Medical Directors Forum

Primary Care Almanac (Leadership Version)

Detailed Notes

Spring 2024

Partnership HealthPlan of California's 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 counties that we serve in Northern California.

Partnership'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.

Facilitator/Presenter
Robert L. Moore, MD, MPH, MBA, FAAFP
Chief Medical Officer
E-Mail: rmoore@Partnershiphp.org

Your Regional Medical Directors:
Marshall Kubota, MD, Regional Medical Director (Marin, Sonoma, Mendocino and Lake counties)
Colleen Townsend, MD, Regional Medical Director (Napa, Solano and Yolo Counties)
Jeff Ribordy, MD, Regional Medical Director (Humboldt, Del Norte, Trinity, Shasta, Tehama, Siskiyou, Modoc and Lassen counties)
Richard (Doug) Matthews, MD Regional Medical Director, (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Yuba counties)

Electronic versions of these notes available at:
http://www.partnershiphp.org/Providers/HealthServices/Pages/Office-of-the-CMO.aspx

Land Acknowledgement: Partnership honors the ancestral stewards of the land on which we meet today and acknowledges the displacement and lost lives due to colonization and ongoing disparities among California Native Americans.

Table of Contents

Clinicians needed to serve on Partnership Advisory Committees.

Partnership is looking for volunteers to serve on our Physician Advisory Committee, our Credentials Committee, and our Quality Utilization Advisory Committee. All meet monthly on different Wednesday mornings.

In particular, we are looking for:

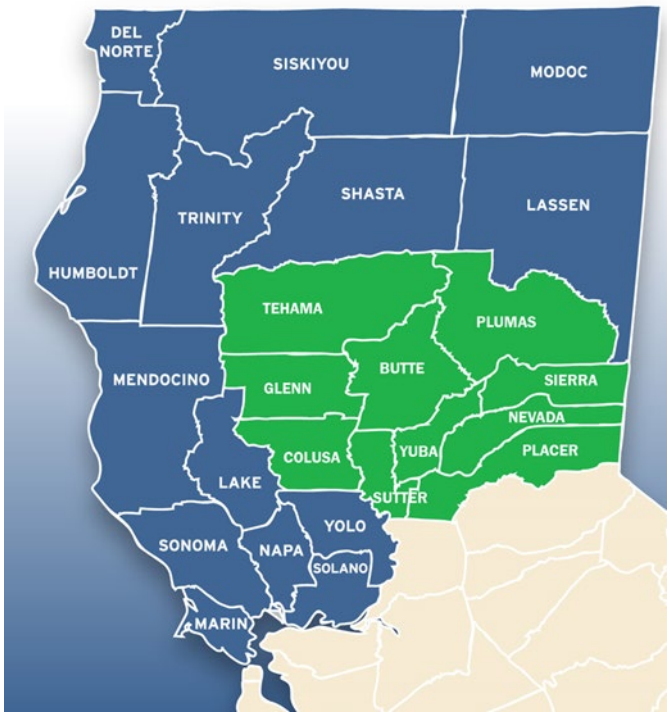
- Non-primary care specialists
- A hospitalist
- A psychiatrist, psychologist or LCSW.

We are especially looking for clinicians who reflect the diversity of our communities, and can bring diverse views to the committees. If you know of any good candidates, please email your Partnership Regional Medical director or Chief Medical Officer at the email addresses on page 1.

Partnership Strategic Issues

Geographic Expansion

On January 1, 2024, Medi-Cal beneficiaries in 10 counties north of Sacramento joined Partnership's County Organized Health System (COHS) Model. A map of the legacy 14 counties (blue) and the 10 new counties (green) is shown.



Membership is currently 915,000.

In March, 2024, Partnership had approximately 1100 employees working in 6 buildings in 4 cities: Fairfield, Santa Rosa, Redding and Eureka. New offices will be opening in Auburn and Chico in the year ahead.

In March, 2024, Partnership had approximately 1,100 employees working in 6 buildings in 4 cities: Fairfield, Santa Rosa, Redding and Eureka. New offices will be opening in Auburn and Chico in the year ahead.

Partnership Board of Commissioners

A County Organized Health System is formally authorized by the County Board of Supervisors in each county in which they serve, which also approves its governance structure and selects representatives to serve on the Board of Commissioners. Partnership is a Commission of the State of California. It is a multicounty government joint organization, governed by many rules of government, with a contract with the State of California through the California Department of Healthcare Services (DHCS).

The full board membership will be about 40 Commissioners altogether, including three Consumer At-Large Members from the North, South and Eastern Regions, and at least one representative from each of the 24 counties. The counties with the largest number of Medi-Cal enrollees will have extra Board representation, as determined based on enrollment on January 1 of each year. Here is the board composition for 2024:

County	Enrollment (Jan. 1, 2024)	Board Seats
Butte	86,573	3
Colusa	10,769	1
Del Norte	12,521	1
Glenn	13,851	1
Humboldt	60,115	3
Lake	35,056	1
Lassen	8,893	1
Marin	46,899	2
Mendocino	41,591	1
Modoc	4,068	1
Napa	27,646	1
Nevada	29,210	1
Placer	59,438	2
Plumas	6,003	1
Shasta	70,694	3
Sierra	867	1
Siskiyou	19,066	1
Solano	103,366	3
Sonoma	109,619	3
Sutter	44,197	1
Tehama	32,021	1
Trinity	5,687	1
Yolo	55,679	2
Yuba	36,913	1
Consumer At-Large	-	3
Total	**920,742**	**40**

The Board of Commissioners meets six times per year in an open meeting governed by the California Open Meeting Act (Brown Act of 2003, updated by Bagley Keen Act of 2023 to allow certain types of virtual meeting participation). The Board of Commissioners hires and oversees Partnership's CEO, who is currently Sonja Bjork, JD. The current chair of the board is **Kim Tangermann**, Director of Yolo County Health and Human Services, and the vice chair is **Dean Germano**, community member from Shasta County.

Terminology

Partnership HealthPlan of California may be shortened to Partnership in this document.

Credentialing Primary Care Clinicians at Partnership

Detailed policies listing credentials requirements can be found in credentials policies retrievable on our website, particularly MCCR17.
For primary care physicians, they include:

- An unrestricted California license
- Either
    - Minimum 2 years of residency training in a primary care residency (Family Medicine, Internal Medicine, Pediatrics). Rotating internships may count, depending on content
    - The alternative pathway noted below.

The "alternative pathway" includes:

- One or both of the following:
    - Adult care - UC San Diego Retraining and Reentry Program
    - Pediatric care – University of Texas KSTAR/UTMB Health mini-residency in Pediatrics
- Even after completing one of these trainings, credentials may exclude prenatal care, and women's health care
- Subscription to "UpToDate"
- Supervision x 12 months – with quarterly reporting
- Post-credentialing medical chart review by Partnership

Health Policy Updates

PCP and Specialty Access

Federal Policy: A substantial driver for limited access to primary care physicians and specialist physicians are 1990s era federal policies which shrank inflation-adjusted Medicare rates by 30% over the last 25 years, and

froze federally funded residency programs.

1. Medicare Rates: An absolute top priority for all physicians and anyone trying to improve clinician access is to convince the U.S. Congress change the Medicare reimbursement system from automatically generating cuts to physician rates to one that inflation-indexes future rates (H.R. 2474). Related to this, short-term relief by actually generating Medicare rate increases is also important (H.R. 6683). Physicians should coordinate communication with their elected representatives with the American Medical Association, being sensitive to how legislative staff respond to arguments that paying physicians more is key for specialty access.
2. Graduate Medical Education: A dramatic increase in funded GME slots nationally is needed in specialties with the greatest shortages (gastroenterology, cardiology, rheumatology, endocrinology, ENT, neurology) as well as for primary care (H.R. 2389 and S. 1302).

Important note: The American Medical Association has been unsuccessful in advocating for these changes for the last 25 years. One reason that has been cited is that physicians going to Washington to meet with low-paid congressional staffers are not very effective at gaining sympathy for their cause. Federally Qualified Health Centers and Tribal Health Centers present a more compelling case, and have been more successful in having their rates keep pace with inflation than private physicians. As local specialists become scarce, health centers have increasing difficulty in finding local specialists to care for your patients, and the situation is likely to get worse in the years to come.

For this reason, although health centers are not paid based on the FFS Medicare fee schedule, they need to mobilize support for the measures above. Their effectiveness in advocating for reversing the effects of the stagnant Medicare rates and Graduate Medical Education slots, based on the effects on their underserved populations that they serve, may provide the support critical to making fundamental changes.

State Policy:

DHCS plans to increase specialist rates for Medi-Cal starting in 2025, but this increase is susceptible to decrease if the state encounters a budget shortfall. For this reason, a ballot initiative is planned for November, 2024 that would lock these into place for the future.

Managed Care Tax (MCO Tax). Starting this past January, 2024 Managed Care plans in California were taxed to help cover the cost of increasing payments through the Medi-Cal program. While many stakeholders were successful at being included in the list of MCO tax covered rate increases, others were left out. Here is what is covered, according to a CMA summary:

Starting in 2024

1. Primary care rates outside of FQHC/Tribal Health/Rural Health Centers.
2. Mental health rates outside of health centers.

3. Maternity Care rates outside of health centers.
4. Money for residency expansion for primary care and specialty care

Starting in 2025

1. Specialist rates
2. Emergency medicine physician rates and emergency department payments
3. Emergency ground transportation
4. Money for health workforce initiatives.
5. Inpatient psychiatric beds
6. Public Hospitals
7. Distressed Hospitals
8. Family Planning services

Access to Maternity Care

In the past 9 years, ten hospitals in the current Partnership service area have stopped providing maternity services. All those that closed had less than 500 deliveries per year, were struggling financially, and had difficulty covering the nursing, anesthesia, pediatric and obstetrical staffing needed to keep a maternity unit running continuously.

Partnership hosted a conference to look into this issue in more detail, to understand the drivers and the policy options to stop this trend. To find a recording of that conference and copies of the slides, scroll down on the Office of the CMO webpage: https://www.partnershiphp.org/Providers/HealthServices/Pages/Office-of-the-CMO.aspx

Based on this conference, the following state policy priorities are identified:

Budget neutral:

1. Pass state legislation to allow a hospital to have a standby perinatal service, as needed for the proposed Plumas model to come to fruition.
2. Pass state legislation to allow Medi-Cal to contract with Alternative Birth Centers that are either licensed or accredited.
3. Change regulations to allow smaller rural hospitals to accept more nursing students for clinical rotations.
4. Change policy at UCSF that requires professors in the Nurse Midwifery Training program to all have a doctorate.

Moderate budget expense:

1. Establish an office of rural maternity access reporting to the Director of the California Department of Health and Human Services. This office would closely track the maternity services at hospitals with low maternity volumes and bring customized support to them to preserve access.
2. Fund (through HCAI or UC Davis Nursing School) a rural RN training curriculum/training network, including a rural nursing residency, to train

nurses skilled in a wide range of nursing roles in rural hospitals.

More costly:

1. Revise hospital financing for distressed hospitals to ensure support for keeping rural maternity units open. This may include payment to cover standby services needed for staffing the maternity unit that is not actively being used. Another option is the Maryland Total Cost of Care/global fixed hospital reimbursement model, which would face considerable political headwinds.

Additional Activities being supported by Partnership

1. Educational programs in each community (centered on a hospital):
    a. Neonatal airway management
    b. Advanced Life Support in Obstetrics/Basic Life Support in Obstetrics, with provision of a low cost birth kit for cars.
2. Converting the specifications for the California Perinatal Services Program (CPSP) to a new Partnership Perinatal Services (PHPS) set of services.
3. Tribal Perinatal initiative and other Birth Equity population of focus for Enhanced Care Management.
4. Track California Maternal Quality Care Collaborative (CMQCC) efforts to analyze outcome data based on maternity unit closure.
5. Spread the four major reframing ideas to multiple audiences.
6. Create an infrastructure for home birth reimbursements.
7. Capture and promote standardized template protocols and procedures for hospitals with low volume OB, based on best practices.

Perinatal Services: Transition from CPSP to PHPS

The Comprehensive Perinatal Services Program (CPSP) was created 40 years ago, to reduce the incidence of low birthweight neonates, with associated higher risk of morbidity and mortality. Core elements of CPSP are:

- Case Management
- Nutrition Counselling
- Mental Health Assessment and Counselling
- Health Education

The CPSP program was built based on a pilot program, showing a decrease in low birthweight, and was passed into statute in 1984 by the California Legislature. For the first 30 years, it was administered at the local level by County Health Departments with some state funding. County Health Departments accepted applications for new CPSP sites and oversaw the quality of those programs.

During the COVID pandemic, state funding and staff attention for County Maternal and Child Health services was diverted to COVID response. Somewhere along the way, CDPH leadership re-interpreted the CPSP program

to be only applicable to fee for service Medi-Cal beneficiaries, in spite of lack of language to that effect in the enabling legislation and multiple references to the CPSP program in Medi-Cal Managed Care Plan policy documents.

In February, 2024, the California State Auditor issued a report on the CPSP program, taking the California Department of Public Health (CDPH) and the California Department of Health Care Services (DHCS) to task for insufficient oversight and data collection related to perinatal support services. In response to the audit, DHCS indicated that responsibility for oversight of perinatal services according to the CPSP standards in the Medi-Cal Managed Care system was now a Managed Care Plan responsibility, and indicated new policy statements and requirements would be forthcoming. It appears that MCPs will be granted flexibility in program details compared to the enabling legislation, if the core services that CPSP requires are covered, available, and the quality ensured.

One coming requirement is for MCPs to officially remind all primary care providers and perinatal care providers that all pregnant Medi-Cal persons intending to continue with their pregnancy should be encouraged to enroll in a CPSP program or a "CPSP-like" program early in their pregnancy. These should include all four core elements of CPSP programs: case management, nutrition counseling, mental health counseling, and health education.

Partnership has found that the decreased county oversight of CPSP programs, combined with staffing strains associated with the COVID pandemic, have led many CPSP programs to now have key gaps in their core requirements that need attention. Many rural areas do not have any sort of CPSP program, and the rate of referral to available CPSP programs is lower than optimal, for logistical and regulatory reasons.

For all these reasons, Partnership is planning a major re-boot of the way perinatal services are provided in our service area, taking advantage of the flexibility offered by DHCS to adapt the CPSP standards to bring them up to date, make them less rigid and more adaptable, to bring the benefits of this program to more women. This will be combined with an oversight mechanism that is agile yet creating accountability for the quality of the services provided.

Our tentative name for this updated CPSP program is the Partnership Perinatal Services program.

Policies and procedures are in development, but here are some early ideas requested by stakeholders:

1. Use the existing CPSP codes to allow payment and to gather data on utilization of different service categories in the PHPS program.
2. Update the eligibility criteria for the different categories of CPSP staff, potentially including certified nutritionists, marriage and family therapists, community health workers and doulas.
3. Leverage newer evidence-based assessments into the standardized

assessment process (ACEs screening, 4 Ps Plus, depression screening standards)
4. Allow virtual options for PHPS services
5. Develop a modular approach to PHPS services so programs can share virtual options to create a complete program.
6. Develop updated training standards.
7. Develop a streamlined system for Partnership to approve and contract with PHPS programs/sites.

Over the next few months, Partnership will convene stakeholders to vet these ideas and develop the framework for our program.

Rural Health Policy

Inequitable Policies for Rural Californians: Structural Urbanism

Between 85-95% (depends on definition used) of all Californians live in an urban or suburban setting, including individuals who develop the regulations in various state departments, so much of the legislation and policy in California is written with an urban or suburban point of view. Inequitable health outcomes associated with rural residence are currently of equal or greater magnitude than ethnicity-associated inequities. Although poverty exists in both cities and rural areas, a higher-density of clinicians, patients, and support services provide urban/suburban areas with more governmental and community resources and funding to help address underlying economic drivers of inequitable health outcomes.

Health policies and funding streams written to apply to both urban and rural areas of California are often written to be not implementable in rural areas, leading to exacerbation of rural inequities. Health outcomes of American Indians in rural California have the highest rates of inequity, so that any policy that is inequitable from a rural perspective, is also inequitable from a California Indian perspective, with an effect that multiplies their historic trauma and discriminatory policies.

Health-related policies that systematically, if unintentionally, disadvantage residents and health care providers in rural areas is a reflection of “Structural Urbanism,” which lead to poorer health outcomes.

Just as intentionality and awareness of implicit bias is needed to address Structural Racism, so too is intentional policy analysis needed to ensure that health policy and regulations are not perpetuating inequities for rural Californians, including Native Americans.

Actions to address Structural Urbanism in health care

1. Join and be active in advocacy groups that represent organized health care professionals and organizations. For physicians, it is essential that state-wide organizations, like the California Medical Association consider and account for a Rural Health perspective as part of their legislative and regulatory advocacy activities. The same is true for organized nursing, physician assistants, midwives, hospital associations, etc.

2. Work with your local legislators to support specific State legislation requiring the following:
    a. As State departments develop regulation, a rural analysis must be performed that identifies any challenges in applying the policy equally and equitably in rural communities. This analysis should include direct feedback from key advisors and associations that represent rural communities.
    b. If a challenge affecting rural application is identified, the policy shall be amended to equitably impact rural areas, with accommodations in regulations and requirements that remedy these challenges. When necessary, this may include a higher level of funding for rural areas compared to urban areas so that the policy can be applied equitably.
    c. The documentation of each policy that is promulgated attests that the above process has been followed.

References:

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Improving Health Outcomes in California Indians

As noted in the equity section, clinical quality outcomes in the self-identified Native American population is the largest category of ethnicity inequity. Two thirds of Native American members are cared for by tribal health centers; most of the remaining one third are cared for by one of the larger Federally Qualified Health Centers.

Partnership's major strategy for eliminating these inequities starts with a deep engagement with our tribal health centers and tribes. The goals are to build trust and to strengthen the economic, infrastructure and leadership capability of tribal health centers.

Areas of engagement currently are:

1. In-person relationship building
2. Annual joint meetings to discuss larger strategic issues.
3. Engagement around quality outcomes.
4. Tribal perinatal initiative.
5. Building tribal consultation into the change process.
6. Tribal-specific approach to supporting Tribal Health Centers that are part of the Equity-Practice Transformation program.
7. Training Partnership Staff on the history of California Indians and the legal and financial policies affecting tribal health centers.

Partnership has designated Yolanda Latham (Hupa, Chilula) as our Indian Health Service Liaison. She can be reached at triballiaison@partnershiphp.org

Grievance and Appeals Process

Grievances and appeals are divided into **member** grievances/appeals, in which an individual member is involved, and **provider** grievances/appeals in which the member is not involved. When a provider files an appeal for a prior authorization denial, this is considered to be a **provider-on-behalf of a member** appeal.

Provider Grievances

Formal provider grievances that are not on behalf of the member are typically related to payment disputes. There is a formal provider grievance process with specific timelines. Informal complaints or inquiries not relating to member care are referred to the best person to respond, within Partnership departmental leadership, escalating to Executive Leadership as needed.

Member Grievance/Appeal

Partnership considers **any** expression of dissatisfaction from a member to be a grievance, i.e., any complaint is considered a grievance. However, investigation and documentation processes are less for complaints or exempt or informal grievances, compared to formal grievances.

All PCPs are required to provide access to Partnership grievance forms in their office. They can also be found on our website.

If a grievance involves a named provider organization or clinician, we may reach out to your organization and/or clinician, as part of our investigation, to get copies of medical records or to hear your side of the issue that was raised.

An appeal of a denied Prior Authorization request/TAR is tracked and handled as a sub-type of grievances from an administrative perspective. In other words, all appeals are considered formal grievances, but not all grievances are related to appeals of denied services. The most common types of grievances are related to:

1. Quality of Service, including disagreements over treatment plans, behavior issues with office staff, issues stemming from miscommunication between a provider and the Partnership member.
2. Access issues, including difficulty getting through to the office on the phone, a prolonged period of time before the member can be seen or cared for, and long waiting times in the office for appointments.
3. Billing issues, most commonly related to patients receiving bills for items covered by Medi-Cal.
4. Quality of Care concerns, including allegations of discrimination by a clinician, and any other concern about the quality of care provided, whether attributed to an individual provider or to the system itself.
5. Appeals of denied prior authorization requests
6. A report of discriminatory practices. Partnership is required to review grievances related to discrimination to consider if the member was treated differently due to race/ethnicity, language, sexual orientation, gender or disability status. In cases of grievances in which the information available shows that discrimination was likely to have occurred, Partnership will send a letter to the practice/provider and also must report this to DHCS.

See the Prior Authorization/TAR topic and the Peer-to-peer sections for more details on the appeal process.

Potential Quality Issues and Peer Review

What is a Potential Quality Issue (PQI) and how are they identified?

A PQI is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern or opportunity for improvement exists. Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to:

- Complaints, grievances, and appeals
- Utilization review
- Claims and encounter data
- Care coordination
- Medical record audits
- Facility site reviews
- Referrals from other health plan staff, providers, and members of the community

What happens when a PQI is identified?

A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

After investigation, when a Partnership Medical Director determines that a significant lapse in quality has occurred, the case is referred for review to the Peer Review Committee (PRC). The PRC includes external practitioners (representing PCPs and board certified specialists) and internal Partnership physicians, nurses and pharmacists. The PRC investigates member or practitioner complaints about the quality of clinical care provided by Partnership contracted providers and makes recommendations for opportunities for improvement and/or corrective action plans, some of which may be required to avoid further actions by the health plan. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

How can a PQI be referred?

1. Partnership Health Plan external website->Providers->Quality & Performance Improvement->Patient Safety-Potential Quality Issues

2. You can email PQI@Partnershiphp.org. Remember to encrypt any patient identifying information you send by email.

What s “Carved-Out” to DHCS or Counties?

1. Dental benefit (Partnership covers dental anesthesia, jaw MRI and a

few oral maxillofacial services, such as jaw trauma and cancer-related services)
2. Serious mental illness, especially inpatient hospitalization (but Partnership partially covers eating disorder treatment, see below)
3. Substance use disorder treatment (outside the 7 county Wellness and Recovery pilot, see below; Partnership also covers medical problems caused by SUD and medical exams conducted in conjunction with admission to a SUD detox program)
4. Pharmaceutical and related supplies, provided through community pharmacies, such as blood glucose monitors and vaccinations (some exceptions are on our direct distribution program, see below). In addition, all medications specifically for HIV treatment or prevention and for hemophilia are carved out to DHCS, regardless of where administered.
5. CCS services for the 10 new counties for 2024 (Partnership has responsibility in current counties, through the Whole Child Model).
6. COVID vaccines are covered by DHCS for all settings.

Partnership Website Highlights for Clinicians

The Partnership website is packed with useful references and resources. We recommend bookmarking the launch page in your internet browser: http://Partnershiphp.org

Website highlights include:

- Links to the **PCP QIP** and all other pay for performance programs:
  - Providers>Quality>Quality-Improvement-Programs
- **Links to all Partnership Policies**
  - Providers>Providers>Provider Manual>Medi-Cal Provider Manual
  - Using our search function may find a particular policy faster
- **Locating contracted specialists** in our Provider Directory
  - Providers>Providers>Provider Directory
- **Community Resources,** by County
  - Community>(select your county)

Other website links will be given elsewhere in this document, related to specific programs.

Monthly Newsletter for PCP Clinical Leaders

The Partnership CMO, Robert Moore, MD, produces a monthly newsletter targeted to Clinical Leaders of Primary Care Practices, although others are welcome to subscribe. We have included an option to subscribe to the monthly newsletter on the sign-up sheet for the in-person orientation session. To sign up other clinical leaders in your organizations to the newsletter, email Dr. Moore at rmoore@Partnershiphp.org or Sarah Browning at

sbrowning@Partnershiphp.org

Past newsletters can be perused on our website at: Partnership website.

Primary Care Blog

Timeless lead articles from the Medical Director Newsletter are also put on the Partnership Primary care blog: http://phcprimarycare.org, Content goes back to 2012. You can review the older articles without subscribing, or you can subscribe if you want to be notified when new articles are posted. Comment posting is turned off, so if you have comments, send them directly to a Partnership Medical Director.

Benefits Updates for Partnership Members

Pharmacy Services for Partnership Members

The state pharmacy carve-out, known as Medi-Cal Rx went live in January 2022. As a result, DCHS directly administers most of the pharmacy benefit, in

Be sure any new clinicians who join your practice sign up for CoverMyMed and have access to the TAR processing system set up by Magellan/DHCS, to allow them to submit TARS more expeditiously. The primary methods for TAR submission is fax, the Magellan Provider Portal, and CoverMyMed (CMM), a commercial online platform for drug prior authorization. Most prescribers and pharmacies are using CMM as the platform for completing TARs. However, pharmacies can only initiate the TAR on CMM and are blocked from submitting the TAR to Medi-Cal. Under Medi-Cal Rx, only the prescriber can submit the TAR to Medi-Cal through CMM. If you receive a notification from CMM or the pharmacy to complete a TAR, please complete the TAR on CMM and submit to Medi-Cal. You can also print out the form and fax the TAR directly to Medi-Cal at 800-869-4325.

Magellan is responsible for fielding calls from both members and providers for problems they encounter. If you or your patients find this system is not working in individual cases, please contact Partnership to assist. Resolution through Magellan should always be pursued first. Here are some options:

1. If you as a prescriber want to have a conversation with Magellan about a TAR deferral to discuss the particulars of the case. Please call Magellan at 800-977-2273. This is especially important for urgent patient needs.

2. 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, clearly identified as appeals to: Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 610. Rancho Cordova, CA 95741-0610. Medi-Cal Rx will acknowledge each submitted TAR appeal within three days of receipt and make a decision within 60 days of receipt.

3. For patients who want to file a grievance related to the process, recommend that they call the Magellan customer support at 800-977-2273.

4. If these options are not yielding results, you can reach out to our Partnership pharmacy staff directly at 707-863-4155 to assist with getting Magellan to respond. Partnership does not have the ability to overturn Magellan/DHCS denials, but we have one additional escalation pathway we can use if the above are not successful.

Blood Pressure Devices and Cuffs through Community Pharmacies

In addition to the option of using Partnership's Medical Equipment Distribution Program (see below), blood pressure devices and cuffs are also available through community pharmacies. TARs will not be accepted for products not on the Medi-Cal Rx list. Covered items include standard blood pressure monitors, monitors with talking functions, and monitors with Bluetooth connectivity and remote patient monitoring capabilities. Please refer to the Medi-Cal Rx Covered Product Lists https://medi-calrx.dhcs.ca.gov/provider/forms/ for additional information.

Click here for a summary of which BP devices are covered.

For convenience, we recommend a generic phrase like: "BP Monitor-Large Cuff" and let the pharmacy see what they have in stock that Medi-Cal will cover and dispensing that. An exception: if you want a specific connected device you will want to specify the device exactly.

Note the options from the list above for devices compatible with remote patient monitoring programs.

For new or a different size BP cuffs only, the pharmacy TARs must indicate that the cuff is for a home use monitor and that the current cuff does not fit or is damaged. The indication of 'home use' is key. For questions regarding Medi-Cal Rx coverage or billing of blood pressure monitors and cuffs please contact Magellan at (800) 977-2273.

Enuresis Alarm Added to Medical Equipment Distribution Program

Partnership is excited to announce the addition of an enuresis alarm to the Partnership's Medical Equipment Distribution Services (PMEDS) program in April 2024. The enuresis alarm is worn by children, age 14 and under, to alert them when they need to go to the bathroom. The child should wear the alarm every night and can stop wearing the device once they have gone 14 days without wetting the bed.

The PMEDS was developed in response to COVID-19, starting as a pilot to offer providers access to medical devices that could be used to treat and care for patients while they remained at home. The program initially included blood pressure monitors, oximeters, and thermometers. Over the past few years, the program has grown to include over a dozen devices. In general, these are items that are covered by Medi-Cal and/or Partnership, but which are relatively inexpensive and therefore with low profit margins leading to lack of access to these devices from contracted, storefront medical equipment vendors and pharmacies.

Providers contracted with Partnership can request equipment from the PMEDS program without the need of a TAR, pharmacy fulfillment, or any cost to the member. The ordering clinician simply completes the request form by providing some basic member demographic information, equipment selection(s), diagnosis code(s), and clinic contact information, then fax or securely email the form to us. Requests can be submitted 24 hours a day, 7 days a week. Orders received by 3 p.m. on a business day are processed that same business day and ship the following business day via USPS Certified Mail. Equipment is typically received by the member within 5-7 days of the date the request was submitted for processing. Program Guidelines are found on the Partnership website.

Equipment available includes:

Blood Pressure Monitors and Accessories	
Blood Pressure Monitor (with medium cuff)	Small Cuff
Talking Blood Pressure Monitor (for low vision members)	Large Cuff
	Extra-Large Cuff
Scales	
Digital smart scale (max weight 330 pounds)	Smart baby scale (infant must be under 40 pounds)
Heavy duty smart scale (330 to 550 pounds)	Talking Digital Scale (for low vision members)

Respiratory-Related	
Pulse oximeter Nebulizer (plug-in electric)	Adult replacement nebulizer mask and tubing kit
Warm Steam Vaporizer	Pediatric replacement nebulizer mask and tubing kit
Cool Mist Humidifier	Portable Nebulizer (for unhoused members)
Other items	
Digital Thermometer	Safer Lock Medication Lock Box
Enuresis Alarm	

Partnership is committed to ensuring our members have access to these small personal medical devices. Every effort is made to process request quickly and accurately. We thank the providers that participate and submit request on behalf of their Partnership members. If you have any questions, please reach out to the PMEDS team at request@partnershiphp.org.

Home Health, DME and Medical Supplies: In Person Visit Required

Prior to the COVID-19 Public Health Emergency (PHE), only physicians were authorized by Medi-Cal policy to prescribe home health services, DME, and medical supplies. Since then, all licensed providers within their scope of practice – to include nurse practitioners, physician assistants, and clinical nurse specialists – have been authorized to prescribe. Although the PHE has ended, DHCS received approval to align with federal regulations to make this change permanent; NPs, PAs, and CNSs can continue to prescribe, however, DHCS requires a face-to-face visit for evaluation of the primary reason services or equipment are required. Partnership considers Certified Nurse Midwives to be a form of CNS. A face-to-face evaluation may be completed with video telehealth, but audio-only or telephone calls are no longer sufficient. The guidelines can be found in the *Home Health Agencies* and *Durable Medical Equipment (DME): Other DME Equipment sections* of the appropriate Part 2 provider manual.

Care Coordination Services at Partnership

Partnership offers comprehensive case management services to all of our members regardless of age or location. Partnership'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 health care system without intensive support of a case manager.

If you believe you have a Partnership member that would benefit from the services available from our Care Coordination department, please refer them by calling (800) 809-1350 or by sending a secure email to cchelpdeskEA@partnershiphp.org

The Intensive Outpatient Palliative Care Benefit

The current Medi-Cal Palliative Care Benefit was based on Partnership's Palliative Care Pilot program, conducted about a decade ago.

Covered conditions for Partnership's Intensive Outpatient Palliative Care program 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 Partnership 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. As patients' health declines, they may become eligible for the more comprehensive Hospice benefit. Other types of palliative care are also covered: primary palliative care covered as a routine part of primary care, and episodic specialty palliative care (fee for service).

Palliative care local in-person resources vary by county. Here is the contact information for current and pending Intensive Outpatient Palliative Care programs.

Counties Served	Organization	Referrals (if contracted)
Del Norte, Humboldt, Lassen, Modoc, Plumas, Sierra, Siskiyou, Shasta, Solano, Trinity, Tehama	Vynca/Resolution Care	Phone: 707-442-5683
Butte (southern), Glenn	MedZed (contract pending, new to PC in this region)	Phone: 1-877-633-9331
Butte (Chico area)	Butte Home Care and Hospice	Phone: 530-895-0462
Colusa, Yolo	Yolo Care	Phone: 530-758-5566
Humboldt	Hospice of Humboldt	Phone: 707-267-9880
Lake	Hospice Services of Lake County	Phone: 707-263-6270 ext. 140
Mendocino	Madrone Care Network	Phone: 707-380-5080
Napa, Sonoma, Solano (Vallejo)	Providence Palliative Care Napa Valley	Phone: 707-258-9080
Marin, Sonoma	Hospice By the Bay	Phone: 415-444-9210
Marin	MarinHealth Medical Network	Pending
Sonoma	St. Joseph Health	Phone: 707-522-4307
Sutter, Yuba	Adventist Health (Contract pending)	
Nevada and Placer (Grass Valley, Nevada City, Auburn)	Hospice of the Foothills	Phone: 530-272-5739
Nevada and Placer (Truckee and North Lake Tahoe)	Tahoe Forest Hospice (Pending)	
Placer County (Roseville area)	Aspire/Carelon Health	www.carelonhealth.com/contact-us

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

Transportation Benefit for Partnership Members

Medi-al offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, physical therapy, dialysis, and substance use disorder appointments (including for opioid treatment centers), and to pick up prescriptions and medical supplies.

There are two types of transportation for medically necessary appointments.

- Non-emergency medical transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation.
- Non-medical transportation (NMT) is transportation by private or public vehicle for people who do not have another way to get to their appointment.

The plan's responsibility is to get members to their medically necessary Medi-Cal covered services using the least costly method of transportation that meets the member's needs.

Partnership manages the Transportation Benefit directly.

Members may request transportation by calling our toll-free number for Transportation Services, **(866) 828-2303** or they can email us at mytrip@Partnershiphp.org .

If you as a **provider** are encountering problems or challenges, you can reach us by phone at 707-420-7863, or by email transportationhelpdesk@Partnershiphp.org. Please make sure your case managers and others that help members with transportation are aware of this method to arrange transportation! If you know of any transportation provider in your community interested in contracting with Partnership, you can also let us know through this email.

How does the request process work? Scheduler software is used to screen members, determine appropriate mode of transportation, make reservations and assign trips to providers. Included options include:

- Requests for travel expenses such as flights and lodging
- Member reimbursements for travel-related expenses and gas mileage reimbursement (GMR)
  - Driver/Payee credentials are managed in the software
  - Must supply current driver's license, registration and insurance
  - Members cannot be reimbursed directly
- Public transportation passes

Interpreter Services

Partnership provides interpreter services for members and our contracted provider network at no cost. Once the system is set up you may use it for non-Partnership members as well.

There are three options for accessing interpreter services for your patients.

1. Preferred Option: To use your own computers in exam rooms for interpreter services, have your IT technical support set up the app to access interpreter services on your desktop/laptop/iPad/iPhone/Android

phone. Detailed instructions are found here VRI guidelines on our website. Each individual device will need to be registered, so having IT do this as a group process is most efficient. Only devices owned by the PCP practice may be registered.

2. Large volume users of interpreter services may qualify for our vendor to place some dedicated devices in your clinical setting (one device for every 5 translations per month at a specific site). There are several options, ranging from iPads on carts ("translation carts") to portable standalone devices that can be brought into the exam room. To learn more, a 2022 recorded webinar on our interpretive services can be accessed here.
3. If you have not set up the above options, and you have a patient requiring interpreter services, either the patient or the provider can contact us to arrange an interpreter: 800-863-4155. (Our main member services line).

AMN Resources:

- AMN Healthcare Training Video: https://bit.ly/3A7x8uM
- VRI Guidelines: https://bit.ly/3DjCF3z
- VRI Setup Form: https://bit.ly/3lchVEv
- Where to find your PHC #: https://bit.ly/2YpnruI

Telemedicine Services at Partnership

Partnership has a robust Telemedicine policy governing all aspects of telemedicine. Even before the COVID-19 pandemic, we covered a wide range of services, from eConsult to synchronous telemedicine, for all ages, and a variety of ancillary medical services. Highlights are listed below.

We have gathered together many resources about all aspects on Telemedicine into a single Toolkit, available on our website.

eConsult Options: ConferMED and Safety Net Connect

Partnership HealthPlan of California is contracted with two e-consultations (eConsult) companies: ConferMED, and Safety Net Connect. ConferMED has a more seamless way of integrating with office electronic health records, and Safety Net Connect is better integrated with our preferred vendor adult specialty telemedicine services, Telemed2u.

A primary care provider (PCP) can consult with a specialist about a patient electronically instead of referring the patient for a face-to-face visit. A referral, along with clinical information, images, lab results, and other content from the

medical record, is sent directly to a specialist, with a complete consult returned within two business days.

eConsults do *not* require prior authorizations.

ConferMED does not charge the PCP for an interface, although your EHR vendor may do so. If you want to use ConferMED with non-Partnership patients, they are able to bill Medicare and private insurance for these services. You would need to have an agreement with them to set it up.

All specialists are Board certified in a specialty or subspecialty, and licensed in California. ConferMED eConsult specialties include:

ConferMED eConsult offers the following specialties:	
Allergy*	Nephrology*
Cardiology*	Neurology*
Dermatology*	Obesity Medicine
Endocrinology*	Orthopedics*
ENT*	Pain Medicine
Gastroenterology*	Psychiatry*
Geriatric Medicine	Pulmonary*
Gynecology*	Retinal Reading
Hematology*	Rheumatology
Infectious Disease*	Urology*
Medical Oncology	
*Indicates specialty is available for pediatrics	

If you are interested in learning more about ConferMED or Telemed2u, contact the telemedicine team at Partnership: telemedicine@Partnershiphp.org.

Adult Specialty Telemedicine

In “traditional” synchronous telemedicine, the patient is physically located in the PCP office and the specialist is remote. The PCP office will coordinate the appointment, check vitals, and may have the PCP clinician step in to examine the patient or speak with the specialist.

Partnership will accept claims from any specialist conducting telemedicine visits. If your primary care center has an existing telemedicine vendor, you may continue to use them. Some FQHCs have put telemedicine into their PCP scope description, and can bill Partnership for these specialty services. There is some set-up involved to have a specialist working out of a PCP office; contact your PR representative for more information.

Another option is to use Partnership's contracted adult telemedicine specialty provider, called Telemed2U. They do have some ancillary providers, such as registered dieticians, available as well. To sign up to use Telemed2U, contact our telemedicine program manager at: telemedicine@Partnershiphp.org
Here are the specialties currently offered through Telemed2U:

- Endocrinology
- Gastroenterology/Hepatology**
- Infectious Disease (HIV, HEP-B, & HEP-C)
- Nephrology
- Neurology
- Nutrition (ages 3+)
- Physical Medicine & Rehabilitation**
- Psychiatry (ages 4+)
- Pulmonology
- Rheumatology
- Transgender Care

**Available only through Direct-to Member

Partnership has an incentive payment system to reward robust use of telemedicine, in the form of a biannual grant payment, depending on volume. The purpose of this is to cover some of the extra administrative cost associated with running a robust telemedicine program. Our telemedicine team will give full details when you reach out to them.

Direct to Member Specialty Telemedicine

This alternative to having the patient in the PCP office became very popular during the COVID-19 pandemic. Patients are located at home or another location with broadband access and communicate directly with the specialist office. This is called Patient to Specialist ("Direct") Telemedicine Services.

Many community specialists have adopted direct to member telemedicine. Direct Specialty Telehealth Services are being provided by "TeleMed2U" for a select set of specialties. More Information can be found here

Now accepting New Patient specialty telehealth referrals for:

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

Pediatric Subspecialties

Pediatric Telemedicine and E-consult services. Partnership and UC Davis Health (UCD) have partnered to expand access to pediatric specialty care

services which is now available through Partnership Telehealth Program. Thirty specialties, representing every major pediatric subspecialty area, are covered. For more information, please visit the Pediatric Telehealth Page, on our website. PCPs must sign up in advance to get systems in place to use this pediatric subspecialty network. Contact telemedicine@Partnershiphp.org to sign up.

Primary Care Telemedicine

Most primary care providers adopted telemedicine to care for their patients during the pandemic. Several have continued to use the flexibility and convenience offered by telemedicine to continue to provide such services now. DHCS and CMS have extended the ability to bill for video and telephone visits and be paid at the same rate as in-person visits.

Procedure code modifiers are required when virtual visits take place:

Telephone-only visits must use a .93 modifier.
Video visits must use a .95 modifier

Partnership does **not** contract with a separate virtual urgent care group (like TeleDoc). Our existing provider network prefers to provide continuity for their patients by arranging urgent or same day care through its own infrastructure.

Certain services must be conducted in a face-to-face format. These include well child visits, and initial OB visits (at least the physical exam portion of these visits must be face to face). In addition, some same-day urgent visits are not appropriate to be addressed without a physical exam. Partnership has noted an increase in quality of care issues related to inappropriate use of virtual visits, when an in-person visit was needed. We encourage clinical leaders to set up protocols and trainings to avoid such poor quality care.

Diabetes Education and Nutrition Counseling for Patients with Diabetes

Diabetes education and nutrition counselling are a necessary component to diabetes care that gives patients an opportunity to better understand their condition and master the tools needed to manage nutrition, activity, and medications. The American Diabetes Association recommends that all people with diabetes participate in diabetes self-management and education to support better outcomes.

Patients with diabetes require these services to receive the support needed and gather knowledge that improve decision-making for diabetes self-care. Referrals to Registered Dietitians (RDs) and Certified Diabetes Educators (CDEs) offer your patients focused consultations to move the dial on glycemic control through health education and self-management using motivational

interviewing and other standardized tools.

To support you and your patients' efforts to manage diabetes, Partnership covers Medical Nutrition Therapy for both diabetes and prediabetes. Please use Partnership resources to integrate Nutrition and Diabetes Education with RDs and CDEs from the Partnership network to optimize care and improve glycemic control in your patients with diabetes.

Medical Nutrition Therapy (with a Partnership credentialed CDE or RD) that takes place in the PCP office, with community RD or CDE in person or via telehealth, is a covered Partnership benefit. If your practice does not offer these services, your patient can access Medical Nutrition Therapy (MNT) within the Partnership network of specialty providers. Partnership Network providers for MNT include: *The Northern California Center for Wellbeing* in Sonoma County and *As You Are Nutrition* in Napa County. These practices may offer flexibility for in-person or telehealth visits. Some practices offer individual and/or group visits. Another option, TeleMed2U offers direct telehealth only visits for Partnership members over three years old. Direct telehealth visits for members are available with referral to TeleMed2U Nutrition through Partnership's Online Services. Referral coordinators can direct referrals via an eRAF or faxing for MNT using the Provider Directory and the Partnership Provider Portal. Please have your referrals team contact your local Partnership Provider Relations representative for more information on details of referring to MNT if they are not familiar with these systems.

For health centers (FQHCs, RHCs, and Tribal Health Centers), registered dieticians are covered by the CPSP program, and payable under the all-inclusive (PPS or OMB) rate.

Behavioral Health

Mild to Moderate Mental Health: Carelon

Partnership contracts with a third part Mental Health provider, Carelon Behavioral Health, to help manage mental health benefits for Partnership Medi-Cal members with mild to moderate mental health conditions in need of outpatient mental health services. Members with severe mental illness are managed by local County Mental Health Services.

Integrating mental health services with physical health services is a best practice for increasing access to mental health services. Partnership encourages PCPs to embrace the integrated behavioral health model of care.

If you do not have internal mental health resources and need to make a referral, you can fill out a referral form to Carelon to connect the patient to services. Alternatively, patients may self-refer. In general, no prior authorization nor referral is required for treatment. Some specialized mental

health services such as a comprehensive psychological screening do require a referral, but not prior authorization (see below).

A toolkit for PCPs around the mild to moderate mental health benefit can be found on our website.

Hints for Getting an Appointment with a Carelon 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 Carelon 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 three options:

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

Partnership's Wellness and Recovery Program

In 2020, Partnership began providing 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. **We expect additional counties to join this model in 2025.** We remain the only managed care plan in California to take on this benefit. For details see the Partnership website.

Certain SUD services are also within the realm of primary care or overlap with mild to moderate mental health issues and can be treated by Partnership PCPs or Carelon clinicians. Examples include office-based medication assisted therapy for opioid use disorder, alcohol use disorder, or other disorders. In such cases, SUD care can be provided by a different primary care clinician from the PCP that the member is assigned to. We request that the following diagnosis codes be used to allow payment without additional manual steps:

- F11.2x for Medication Assisted Therapy for Opioid Use Disorder
- F10.2x for Medication Assisted Therapy for Alcohol Use Disorder

Members with High Complexity Eating Disorders

Partnership has an internal team for case managing patients with complex eating disorders, for whom you are having difficulty finding treatment options.

If you have identified someone with an eating disorder for whom a higher level of care or intervention may be warranted, please complete the Eating Disorder Collaboration Request Form (posted with meeting materials) and send it to: ED_Collab@Partnershiphp.org Partnership will review the form and work with you to identify possible options.

Supporting Behavioral Health Needs in Children: UCSF's Child & Adolescent Psychiatry Portal

Do you have children and adolescents with mental health needs? Do you have difficulty finding local child psychiatry specialists to whom you can refer them? Are you looking for ways to increase your skills to handle common behavioral health challenges yourself?

UCSF has developed a Child & Adolescent Psychiatry Portal (CAPP) to help meet increasing needs of pediatric primary care with mental health in the youth population.

Resources:
• CAPP Services and FAQ
• CAPP Fact Sheet

Webinars on Topics Related to Substance Use Disorder

Past webinars on the following topics are available on the Partnership 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

Obtaining Psychological and Neuropsychological Testing

Partnership covers psychological and neuropsychiatric testing though our mental health intermediary, Carelon.

To request this testing, the PCP should 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 Carelon to conduct member outreach to assist with linkage to a psychologist. The psychologist will complete an intake assessment to determine if testing is indicated. Carelon will send a fax notification back to the PCP with the outcome of the request.

If your patient requires additional assistance in getting connected and coordinating their neuropsych evaluation, check the box "Referral for Local Care Management" for Beacon/Carelon Care Management 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 Carelon contract with Bright Heart Health for:

1. Mental health services;
2. Medication assisted treatment
3. Services related to eating disorders
4. Chronic Pain

In conjunction with County mental health plans, members may also receive intensive outpatient eating disorder services involving a team.

Partnership has contracted with Bright Heart Health to provide services in all 24 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.brighthearthealth.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 Partnership, Bright Heart Health accepts fee-for-service Medi-Cal, Medicare, most commercial insurances and self-pay.

Supplemental Benefits

Partnership covers certain services that are not covered by other Managed Care Plans or covers them more expansively than is required by DHCS. Here is a reference list:

Covered by Partnership but not DHCS

- Neonatal circumcision
- Hospital Admission for induction of MAT for those on Fentanyl (UM criteria apply)
- Bone anchored hearing aids
- Medication Lock boxes (through medical equipment distribution system, see above)
- Humidifiers and Vaporizers (through medical equipment distribution system, see above)

Expanded Coverage

- Well child visits covered if at least 14 days apart
- Registered dietician visits covered for most diagnoses (see policy)
- Lactation consultation and education covered (see policy)
- Prenatal/CPSP appointments: no extra documentation until over 15 prenatal visits.
- CPSP codes covered to 12 months post-partum (DHCS only covers 2 months post-partum)
- Scales covered for any medical indication (through medical equipment distribution system)
- Eating disorder coverage (see mental health benefit section)

Medi-Cal Benefits: Recent Changes

CalAIM Update

Two components of CalAIM that began in January 2022 are Enhanced Care Management (ECM) and Community Supports (CS), formerly known as In Lieu of Services).

For documents and presentations related to the ECM and CS programs, see our website:
http://www.Partnershiphp.org/Community/Pages/CalAIM.aspx

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

ECM target populations:

The following populations are currently approved:

1. Adults and children at risk for institutionalization with serious mental illness (SMI), substance use disorder (SUD) with co-occurring chronic health conditions, or children with serious emotional disturbance (SED),
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.
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.
7. Perinatal population of African American, Native American and Pacific Islander ethnicity.
8. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. (Note: many individuals in this population may qualify sooner if they have one of the above other conditions.)

Community Support Services covered by Partnership include the following:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Meals/Medically Tailored Meals
- Personal Care and Homemaker Services

If you wish to refer a patient for consideration for ECM or CS services, have your care coordinator contact our Care Coordination team by securely emailing us at: CareCoordination@Partnershiphp.org.

Additional components of CalAIM of interest to Primary Care Providers:

1. A new *transitions of care* requirement, DCHS expects Partnership to be more actively involved in the discharge planning of all inpatients.
2. *Data collection and reporting*, DHCS has convened a technical advisory committee to work on the data and risk assessment models. At some point, DHCS plans to require health plans to absorb this risk

data and act upon it, including passing it on to our PCP network to act upon. This will be a large IT lift in the future, possibly in 2025.

3. *Behavioral Health:* Proposal to steadily integrate behavioral health services with the rest of the health care system.
4. *Requirement all Managed Care Plans to implement a Medicare-Medi-Cal* joint health plan product (also known as a Dual-Special Needs Plan or a D-SNP) by 2026. Partnership has begun planning for this.

CalAIM Grant Program (2024-25)

Community Join Partnership HealthPlan of California for an overview of the 2024-2025 CalAIM Grant Program. Utilizing CalAIM Incentive Payment Program (IPP) funding, Partnership has developed 2024-2025 CalAIM grants to invest in Enhanced Care Management (ECM) and Community Supports (CS) providers. Grants are open to all ECM and CS providers in Partnership's 24 counties.

To register for the webinar, CLICK HERE.

After registering, participants will receive a confirmation email.

The following categories of 2024-2025 grants are available (applicants may apply to ONE category):

- Information technology/data exchange infrastructure (for providers contracted after July 1, 2023)
- Justice involved population of focus – infrastructure and capacity building
- Children and youth population of focus – infrastructure and capacity building
- Community health workers – infrastructure and capacity building
- Build capacity and/or expand short-term post hospitalization and/or recuperative care facility
- Capital project that adds permanent supportive housing

The application review process and timing is as follows:
Application will be available on **April 1** at:
www.partnershiphp.org/Community/Pages/CalAIM.aspx.

For questions, please contact: Grants@partnershiphp.org

Click here for the complete flier.

Coverage for Community Health Workers

Community Health Workers (CHWs) began to be covered on July 1, 2022. State policy details can be found here.

Some highlights:

1. CHW services require a written recommendation by a certified health care provider. The supervising provider must be an approved Medi-Cal provider.
2. Encounters must be documented in a medical record system of some sort, including the topics discussed and the duration of the encounter.
3. CHW must meet minimum requirements by either a certification pathway or a work experience pathway. Six hours of annual continued education is required. Partnership will establish a process to credential CHWs, according to these criteria. Generally, the organization employing the CHW will submit claims, and thus will need to be a Medi-Cal provider.
4. DHCS specified covered and non-covered services in their policy document.
5. The only billing codes that are acceptable are for face-to-face self-management education and training: 98960 for individuals and 98961 or 98962 for groups of patients.

Special note for FQHCs, RHCs, and Tribal Health Centers: CHWs are not considered PPS-providers by the state. This means that although services can be provided, they would be considered part of the current scope of an FQHC or Rural Health Center. For FQHCs and RHCs, if CHWs are added, they may be counted in a future scope change request, which could incorporate the cost of CHW service into the overall PPS rate. Tribal health centers are eligible for a FFS payment for CHWs, but not their OMB rate.

This reimbursement challenge has led to a rather limited availability of CHWs in the Partnership region, thus far. As a result of this, Partnership is piloting several options for implementing CHWs in our service area.

Street Medicine

Street Medicine is defined as medical care provided by a licensed medical provider where the patient lives, when a patient is unhoused (i.e., not living in a shelter, home or apartment).

Primary care providers may provide such services for their assigned members, as part of those members' primary care services.

An organization or individual who does not routinely provide primary care may contract with Partnership as a Street Medicine Provider. In this case, they may provide medical services to any Partnership member they come across,

regardless of their assigned PCP. Such Street Medicine Providers are expected to communicate with the assigned PCP about the activities performed.

Change: Whether street medicine services are provided by a PCP or a Street Medicine Provider, **please let your billing departments and providers know that we need them to use the place of service code "27" when services are provided outside a usual health care facility, where the patient lives**. The previously recommended place of service code was 16, which will still work for a while, but we recommend you change your templates and processes to use the new code. You may need a special workflow (like a separate schedule) with this place of service code assigned to make this happen.

Genetic Testing

The number of genetic tests available is growing rapidly, as is the complexity of deciding which test to order and how to interpret the results. While the prices are starting to drop, many cost several thousand dollars, and we find that many clinicians are ordering the wrong tests for the wrong reasons. Thus, these lab tests often require a Treatment Authorization Request (TAR) to be paid.

While most are typically ordered by specialists, tests for hereditary conditions and pediatric developmental disorders are increasingly being ordered by primary care clinicians. Note that prenatal screening tests are covered directly by the California Prenatal Screening program.

To view the list of tests that require prior authorization and to view the most recent form for screening for familial genetic syndromes, see the genetic testing policy addendum.

Another resource for the large majority of our network that uses Quest Diagnostics is to contact Quest's genetic counselors to get advice on the correct test to order for a patient's particular circumstances. The phone number is: 1-866-GENE-INFO (1-866-436-3463).

Mobile Mammography Program

Partnership contracts with a Mobile Mammography Company to bring Mobile Mammography to locations within the Partnership service area where Mammography access is constrained, and mammography rates are low.

If your organization meets the following criteria, contact us to discuss sponsorship opportunities:

- Located in Partnership regions and counties below the 50th percentile benchmark for breast cancer screening
- Provider locations far below the 50th percentile benchmark
- Provider locations in imaging center "deserts"
  (Patients' travel to imaging center is unusually long or difficult.)
- Provider locations with lack of access at nearby imaging centers
  (More than one month to Third Next Available Appointment.)
- Provider locations with Partnership care gaps to support desired event
  (A full day event would require at least 60 - 90 Partnership members with mammogram care gaps. Providers can also consider partnering with nearby provider organizations in the Partnership network to meet the volume needed for a successful event. The majority of patients served at a Partnership-sponsored event should be Partnership members.)

For further information, contact**:** mobilemammography@Partnershiphp.org

Partnership Updates

Partnership Provider Recruitment Program (PRP)

To help increase the supply of Primary Care providers seeing Partnership members, we offer a generous signing bonus program, plus other recruiting support. For new counties, this program began on January 1, 2024.

Providers

- $100,000 signing bonus for physician candidates (Primary care specialties plus OB/GYN)
- $120,000 for medical residents training in Partnership's 24-county region ($20K payable in program year 3 with a five-year commitment post-graduation)
- $50,000 signing bonus for NP/PA/CNM candidates
- Enhanced bonus disbursed over a five-year term

Behavioral Health

- $20,000 signing bonus for licensed behavioral health professionals: licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical psychologists
- **$4,000/$5,000** signing bonus for certified substance use disorder (SUD) and bilingual certified SUD counselors

Key Criteria

- Candidates must not have accepted an offer to practice at a partner site under the previous PRP version.
- If the candidate is currently practicing, they must be from outside of Partnership's 24 counties. Exceptions:
  - Currently working for Kaiser within one of Partnership's counties
  - Providers in training or residency programs within Partnership's 24 counties
- Requests for program support must be provided to Partnership before formal offers are made to candidates.
- Please see Partnership's PRP webpage for additional important program criteria.

Organizations with an existing PRP grant agreement with Partnership must execute an amended agreement to participate with the updated incentives. Organizations not currently participating in the PRP must have executed a grant agreement to submit requests for grant funds.

Please contact the Workforce Development team with any questions or requests: wfd@Partnershiphp.org | (707) 430-4846

Provider Retention Initiative Pilot

Partnership is launching a new Provider Retention Initiative (PRI) Pilot. The PRI is intended to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while a younger generation of providers can learn from and train with these committed health professionals.

PRI eligibility is limited to practitioners who provide services to Partnership members with Partnership's contracted partners within our 24-county region.

Provider Program Highlights / Incentives Available:

- $45,000 award for Doctor of Medicine (MD) / Doctor of Osteopathic Medicine (DO) – three- year commitment
- $30,000 award for Nurse Practitioner (NP) / Physician Assistant (PA) – three-year commitment

Award Payment Cycle:

Award	FY 23/24	FY 24/25	FY 25/26	FY 26/27
$45,000 MD/DO	$7,500	$7,500	$15,000	$15,000
$30,000 NP/PA	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA) has provided services with organization for 15 years or more and has confirmed commitment for practicing at least three more years.
- Provider eligibility is limited to family medicine, internal medicine, and pediatrics.
- Provider must serve in a leadership or mentorship capacity within organization.
- Given funding limitation, provider organization must complete a competitive grant application.
- Provider organization must have a signed Provider Recruitment Program agreement.

Please contact the Workforce Development team with any questions or requests: wfd@partnershiphp.org | (707) 430-4846

Kaiser Statewide Contract

The California legislature passed enabling legislation to allow Kaiser to have a state-wide contract for Medi-Cal, starting January 2024. Currently, transition of patients from Partnership will be limited to dual eligible members, foster children, and those meeting Kaiser's family connection or continuity of care rules. Gradually, they are planning on expanding the number of Medi-Cal patients served, state-wide.

Kaiser Foundation has medical offices or hospitals in Marin, Sonoma, Napa, Solano, Yolo and Placer Counties. There are a few Kaiser patients in Yuba and Sutter counties, and DHCS is allowing Kaiser Health Plan to cover those counties as well.

Patients new to Medi-Cal in these 8 southern counties will be asked to select Partnership or Kaiser by a State organization called "Healthcare Options", but many who select Kaiser will not meet the criteria that Kaiser has set forth (for example: previously a Kaiser member or a family member with Kaiser coverage), and so will ultimately be assigned to Partnership, regardless of their choice. Grievances about Healthcare Options will be directed through the state grievance mechanism, not through Partnership.

Implementation of New Core Claims Processing System

For a Health Plan, the claims processing system is the single most important IT software system in the organization. Tens of millions of claims are processed each year, over $3 billion worth at Partnership. All our providers count on that system to be paid accurately and timely.

After several delays, Partnership is on track to change from our legacy system, called Amysis, to a new system called Health Edge Health Rules Payer (HRP) around July of 2024. All electronic data interfaces from PCPs and other providers will need to be re-directed to HRP and tested in Spring of 2024. If you use a claims clearinghouse, they will do this testing for you.

Connecting to a Certified Health Information Organization

One note for those who applied for HEPT. The IT deliverable for having a two-way interface with a certified Health Information Organization is something every grantee will need to do. Partnership has long-standing collaboration with the Health Information Organization (HIO) *Sac Valley Med Share,* whose geographic footprint largely matches the Partnership footprint.

Of note, California will begin enforcing the required California Data Sharing agreement (DSA) for all PCPs by January 31, 2026. Larger Medical Groups are required to comply by January 31, 2024.

For more information on the grants to help establish connections see the California Data Exchange Framework website.

Prior Authorizations in Primary Care

As a not-for-profit, community-based health plan, Partnership only uses the Prior Authorization (PA) process (also called the Treatment Authorization Request or TAR process) to ensure that the taxpayer resources that are given to Partnership from the State are spent responsibly, avoiding un-necessary expenses and un-necessary or harmful procedures and care. Both DHCS and NCQA regulate this process.

Another way Partnership prevents fraud, waste and abuse is through the configuration of our claims processing system, which is configured to deny claims exceeding logical or reasonable limits. When such denials are appealed, on the basis that the claim represented a medically necessary service, the resulting review is retrospective, sometimes called a retro-TAR. Since the service was already provided, a denied retro-TAR results in a service being provided that will not be reimbursed.

Almost no TARS come from primary care practices. Even for services that are ordered by a PCP, the TAR is generated by the organization that will actually be providing the service and billing for it. If your practice has specialists, each specialist should become familiar with the procedures that they do that require prior authorization. The services and procedure codes that generally require a TAR can be found on the Partnership website.

Some services *sometimes* associated with primary care that require a TAR are listed here. If your organization participates in these programs, ensure a staff person has expertise on completing TARS properly.

- Enhanced Care Management
- Community Supports
- Physical Therapy
- Chiropractic Services if more than 2 per month
- Acupuncture services if more than 2 per month
- Any procedure which may be performed for either cosmetic reasons or reconstructive purpose

Certain procedures and supplies ordered by the PCP will need sufficient information documented so that when medical records are sent to the service provider to submit with the TAR, these records are adequate and complete enough to justify medical necessity when the ancillary provider submits them with the TAR. We recommend extra diligence in clinical documentation when one of these is ordered by the PCP. The most commonly ordered by PCPs include:

- CT Scans
- MRI Scans
- Certain genetic blood tests, most commonly cancer screening tests
- Circumcision in children over 4 months of age
- Facility-based sleep studies
- Hospice and Palliative Care

Partnership Specialty Referral Process Refresher

In general, Partnership members needing specialty care should be referred to the appropriate specialist by the Primary Care Practice. Most practices designate a referral coordinator who becomes expert in the local nuances of this process, to complete the electronic referral authorization process. This referral coordinator takes the clinical and demographic information from your electronic health record, and enters it into Partnership's Electronic Referral Authorization (RAF) system.

If a contracted PCP refers a Partnership member to a contracted Partnership specialist, no further review by Partnership staff is needed; the referral is auto-approved, and the specialist will be paid for any services provider to the

referred member (subject to the TAR requirements mentioned earlier).

Partnership nurses and medical directors only review referrals for assigned members who are referred to non-contracted specialists, especially out of state specialists. In this case, we evaluate the medical necessity of the referral and the availability of contracted specialists within a reasonable distance who could provide comparable care. We will look for documentation for this in the RAF itself, with the medical record as a backup.

Referral Authorization is not required for Partnership members to access obstetrics or family planning and nonspecialist, preventive women's health care services. Pregnant individuals who require a non-obstetrics specialist consultation (endocrine, cardiology) will need a referral authorization from the PCP to be submitted to Partnership. Individuals who need specialty follow up with after an abnormal screening mammogram ordered by a non-assigned PCP provider will need a referral authorization submitted to Partnership by the assigned PCP.

The list of specialists in the network is updated very frequently, and is available through the Partnership website in a searchable format, as well as a printable directory.

Some Partnership members are in a status called "Direct Members," which means that technically they do not need prior authorization to see any Medi-Cal provider willing to see them. This includes members of Indian tribes, children on CCS, those with Medicare insurance primary, and other categories.

Most CCS children are assigned to a PCP medical home to coordinate their care. Although a RAF is not required, we recommend that the PCP complete a RAF for any new problem that comes up, so the specialist is confident that the patient had some screening for the appropriateness of the referral, and that they will be paid by Partnership.

This same principle applies to unassigned Partnership members who may be seen in your PCP office. Specialists appreciate that you screen patients for appropriateness and the RAF is reassurance that they will be paid. Thus it is best practice to use the RAF system for both assigned and unassigned Partnership Patients needing a new referral.

One quick note on tertiary care centers in Northern California. Partnership is contracted with all tertiary care centers in Northern California **except for Stanford University for Adults**. This is especially true for transplants. Adults needing tertiary care should be referred to any Sacramento Hospital including Sutter, Dignity, or UC Davis, to a San Francisco based hospital including UCSF or California Pacific Medical Center. Children may be referred to Children's Hospital Oakland, UC Davis, Lucille Packard Children's Hospital, or UCSF.

Strategies for Difficult Referrals

Partnership strives to contract with every willing specialist in our geographic area. Over the last 20 years, there has been a steady decrease in the number of specialists available in rural and many suburban areas. To preserve the specialty network we have, and prevent them from burning out, it is critically important to ensure that referrals are judicious and the referral process is completed efficiently and respectfully. Here are some best practices and hints:

1. Avoid unnecessary referrals to in-person specialists. This has an immediate result of increasing access for patients who really need the specialist. Ways to do this include:
    - Start with using e-Consult wherever appropriate to begin the workup before sending the patient to the specialist. As many as 60% of eConsults that are done result in a workup that does not need an in-person visit.
    - Use telemedicine for cognitive specialties, such as rheumatology, endocrinology, or specialties that lend themselves to transmission of digital images, like dermatology.
    - Use UpToDate or other references to narrow down your diagnosis and drive your initial workup. Use your primary care training to do as much as you can for your patient! This can often be combined with eConsult to excellent effect.
    - If you have a colleague at your office with some specialized expertise have a patient see your internal expert before deciding if an external referral is needed.
    - If you have new providers, especially Nurse Practitioners or Physician Assistants, review their referrals before they are sent. In our review, the percentage of inappropriate referrals is higher from NPs and PAs than from physicians.

2. Ensure your communication to the specialist is clear, either from your progress note or from your referral note. If you are willing to manage the patient after the diagnosis and treatment plan is made by the specialist, let them know that you would happy to manage the patient with their guidance. If you need them to take over care, indicate that on the referral. If you just want a second opinion, note that. If you are trying to sort out between two different diagnoses, let them know what you have done so far.

    Nothing justifiably irritates a specialist as much as a cryptic note as to the purpose of the referral with complete lack of appropriate workup done before referral.

3. Local specialists will develop their own rules about pre-reviewing and approving referrals. This is usually done because inappropriate referrals have been made in the past, so PCPs should honor the

requests of the specialists and try to re-earn trust in appropriateness of referrals. Which specialists want what type of review before referrals varies by community. Often these are communicated at Partnership-sponsored referral roundtables. Be sure your referral coordinator attends these (and potentially office manager and a clinician leader as well).

4. The medical director or CMO should make an effort to engage with specialists on referral appropriateness on a regular basis. Please let your Partnership Regional Medical Director know of any specific specialists or specialties which are a challenge in your area, so we can assist.

5. If you are able to secure a needed in-person specialty appointment further away from the patient's home, keep the transportation benefit in mind to help the patient go to that appointment. Closer care or virtual care is preferred to seeing a specialist located far away, but that is sometimes the only option, especially for

6. If you have a patient that you feel really needs a specialty referral and your referral coordinator is having difficulty, contact the Partnership Care Coordination Department for assistance (see section on Care Coordination, above). Be sure they really need this referral, that you have done step 1 above. It is a waste of everyone's time to activate this care coordination step for an inappropriate referral.

Longer Term Strategies to Support Specialty Care

In addition to the policy options mentioned earlier, and the best practices noted above, there are additional ways Primary Care Providers, Hospitals and Partnership can work together to support critical local specialty needs.

Mobilizing Hospital Recruitment: If a shortage of a specialty leads a local hospital to lose outpatient or inpatient income, the hospital may be amenable to supporting community recruitment activities.

Health Center recruitment and hiring of specialists. Larger health centers, in particular larger tribal health centers may be able to either hire, or share the hiring of a specialist who could see outpatients at the health center, where the payment rate is more favorable that straight Medi-Cal or Medicare. FQHCs would need to demonstrate a significant community need to get the required scope change, so some planning and financial modeling is required. The main message is: don't rule it out simply because it wasn't the model of the past, when specialists were plentiful. Work on the financial modeling to see how it could work.

Expanding Medical School and Residency Training. The number of medical students graduating from allopathic medical schools has been fairly stagnant over the past 2 decades. A substantial increase in the number of osteopathic medical student graduates, combined with an increase in foreign medical graduates has allowed growth in family medicine and internal medicine residency positions in the past decade. With a large number of physicians projected to retire in the next 5 years, a substantial increase in both medical schools and residencies is needed. Partnership supports the development of both in Northern California, but broader support from hospitals, large health centers, community physicians, and government is a key to success. The logistical challenges facing new programs need all of our help to overcome, to make the training experience as strong as possible.

Health Plan Activities. When Partnership identifies a geographic area without sufficient specialist coverage, but with uncontracted specialists in the community, we will endeavor to contract with them to improve network coverage. This strategy won't create specialists in a community without them, so its helpfulness in helping with specialty access is rather narrow.

Public Health Data: County Profiles

County Profiles are an annual compilation of data from Partnership and from publicly available resources. They were distributed with the meeting materials, and will be posted on the Partnership website in late April.

Clinical Practice Guidelines and Best Practices

Preventive Services Updates

Each year Partnership's Quality Utilization Advisory Committee reviews the adult preventive care recommendations of various organizations and updates Attachment A of our Adult Preventive Services Guideline. The updated version will be posted to our website in April. Here are the major changes:

1. Persons at increased risk of HIV acquisition: recommendation for pre-exposure prophylaxis (PrEP).
2. While the USPSTF does not make a specific recommendation about routine screening for oral health conditions, the American Academy of Family Physicians recommends including counselling on oral health in health maintenance visits.
3. While screening for adults and teenagers for depression is recommended, routine screening for suicide risk is without evidence of benefit or harm. Individuals with depression should be assessed for suicide risk.
4. Screening adults under age 65 for anxiety is now routinely recommended. While the interval is undefined, at a minimum screening at preventive health visits seems prudent. For a webinar on this topic conducting in 2023, see the linked PowerPoint and Recording.
5. The guidelines for prostate, breast, cervical, and ovarian cancer screening and osteoporosis screening were updated with gender neutral language.
6. Updated prenatal screening recommendations will be added to the Prenatal Care policy in the next few months.
7. Universal Hepatitis B Screening is now recommended (see details below)

New Universal Hepatitis B Screening Guidelines

In March of 2023, the CDC released updated guidance on screening and testing for Hepatitis B virus (HBV) infection calling for universal screening of all adults,18 years and older, once per lifetime and then periodically as indicated by testing results and vaccination status.

Chronic Hepatitis B virus (HBV) infection places individuals at higher risk for cirrhosis and liver cancer. Per the CDC, those with chronic HBV infection are 70%–85% more likely to die prematurely than the general population. An

estimated two thirds of the 580,000 to 2.4 million people living with HBV infection in the United States are unaware of their infection. Foreign-born residents of the US are disproportionately impacted, comprising only 14% of the general population but 69% of those living with chronic HBV infection.

Previous screening recommendations were focused primarily on risk assessment. This recommendation has not worked well in identifying most cases of chronic HBV infection and is difficult to implement on the front lines. The move to universal screening opens the door for Hepatitis B screening to be added to the EMR as a health maintenance item and simplifies implementation in the primary care setting. Utilizing all available tools including vaccination, universal screening of adults and periodic testing of those at high risk for infection, as outlined below, is expected
to decrease the prevalence of HBV virus infection and improve health outcomes for those infected.

Universal Hepatitis B screening recommendation is added to the April 2022 recommendation that the Hepatitis B vaccination series be added to the list of routine adult vaccinations. Combined with universal pediatric vaccination against Hepatitis B, the CDC's policies should reduce the public health burden of Hepatitis B.

Summary of CDC 2023 HBV screening and testing recommendations

- Screen all adults aged 18 years and older at least once in their lifetime using a triple panel test including (HBsAg, anti-HBs, and total anti-HBc). Since there is an existing recommendation to also screen for Hepatitis C at least once in a lifetime, a Hepatitis C and an HIV antibody test should be added if this has not been ordered previously.
- Screen pregnant people for hepatitis B surface antigen (HBsAg) during each pregnancy regardless of vaccination status and history of testing
- Expand periodic risk-based testing to include people incarcerated, people with a history of sexually transmitted infections or multiple sex partners, and people with hepatitis C virus infection. The expanded list of those at increased risk can be found at the link below.
- Test anyone who requests HBV testing regardless of disclosure of risk

The new recommendations may be found in their entirety in the MMWR (link below). A summary table for interpreting testing and management of results is included below. The article also includes a table outlining how to implement the guidelines into workflows for the primary care setting

Interpretation of screening test results for hepatitis B virus infection and recommended actions

Clinical state	HBsAg	Anti-HBs	Total anti-HBc*	IgM anti-HBc	Action†
Acute infection	Positive	Negative	Positive	Positive	Link to HBV infection care
Chronic infection	Positive	Negative	Positive	Negative§	Link to HBV infection care
Resolved infection	Negative	Positive	Positive	Negative	Counsel about HBV infection reactivation risk
Immune (immunity inferred from receipt of previous vaccination)	Negative	Positive¶	Negative	Negative	Reassure if history of HepB vaccine series completion; if partially vaccinated, complete vaccine series per ACIP recommendations
Susceptible, never infected	Negative	Negative**	Negative	Negative	Offer HepB vaccine per ACIP recommendations
Isolated core antibody positive††	Negative	Negative	Positive	Negative	Depends on cause of positive result.

§ IgM anti-HBc also might be positive in persons with chronic infection during severe HBV infection flares or reactivation.

¶ Immune if anti-HBs concentration is >10 mIU/mL after vaccine series completion.

** Anti-HBs concentrations might wane over time among vaccine responders (Source: Schillie S, Vellozzi C, Reingold A, et al. Prevention of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices. MMWR Recomm Rep 2018;67[No. RR-1]:1–31).

†† Can be the result of a past infection when anti-HBs levels have waned, occult infection, passive transfer of anti-HBc to an infant born to an HBsAg-positive gestational parent, a false positive, or mutant HBsAg strain that is not detectable by laboratory assay. Management recommendations found at the link below.

Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infe Recommendations — United States, 2023.
DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1

Check your knowledge: How should a positive anti-HBc with negative anti-HBs be managed?
According to the CDC, it depends on the clinical scenario! In general, a good rule of thumb is to start by repeating the Hep B screening tests (HBsAG, HBsAb, HBcAB), to evaluate for false positives/negatives, and to add a Hep B DNA test and a Hep C antibody
test. Here is the detailed rationale:

"Persons with isolated anti-HBc should have their immune status and risk history considered before deciding next steps. The specificity of total anti-HBc tests is 99.8%. However, if a person does not have risk factors, the result might be a false positive; repeat testing with the same assay is warranted to confirm the results. A false-positive isolated core antibody result means the person is susceptible and should be offered HepB vaccine per current ACIP recommendations.

A 2001–2018 national survey found the prevalence of isolated positive anti-HBc to be 0.8% (approximately 2.1 million persons). Among patients exposed to HBV, an isolated positive anti-HBc result might be the result of loss of anti-HBs after past resolved infection, occult infection (i.e., HBsAg is negative, but HBV DNA is positive), being in the window period before appearance of anti-HBs, or an HBsAg mutant infection (i.e., an infection that is not picked up by an HBsAg test unable to detect mutants). Patients who are immunosuppressed should be considered at risk for HBV reactivation, and HBV DNA testing is recommended to assess for occult infection. Among infants, an isolated anti-HBc result might be a consequence of passive placental transfer from an HBsAg-positive

mother, which is why testing for anti-HBc is not indicated before age 24 months."

Clinical Practice Guidelines

Partnership has posted clinical practice guidelines for depression, chronic pain management, diabetes management, lactation management, and asthma management on our website at: http://www.Partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Specific Pediatric Guidelines

The following guidelines are of particular interest to the California Legislature, DHCS and Partnership.

Lead Screening Requirements

DHCS added the HEDIS measure of blood lead screening by age 2 to its Managed Care Accountability Set (MCAS). Performance on this measure was low before COVID and dropped during COVID. In spite of educational interventions, sharing lists of patients due for lead screening with providers, and posting comparative data, the rates remained low.

Here are the MY 2022 HEDIS rates for lead screening between 1-2 years of age for the Anthem Blue Cross/California Health and Wellness Region 1, which includes 9 of the 10 new counties in Partnership's new Eastern Region. Partnership's overall rate and the National Medicaid Health Plan average rate are shown for comparison.

Health Plan/Geography	Lead Screening Rate Between ages 1 and 2
Anthem Blue Cross (Region 1)	53%
California Health and Wellness (Region 1)	40%
Partnership (overall)	40%
National NCQA Medicaid Health Plan average	63%

Partnership is instituting a number of additional measures to support more universal lead screening:

1. Blood lead screening is now a core measure for the 2024 PCP QIP.
2. Supporting providers who wish to move to providing lead testing on site, using point of care devices.

3. Doing more follow up with providers on their efforts to reach out to children overdue for screenings, with potential corrective action plans if actions are not taken by PCPs.

For a detailed, recorded presentation on the clinical, public health and regulatory aspects of the lead screening (with CME available): see our website.

If you do not yet have Point of Care Lead testing units in your office, there may be some grant funding available to supporting staring this testing. Contact us at: leadPOC@partnershiphp.org

Evolving Sources of Lead Exposure

Recent headlines about high lead levels found in fruit pouches consumed by young children highlight the fact that lead exposure is not a thing of the past; it is an important part of our present. Exposure to this metal can cause a wide range of health problems, including irreversible brain damage, particularly in young, developing brains. There is no known “safe” level of lead exposure.

In your practice, you have likely spoken with parents about lead exposure occurring in older (pre- 1978) homes, due to lead-based paints that were widely used prior to that time. Of course, lead may be found in soil, particularly around older homes and industrial sites and in water that flows through older pipes containing lead. Until relatively recently, parents were advised primarily about these sources of exposure. However, lead is also found in other unexpected places, necessitating a change in what we communicate to parents about exposure risks.

The U.S. and every country around the world deals with food-safety and product-safety issues. As the world becomes smaller, the items we all eat, drink, and use every day (such as cookware, herbal medicine, and cosmetics), now come from places around the globe. As countries have varying customs and regulations regarding food and product safety, the potential for lead exposure has grown.

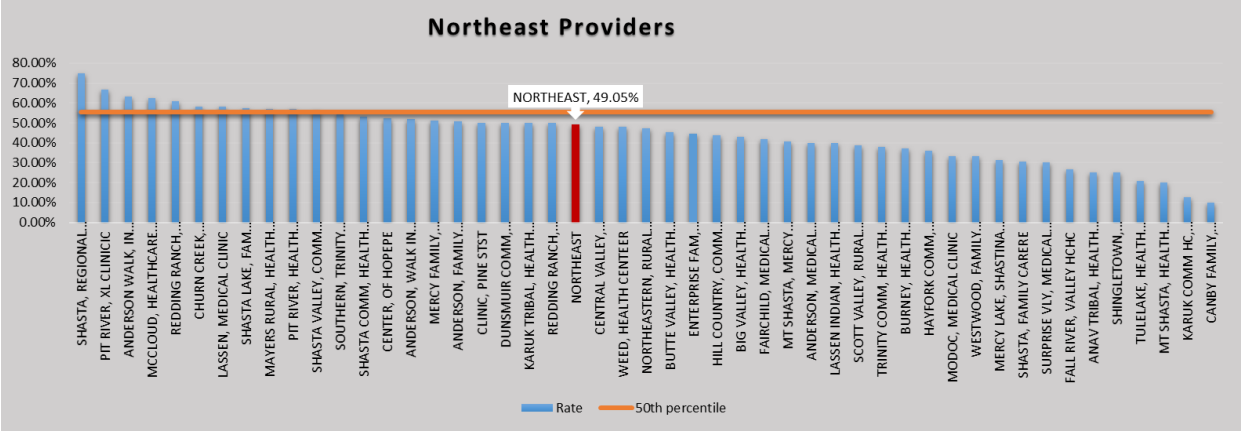
For example, the contaminated apple-cinnamon fruit pouches mentioned above were made in Ecuador and sold under various brand names in the United States. The source of contamination is suspected to be cinnamon. Furthermore, in parts of South Asia, the beautiful golden-yellow spice, turmeric, has long been used in traditional medicines and in food. In that part of the world, the turmeric roots are commonly dusted with a lead-containing compound to further enhance the spice’s color. This may be one reason that South Asia has some of the highest rates of lead poisoning in the world.

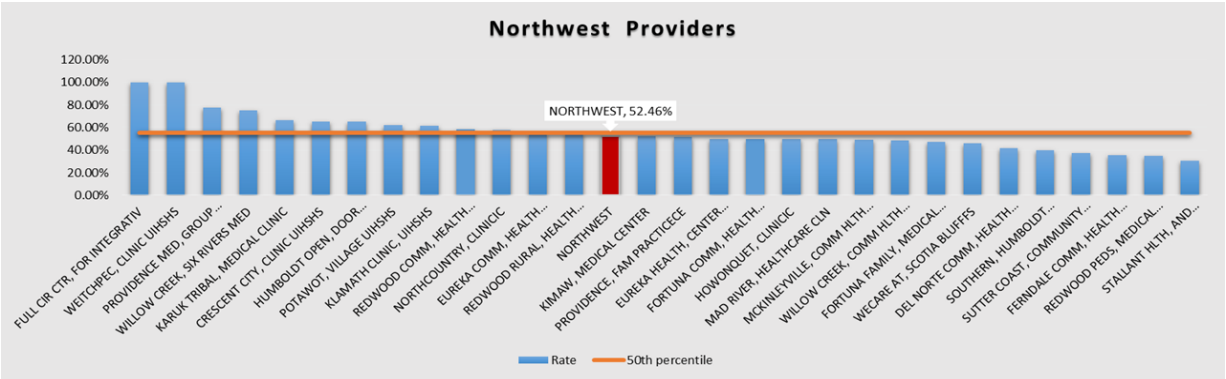
It is important that clinicians update their discussions about lead risk to include information about potential exposures from across the globe through food products, cosmetics, traditional remedies and objects such as toys, pottery and cookware.

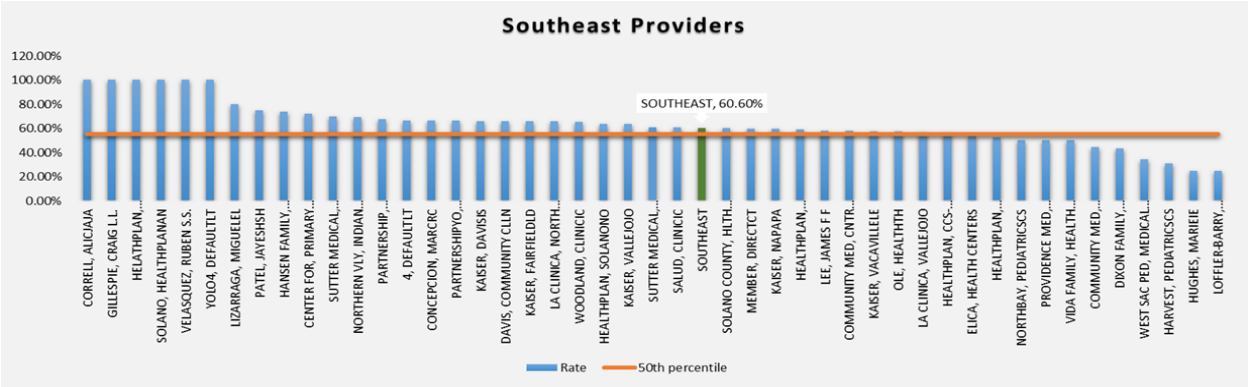
Chlamydia Screening

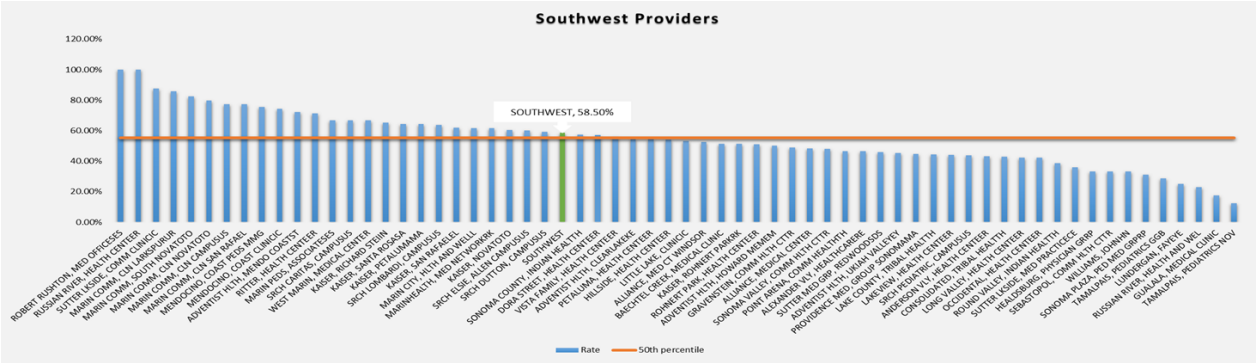
Chlamydia screening is not currently part of the Partnership pay for performance program, but Partnership was sanctioned by DHCS for low Chlamydia screening rates in the Northeast and Northwestern regions. This NCQA HEDIS measure is defined as the percentage of women 16-24 years of age who were identified as sexually active and completed at least one test for chlamydia during the measurement year. Of note, there is significant variation in screening, indicating that provider behavior influences this rate. In particular, the screening rate in teenagers varies widely, with some providers clearly not routinely screening teenagers, suggesting discomfort in talking with teens or parents about potential sexual activity.

Here are the rates of screening for all PCPs in the 14 legacy counties, by region. If your screening rate is low, we ask that you discuss this with your providers and consider template changes or alerts that will increase the screening rate. Remember to consider screening for HIV and syphilis at the same time, if appropriate.









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:
      1. G9919: Screening performed and positive and provisions of recommendations (4 and greater)
      2. G9920: Screening performed and negative (0 to 3)
   iii. Children up to age 19
b. PEARLS (Pediatric ACEs and Related Life-events Screener; includes screening for several social determinants of health) – child tool (0-11) and adolescent tool (12-19)
      1. Up to every 1 year
      2. Parents/caregiver may complete age 0-19; adolescent may answer self-report version of adolescent tool, 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

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.

Testing for Streptococcal Pharyngitis

The standard of care for treatment of streptococcal pharyngitis is to confirm infection with a rapid strep test or throat culture prior to prescribing antibiotics, or at the latest concurrent with antibiotic treatment.

Both UpToDate and the Cochrane Library summary support this standard.

NCQA has a HEDIS measure that looks at the lack of any strep test associated with antibiotic prescription for strep pharyngitis, called "Appropriate Testing for Pharyngitis" or CWP. Nationally, the 33rd percentile for this measure is 73% percent in Medicaid.

The rate of testing is far lower for Partnership members. The overall rate is just 53%, which is far below the 33rd percentile. The rate did drop about 20% during the COVID pandemic, likely a product of the increased use of virtual visits, and hesitation to send patients to the office or a lab for confirmatory testing. We ask you all to create processes to allow strep testing even if visits are done virtually.

Referral for Routine Dental Care

Denti-Cal payment rates were stabilized about 10 years ago, so dental access is better than it was before that. Medi-Cal covers two dental hygiene visits per year; this is especially important for children and pregnant women. When dental hygienists apply topical fluoride varnish at their preventive visits with children (and bill for this on their claim), this can count towards a PCP QIP unit of service measure (see below).

To locate Denti-Cal dentists with offices near you, you can search here.

Developmental Screening

FQHCs, RHCs, Tribal Health and other PPS providers are eligible, for supplemental payments for developmental screening of children in certain age ranges, 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.

g. Developmental screening:
    i. Paid based on use of CPT code: 96110, without a modifier, once for each age group: 2 months -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). 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 for billing with 96110 without a modifier. 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)

Misuse of Developmental Screening Code

In 2019, DHCS set new rules around the use of CPT Code 96110 to document comprehensive developmental screening. More than half of pediatric and family medicine providers had not performed a comprehensive developmental screening when the 96110 code was used. While several developmental screening tools are allowed, the most commonly used is the Ages and Stages Questionnaire (ASQ).

In most cases, the charts associated with use of the 96110 code documented a screening for autism with a tool such as the M-CHAT, neglecting to use the required KX modifier. Prior to 2019, the modifier was not required for autism screening.

When autism screening is provided **in addition to** a comprehensive developmental assessment, both 96110 without a modifier and 96110.KX may be billed together.

A comprehensive developmental screen is considered standard of care by the American Academy of Pediatrics, the American Academy of Family Physicians, CMS, NCQA, and DHCS. Please ensure your well-child visit process and templates include the use of a comprehensive tool such as the ASQ and documents this appropriately with 96110.

Like ACES screening, developmental screening is carved out of the PPS reconciliation process, so an additional $59.50 is paid when a comprehensive developmental screen is done, regardless of provider type. Many FQHCs are not billing 96110 at all, meaning either that they are doing developmental screening but giving up the revenue from doing so, or they are not following standard of care for pediatric preventive care. In either case, a remedy is needed. We ask Medical Directors and CEOs to take a lead in this.

Adult Guidelines

Surgeon General Call to Action: Addressing Loneliness

Key Points Surgeon General Dr. Vivek Murthy recently released a Surgeon General Advisory to call attention to “a public health crisis of loneliness, isolation, and a lack of connection in our country (HHS, 2023).” Within the advisory, he lays out a framework for a National Strategy to Advance Social Connection and states:

"Given the significant health consequences of loneliness and isolation, we must prioritize building social connection the same way we have prioritized other critical public health issues such as tobacco, obesity, and substance use disorders. Together, we can build a country that's healthier, more resilient, less lonely, and more connected (Murthy, 2023)."

The U.S. Department of Health and Human Services (HHS) published a news release discussing the Surgeon General's Advisory and highlights the physical effects of loneliness:

"The physical health consequences of poor or insufficient connection include a 29% increased risk of heart disease, a 32% increased risk of stroke, and a 50% increased risk of developing dementia for older adults. Additionally, lacking social connection increases risk of premature death by more than 60% (HHS, 2023)."

Read the Surgeon General's Advisory on Our Epidemic of Loneliness and Isolation to learn more about what your Primary Care Organization could do to address this issue with your patients.

COPD Exacerbation Management

Key Points from the 2022 Global Initiative for Chronic Obstructive Lung Disease (GOLD) report for management of exacerbations include:

- Systemic corticosteroids can improve lung function (FEV1), oxygenation and shorten recovery time and hospitalization duration. Duration of therapy should not be more than 5-7 days.
- Short-acting inhaled bronchodilators (usually a combination of beta adrenergic agent like albuterol with a muscarinic antagonist like ipratropium) are recommended as initial treatment of an acute exacerbation. Long acting bronchodilators should be continued if the patient is using them at baseline, but GOLD does not recommend adding long acting bronchodilators for acute exacerbations of COPD. This is in contrast with asthma exacerbations, in which quick acting but long-lasting formoterol containing MDIs are an option.
- Maintenance therapy with long-acting bronchodilators should be initiated as soon as possible before hospital discharge.

Statin Therapy in Patients with Cardiovascular Disease or Diabetes

In 2022, about 36% of Partnership members with diabetes were not being prescribed recommended cholesterol-lowering medications. For patients with diagnosed cardiovascular disease, about 19% had not received statin therapy.

In formal studies of other populations, the patients not on statins (where statin therapy was indicated:

1. 60% of those not taking statins were not offered them by their doctor/clinician. This study found that women and African American/Black patients were less likely to have been offered statin therapy, suggesting possible underlying bias.
2. 30% had been on treatment and discontinued therapy. Most of these expressed a willingness to reconsider therapy with another medication.
3. 10% had declined statin therapy.

The Partnership Pharmacy team is meeting with PCP sites with a list of patients who are not taking statin therapy, part of our focused academic detailing program. **If you are interested in having the pharmacists visit, please contact your regional medical director who will pass on the request to the pharmacy team.**

Here is a summary of best practices for adding appropriate statin therapy and improving adherence for patients with diabetes and/or cardiovascular disease:

1. Members who do not tolerate one statin may be able to tolerate a different statin.
2. Consider statins with fewer drug interactions, such as rosuvastatin, pravastatin, and fluvastatin.
3. Review medication lists to confirm a statin has been prescribed when indicated.
4. Provide patient education: explaining goals of statin therapy and need for adherence.
5. Prescribe statins as 90 day supplies, once therapy is stable.
6. Ask your patients open-ended questions to monitor for adverse drug reactions, drug-drug interactions, and other obstacles that may hinder medication adherence.
7. Collaborate with dispensing pharmacies to identify and address medication adherence gaps.
8. Specific medication recommendations:
    a. For high intensity statin therapy (lowers LDL-C by >50%), consider atorvastatin 40-80 mg or rosuvastatin 20-40 mg.
    b. For moderate intensity statin therapy (lowers LDL-C by 30% to <50%), consider atorvastatin 10-20 mg, rosuvastatin 5-10 mg, or simvastatin 20-40 mg.

Cognitive Health Assessments Required Annually for Patients over age 65

The California Legislature passed a bill requiring that all patients age 65 or older receive an annual cognitive health screening to detect early dementia. This went into effect on July 1, 2022. DHCS released policy language about this requirement. Here are some highlights.

1. For Medi-Cal beneficiaries over the age of 65 who do not have Medicare, a CPT2 code (1494F) has been designated to be used to indicate that such a cognitive screening was performed. If billed with the visit, an enhanced payment will be paid on a fee for service basis.
2. DHCS has a mandatory training that must be completed by clinicians wishing to be paid for billing 1494F. This training can be accessed at: www.dementiacareaware.org . Few primary care clinicians in our 24 counties have completed this training, so far.
3. DHCS has added additional options for which cognitive assessment tools may be used. Early options presented included the mini mental status exam (MMSE) and the St. Louis University Mental Status Exam. The draft policy change added the General Practitioner Assessment of Cognition (GPCOG), the Mini-cog, the Informant Interview to Differentiate Aging and Dementia, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

Of note, Cognitive Health Assessments are required for Medicare-Medi-Cal covered patient enrolled in a Medicare advantage plan, so everyone caring for patients over age 65 should complete the trainings on the dementia care aware website.

Are Urine Tests Missing STI Diagnosis?

A recent article published in the *Journal of the American Medical Association (JAMA)* indicated vaginal swabs detected significantly more cases of sexually transmitted infections (STIs) than urine samples. Results from 28 studies conducted between 1995 and 2021 indicated vaginal swabs were more effective at detecting chlamydia and gonorrhea, but only marginally so at detecting trichomonas (Harris, 2023).

The US Centers for Disease Control and Prevention released new guidelines in 2014 favoring vaginal swabs for STI detection; however, urine samples continue to be the most popular form of testing (Harris, 2023). The researchers hypothesized that over-reliance on urine testing could result in several hundreds of thousands of missed STI diagnosis each year (Harris, 2023).

The full study is published in the *Annals of Family Medicine* and concludes that, “vaginal sampling should be the initial choice offered to patients

(Aaron, et al, 2023).” Additional research is needed for implementation of physicians’ preferred testing methods (Harris, 2023).

Read the original *JAMA* article at https://jamanetwork.com/journals/jama/fullarticle/2804007

Read the full study at https://doi.org/10.1370/afm.2942

New One Month Treatment for Latent Tuberculosis

A more convenient, one-month treatment for latent tuberculosis infection (LTBI) is now available.

Treatment of LTBI is essential to controlling tuberculosis (TB) disease in the United States because it substantially reduces the risk that LTBI will progress to TB disease. While all LTBI regimens have good efficacy, clinicians should consider factors that include but are not limited to comorbidities, safety & tolerability, and drug interactions when selecting a LTBI regimen. Current recommendations from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) includes the following: 6 or 9 months of daily isoniazid (6H, 9H); 3-month regimen of weekly rifapentine plus isoniazid (3HP); 3-month regimen of daily isoniazid plus rifampin (3HR); 4 months of daily rifampin alone (4R), and a new1-month regimen of daily rifapentine plus isoniazid (1HP).

While isoniazid administered daily for 6 to 12 months has been the mainstay of treatment for more than half a century, newer and shorter treatment regimens have emerged that show similar efficacy and tolerability to the isoniazid regimen. Shorter regimens such as 4R and 3HR when compared to 9H not only have similar efficacy but also higher completion rates and less hepatotoxicity. More recently, a Phase III randomized, open-label, controlled trial showed a 1-month regimen of daily rifapentine plus isoniazid (1HP) given to HIV-infected patients aged 13 years and above, living in areas of high TB prevalence or who had evidence of LTBI was non-inferior to 9 months of isoniazid alone (9H) treatment.

The CDC and WHO guidelines and recommendations for TB prevention and LTBI treatment are linked below.

https://www.cdc.gov/mmwr/volumes/69/rr/rr6901a1.htm?s_cid=rr6901a1_w

https://www.who.int/publications/i/item/9789240001503

Health Equity

According to the World Health Organization, equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.

Health Equity: What it means for Primary Care

There are three pillars to Health Equity work: 1. Workforce diversity and cultural responsiveness, 2. Data Collection and Stratification, and 3. Reducing Healthcare Disparities, with examples. See the August 2022 Newsletter for details.

Mandatory Diversity-Equity-Inclusion Training – Coming soon.

DHCS is requiring Medi-Cal Managed Care Plans to mandate and monitor regular trainings on Diversity-Equity-Inclusion (DEI) for all patient-facing staff working in the primary care and specialty setting. This will begin in late 2024. Online options will be available. More details will be coming in the months ahead.

Measuring Health Inequities

Partnership can use two primary sources to look for plan-wide health inequities:

1. HEDIS data includes more measures (approximately 50 measures), but Hybrid measures have small denominators making statistical significance for disparities harder to find.
2. PCP QIP data is a smaller set of measures, but achieves statistical significance on HEDIS hybrid measures.

In both cases, inequities are identified by finding statistically significant differences between a historically disadvantaged population versus the historically favored population. At this point in time, we have only completed analyses of inequities based on self-identified race/ethnicity (based on U.S. census criteria) and language data. There are many other likely inequities present which deserve analysis in the future:

a. Disability
b. Gender

c. Gender identity
d. Sexual orientation
e. Income
f. National origin
g. Geography, especially rural vs. suburban/urban and neighborhood-based
h. Educational attainment

Major findings:

A. Ethnic disparities in the MY 2022 MCAS data which were statistically significantly worse than the reference white population

Summary:
Total MCAS measures (MY 2022): 29 (excluding birth control and utilization and duplicate measures)
Number of measures with Native American inequity: 19 (66% of measures)
Number of measures with Black inequity: 10 (34% of measures)
Number of measures with Pacific Islander inequity: 6 (17% of measures)
Number of measures with Hispanic inequity: 5 (14% of measures)
Number of measures with Asian inequity: 2 (7% of measures)

1. Follow up after initiation of medication for attention deficit disorder
    a. American Indian (32%) Pacific Islander (20%) compared to white (41%)
2. Antidepressant Medication Management, both Acute and Chronic
    a. American Indian (40%), Pacific Islander (38%), Black (51%), Hispanic (46%) compared to white (55%)
3. Monitoring children taking second generation antipsychotic medication for cholesterol
    a. American Indian (26%), compared to white (37%)
4. Breast Cancer screening
    a. American Indian (35%), Pacific Islander (42%), compared to white (47%)
5. Cervical Cancer screening
    a. American Indian (42%), compared to white (67%)
6. Vaccines under age 2 (CIS-10)
    a. American Indian (18%) compared to white (25%)
7. Colorectal cancer screening
    a. American Indian (17%), Pacific Islander (21%), compared to white (27%)
8. Developmental screening in children
    a. American Indian (9%), compared to white (20%)
9. Depression Screening
    a. American Indian (0.3%), compared to white (1.27%)
10. Follow up for ED visit for SUD 7 day
    a. American Indian (20%), Asian (38%), Black (20%), Hispanic (19% overall, 14% in Spanish speaking) compared to white (27%)

11. Follow up for ED visit for SUD 30 day
    a. American Indian (28%), Asian (32%), Black (30%), Hispanic (29% overall, 25% in Spanish speaking) compared to white (37%)
12. Follow up for ED visit for Mental Health Diagnosis 7 day
    a. American Indian (8%), Black (10%), compared to white (14%)
13. Follow up for ED visit for Mental Health Diagnosis 30 day
    a. American Indian (10%), Black (19%), compared to white (25%)
14. Diabetes poor control
    a. American Indian (36%), compared to white (33%)
15. Adolescent Immunization
    a. American Indian (16%), compared to white (23%)
16. Lead Screening
    a. Black (32%), compared to white (36%)
17. Early prenatal care
    a. Black (78%), compared to white (88%)
18. Postpartum visit
    a. Black (78%), compared to white (84%)
19. Monitoring adults taking second generation antipsychotic medication for cholesterol
    a. American Indian (69%), compared to white (80%)
20. Topical Fluoride coded for in children (medical or dental visit)
    a. American Indian (0%), compared to white (0.12%)
21. Well child visit between 15 and 30 months of life (2 visits)
    a. American Indian (51%), Black (49%), Pacific Islander (50%), compared to white (56%)
22. Well child visit before 15 months of age (6 or more visits)
    a. American Indian (33%), Black (36%), Hispanic (39%), compared to white (42%)

Rural MCAS measures lower than Urban in 20/29 measures (69%)

Urban only statistically **worse** in:

1. Well child visits in the first 15 months (6 or more visits) 39% vs 44%
2. Topical Fluoride 0.12% vs 0.28%
3. Pharmacotherapy for Opioid Use Disorder 23% vs. 26%
4. Lead screening 40% vs. 45%

B. PCP QIP Equity Analysis

In 2022 there were 11 clinical measures

- Native American: 10/11 have worse outcomes than the white population (only exception: Adolescent vaccination, equally below average for AA/AN and white population)
- Black/African American: 5/11 have worse outcomes than the white

population (W15, Well child visits, Blood pressure control, colorectal cancer screening, A1c poor control)

- Pacific Islander and South-east Asian: 1/11 worse than white population: W15, but denominators are small, so likely random variation.

- No disparities: Hispanic, South Asian, East Asian

Trends:

- Increased number of disparities in Black, Pacific Islander, and SE Asian populations.

Partnership is addressing these inequities with a series of interventions, as outlined in our Quality Improvement, Health Equity, and Population Health program documents.

2023 Population Needs Assessment Now Available

Partnership's 2023 Population Needs Assessment (PNA) is now available and can be accessed at this link. It includes a review of population health parameters from a variety of sources and analyzes these parameters to inform Partnership's population health activities.

Health Equity/Practice Transformation Directed Payment Program

In January 2024, DHCS announced awardees of the long awaited Equity Practice Transformation Directed Payment program. Based on achievement of specified deliverables, payments will be made twice yearly, depending on the size of the organization.

Of the 56 organizations in the Partnership service area that applied, 27 were awarded, a higher success rate than any other health plan in California. For these 27 organizations, the amount of money available for directed payment totals: $48,825,000

Statewide, 207 organizations were awarded. Awards were weighted based on the sociodemographic risk of their population, and based on selecting specified elective activities, with some accounting for geographic distribution.

Name of Organization Awarded	Health Center Type
Ampla Health	FQHC
Alexander Valley Healthcare	FQHC
Harmony Health Medical clinic and Family Resource Center	FQHC
Mountain Valleys Health Centers	FQHC
Northeastern Rural Health Clinics Inc.	FQHC
Open Door Community Health Centers	FQHC
Peach Tree Healthcare	FQHC
Petaluma Health Center, Inc.	FQHC
Redwood Coast Medical Services	FQHC
Shasta Community Health Center (SCHC)	FQHC
Solano County, Family Health Services	FQHC
West County Health Centers Inc.	FQHC
Western Sierra Medical Clinic, Inc.	FQHC
St. Elizabeth Hospital Lassen Medical Clinic	Rural-Hospital
Eastern Plumas Health Care	Rural-Hospital
Fairchild Medical Center dba Siskiyou General Hospital	Rural-Hospital
Southern Humboldt Community Healthcare District	Rural-Hospital
Baechtel Creek Medical Clinic	Rural-Independent
Stallant Medical Group Inc.	Rural-Independent
Chapa-De Indian Health Program	Tribal
Kimaw Medical Center	Tribal
Lassen Indian Health Center	Tribal
Northern Valley Indian Health	Tribal
Pit River Health Service, Inc.	Tribal
Round Valley Indian Health Center	Tribal
Sonoma County Indian Health Project, Inc.	Tribal
United Indian Health Services, Inc.	Tribal

Congratulations to all the awardees! Partnership Performance Improvement staff and DHCS will be working with them over the next 5 years to achieve the ambitious goals of the EPT program.

General Quality Updates

DHCS Quality Oversight of Managed Care Plans

The accountable measures in the DHCS Managed Care Accountability Set (MCAS) for reporting year RY2025 (measurement year MY2024) are:

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Behavioral Health Domain Measures					
1	Follow-Up After ED Visit for Mental Illness—30 days[*,iv]	FUM	NCQA	Administrative	Yes
2	Follow-Up After ED Visit for Substance Use—30 days[*]	FUA	NCQA	Administrative	Yes
Children's Health Domain Measures					
3	Child and Adolescent Well-Care Visits[*]	WCV	NCQA	Administrative	Yes
4	Childhood Immunization Status—Combination 10[*]	CIS-10	NCQA	Hybrid/Admin[**]	Yes
5	Developmental Screening in the First Three Years of Life	DEV	CMS	Administrative	Yes[iii]
6	Immunizations for Adolescents—Combination 2[*]	IMA-2	NCQA	Hybrid/Admin[**]	Yes
7	Lead Screening in Children	LSC	NCQA	Hybrid/Admin[**]	Yes
8	Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes[iii]
9	Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits[*]	W30-6+	NCQA	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits[*]	W30-2+	NCQA	Administrative	Yes
Chronic Disease Management Domain Measures					
11	Asthma Medication Ratio[*]	AMR	NCQA	Administrative	Yes
12	Controlling High Blood Pressure[*,iv]	CBP	NCQA	Hybrid/Admin[**]	Yes
13	Glycemic Status Assessment for Patients With Diabetes (>9%)[*,iv]	GSD	NCQA	Hybrid/Admin[**]	Yes

Reproductive Health Domain Measures					
14	Chlamydia Screening in Women	CHL	NCQA	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	NCQA	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Yes
Cancer Prevention Domain Measures					
17	Breast Cancer Screening*	BCS-E	NCQA	ECDS	Yes
18	Cervical Cancer Screening	CCS	NCQA	Hybrid/Admin**	Yes

Electronic Clinical Data Systems (ECDS) Measures: DataLink

ECDS is a HEDIS reporting standard for health plans collecting and submitting quality measures to NCQA. This reporting standard defines the data sources and types of structured data acceptable for use for a measure. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

ECDS reporting is part of NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. ECDS measures are indicated by a "-E" after the measure name.

<u>The following ECDS measures require data to be extracted from the Electronic Health Record</u>:

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

There is an ECDS Unit of service measure in the 2024 PCP QIP, but it is very likely that this measure will be converted midyear to a related measure: Integration with DataLink, a program which extracts this data automatically from all electronic health records. If this conversion occurs, it will be announced in May or June.

Facility Site Review and CPSP Oversight

There are three types of site review: Facility Site Reviews, Medical Record Reviews, and Disability Accessibility Reviews. The third type of review will not be covered in this overview. For the detailed policy on Site Reviews, see the Site Review Policy, with related Attachments A, B, C, D, and E.

If you have not had a Site Review in the past year or two, please note that DHCS increased the requirements of Site Reviews to be much more challenging, as of 2022. Even if you passed easily in the past, we recommend your compliance team review the requirements carefully now to begin preparing for your next review well before it happens, to increase the probability of passing on the first review.

New, starting later this year: DHCS has directed Partnership to monitor the quality of CPSP and CPSP-like services. This will begin to be audited by the end of 2024, in conjunction with every 3 year audits of prenatal care sites. Partnership will have the flexibility to specify variations from the state CPSP program. We will be working on a draft of these program descriptions in the spring of 2024.

We offer training on any topics covered in our tools and within the site review. Please feel free to contact us with any questions.

If you are interested in a more elaborate training related to all the site review changes as of 7/2022 please email the FSR inbox at FSR@partnershiphp.org.

Improving the Patient Experience

Since the COVID pandemic, patient experience surveys conducted by Partnership have shown concerning below average scores for both Adults and Children. Partnership's Clinical Quality Scores were above average; our overall Health Plan rating would have been 4.0 Stars if the CAHPS score had been better. In addition, a new state quality program in 2024 withholds substantial capitation money from Partnership, with 20% of this dependent on CAHPS scores.

For this reason, improving all aspects of our members' experience of care is a high priority. We can only substantially improve with the attention and support of our primary care network.

Here is the summary for the CAHPS surveys done in 2022 and 2023:

● Survey Gate Question ● QC ≥ 50th Percentile

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2021 HEDIS Quality Compass (QC) Percentile	Performance	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2022 HEDIS Quality Compass Percentile
Rating Measure	Rating of Health Plan (% 8, 9, 10)	69.9%	<5th	3.9%	73.8%	18th
	Rating of All Health Care (% 8, 9, 10)	70.0%	<5th	4.9%	74.9%	40th
	Rating of Personal Doctor (% 8, 9, 10)	77.6%	6th	3.9%	81.5%	42nd
	Rating of Specialist Seen Most Often (% 8, 9, 10)	● 82.3%	34th	-1.2%	81.1%	26th
Composite Measure	Getting Needed Care (% Always or Usually)	76.0%	7th	0.4%	76.4%	14th
	Getting Care Quickly (% Always or Usually)	72.9%	5th	-3.4%	69.5%	5th
	Care Coordination (% Always or Usually)	● 81.3%	15th	5.3%	● 86.6%	73rd
	Customer Service (% Always or Usually)	● 87.2%	25th	1.4%	88.6%	38th

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2021 HEDIS Quality Compass (QC) Percentile	Performance	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2022 HEDIS Quality Compass Percentile
Rating Measure	Rating of Health Plan (% 8, 9, 10)	82.2%	11th	2.5%	84.7%	33rd
	Rating of All Health Care (% 8, 9, 10)	83.7%	<5th	-3.3%	80.4%	<5th
	Rating of Personal Doctor (% 8, 9, 10)	89.0%	26th	1.5%	● 90.5%	51st
	Rating of Specialist Seen Most Often (% 8, 9, 10)	● 81.6%	6th	3.6%	85.2%	34th
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	-2.9%	76.7%	10th
	Getting Care Quickly (% Always or Usually)	84.1%	25th	-7.8%	76.3%	<5th
	Care Coordination (% Always or Usually)	● 85.3%	34th	-4.2%	81.1%	19th
	Customer Service (% Always or Usually)	● 89.4%	60th	0.5%	● 89.9%	73rd

Here are the questions that feed into the four composite measures:

Getting Needed Care

Q9 Easy for respondent to get necessary care, tests, or treatment
Q18 Respondent got appointment with specialists as soon as needed

Getting Care Quickly

Q4 Respondent got care for illness/injury as soon as needed
Q6 Respondent got non-urgent appointment as soon as needed

NOTE: These two categories; Getting Needed Care and Getting Care Quickly can be collapsed into a single Access Composite score.

How Well Doctors Communicate

Q12 Doctor explained things in a way that was easy to understand
Q13 Doctor listened carefully to enrollee
Q14 Doctor showed respect for what enrollee had to say
Q15 Doctor spent enough time with enrollee

Health Plan Customer Service

Q22 Customer service gave necessary information/help
Q23 Customer service was courteous and respectful

Primary Care Patient Experience Survey Results (2023)

Each spring, as part of our Primary Care Provider Pay for Performance Program (PCP QIP), we utilize a certified vendor to conduct the Agency for Healthcare Research standardized patient experience survey called the Clinician and Group – Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey, for our PCP Parent Organizations with at least one visit by 2400 unique Partnership members. The QIP performance is based on the overall group score, as individual site scores often have too low a denominator to be statistically valid. Parent organizations of less than 2400 members may earn points base on conducting a survey of their own and acting to improve the patient experience using the results of the survey. The Patient Experience Measure is worth 10% of the PCP QIP.

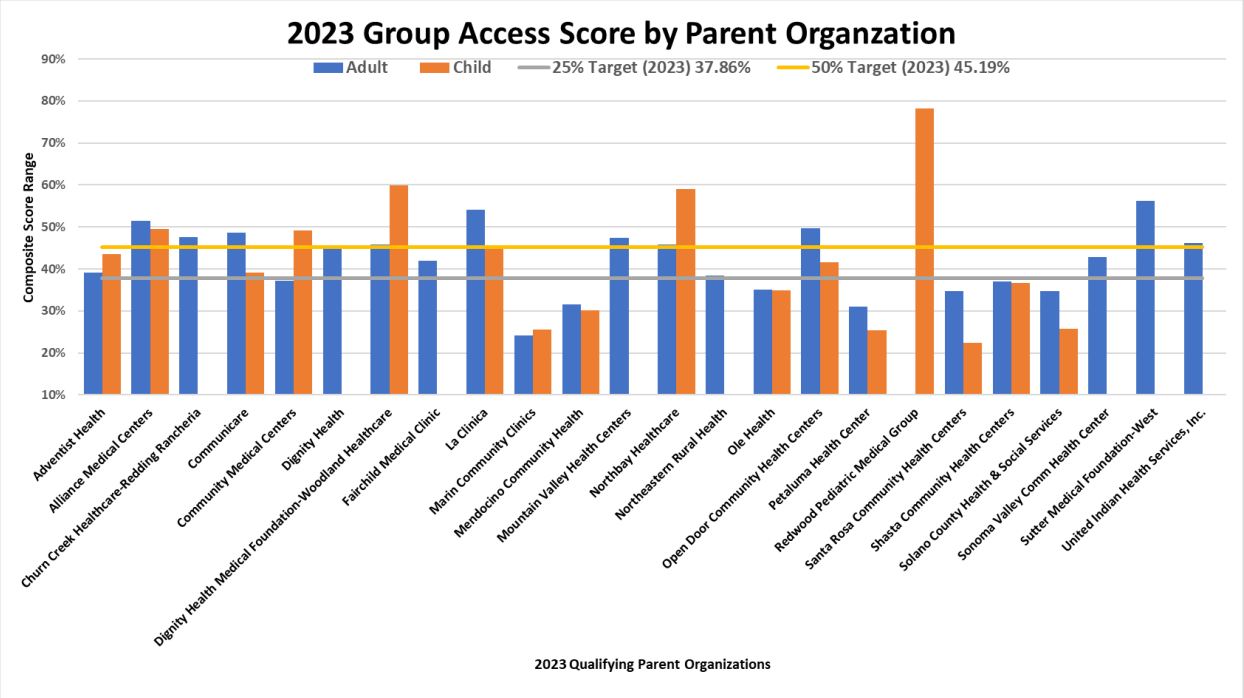
Two benchmarks are listed, for the 25th percentile and the 50th percentile based on our Partnership results.
Up to four results are noted for each PCP: Adult and Caregiver on behalf of child are the age categories, and Communication and Access are the two composite scores reported for each. Two other composite scores will be sent to the PCP, but not used for scoring: Coordination of Care and Office Staff.

Here are the results for our 14 legacy counties, for the Access and Communication Composite Scores.

Access Scores:

Highest scores for Children: Redwood Pediatric Medical Group, NorthBay, and Dignity Woodland

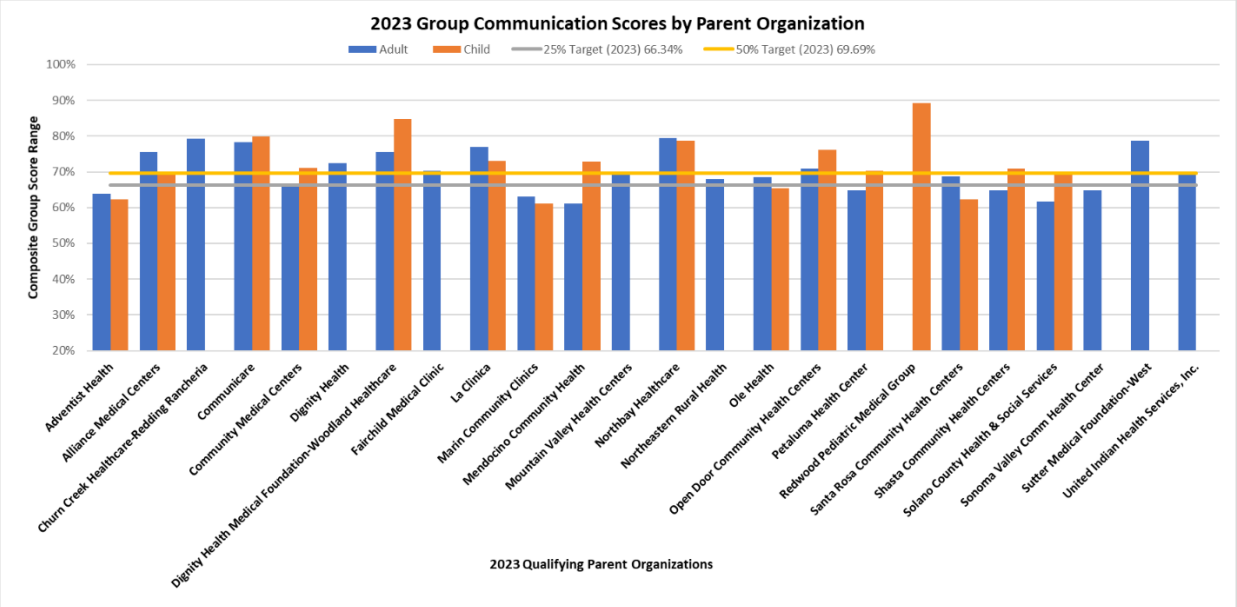
Highest scores for Adults: Sutter Medical Foundation West, La Clinica, Alliance Medical Center



Communications Scores:

Highest for Children: Redwood Pediatric Medical Group, Dignity Woodland, Communicare

Highest for Adults: Northbay Healthcare, Churn Creek Redding Rancheria, Sutter West



Reflections on the Patient Experience

Think for a moment of the last time you needed to interact with the health care system. What were the things that made you like or not like the way that care was delivered?

Having amazing patient experience is not an easy lift. There are many factors which can impact it. Fundamentally, there is a constant tension between optimizing clinician productivity (with shorter visits) and having optimal access and communication (this is one reason for the rise of concierge medicine, where a few patients have great access and communication, if they can afford it). If there is a large demand for services, the balance is between shutting down access altogether to some patients to give better access and service to a smaller group. For the most part this is not aligned with the mission of health centers, so they are continuously working to find the best balance possible between productivity, access and communication.

Here are some of the many factors that busy practices need to keep track of to have optimal customer experience:

On the access side, here are some factors that impact your experience:

1. How easy is it to get medical advice during the day? After hours?
2. How easy is it to talk to your doctor?
3. How easy is it to make an appointment at a time that works for you? Are there options for care in the evening or the weekend? Did the staff ask if you needed help with transportation to the visit?
4. Were you able to see your personal PCP or did you see someone else for your visit?
5. How easy and fast is it to get through to the office on the phone?
6. Is there a well-functioning internet-based portal that allows you to do many things yourself?
7. How easy is it to get needed medication refills?
8. How long did you wait in the waiting room to be seen?
9. How long did you wait in the exam room to be seen?
10. Once the doctor/clinician saw you, was the visit efficient or drawn out?
11. If you needed to see a specialist, how easy was it to get an appointment?
12. Was the specialist appointment as soon as you wanted it, or was it far in the future?
13. Was the specialist visit close to home or did it require traveling a longer distance?
14. Were you offered the option of a virtual visit?

On the communication side, here are some factors that impact your experience:

1. When you communicate with your doctor's office by phone, text or email, was the interaction professional, polite, and respectful?
2. When you arrive to the doctor's office for a visit, do the receptionist and medical assistant and other support staff, interact with you in a

professional, polite, respectful and warm way?
3. If your wait was long in either the waiting room or the exam room, did someone keep you up to date on the status and offer to reschedule if the wait was too long?
4. Is the building where the visit occurs in good repair, clean, and inviting?
5. Does it feel like the staff in the doctor's office communicate with each other, so you don't have to repeat yourself?
6. If English is not your first language, did the office staff speak your language understandably? If not, were you offered video or phone translation?
7. Does your doctor/clinician:
    a. Seem to care about you as a person. (Make eye contact, smile, show curiosity about you as a person).
    b. Ask questions to find out what the reason for the visit is, and about your symptoms (collect a good history)
    c. Examine you (at a minimum the part of your body with symptoms or related to your problem)
    d. Clearly Explain what your diagnosis/problem is
    e. Clearly explain their recommendations for treatment, answering all questions you have about this.
    f. Describe what symptoms or changes should prompt you to call or return sooner than scheduled.

We are all patients and customers at when we need to access health care. The questions above may seem a stretch for your practice, but they reflect the service you deserve and also what our patients deserve.

When a patient answers a CAHSP survey indicating that access or communication was below average, that survey is not sufficiently granular to know which one or more of the above factors was the reason. For this reason, it is essential to not use the CG-CAHPS as the only tool for deciding what interventions are needed to improve the customer experience. More detailed questions from a sample of your patients is one way to do this. Having office staff hyper-attuned to the experience of care is another (think of the staff of the Ritz Carlton Hotel or Disneyland). Having some patients who are "secret shoppers" is another. The key is to be continuously looking for ways to get better, not being complacent and thinking, "well this is the way it is; there isn't anything we can do to make it better," or "I don't believe that survey, our patients all say they are happy."

Regardless of the method used to get the granular detail, you can see that broadly interventions can be grouped by these main drivers, which are in approximate order of increasing effort.

1. <u>Optimize the Physical Space for Healing:</u> Keep the parking lot, building, waiting rooms, exam rooms, hallways and restrooms clean, bright, odor-free and inviting. (Design, upgrades, maintenance)
2. <u>Workforce:</u> If your clinician or non-clinician staffing is insufficient to meet the needs, work to increase staffing hours (adjusting hours; recruitment and retention)
3. <u>Operational Activities:</u>
    a. Develop systems and policies that make the office run as efficiently as possible, reducing non-value added waiting time for patients and clinicians. (Office workflows and scheduling practices)
    b. Arrange your systems so that patients can see their personal

doctor/clinician instead of another clinician as much as possible[1] (empanelment and balancing supply and demand).

4. Optimize interpersonal interactions:
    a. Support Staff: Ensure all support staff are trained, retrained, and proficient in communicating warmly, clearly, accurately, and respectfully. (Monitor and look for ways to improve in daily huddles, evaluating any challenging encounters. Customer service training from service industry)
    b. Clinical Staff:
        i. Ensure your clinical staff are resilient, happy, and feel valued for their work. (burnout prevention activities)
        ii. Help your clinical staff improve the clarity and accuracy of their communication. (coaching, review of video/audio interactions, training, self-learning)
        iii. Help your clinical staff improve their non-verbal and verbal communication of attention, respect and caring for the patients. (same as ii, plus staff training/coaching conducted by behavioral health professionals; Medical Improv; business trainers)

The first three main drivers (physical space, staffing, and operational activities), and optimizing the interpersonal interactions of support staff require clinical leaders to partner closely with the overall office/clinic leadership. This relationship between the clinical leader and the organizational/operational leadership is essential, and must be nurtured and developed over time, in an environment of mutual respect and teamwork.

Optimizing the interpersonal interactions of the clinical staff is one of the major responsibilities of their clinical leader. While they will need some support from administration, it is the clinical leaders who need to own and lead these efforts, serving as mentors and coaches, bringing in outside resources as needed.

An underlying principle is that clinical and non-clinical leaders must strive to promote a culture of continuously striving for excellent (and improving) customer service. Specific actions that can promote this culture may include:

- Develop a team culture committed to high customer service standards.
- Daily team huddles, less than 5 minutes.
- Patient care affirmations to nurture positive workspace.
- Daily touchpoints to reset and closeout the day.
- Create a thoughtful and empathic culture, both outward and inward.

Quality Improvement Program Description, Annual Evaluation and Work Plan

Each year, Partnership updates three core documents: the Quality and Performance Improvement Program Description, the Annual Quality Improvement Evaluation, an annual update of our QI Work Plan. If you are interested in reviewing these documents, they are available here: Quality page

[1] A Kaiser study from the 2000s showed that having a patient appointment with their personal primary care physician was the single factor that predicted a higher response on all other questions of patient satisfaction.

Listening Campaigns for Preventing Clinician Burnout

From the American Medical Association

When it comes to the critical question of how to alleviate the nation's physician burnout epidemic, here is an approach that offers an intriguing answer: First, ask your doctors.

"We really developed this to make sure that every physician's voice could be heard and to address the practical, daily issues and then prioritize those for that group," said Dr. Sarah Richards, a practicing hospitalist and senior medical director for clinician experience at Nebraska Medicine.

This sort of listening campaign should be customizable and flexible, Dr. Richards said. The general idea is that during a meeting with physicians in the same group, a leader or facilitator will use written and verbal prompts to propel discussion about what's going well and how their jobs can be improved.

Dr. Richards says the listening campaign differs from other methods of gaining feedback on physician burnout because it creates an easier way for doctors' voices to be heard.

One-on-one discussions or group surveys can lead to an imbalance in participation, Dr. Richards said.

"Oftentimes, we were hearing from the same physician over and over, maybe the person that was more senior or felt more comfortable speaking up," she said. Organizations may not hear as much from younger or midcareer physicians who may not "feel safe, for whatever reason, bringing up issues or concerns."

The written component of a listening campaign makes it easier to anonymously offer negative feedback, she said. And the oral component focuses on positivity—the group successes—making it less stressful to chime in.

"The listening session is structured in such a way to allow us to make sure everybody is heard," said Dr. Richards, who also spoke about the power of listening campaigns to reduce burnout in an episode of the "AMA STEPS Forward Podcast."

Listening campaigns can be conducted through videoconferencing, in larger or smaller groups, and can be shortened in duration or the components included. A good way to engage physicians, Dr. Richards said, is to start with just one part

of the campaign: asking each doctor to share one wish for something that would most improve their professional fulfillment. Then, the group rates each wish on a one-to-10 scale to produce a prioritized wish list for the group.

There is, though, one hard-and-fast rule to the listening campaign: Leaders must follow up.

Dr. Richards said a lack of leadership buy-in and follow up in a listening campaign—even if it's just communicating what the barriers are to the concerns raised by physicians is essential.

"The last thing you want is for people to spend time to bring up these ideas, to go through this activity and then have it be kind of a one-and-done. If you never hear anything, that can actually be worse than not doing it at all," she said. "If the physicians' most popular wish is that everyone gets a scribe, that might just not be financially viable at that moment. But the leader needs to be committed to taking the time doing the research, looking into the why and the why not."

AMA STEPS Forward open-access toolkits offer innovative strategies that allow physicians and their staff to thrive in the new health care environment. These resources can help you prevent physician burnout, create the organizational foundation for joy in medicine and improve practice efficiency.

Reducing Note Bloat: Revise your EMR templates to meet 2021 coding standards

In 2021, while most health care professionals were focused on caring for patients with progressively more dangerous strains of COVID and promoting vaccination to a polarized public, a revolutionary change in coding requirements for Evaluation and Management codes was released.

This change was based on a simple premise - that coding should be based on time and complexity of medical decision making, with the supporting documentation customized and focused on the problems at-hand.

After two decades of focusing on a matrix of documentation requirements (which have been built into EMRs and often left in progress notes regardless of accuracy), the unintended negative consequences of the previous system have persisted beyond 2021, as the templates built before 2021 have mostly persisted.

This results in lengthy progress notes with many errors, some of which result in diagnostic or treatment errors. These errors are so prevalent that reading a concise and well-constructed progress note now elicits surprise and pleasure in the reader.

Disentangling ourselves from the bloated notes our EMRs are producing requires commitment and intentionality. One option is to strive every day to generate concise and meaningful progress notes without information that is not relevant to the visit. Another option is to use new AI-assisted transcription services that organize your conversation with your patient into a coherent progress note. A practice planning to switch EMRs in the near future can wait and start over with the 2021 standards built in from the beginning, during the configuration process.

Lastly, a practice not planning to change EMRs could prioritize an initiative to systematically review templates and workflows, combined with clinician training. The American Medical Association has a toolkit to help with this last option.

Ensuring your clinicians are knowledgeable on the new standards is an important first step. Since this knowledge will result in less unnecessary documentation, it will ultimately save time and support the well-being of our clinicians, a worthy investment.

Pay for Performance Program for Primary Care (PCP QIP)

PCP QIP Program Overview

Partnership's PCP Quality Incentive Program (QIP) has been in place for more than 25 years, and has evolved over that time period. Designed in collaboration with our PCP provider network, the goal is to align Partnership and our Primary Care Providers on Quality Goals, and to transfer substantial resources to PCPs that they can leverage to improve quality.

The QIP uses nine (9) guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The detailed specifications for the 2024 version of the PCP QIP can be found here. The material below is an abbreviated version.

PCP QIP Measure Sets

There are two measure sets in the PCP QIP: The Core Measure Set (with a mix of Clinical Measures and Non-clinical Measures) and the Unit of Service measure set.

(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. Below are the three measure sets with targets and points for each:

2024 Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening	90th Percentile (63.37%)	50th Percentile (52.20%)	6	5
Cervical Cancer Screening	90th Percentile (66.48%)	50th Percentile (57.11%)	6	5
Child and Adolescent Well Care Visits	90th Percentile (61.15%)	50th Percentile (48.07%)	9	7
Childhood Immunization Status: Combo 10	90th Percentile (45.26%)	50th Percentile (30.90%)	6	4
Colorectal Cancer Screening	50th Percentile (%)-TBD	25th Percentile (%)-TBD	5	4
Comprehensive Diabetes Care: HbA1c Control	90th Percentile (60.34%)	50th Percentile (52.31%)	6	5
Comprehensive Diabetes Care - Retinal Eye Exams	90th Percentile 63.33%)	50th Percentile (52.31%)	5	4
Controlling High Blood Pressure	90th Percentile (72.22%)	50th Percentile (61.31%)	6	5
Lead Screening in Children	50th Percentile (62.79%)	N/A - New measures do not qualify for partial points in the first measurement year	6	N/A
Immunizations for Adolescents – Combo 2	90th Percentile (48.80%)	50th Percentile (34.31%)	6	4
Well-Child Visits in the First 15 Months of Life	90th Percentile (68.09%)	50th Percentile (58.38%)	9	7
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0-1.2	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.9 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	5 points each are available for: 50th Percentile (Access 41.97%) 50th Percentile (Communication 70.31%)	4.5 points each are available for: 25th Percentile (Access 34.83%) 25th Percentile (Communication 65.12%)	10	9
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is at or above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

2024 Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening	90th Percentile (63.37%)	50th Percentile (52.20%)	15	11
Cervical Cancer Screening	90th Percentile (66.48%)	50th Percentile 57.11%)	15	11
Colorectal Cancer Screening	50th Percentile- TBD	25th Percentile- TBD	12	9
Comprehensive Diabetes Care: HbA1c Control	90th Percentile 60.34%)	50th Percentile (52.31%)	12	9
Comprehensive Diabetes Care - Retinal Eye Exams	90th Percentile (63.33%)	50th Percentile (52.31%)	6	4
Controlling High Blood Pressure	90th Percentile (72.22%)	50th Percentile (61.31%)	10	7
NON-CLINICAL DOMAIN:APPROPRIATE USE OF RESOURCES[3]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	Score < 1.0	Score ≥ 1.0-1.2	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.9 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	5 points each available for: 50th Percentile (Access 41.97%) 50th Percentile (Communication 70.31%)	4 points each are available for: 25th Percentile (Access 34.83%) 25th Percentile (Communication 65.12%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

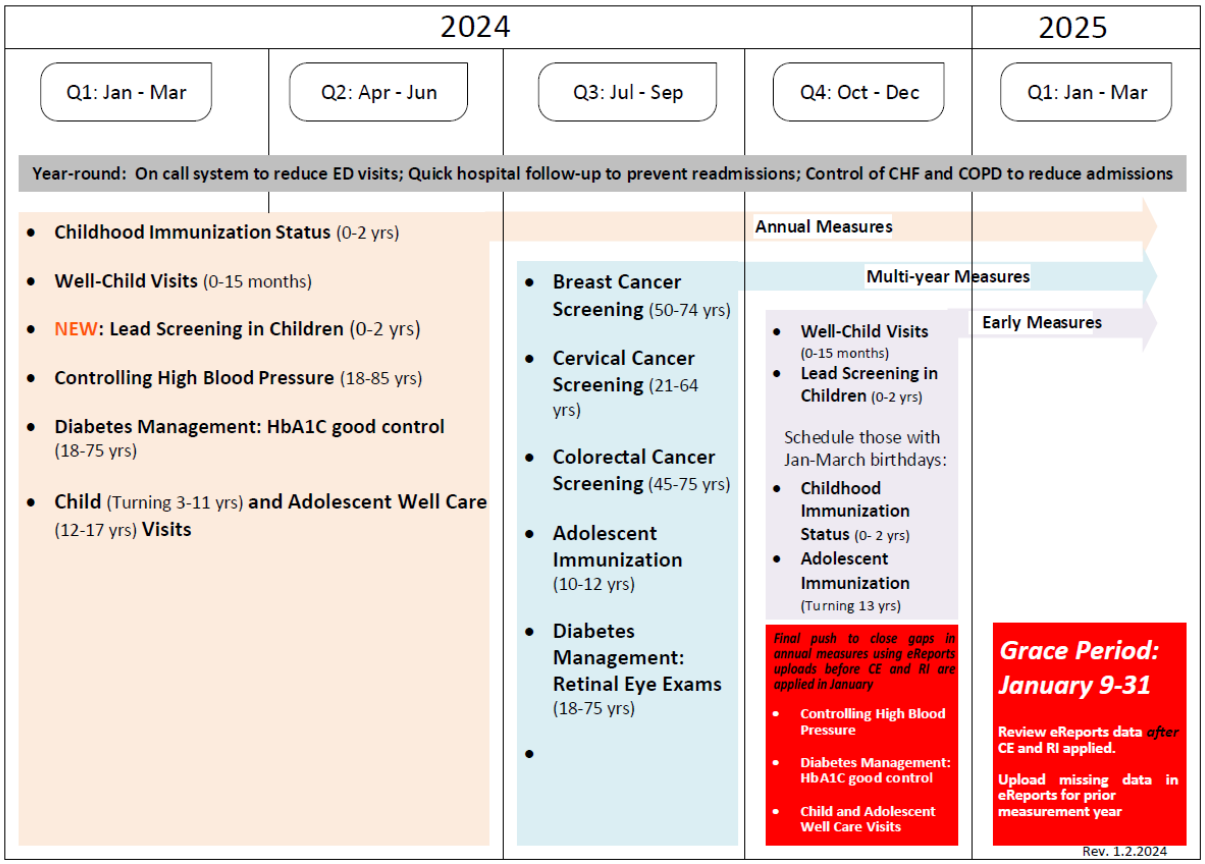
2024 Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Child and Adolescent Well Care Visits	90th Percentile (61.15%)	50th Percentile (48.07%)	21	17
Childhood Immunization Status: Combo 10	90th Percentile (45.26%)	50th Percentile (30.90%)	13	11
Lead Screening in Children	50th Percentile (62.79%)	N/A - New measures do not qualify for partial points in the first measurement year	8	N/A
Immunizations for Adolescents – Combo 2	90th Percentile (48.80%)	50th Percentile (34.31%)	13	11
Well-Child Visits in the First 15 Months of Life	90th Percentile (68.09%)	50th Percentile (58.38%)	13	10
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	TBD	TBD	10	8
PCP Office Visits	Greater than 1.6 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	10	8
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	6 points each available for: 50th Percentile (Access 41.97%) 50th Percentile (Communication 70.31%)	5 points each available for: 25th Percentile (Access 34.83%) 25th Percentile (Communication 65.12%)	12	10
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is at or above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

Prioritization of PCP QIP measure interventions, by time of year.

Timeline for addressing 2024 and 2025 PCP QIP Measures



(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

All Sites:

1. Advance Care Planning Attestations
2. Extended Office Hours (Capitated sites only)
3. PCMH Certification
4. Peer-led Self-Management Support Groups and Pediatric Group Visits
5. Health Information Exchange
6. Health Equity
7. Dental Fluoride Varnish Use
8. Tobacco Use Screening
9. Electronic Clinical Data Systems (ECDS)
10. Early Administration of the 1st HPV Dose
11. Early Administration of Initial Flu Vaccine Series

Online Tools for Quality Measurement and Reporting

Partnership offers two primary online tools for monitoring quality performance at your sites: eReports and the Partnership Quality Dashboard (PQD). For our new counties, access will begin in the late Spring, 2024. We will hold online trainings for new sites on how to use these two tools at that time. Below is a brief description of each.

Important note: while you may be very new to accessing eReports and awaiting a fuller view of performance trends for your organization in PQD, you do not need to wait to begin working on quality improvement. In particular, several measures depend on activities being done early in the year; you should start focusing on these immediately using your existing EMR or population health management tool!

<u>High priorities for immediate attention:</u>

1. <u>Children turning 2</u> years old in January through May: looking for opportunities to get their vaccines caught up, especially to offer the primary series of two flu vaccines.
2. <u>Adolescents turning 13</u> years old in January through May: looking for opportunities to get their vaccines caught up, especially the second HPV vaccine.
3. <u>Infants turning 15 months old</u> in January through May, to ensure they are being scheduled for regular well child exams, catching up with some shorter time intervals if needed.

eReports

eReports is an online application by which PCP sites can monitor their own performance within the QIP Clinical measures and submit supplemental data to Partnership. The eReports portal may be accessed two ways: through Provider Online Services, which has a link at the top of the main Partnership webpage or by webpage link emailed by the PCP QIP team. Provider Online Services is a pass-word protected part of the Partnership webpage, allowing access to Patient-specific information related to billing and quality.

Generally, one person at each PCP site (often someone from the billing or IT department) is the administrator for Partnership's Provider Online Services, and this administrator manages access and assignment of passwords for other staff at their organization. If you have questions about access to Partnership's Provider Online Services, contact your assigned Provider Relations Representative to help.

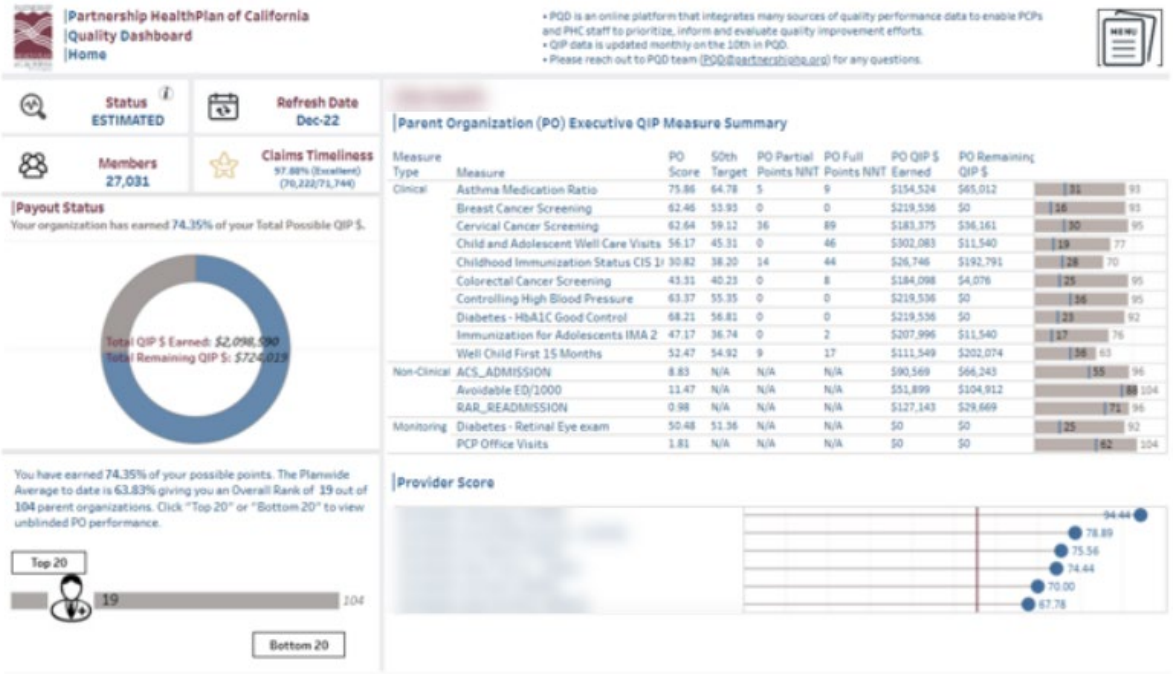
Access to eReports requires a unique, secret key assigned to each organization. Generally, one person at each organization acts as the eAdmin for all PCP sites dependent on the size of the organization. The function of the eAdmin allows the organization to add new users and enable/disable user accounts to their organizations eReports platform. Access for eReports, including the organizations secret key was emailed in March 2024 to all expansion county sites.

The launch date of eReports typically falls within the first quarter of the measurement year to ensure availability of data throughout the year. eReports launched on March 1. PCP sites have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 9th – 31st following the measurement year, and is intended to allow for final data collection and upload.

Partnership Quality Dashboard (PQD)

The Partnership Quality Dashboard (PQD) is a Tableau dashboard that is integrated into eReports and designed to visualize Primary Care Provider Quality Incentive Program (PCP QIP) data. The PQD dashboard is designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Performance data in PQD can be rolled up, in executive summary views and in drilldown views to the patient demographic level.

Below is the **Home View**, one example of many pages that available on PQD:



Features found on the **Home View**:

- Claims Timeliness score – the percentage of claims at the parent organization level that are received by Partnership 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.
- 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.
- Highest and Lowest performing providers identified. Based on overall, year- to-date QIP score. The Top and Bottom 20 ranked organizational providers are displayed.

Once launched in the spring, we highly recommend that CMOs/Medical Directors and CEOs/Executive Directors/Office Managers 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.

Payment Methodology for Core Measure Set

How much payment can you expect from the PCP QIP?

Partnership's PCP QIP program is one of the most generous pay for performance or pay for value programs in California.

The Core measure set represents an average of about 90 percent of the annual incentive earned. Since the payment associated with the Unit of Service Measures is evident from the specifications of each measure, we won't cover that in more detail.

The following 4 steps are used for calculating the payment for the core measure set:

1. The dollars put into the QIP pool depends first on the monthly assigned members for each PCP site. This $4 per assigned member per month (or $4 PMPM) is put into the pool for all primary care sites.
2. *Additional* dollars are put into the pool, as an "equity adjustment." The details of the components of the equity adjustment are listed in the next section. The range of additional funds are projected to range from $0 to $12.50 PMPM for 2023. Added to the $4 PMPM base rate, the range of projected payouts is estimate to range from $4 to $16.50 PMPM.
3. At the end of the year, a score is calculated on the Core Measure set, from 0% to 100%, based on the performance of each measure. In 2022, the weighted average score was 62%, with the range from 0% to 100% per site.
4. The total dollars in the pool (1 and 2 above) are multiplied by the quality performance on the Core Measure set, giving the amount that each site is paid. This payment will be sent out during the month of May, in the year after the close of the measurement year.

Equity Adjustment of the Core Measure Set

Here are the components of the additional dollars in the Equity Adjustment:

- Gateway
  - Must have at least 100 assigned members as of December 1, 2023
- Core adjustments
  - Acuity of patient panel
  - Socio-demographic risk, at patient level, rolled up to PCP site level
  - Site difficulty in recruiting PCP physicians
  - Lower than average baseline per visit resources available to PCP
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year

Here is the weighting of the four core adjustments:

Percentage Weight	Equity Factor
20%	Acuity Adjustment a: Average number of diagnoses/encounter
20%	Acuity Adjustment b: Average engagement of population
20%	Socio-demographic risk of assigned patients
10%	Frontier location
10%	PCP to population ratio
20%	Below average practice resources

Factors under the control of the practice
Factors more intrinsic to the practice setting/population served

Here is the detail on the thresholds used for each component:

Factor	Description	Level of adjustment	Adjustment Method	Zero Adjustment	Max Adjustment	Data Source
1a	Acuity: Number of diagnoses	PCP Site	Continuous	<2.5 diagnoses/ encounter	>4 diagnoses/ encounter	Partnership Claims Data; Denominator=claims from PCP site
1b	Acuity: Non Utilizer rate	PCP site	Continuous	>20%	<10%	Partnership Claims Data; Denominator=assigned patients with some utilization in past 2 years
2	Sociodemographic Factors	Rolled up member risk to PCP site	Continuous	>0.8	< -0.4	Address of each Resident (homeless patients assigned to Partnership location for address)
3a	Physician Shortage area- Frontier Location	Location of PCP Site (Frontier)	full credit for frontier level 2 (all or nothing)	Non-frontier	Frontier Level 2	USDA
3b	Physician Shortage area PCP density in county	County of PCP site (PCPs/1000 residents	Continuous	Greater than 1.05 PCPs/1000 residents	0.4 or less PCPs/1000 residents	County Health Rankings (Updated data source)
4	Structurally unfavorable per visit reimbursement	Site level	Continuous	> $220	< $120	DHCS, Partnership contracts

Hint: Focus on improving Acuity Adjustment

Partnership recommends you immediately use your EMR to measure your baseline number of diagnosis codes per encounter, and work to improve this

number through provider trainings and system changes.

Additionally, once you get your list of assigned patients from Partnership in January, we recommend you compare that list to patients you have seen in the past year, and begin outreaching to those you have not seen in the past year.

A recorded webinar with more detail on the Equity Adjustment Process can be found here.

Consequences of Poor Performance on the PCP QIP

PCP Parent Organizations who score less than 25% on the PCP QIP Core Measure Set may be put into a modified QIP and subject to additional requirements, collectively called Enhanced Provider Engagement. The main components of this are:

1. A reduced set of measures in the PCP QIP (4)
2. A Performance Improvement coach assigned to the practice
3. The CMO or Director of Quality will meet with the governing board to give a presentation on the quality performance of the organization

Training Resources for Quality and Performance Improvement

Customizing your Electronic Health Record for Quality

Each summer, Partnership updates a white paper entitled "Optimizing the Configuration of the Electronic Health Record for Quality." It contains 41 specific, detailed recommendations for how the electronic health record should be configured to optimize the capture of quality measures and improve the quality of care provided.

The 2023 white paper, and recorded webinar can be accessed through our website.

Quality & Performance Improvement Online Training

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.
- Advanced Access Webinar Series for Primary Care Providers.
- The Role of Leadership in Quality Improvement Effort: Leaders from top performing organizations share how they were able to build a culture of quality.
- PCP QIP High Performers – How'd They Do That? Learn how other PCPs accelerated in their QIP performance.
- **Exclusively for our expansion providers - How to Succeed in the PCP QIP; a monthly office hours series hosted by QIP and Regional Performance Improvement leaders**
- 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. If you are an expansion provider, feel free to email QIP@partnershiphp.org for registration details.

Improving the Patient Experience through Communication Workshops

Does your staff need training to improve their communication with patients? Are you worried about how they will perform on the Partnership CG-CAHPS survey in April?

Consider a communication training workshop!

One California-based option we have found to be very effective is EM Consulting, which has a variety of workshops available:

1. Trauma informed de-escalation
2. Motivational interviewing Part 1 and Part 2
3. Helping people with Addictive Disorders
4. Building Trust
5. Enhancing Trust
6. Empathic Communication at Home and at Work
7. Telehealth: best practices for communication
8. Custom Communication Workshops

For more information email: contact@emorrisonconsulting.com

A Quick Guide to Starting Your Quality Improvement Projects

The Performance Improvement Team at Partnership 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 Partnership's Partnership Improvement Academy webpage, under resources.

Southcentral Foundation's New Playbooks Available for Download

The Southcentral Foundation is likely the best Health Center in the United States, having won the Baldrige National award for quality - twice! Their playbooks are now available for free download.

SCF was one of the first organizations to implement integrated primary care (also known as team- based or multidisciplinary care), pioneering its Integrated Care Teams as part of the rollout of the relationship-based Nuka System of Care in the late 1990s.

Now, in order to support sustainability of our own transformation, as well as to help other health care organizations implement and improve integrated care teams, SCF has created the Integrated Care Teams Playbook and the Behavioral Health Integration Playbook, which are based on SCF's experiences and lessons learned in implementing these systems. The playbooks are organized using SCF's READI model, which SCF uses in other areas, including improvement and innovation, and consulting with outside organizations. Learn more in their latest blog post.

Upcoming trainings

ABCs of Quality Improvement

Partnership's signature one-day training introducing the core principles of quality improvement.

By the end of the day, you can make lasting improvements at your organization! Learn concepts behind:

- The model for improvement
- What is Quality Improvement?
- Setting project goals and measures
- How to use data to measure quality and drive improvement
- Methods for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act cycle

Who should attend? This course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Date: Wednesday, May 1, 2024
Time: 8:30 a.m. – 4:30 p.m.
Registration link: Here

No charge.
Attendance limited to contracted Partnership provider organizations.

Improving Measure Outcomes Webinar Series

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

The ***Improving Measure Outcomes Webinar Series*** allows Quality Improvement teams to make knowledge actionable, improving quality service and clinical outcomes around specific measures of care.
These learning sessions will cover Partnership's Primary Care Provider Quality Incentive Program measures. Content will focus on direct application on best practices including eliminating health disparities with examples from quality improvement teams who are doing the work.

Remaining 2024 sessions:

- •March 27, 2024 - Diabetes Management
- •April 10, 2024 - Breast and Cervical Cancer Screenings
- •April 24, 2024 - Perinatal Care and Chlamydia Screening
- •

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

Suggested "To Do" List

Medical Directors/Clinic Directors

1. Sign up your physicians with your local Medical Society. If possible, subsidize their membership.

2. Ask your Nurses, Nurse Practitioners, Physician Assistants, and Nurse Midwives to join their California trade organizations. If possible, subsidize their membership. Ask them to be active in promoting a rural perspective in these organizations (forward them pages 12-13 for background).

3. Physicians: Block out weekend of October 26-27 to participate in CMA house of Delegate to advocate for Rural Health Issues. (Meeting will be in Sacramento)

4. Talk to non-primary care specialists and psychologists/psychiatrists/social workers who are working at your health center or in your community who are community-minded (maybe an interest in health policy), to see if they would we willing to represent their community and their specialty on one of our partnership committees.

5. Advocate for CPCA/NACHC to support fixing the MediCare fee schedule at the federal level, focusing on the impacts on specialty access your patients face. (See page 8)

6. Forward the section on OB Access (pages 9-12) to your prenatal care providers. Make sure they know of the changes coming to the CPSP program.

7. If you are not yet signed up for Partnership's eConsult or Telemedicine program, have your telemedicine coordinator reach out to sign up. (see pages 25-29). Consider optimal use of eConsult to make most efficient use of in-person consultation.

8. Look at outpatient specialist needs in your community, and strongly consider changes in scope to allow hiring specialists to work shifts at your health center.

9. Select a clinician to lead efforts to meet with local specialists to agree on referral criteria/workups needed/retro-RAF practices.

10. If your in-house behavioral health resources are not sufficient to meet your needs, sign up for virtual counselling/MAT service options for your patients.

11. Find a date sometime in the next year to invite the Partnership Pharmacy team to visit with your clinicians. The pharmacists will use individual prescriber data to show individualized ways to improve care and outcomes through medication interventions based on best practices/standards of care.

Quality Leaders

1. When the Partnership Quality Dashboard goes live in May, set up a meeting with your quality team to look at the disparity dashboard for your sites. Identify the largest inequities and start thinking about how can address these inequities. When the Partnership webinar on the disparity dashboard is announced, ensure a clinician with an interest in health equity and a QI leader attends to learn more.

2. Make sure you, your medical director and your CEO have access to Provider Online Services (username and password).

3. Convene a group within your organization to prioritize annual activities to assess your patients' experience and prioritize interventions to improve this. See pages 70-74.

4. If you do not have a point of care Lead testing unit, consider applying for one from Partnership. (see pages 50-51).

5. If your Chlamydia testing rate is low, convene a meeting of your providers to discuss the recommendation and your sites current results, evaluate for barriers, and have the team consider ways of increasing Chlamydia screening rates in teens and young adults.

6. Read the version of the PCP QIP specifications on the eReports website (the one "behind the firewall") **very carefully,** noting especially the timelines for various activities. Put calendar reminders for these deadlines on your calendar so you won't miss any (and cost your organization thousands of dollars).

7. Train and retrain your clinicians on better diagnosis coding practices!