 women and 80,329 men).
- Of those with an eating disorder, 50% have a co-occurring major depressive episode; there are also close associations with substance use disorders and substance misuse and other issues. Suicide and suicidal behaviors are also highly prevalent in populations of individuals with eating disorders.
- While the prevalence of eating disorders is lower in males versus females, the incidence in men is growing rapidly. Different screening and diagnostic tools may be required for men.

Goal

90% of those diagnosed with an eating disorder for the first time in 12 months will have a follow-up visit within 90 days.

Methodology

Data Source:	Claims and encounter data from both PHC and Carelon providers
Denominator:	Number of unique members diagnosed with an eating disorder for the first time in 12 months
Numerator:	Of those diagnosed, number of members who have a follow-up visit within 90 days of the diagnosis.
Measurement Period:	2020-2023 Calendar Years

Results

Timely Follow-up for those Diagnosed with an Eating Disorder for the First Time in 12 Months

Calendar 2020			Calendar 2021		
% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed	% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed
79.66%	376	472	78.05%	441	565
Calendar 2022			Calendar 2023		
% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed	% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed
76.73%	409	533	89.07%	375	421

Quantitative Analysis

Throughout 2020, 2021, and 2022 fewer than 90% of members diagnosed with an eating disorder received follow-up treatment within 90 days; 79.66% in 2020, 78.05% in 2021, and 76.73% in 2022, failing to meet the goal for those years. However, in 2023, 21% less cases were diagnosed in 2023 than in 2022, although still failing to reach the goal of 90% receiving follow-up treatment within 90 days. While it is uncertain the cause of the decrease in number of cases identified in 2023, history has indicated claims lag may influence the measure as Medi-Cal allows for billing up to 365 days' post service.

Of the 421 individuals newly diagnosed with an eating disorder in 2023, 9 were diagnosed in an acute (emergency room or inpatient) setting, with 6 receiving follow-up care within 90 days. Primary care and Carelon mental health services resulted in a larger quantity of diagnosis with similar follow-up outcomes with 369 of 412 receiving care within 90 days.

Qualitative Analysis

The intervention and associated activities appear to be effective, with a consistent number of members being diagnosed and treated within 90 days. The lack of access and associated barriers were initially identified in 2019, with interventions carried from 2020 through 2023.

Collaborative Activities

This was one of the two measures selected for further study and engagement. Activities and efforts to collaborate with counties and providers on this measure, and to address the various challenges associated with care for eating disorders.

In discussions with counties, providers and others (see Appendix for sample minutes) a variety of challenges were identified, including the providers' and plans' inexperience with this disorder due to the relative infrequency of its occurrence and the complexity of its diagnosis; the absence of a clear Medi-Cal provider structure to address the problem; and confusion due to the differing responsibilities to address eating disorders. The issue of eating disorders involves a range of providers, counties, and Medi-Cal health plans. Clients may be diagnosed in the primary care or outpatient behavioral health setting, but also in the hospital and in specialty mental health clinics. Over previous years providers from throughout PHC's networks and from each of our 14 County (specialty) Mental Health Plans reported their lack of familiarity with this disorder and difficulties in arranging for effective care.

In 2022 the Plan continued collaborative activities with providers and counties to break down barriers and identify opportunities for improvement for eating disorder services. This partnership has allowed for the following:

- Barrier:
    - Widespread knowledge of the detection, diagnosis, and treatment of eating disorders lacks throughout the region, and often county staff do not specialize in the disorder.
- Actions:
    - A series of meetings with other Medi-Cal managed care plans, with County Mental Health Plans, with eating disorder experts, and with primary care and behavioral health providers to discuss the prevalence and approaches to eating disorders.
    - Presentation of a series of webinars focused on the handling of eating disorders. The webinars have remained accessible to all via PHC's website.
    - Annual targeted trainings for PHC and county mental health plan staff presented by Dr. Erin Accurso, an eating disorder expert at UCSF, with the most recent hosted on February 28, 2024.
- Barriers:

    - Bottlenecks in access to care exist due to resistance from providers in accepting Medi-Cal clients due to rates, lengthy enrollment processes, and significant administrative oversight. Lack of access contributes to significant wait times from initiation to treatment often allowing for disengagement.
- Actions:
    - Strategies were identified to leverage Letter of Agreements (LOAs) with PHC for providers unwilling to enroll in Medi-Cal, ultimately building a "trust first" pathway to contracting. This process has allowed for a regional approach where providers have the opportunity to work with one entity (PHC) rather than 14 (individual counties).
- Barriers:
    - Referral pathways between and to PHC and counties were unclear, often causing confusion amongst the provider network as to who to coordinate treatment with.
- Actions:
    - Continued allocation of a single point of contact for providers and counties allowing PHC to identify more ED cases and address them sooner. This has allowed for added trust within the provider network throughout the coordination efforts. By now being engaged in all eating disorders requiring specialty services we have been able to improve tracking which allows assurance that beneficiaries are not slipping through the cracks.
- Barriers
    - Often the diagnosis and treatment of eating disorders is managed by PCPs due to lack of access to additional options, especially in rural communities.
- Actions:
    - PHC has continued to build the relationship with telehealth intensive outpatient programs intended to provide an alternative for higher acuity cases where transportation or access may be a barrier.

Measuring Effectiveness

As was discussed, our work appeared to lead to an improvement in the diagnosis and follow up of those with eating disorders, however it did take time for the interventions to show improvement. PHC plans to continue to offer trainings; recruitment support and an innovative "wrap around" telehealth program. The Plan also continues to identify resources to help providers care for clients with eating disorders, including as noted above, the use of an expert agency to review cases and help determine the appropriate level of care; providing incentives to providers to hire staff with eating disorder treatment experience; and working to add specialist providers to the network to help address this issue.

However, a total of 1991 PHC members have been diagnosed with any type of eating disorder in during our intervention period between 2020-2023. As was noted, 0.67% to 1.2% of women would be expected to develop anorexia nervosa (reflecting potentially between 544 to 975 female PHC members between 12-25 years of age in 2023) and about 0.1% of men (potentially 80 male PHC members between 12-25 years of age in 2023.). 0.6% of women aged 12 to 25 are predicted to have bulimia nervosa (upwards of 487 PHC members in 2023). While follow-up percentages near the goal of 90%, it is recognized the rate of new diagnosis is comparable to national data. PHC will focus on the early and

correct diagnosis of eating disorders, as well as the timeliness of the treatment after this diagnosis through collaborative activities with counties and community partners, providing tools to help providers diagnose eating disorders at early stages, provide specialists available for PCP consultation, more trainings for providers and encouraging continued outreach and prevention activities aimed at adolescents.

Next Steps

While existing interventions appear to be working, a period of sustainability and efficacy measurement will continue. PHC will strive to improve our work on behavioral and medical care coordination, focusing more closely on the diagnosis, treatment, and follow-up of substance use disorder and eating disorders. The upcoming work for each of these two factors will continue to involve data gathering and analysis with individual providers to supplement our understanding of the issues and barriers they face and how to address them most effectively.

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Behavioral Health Overview

May 2024

BH Overview

- Children & Youth Behavioral Health Initiative – School Initiatives
  - Student Behavioral Health Incentive Program (SBHIP)
  - School-Linked Multi-Payer Fee Schedule
- Mental Health
- Mental Health QIP
- Eating Disorder Treatment – “shared levels of care”
- Wellness & Recovery (SUD)

Student Behavioral Health Incentive Program (SBHIP)

SBHIP: Three-year project for MCPs to partner with schools

- PHC legacy 14 counties
  - 14 County Offices of Education (COE)
  - 86 partner School Districts (LEAs)
  - Monthly 'Learning Collaborative'
  - $22 million over three years
- Expansion Counties
  - Completed transition plans along with exiting managed care plans ($2.3 million 2024)
  - Joined Monthly Learning Collaborative

Final Year 2024!

SBHIP Interventions by County

INTERVENTION	COUNTY
BH Wellness Programs	HUMBOLDT, LAKE , MENDOCINO, SISKIYOU, SOLANO, SONOMA, TRINITY, NEVADA, PLACER, SIERRA, TEHAMA, YUBA
BH Wellness Centers	BUTTE, COLUSA, NEVADA, YOLO, NAPA, TRINITY, DEL NORTE
BH Screenings & Referrals	PLACER, TEHAMA, YUBA, SOLANO, MENDOCINO, SISKIYOU, LAKE
Build Stronger Partnerships to Expand Medi-Cal Services	MARIN, SHASTA, SONOMA, SOLANO, HUMBOLDT
TA Support for Contracts	PLACER
Expand BH Workforce	MODOC, MARIN, NAPA, SOLANO, SONOMA, BUTTE, COLUSA, SUTTER
Care Teams	LASSEN, SHASTA, SUTTER
Expand Telehealth	PLUMAS
IT Enhancements	YOLO
Substance Use Disorder	PLACER
Suicide Prevention Strategies	SONOMA, PLACER

Multi-Payer Fee Schedule

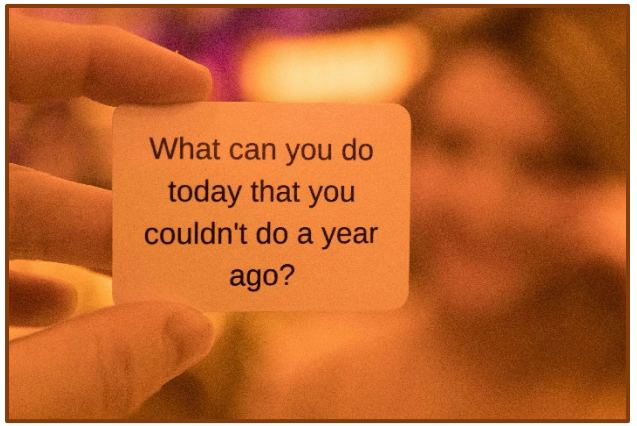
All health plans will reimburse for 'school-linked' behavioral health services beginning 2024

How?

School sited or arranged for services

New, expanded provider types

Non-contracted providers



Cohort I:

PHC Counties:

Butte – Butte COE

Humboldt – Humboldt Court & Community; Southern Humboldt USD

Nevada – Nevada Joint USD

Placer – Placer COE; Roseville Joint USD

Shasta – Shasta COE

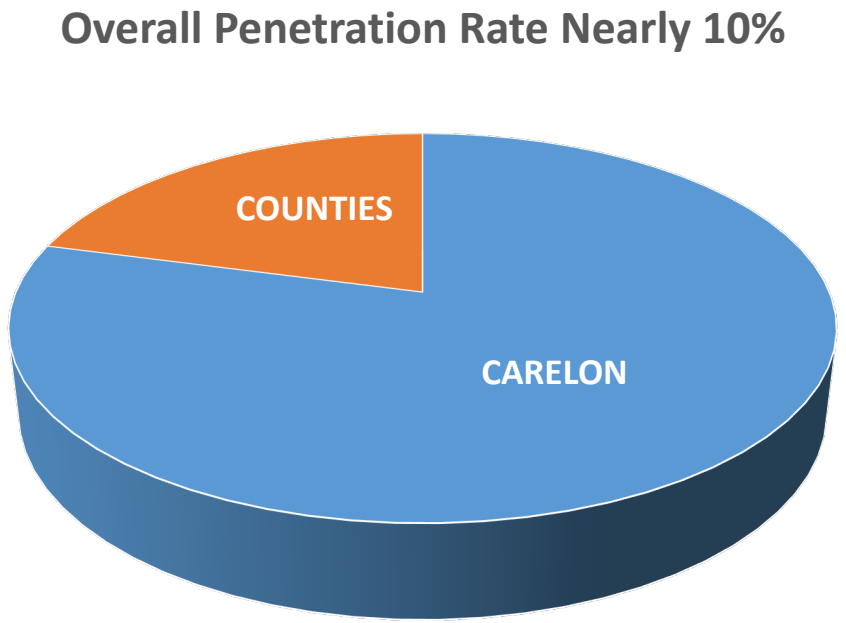
Solano – Solano COE

Tehama – Tehama COE; Red Bluff Union SD

Cohort II: July 2024; statewide January 2025

Mental Health- Utilization Rates

Calendar Year 2023



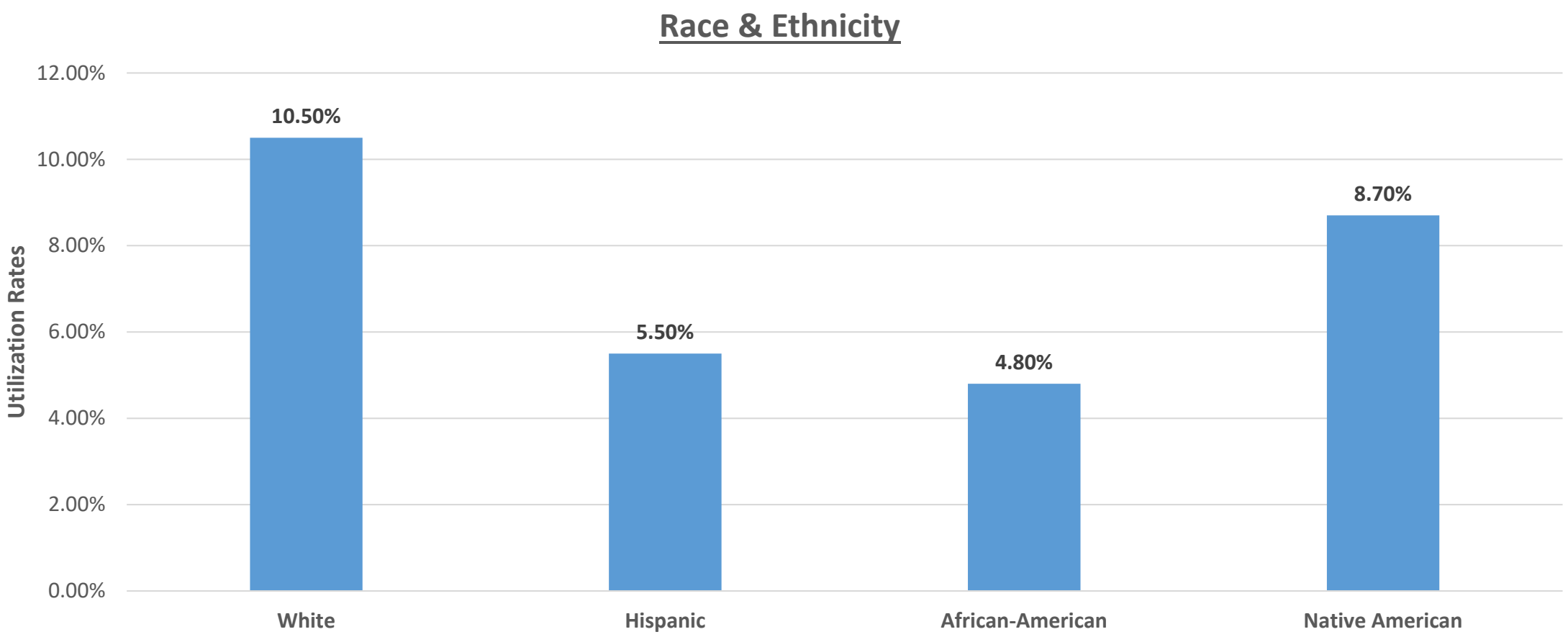
- Members Utilized Mental Health Services through network administered by Carelon = 48,985
- Members Utilized County Speciality Mental Health = 12, 920

What do we know about our Utilizing Members?

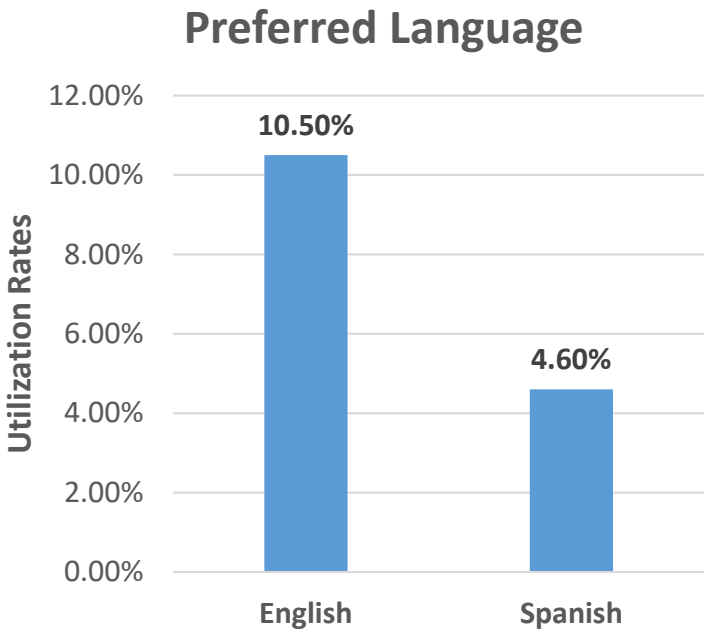
Members Utilizing Services in our Non-Specialty System:

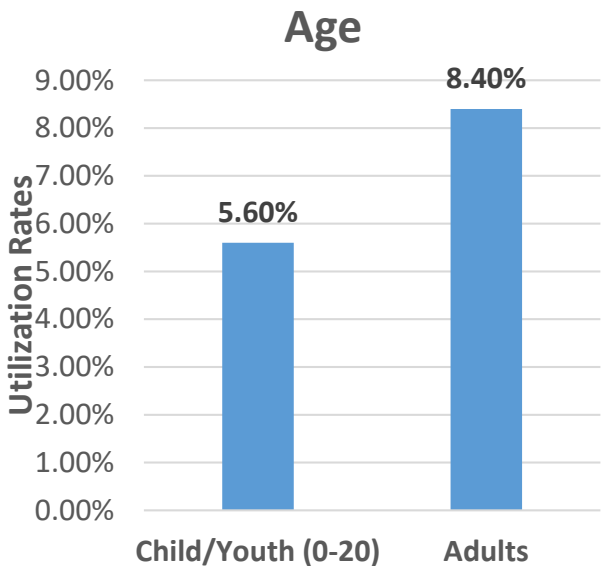
- Overall average of 10 visits per utilizer
- 32% Telehealth Visits
- 88% Therapy
- 12% Medication Management
- Diagnoses:
    - 45% Anxiety Disorders
    - 25% Depressive Disorders

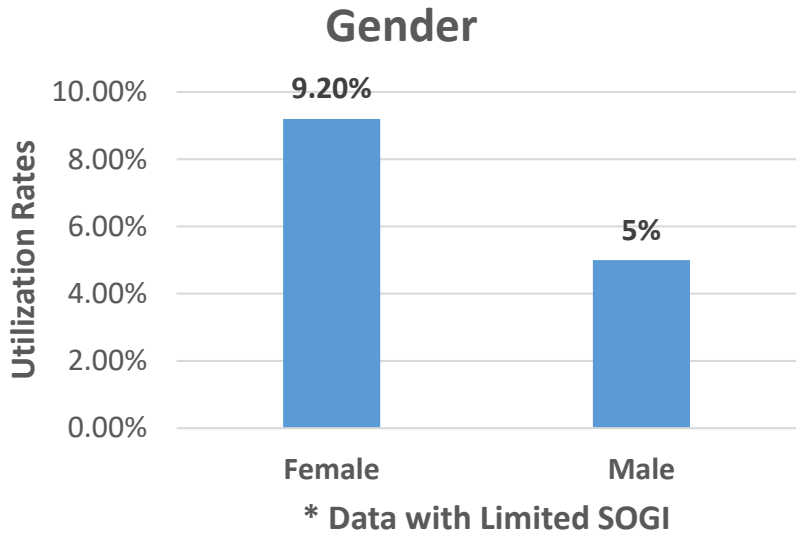
Utilization of Mental Health Services CY 2023



Utilization of Mental Health Services CY2023







What do we know about our Network?

Top Providers by Utilizing Members:

North American Mental Health Services *(Nearly 6,600 members!)*

Open Door

Marin Community Clinic

Petaluma Health Center

Shasta Community Health Center

Adventist Health Clearlake

Clinic Ole/Communicare

Mendocino Community Health Center

Santa Rosa Community Health Center

Mental Health Quality Incentive Program

Structure: ✓

- Adoption of Measurement Based Care (MBC) to answer the fundamental questions: ***Are clients getting better & can we improve care using MBC?***
- Invited contracted group practices to participate in QIP
- Implemented Kiosks at each practice site for clients to complete screenings

Process: ✓

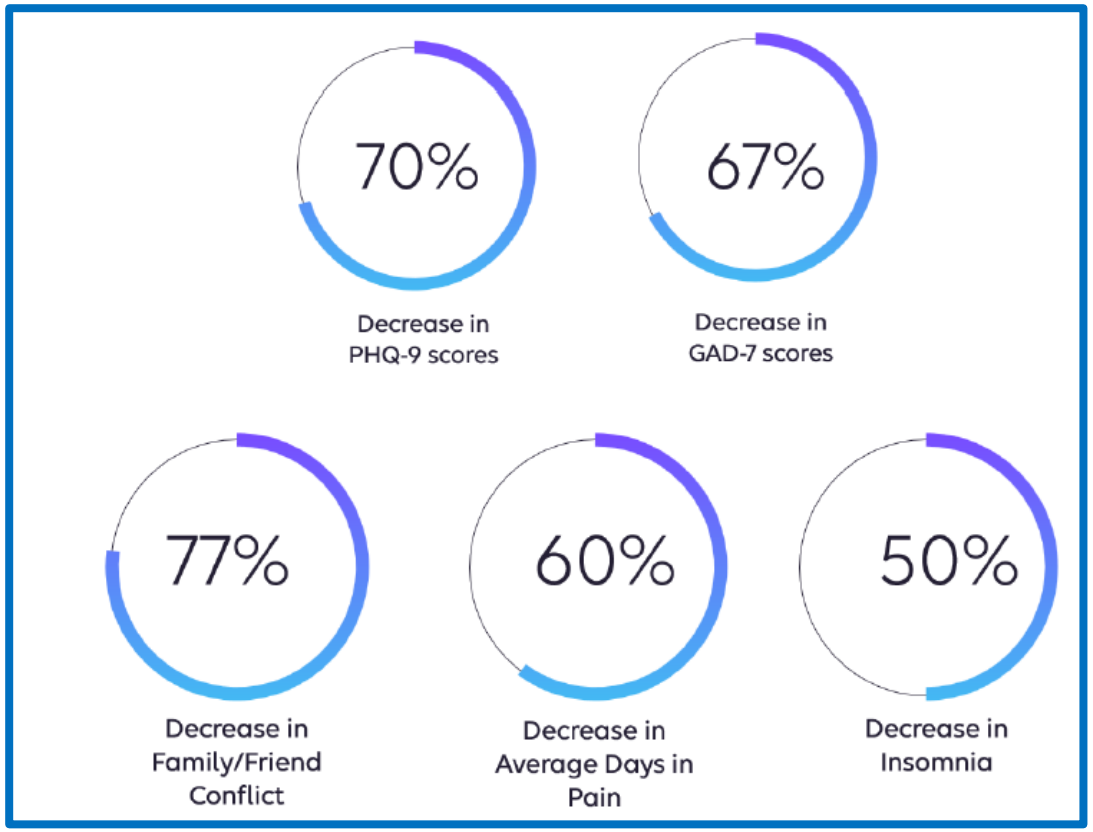
- Sites were incentivized to get clients to complete screenings at each visit
- Summary of results were provided to the treating provider to be used with client
- Staff incentivized to participate in quarterly learning collaborative

Challenges: ⚠

- Client friction due to the number of screening tools and duration
- Provider inclusion of the results in treatment difficult to track

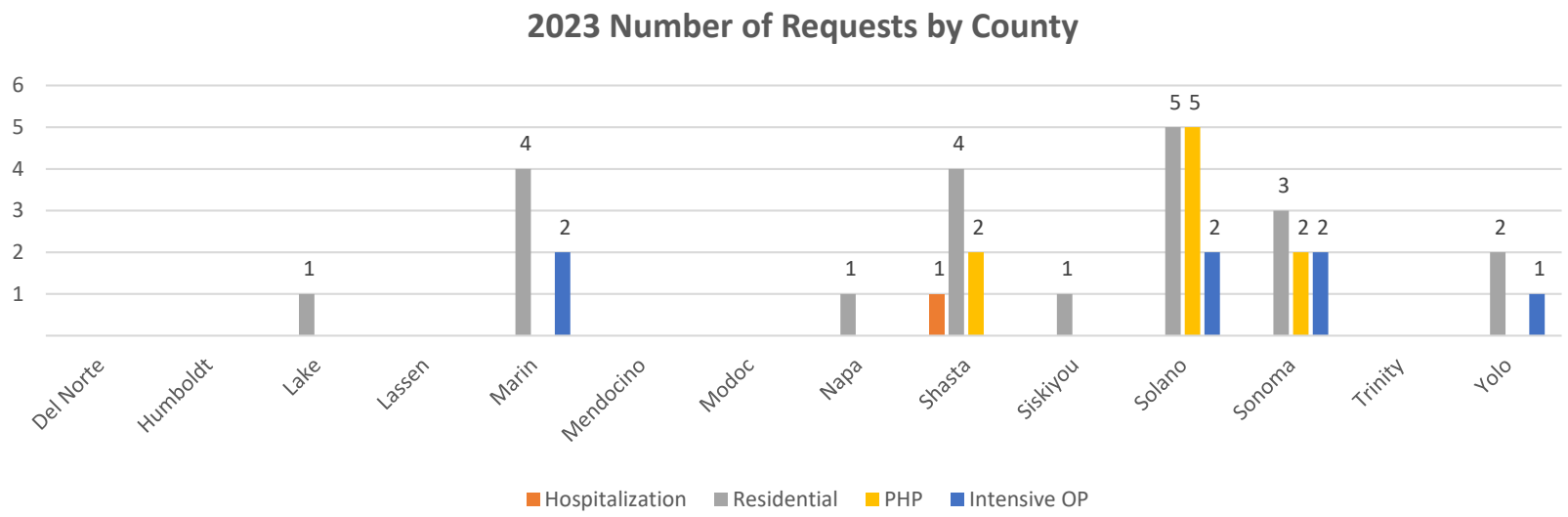
Mental Health QIP Results

Over the course of 6 months of treatment, MBC QIP indicated symptom reduction over multiple domains:



Eating Disorder Treatment

Eating Disorder Treatment is a shared financial responsibility with county Mental Health Plans (MHPs) at certain treatment levels: <u>Residential</u>, <u>Partial</u> and <u>IOP</u>

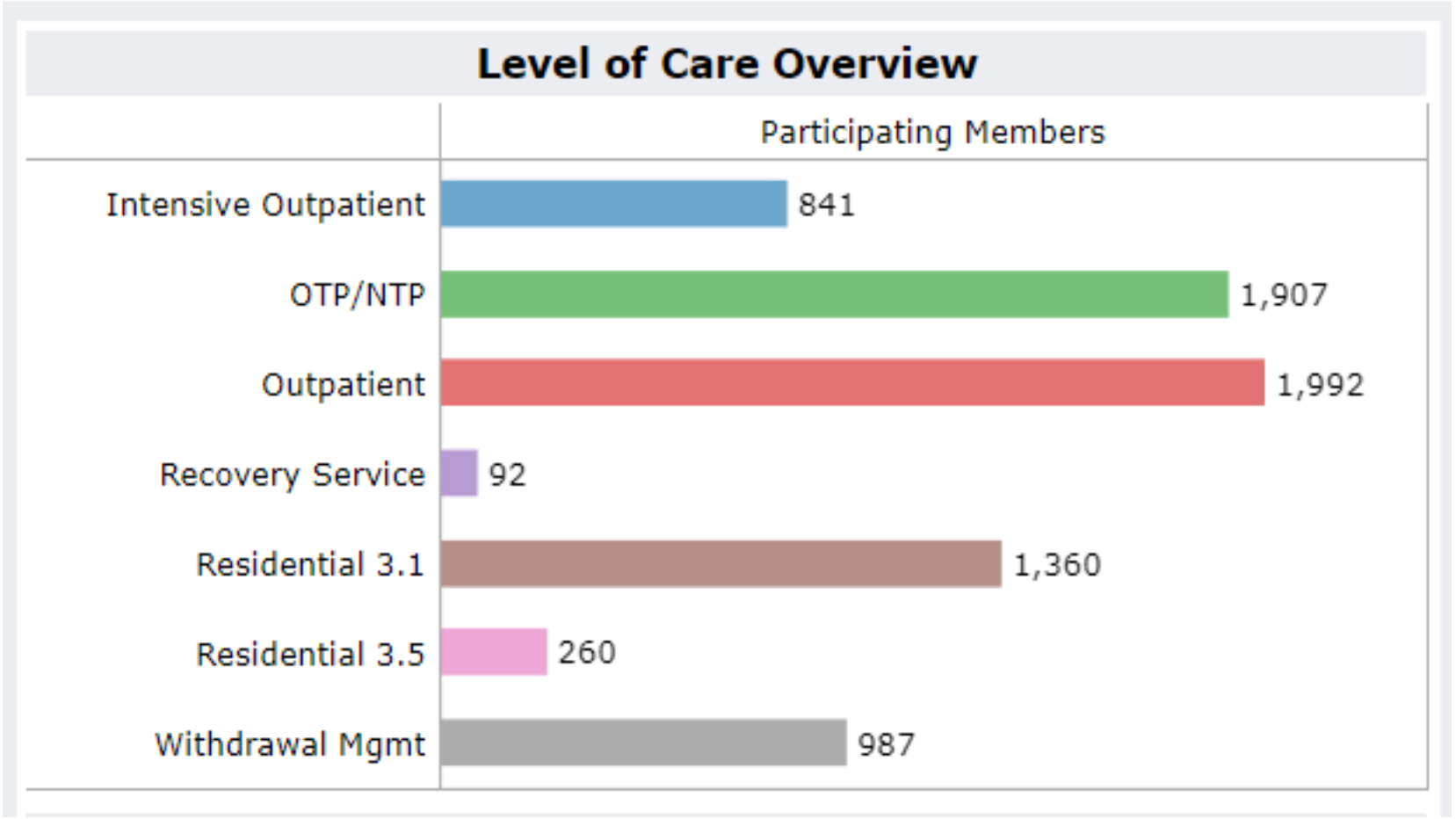


Wellness & Recovery - Overview of Services - 2023

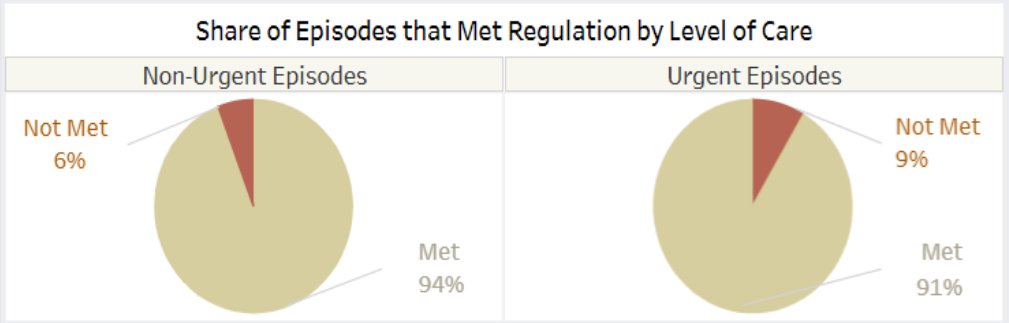
5222 members accessed SUD services 2023

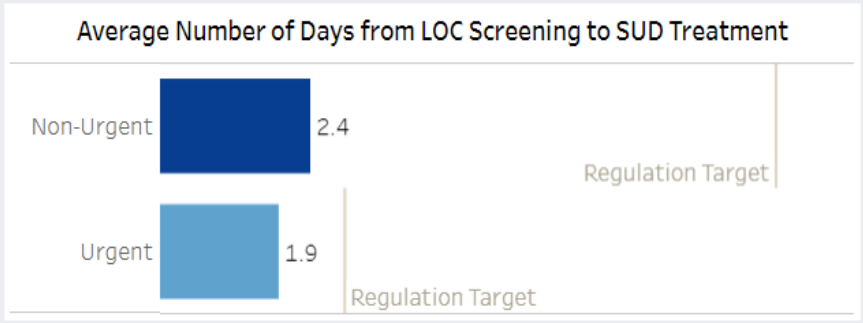
- Increase of 9.2% over 2022

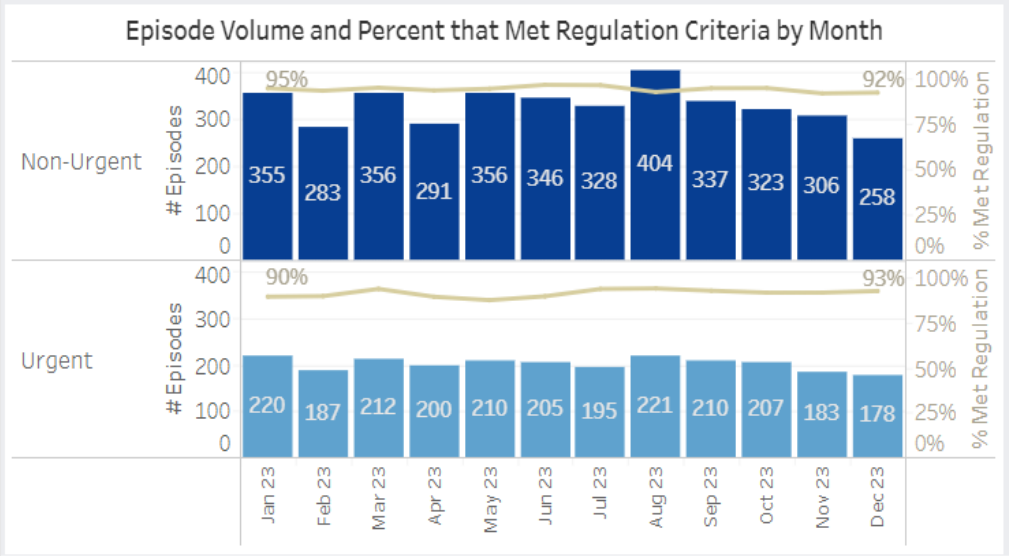
To date 9915 members have accessed treatment since inception of the program in 2020

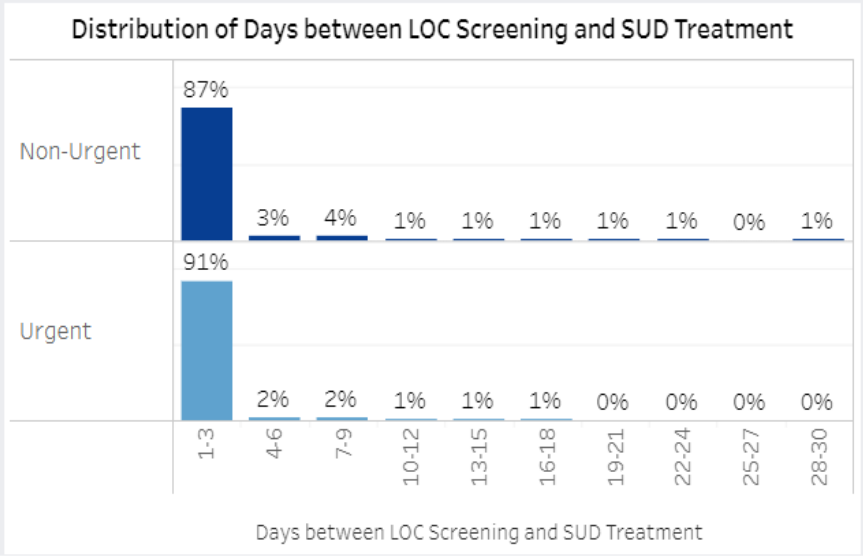


Wellness & Recovery - Timely Access









93% of episodes met timeliness requirements

Direct referrals are up 9% over previous year

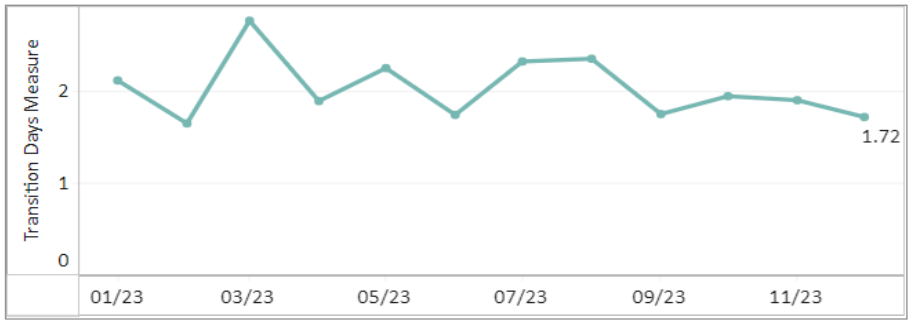
Wellness & Recovery - Transitions of Care

Transition Days Measure
- (•) Average
- ( ) Median

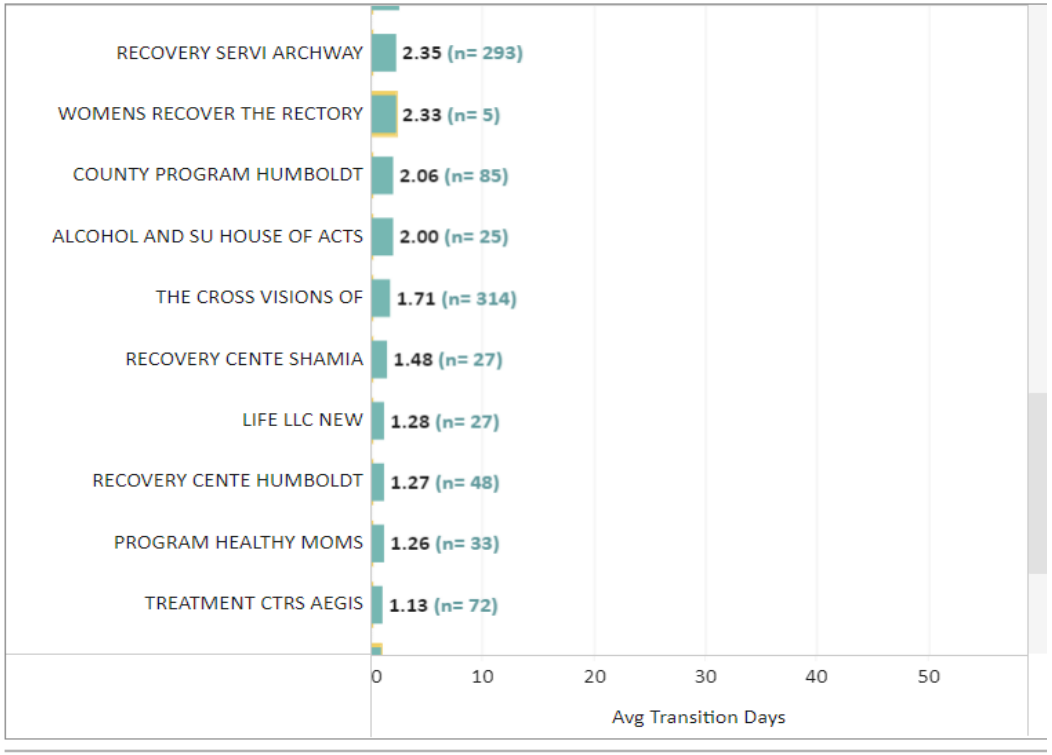
Members without transition	Members with transition	Step Down	Step Up	No Change
2,001	1,512	1,212	766	300

Average Transition Days	Step Down	Step Up	No Change
2.03	2.40	8.36	0.95

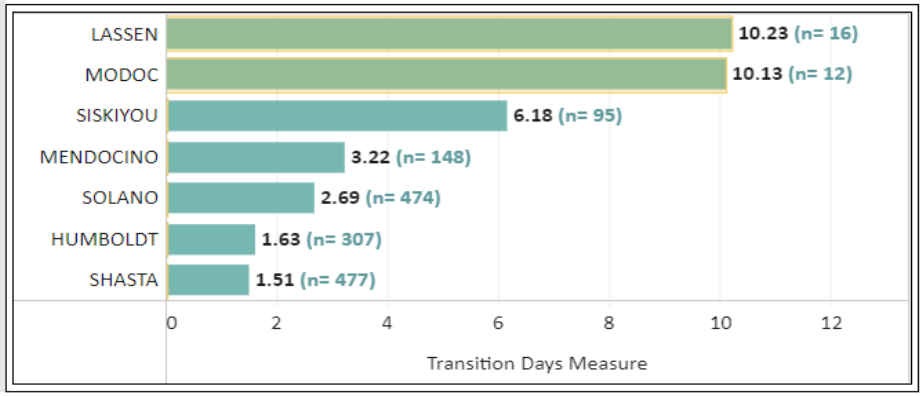
Average Days of Transition over Time



Average Days of Transition by Service Provider



Average Days of Transition by County



Average transition of care 1.72 days

Reflective of programs expanding to serve multiple levels of care

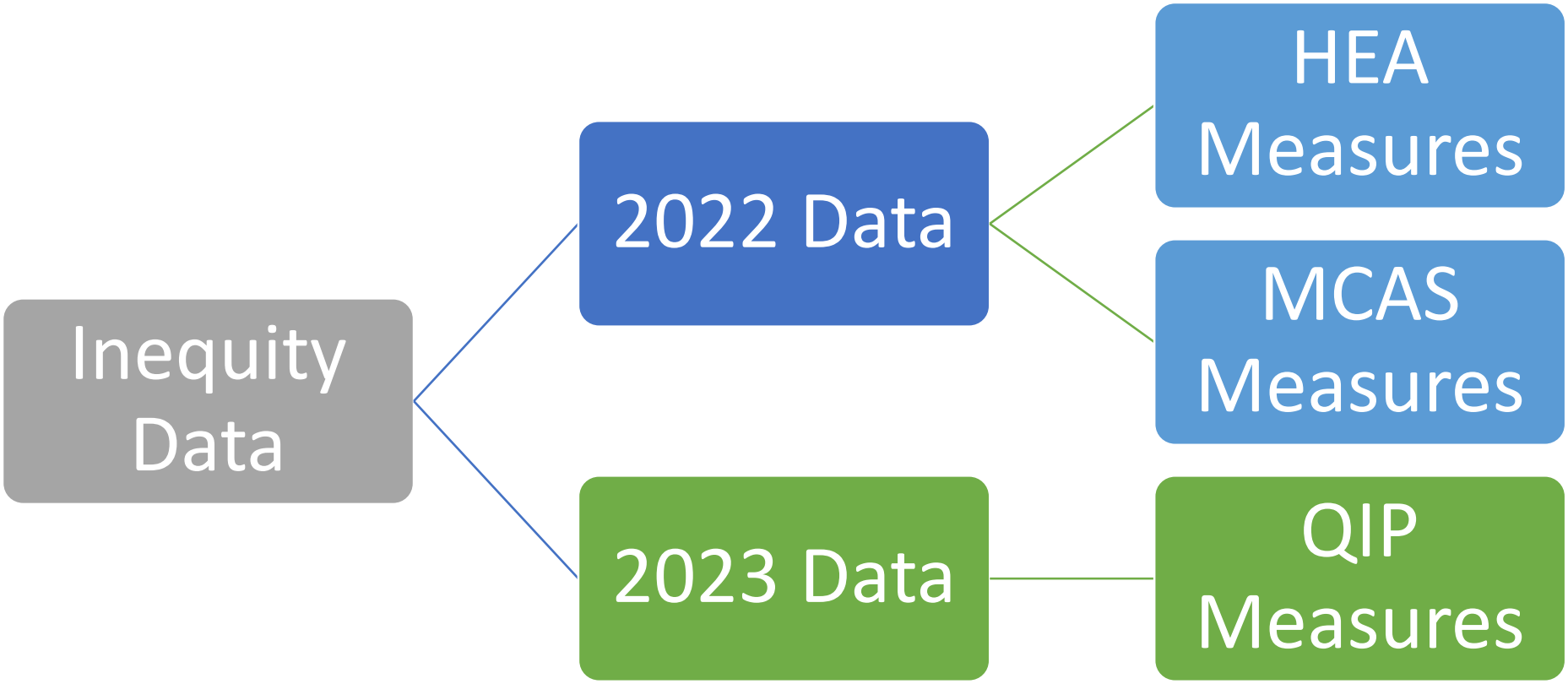
PARTNERSHIP HEALTHPLAN of CALIFORNIA

2024 Inequity Analysis

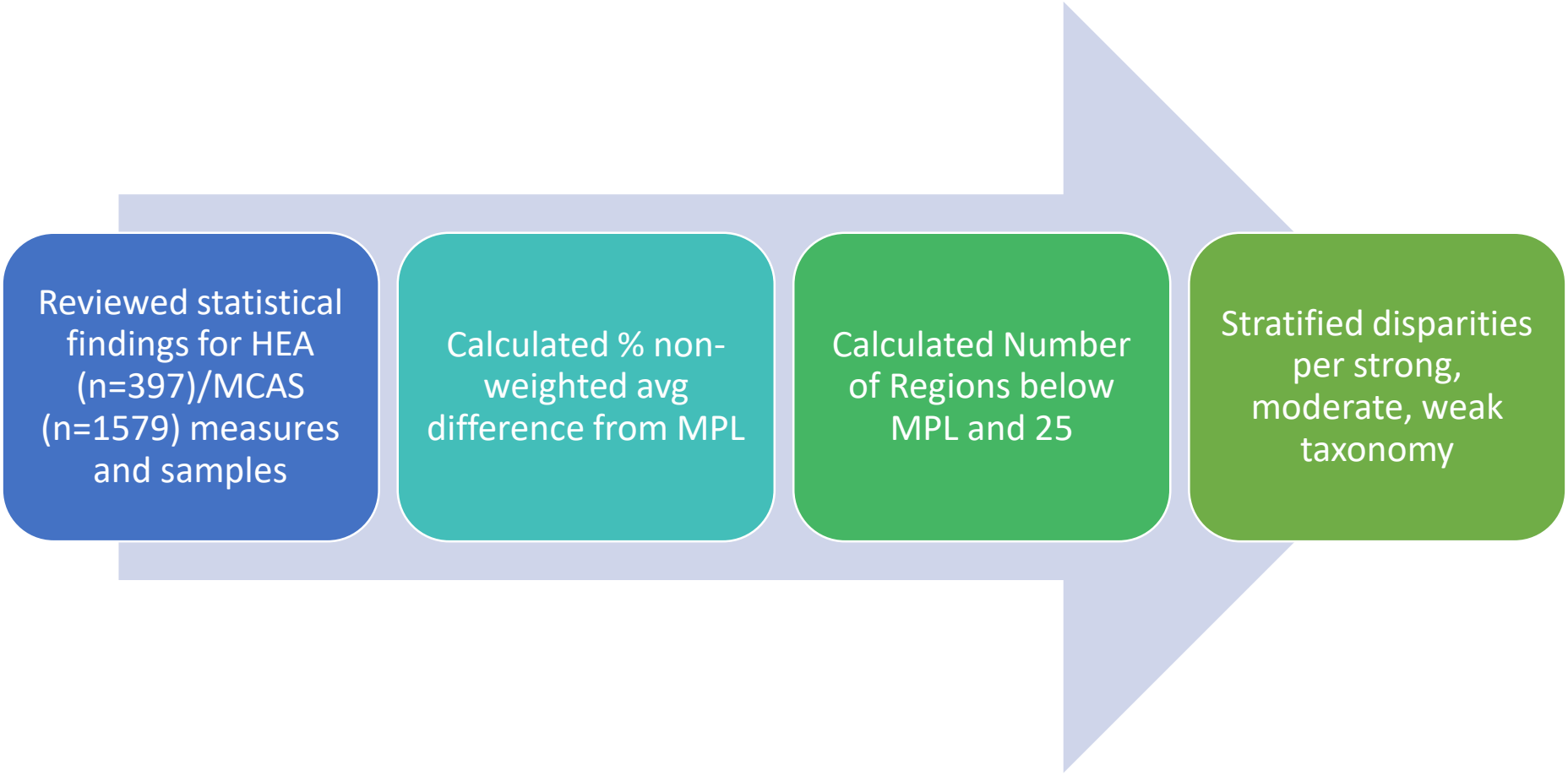
Mohamed Jalloh, PharmD
Director of Health Equity
(Serving as PHC Health Equity Officer)

•Methodology

Methodology



HEA/MCAS Analysis



2023 QIP Data

- 2023 PCP QIP Granular Data
- Geographic Drivers and Community Profile Analysis
- Less Effect of COVID than in 2022
- Performance of White ethnicity was benchmark

Quality Concerns

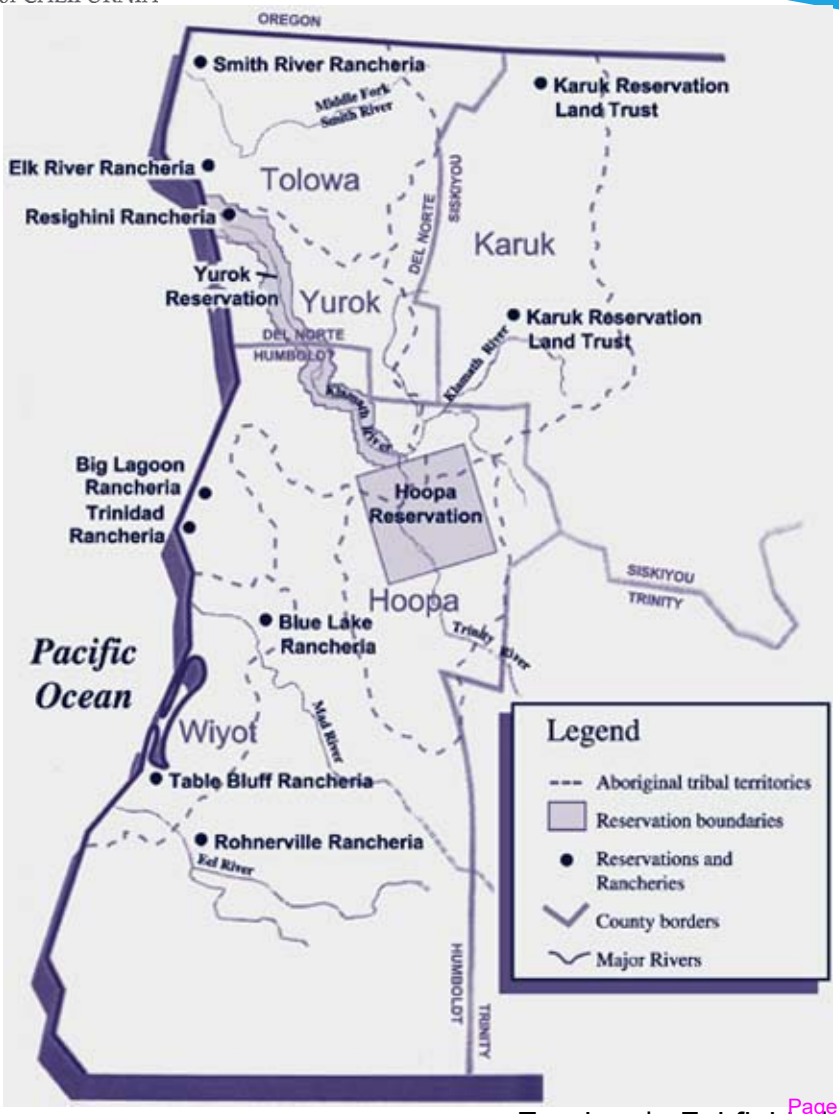
- Poor performance among majority of groups in majority of regions

Well Child Visits

2023 Equity Analysis

- American Indian/ Alaska Native Group

American Indian/Alaska Native

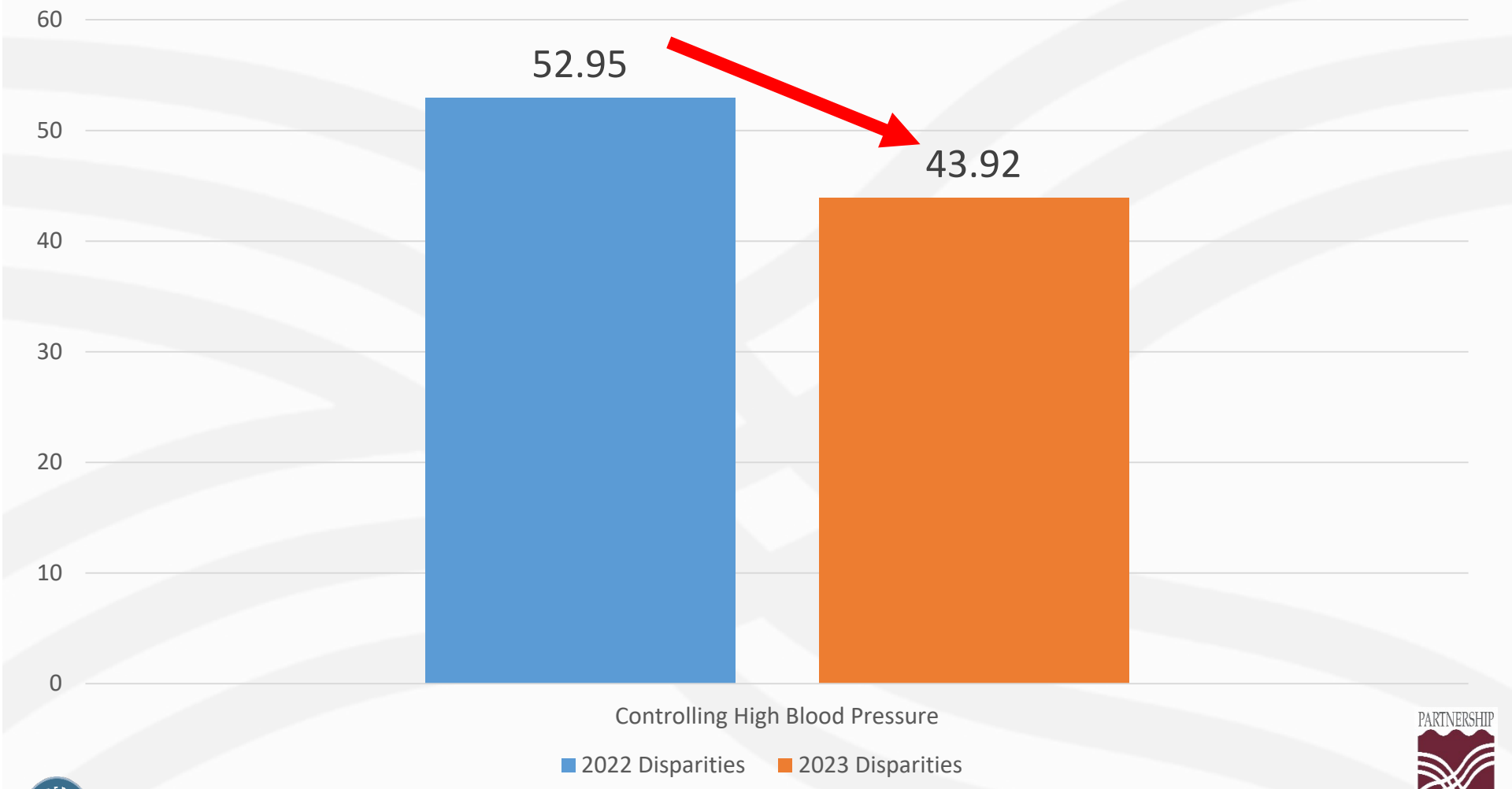


- **Overall Tribal Members**
  - 16,435 Members (1.8%)
- **Karuk, Hoopa, Tolowa, Wiyot, and Yurok tribes**
  - Most Common in Humboldt, Mendocino, Shasta, Del Norte, and Lake counties
- **Religion and Ceremonies**
  - World Renewal Ceremonies
- **Key Community Activities**
  - Weaving and basketry is common practice for baby baskets, collecting vessels, food bowls, cooking items, and ceremonial items
  - Poly Cal U has strong AI/AN

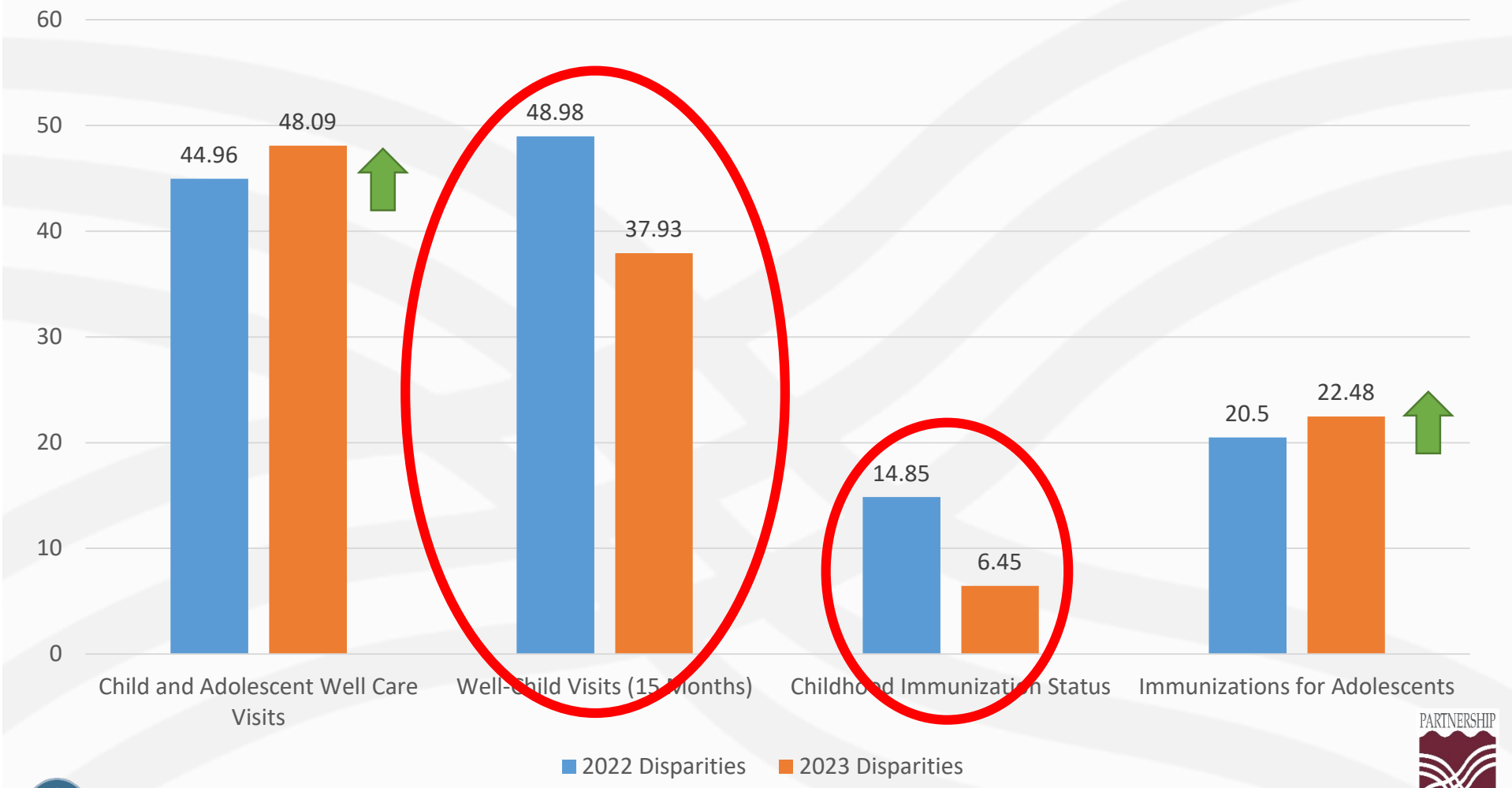
American Indian/Alaska Native Population: HEA/MCAS

HEDIS Measure	HPA Sample Findings	MCAS Sample Findings	Regions below 25th Performance Level	Absolute Average Percentage below MPL across regions	Category of Disparity
Controlling Blood Pressure	No significant difference with white group	No significant difference in all 4 regions	3	13.18%	Strong
Breast Cancer Screening	----------	Performed significantly worse in 3 regions when compared to white group	4	12.84%	Strong
Cervical Cancer Screenings	----------	Performed significantly worse in 1 region when compared to white group	4	12.65%	Strong

American Indian/Alaska Native Population: QIP



Children's Health Disparities



2023 PCP QIP American Indian/Alaska Native Inequities

(Native American rate vs. White rate)

- Asthma Medication Ratio (67% vs. 65%) → 2% Difference
- Breast cancer screening (39% vs. 48%) → 9% Difference
- Cervical cancer screening (41% vs. 53%) → 12% Difference
- Childhood immunization (6% vs. 15%) → 9% Difference
- Colorectal cancer screening (26%vs. 35%) → 11% Difference
- Blood pressure control (44% vs. 63%) →19% Difference
- Blood sugar control (49% vs. 67%) → 16% Difference
- DM Retinopathy screening (40% vs. 50%) → 10% Difference
- Adolescent immunization (23% vs. 23%) → ~1% Difference
- Nutrition counseling – N/A
- Physical activity counseling – N/A
- Well child visits (38% vs. 57%) → 19% Difference

Further Analysis

- Blood Pressure
  - *Lowest Performance: K'ima:w; Consolidated Tribal Project, Karuk Tribal Project, Lassen Indian Health Center*
  - ****Sonoma County Indian Health Project highest performance***
- Childhood immunization (CIS-10) (*Very* low at all PCPs: average just 6.5%! with average of 1 member receiving immunization at sites)
  - Fairchild Medical Clinic (Zero)
  - *Willow Creek Community Health Center (Zero)*
  - Lake County Tribal health (Zero)
  - Stallant Health and Wellness (Zero)
- Diabetes HbA1c Good Control
  - *Lowest Performance: Crescent City Health Cener, Hillside Health Center, Potawot Health Village*
  - ****Sonoma County Indian Health Project highest performance***

Key Priorities

Blood Pressure Control (MCAS and QIP)

Blood Sugar Control (QIP)

2023 QIP Data

- African American/ Black Group

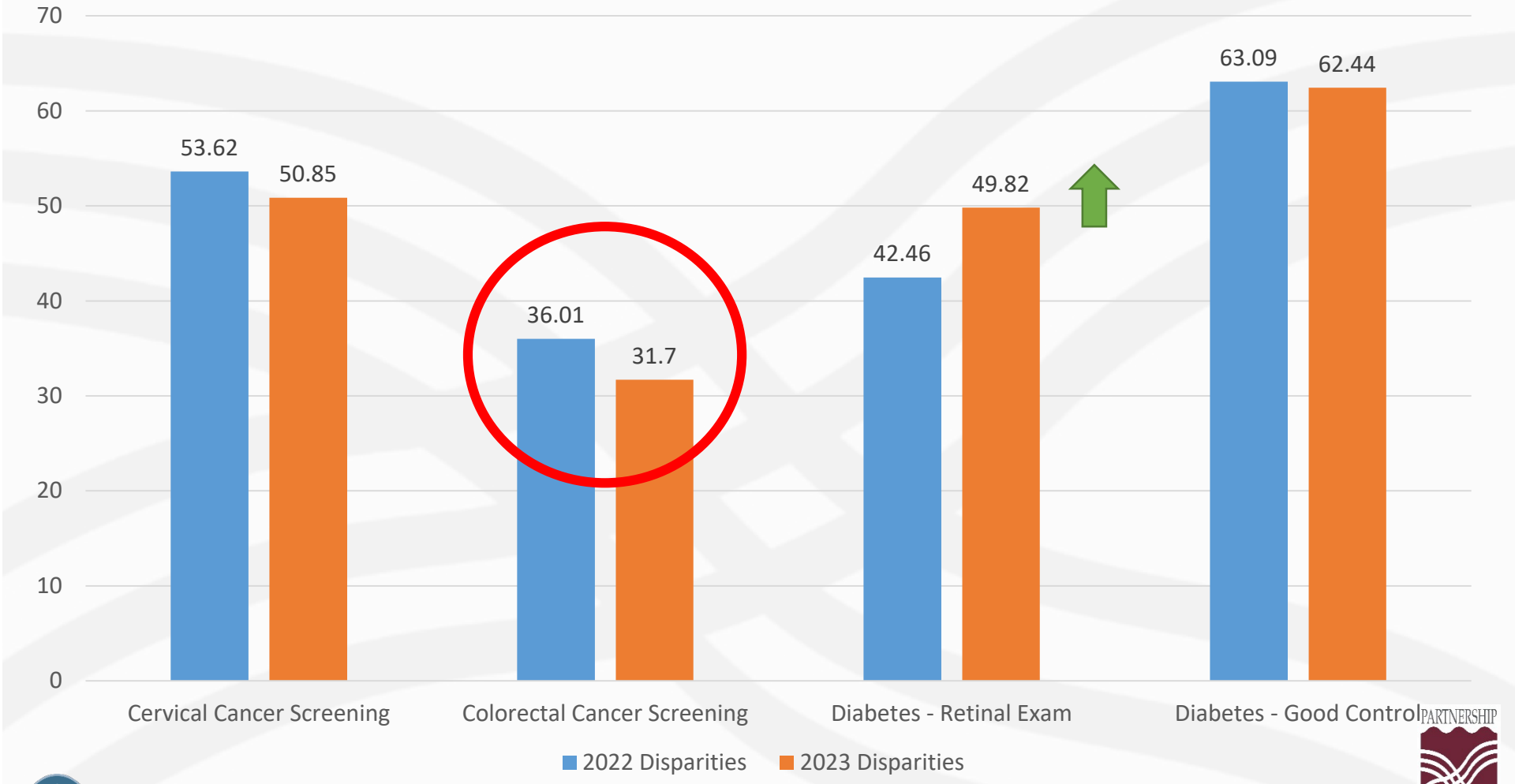
Black Community

- **Overall Black Members**
  - 32,510 (3.5% of total Partnership population)
- **Primarily in Southern Region**
  - Solano, Butte, Yolo, Sonoma, and Marin have highest numbers
  - Vallejo and Fairfield are prominent cities
- **Key Community Activities**
  - Community Events (e.g Juneteenth) are common for gatherings

Black Population: HEA/MCAS

HEDIS Measure	HPA Sample Findings	MCAS Sample Findings	Regions below 25th Performance Level	Absolute Average Percentage below MPL across regions	Category of Disparity
Timeliness of Prenatal Care	No significant difference with white group	Performed significantly worse in 1 region (NW) when compared to white group	1	25.1%	Strong
Timeliness of Postpartum Care	No significant difference with white group	No significant difference with white group	2	9%	Strong
Follow-up for mental health within 30 days of ER	----------	No significant difference with white group	3	23.19%	Strong

Key Black QIP Findings



Further Analysis

- Colorectal Cancer Screenings
  - Southeast, South Asian, Asian Pacific Islander performed at higher level (50th percentile)
  - *Lowest Performance: Solano County FHS, La Clinica, and OLE Health Fairfield Sites*
  - ****Community Medical Center, Vacaville highest performance****

2023 PCP QIP Black Inequities

Total Number of Disparities: Five Measures out of 11 (Excluding Nutrition/Physical Activity)

- Many other measures have now reached 50th percentile (e.g., breast cancer screening, well child visits in first 15)

Strong (>15% Difference) or Moderate (>10% Difference) or Weak (>5% Difference)

- Cervical Cancer Screening (Weak)
- Colorectal Cancer Screening (Weak)
- DM Retinopathy Screening (Weak)
- DM Good Control (Weak) **Lowered from 75th percentile to 50th percentile**

Priorities

Follow-up for mental Illness post ED visit (MCAS)

Prenatal/Postpartum Care (MCAS)

Colorectal Cancer Screenings (QIP)

Summary: 2023 PCP QIP

- The largest number of inequities are in the Native American ethnicity group (10/11)
  - Key concern: Controlled Blood Pressure
- African American population has 5/11 measures with inequities.
  - Key Concern: Prenatal/Postpartum Care and F/U for mental illness
- Pacific Islander, SE Asian, Eastern Asian all show 1 inequity.
- No inequities were identified in the Hispanic, South Asian groups.
- Summary: No significant improvement in inequities from 2022 to 2023.


Questions?

2023 Mobile Mammography Program Evaluation

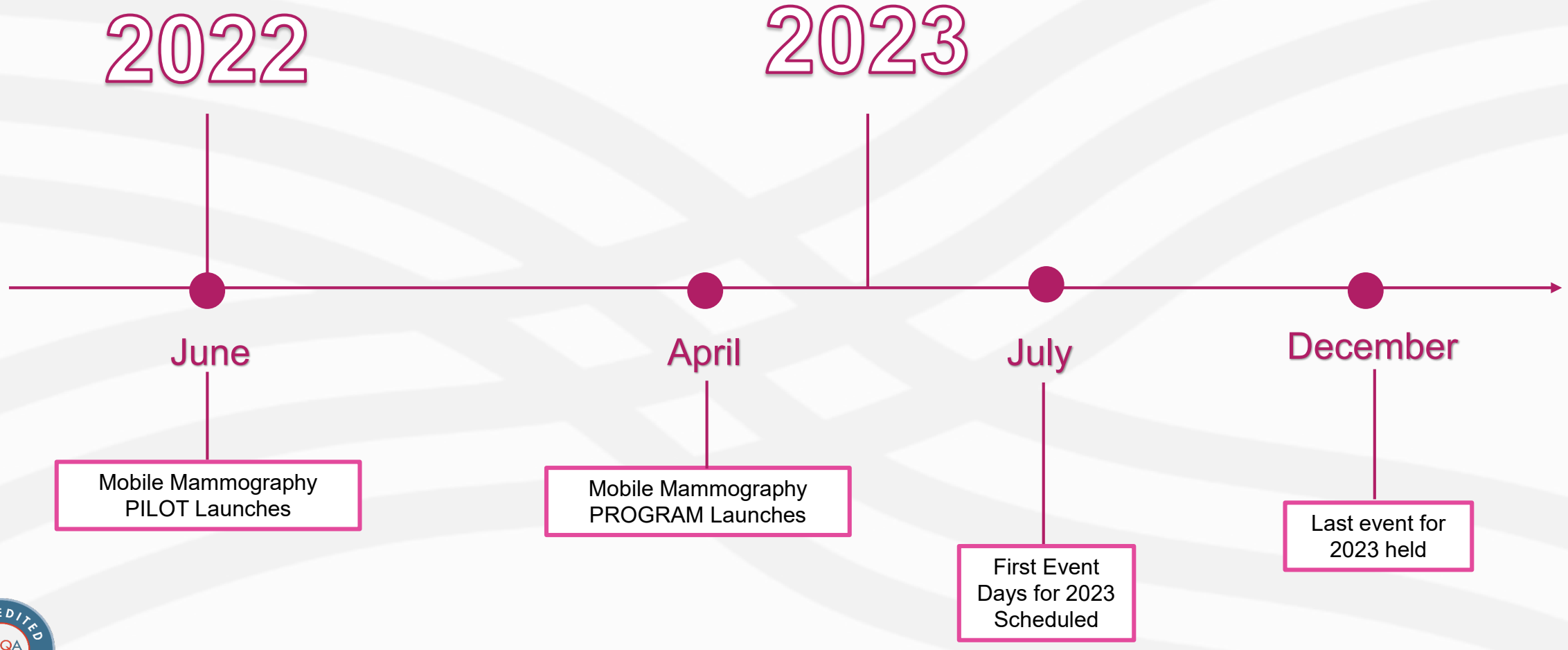
Arelí Carrillo, Program Manager II

Tuesday, May 7, 2024

Agenda

- Program Overview
- Alinea Medical Imaging
- Partnership Sponsorship
- Event Days
- Impact and Successes
- Progression and Engagement Strategy
- Event Day Summary and Surveys
- Next Steps
- Questions
- Additional Resources

Timeline


2022
2023
June
April
July
December
Mobile Mammography PILOT Launches
Mobile Mammography PROGRAM Launches
First Event Days for 2023 Scheduled
Last event for 2023 held

Alinea Medical Imaging

- Partnership has contracted with Alinea Medical Imaging to bring onsite breast cancer screenings to eligible provider organizations.
- Service available in all Partnership regions, including our new Eastern counties.
- Screenings are done indoors using a portable unit or outdoors using full-service, self contained 34’ coach.

Portable Unit
Requires a 10’ x 10’ room

34’ coach
Requires 8 – 10 uncovered parking spaces

Partnership Sponsorship

Eligibility

Provider locations:

- Below the 50th percentile benchmark
- In imaging center "deserts"
- With lack of access at nearby imaging centers

Criteria

- 30 patient minimum requirement.
  - Target of 80% must be Partnership members
- Providers are responsible for conducting all outreach
- Preventative screenings only

Planning and Collaboration

Alinea

- Provides availability
- Assign technicians to routes
- Provides the screenings

Provider Organization

- Provides availability
- Conducts outreach, marketing, appointment scheduling
- Attends the check-ins
- Host the event day
- Provides completed event data to Partnership

Partnership's Project Management Team

- Identifies and meets with eligible provider organizations
- Puts together routes
- Coordinates check-ins, provides resources and support leading up to and for the event day
- Post event data collection and analysis

Partnership's Population Health Team

- Supports with the check-ins
- Attends the event day
- Provides event day summary and surveys to the PM team

A Successful Event Day

A Look into an Event Day

July 2023
Hill Country Community Clinic
(Round Mountain site)

October 2023
Marin City Health & Wellness

October 2023
Stallant Health and Wellness

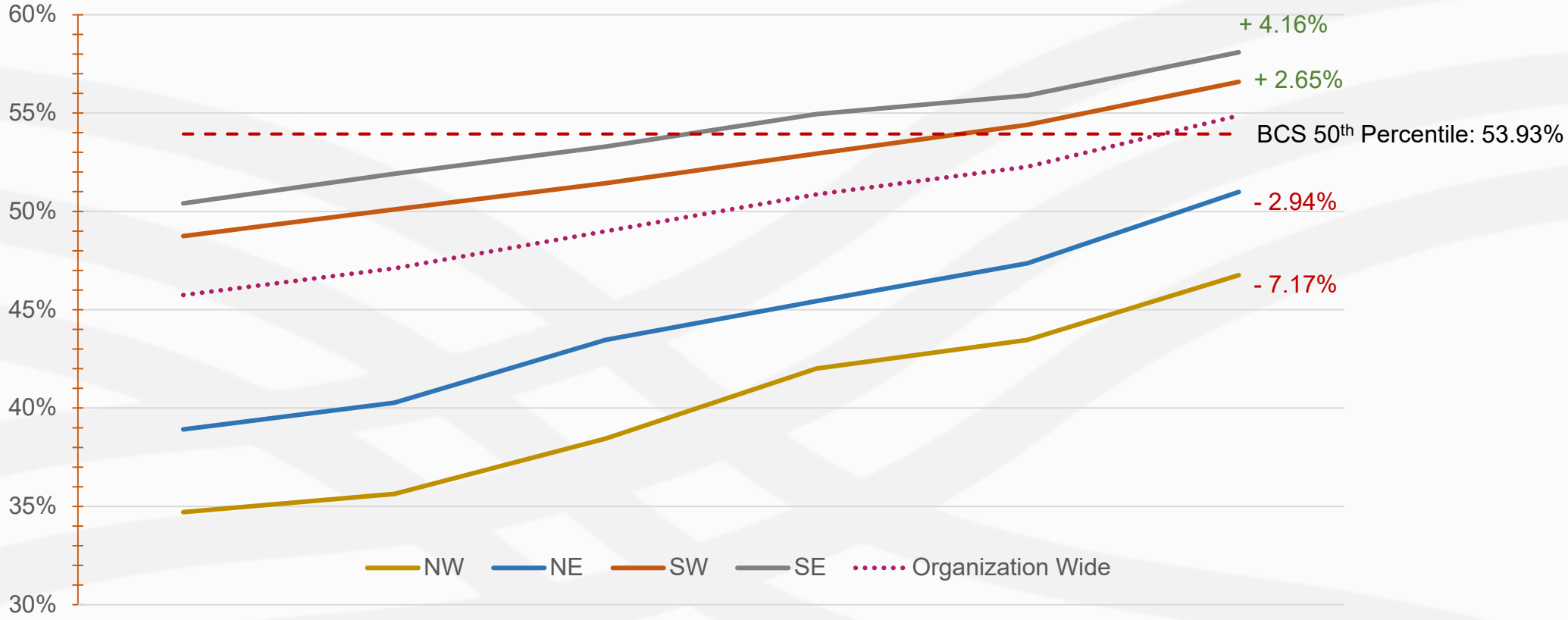
July 2023
Long Valley Health Center

October 2023
Ritter Health Center

Impact and Successes

PCP QIP Breast Cancer Screening by Region

(July 2023 – December 2023)



	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
NW	34.71%	35.64%	38.44%	42.01%	43.47%	46.76%
NE	38.92%	40.27%	43.47%	45.44%	47.36%	50.99%
SW	48.74%	50.10%	51.43%	52.93%	54.40%	56.58%
SE	50.41%	51.91%	53.29%	54.94%	55.89%	58.09%
Org Wide	45.75%	47.10%	48.9%	50.86%	52.27%	54.87%

Regional Impact
(July 2023 – December 2023)

Organization Wide

**Data is from July to December 2023*

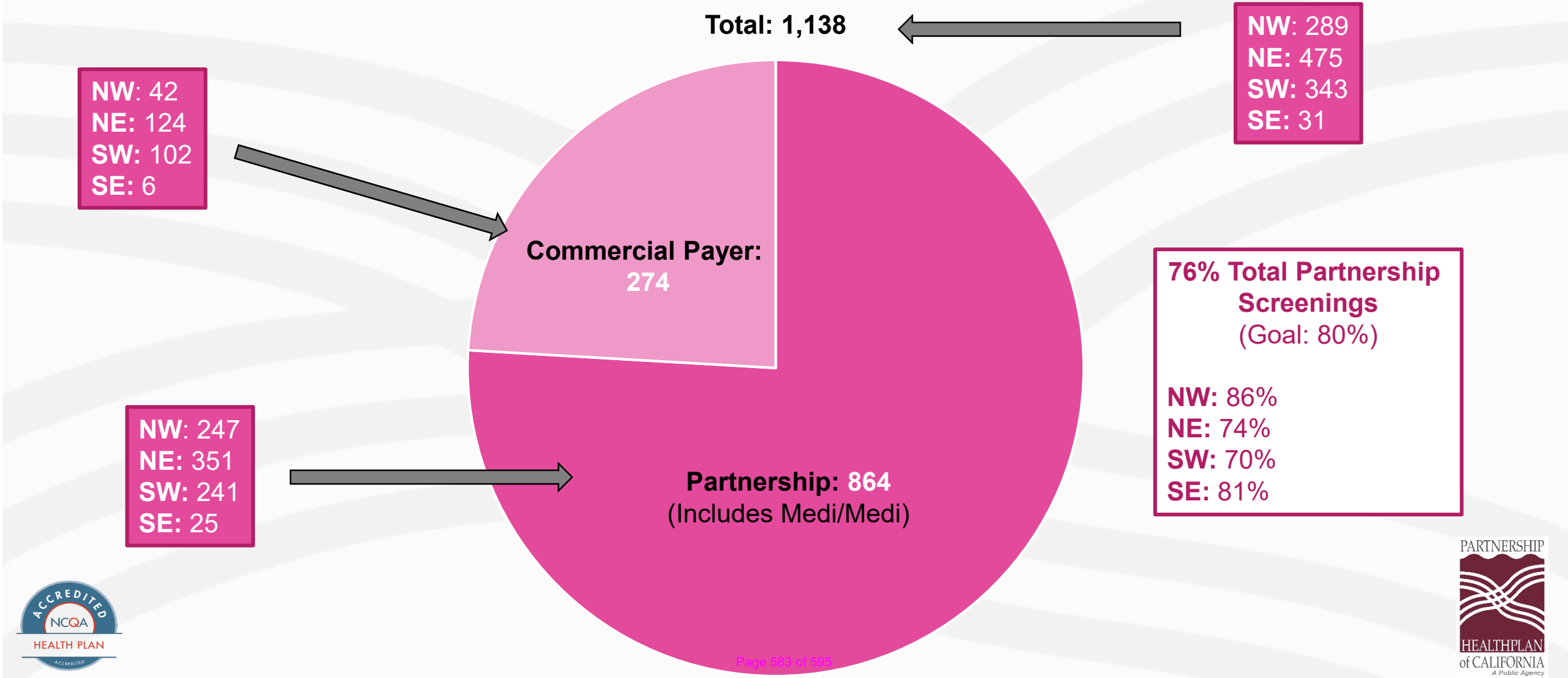
Region	PCP QIP % Change	# of Event Days in 2023	# of Provider Organizations
NW	+12.05%	9	4
NE	+12.07%	14	6
SW	+7.84%	14	9
SE	+7.68%	1	1
Organization Wide	**+9.12%**	**38**	**20**

Tribal Health Centers

**Data is from the event month to December 2023*

Region	Provider Organization	Event Month	PCP QIP % Change	# of Event Days in 2023	# of Completed Screenings	# of Completed Partnership Screenings
NW	K'ima:w	August	+14.34%	1	30	27
NE	Pit River	December	pending	1	30	24
	Redding Rancheria	August	+16.97%	3	97	82
SW	Consolidated Tribal	July	+16.34%	1	33	26
	Round Valley	July	+31.83%	1	29	21
Total			**+18.51%**	**7**	**219**	**180**

Breast Cancer Screenings Completed in 2023



76% Total Partnership Screenings
(Goal: 80%)

NW: 86%
NE: 74%
SW: 70%
SE: 81%

Progression and Engagement Strategy

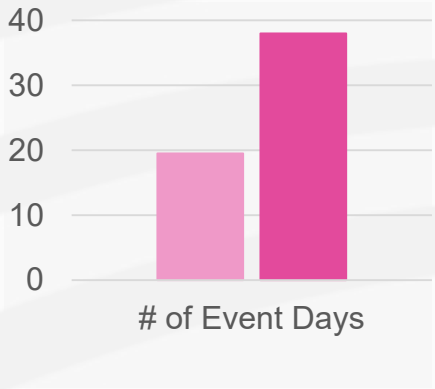
Progression

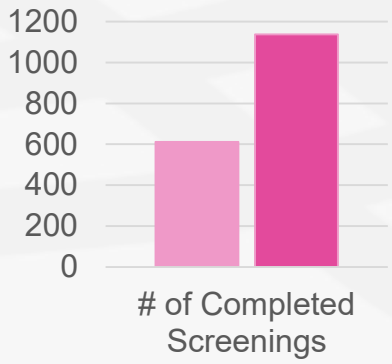
2022

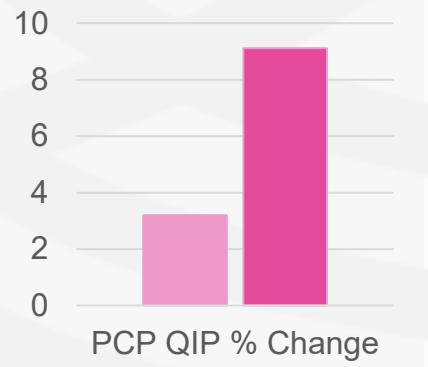
- 19.5 Event Days
- 612 Screenings
- + 3.2% PCP QIP
- 42% no show-rates

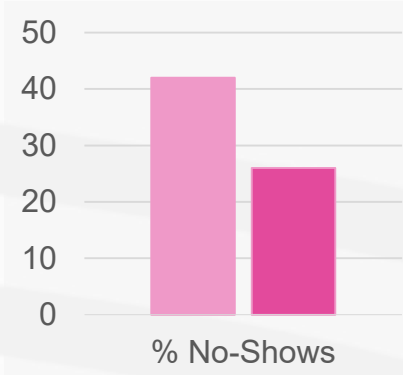
2023

- 38 Event Days
- 1,138 Screenings
- + 9.12% PCP QIP
- 26% no show-rates



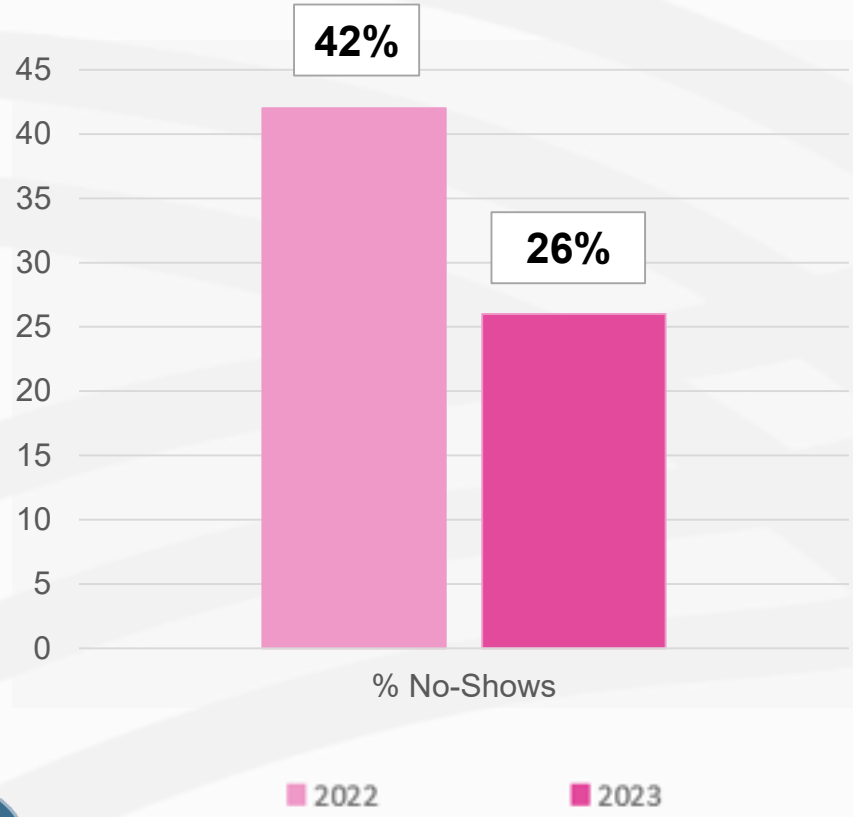






2022 2023

Engagement Strategy



Current Engagement Strategy

1) **Overcoming Top Barriers**
   - Education
   - Language
   - Trusted place of care
   - Transportation

2) **Customizing Event Days**
   - Include additional preventative screenings

Event Day Summary and Surveys

Provider Feedback

"Everything ran smoothly and everyone was very professional. Our patients were so happy to have this opportunity for a local mammogram and to visit in person with Partnership representatives about other benefits. Almost every patient completed a survey and all enjoyed the gift bags." – Long Valley Health Center

"Patients were so thankful for the MM event. Plus was having bi-lingual staff helping support diversity. We were able to screen a good number of Spanish speaking patient population."
– Shasta Community Health Centers

"30 women were screened for their mammograms which saved them time from having to travel 1 hour away for this screening. The smiling faces from women who loved the experience."
– K'ima:w Medical Center

"Patients were very thankful to have this offered locally. Many are not able to travel."
– Churn Healthcare

"We love this event for our community. Many patients would not get a mammogram if not for this event."
– Open Door Community Health Centers

"Midday, we started to get very busy with many women coming in and enjoying complementary chair massage, having mammograms done, and cervical cancer screenings done. We had gift bags and snack bar. Women were having fun and once we started getting busy there was a buzz of excitement in the air."
– Stallant Health and Wellness

Provider Feedback

"It was a beautiful event that we honestly couldn't have done without Partnership's support, we truly appreciated it. It was great having Partnership's Pop Health team out there with us. The patients loved the goodie bags and blankets. We are very happy that we were able to get 31 women screened for breast cancer. Many of our patients were getting their mammograms done for the first time because it was easily accessible. For patients who weren't able to get screened, they showed interest in learning more about breast cancer screenings. Overall it was a great event with an amazing outcome.

Some highlights were having our patients who normally have difficulty accessing care, were able to get mammograms done in an environment that was comfortable and safe for them. Many of our patients that weren't able to get screened wanted to come back to get their mammograms done, this increased more breast cancer awareness. With this event, we were able to celebrate women that are unhoused, trauma victims and low income, by providing them with facials, nails, massages, grab bags etc. Being able to make them feel special and give them a day of pampering was beautiful to see.

We loved having the Partnership Pop Health team out there with us, we greatly appreciate Partnership's support with this event. It would not have been successful without them."

– Ritter Health Center

Next Steps

- Plans for 2024:
  - Continue outreach to Northern and Southern Region eligible provider organizations
  - Include Eastern Region counties
  - Target focus on
    - Tribal Health Centers
    - Counties impacted by loss of Dignity imaging services
    - Enhanced Provider Engagement (EPE)
    - Equity Practice Transformation (EPT)

Additional Resources

Regional Impact & Participating Providers

(July 2023 – December 2023)

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NE	+12.07%	14	6
SW	+7.84%	14	9
SE	+7.68%	1	1
Organization Wide	+9.12%	38	20

➢ NW

Humboldt County
- K'ima:w Medical Center
- Open Door Community Health Centers *(5 days, 2 sites)*
- WeCare Group *(2 days, 1 site)*

Del Norte County
- Stallant Health and Wellness

➢ NE

Shasta County
- Hill Country Community Clinic Inc. *(4 days, 2 sites)*
- Mountain Valley Health Centers
- Pit River Health Services
- Shasta Community Health Centers *(3 days, 3 sites)*

Shasta/Trinity County
- Churn Creek Healthcare – Redding Rancheria *(3 days, 2 sites)*

Trinity County
- Mountain Communities Healthcare *(2 days, 1 site)*

➢ SW

Lake County
- Adventist Health *(5 days, 4 sites)*

Marin County
- Marin City Health & Wellness Center
- Ritter Health Center

Mendocino County
- Consolidated Tribal Health Project
- Long Valley Health Center *(2 days, 1 site)*
- Redwood Coast Medical Services
- Round Valley Indian Health Center

Sonoma County
- Alliance Medical Centers
- West County Health Center

➢ SE

Yolo County
- Elica Health Center

Tribal Health Centers

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*Data is from the event day month to December 2023

- **NW**

Humboldt County

K'ima:w Medical Center

- **NE**

Shasta County

Pit River Health Services

Shasta/Trinity County

Churn Creek Healthcare – Redding Rancheria
(3 days, 2 sites)

- **SW**

Mendocino County

Consolidated Tribal Health Project
Round Valley Indian Health Center

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2024 QI Committee Presentations Calendar

As of April 25, 2024 (subject to change)

The Internal Quality Improvement (IQI) and Quality/Utilization Advisory Committee (Q/UAC) will not meet in July and December.

Non-footnoted topics are scheduled for full presentations at both IQI and Q/UAC.

January – *due Wed., Dec. 27, 2023* 2023 Referral Follow-up (Robert Moore, MD) [1] 2022-23 Hospital QIP Evaluation (Troy Foster)[1a] 2022-23 Perinatal QIP Evaluation (Deanna Watson) [1a] 2023 CG-CAHPS Analysis (Amy McCune) QI Initiative: Cologuard Bulk Ordering Pilot (Tiffany Tryan)[8]	**February** – *due Tues., Jan. 30* PQI/PPC 2023 Annual Report (Robert Bides) Care Coordination Grand Analysis (Brigid Gast) 5-Star QI Strategy Plan / QI Tactical Plan (Nancy Steffen) 2023 Oversight Audits: CY2022 Carelon and Kaiser Findings (Gary Robinson) [2]
March – *due Tues., Feb. 27* Site Review Report (Rachel Newman) PARS Report (Rachel Newman) IHA – Claims & Encounters Summary (Rachel Newman) [1] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 2023-2024 QI Work Plan Update (Nancy Steffen) [2a] QI Initiative: Enhanced Provider Engagement Eval (I. Brown)[8]	**April** – *due Tues., March 26* UM Program Description (Tony Hightower) [3] UM/Pharmacy Evaluation/Grand Analysis (UM/Pharm Team) [3] Pharmacy Operations Update (Stan Leung, Pharm.D)[2a] Population Needs Assessment (Hannah O'Leary) [3] Proposed 2024-25 HQIP Measures Summary (Troy Foster) [1] Proposed 2024-25 Perinatal QIP Measure Summary (Deanna Watson) [1]
May – *due Tues., April 23 because May 7 is a first Tuesday* Grand Analysis: Behavioral Health Coord (Renee Escobar) [3] Behavioral Health Overview (Mark Bontrager/Jeff Devido, MD)[7] Inequity Analysis of HEDIS® / PCP QIP (M. Jalloh, Pharm.D) QI Initiative: Expanded Mobile Mammo Prog. (Areli Carrillo)[8]	**June** – *due Tues., May 28* PHM Work Plan (TBD) [2a, 3] PHM Strategy & Grand Analysis (TBD) [3, 4] InterQual® Annual Review (UM Team) [3] Annual Grievance & Appeals (Kory Watkins) [3]
August – *due Tues., July 30 (Q/UAC minutes to NCQA for QI Trilogy)* HEDIS® Annual Performance (Sue Quichocho) [4] Annual Update: Pathways to Excellence (Dr. Moore) [1a] QI Tactical Plan Update (Nancy Steffen) [2a] PQI/PPC 1st & 2nd Qtr 2024 (Robert Bides) [2] 2023-2024 QI Work Plan Final Update (Nancy) [3, 4, 5] *QI Trilogy (Nancy)*: 2023-2024 Evaluation, [3, 4, 5] 2024-2025 Work Plan, [3, 5] and 2024-2025 Program Description [3, 5]	**September** – *due Tues., Aug. 27* 3NA Survey Results (Ledra Guillory/Liat Vaisenberg) Proposed 2025 Palliative Care & ECM Measure Summaries (Amy McCune) [1] 1st/2nd Qtr UM/Pharmacy IRR/Timeliness (UM Team/Stan) [1, 3] Transportation Update (Melissa McCartney) [1a] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2]
October – *due Tues., Sept. 24* Grand Analysis: Health Equity (D. Roberts and M. Jalloh) Cultural & Linguistic Program Description (Hannah O'Leary) 2024 C&L/QIHETP Work Plan – Final Update (TBD/M. Jalloh) 2025 C&L/QIHETP Work Plan (TBD/M. Jalloh) Proposed 2025 PCP QIP Measures Summary (Amy McCune)[1] UM Delegation to Capitated Hospitals (Tony Hightower) [2]	**November** – *due Tues., Oct. 29* 2023 PCP QIP Program Evaluation (Athena Beltran-Nampraseut) Grievance & Appeals PULSE Quarterly (Latrice Innes) [2, 6] 2024 CG-CAHPS Analysis (Amy McCune) Grand Analysis: Member Experience (Anthony Sackett) [6] Grand Analysis: Network Access/Adequacy (Renee Trosky)
January 2025 – *due Tues., Dec. 24, 2024* 2024 Referral Follow-up (Robert Moore, MD) [1]	2023-24 Hospital QIP Evaluation (Troy Foster)[1a] 2023-24 Perinatal QIP Evaluation (Deanna Watson) [1a]
February 2025 – *due date: Jan. 28, 2025*	2024 C&L Program Evaluation (TBD)

[1] Short presentation at IQI; on Q/UAC consent calendar for acceptance (no presentation)
[1a] Short presentation at IQI; FYI handout at Q/UAC (no vote required)
[2] On both IQI & Q/UAC consent calendars for acceptance (no presentation)
[2a] FYI handouts at both IQI and Q/UAC (no presentation; no vote required)
[3] Timed for NCQA considerations
[4] to include HEDIS® Activity Update
[5] QI Trilogy documents to be approved at Q/UAC in August, PAC in September, Board in October (Q/UAC & PAC minutes included in NCQA evidence for QI 1 Element D)
[6] includes analysis of annual CAHPS data
[7] includes Wellness & Recovery Benefit components
[8] Short presentation at IQI. Will be presented at Q/UAC if time allows; otherwise, will be included as FYI in the Q/UAC packet. 2024 topic may not repeat in 2025