Virtual Medical Directors Forum

Spring 2021

Detailed Notes of Clinical Topics

(Leadership Version)

Primary Care Almanac

Introduction:

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

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

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

PHC's vision is:

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

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

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Your Regional Medical Directors:
Marshall Kubota, MD, Regional Medical Director (Marin, Sonoma, Mendocino and Lake Counties)
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David Glossbrenner, MD, Northern Regional Medical Director (Trinity, Shasta, Siskiyou, Modoc and Lassen Counties)

PHC website: www.partnershiphp.org

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County Profiles

County Profiles (with a pediatric focus) were distributed with the meeting materials. Highlights:

PHC Data

- Enrollment
- QIP outcomes
- Blood lead screening levels
- Behavioral health use rates
- ACES screening
- Developmental screening

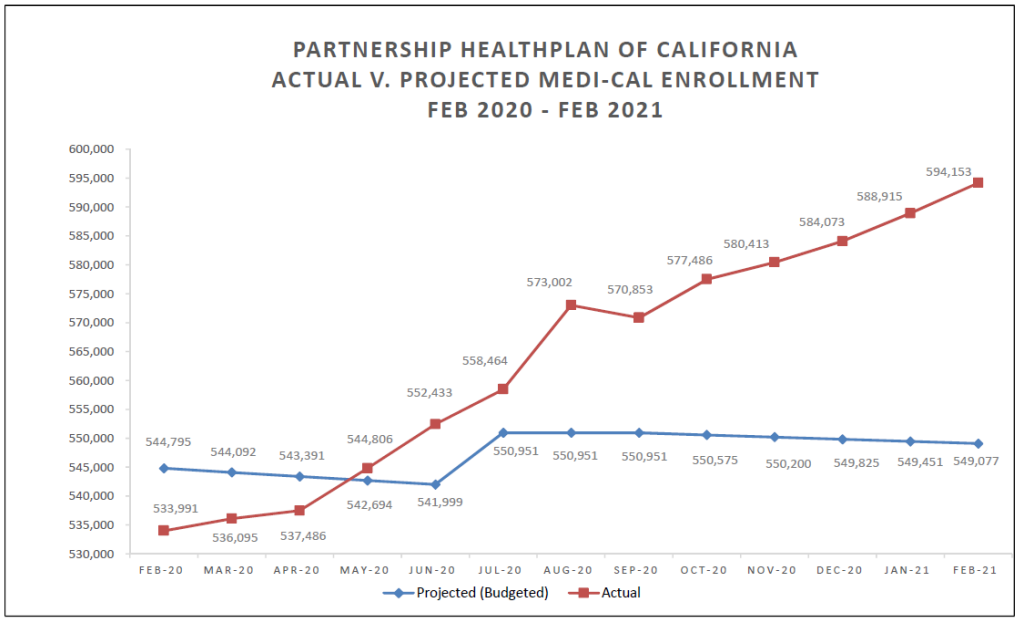
Other Data

- Perinatal health factors
- Income, poverty, and food security
- Well-child health metrics
- Elementary and high school outcomes
- Student mental health factors

PHC Strategic Issues

PHC Enrollment Trends since COVID-19

By April 2021, PHC enrollment exceeded 600,000. Since county re-determination is on hold until January 2022, the numbers are expected to rise until then, and then fall steadily as the counties catch up on their backlogs of redeterminations.



Medi-Cal Reprocurement

The boards of supervisors of ten counties north of Sacramento (in red below) voted to submit a letter of Intent (LOI) to DHCS to become a County Organized Health System (COHS) Model as part of PHC, starting in 2024. These LOI initiate the process and permit the counties to explore this possibility of becoming a COHS. There are many steps that would still need to happen to make this requested change come to fruition. The PHC Commission has adopted principles for this process and expressed its willingness to work to expand the PHC model to additional counties, to provide the Medi-Cal beneficiaries and providers with the advantages of the County Organized Health System Model, but that such an expansion should not harm the existing PHC counties (in green below).

National Committee for Quality Assurance (NCQA) Accreditation

PHC received NCQA Accreditation in January 2021.

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality. The

NCQA seal is a widely recognized symbol of quality. The seal is a reliable indicator that an organization is well-managed and delivers high-quality care.

In 2023 PHC will be assigned its first rating. NCQA now uses a five point scale, with one third of the points coming from a member experience survey, and two thirds coming from the NCQA set of Medicaid HEDIS measures. Our audacious goal remains to achieve a 5-star rating by 2025, although the two year setbacks from COVID may make this more challenging.

PCP Access: Technical Support Grants to Improve HPSA Scores

After input from our provider network on workforce development needs, PHC announced a new technical assistance grant for Health Professional Shortage Area (HPSA) scoring. HPSA scores are used for prioritization for federal health professional loan repayment programs, which are often used by federally qualified health centers (FQHCs), although clinicians working at some other types of safety net practices are also eligible.

Who is eligible?
Contracted primary care provider organizations who will undergo HPSA review within the next two years are welcome to apply.

Important Dates:

- Application period: May 10 - June 25, 2021
- Awardees Notified: July 2021
- Grant program begins: August 2, 2021

How to apply:
Visit our Workforce Development page for additional information and to access the grant application (opened on May 10, 2021).

http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Workforce-Development.aspx

Please contact our Workforce Development Team with any questions: WFDGrants@partnershiphp.org

State Policy Updates

California Budget for 2021-2022: May Revise Highlights

The large scale state budget surplus ($75.7 billion surplus with a budget of $267 billion) has led to some significant proposed changes in the year ahead. Of note, one third of this surplus is the $27 billion in federal pandemic relief earmarked for California. Reminder that these are all Governor's proposals and may be changed by the Legislature by the time the budget is passed in mid-June.

The California Department of Health Care Services (DHCS) budget proposal is $129.2 billion. Significant proposed changes:

1. **Investments in Children and Youth Behavioral Health: total: $1.8 billion plus 78 new state FTEs, including:**
    a. $750 million for Behavioral Health Continuum Infrastructure
    b. $190 million for a children and youth targeted statewide behavioral health services and supports initiative
    c. $550 million for capacity and infrastructure for behavioral health in schools
    d. $10 million in grants for developing and expanding BH programs
    e. $50 million in training for clinical providers
    f. $200 million for integrated physical and behavioral health screening and services for the family.
2. Health Equity
    a. Expanding Medi-Cal eligibility for undocumented adults aged 60 and over. ($68 million)
    b. Adding a doula benefit (starting January 2022, $402K)
    c. Adding Community Health Workers (CHWs) as covered by Medi-Cal (starting January 2022, $16.3 million)
3. COVID related
    a. $575 million for COVID testing in schools
    b. $104 million for vaccine administration
    c. $73 million for counties to catch up on redeterminations
    d. $650 million Cost of COVID contingencies
    e. $300 million for safety net hospitals
    f. Funding of audio-only care at 65% of in-person, including for PPS providers!
4. **Post-partum coverage extended to 12 months, starting April 2022**
5. Increased SUD funding, pass through from federal funding
6. Continued funding of optional benefits and proposition 56 funding. ($550 million)
7. **Moving State Office of Rural Health and J-1 Visa Waiver Program from OSHPD to new Department of Health Care Access and Information.**
8. **HIE Interoperability: $51 million for supporting other interoperability**

and data exchange efforts.

9. Other Initiatives
    - **a. Department of Managed Health Care to establish and enforce health equity and quality standards.**
    - b. Behavioral health quality improvement program: to improve quality of care in county-run Mental Health Plans and substance use programs.
    - c. New office of Medicare Innovation and Integration.
    - d. Managed Care Plan Statewide Reprocurement
10. Non-DHCS, health related proposals
    - a. $12.4 million for seven demonstration projects on treating and preventing ACEs.
    - b. School level investments in behavioral health programs (not sure if in addition to the funding in DHCS, noted above)
    - c. Funding to reduce homelessness
    - d. Universal basic income pilot ($35 million); city or county administered.
    - e. Older adult recovery and resiliency ($106 million)
    - f. Many other initiatives targeting the older population
    - g. Restoration of Indian Health Clinic funding to pre-2009 levels.
    - h. Support for Undocumented, Unaccompanied Minors ($25 million)
    - i. Increased child care support ($280 million)
    - **j. Review of Public Health response to COVID, root causes of disparities ($3 million).**
    - k. COVID-19 Response costs: $1.08 billion for 2021-2022
11. **California Advancing and Innovating Medi-Cal (CalAIM):** See below for the expenditures proposed for the many parts of CalAIM.

CalAIM Proposal	FY 2021-22		FY 2022-23 [a]	
	Total Funds	General Fund	Total Funds	General Fund
Enhanced Care Management	$187.5	$93.8	$466.7	$233.3
In Lieu of Services	$47.9	$24.0	$115.0	$57.5
Incentives	$300.0	$150.0	$600.0	$300.0
Transitioning Populations	$401.6	$174.7	$0	$0
Dental Preventive Services	$59.5	$29.8	$119.1	$59.5
Dental Continuity of Care	$43.5	$21.7	$87.0	$43.5
Dental Caries Risk Assessment	$12.1	5.0	$24.2	$9.9
Dental Silver Diamine Fluoride	$1.1	$0.5	$2.1	$1.0
Behavioral Health Quality Improvement Program	$21.8	$21.8	$32.1	$32.1
Carve Organ Transplant into Managed Care	$4.7	$1.4	$0.9	$0.3
Carve Multipurpose Senior Services Program Out to FFS	$1.6	$0.8	$0	$0
Carve Specialty Mental Health Services Out of Managed Care Statewide	-$4.8	-$2.3	$-5.3	-5.2
Population Health Management [b]	$300.0	$30.0	$0	$0
Medi-Cal Providing Access and Transforming Health (PATH) [b]	$200.0	$100.0	$0	$0
Medically Tailored Meals Augmentation	$9.3	$9.3	$0	$0
State Operations Funding	$38.9	$12.5	$43.2	$14.7
Totals	**$1,624.7**	**$673.0**	**$1,485.0**	**$746.6**

**Dollars in Millions*

a. Only reflects impacts of CalAIM policies proposed to implement in FY 2021-22.

b. Proposed to have multiyear expenditure authority.

CalAIM: California's 5-year waiver for 2020 to 2025

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

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

Throughout 2019 and in early 2020, DHCS conducted extensive stakeholder engagement for both CalAIM and the renewal of the 1115 waiver and transition of managed care authority from various waiver authorities to one consolidated 1915(b) CA Managed Care waiver, comprised of Medi-Cal managed care plans, mental health plans, substance use disorder plans, and dental managed care. The DHCS

website has extensive documentation of this process.

Due to the COVID-19 pandemic, DHCS postponed the implementation timelines for many of the planned initiatives.

Major components that impact Medi-Cal Managed Care include:

1. *Enhanced Care Management (ECM) and In Lieu of Services (Starting in January 2021 in counties with Whole Person Care funding (Marin, Sonoma, Napa, Mendocino and Shasta counties) and in July 2021 in other counties:* Enhanced care management services designed for a whole-person approach that addresses the clinical and non-clinical needs of complex Medi-Cal beneficiaries. The benefit requires that Medi-Cal managed care plans offer a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The current Whole Person Care pilots (including those in five PHC counties) and the PHC Intensive Outpatient Care Management Program (IOPCM) will fold into this new ECM benefit. PHC conducted an in-depth analysis of the data needs of the future program, the current data systems used in the WPC counties, and developed a framework for data exchange to support ECM using the Collective Medical Technologies' Collective Plan framework.

   Additionally, we will be able to offer "in lieu of services" (ILOS), flexible wrap-around services, as part of our population health management strategy. These services are provided as a substitute, or to avoid, other costs and services, such as a hospital or skilled nursing facility admissions or discharge delays. Other in lieu of services may be integrated with case management for members at medium to high levels of risk and may fill gaps in State Plan benefits to address medical or social determinants of health needs.

2. *Population Health Management (projected to start January 2023)* Medi-Cal managed care plans will develop and maintain population health management strategies that include initial and ongoing assessments of risk and need, leverage risk stratification in care planning, consider social determinants of health, ensure smooth transitions of care, and focus on data collection and reporting.
3. *Behavioral Health:* Proposal to steadily integrate behavioral health services with the rest of the health care system.
4. *Full Integration Plans:* A pilot to test the effectiveness of full integration of physical, behavioral, and oral health under one entity.

5. *NCQA Accreditation* will be required for all Medi-Cal managed care plans as of 2023.
6. *Requirement all Managed Care Plans to implement a MediCare-MediCal* joint health plan product (also known as a Dual-Special Needs Plan or a D-SNP) by 2025.

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

Proposed ECM target populations:

Starting in January 2022:

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

Starting in July 2022

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

Starting in January 2023

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

The current list of potential in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home

- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Medi-Cal Rx: Pharmacy Carve-Out

In early January 2019, Governor Newsom released an executive order to change and study how the state pays for prescription drugs, with the goal of reducing the state's prescription drug spending. The executive order included the order to transition —by January 2021— the pharmacy services benefit in Medi-Cal from managed care to entirely a fee-for-service (FFS) benefit directly paid for and administered by the state. (Transitioning a Medi-Cal service from managed care to FFS for managed care enrollees is referred to as "carving out" a service.)

In late 2019, DHCS moved the transition date to April 2021. DHCS announced in mid-February 2021 that the planned April 1, 2021, transition of prescription drug coverage from PHC, and other managed care organizations, to DHCS through the selected pharmacy benefit manager Magellan will not take place as scheduled. This has been postponed due to challenges with resolving conflict of interests arising from the announced acquisition of Magellan by Centene Health Plan. No new timeline has been announced, although the DHCS May Revise plans, for budget purposes, anticipates a delay of Medi-CalRx until at least January 2022. The May Revise also has an increased allocation of analytics resources to develop new data models for this transition, which they now categorize as "high risk."

In an additional related proposal in the May revise, $222 million of the Medi-Cal Drug Rebate Fund is allocated to a reserve for volatility. This may be a reflection of the risk from not scoring rebates expected by the carve-out.

Federal Policy Update

Future of the Affordable Care Act (ACA)

About one third of PHC members are insured as part of the Medi-Cal expansion allowed by the Affordable Care Act.

The US Supreme Court is considering a lawsuit claiming the ACA is unconstitutional. The decision will not be released until July 2021.

Two major legislative options in 2021 are to "repair" the ACA (restore the individual mandate penalty, commit to paying health plans according to risk formulas, and other fixes) or to overhaul the program more fundamentally (for example, the MediCare-for-all proposals). Several steps in this direction were taken by Congress as part of the COVID relief bill in March 2021. Additional clarifying language would solidify these fixes and limit the risk of an adverse Supreme Court ruling.

OIG: Health Center Incentives for Well-Child Visits Permissible

The U.S. Office of the Inspector General (OIG) has ruled that financial incentives (gift cards) provided through the provider of care, are allowed for up to $20 for parents who bring their children to the office for well child visits at Federally Qualified Health Centers if they missed or rescheduled two care appointments in the past, are now covered.

Children must be under 19 years of age.

PHC notes that the $20 limit specified by OIG is less than the $25 limit used by DHCS.

CMS: Gradual Increase in PPS Rate for Rural Health Clinics

The U.S. Centers for Medicare and Medicaid Services (CMS) announced a steady increase in the Prospective Payment System (PPS) rate for Rural Health Clinics (RHCs), presumably for patients with **MediCare**:

- In 2021, after March 31, at $100 per visit
- In 2022, at $113 per visit
- In 2023, at $126 per visit
- In 2024, at $139 per visit
- In 2025, at $152 per visit
- In 2026, at $165 per visit
- In 2027, at $178 per visit
- In 2028, at $190 per visit

The actual regulation is complicated with exceptions, etc.

Reference: https://www.cms.gov/files/document/mm12185.pdf

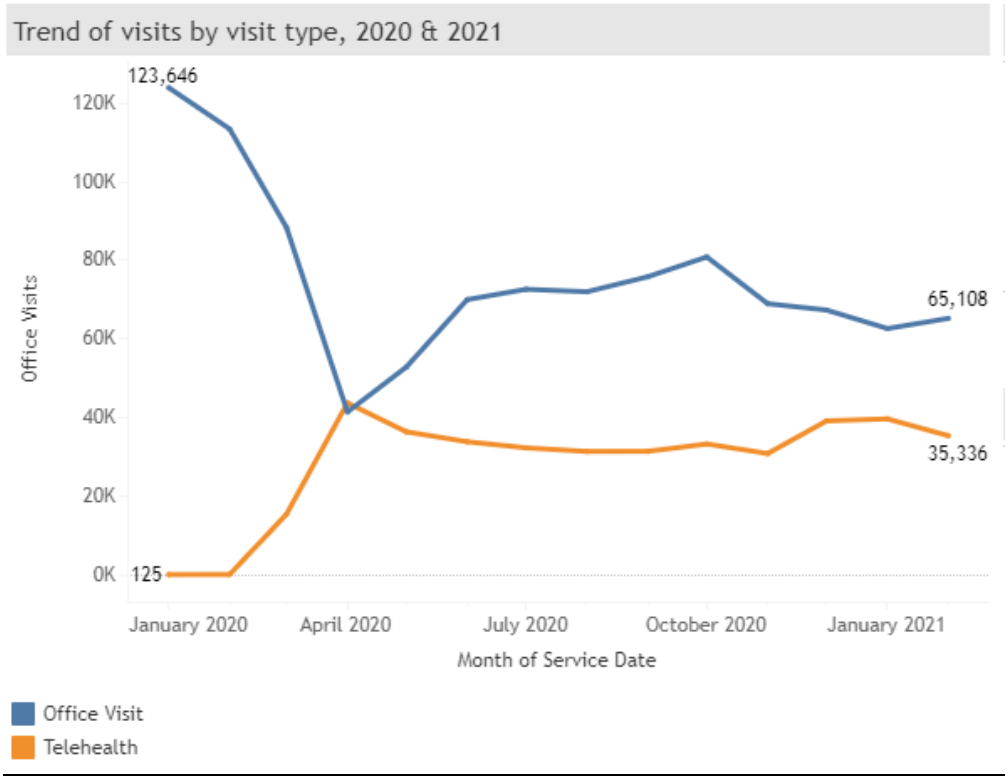
Our understanding is that the **Medi-Cal** PPS rate for RHCs is set by the state, based on a number of factors specific to the individual RHC.

DHCS COVID-19 Flexibilities:

DHCS has enacted many flexibilities in response to COVID-19. It seems likely some will be considered improvements and will continue after the public health emergency is over, currently scheduled for July 2021. See the budget section above for the Governor's proposal for the future of telephone visits.

This will require some modification of current DHCS directives, since currently phone visits and video visits are coded in the same way.

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



Hospitals Offering COVID-19 Monoclonal Antibody Treatment

With decreasing rates of COVID and a focus on vaccine, we should not forget that some higher risk patients who contract COVID (especially those not vaccinated) might benefit from treatment with one of the two combination Monoclonal antibody treatments, approved under emergency use authorization: bamlanivimab plus etesevimab and casirivimab plus imdevimab. Of note, the first (bamlanivimab plus etesevimab) is markedly less effective against the California variants, so the second (casirivimab plus imdevimab) should probably be the first choice in California.

Indications for use of monoclonal antibodies are for those with mild to moderate early COVID infection (as soon as possible after diagnosis), who can be treated as an outpatient, who are at high risk of clinical progression, and who are within ten days of symptom onset.

A website to show infusion centers offering this option can be found here: https://covid.infusioncenter.org/. Hospitals in our service area offering monoclonal antibody infusion are:

Northern Region:

- Modoc Medical Center
- Fairchild Medical Center
- Sutter Coast medical center, Crescent City
- Banner Lassen
- Mercy Redding
- Shasta Regional Medical Center

Center Southern Region:

- Adventist Ukiah Valley
- Adventist Clearlake
- Novato Community Hospital
- Marin Health
- Healdsburg District Hospital
- Woodland Memorial Hospital
- Northbay Hospital

COVID Vaccine and Vaccine Administration Fee Both Covered Through DHCS/State Medi-Cal

DHCS announced that the vaccine administration fee for Medi-Cal beneficiaries will be paid directly by the state, not by managed care plans.

The vaccine itself is currently pre-paid for by the federal government, and the billing code for the vaccines have a nominal charge/payments of one cent for tracking purposes. The additional vaccine administration fee would also be billed to State Medi-Cal, even if they are PHC members.

For more information, including allowable payment rates, please visit DHCS' webpage on COVID-19 Vaccine Administration.

Kaiser Series Focused on COVID Vaccine Concerns of Different Ethnicities

Kaiser Napa-Solano is hosting a number of live events on "An Open Conversation about COVID-19 and the Vaccine," featuring ethnically concordant clinicians. They agreed to open these up to the wider community, so you can have your staff or patients attend.

Pre-recorded conversations:

- Spanish-speaking population: Click here for recording
- English-speaking Latinx population: Click here for recording
- Tagalog-speaking community: Click here for recording
- African-American community: Click here for recording

Effective Promotion of COVID-19 Vaccination

The first step to encouraging our patients to take advantage of the opportunity and privilege of being vaccinated against COVID-19 is to understand and communicate some core facts on vaccine development, efficacy, and safety. Here are some examples that may be helpful.

Have you ever seen a home makeover TV show, where they build a sturdy beautiful home in a week? New homes typically take months to build. How is this possible?

1. By having prefabricated parts ready to assemble rapidly. Don't build everything from scratch.
2. By pouring resources (workers and money) into the building process, and working long hours.
3. Wherever possible, by doing different parts of the project simultaneously, instead of sequentially.

These same three steps have been the key to developing highly effective COVID vaccines with thorough safety testing:

1. Re-purposing a vaccine platform that has been proven effective and safe on other similar infections, adapted to the specific genetic code of the COVID-19 virus.
2. Getting up-front funding for the final product, allowing people and facilities to be re-purposed to produce the vaccine on a large scale, quickly.
3. Do all the usual steps in testing a vaccine for effectiveness and safety without unnecessary delay between steps, WHILE large scale production is already going on, in case it works well.

Efficiency while assuring quality. No corners were cut!

Frequently asked questions and some responses:

I heard you can still catch COVID after being vaccinated. If that's the case, why should I get vaccinated? Do COVID vaccines protect against COVID infection?

The COVID-19 vaccines are amazingly effective against both *serious* COVID-19 infection (close to 100%) and *symptomatic* COVID infection (95% for two doses of the two mRNA vaccines, 72% for a single dose of the Johnson and Johnson vaccine).

Importantly, protection against *asymptomatic* infection is probably in the ballpark of 50%, so vaccinated individuals can still carry infection home to their family and friends who are not vaccinated. Because of this, it is very important to continue to diligently use masks, physically distance and avoid indoor gatherings with individuals outside of your COVID bubble. This won't last forever. We need many people to be vaccinated AND little COVID to be circulating in the community before we consider easing up on other protective measures.

I'm worried about the side effects of the vaccine. Could I catch COVID from the vaccine? Can't the RNA in the vaccine become a part of my own DNA, causing problems down the road? What about long term side effects?

First and foremost, COVID vaccination cannot cause COVID-19 (about 30% of Americans believe this, so it is important to address this up front). No COVID virus was used in production of the vaccine. The messenger RNA in the vaccine codes for just one protein of the virus. This messenger RNA was manufactured from chemical building blocks in vaccine production facilities.

The messenger RNA is quickly digested by our bodies back into these building blocks, just after it instructs the protein factories within cells to produce the spike protein in large amounts, so your body can learn to react against it in the future. Messenger RNA does *not* become part of your body's DNA. Your DNA is safely located in the nucleus of the cell, away from

the protein factories where the messenger RNA does its work.

In the past year, about 1 in 700 Americans have died of COVID. In comparison, the major risks of the mRNA vaccines are exceedingly rare: four hospitalizations per million doses of the current vaccine for either anaphylaxis or low platelet count (immune thrombocytopenia). Longer term side effects affect about 5-10% of those infected with COVID-19 (sometimes called “long haulers”), while *no* long-term side effects have yet been described for the mRNA vaccines (at least 260 million doses given so far, in just the United States).

Short-term side effects of the vaccine include arm pain, muscle aches, headache, fever, and fatigue. These minor side effects are quite common, and usually last no more than 24 hours.

Framing the Conversation

Frame COVID-19 vaccination conversations with messages that resonate. Here are three ways of framing recommended by the Ad Council COVID Collaborative:

1. Moments Missed. Reference things your patients miss the most. With many feeling COVID-19 fatigue, missed moments (especially human connections that we took for granted like visiting family and friends) serve as a powerful reminder of the ultimate end goal: vaccination as a pathway to the possibility of regaining these moments (don’t use the term “return to normal” though as this overpromises and may lead to unsafe behavior after vaccination).
2. Protection. Emphasize a shared goal of “protecting yourself, loved ones, and those in your community” (rather than “coming together as a nation”).
3. Positive tone. Be inviting and respectful as opposed to demanding. Start with the assumption that the person would want to be vaccinated. If they say they don’t want the vaccine, then acknowledge “the choice is yours to make,” which connects with the deeply rooted American value of liberty. Trying to harness fear of COVID can backfire, leading to fear of the vaccine.

In this pandemic, all of us in the health care community have the privilege and the responsibility to be public health ambassadors, for our patients, our families and our communities. As ambassadors, to be most effective we must be energetic, committed, and diplomatic.

Virtual Visits

New PHC Telehealth Toolkit Available

PHC's Telehealth Toolkit is designed to inform providers and healthcare organizations about the various telehealth technologies and resources being utilized within our network. The Telehealth Toolkit can be found in the Provider Telehealth Services section of the PHC website at http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Toolkit.aspx

The toolkit features trainings on how to get started with telehealth technologies such as: Zoom, Doxy.Me, SecureVideo, Doximity and Webex. The toolkit also includes information and links to other reliable telehealth resources including but not limited to the following topics:

- Available grant and funding opportunities
- Telehealth technology comparison chart
- Tips to help patients prepare for telehealth visits
- How to initiate a telehealth program during a pandemic
- How to get reimbursed for telehealth services
- Reasonable accommodations for telehealth
- Testimonials from providers who are currently using telehealth

Visit our Telehealth Toolkit webpage today and learn more. For any questions, contact telemedicine@partnershiphp.org.

New PHC Benefits and Programs

Direct Telehealth Specialty Services Now Available

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

Direct specialty telehealth referrals are available for these specialties:

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

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

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

It’s easy to refer, here’s how:

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

More Information

PHC Medical Equipment Distribution

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

- Blood pressure monitors
- Pulse Oximeters

- Digital thermometers
- Humidifiers
- Nebulizers
- Scales
- Vaporizers

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

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

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

Pediatric Specialty Telehealth Program

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

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

Here are the specialties available:

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

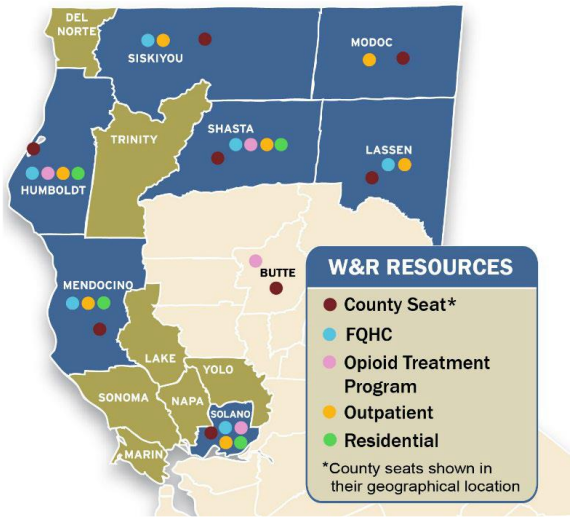
Once your office is signed up, a pediatric telehealth appointment can typically be made in 5-20 days.

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

Behavioral Health Updates

PHC's Wellness and Recovery Program Update

In July, 2020, PHC started to provide comprehensive substance use treatment (SUD) services through our new Wellness and Recovery Program in seven of our counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.



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

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

The range of services include:

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

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

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

Major Changes in X-waiver Announced

Starting 4/28/2021, there are major changes to requirements to prescribe buprenorphine for the treatment of opioid use disorder.

Previously, it was necessary to complete 8 hours (physicians) or 24 hours (PAs and NPs) in order to get the waiver. **This is no longer the case**.

Through this new pathway, providers granted the waiver can prescribe up to 30 active patients at any given time. If providers wish to exceed 30 patients at any time, they will have to undergo the training as before.

Waiver requires submitting a letter of intent (LOI) with the Substance Abuse and Mental Health Services Administration (SAMHSA). DEA and licensure will be required at time of submitting LOI) online at: https://www.samhsa.gov/medication- assisted-treatment/become-buprenorphine-waivered-practitioner.

A "Waiver" will still be required to prescribe buprenorphine for the treatment of **opioid use disorder**. No waiver is required for the prescribing of buprenorphine for the treatment of **pain**, as has been the case to date.

Waivers can be obtained by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives with valid DEA registration and a valid state medical license.

Clarification of privacy issues: SAMHSA has now clarified that possession of the waiver alone does *not* automatically make one a **42 CFR Part 2 entity**. This is important, since 42 CFR Part 2 places many restrictions on the exchange of health information, compared to the restrictions under HIPAA. Here is a summary of the rationale:

> "Practitioners with a waiver who prescribe buprenorphine only need to follow Part 2 if they meet the definition of a “federally assisted program” as defined in 42 CFR 2.11 and 42 CFR 2.12(b). The waiver meets the regulatory definition for “federal assistance,” (see 42 CFR 2.12(b)), so the issue is whether the care is provided in a setting that meets the definition of a program (42 CFR 2.11):
> - if they work in a standalone SUD treatment program that holds itself out as providing, and provides, SUD services; or
> - if they work in an identified SUD unit of a general medical

facility that holds itself out as providing, and provides, SUD services; or
- their primary function consists of providing SUD services, and is identified as such.

Many practitioners in general medical facilities do not meet these criteria. Therefore, Part 2 generally does not apply to their patient records, and they do not need to follow Part 2, even if they have received a DATA-2000 waiver and prescribe buprenorphine. HIPAA protections still apply."

Resource for Patients with Obsessive Compulsive Disorder (OCD)

We are excited to announce Beacon Health Options has contracted with a group called NOCD to help members dealing with OCD. NOCD's providers are trained in using the treatment –Exposure and Respond Prevention (ERP). They developed a member friendly platform to assist members in getting appropriate, time sensitive care. Members can go directly to their website, or call their phone number to get started.

Flyer

Obtaining Psychological and Neuropsychological Testing

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

Q: When is testing commonly recommended?

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

Q: Does the member require an authorization for testing?

A: No. Beacon no longer requires an authorization for testing effective 1/1/2020. Prior to 1/1/2020 Beacon providers were required to request an authorization for psych and neuropsychological testing prior to rendering the testing.

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

testing?

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

Q: Who conducts the psychological and neuropsychological testing?

A: Beacon contracts and credentials licensed Ph.D. psychologists. Beacon psychologists are licensed by the state of California, and Medi-Cal certified. To view the codes, full descriptions, coding assistance tables, and associated coding guidelines can be found in the 2019 American Medical Association (AMA) Current Procedural Terminology (CPT) Code Book, which is available at https://www.ama- assn.org/practice- management/cpt/finding-coding-resources. We also recommend contacting your professional industry organizations (example, https://www.apapracticecentral.org/reimbursement/health-codes for information about code updates, webinars, code crosswalks, and tip sheets that may also be available.

Q: What are examples of members who may benefit from testing?

A: Below are three vignettes of testing requested; differential diagnosis, treatment planning and response.

- 18 year old on meds: Lamictal, Latuda and Intuniv, hearing intermittent voices, family history is unknown due being adopted. Side effects on Lutuda, not responding to meds, possible rule out psychotic illness or mood disorder or if part of personality.

- 8 year old has a history of inattention, poor impulse control, not failing grades, and father held back in education, mother is sole care taker, father not involved, testing could be to rule out ADHD or mood disorder.

- 69 year old getting agitated, very forgetful of recent events, change in mood and behavior, possible hallucinations, no history of psychosis. Possible rule out of dementia, Alzheimer's, mood disorder or brain injury.

Hints for Getting an Appointment with a Beacon Provider

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

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

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

3. Have your patient contact PHC's Care Coordination Department to get assistance.

Bright Heart Health: On-Demand Behavioral Health

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

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

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

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

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

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

Standards for Screening for Syphilis in Pregnancy

Case study: A 25-year-old woman who denies history of drug use, and has one sexual partner, gives birth to a baby diagnosed with congenital syphilis. The mother had a negative RPR at the initial blood test in the first trimester, but no follow-up RPR tests were done because the prenatal care provider did not identify any risk factors. She was seen in the emergency department at 34 weeks gestation for dizziness; she was given IV fluids and sent home.

What new recommendation by the CDC and CDHP could have prevented this case of congenital syphilis?

Rising syphilis rates (five-fold increase in six years) are now leading to increased numbers of newborns diagnosed with congenital syphilis (a nine-fold increase in six years). This is completely preventable with antibiotic treatment of the mother before delivery.

Previously, all major expert groups recommended universal screening of pregnant women for syphilis at the first prenatal visit, and repeat tests if a woman was at an increased risk of acquiring syphilis during pregnancy.

The new standard, just released by the California Department of Public Health, is to have *all* women receive a second screening test for syphilis (the RPR test) in the early third trimester (in our region, this was previously only recommended in Shasta County). This may be combined with the screening test for gestational diabetes if needed, for logistical reasons. In addition, most pregnant women are recommended to have a repeat RPR when they arrive in labor, unless they have documented low risk of infection AND they have a recent negative test in the third trimester.

Risk factors for syphilis infection include:

- *Any* recreational drug use, especially methamphetamine use or IV drug use
- Homelessness or unstable housing;
- Limited or no prenatal care
- Incarceration in the past 12 months and/or having a partner who was incarcerated in the past 12 months
- Reported sex exchange
- Current or past infection with any other sexually transmitted illness, including pelvic inflammatory disease
- Having multiple sexual partners or a single partner with multiple partners.

If staff are not universally checking for these risk factors in the last trimester, ordering a routine RPR with hospital admission labs would be advisable.

Finally, CDPH is recommending that emergency departments routinely screen pregnant women for syphilis if they come to the emergency room or

are newly incarcerated in correctional facilities, and there is not a recent negative test available.

Enhanced Oversight of Pediatric Lead Screening Requirements

Lead screening is far below average in the PHC service area.

Case study: A parent brought in their 4-year-old PHC member for a health maintenance examination. The physician discovers that the child has never had a lead screening test as an infant. What should the clinician do, according to the CDC and the CDPH?

1. Since there are no old homes in the area, no need to ask questions or screen the child.
2. Screen for exposure to lead, and not screen the child if no risk factors are found.
3. Order a capillary or venous lead level.

For children age 2 to 6 years, who have *not* had a lead test *after* age 24 months, a single lead test should be ordered. This is the age range in which there is higher risk of elevated blood lead levels, and also the age in which mild elevations in blood lead is associated with long-term cognitive deficits.

Parents of children aged 2 to 6 years, with a *normal* lead screening test *after* age 24 months, should answer questions to ensure they are not having new exposures to lead. While CDPH does not have an official screening form, here is one from South Carolina. If a new exposure is found, lead screening is indicated.

Finally, if a child has a history of previous elevated blood lead levels, follow-up testing is indicated after environmental mitigation activities are completed, as directed by your local county health department.

The correct answer to the case above is number 3. Having Medicaid (through PHC) – as a proxy for family income level - is considered a risk factor for elevated lead levels in the United States, and state and federal policy/law require routine screening with catch-up screening if no timely screening has been done.

PHC recorded a webinar which included a comprehensive clinical summary of the evidence on lead toxicity and effects of elevated blood lead on pediatric development. It details on State, Federal and PHC regulatory requirements. CME now available for watching this program.

- Pediatric Screening for Elevated Lead Levels: Recording and PowerPoint

View more on-demand trainings on the PHC Provider Learning Portal. Join our email list for upcoming and up-to-date content.

We know of four different options for PCPs to conduct these screenings, each with their own pros and cons:

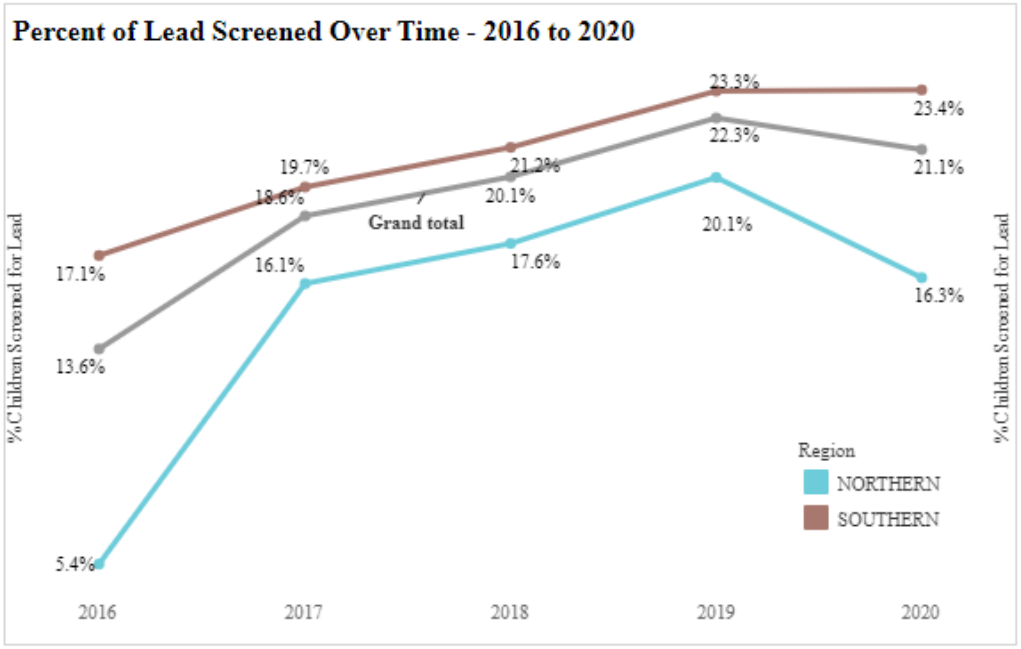
1. Venous blood draw, conducted at a commercial laboratory, like Quest or Lab Corps. This is the gold standard for accuracy, without the false positives sometimes found with the remaining 3 options. However a venous blood draw for infants can be challenging if the phlebotomist is not experienced in pediatric blood draws, resulting in a bad experience by the infant and their parent. In addition, many parents who receive the order for the lead screening fail to follow up by going to the lab for the blood draw.
2. Point of care capillary blood screening for lead, done in the PCP office. The capillary collection is similar to collecting a specimen to test for anemia (hemoglobin), but requires a different skin prep to decrease the chance of contamination by lead on the skin. Elevated levels (above 5 micrograms/dl) require a secondary confirmatory test with a venous specimen. The device used by offices that is FDA approved is called the Leadcare II, which costs about $2400 for the device and the testing materials cost about $8 per test. Office lead testing requires more oversight than other CLIA waived tests, including a requirement that all results be submitted to the California Department of Public Health and a separate parallel certification and quality control process.
3. Collection of a capillary specimen in the PCP office, which is then transported to a local public health laboratory or commercial lab for analysis. This offers the advantages of point of care testing (higher adherence to testing, less traumatic specimen collection), without the office bearing the cost, staff time or regulatory requirements associated with point of care lead testing. Specimens are stable for 48 hours at room temperature or 7 days if refrigerated. Like the point of care testing, results showing elevated levels need to be confirmed with a venous specimen. This model is used in Solano, Humboldt and Del Norte Counties. It takes some coordination with the reference lab to set up.
4. New: LabCorp is introducing a filter paper test similar to newborn screening tests. These are stable for up to 30 days. Quest does not yet offer this option. Special training of staff may be needed, since this is different from the capillary specimens used for in-office hemoglobin tests.

On a side note, a study published in the November 17, 2020 issue of JAMA evaluated the long-term neurocognitive and CNS structural effects of elevated lead levels in a population in New Zealand in which the lead exposure pattern was *not* associated with sociocultural factors (unusual in studies of infant lead exposure). Prior study of this population showed a

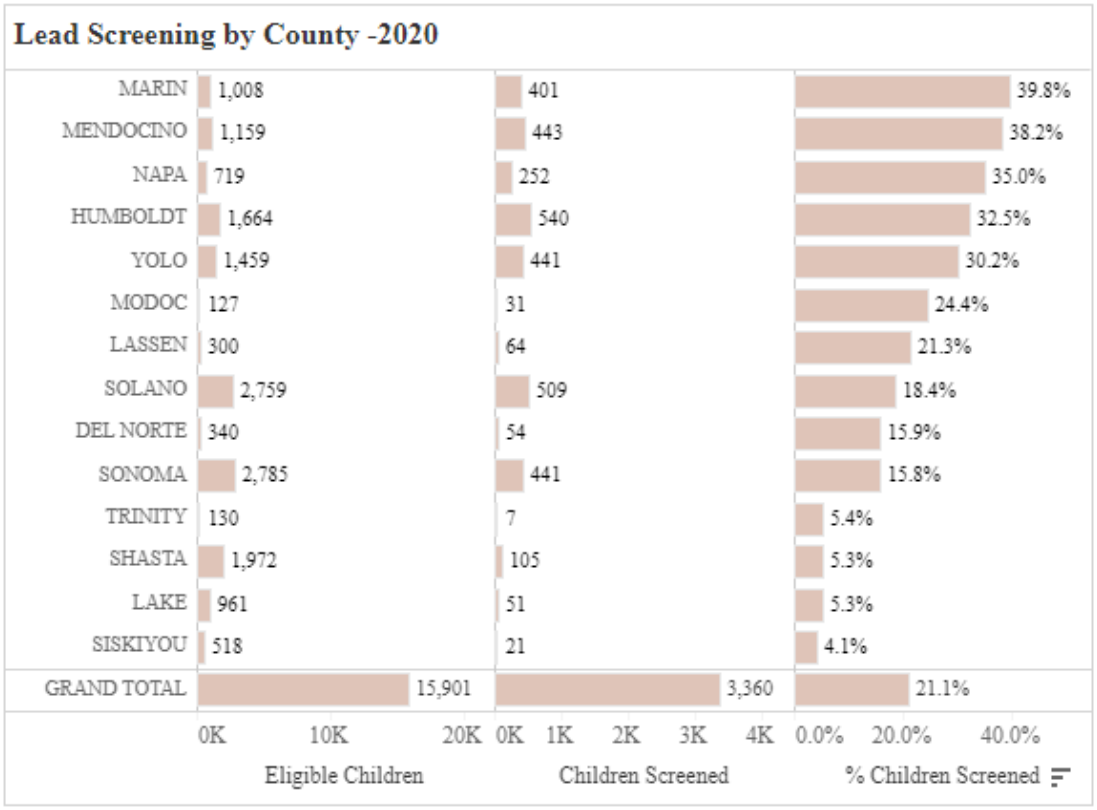
linear decrease in long term IQ in relation to blood lead levels when the study subjects were children. In this study, several measures of impaired brain architecture were similarly associated with increased childhood lead levels. This adds a plausible biological mechanism to the associated cognitive deficits noted in prior studies.

For Reference: Current Lead Screening Rates:

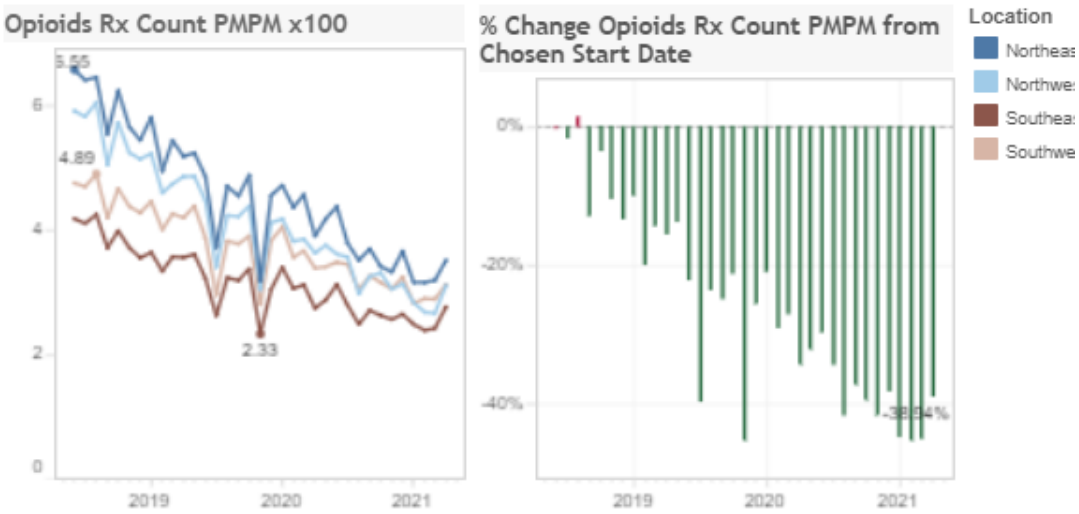
How is PHC doing? Lead screening declined in 2020 in the Northern Region.



Lead screening rates by county:

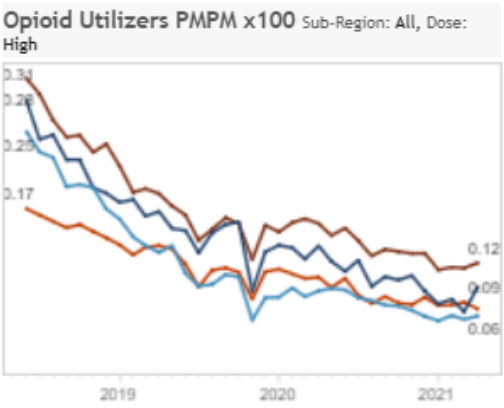


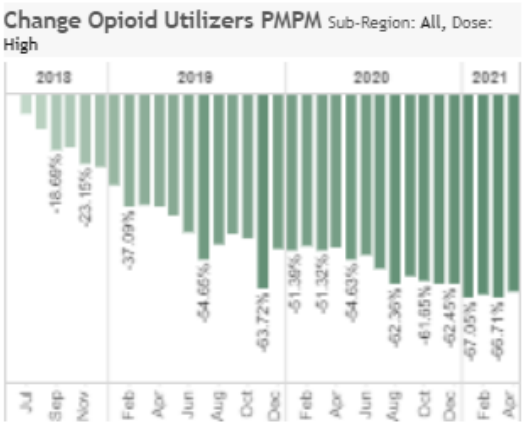
Managing Pain Safely: Updated Data



Summary: Over the last three years, overall opioid prescription rates continue on an overall downward trend, but leveling off a bit. The regional trends have been converging.

The next tables show the trend just for those on high dose opioids (defined on this graph as average dose over 120 MED/day, although we acknowledge the new standard for this is lower). In this case, the trend leveled out in mid-2019, but is still declining slowly.

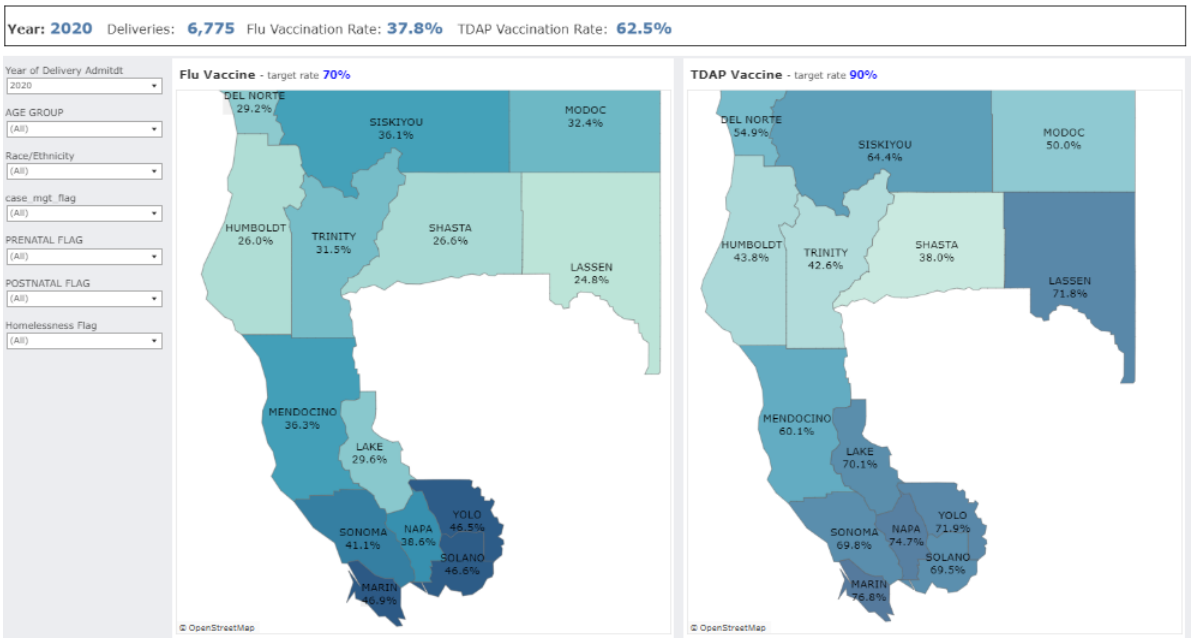




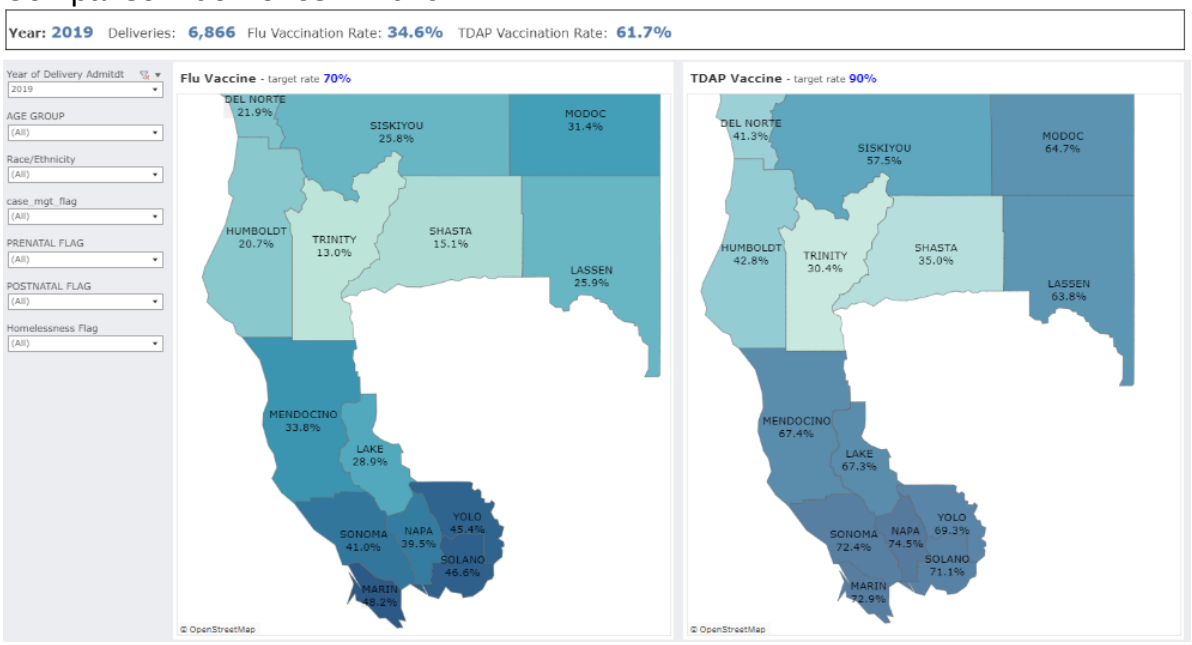
The prescription rates have declined dramatically since January 2014, when the Managing Pain Safely Initiative started. Data since 2018 are shown to more clearly show recent trends.

Vaccination Rates in Pregnancy: Updated Data

For deliveries billed in 2020:



Comparison: deliveries in 2019:



Summary: Immunization rates appear to be improving in most counties from 2019 to 2020, but are still lagging for both vaccines in Modoc and Mendocino counties. Even the counties with the highest rates have opportunities for improvement.

Clinical Updates

USPSTF Major Updates

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

1. **Colon Cancer Screening.** On May 18, the USPSTF lowered the starting age for colon cancer screening to age 45 years (Age 45 to 49 years old: Class B recommendation; ages 50-75 remains a Class A recommendation; selective screening for ages 76-85 remains a Class C recommendation). PHC will phase in the resulting PCP QIP and audit changes over the next few years, to give providers a chance to make changes in their practices.
2. **Lung Cancer Screening.** The age range for screening with low-dose lung CT scan expanded to individuals aged *50* to 80 and the minimum pack-years of smoking is reduced from 30 to *20* pack-years, who either still smoke or quit within the past 15 years. Of note, there is a new CPT code for low dose lung CT scan: 71271 which does not require a TAR if ordered for individuals in the above age range.
3. **BP Screening.** Elevated BP found in the office setting should be confirmed outside of the office setting.
4. **Screening for Drug Misuse.** In addition to screening for alcohol misuse, the USPSTF added a new Class B recommendation to screen for drug misuse. See below for more information.
5. **Cervical Cancer Screening.** Although the American Cancer Society changed its recommendations in 2020 to recommend later initiation of screening and less frequent screening, PHC continues to recommend following the recommendations of USPSTF/ACOG.
6. **Quantitative interferon** testing is preferred over skin testing in screening for TB.
7. **Hepatitis C screening** continues to be recommended at least once for all adults. In addition, those at increased risk of contracting Hepatitis C (such as those using injectable drugs of abuse) should be screened annually.
8. **Hearing Screening.** USPSTF does not rank audiologic screening as either class A or class B because of the lack of benefit derived from unstratified screening. Of note, Medicare recommends annual screening for those age 65 and older. In a study published in JAMA in March 23/30, 2021, the benefit of screening

is increased if the decision to do audiometric screening is preceded by affirmative responses to these three questions:

a. Do you have difficulty with your hearing?
b. How bothered are you by your hearing loss?
c. How motivated are you to do something about it?

Screening for Drug Misuse: A New USPSTF Recommendation

Why Screen? 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.

DHCS is working on billing codes and regulations around this new requirement. Keep an eye out for these regulations in the months ahead. The following is PHC's estimation of what this policy will look like, based on the USPSTF recommendation.

The following screening tools for unhealthy drug use are considered validated and highlighted by the USPSTF:

1. National Institute on Drug Abuse (NIDA) Quick Screen and NIDA Modified ASSIST
    a. Quick Screen: 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.
    b. NIDA Modified ASSIST: Guides clinicians through an eight-question process of obtaining further information about use patterns and consequences of use of ten specific categories of substances. This tool culminates with calculation of a score that allows the clinician to stratify risk of the client having a SUD previously "Dependence" from earlier editions of the DSM.
2. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS)
    a. Self or clinician-administered tool available in online platform
3. Prenatal Risk Overview (PRO)
    a. A multi-dimensional assessment of 12 domains of

psychosocial risk in pregnancy, of which one domain (three questions) addresses drug use.

4. Unsafe Drug Use Screening includes discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Screening results, interpretation, and any resulting patient-specific recommendations must be documented in the medical record.

Online Toolkit for Treating Substance Exposed Mothers and Babies

Formulated by national experts led by the California Maternal Quality Care Collaborative, the toolkit supports neonatal and perinatal providers in addressing the full continuum of care for mothers and babies affected by opioid and other substance use disorders while maintaining the mother/baby dyad whenever possible. This is accomplished through the provision of numerous evidence-based, best practices addressing screening for identification, treatment for the mother and the exposed infant, care transitions, and education options for staff and families.

The toolkit considers the intricacies that potential scenarios present: difficulties in screening, stigmatized care, variability of provider and staff knowledge, the challenges of care coordination, and the different settings in which services may be provided. These goals drive a lucidity of purpose to offer safe, effective, patient-centered, hopeful care that is free of stigma and prejudice.

The online toolkit can be accessed here: https://nastoolkit.org/

Clinical Practice Guidelines for Primary Care

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

Well-Child Visits for Babies Born Premature

Newborn babies hospitalized for several weeks or months before going home are more fragile than term newborns, and should have a slight

acceleration of their well-child visit schedule to ensure they receive at least six well-child visits before 15 months of life.

Here is our recommendation:

- First visit: within 7 days of hospital discharge.
- Second visit: 14-21 days later (will not count if less than 14 days between visits).
- Third visit: 4 weeks later.
- Subsequent visits: every 2 months until 15 months of age.

Billing Frequencies Allowed for Well Child Visits

Note that PHC allows *different billing frequencies* for well child visit CPT codes 9938x and 9939x, compared to fee-for-service DHCS, to better align with NCQA and AAP recommendations. Up to two visits per calendar year are allowed for codes 99383 – 99385 and 99393 – 99396. For children under one year of age (codes 99381 and 99391), and for children one through four years old (codes 99382 and 99392), well-child visits may be done as medically necessary, but should be at least 14 days apart.

Health Services Updates

Enuresis Alarms Covered by PHC

For many children with monosymptomatic enuresis, one very effective treatment option is behavioral modification using enuresis alarms. The best meta-analysis of therapeutic options showed less relapse with alarms versus children treated with desmopressin. The cost is also significantly less.

While PHC covers enuresis alarms as a pharmacy benefit without a TAR for children aged five and older, many pharmacies struggle with billing for this device. If the long- anticipated Medi-Cal Rx pharmacy carve out occurs, this option will no longer be available.

A more reliable way to get enuresis alarms for children is through Broadway Medical. They stock the NiteTrain-R Bedwetting Alarm. They will take the order by fax or on-line submission and deliver the device directly to the patient. The ordering clinician should ensure the parents are educated on appropriate use of the device.

Here is the contact info for Broadway Medical Supplies:

Eureka, CA
Phone (707) 442-3719
Fax (707) 442-0237

Sacramento, CA
Phone (916) 927-4047
Fax (916) 927-5383

You may also submit the request directly through the providers' website: https://www.broadwaymed.com/providerforms

Thanks for passing this on to your pediatric clinicians!

Zio Patch Cardiac Event Monitor now Covered

Medi-Cal and PHC now cover the use of the Zio Patch for cardiac event monitoring. This patch is best used for diagnosing intermittent arrhythmias that do not occur every day (a Holter monitor is preferred for more frequent arrhythmias). The CPT codes for this are 93241-93248.

Unlike traditional event monitors, the Zio Patch is an all-in-one unit that sticks firmly to the chest wall and can be used for patients with vigorous physical activity. When symptoms occur, the patient can push on the single button to capture it. When the analysis is completed, the patch is removed from the chest wall and mailed in for analysis.

Careful patient education is essential for the unit to be most accurate for diagnosing an arrhythmia. See https://www.irhythmtech.com/patients/faqs for details. If a PCP is not sure if the Zio Patch is appropriate for a specific patient, they may want to consult or talk with a cardiologist first.

Here is one common scenario to avoid. A patient with hyperthyroidism complains of intermittent palpitations and has a normal baseline EKG. They have a Zio Patch placed and they push the button when they have an episode, which they think is typical. Analysis shows sinus tachycardia and no pathologic arrhythmias. The patient is a bit anxious and wants another Zio Patch to try again to look for pathology that she is sure is present. A repeat Zio Patch in this instance is almost never helpful.

The correct diagnosis is palpitations due to sinus tachycardia associated with hyperthyroidism. The patient should be given this diagnosis with confidence, and have their hyperthyroidism treated without a repeat Zio Patch.

Another Option for Medical Nutrition Therapy and Diabetes Education

For almost 20 years, PHC has covered Medical Nutrition Therapy services provided by Registered Dieticians (RDs) and Diabetes Education provided

by Certified Diabetes Educators (CDEs). These services require neither prior authorization nor referral pre-authorization. In-person services may be provided in some counties.

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

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

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

Care Coordination Services at PHC

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

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

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

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

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

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

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

We look forward to partnering with you on behalf of our members!

Feedback on RAF "Pop-ups"

Last December, PHC's Provider Relations Department added some reminders to the Referral Authorization System (RAF) used to by PCP offices to make specialty referrals. We call these reminders "pop-ups" because they pop-up when specific referrals are made.

Prior to December, pop-ups were set up only for specific physician specialists. Since December, standardized pop-ups were created by PHC Medical Directors with input from specialist offices, for the specialties:

1. Cardiology
2. Orthopedics
3. Ophthalmology
4. Pain Medicine
5. Podiatry
6. Vascular Surgery

These specialties were selected because the pop-ups were the shortest and most general. An example for Podiatry follows:

Podiatry

Black – For Referral Staff
Purple – For Referral Staff/Clinicians
Blue – For Clinicians

Referral request should include:

- relevant medical history and pertinent findings on physical examination

Appropriate Referrals include:

- Foot/ankle pain
- Medical/surgical problems of the foot/ankle, e.g., problems of:
  - Skin/nail problems such as rashes, nail deformity, skin/nail infections, wounds, corns, calluses, nodules, tumors
- Musculoskeletal deformities of the foot
- Traumatic injuries to the foot – non-emergency
- Palliative care (debridement of nails/calluses) in patients at high risk for limb loss, i.e., any patient with vascular impairment, neuropathy
- Diabetic neuropathy, for nail care

Inappropriate referrals include:

- Children under the age of 14 years with pes planus

We are considering turning on some additional pop-ups that are a bit more complex and directed more towards clinicians. We would like feedback on the current pop-ups from the PCP perspective. Please check with your referral coordinator and let us know: loconnell@partnershiphp.org

The Intensive Palliative Care Benefit

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

Here is the contact information for contracted Palliative Care Provider Organizations in our service area:

Counties Served	Organization	Referrals
Del Norte, Humboldt, Lassen, Modoc, Siskiyou, Shasta, Trinity	Resolution Care	Phone: 707-442-5683
Shasta (Redding vicinity)	Medical Home Care Professionals	Phone: 530.226.5577
Siskiyou (Yreka vicinity)	Madrone Hospice	Phone: 530-842-3160
Lake	Hospice Services of Lake County	Phone: 707-263-6270 ext 140
Mendocino	Madrone Care Network	Phone: 707-380-5080
Napa, Sonoma, Solano (Vallejo)	Collabria Care	Phone: 707-258-9080
Marin, Sonoma	Hospice By the Bay	Phone: 888-720-2111
Solano	Continuum Hospice	Phone: 707-540-9838
Yolo	Yolo Hospice	Phone: 530-758-5566
Yolo	Dignity Health - Woodland	Phone: 916-281-3900

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

Rx Locking Cap and Lock Boxes for Prescriptions

PHC will be implementing a new benefit in the near future to reduce drug diversion. Prescribers and pharmacies will play a central role in this effort.

According to the SAMHSA (Substance Abuse and Mental Health Services Administration) 2014 report, two out of three teens who report abuse of prescription pain relievers are getting them from friends, family, and acquaintances. Teens and other young adults often do not associate this behavior as risky since many believe the medicine is created and evaluated in a scientific environment and thus are safer than illegal drugs. Unfortunately, this misconception often results in physical harm, other substance abuse, addiction, and even death. Preventing drug diversion and misuse in the home is a critical step in the battle against teens and others inappropriately using prescription medications and part of the bigger fight against the opioid and substance abuse epidemic.

Good communication while building trust with teens are vital parts of the strategy on preventing misuse of prescription medications. Securing prescriptions with locking caps and lock boxes may also play an important role in preventing misuse. Locking caps fit on regular prescription vials and use a combination to secure the vial. It's a quick and easy way to secure prescription medications to stop diversion, as well as, preventing small children from accidentally getting access to these drugs. Starting June 2021, PHC will add locking caps and lock boxes as a benefit. **PHC members will be allowed to receive up to five locking caps and one lock box per year to secure their prescription medications that are high risk for misuse.**

Here is how prescribers can provide locking cap and box to patients:

1. Prescriber issues a prescription for a class 2 (CII) controlled medication. On the prescription, please also add "dispense Locking Cap and/or Lock Box".
2. Pharmacist will fill the prescription for the medication and a separate prescription for the Locking Cap and/or Lock Box.
3. Pharmacist will fill and dispense CII medication in regular vial and cap and add Locking cap or Lock Box to the CII prescription bag.
4. Pharmacist will provide the locking cap/box information sheet and patient education (can be performed by pharmacy technician) to help teach the patient how to use these devices and secure their CII prescriptions.
5. Pharmacist will document Locking Cap or Lock Box security combination in their system's patient notes.

Providing locking caps and boxes is one simple measure prescribers and pharmacies can take in combating the misuse of prescription medications.

In the coming weeks, we will be informing prescribers, clinics, and pharmacies about PHC's new benefit and how we can all partner together to help PHC members obtain these devices and secure their prescriptions. Thank you for your support in this important fight!

Formulary Updates

1. Non-formulary SGLT-2 inhibitor criteria were revised based on recent clinical trials, and in some cases expanded FDA-approved indications, showing that SGLT-2 inhibitors can have a benefit in cardiac and renal risk reduction distinct from HgA1C reduction.

2. Removal of prednisolone tablets from formulary, due to being high-cost generic ($16-18/tablet) and the availability of multiple lower cost alternatives.

CMO Updates

The following articles are extracted from the PHC Primary care blog: http://phcprimarycare.org, containing content from the past 9 years. In addition, an archive of prior Medical Directors newsletters can be found on the PHC website.

Improving Quality of Patient-Clinician Interactions

Bringing the Patient Story Back to the Medical Record

Linguists have shown that humans that do not store their thoughts or memories in written form have a remarkable ability to remember and relate long stories orally, from generation to generation. Even with written language and now audio-visual capture of information, stories are easier to remember than a stream of facts, events or even a theoretical framework. (The early chapters of *Sapiens: A Brief History of Humankind* offers a good summary.)

There is a neurologic basis for this. Streams of facts or ideas mainly stimulate the auditory processing portion of the brain, while stories activate the deep brain structures associated with emotions and long-term memory, as well as various portions of the cortex. A story puts our whole brain to work.

This may explain why studies of Electronic Health Records that segregate clinical tidbits into different discrete parts of the medical record decrease the ability of a subsequent reader to really understand what was going on with a

patient. The patient story is lost, making the medical record a poor communication tool.

A well-written opinion article in the September 1, 2020 Annals of Internal Medicine calls on clinicians to "Restore the Story" in clinical notes. The American College of Physicians created a "Restoring the Story Task Force" to promote this effort. The article summarizes the attributes of an ideal clinical note:

> "The ideal clinical note is more than a verbatim transcript. It is a coherent representation of relevant data that have been sifted through and examined in the context of the patient's life and priorities, yielding an assessment of the situation and rationale for recommended next steps."

In the electronic health record, the two most important places for telling the story are the history of present illness and the assessment. Utilizing the free text option in these two locations is essential to achieve this.

Patient-Centeredness: In the Eye of the Beholder

April 26-30, 2021 was National Patient Experience Week, a time for health care organizations to celebrate and reflect upon their efforts to improve the way their consumers perceive the care they receive, a time for health care organizations to proclaim that they are "Patient-Centered."

What does it mean to be patient-centered? The answer depends on who you ask.

The root of the term "patient-centered" goes back to the 1940s with a school of psychological thought that promoted counseling that was centered on the needs of the client: *client-centered counseling*. In the 1950s and 1960s, Hungarian-British psychologists Michael Balint, Enid Balint, and Paul Ornstein brought a basic psychodynamic approach to primary care clinicians –the "Balint Group" approach now used in primary care medical education around the world. The Balints coined the term patient-centered medicine, which "should include everything the doctor knows and understands about his patient . . . understood as a unique human being," as *distinct from illness-oriented medicine* that focuses more narrowly on diagnosis and treatment of localizable pathology.

In 2001, the National Academy of Medicine identified being "Patient-Centered" as one of the six aims of health care quality (the others being safe, effective, timely, efficient, and equitable). They defined Patient-Centered as care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring their values help guide all

clinical-decisions. This idea of *customizing* the care to the patient seems consistent with the Balints' ideas.

Starting in 2007, some larger institutions have appropriated the term patient-centered to have different definitions.

In 2007, all the American organizations representing primary care clinicians (AAFP, AOA, ACP, and AAP) combined the concept of a Primary Care Medical Home (the 1967 AAP idea of a PCP who coordinates the care provided by specialists), with the idea of patient-centeredness to create the Joint Principles of the Patient-Centered Medical Home. While the goal of this structure is to *serve the needs* of the patient, this initial conceptualization focused on putting the primary care physician at the center of this care—more of a *primary care physician-centered* medical home.

Sensing an opportunity, in 2008 the major accreditation agencies (NCQA, URAC, Joint Commission, and AAAHC) launched Patient-Centered Medical Home (PCMH) accreditation and recognition programs. Their focus is on elements of operational and quality infrastructure thought to be good for patients and their outcomes. Moving beyond a narrow physician-centered focus, meeting these elements helps move primary care organizations in the direction of higher quality care, using a *compliance with standards* approach.

In the meantime, organizations and scholars that were focused on primary care moved in two different directions.

The first of these focuses on *relationships* between patients and those clinicians who are able to communicate with empathy. This emphasis on relationships is epitomized by the Nuka Model of Care at the Southcentral Foundation in Anchorage, the only health center in the U.S. to win the Baldrige National Quality Award. Health care in the Nuka model is relationship-based and customer-owned. Nuka focuses on understanding each customer-owner's unique story, values and influencers in an effort to engage them in their care and support long-term behavior change. Note the additional element of *community empowerment* included in this approach.

The second direction was a focus on more actively seeking input of patients on how to improve the provision of health care, called Patient and Family Centered Care (PFCC). The four fundamental principles of PFCC are treating patients and families with respect and dignity, sharing information, encouraging their participation in care and decision making, and fostering collaboration in care delivery and program design, implementation, and evaluation. The new element here is the idea of moving beyond gathering survey feedback from patients, to *partnering* with patients to identify service problems and *co-design* the solutions. "Nothing about us, without us" is their catchphrase.

Both the Nuka model and the PFCC move beyond the *individual* clinician-patient interaction to look at what the *organizations* that hire these clinicians must do to be patient-centered, in ways that are challenging for standards organizations like NCQA to fully capture.

Jumping up another level above the organizations that provide care, how can health plans like PHC (as well as suppliers and state regulators like DHCS) promote patient-centered care?

1. Make patient-centeredness a guiding principle — a frame-of-mind — that guides decisions and prioritization.
2. Ensure consumers of health care have a voice. This includes a process that uses grievances to drive improvement, including consumers in governance and policy-making, and ideally with some joint design activities.
3. Support providers, especially your primary care organizations, with financial incentives, comparative data, and sharing of best practices around optimizing the patient experience of care.

Becoming truly patient centered, meeting all the different definitions of this term, requires sustained attention from all of us.

Re-framing POLST Completion as a Procedure

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

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

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

- Procedure performed
- Date and time of the procedure
- Name of surgeon/assistants
- Indication for procedure
- Pre-operative diagnosis
- Post-operative diagnosis
- Anesthesia

- Narrative description of the procedure
- Findings
- Specimens
- Sponge and needle counts
- Drains left in after surgery
- Disposition/status of the patient

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

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

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

1. A clinician needs to have a goals-of-care conversation with the patient and potentially their family.
2. When appropriate, a POLST form must be filled out correctly, without missing signatures or inconsistent directives.
3. The POLST form must be available to any EMS responding to an emergency call.
4. The family needs to understand and respect the orders expressed in the POLST (or they may hide the POLST or direct the care team to ignore the POLST).
5. The emergency medical technicians, emergency department physicians and ICU physicians must understand what a POLST is, how to read the POLST, what it means, what the legal requirements are, and agree to following the directives expressed in POLST forms.
6. The POLST form must be available to the emergency department physician and potentially the ICU physician caring for a patient who is unable to express their own wishes.

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

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

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

This sometimes leads to care that is inappropriate and unwanted.

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

Leadership Lessons

Focusing Leadership Energy

The “Rule of Three” is a principle in writing and public speaking that states that ideas presented in threes are inherently more interesting, more enjoyable, and more memorable for your audience. Information grouped into threes will stick in our heads better than other sized groups.

For lexophiles, there are two single words for the rule of three.

The first is **tricolon**, derived from the Greek *tria* (three) and *kolon* (clause or member). The idea is old; Aristotle described it in his book *Rhetoric*. The three words or phrases have different meanings but are grouped together for a common purpose.

Some medical examples:

> *Airway, breathing, circulation*
>
> *Oriented to person, place and time.*

The second word is **hendiatris,** derived from the Greek *hen dia treis* (one through three), in which three words are used to convey a single concept. For example, Shakespeare’s Julius Caesar says:

> *Friends, Romans, Countrymen, lend me your ears.*

Why does this rule work so well? One theory is that our minds naturally organize information into patterns so that they can process and retain information. The smallest number in a pattern is three, hence the rule-of-three.

Leaders throughout history have used the tricolon to communicate, inspire and motivate those around them. There is another variation on the Rule of Three used by leaders to focus their strategic energy and achieve success on what matters most. To be effective, we need to regularly decide what our top three priorities are for focusing our discretionary energy. Write them down, talk about them, and remember them when you can take a break from

the myriad of busy tasks (email, meetings, patient care) that take up so many hours each day.

Focusing on your top three priorities requires discipline to defer lower priorities to later, or perhaps delegate them to someone else. This discipline also forces us to be clear on the *criteria* for prioritizing the highest priorities, a process sometimes called "remembering our north star", the guiding light in the darkness which is steadfast, and present, night after night.

So take a moment to remember the principles that guide you, and set your top three priorities for the next week/month/year. Then, as you seek to inspire others to work on these priorities, consider how rules-of-three can help you.

Scaling Up: Reflections on the Science of Implementation and Spread

In spite of several months of planning, the scaling up of the COVID vaccine has been challenging. Often, the scaling up of successful pilot programs and improvement projects encounter problems. Successful large scale implementation is a skill set *not* necessarily associated with good intentions, innovative thinking, or the size of the organization.

Stephen Dubner offers a nice introduction to this challenge in a Freakonomics Radio podcast, from early 2020.

In the last 10-15 years, a new social science concept called "Implementation Science" seeks to explain the factors leading to implementation challenges and how to overcome them.

Here are a few major reasons that scaling up of successful pilots may fail:

- The pilot did not actually work (look at the actual data, not the hype).
- The people studied in the pilot are not representative of the general population.
- Efforts to scale up implementations cut corners and no longer follow key aspects of the pilot program.
- Scaling up does not account for limited supply of qualified staff and other inputs.
- Scaling up assumes the "build it and they will come" theory; that demand for the intervention will spontaneously be high. An insufficient marketing plan is included.

Over the course of our careers, as we experience or witness failed implementations, it is too easy to develop a sense of fatalism about many proposed expansions. In the case of mass COVID vaccination, our society, health care delivery system, and economy, demand that we have a

different mindset. Successful implementation is hard, it is a skill-set, but it importantly reflects a “can do” mindset, not a “can’t do” mindset. It means tackling challenges head on, seeking new solutions to problems encountered, including the key challenge of vaccine hesitancy.

Health Equity

Roadmap for Resilience: The California Surgeon General’s Report on Adverse Childhood Experinces, Toxic Stress, and Health

The Office of the California Surgeon General released the frist Californai Surgeon General’s Report – roadmap for Resilience: *The California Surgeon General’s Report on Adverse Childhood Experiences, Toxic Stress, and Health*. The report serves as a blueprint for how communities, states, and nations can recognize and effectively address Adverse Childhood Experiences (ACEs) and toxic stress as a root cause to some sort of the most harmful, persistent, and expensive societal and health challenges facing our world today.

A special webinar was held in December 2020, where California Surgeon General Dr. Nadine Burke Harris shared key findings of the report along with critical insights for policymakers, scientists, healthcare providers, educators, and advocates to advance evidence-based solutions and approaches to act now to improve health outcomes and prevent and childhood adversity.

The webinar materials, including a recoring of the broadcast, are avaiable for viewing and download on the ACEs Aware Educational Events page.

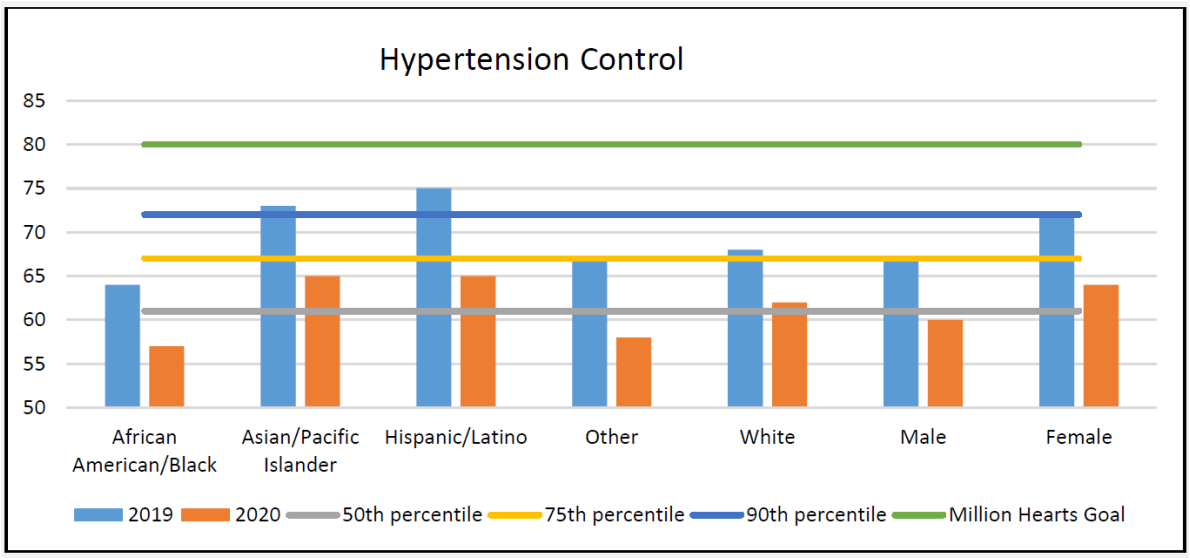
Outcome Disparities vs. Outcome Inequities

Health equity is the focus of much attention recently, with NCQA and DHCS looking for ways to measure and remediate inequities. A major limitation to analysis of health equity in the Medi-Cal population, is that the data available on race, ethnicity, language and gender are self-identified at the time of Medi-Cal application based on limited standardized categories. While some providers gather more detailed demographic data, such as gender identity, sexual orientation, or more nuanced ethnicity information, it is not captured in a standardized way and there is no accepted way for this to be reported to and adopted by the health plan or the state. Thus, no analysis based on this more detailed demographic information is possible outside of the provider-level databases. A high priority for making health equity analysis less blunt will be to standardize more detailed

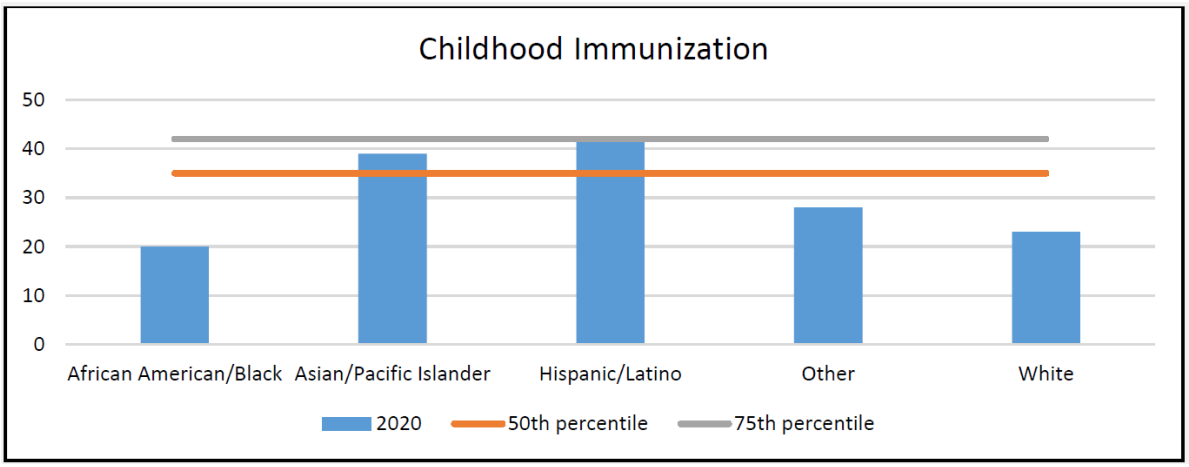
race/ethnicity/gender etc. data collected from beneficiaries at the time of application, and to ensure that this information can be used to correct the plan and State data.

Partnership uses the basic member-level ethnicity data we have to evaluate certain clinical data elements that are collected more systematically, as part of HEDIS administrative measures (such as breast cancer screening) or hybrid measures collected as part of the PCP QIP (such as blood pressure control). Outcome data, like maternal mortality or neonatal mortality, is not coded in a way that we can use to generate accurate rates within our health plan data (county level and state level mortality data is available from CDPH).

There are two patterns that we find with this approach, which are illustrated with the following examples:



a. Hypertension control: Note the declining control overall in 2020, due to the COVID pandemic. Additionally, note less control of blood pressure in the Black and male populations. This chart is based on QIP data, the denominator being much larger than for HEDIS data, where only a small sample of the overall population is evaluated. Consequently, while we are not able to find statistically significant disparities from HEDIS data, we are able to see statistical differences in the QIP dataset. Diabetes control exhibits a similar pattern.



b. Childhood Immunization: 10 vaccine series completed by age 2. White and Black children have similarly low vaccination levels, compared to the Asian/Pacific Islander and Hispanic children. Many other clinical measures have a similar pattern, with the health status of white members below that of other ethnic groups.

As this illustrates, not all health disparities are a reflection of inequities. If a socially favored demographic (such as white males) has a worse health status, this disparity would not be considered a reflection of systematic bias or unequal privileges. Such ethnic disparities (in the setting where all groups have Medi-Cal, and so all the comparison groups have low income) may be associated with *other* factors which could be considered inequities. Examples include, living in a rural area with less access to medical care or having a higher exposure to factors that increase health risk, such as housing instability or substance use.

These examples illustrate the challenges DHCS and NCQA will have as they try to define standardized equity measures that measure performance of health plans. Nonetheless, analyzing the data we have to look for disparities is well worth the effort, to allow a thoughtful contemplation of associations and potential causal factors that we may be able to address.

Quality Improvement Updates

DHCS and NCQA Quality Measurement Changes

In July, DHCS announced updated measures for measurement years 2020-21. Here are the highlights:

1. **Virtual preventive visits.** Previously, many health maintenance and other visits were specifically prohibited from being satisfied

by telemedicine or virtual visits. The new standards allow virtual visits to satisfy well-child visits, prenatal visits, post-partum visits, various counselling visits, and follow up visits.

2. Several additional changes in the well-child visit measures:

    a. **All well-child visit measures are now administrative measures**, meaning that if a well-child visit CPT or ICD10 code is associated with the visit, it is considered numerator compliant. Previously, chart searches that found other visits that met enough factors to be considered well-child visits could be identified by HEDIS nurses reviewing actual medical records.
    b. For the six well-child visits in the first 15 months of life, a **minimum 14 days must elapse between appointments** to count as a separate visit.
    c. **Additional ages were added to the well-child visit** options measured. Unchanged are the well-child visits in the first 15 months of life. Changes include
        i. Adding a measure requiring two well-child visits between 15 and 30 months of age
        ii. The 3-6 year old and 12-17 measures were combined into one measure to cover the age ranges of 3-21 and divided into four rates:
            - 3–11 years
            - 12–17 years
            - 18–21 years
            - Total

3. The rules for allowing measured home blood pressures to count in the Controlling High Blood Pressure (CBP) measure now specifically allow any reported digital blood pressure recorded by the patient at home to be entered into the medical record and count towards blood pressure control.

    We recognize that UDS specifications still require direct provider measurement or use of a connected BP monitor.

    Additionally, the denominator timeframe has narrowed which will help identify eligible patients under CBP earlier in the measurement year. In 2021, eligible patients include those who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year AND **June 30th** of the measurement year (01/01/2020 – 06/30/2021).

4. A new measure, the **Kidney Health Evaluation for Patients with Diabetes (KED)**, was announced. As a first year measure, we are not yet responsible for it, but we will likely be accountable to it starting in 2022. This measure is similar to the recently retired measure of treatment or testing for diabetic nephropathy. In the old measure, patients taking an ACE inhibitor or Angiotensin Receptor Blocker (ARB) were considered numerator compliant, but this is no longer the case for the new KED measure. The only way to achieve numerator compliance is to obtain a serum creatinine (to calculate an estimated Glomerular Filtration Rate (eGFR) and a urine albumin to creatinine ratio (uACR) each year.

HEDIS Performance in 2020

Not surprisingly, preliminary results of the Measurement Year 2020 HEDIS results show broad declines in almost all clinical quality scores. We will present more details in the autumn of 2021.

We recognize that the best ways to rebound from the clinical quality declines are to have COVID-19 under control and to move clinical operations to a more stable steady state.

Pay for Performance Program for Primary Care (PCP QIP)

Top PCP QIP Performers for 2020

Scoring 100%

Provider Name	County
Petaluma Health Center, Petaluma site	Sonoma
Ole Health, South Napa site	Napa
Martha Cueto Salas	Sonoma
Annadel Medical Group, Santa Rosa (Two sites)	Sonoma
Communicare Health Center (Davis, Woodland sites)	Yolo
NorthBay Center for Primary Care (Vacaville, Hilborn sites)	Solano
Santa Rosa Community Health (Pediatric, Vista, Dutton sites)	Sonoma
Mendocino Community Health, Hillside site	Mendocino
Marin Community Clinics (South Novato, two Kerner Blvd. sites)	Marin
Adventist Health Clearlake, Hidden Valley site	Lake

Highest Scores in the Northern Region

Site Name	County
Open Door Community Health Centers, Humboldt OD and Eureka CHC sites	Siskiyou
Mercy Mt. Shasta Community Clinic	Siskiyou
Mountain Valleys Health Centers (Burney site)	Shasta
Fairchild Medical Center, Scott Valley Rural Health Center	Siskiyou

PCP QIP Measures for 2021

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

2021 Measures

Clinical Domain

Family Medicine:

1. Asthma Medication Ratio
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Colorectal Cancer Screening
5. Controlling High Blood Pressure
6. Diabetes Management: HbA1C Good Control
7. Child and Adolescent Well Care Visits (3-17 years of age)
8. Childhood Immunization (10 vaccines by age 2)
9. Immunization for Adolescents (3 vaccines by age 13)
10. Well Child Visits First 15 months of Life

Monitoring Measures:

11. Diabetes Management: Eye Exams

Clinical Domain

Internal Medicine:

1. Asthma Medication Ratio
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Colorectal Cancer Screening
5. Controlling High Blood Pressure
6. Diabetes Management: HbA1C Good Control

Monitoring Measures:

1. Diabetes Management: Eye Exams

Clinical Domain

Pediatric Medicine:

1. Asthma Medication Ratio
2. Child and Adolescent Well Care Visits (3-17 years of age)
3. Well Child Visits First 15 months of Life
4. Childhood Immunization (10 vaccines by age 2)
5. Counseling for Nutrition for Children/Adolescents
6. Counseling for Physical Activity for Children/Adolescents
7. Immunization for Adolescents (3 vaccines by age 13)

Monitoring Measures:

None

Appropriate Use of Resources

Family Medicine & Internal Medicine:
1. Ambulatory Care Sensitive Admissions
2. Risk Adjusted Readmission Rate (RAR)

Access and Operations

All Practice Types:
1. Avoidable ED Visits
2. Ambulatory Care Sensitive Admissions

Monitoring Measures:
1. PCP Office Visits

Patient Experience

All Sites:

1. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service

All Sites:

Advance Care Planning Attestations
Alcohol Misuse Screening and Counseling
Extended Office Hours
Health Information Exchange
Initial Health Assessment
PCMH Certification
Peer-led Self-Management Support Groups

Threshold and Points:

Points and Thresholds by Clinical and Non-Clinical Domain:

Core Measurement Set – Family Practice

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (68.52%)	50th Percentile (63.58%)	7	5
Breast Cancer Screening	75th Percentile (63.98%)	50th Percentile (58.67%)	7	5
Cervical Cancer Screening	75th Percentile (66.49%)	50th Percentile (60.65%)	7	5
Child and Adolescent Well Care Visits	50th Percentile (47.54%)[2]	New Measure, First year	10	0
Childhood Immunization Status: Combo 10	75th Percentile (42.02%)	50th Percentile (34.79%)	7	5
Colorectal Cancer Screening	50th Percentile (41.84%)	25th Percentile (32.24%)	6	5
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (67.15%)	50th Percentile (61.48%)	7	5
Controlling High Blood Pressure	75th Percentile (66.91%)	50th Percentile (61.04%)	7	5
Immunizations for Adolescents – Combo 2	75th Percentile (40.39%)	50th Percentile (34.43%)	7	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (69.83%)	50th Percentile (65.83%)	10	8
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [3]				
Ambulatory Care Sensitive Admissions	60th Percentile (6.88)	70th Percentile (8.56)	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0 -1.2	5	4
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access) (45.00%) 50th Percentile (Communication) (70.30%)	25th Percentile (Access) (41.00%) 25th Percentile (Communication) (67.00%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8

Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (68.52%)	50th Percentile (63.58%)	12.5	9
Breast Cancer Screening	75th Percentile (63.98%)	50th Percentile (58.67%)	12.5	9
Cervical Cancer Screening	75th Percentile (66.49%)	50th Percentile (60.65%)	12.5	9
Colorectal Cancer Screening	50th Percentile (41.84%)	25th Percentile (32.24%)	12.5	9
Comprehensive Diabetes Care - HbA1c Control	75th Percentile (67.15%)	50th Percentile (61.48%)	12.5	9
Controlling High Blood Pressure	75th Percentile (66.91%)	50th Percentile (61.04%)	12.5	9
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Ambulatory Care Sensitive Admissions	60th Percentile (6.88)	70th Percentile (8.56)	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0 -1.2	5	4
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access) (45.00%) 50th Percentile (Communication) (70.30%)	25th Percentile (Access) (41.00%) 25th Percentile (Communication) (67.00%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8

Core Measurement Set – Pediatrics

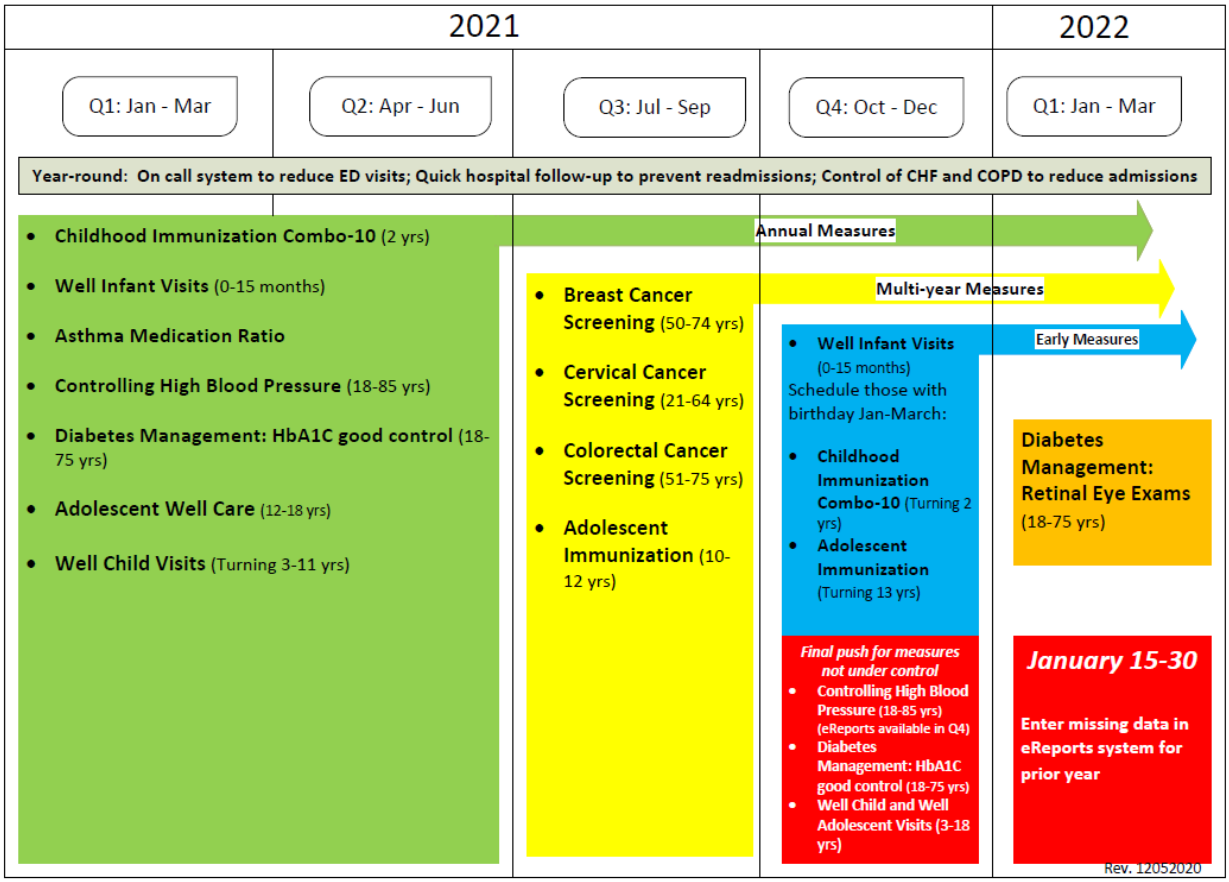
Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (68.52%)	50th Percentile (63.58%)	12	9
Child and Adolescent Well Care Visits	50th Percentile (47.54%)[5]	New Measure, First year	12.5	0
Childhood Immunization Status: Combo 10	75th Percentile (42.02%)	50th Percentile (34.79%)	12	9
Counseling for Nutrition for Children/Adolescents	50th Percentile (64.96%)	New Measure, First year	12	0
Counseling for Physical Activity for Children/Adolescents	50th Percentile (70.92%)	New Measure, First year	12	0
Immunizations for Adolescents – Combo 2	75th Percentile (40.39%)	50th Percentile (34.43%)	12	9
Well-Child Visits in the First 15 Months of Life	75th Percentile (69.83%)	50th Percentile (65.83%)	12.5	9
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access) (45.00%) 50th Percentile (Communication) (70.30%)	25th Percentile (Access) (41.00%) 25th Percentile (Communication) (67.00%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8

Relative Improvement

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

Calendar for Focusing on Measures

Timeline for addressing 2021 and 2022 PCP QIP Measures



Specific Support for Priority Quality Measures

Strategies to Affect Improvement in Measures during COVID-19

Throughout the Pandemic, patients have been reluctant to attend many of their health care appointments and screenings. This is a concern for all of us especially as it relates to Adolescent Immunizations and Breast Cancer Screenings.

In collaboration with some of our network providers, we have developed a few promising practices based on our research throughout the Pandemic which are available for you:

- Shot at Success: Integrating the Immunization Dose Report into the Vaccine Process

- Primary Care – Imaging Center Connections: Collaborating to Improve Mammography Screening Rates
- Member Online Tool: Routine Mammogram Screenings (Information & Resources)

Telehealth for Diabetic Retinopathy Screening Services

Digital Health, a service of the UC Berkeley School of Optmetry, provides fast and convenient telehealth point-of-care diabetic retinopathy screening services to over a hundred health clinic systems and organizations throughout California, including many PHC provider health centers.

Digital Health is now contracted with PHC as an option for reading retinal images taken at the PCP office. Benefits include:

- 100% screening (financial) cost coverage for any PHC patient screened by Digital Health.
- Automatic registration of Quality of Care measures for HEDIS purposes, which reduces administrative cost and effort that clinic staff would otherwise expend attempting to capture that data.
- Digital Health handles all administration of this third-party billing program at no extra cost to your health center.

For more information, please email Digital Health at ucbdh@berkeley.edu.

Asthma Medication Ratio

The Asthma Medication Ratio (AMR) is a current HEDIS measure whose performance is below average in the Northern Region. One important note: because of the nature of the way the AMR is calculated, the AMR score in the Partnership Quality Dashboard (PQD) tends to decrease over the course of the year, so all PCPs should focus attention on the AMR even if their early score is OK, *especially* if they failed to do well in prior years.

Here is some information to help improve performance.

Symbicort and Dulera on PHC formulary; an important alternative to albuterol

Intermittent use of Symbicort (various strengths of the corticosteroid budesonide combined with the long acting beta agonist formoterol (4.5mcg/dose)) and Dulera (various strengths of the corticosteroid mometasone combined with 5mcg formoterol) may be an effective single inhaler combination-therapy option as budesonide-formoterol

combination was found in a May 23, 2019 article of *The New England Journal of Medicine* to work equally well as continuous use of inhaled corticosteroid + prn albuterol for mild asthma. Formoterol has a **fast onset of action similar** to short acting beta agonists. The FDA has not yet approved formoterol for this indication, since the release of this new information, but specialty guidelines recognize this use of formoterol.

Additionally, PHC allows a 90 day-supply dispensing on formulary inhaled corticosteroid (ICS) and combination LABA/ICS inhalers.

Educational Interventions

The PHC QI and Pharmacy Departments set up Asthma Education visits with primary care clinicians to review the Asthma Medication Ratio measure, sites' current measure results, and best practices for asthma care that will help improve performance on the AMR measure. Since mid-March, the PHC team has converted these offerings into a virtual format (with CE/CMEavailable).

The objectives of these offerings are:

1. Define the Asthma Medication Ratio PHC's Primary Care Provider Quality Incentive Program (PCP QIP) measure specifications, timeframes, and documentation to maximize measure adherence
2. Review Global Initiative for Asthma (GINA) updated guidance regarding SABA-only treatment for asthma patients.
3. Review updates made to the PHC formulary to better align with GINA guidance.
4. Identify best and promising practices that providers can use to address clinical process, interpersonal communication, education/outreach, and technical barriers to asthma care and treatment that may prevent exacerbation.

These virtual educational sessions also include a provider-specific analysis of the assigned member population's performance under AMR with different visualizations to drive discussion under #4.

PHC has posted a webinar that combines technical QIP data analytic information and clinical information that aims to improve the Asthma Medication Ratio and patient care. This webinar is less than one hour and can be accessed here: Tips and Tricks to Improve Your Site's Asthma Medication Ratio Webinar. (scroll down the page to find it)

Other Ways to Improve the Asthma Medication Ratio

1. Think twice before refilling a rescue inhaler. Make it a short-term refill; check for a controller prescription; and evaluate controller medication compliance.
2. Consider using oral montelukast if mild-moderate asthma. This also helps with allergic rhinitis and has higher adherence than inhaled corticosteroids. Prescribe for three months at a time with three refills. Watch for behavioral side effects (there is a new black box warning).
3. Manage the denominator. Review the charts of those patients you have coded with asthma to see if they have had a good workup to confirm the diagnosis. Consider ordering spirometry or pulmonary function tests if not clear. Coding for COPD, for example, will remove that patient from the denominator.

A Call to Action on Hypertension Control

Controlling blood pressure (BP) decreases heart attacks and strokes, which decreases suffering and death. The **U.S. Surgeon General has declared a Call to Action on Hypertension Control,** with the goal of the U.S. Department of Health and Human Service's Million Hearts campaign to increase good blood pressure control to 80% of patients with hypertension. **Good blood pressure control is defined as a blood pressure under 140/90.**

Approximately **25% of adult PHC members have hypertension**. PHC data shows 17% of our members take at least one BP medication. The level of BP control among PHC members with hypertension in 2019 was approximately 65%. While better than the national rate of BP control, this is below the 80% goal of the Million Hearts campaign.

PHC supports our providers and members in improving BP control by covering blood pressure monitoring equipment for members to use at home for self-management. This will allow patients to measure their blood pressure and share this information with providers to gauge how well medications are working and when adjustments need to be made. **PHC aims for a goal of 80% of our members with hypertension to achieve BP control at less than 140/90.** This 80% goal is achievable. When patients are given tools to support self-management, the medical providers can work more effectively with their patients to make meaningful change in blood pressure control.

PHC has expanded its distribution of BP monitoring devices for PHC members when requested by their provider.

Contracted clinical providers can **submit requests directly to PHC for eligible members at no cost** by submitting a completed Medical Equipment request form. Upon receiving the provider request, PHC will send the device directly to the member via routine delivery (i.e., two to three days). Medical Equipment request forms can be found on the PHC website.

Clinical providers requesting the device must educate members on the proper use and setup of the device. This includes setup of any necessary remote patient monitoring options if needed. For members experiencing homelessness or members without a steady place of residence, clinical providers can have the device sent to their clinic/office for distribution to the member.

Below, PHC has listed several resources to help both providers and members reach the 80% goal.

For more information, please contact request@partnershiphp.org

Information on BP pressures/benefits of monitoring:

- AAFP recommendations: https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/highbloodpressure.html
- JNC8 recommendation: https://jamanetwork.com/journals/jama/fullarticle/1791497
- American Academy of Cardiology, 2017: https://www.jacc.org/doi/full/10.1016/j.jacc.2017.11.006?_ga=2.127564877.1975973149.1613582 357-2010972185.1613582357
- Editorial explaining AAFP and ACP differences: https://www.aafp.org/afp/2017/0501/p547.html

Blood Pressure Devices: Pharmacy Option

In addition to the PHC Medical Equipment Distribution program mentioned earlier, PHC covers Blood Pressure Monitors at community pharmacies. The coverage process initiates with a prescriber writing for a “blood pressure kit” or “blood pressure monitor.” (**Do not prescribe for “blood pressure cuff,” as the dispensing pharmacy could interpret this as for the cuff only**.) A hypertension diagnosis is *not* required.

Blood pressure monitors for home use are also available through community pharmacies, until such time as a state pharmacy carve-out begins. On the PHC Pharmacy home page, users can click on the “Formulary Blood Pressure Kits” link to see the list of covered items by NDC. The list is updated periodically to reflect BP monitors available on the market. We ask prescribers to write “Blood Pressure Kit” at minimum and include digital,

automatic, wrist, upper arm, and cuff size if they want more specificity for the patient. The prescription does not need a Hypertension (HTN) diagnosis and will be covered if the billed amount is less than $100.

If you encounter any problems, you can reach out to the PHC pharmacy department. We will need to know:

- Dispensing pharmacy name (and address if possible)
- If *dispensing pharmacy* is getting a rejected point-of-sale claim, or is *PHC* denying a TAR request for a monitor
- Member CIN (to research member-specific complaints)

Quality Measure Highlights

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

A Quick Guide to Starting Your Quality Improvement Projects

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

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

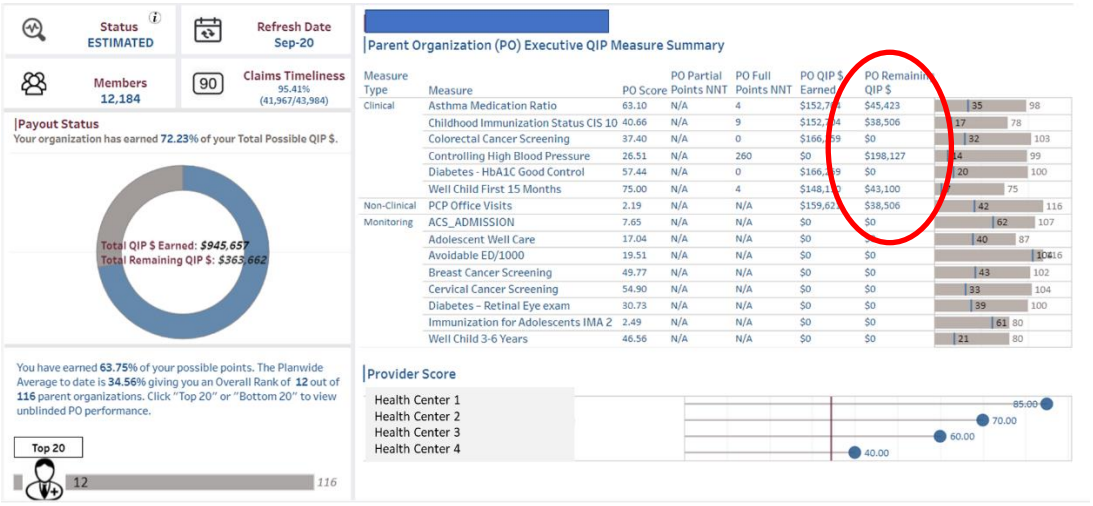
Other Quality Updates

Partnership Quality Dashboard

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

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

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



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

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

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

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

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

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

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

Proposition 56 Funded Programs: Update

Background:
Back in November 2016, the voters of California passed Proposition 56, also known as the California Healthcare, Research and Prevention Tobacco Tax Act. Approved by a 64% to 36% margin, it imposed a $2 per pack tax on cigarettes and a proportional tax on other nicotine products, as of April 2017. While the proposition allocated money for many things, a large percentage of the money was earmarked to support Medi-Cal providers. While the proposition itself does not have a sunset date, expenditure methods are for defined periods of time, as set by the California Legislature and CMS.

The funding for the first two years (2017-2019) was primarily distributed as supplemental payments for medical and dental clinicians caring for MediCal beneficiaries. Clinicians working at Federally Qualified Health Centers, Rural Health Centers, and Tribal Health Centers (also known as PPS eligible providers) were excluded. Payments that flowed though PHC were only paid to contracted providers (both primary care and specialists), and were paid based on visit volume. This helped us maintain our physician access and probably contributed to their satisfaction with PHC. These payments have continued.

Overview:

Starting in July 2019, Proposition 56 funds (combined with federal funding) were leveraged in 5 additional ways:

1. Loan Repayment
2. Value Based Payment Program
3. Developmental Screening and ACEs screening
4. Family Planning Incentives
5. Behavioral Health Integration Grants

Managed Care plans are the payers for the latter four programs.

Here is a brief update on each of these:

1. Loan Repayment Program: First three years out of five years of awardees have been selected, although details of the second cohort have not yet been released. The fourth cycle is anticipated in early 2022.
2. Value Based Payment Measures: Payments are sent quarterly. Early data show low billing for screening for alcohol misuse and dental fluoride varnish.
3. Developmental Screening and ACES: Payments for eligible Developmental screening sent quarterly. Payments for ACES have been incorporated into claims processing. FQHCs, RHCs and Tribal Health will need to separate these out from the cost basis for services included in the PPS system, as these are not reconciled with other services provided (they are considered by DHCS to be an incentive). See below for additional detail.
4. Family Planning Services: Payments sent quarterly.
5. Behavioral Health Integration Grants: PHC providers have been awarded over $30 million for a wide variety of projects to improve behavioral health integration. The grants started January 1, 2021 and will end December 31, 2023.

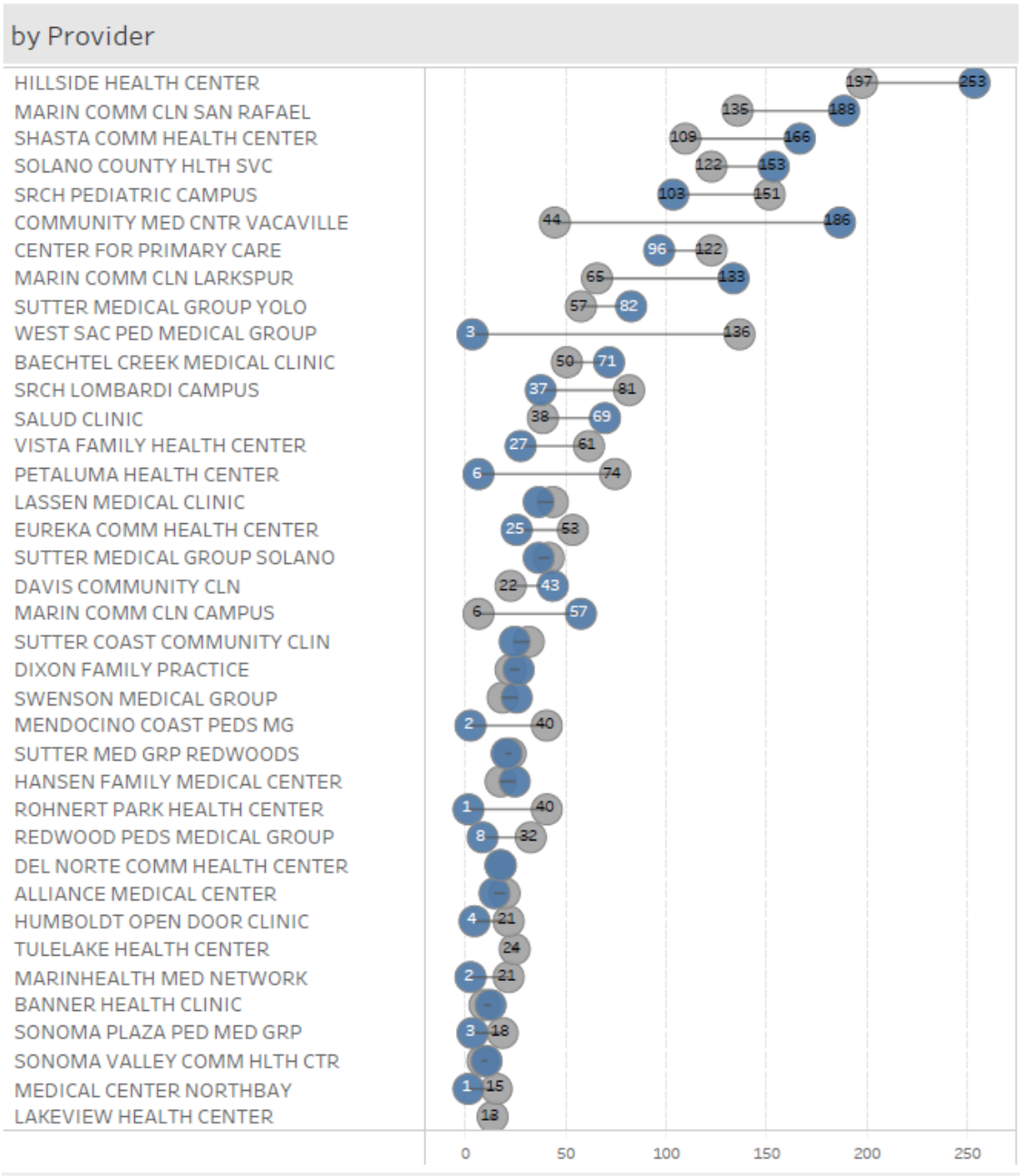
Additional Detail on Proposition 56 Developmental and Trauma Screening

Developmental Screening

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

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

The County Profiles included performance of this, by county. The chart below shows the rates of use of the 96110 for 2020 for all PCP providers billing 96110, looking at a comparison between the first 6 months (blue) and the second 6 months (gray) of the year:



Blue: Jan 2020 to June 2020
Grey: July 2020 to December 2020

ACEs Screening

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

a. ACEs screening:
    i. Rate: $29 each
    ii. Paid based on use of the following code:
        10. G9919: Screening performed and positive and provisions of recommendations (4 and greater)
        11. G9920: Screening performed and negative (0 to 3)
    iii. PHC will audit the appropriate use of these codes
    iv. Children up to age 19
b. PEARLS (Pediatric ACEs and Related Life-events Screener; includes screening for several social determinants of health)
    1. Up to every 1 year
    2. Parents may complete age 0-19; child may answer ages 12-19
c. Adults ages 18 to age 65: ACES screening tool, once in a lifetime per provider per patient; OK to repeat for new provider.
d. Age 18 and 19: either tool can be used.
e. DHCS has posted translations of these tools.
f. Providers must complete a 2 hour training and attest to completion of the training to be eligible to be paid the supplemental payment! Training available at: www.acesaware.org

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

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

Many eligible clinicians have not completed mandatory ACES aware training.

Effective July 1, 2020, only clinicians who have completed the ACES aware

training *and* *attested to completion* are eligible to bill for ACES/PEARLS screening. It is an excellent training and highly recommended, whether or not you plan to bill for ACES screening.

A search tool of all clinicians who have completed this training is found here.

Upcoming Educational Events

PHC Sponsored Events

Webinars on Topics Related to Substance Use Disorder

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

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

Quality & Performance Improvement Training Events

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

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

- ABCs of Quality Improvement: An introduction to the basic principles of quality improvement.
- Accelerated Learning Educational Program: An overview of clinical measures including improvement strategies and tools.
- Project Management 101 – An introduction to the basic principles and tools used in project management.

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

Accelerated Learning Education Programs

These learning sessions will cover PHC's Primary Care Provider Quality Incentive Program measures.

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

Diabetes Management HbA1C Good Control
Flyer
Date: Tuesday, May 25, 2021
Time: Noon – 1 p.m. Sign-up Now

Improving Asthma Care and the Asthma Medication Ratio
Flyer
Date: Wednesday, July 14, 2021
Time: Noon – 1 p.m. Sign-up Now
Child and Adolescent Well-Care Visits (3-17 years)
Flyer
Date: Tuesday, July 27, 2021
Time: Noon – 1 p.m. Sign-up Now

PCP QIP High Performers – How'd They Do That?

Targeted Audience: For those involved with PHC's QIP program (leading and/or participating in efforts to address their QIP measures) to learn how other PCP's accelerated in their QIP performance.

High Performing PCP Santa Rosa Community Health
Date: Tuesday, May 27, 2021
Time: Noon - 1 p.m. Sign-up Now

Virtual ABCs of QI

This virtual training consists of five sessions via webinar. The following topics will be covered:

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

Participants are eligible for 1:1 coaching with an Improvement Advisor after attending. These courses are FREE. All webinars are scheduled noon to 1 p.m. on the dates below. Ideally they are taken in sequence, but it is OK to sign up for just one or two.

Target Audience: Clinicians, practice managers and quality improvement team who are new or need a refresher on the basic principles of quality improvement.

Session 1 of 5: The Model for Improvement and Creating an Aim Statement
Description: The ABCs of QI is designed to teach the basic principles of quality improvement. Session 1 will provide an overview of the Model for Improvement, how to create aim statements and an introduction to project charters.
Date: Wednesday, June 02, 2021
Time: Noon – 1 p.m. Sign-up Now

Session 2 of 5: Using Data for Quality
Description: Session 2 will provide an overview of how data is used in quality improvement.
Date: Wednesday, June 09, 2021
Time: Noon – 1 p.m. Sign-up Now

Session 3 of 5: Understanding the Role of Measurement in Quality Improvement
Description: In Session 3, we will take a deep dive into the role of measurement in quality improvement.
Date: Wednesday, June 16, 2021
Time: Noon – 1 p.m. Sign-up Now

Session 4 of 5: Tips for Developing Change Ideas for Improvement
Description: In Session 4, we will review and practice creating Driver Diagrams and Process Mapping, tools used to brainstorm change ideas.
Date: Wednesday, June 23, 2021
Time: Noon – 1 p.m. Sign-up Now

Session 5 of 5: Understanding the Role of Measurement in Quality Improvement
Description: In Session 5, we will cover the use of the Plan-Do-Study-Act Cycle and the required steps from testing to implementing changes.
Date: Wednesday, June 30, 2021
Time: Noon – 1 p.m. Sign-up Now

The Role of Leadership in Quality Improvement Efforts – Interview with Top-Performing Leaders

Leaders from top-performing organizations will share how they were able to build a culture of quality.

Target Audience: This course is intended for executive leaders, managers, and supervisors.

The focus of this training is to:

- Understand the role of leadership in quality
- Learn how to successfully build a culture of quality from proven leaders
- Understand how a culture of quality impacts an organization
- Learn the key principles to improving quality

Petaluma Health Center
Leadership includes CEO and CMO
Date: Thursday, September 23, 2021
Time: Noon – 1 p.m.
Sign-up Now

Community Medical Center
Leadership includes CMO, COO, Director of Quality, and FNP
Date: Tuesday, October 05, 2021
Time: 11 a.m. – Noon
Sign-up Now

Improving Access through Office Efficiency

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

Mandatory Cultural Competency Training

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

Recommended Educational Opportunities Outside of PHC

Dignity in Pregnancy and Childbirth

Rachel Hardeman, PhD, MPH of the University of Minnesota developed an interactive training course and resources for perinatal providers focused on implicit bias and reproductive justice.

These resources are developed in accordance with the training requirements outlines in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464) which went into effect in January 2020.

All of the e-learning modules and resources developed for this project will be available free of charge. This project was funded by the California Health Care Foundation in response to strong evidence of racial inequalities in perinatal care and outcomes.

Free Perinatal Health Equity Resources

UpSkillMA Courses by the Weitzman Institute

UpSkillMA provides practicing Medical Assistants with next level training and expertise to excel in high-performing Primary Care teams. Participants learn at their own pace through an online platform that is user friendly, secure, and HIPAA Compliant.

Click here for course information and to sign-up.

Annual Palliative Care Summit

Working Together: Forging the Future of Serious Illness Care

The Coalition for Compassionate Care of California will host its annual summit virtually, again this year, partnering with coalition partners in Arizona and Hawaii. Don't miss this the presentations by national thought leaders in advanced illness, palliative care and end-of-life issues. CME available, including for a poster session on the evening of June 22.

Dates: June 22 and 23, 2021
Time: 11:30 a.m. – 4 p.m.
Full Agenda and Registration: www.CCCCsummit.org

CSAM State of the Art Addiction Medicine Available Online

Earn up to 17.25 AMA PRA Category 1 Credits™ and 16.25 MOC credits!

The California Society of Addiction Medicine (CSAM) brings together national experts to share frontiers of research, treatments, and policies in the field of Addiction Medicine. This conference covers expansion of treatment into correctional health, hospital consultation services, emergency rooms, and even across the Border. It will cover how, despite the pandemic, telehealth can reach those who are isolated. It will address the worrisome trends in fentanyl, methamphetamine, tobacco and benzodiazepines use; legalization of cannabis, treatment updates for youth, cannabis and alcohol in pregnant women; and novel treatments such as non- benzodiazepines for alcohol withdrawal and psychedelics for substance use disorders.

The activity consists of 22 lectures that were presented live (virtually) on September 22-25, 2020.

Member Rate: $345
Non-Member Rate: $495
More Information
Registration

On-Demand Webinars by ECHO

All available trainings are available on-demand and free of cost:

- Leveraging Telehealth and Remote Monitoring to Support Patients with Diabetes
- Diabetes Patient Needs in the Time of COVID-19
- Continuous Glucose Monitoring (CGM) & Beyond A1c Targets in the Time of COVID-19
- Platforms to Support Remote Diabetes Monitoring in your Practice in the Time of COVID-19
- COVID-19 & Sick Day Management for People with Diabetes
- Identifying High-Risk Diabetes Patients for COVID-19 Triage
- Insulin Dosing & Therapeutic Inertia in the Time of COVID-19
- DPP-4 Inhibitor, GLP-1 Receptor Agonist, & SGLT Inhibitor Therapies
- Tackling Therapeutic Inertia: American Diabetes Association Standard of Care Updates