Medical Directors Forum

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Spring 2023

Mission: *To help our members and the communities we serve, be healthy*

Vision: *To be the most highly regarded managed care plan in California*

Partnership Medical Director Team

Chief Medical Officer:

- Robert L. Moore, MD, MPH, MBA

Regional Medical Directors:

- Marshall Kubota, MD, (Marin, Sonoma, Mendocino and Lake Counties)
- Colleen Townsend, MD, (Napa, Solano and Yolo Counties)
- Jeff Ribordy, MD MPH, (Humboldt, Del Norte, Trinity, Shasta, Siskiyou, Modoc and Lassen Counties)

Associate Medical Directors:

Mark Netherda, MD, AMD Quality
Bettina Spiller, MD
Bradley Cox, DO
Aaron Thornton, MD
David Katz, MD
Mark Glickstein, MD
Jim Cotter, MD MPH
Teresa Frankovich, MD MPH

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Agenda

- Welcome, Introductions, Agenda Review
- County Profiles
- PHC Updates
- Behavioral Health Updates
- Public Health Updates
- Clinical, Health Services, CMO updates
- Quality Improvement and PCP QIP Updates
- Trainings and Upcoming Events

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Introductions

- Name
- Where you work
- What you do
- Share some activity that you or your organization does to make staff feel valued and happy

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Review of Materials

Handouts:

- Agenda
- Detailed Notes (Leadership version)
- Detailed Notes (Front line clinician version)
- County Health Profile
- Your PCP site's quality data by ethnicity

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Partnership Recruiting:

Committee members for

1. Quality Utilization Advisory Committee/Peer Review Committee
2. Physician Advisory Committee
3. Credentialing Committee

Especially looking for specialists, mental health professionals, hospitalist.

Also especially looking for clinicians who reflect the diversity of our communities, and can bring diverse views to the committees

- All meet monthly early on Wednesday morning
- Contact your PHC Regional Medical Director if you know anyone who might be interested

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County Profiles

Profile Highlights

- **Table of Contents:**
- Enrollment & Ethnicity
- Health Status
- Quality Metrics
- Access & Telehealth
- Member Engagement
- Geographic Expansion

County Health Profile Report:
Summarizes relevant social and clinical data for Napa County from Partnership and other state and national sources. The Report helps to identify important trends and compare metrics for Napa County with other counties in the Partnership region. The Report highlights the unique strengths and challenges of each Partnership County.

Napa County Highlights

- New Kaiser direct contract with State and redetermination may decrease enrollment by 39%
- Over half of members indicate English as their preferred language.
- Achieved high QIP scores in 2022, two measures, CIS 10 and Well Child 1st 15 Months, below the State minimum performance level
- Primary care visit and ED rates slightly less favorable than Plan average
- 28% of specialty visits via telehealth
- Primary care provider vacancy ~ 25%

Eureka | Fairfield | Redding | Santa Rosa

Partnership Strategic Issues

- Geographic Expansion
- Medi-Cal Redetermination
- CalAIM Update
- MediCalRx: Pharmacy Carve Out
- Kaiser Statewide Contract
- New Core Claims Processing System

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Geographic Expansion

- 10 counties (green)
- Beginning January 2024
- Few steps left, mainly agreement on rates
- Recruiting for part-time Regional Medical Director

Medi-Cal Redetermination

Starting in April 2023: Age under 26 and 50 and older

- Beneficiaries will receive reenrollment packet mailed to their home/mailing address on the anniversary of their most recent enrollment.
- If they fail to return the packet, they may be dropped from MediCal
  - Individuals on Cal Fresh and some other programs will be auto-renewed

Staring January 2024: all ages will begin re-enrolling on their anniversary date.

- Re-determination process likely to be completed (i.e. population stabilized) December 2024.

Usual annual process continues into 2025 and beyond.

CalAIM

Major Provisions

- Enhanced Case Management/Community Supports (formerly In Lieu of Services)
- Population Health Management Services
- Supports for Justice Involved Individuals (2024)
- NCQA Accreditation (2026)
- Dual Eligible Special Needs MediCare Plan (D-SNP) (2026)

Pharmacy Carve-Out

1. Use the **Contract drug list** and make changes to your patients' prescriptions to synchronize the medications to that list before May.
2. If you as a prescriber want to have a **conversation with Magellan** about a TAR deferral to discuss the particulars of the case. Call Magellan at 800-977-2273. Especially important for urgent patient needs.
3. If an **inappropriate denial** of a medication is made, but it is not urgent, the standard process for appealing a denied TAR is to submit an appeal for the TAR adjudication results.
4. For **patients** who want to file a grievance related to the process, they should call the Magellan customer support at 800-977-2273.
5. If these options are **not yielding results**, reach out to our PHC pharmacy staff directly at 707-863-4155 to assist with getting Magellan to respond.

Policy Updates

State

- California January Budget
- State legislature: bills
- Ballot initiatives
- Partnership priorities
  - Rural health
  - Hospital maternity care
- California POLST Registry

Federal

- Regulation
  - Prior Authorization
  - Potential Changes in Race/Ethnicity categories
- Telemedicine
- Rural health

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COVID-19 Updates

- Covid-19 Therapeutics
- Covid Home Test Kits
- COVID-19 Vaccines

Paxlovid tablets

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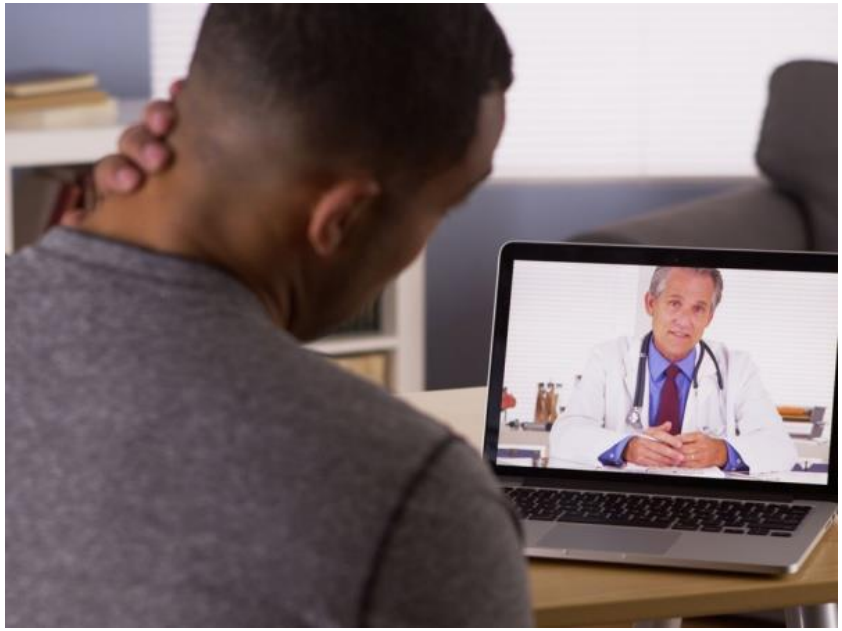
PHC Benefits and Programs

- Reminder of Prior Year Additions:
  - New Interpreter Service
  - Direct Telehealth Specialty Services
  - PHC Medical Equipment Distribution
  - Pediatric Specialty Telehealth
- BP monitors
- Community Health Workers
- Doulas
- Dyadic Services
- Street Medicine



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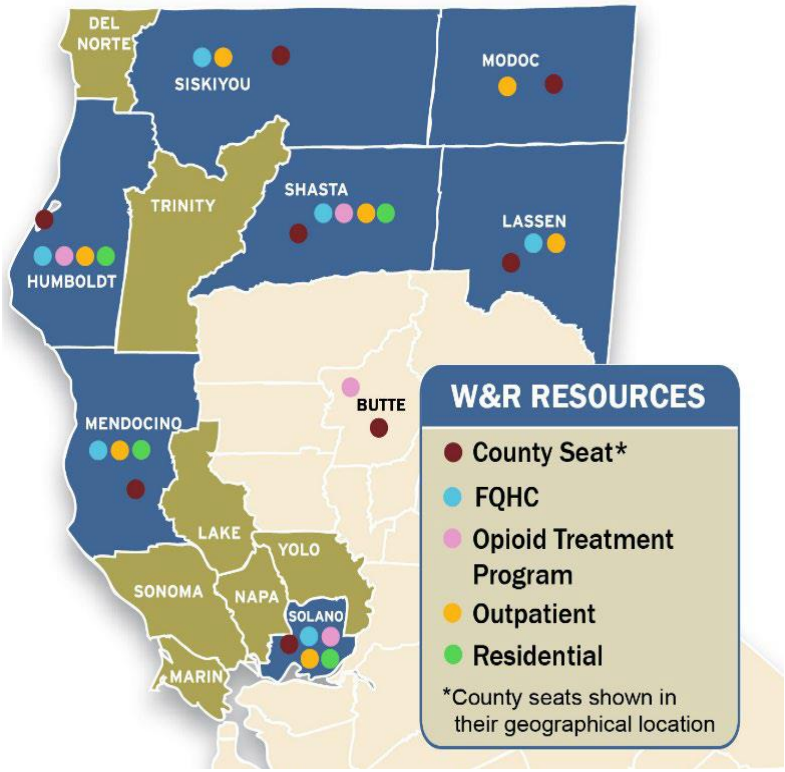
Behavioral Health Updates

- Beacon now Carelon
- Prescriber Letters
- End of X-waiver
- Wellness and Recovery
- Complex Eating Disorders
- Getting a Carelon Appointment
- UCSF Child and Adolescent Psychiatry Portal
- Psych and Neuropsych testing
- On Demand Behavioral Health: Bright Heart Health



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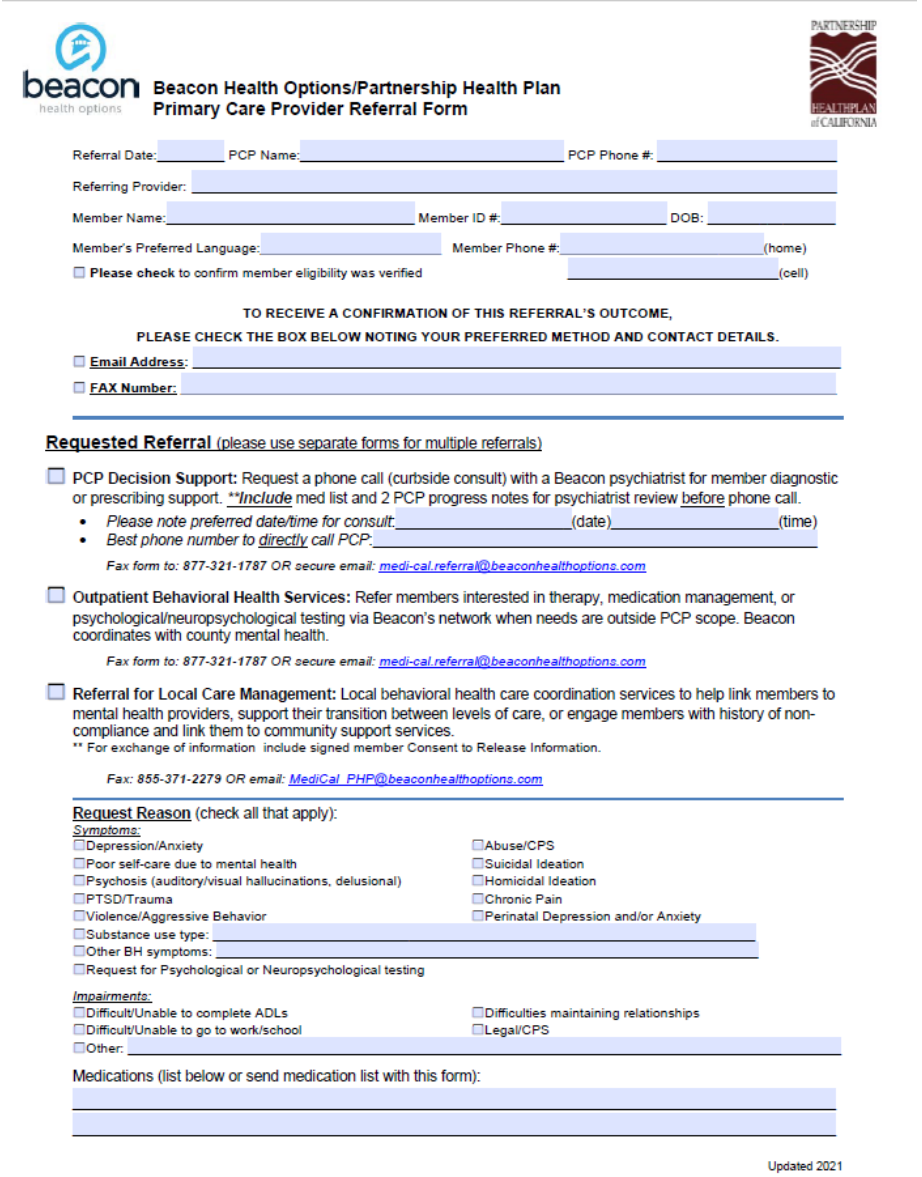
Psychological Testing and Neuropsychological Testing

- When is it recommended?
- Who benefits? Examples
  - Early psychotic disorder vs. mood disorder vs. personality
  - ADHD vs. mood disorder vs. learning disorder
  - Demential vs. mood disorder vs. brain injury
- How to refer



beacon health options

Beacon Health Options/Partnership Health Plan
Primary Care Provider Referral Form

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Referral Date:_____ PCP Name:_____ PCP Phone #: _____

Referring Provider: _____

Member Name:_____ Member ID #:_____ DOB: _____

Member's Preferred Language:_____ Member Phone #:_____(home)

☐ **Please check** to confirm member eligibility was verified _____(cell)

TO RECEIVE A CONFIRMATION OF THIS REFERRAL'S OUTCOME,
PLEASE CHECK THE BOX BELOW NOTING YOUR PREFERRED METHOD AND CONTACT DETAILS.

☐ **Email Address:** _____

☐ **FAX Number:** _____

Requested Referral (please use separate forms for multiple referrals)

☐ **PCP Decision Support:** Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support. ***Include*** med list and 2 PCP progress notes for psychiatrist review before phone call.

- *Please note preferred date/time for consult:*_____(date)_____(time)
- *Best phone number to directly call PCP:*_____

Fax form to: 877-321-1787 OR secure email: medi-cal.referral@beaconhealthoptions.com

☐ **Outpatient Behavioral Health Services:** Refer members interested in therapy, medication management, or psychological/neuropsychological testing via Beacon's network when needs are outside PCP scope. Beacon coordinates with county mental health.

Fax form to: 877-321-1787 OR secure email: medi-cal.referral@beaconhealthoptions.com

☐ **Referral for Local Care Management:** Local behavioral health care coordination services to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community support services.
** For exchange of information include signed member Consent to Release Information.

Fax: 855-371-2279 OR email: MediCal_PHP@beaconhealthoptions.com

Request Reason (check all that apply):

Symptoms:

☐Depression/Anxiety
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusional)
☐PTSD/Trauma
☐Violence/Aggressive Behavior
☐Substance use type: _____
☐Other BH symptoms: _____
☐Request for Psychological or Neuropsychological testing
☐Abuse/CPS
☐Suicidal Ideation
☐Homicidal Ideation
☐Chronic Pain
☐Perinatal Depression and/or Anxiety

Impairments:

☐Difficult/Unable to complete ADLs
☐Difficult/Unable to go to work/school
☐Other: _____
☐Difficulties maintaining relationships
☐Legal/CPS

Medications (list below or send medication list with this form):

Updated 2021

Bright Heart Health

Bright Heart Health is an On-Demand behavioral health and pain management telemedicine program providing complete wrap around services across the United States.

We assign each patient a multi-disciplinary team, consisting of:

Patients receive **comprehensive care,** including:

- ✓ Medication Management
- ✓ Counseling
- ✓ Support Services

The **Bright Heart Health Virtual Clinic** allows for 24/7 admission and can be accessed by patients and providers at https://www.brighthearthealth.com/contact-us/.

Getting treatment is as easy as 1, 2, 3:

1. Visit the Virtual Clinic or call us at (800) 892-2695
2. Complete enrollment documentation with a Care Coordinator
3. Get scheduled to see a licensed physician or therapist through Zoom

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Bright Heart Health

Bright Heart Health provides telemedicine treatment options for:

Medication-Assisted Treatment (MAT)

Comprehensive evidence-based care from a multi-disciplinary team of experts:

- Individual & Group Therapy
- Medication Management
- Life-Saving Treatment

Mental Health

Utilizing a metrics-based care model to provide comprehensive mental health outpatient care:

- Psychiatric Services
- Eating Disorder Services
- Individual & Group Therapy

Chronic Pain Program

Focuses on functional restoration by using evidence-based care for long-term pain management:

- Behavioral Therapy
- Non-Procedural Interventions
- Physical Health Interventions

We accept several methods of payment: Medicaid, Medicare, most commercial insurances, and self-pay.

For more about rates and payment options, visit the Virtual Clinic or call (800) 892-2695.

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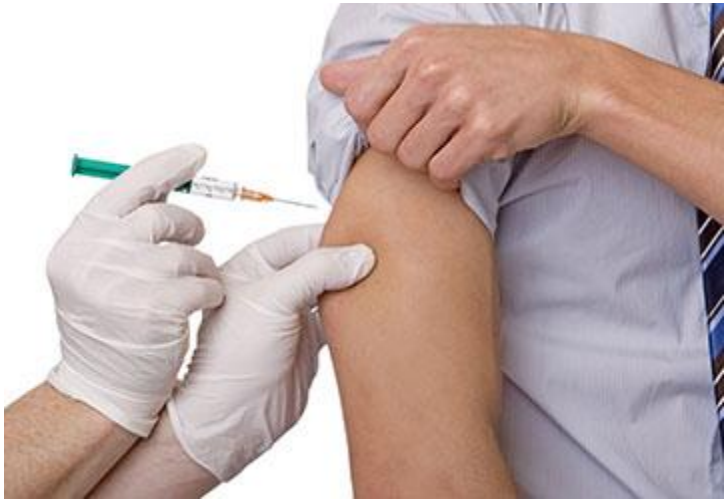
Public Health Updates

- Pediatric Blood Lead Screening
- Vaccination Rates in Pregnancy



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Blood Lead Screening

- Existing HEDIS measure (one screen between age 12-24 months)
- New MCAS measure
- New PCP QIP measure
- Quarterly List of status of all young children to PCPs
- **Recorded Webinar**

Region	2019 HEDIS rate	2022 HEDIS rate
Northwest Region	**72%**	**35%**
Northeast Region	**15%**	**24%**
Southwest Region	**52%**	**42%**
Southeast Region	**51%**	**47%**

50th Percentile: 73% (2019)
71.5% (2022)

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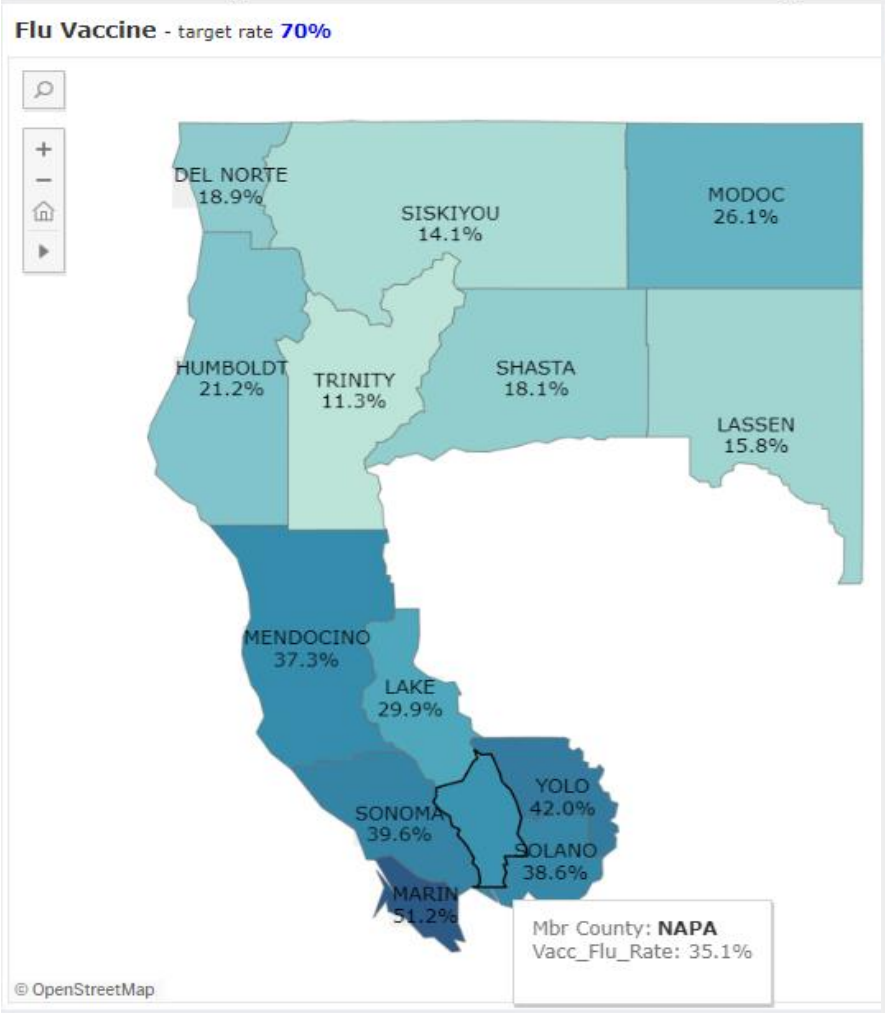
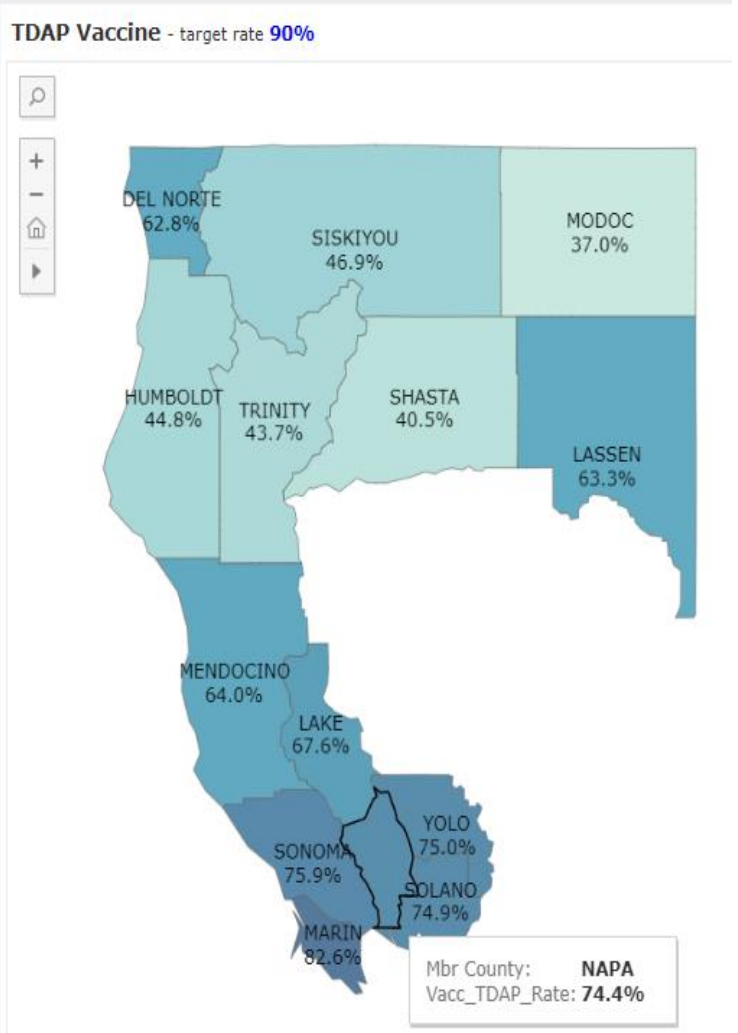
Vaccination Rates in Pregnancy: 2022

8,059 Deliveries	33.7% Flu Vaccination Rate	66.4% TDAP Vaccination Rate





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Break

Family Medicine Rotations: Rural or Specialty Rotations (like care for the unhoused or transgender care).

If you are interested in potentially having residents rotate through your office/clinic for a rotation, please email cthompson@partnershiphp.org

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Clinical Updates

- USPSTF updates
  - Aspirin
  - Syphilis screening
  - Chlamydia/Gonorrhea screening
- Vaccination Recommendation Changes
  - Hepatitis B for adults
  - Pneumococcal vaccination
  - CAIR required for all vaccinators
- Cognitive Health Assessments
- **Initial Health Appointment:** Pediatric Well-Child Care Screening Tools
- Continuous Glucose Monitors and Insulin Pumps
- Foot Care for Patients with Diabetes
- Mycobacterium Genitalium
- Clinical Practice Guidelines for Primary Care

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Health Services Update

- Transportation benefit news
- Genetic testing
- Medical Nutrition Therapy and Diabetes Education
- Care Coordination
- Intensive Palliative Care Benefit

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Reminder: Pediatric Specialty Referrals

If you have a choice of where to send patients, we recommend you select specialty centers in this order:

1. Oakland Children's Hospital
2. UC Davis Medical Center (including pediatric telemedicine pilot, which is likely to expand in the coming year)
3. Shriner's Sacramento (generally for complex surgical needs)
4. UCSF (San Francisco)
5. Lucile Packard

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CMO Updates

- Blog Articles
  - Half-life of Medical Knowledge
  - Shortage of Primary Care Clinicians
  - Collaborating to Achieve System Wide Changes
  - Peer Review
  - Domains of Health Equity
  - Knowledge Management
  - Medical Spanglish
  - Series on Diagnostic Accuracy
- Customizing the EHR for Quality
- 2021-2022 Health Equity Data

Blog: phcprimarycare.org

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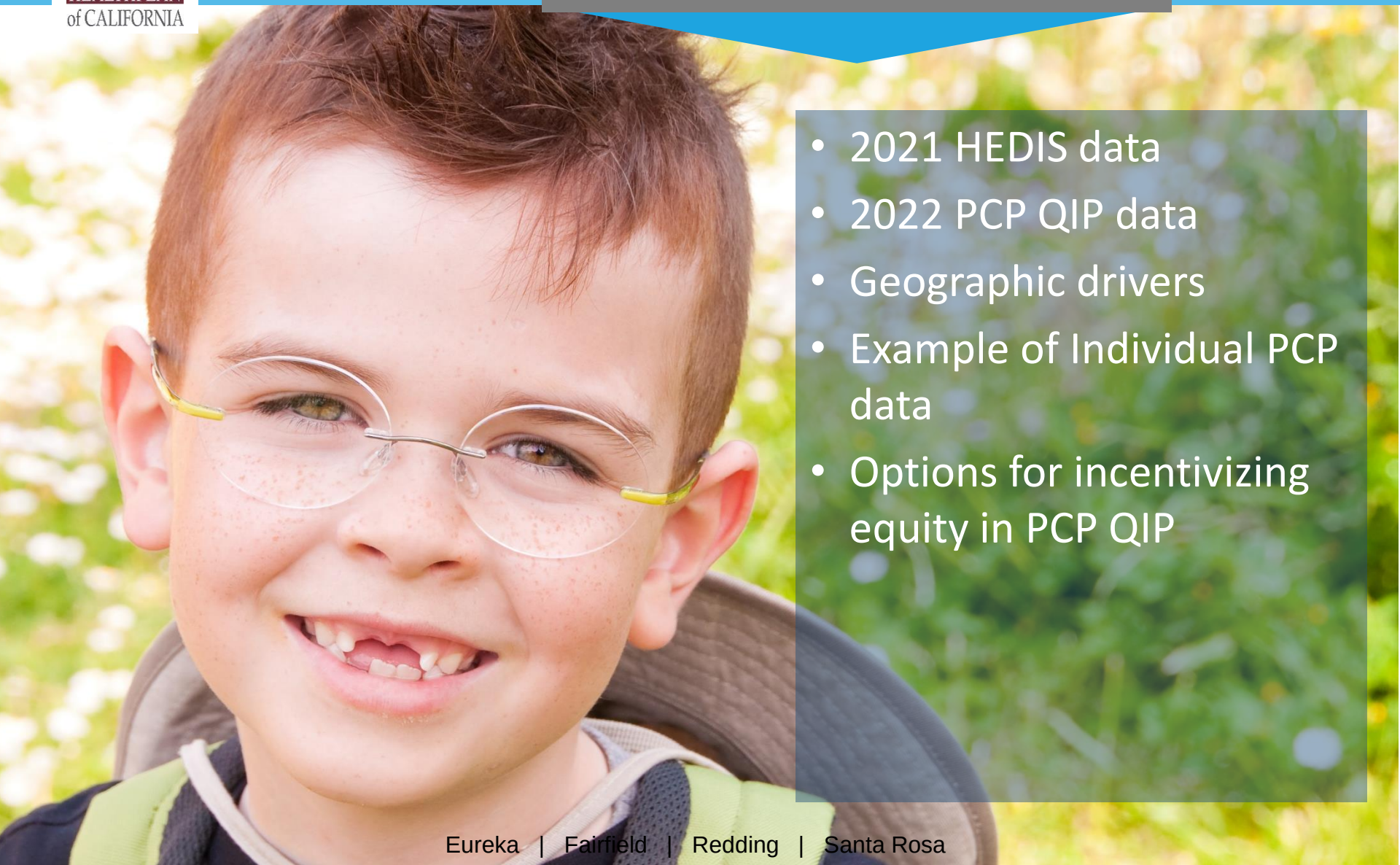
2023 Partnership Equity Data Overview



- 2021 HEDIS data
- 2022 PCP QIP data
- Geographic drivers
- Example of Individual PCP data
- Options for incentivizing equity in PCP QIP

2021 HEDIS Data

- Analysis done by DHCS
- 52 Different Measures
- Only Ethnicity and Language Analysis possible
- Performance of White Ethnicity Group is Benchmark
- Tests for statistical significance using Chi-Square or Fisher's Exact test

Important Caveats

1. 2021 was a COVID year. Step 1 is to look at 2022 data to see if any given inequity has resolved.
2. Disparities in contraceptive use are interesting and are presented, but are not outcomes/inequities per se
3. If white population scores low on a measure:
   - There may not be an *inequity*
   - But that does NOT mean the score is at target in other ethnicities

Excluded Measures

- Total Measures: 52
- Measures with no statistically significant inequities: 23
- Contraceptive use measures with inequities: 5

- Remaining measures: 24

2021 HEDIS: Hispanic Inequities

Five measures (three are also Spanish language inequities)

1. Antidepressant medication management (AMM-A and AMM-C) follow up after initiation of medication for depression, both short term and long term (Note: very incomplete data for these ECDS measures)
2. Lower rate of follow up after ED visits for Alcohol and Substance Use Disorder (Both 7 days and 30 days)
3. Lower rate of well child visits from birth to 15 months of age. (W30-6)

2021 HEDIS: Black/AA Inequities

Five measures:

1. Antidepressant medication management (AMM-A and AMM-C) follow up after initiation of medication for depression, both short term and long term (Note: very incomplete data for these ECDS measures)
2. Higher rate of visits to the emergency room (AMB-ED)
3. Lower rate of well child visits below 3 years of age W30-2 and W30-6)

2021 HEDIS: Native American Inequities

Eleven measures:

1. Antidepressant medication management (AMM-A and AMM-C) follow up after initiation of medication for depression, both short term and long term (Note: very incomplete data for these ECDS measures)
2. Lower rates Breast Cancer Screening (BCS)
3. Lower rates Controlling Blood Pressure (CBP)
4. Lower rates of screening for depression (CDF-18+)
5. Lower rates of developmental screening of infants (DEV)
6. Lower rates of prenatal and postpartum visits (PPC-Pre and PPC-Post)
7. Lower rates of well child visits from 15 months of age to 21 years of age. (WCV and W30-2)
8. Lower rates of documentation of BMI in children (WCC-BMI)

Language Inequities

- The Armenian speaking population (n=19) has a very high use of the emergency room (12% vs. 4% for English speakers)
- The Hmong speaking population (n=730) has a low rate of Breast Cancer Screening (32% vs. 47% in English speakers) and well child visits (34% vs. 42% in English speakers)
- The Tagalog speaking population has low rates of well child visits (35% vs 42% in English speakers) and visits between 15 and 36 months of age (32% vs. 55% in English speakers).
- For screening for depression and follow up in adults, **six language groups** had lower rates than the English speaking population: Hmong, Spanish, Tagalog, Russian, Vietnamese, and Chinese.

Summary
2021 HEDIS

- The largest number of inequities are in the Native American ethnicity group.
- The Hispanic and Black/AA population have a few inequities each
- No inequities were identified in the Asian and Pacific Islanders groups
- However, all the largest non-English language groups had low rates of depression screening and follow up, an ECDS measure in which data collection is somewhat incomplete

2022 PCP QIP Data

- More granular ethnicity categorization
- Larger denominator for hybrid HEDIS measures (10/12)
- Less effect of COVID than 2021
- All comparisons to white ethnicity group

2022 PCP QIP Native American Inequities

Eleven measures (out of 12)

- Asthma Medication Ration (60% vs. 66%)
- Breast cancer screening (34.4% vs. 45.8%)
- Childhood immunization (13% vs. 20%)
- Colorectal cancer screening (27% vs. 36%)
- Blood pressure control (52% vs. 61%)
- Blood sugar control (48% vs. 62%)
- DM Retinopathy screen (30% vs. 38%)
- Adolescent immunization (19% vs. 21%)
- Nutrition counseling (35% vs. 57%)
- Physical activity counseling (41% vs. 55%)
- Well child visits (48% vs. 55%)

2022 PCP QIP Black/AA

Three measures out of 12

- Well child visits (ages 3-20) (39% versus 42%)
- Childhood immunization (17% vs. 20%)
- Blood sugar control (59% vs. 62%)

Summary
2022 PCP QIP

- The largest number of inequities are in the Native American ethnicity group (10/13)
- Black/AA population has 3/13 measures with inequities
- No inequities were identified in the Hispanic, Asian and Asian subgroups, and Pacific Islanders groups

Black/AA Population

- Southern Region: 33,277
  - Solano: 24,444
  - Yolo: 2443
  - Marin: 2293
  - Sonoma: 2238

- Northern Region: 2929
  - Shasta: 1170
  - Humboldt: 1106

March 2023 Data

Well child visits for Black Children by PCP 2022

Provider Name	Ytd Numerator	Ytd Denominator	Score
Solano County Family Health & Social Services, Vallejo (1034)	165	726	22.73
La Clinica, Vallejo (11975)	218	509	42.83
Solano County Family Health & Social Services, 2101 Courage..	147	503	29.22
La Clinica, North Vallejo (18926)	225	471	47.77
NorthBay Center for Primary Care, Hilborn Rd. (17294)	131	292	44.86
Community Medical Center, Vacaville (10992)	89	241	36.93
Ole Health, Fairfield (36802)	84	178	47.19
Solano County Family Health & Social Services, Vacaville (26..	25	168	14.88
NorthBay Center for Primary Care, Vacaville (10717)	98	163	60.12
Ole Health, East Fairfield (48514)	46	156	29.49

Childhood Immunization Rate for Black Children by PCP in 2022

Provider Name	Ytd Numerator	Ytd Denominator	Score
Solano County Family Health & Social Services, Vallejo (1034)	6	56	10.71
La Clinica, North Vallejo (18926)	5	33	15.15
Solano County Family Health & Social Services, 2101 Courage..	7	26	26.92
NorthBay Center for Primary Care, Hilborn Rd. (17294)	5	22	22.73
Community Medical Center, Vacaville (10992)	5	17	29.41
La Clinica, Vallejo (11975)	1	15	6.67
Ole Health, Fairfield (36802)	2	14	14.29
Ole Health, East Fairfield (48514)	2	10	20.00
Solano County Family Health & Social Services, Vacaville (26..	1	9	11.11
Marin Community Clinics, 3110 Kerner Blvd. (22856)	2	8	25.00

DM Blood Sugar Control by PCP in 2022

Provider Name	Ytd Numerator	Ytd Denominator	Score
Solano County Family Health & Social Services, Vallejo (1034)	52	100	52.00
La Clinica, North Vallejo (18926)	59	93	63.44
Solano County Family Health & Social Services, 2201 Courage..	49	78	62.82
La Clinica, Vallejo (11975)	44	76	57.89
Community Medical Center, Vacaville (10992)	16	39	41.03
Solano County Family Health & Social Services, Vacaville (26..	21	36	58.33
Adventist Health Clearlake (26800)	23	34	67.65
NorthBay Center for Primary Care, Hilborn Rd. (17294)	21	33	63.64
Ole Health, Fairfield (36802)	19	30	63.33
Ole Health, East Fairfield (48514)	14	28	50.00

Native American Population

15,010 Total in Partnership's current 14 counties (March 2023)

- 4389 in Humboldt
- 2174 in Mendocino
- 1889 in Shasta
- 1351 in Sonoma
- 1261 in Del Norte
- 1194 in Lake
- 986 in Siskiyou
- 621 in Solano
- 326 in Lassen
- 317 in Yolo
- 230 in Modoc
- 151 in Trinity
- 76 in Marin
- 45 in Napa

PCPs with most Native American members* from highest number

- United Indian Health (Humboldt/Del Norte) 100
- K'ima:W Medical Center (Humbolt) 65
- Redding Rancheria (Shasta/Trinity) (estimated)
- Open Door CHC 61
- Consolidated Tribal (Mendocino) 48
- Sonoma County Indian Health 31
- Round Valley Tribal (Mendocino) 23
- Pit River Tribal Health (Shasta) 19
- Shasta CHC 17
- Lake County Tribal Health 18
- Mendocino CHC 16

Tribal Health Centers

*Number = Denominator for Breast Cancer Screening (only parent organizations with 15+ are shown)

Example of Disparity Data

Measure Name	NATIVE AMERICAN	WHITE
Asthma Medication Ratio	61.54	61.46
Breast Cancer Screening	29.51	39.10
Child and Adolescent Well Care Visits	37.34	35.30
Childhood Immunization Status CIS 10	6.45	25.85
Colorectal Cancer Screening	17.83	30.78
Controlling High Blood Pressure	40.00	59.14
Diabetes - HbA1C Good Control	37.93	61.33
Diabetes - Retinal Eye exam	8.62	20.76
Immunization for Adolescents IMA 2	12.50	18.56
Well Child First 15 Months	50.00	54.29

Comparing Native American to White Ethnicity Populations

Tribal Health Centers by Membership Size

- Redding Rancheria (Shasta, Trinity) 10,850
- Lake County Tribal Health 5614
- United Indian Health (Humboldt/Del Norte) 3550
- K'ima:W Medical Center (Humbolt) 1684
- Karuk Tribal Health (Siskiyou, Humboldt) 1985
- Consolidated Tribal (Mendocino) 1814
- Sonoma County Indian Health 1491
- Round Valley Tribal (Mendocino) 1062
- Pit River Tribal Health (Shasta, Modoc) 892
- Lassen Indian Health 561
- Anav Tribal (Siskiyou) 529
- North Valley Indian Health (Yolo) 421
- Warner Mountain Indian Health (Modoc) Not contracted

Only serves Native population

Membership as of March 2023

Redding Rancheria includes tribal special members

Example of Disparity Data

Measure Name	NATIVE AMERICAN	WHITE
Asthma Medication Ratio	61.54	61.46
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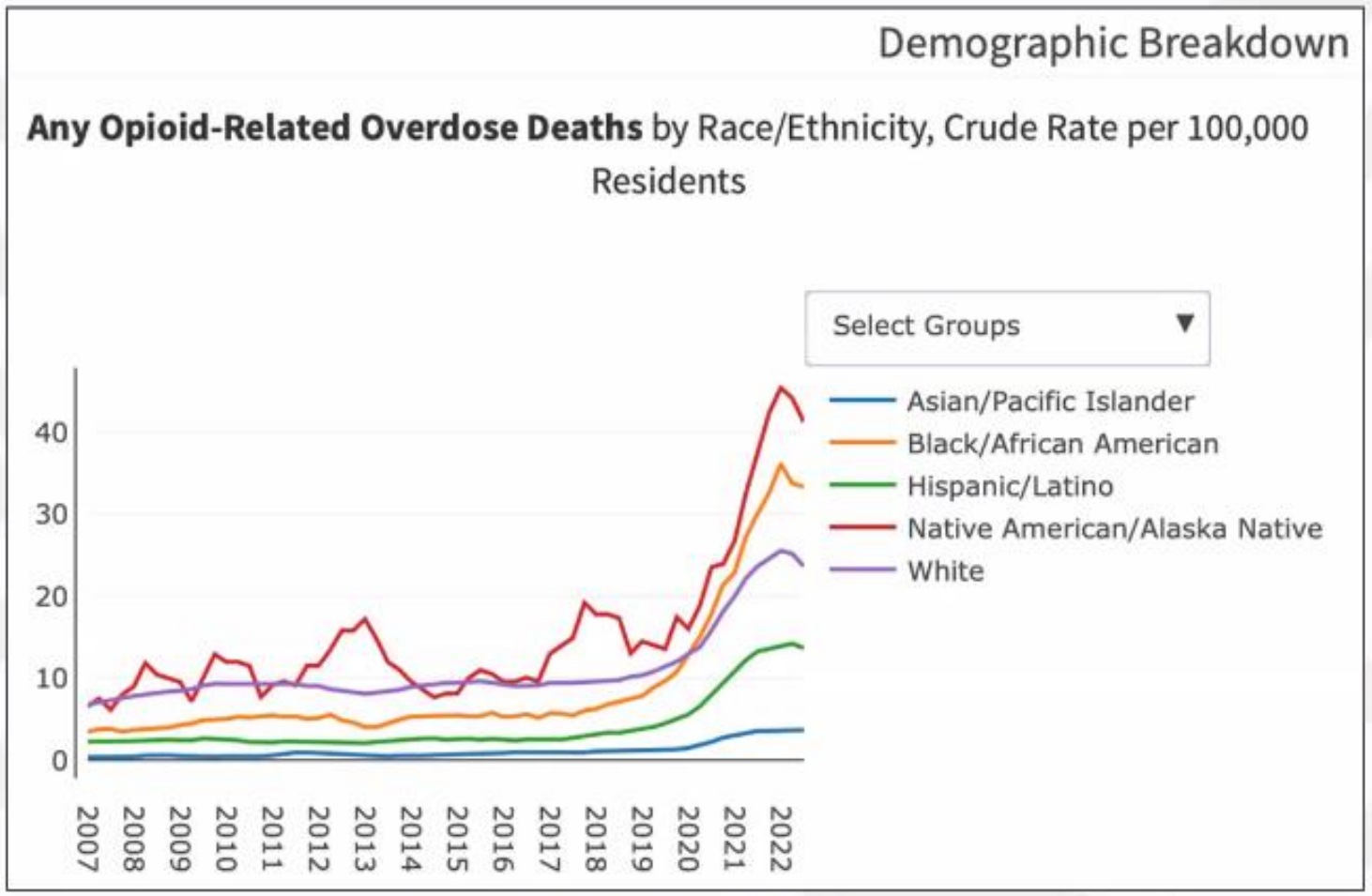
Immunization for Adolescents IMA 2	12.50	18.56
Well Child First 15 Months	50.00	54.29

Comparing Native American to White Ethnicity Populations

Other Inequities



(NIDA, 2023; CDPH, 2023)

Interventions for Equity

- Integrate elimination of an inequity into PCP QIP
- Share granular data with PCPs
- Direct member outreach
- Tribal health center leadership engagement
- Leveraging Health Equity/Practice Transformation Grants

Equity in Health Care - Provider Training Series

Together with CPS HR Consulting, the PHC Improvement Academy, is hosting a training series in which health care leaders will have the opportunity to engage in discussions to promote a greater understanding of health equity and equip them with concrete strategies to incorporate and advance health equity within their organizations.

Target Audience: Organizational leaders who are change-facilitators in their system.

Attendance: Commitment to attend all three sessions is mandatory and is limited to one individual per organization within the Partnership network. AAFP CME and BRN CE will be offered for attending this series.

Session 1 of 3: Implicit Bias
June 13, 2023, Noon – 2 p.m.

Session 2 of 3: Defining Health Equity and Strategies to Improve Organizational Practices
July 18, 2023, Noon – 2 p.m.

Session 3 of 3: Toolkit to Support Health Equity Practices
August 15, 2023, Noon – 2 p.m.

Due to limited seating, there is a brief application process required for approval to attend these sessions.
Click Here to Complete the Application

Please contact improvementacademy@partnershiphp.org if you have any questions.

Equity in Health Care - Provider Training Series

Learning objectives for each session:

Session 1 of 3: Implicit Bias

- ✓ Explain the concept and research associated with implicit bias and provide examples
- ✓ Apply strategies to minimize the impacts of implicit bias in the health care setting.
- ✓ Identify techniques for effective anti-bias communication, key in patient-centered care.

Session 2 of 3: Defining Health Equity and Strategies to Improve Organizational Practices

- ✓ Define health equity and identify ways to support organizational learning and conversations about diversity, inclusion, racial equity, racism, and antiracism into the delivery of service
- ✓ Identify opportunities to operationalize health equity strategies in your day-to-day work.

Session 3 of 3: Toolkit to Support Health Equity Practices

- ✓ Review the foundational concepts of the toolkit.
- ✓ Describe practice-level opportunities, tips, and resources to strengthen and center racial health equity in care improvement work.
- ✓ Learn ways to integrate racial and health equity into your quality improvement activities and goals.

Advancing Health Equity: Linking Quality and Equity in QI Projects

Target Audience: Quality improvement staff, team leaders, managers, and front-line staff.

Presented by: The Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)

In order to reduce health disparities and health care disparities in our patient populations, our actions must be part of a broader shift to build the culture of equity. Similar to building a culture of quality in our organizations, creating and sustaining a culture of equity takes time, teamwork, and continual attention. This webinar presents information from the Roadmap to Advance Health Equity developed by Advancing Health Equity: Leading Care, Payment and Systems Transformation (AHE). The webinar will discuss key topics including: discovering and prioritizing differences in care, outcomes, and/or experiences across patient groups; planning equity-focused projects; and measuring impact.
Planned session: Tuesday, April 18, 2023, Noon – 1 p.m.

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: cackerman@partnershiphp.org

Break

At Home Test Collection Kit Target: **Lab Corps has a program allowing at home collection of blood tests for diabetes: (Hemoglobin A1c and blood/urine test for Kidney Health Evaluation)**

If you are interested in piloting this (best if you already have an interface with Lab Corps), please contact rmoore@partnershiphp.org

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Lunch

Quality Improvement - I

- DHCS Quality Measurement Changes
- ECDS Measures
- 2022 CG-CAHPS results
- Hospital OB Measures
- PCP QIP 2023 Measures
- Discount for Initial NCQA PCMH Certification
- Calendar for Focusing on Measures

PARTNERSHIP HEALTHPLAN of CALIFORNIA

DHCS Quality Measures 2023

Adult Measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening (two measures)
- Asthma Medication Ratio (adults and children)
- Diabetes Control**
- Blood Pressure Control**

Maternity Care Measures

- Timely Prenatal**
- Post-partum visit**

Mental Health

- Follow up after ED visit for Alcohol or Drug Dependence** (30-day measure)
- Follow up after ED visit for Mental Illness** (30-day measure)

Child Measures:

- Immunizations by 2 years**
- Adolescent Immunizations**
- Well child visits in first 15 and 30 months of age**
- Child and Adolescent visits (age 3-21)**
- Lead Screening in Children
- Dental Fluoride Varnish (Non-HEDIS measures)
- Developmental Screening in First Three Years of Life (Non-HEDIS measure)

DHCS Quality Measure Changes

Adult Measures

- Colorectal Cancer**
- Adults Access to Preventive/Ambulatory Health Services
- Ambulatory Care: ED visit rate

Maternity Measures

- NTSV C-Section
- Prenatal Immunization Status (ECDS measure)
- Two Contraceptive measures

Long Term Care Measures

- Potentially Preventable Readmissions from SNF (non-HEDIS measure)
- SNF-acquired infections resulting in hospitalization (non-HEDIS measure
- Outpatient ED visits per 1000 LTC days. (non-HEDIS measure)

Behavioral Health Measures

- Use of Antipsychotic Medication: Screen for Diabetes (Adult and Children)
- Pharmacotherapy of Opioid Use Disorder
- All Cause Readmission
- ADHD Medication follow up. (Two ECDS measures)
- Depression Measures: (mostly ECDS measures)
  - Antidepressant Medication Management: Acute Phase (proposed for NCQA retirement, see below)
  - Antidepressant Medication Management: Continuing Phase (proposed for NCQA retirement, see below)
  - Screening for depression and follow up plan
  - Prenatal depression screening and follow up plan **
  - Postpartum depression screening and follow up **
  - Depression Remission and response

Electronic Clinical Data Systems (ECDS) Measures

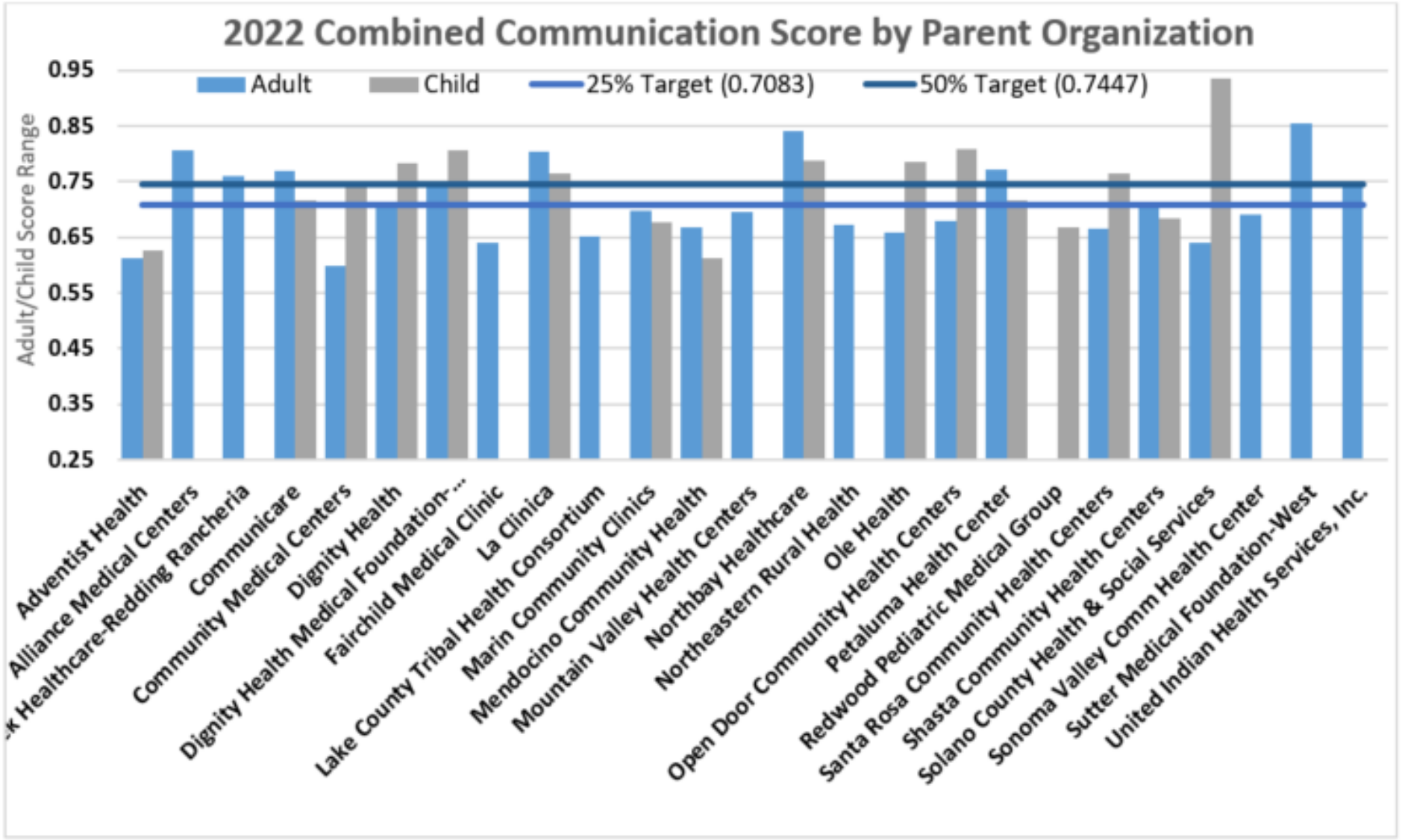
Current ECDS measures:

1. Several Depression Related Measures: (DMS-E, DSF-E, DRR-E), including screening for depression in prenatal and postpartum periods, depression screening rates, appropriate follow up for depressed individuals, and improvement depression symptoms.
2. Breast Cancer Screening (BCS-E)
3. Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

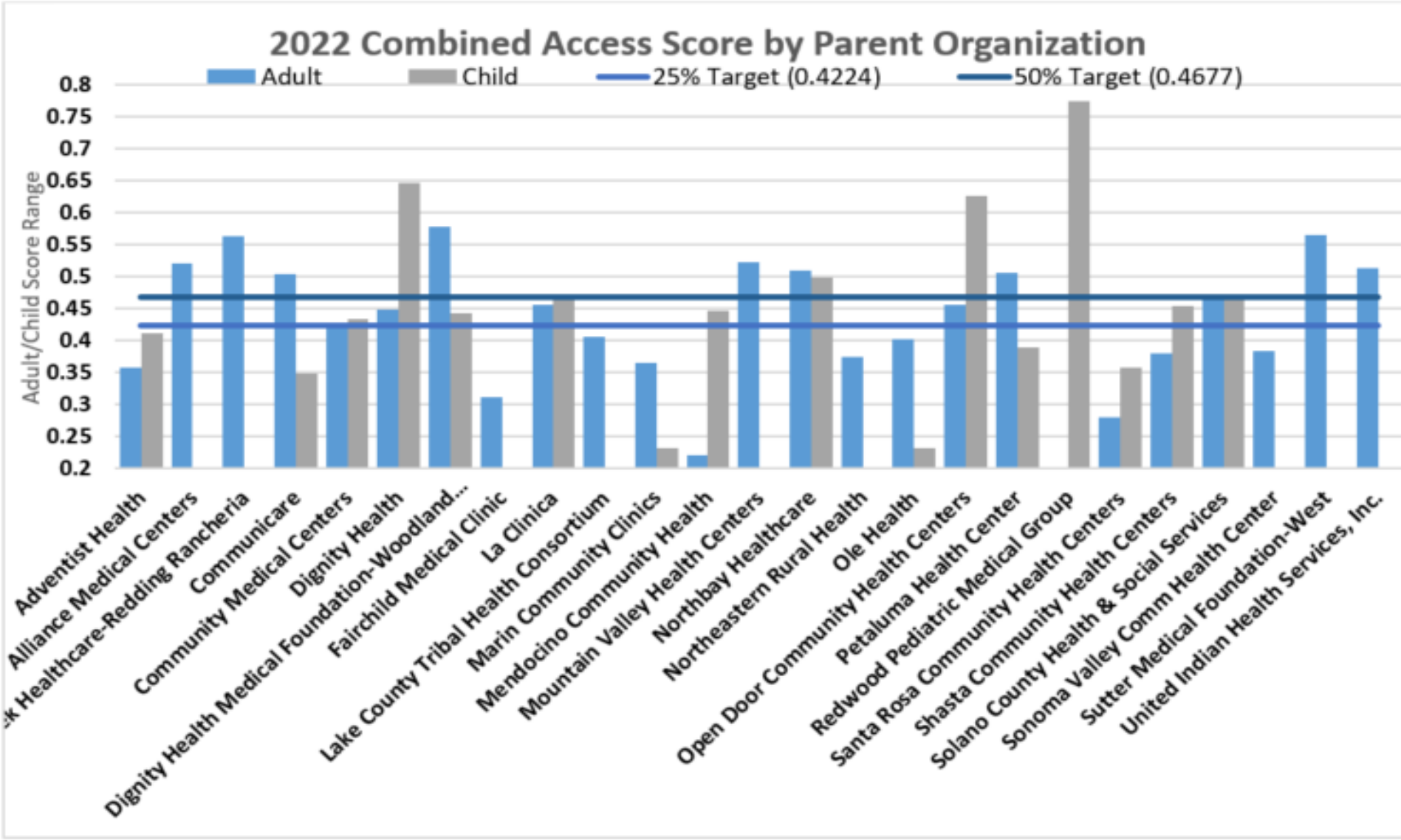
The following are new for 2022:

1. Follow up Care for Children Prescribed ADHD Medication (ADD-E)
2. Colorectal Cancer Screening (COL-E)
3. Prenatal Immunization Status (PRS-E)
4. Adult Immunization Status (AIS-E)
5. Childhood Immunization (CIS-E)
6. Adolescent Immunization (IMA-E)
7. Metabolic Monitoring for Children/Adolescents on Antipsychotics (APM-E)
8. Cervical Cancer Screening (CCS-E)

Member Experience Survey 2022



Member Experience Survey 2022



			NTSV C-Section		Breastfeeding Rate		Episiotomy Rate		VBAC Rate		VBAC Routinely Available	CNM Delivery Rate
HOSPITAL NAME	**PHC Region**	**County**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Score [%]**	**Rating**	**Yes/No**	**Score [%]**
Adventist Health Clear Lake	SW	Lake	16.7	Average	73.1	Average	0	Superior	5.6		No	0
Sutter Lakeside Hospital	SW	Lake	14.1	Above Avera	64.5	Average	0.5	Above Averag	2.5		No	0
MarinHealth General Hospital	SW	Marin	17.9	Above Avera	89.2	Superior	1.1	Above Averag	28.2	Above Avera	Yes	40.5
Adventist Health Ukiah Valley	SW	Mendocino	20.9	Average	74.7	Average	3.2	Average	11.6		No	48.4
Petaluma Valley Hospital	SW	Sonoma	26.2	Average	87.8	Above Averag	2.2	Average	18	Average	Yes	10.7
Santa Rosa Memorial Hospital	SW	Sonoma	25.9	Average	88	Above Averag	1	Above Averag	35.2	Superior	Yes	44.4
Kaiser Permanente Santa Rosa Medical Center	SW	Sonoma	26.6	Average	89.7	Superior	2	Average	29	Above Avera	Yes	52.5
Sutter Santa Rosa Regional Hospital	SW	Sonoma	20.6	Average	70.4	Average	1.1	Above Averag	0.6			3.4
Queen of the Valley Medical Center-Napa	SE	Napa	22.9	Average	83	Above Averag	1.5	Average	21.2	Average	Yes	0
Kaiser Permanente Vallejo Medical Center	SE	Solano	26.7	Average	82.9	Above Averag	0.7	Above Averag	22	Average	Yes	34.8
NorthBay Medical Center	SE	Solano	23.9	Average	83.1	Above Averag	3.1	Average	19.4	Average	Yes	0
Kaiser Permanente Vacaville Medical Center	SE	Solano	22.3	Average	85	Above Averag	1.5	Average	27.8	Above Avera	Yes	55.3
Woodland Healthcare	SE	Yolo	16.1	Above Avera	87.7	Above Averag	0.5	Above Averag	1.4		No	0
Sutter Davis Hospital	SE	Yolo	16.9	Superior	91.7	Superior	1.7	Average	30.8	Above Avera	Yes	55.7
Sutter Coast Hospital	NW	Del Norte	23.4	Average	71.2	Average	8.1	Below Averag	6.5		No	0
Mad River Community Hospital	NW	Humboldt	23.6	Average	88	Above Averag	1.3	Average	19.4		No	10.5
St. Joseph Hospital, Eureka	NW	Humboldt	23.9	Average	65.1	Average	3.1	Average	20.6	Average	Yes	22.7
Banner Lassen Medical Center	NE	Lassen	14.5	Above Avera	77.9	Average	2.5	Average	2.6		No	0
Mercy Medical Center-Redding	NE	Shasta	23.4	Average	75.8	Average	2.2	Average	1.5		No	0
Mercy Medical Center-Mt. Shasta	NE	Siskiyou	23.8	Average	78.8	Average	3.5	Average	0		No	0
Fairchild Medical Center	NE	Siskiyou	18.9	Average	80.9	Average	3.7	Average	17.6	Average	Yes	0
St. Elizabeth Community Hospital	NE	Tehama	17.9	Above Avera	74	Average	1.7	Average	2.4		No	21.2
Oroville Hospital	E	Butte	31.8	Below Averag	61.8	Average	4.7	Average	0		No	50.1
Enloe Medical Center-Esplanade Campus	E	Butte	23.2	Average	84.9	Above Averag	2.7	Average	18.4	Average	Yes	16.1
Sierra Nevada Memorial Hospital	E	Nevada	15.5	Above Avera	91.5	Superior	4.9	Average	0		No	6.7
Tahoe Forest Hospital District	E	Nevada	21	Average	94.8	Superior	2.7	Average	2.4		No	0
Sutter Roseville Medical Center	E	Placer	24	Average	76.2	Average	3.4	Average	15.1	Average	Yes	0
Adventist Health and Rideout	E	Yuba	24.8	Average	68.7	Average	2.8	Average	8.6	Below Avera	Yes	1.5

OB Hospital Measures 2021
(California Hospital Compare)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PCP QIP 2022 Family Medicine Core Measurement Set

1. Asthma Medication Ratio
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Colorectal Cancer Screening (age 45-75)
5. Controlling High Blood Pressure
6. Diabetes Good Control (HbA1c<9)
7. Diabetes Retinal Eye Exam
8. Well child and adolescent visits (3-17 year old)
9. Childhood Immunization (10 vaccine series)
10. Adolescent Immunization (3 vaccine series)
11. Well child visit first 15 months of life
12. Ambulatory Sensitive Admissions
13. Readmission Rate
14. Avoidable ED visits
15. PCP Office Visits
16. Patient Experience

PCP QIP 2023 Unit of Service Measures

1. Advance Care Planning
2. Extended Office Hours
3. PCMH Certification
4. Peer-led Self-Management Support Groups
5. Health Information Exchange
6. Health Equity
7. Blood Lead Screening
8. Dental Varnish
9. Tobacco Screening
10. ECDS

PCP QIP Updates I Preliminary Results

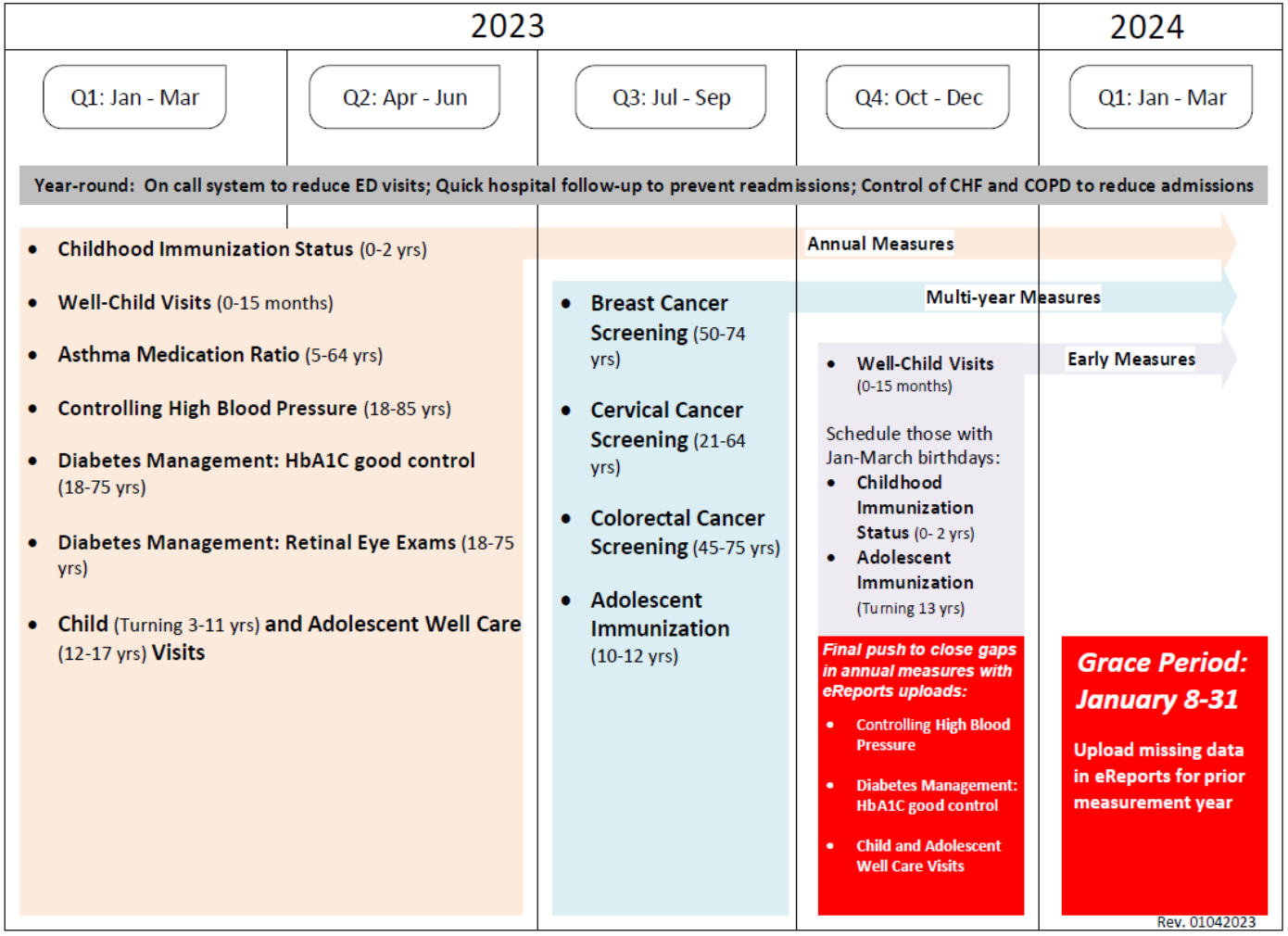
- Summary of 2022 results for clinical measures only (final scores pending non-clinical data measures)
- 2022 weighted average score (clinical measures only): 62%
- 2022 non-weighted average score (clinical measures only): 44%
- For reference, *final* 2021 weighted average score was 58% (including non-clinical measures)
- For reference, *final* 2021 non-weighted average score was 53%
- Two parent organizations are at 100%
- Eleven organizations have 90% or greater points on clinical measures. All are in Southern Region. Seven of these are FQHCs.

PCP QIP Updates II

- Modified QIP for low performers in 2022
  - Nine sites selected for intervention: at least 1000 members, scores 25% or lower on clinical measures
  - Outreach to these sites has occurred
  - Two additional sites meeting criteria deferred due to extreme organizational stresses
- At risk for 2023: 14 additional sites with >500 members, scores <33% on Clinical measures
  - Outreach in a few months
  - Many eligible for Health Equity Practice Transformation Grants

Calendar of Recommended Activities for PCP QIP

Timeline for addressing 2023 and 2024 PCP QIP Measures



Quality Improvement - II

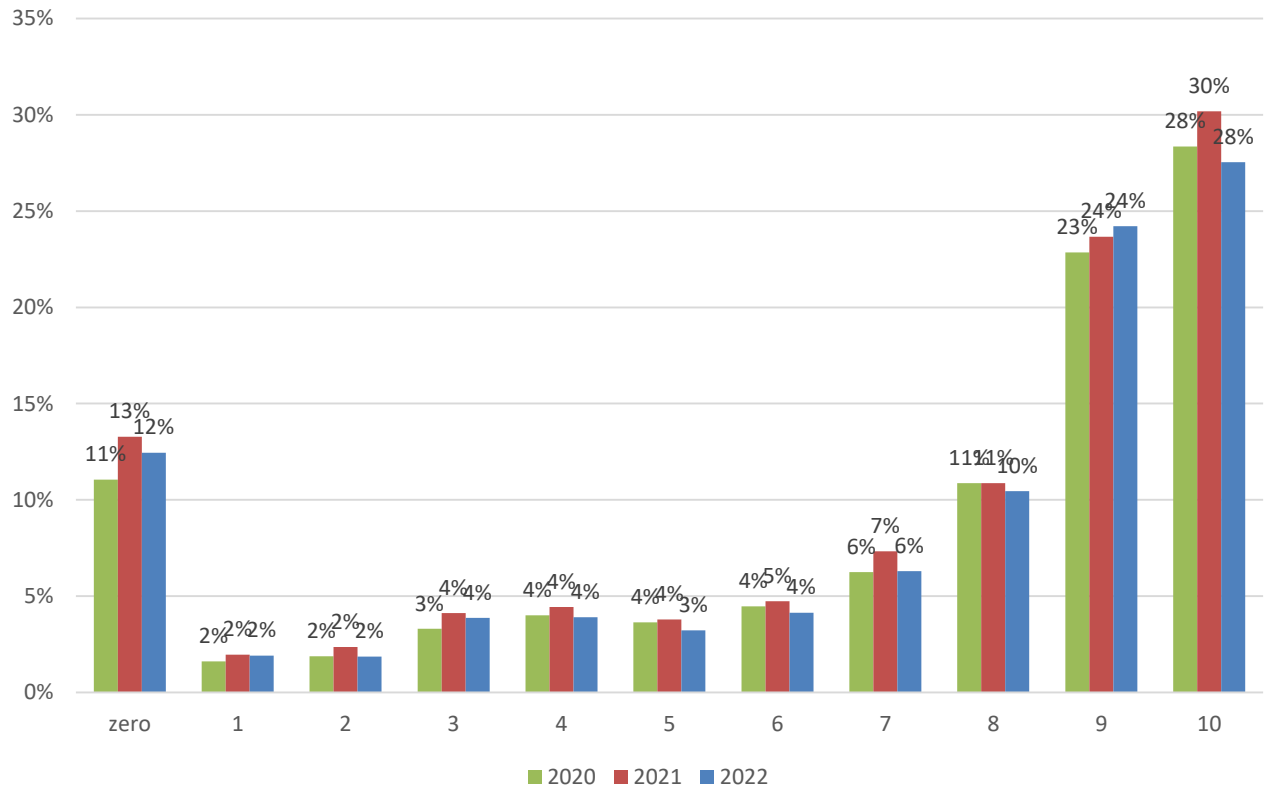
HEDIS measures of Concern:

- Childhood immunization: driven by Influenza vaccine
- Testing for Streptococcal Pharyngitis
- COPD Exacerbation
- Statin Therapy

Starting your QI Projects

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Three Year Trend in Completed Immunization Families

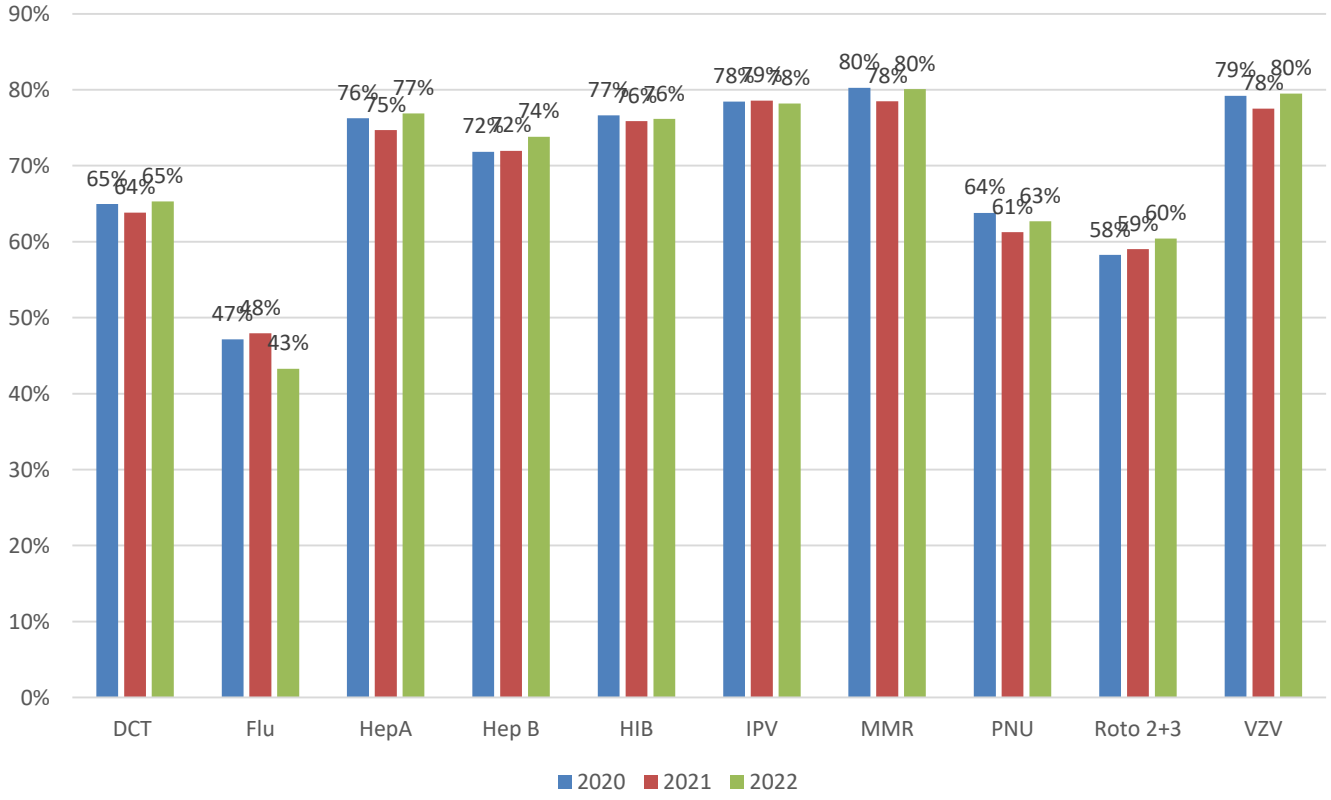


10 Vaccine Families

- Hep B (3)
- Rotovirus (2-3)
- DTaP (4)
- Hib (3)
- PCV (4)
- IPV (3)
- Influenza (2)
- MMR (1)
- Varicella (1)
- Hep A (1)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Three Year Trend - Individual Vaccine Family Completion



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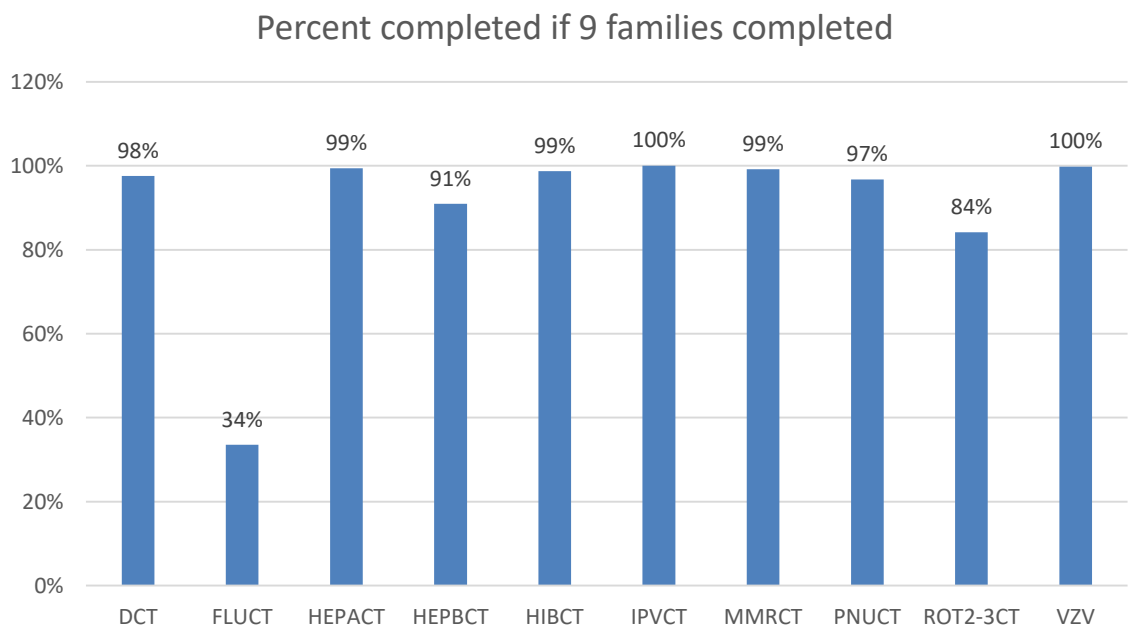
The Missing Vaccine Family in Those Completing 9 out of 10 Vaccine Families



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- IPV (3)
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- MMR (1)
- Varicella (1)
- Hep A (1)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Other Quality Updates

- Health Equity Practice Transformation Grants
- Partnership Quality Dashboard
- Developmental Screening
- ACEs Screening

Health Equity Practice Transformation Grants

- 2023 Planning grants only (guestimate: possible range $1.2 to 3 million for PHC)
  - Small to medium sized practices
  - Poor quality performance
  - High percentage of populations with inequities
- Process
  - Assessment
  - Prioritization of Focus Area
  - Select intervention strategy
  - Write plan
- State funding will flow in the next few months
  - Process must be completed by December 2023
  - PHC has ID'd target sites and begun outreach
- CY 2024: Larger grants begin
- Sites participating in Kaiser PMHI not eligible for funding (redundant process)

Partnership Quality Dashboard

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Developmental Screening

- 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.
- Rate: $59.50
- 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).
- Any claim for 96110 without a KX modifier MUST be for the use of one of these nine specified tools.
- 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.**

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Common Deficiencies During Site Reviews

- Initial Health Appointment must be completed within 120 days of enrollment
- Health Questionnaire you choose should screen for all recommended items.
- Advance Health Care Directive for all members over 18
- TB Screening- every well visit

If you have further questions or would like a 1:1 education with our nursing team please email us at:

fsr@partnershiphp.org

Upcoming Events

PHC Sponsored:

- Equity in Health Care
- ABCs of QI
- Substance Use Disorders Webinars
- Accelerated Learning Programs
- QI Training Events
- Advanced Access Webinars
- Option for Cultural Competency Training

External:

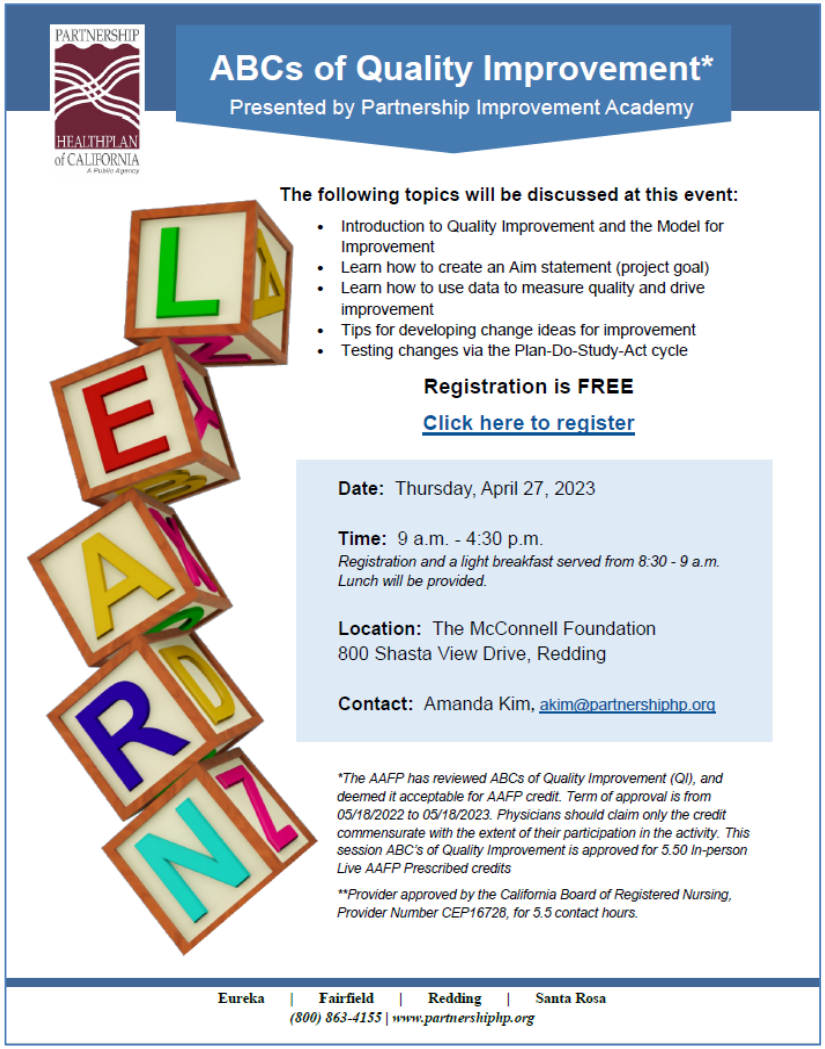
- Advancing Health Equity
- Grow Your Own Workforce
- Palliative Care Summit
- Rural Health Innovation (MPH program at UC Berkeley)
- Communication Training

Coming Soon:

- Diabetes Management

PARTNERSHIP HEALTHPLAN of CALIFORNIA

ABCs of Quality Improvement



Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: akim@partnershiphp.org

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Accelerated Learning: Early Cancer Detection: Cervical, Colorectal, Breast Cancer Screening Webinar

Accelerated Learning Webinar

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

The Accelerated Learning Series offers Quality Improvement teams the opportunity to take the next step towards improving quality service and clinical outcomes around specific measures of care. These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures with a focus on direct application on best practices with examples from quality improvement teams who are doing the work.

Sessions will be offered during the lunch hour and will be approximately 60-90 minutes in length. CME/CEs will be offered for live attendance.

Final remaining session:
04/25/23 - Early Cancer Detection: Cervical, Colorectal, Breast Cancer Screening

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

Diabetes Management - HbA1C Good Control Self-Study Webinar

of CALIFORNIA
A Public Agency

COMING SOON!

View this self-study webinar and complete an evaluation to receive CME/CE credit.

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

Topic: This learning session will cover Partnership HealthPlan of California's (PHC) Primary Care Provider Quality Incentive Program measures.

Objectives:

- Provide an overview of clinical measure background, specifications, and performance threshold definitions for the 2023 PCP QIP *Comprehensive Diabetes Management - HbA1c Good Control* measure.
- Review documentation requirements to maximize adherence and measure performance for the *Comprehensive Diabetes Management – HbA1c Good Control.*
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications, and technical tips to improve *Diabetes Management HbA1c Good Control* rates.

http://phcwebsite/Providers/Quality/Pages/Self-Study-Webinar-Diabetes-Management---HbA1C-Good-Control.aspx

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Questions and Feedback

- Suggestions for Medical Director Newsletter topics
- Let us know about system issues you encounter

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