Committee Approved 01/13/2021

Committee: Physician Advisory Committee
Date / Time: November 11, 2020 - 7:32 to 9:03 am

Per Governor Newsom's Executive Order, N-25-20 that relates to social distancing measures being taken for COVID-19: The Executive Order authorizes public meetings with Brown Act requirements to be held via teleconference or telephone. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/ or other personnel of the body as a condition of participation for a quorum. However, the Executive Order requires at least one public location consistent with ADA requirements to be made available for members of the public to attend the meeting, so all PHC offices will be available for members of the public to attend the meeting in-person.

Members Present:	Jeffrey Bosworth, MD – *TC* Angela Brennan, DO - *TC* Jeffrey Gaborko, MD (Chair)	Steve Gwiazdowski, MD - *TC* Michele Herman, MD – *TC* Willard Hunter, MD - *W*	Mills Matheson, MD – *TC* Danielle Oryn, DO - *TC (7:50 start)* Teresa Shinder, DO – *W*	Karen Sprague, MSN, CFNP - *W* Suzanne Eidson-Ton, MD - *TC*
Members Excused:	Matthew Symkowick, MD Lisa Ward, MD			
Members Absent:	David Gorchoff, MD Thomas Paukert, MD		*Note: via Video Conf. (VC)* *via WebEx (W)* *via Teleconference (TC)*	
Visitor:	Francisco Trilla, MD			
PHC Staff Present:	Liz Gibboney, Chief Executive Officer – *W* Sonja Bjork, Chief Operating Officer - *W* Patti McFarland, Chief Financial Officer-*W* Lynn Scuri, Regional Director - *VC* Mary Kerlin, Sr. Dir., Prov. Relations (PR) - *W* Tahereh Daliri Sherafat – Dir. Member Svcs/ Prov. Relations (N) – *W* Chloe Secor-Schafer, N. Regional Manager	Robert Moore, MD, Chief Medical Officer Peggy Hoover, RN, Senior Dir., Health Services -*TC* Colleen Townsend, MD, Regional Med. Director Mark Netherda, MD, Assoc. Med. Director, Quality-*W* Stan Leung, Pharm.D., Dir., Pharmacy Svcs–*W* Bettina Spiller, MD, Associate Medical Director – *VC* Sharon Hoffman-Spector, RN, N. UM Mgr.-*VC* Margarita Garcia-Hernandez, Mgr. Health Analytics	David Glossbrenner, MD, N. Regional Medical Dir. - *VC* Marshall Kubota, MD, Regional Medical Director - *VC* Jeffrey DeVido, MD, Behavioral Health Clinical Dir. -*T* Michael Vovakes, MD, Associate Medical Director - *W* James Cotter, MD, Associate Medical Director - *W* Erika Robinson, Dir., S. Quality & Perf. Improvement – *TC* Nancy Steffen, Dir., N. Quality & Perf. Improvement - *TC* Debra McAllister, RN, Assoc. Dir., UM Strategies - *W*	

Note – All Telephone Participants may not be listed – Unidentifiable on Report

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Public Comments	The Committee's Chairperson, asked for public comments. None were presented.	N/A		N/A
Quorum		Committee quorum requirements met.		
I. Approval of Minutes	The Committee's Chair presented the meeting minutes for approval.	**MOTION:** Dr. Gwiazdowski moved to approve Agenda Item [I.] as presented, seconded by Dr. Matheson. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions. Motion carried.		11/11/20

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A. Status Update Administration	The HealthPlan's Chief Executive Officer (CEO), provided the following report on PHC activities. In addition to those listed below, other important topics will be discussed later on the agenda. - Change in National Leadership – With the election over, Partnership will be focused on potential changes to Medicaid and health care across the country, along with the impact on PHC. These areas include the national COVID strategy and preventive measures. It is anticipated that funding will be increased to assist these efforts (i.e. manufacturing and distribution of the vaccine[s], along with greater production of personal protective equipment [PPE].) On Monday, President-Elect Biden announced his panel of public health medical experts to address the pandemic, some of whom are from the University of California, San Francisco (UCSF). The other piece being watched is the greater possibility of a fourth Federal Stimulus Package, which could provide some needed relief to states, though there is still a considerable variance in the amount between the House and the Senate. - COVID-19 and PHC – Many staff continue to work remotely, as management works closely with public health to ensure its messaging mirrors that of public health (i.e. social distancing, vaccine availability, etc.) Partnership will continue to support virtual health care, particularly video visits through its grants. PHC also wants to continue its pilot program on remote monitoring equipment. - Wellness and Recovery Program – This continues to gain momentum in the seven counties currently handling the program. Though referrals are down, member outreach is ramping up to encourage self or provider initiated referrals. The State has issued some more flexibilities this past week, relaxing some requirements for those who have sought residential treatment stays within the year. This information will also be publicized. - California Advancing and Innovating Medi-Cal (CalAIM) Waiver (Waiver) – This continues to ramp up with more of the workgroups reconvening. PHC will be participating in the Behavioral Health Workgroup, as well as a group advising the State on the In-Lieu of Services portion of the Waiver. These are services that are not traditionally covered by Medi-Cal, but hold promise for lowering costs and effectiveness for the Medi-Cal population. Staff is excited to get back to this important planning. Dr. Trilla, previous Chief Medical Officer at Santa Rosa Community Health Centers and covering the vacancy left by Dr. Ward's relocation to Marin Community Clinics, asked where PHC sees virtual visits (telephonic and video) a year from now. What is the overall sense of the role this type of visit will have? He agrees that home-monitoring is tremendously important. PHC's CEO shared that Partnership is very supportive of virtual visits and would like to see those continue post-pandemic. Telehealth has been something PHC has promoted for a number of years, which did not really take off until COVID. Partnership will continue to advocate for these services. There is disagreement in the medical community around video and telephonic visits having the same weight and level of reimbursement as in-person visits. The efficacy of virtual visits will need to be discussed by clinicians. But, PHC hopes that these visits will continue to be supported, as it will continue to support virtual visits through its grant funds program. The longer virtual visits are being used by practices, the more their importance in the future of medicine can be demonstrated.	For information only, no formal action required. For information only, no formal action required. For information only, no formal action required. For information only, no formal action required.	11/11/20 11/11/20 11/11/20 11/11/20
II.A. Status Update, Medical	The HealthPlan's Chief Medical Officer (CMO) presented an overview of some Health Services activities. - There are two items on the agenda that are very important (Pharmacy Carve-Out and Options for Connected Devices.) Hopefully, Committee members will be able to stay for the duration of those topics.	For information only, no formal action required.	11/11/20

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A. Status Update, Medical	- Influenza (flu) Vaccination for Children – Partnership now covers flu vaccinations given to children at community pharmacies, which will last until the end of the year. PHC's data indicates that vaccinations have increased 100% to date, as compared to last year. Though more vaccinations were produced, the increased use raises the question of a possible transient shortage during the vaccination months. - Highlights from Virtual Meeting with Public Health Officers and Directors – A big takeaway was a discussion with the State around pediatric COVID vaccinations. Until now, vaccination tests have not included children. There is significant evidence of differential immune responses in children, as compared to adults. This will need to occur before a high level vaccination rate can be achieved. Also, to achieve "herd immunity" at least 60% of the population will need to be vaccinated. To put this into perspective, compare that to the challenges of getting testing done, which had many hurdles. California's population of 40 million equates to 60 million doses (2 doses per individual.) Aside from the number of doses, other challenges include the inability to mix the vaccines (different manufacturers), the -90 degree storage temperature (this is a significant challenge), and the prioritization system they are trying to administer. In spite of the optimistic views, the State predicts that it will be the end of 2021 before "herd immunity" is achieved, due to the logistical challenges. - Regional Medical Directors' Meeting – The meeting was well attended, and was recorded for those who were unable to participate. The link to that recording will be included in the clinical newsletter, scheduled to go out later today. Access to two versions of detailed notes (Leadership and Front Line Clinicians) will also be included. - COVID-19 – The increase across the country is also being experienced in PHC counties. It was announced yesterday and this morning that many counties are moving backwards. Partnership has only one county in the yellow tier (Humboldt.) There have been big outbreaks after Halloween, and some significant concerns around the upcoming holidays.		
	PHC's Regional Medical Director for Napa and the Southeast (SE) counties presented a brief update. - There is not much to report for the Southeast counties. In terms of COVID, Solano and Yolo counties are in the red tier. Napa County remains in the orange tier, though it is expected that the county will be downgraded to red. - Public Health Collaboration, Solano County – This project is looking at ways that provider groups and organizations can work together to provide immunizations better across the county. The project is being led by the maternal health and vaccine programs, with the goal of improving vaccinations for children. This is a precursor to what COVID vaccinations may look like. - Access – There are few changes with providers in the region. St. Helena Hospital continues to be closed after the Glass Fire in October. Their goal was to reopen at the end of November, but that has not been confirmed yet.	For information only, no formal action required.	11/11/20
	PHC's Regional Medical Director for the Southwestern (SW) counties presented a brief overview. - COVID-19 – Sonoma County is struggling to get out of the purple tier. The other counties are in the red tier, with the exception of Marin County, which is in the orange tier.	For information only, no formal action required.	11/11/20
	PHC's Regional Medical Director for the Northwestern (NW) counties was unavailable to present a brief overview.	N/A	--

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A. Status Update, Medical, Continued	PHC's Northern Regional Medical Director presented a brief overview. - COVID-19 – The number of cases in the region has increased, but the hospital systems are not stressed. While there are a lot more positive cases, individuals do not seem to be as sick as those who presented in April. One of the hot spots for COVID testing has been in Modoc County, which was the last county in the state with a positive test. The hot spot seems to be centered more with military personnel, and not the general public. - Access – Anderson Walk-In Clinic in Shasta has been having continued telephone issues, which is being addressed. Banner Lassen has consolidated their operations into one building, partly due to decreased volume. Northeastern has added a quality manager and case management coordinator. The Karuk Tribe system has a new family nurse practitioner. And, there are some retirements occurring in the Northern counties. Sky Lakes Medical Center in Klamath Falls had a Ransomware attack, forcing them to return to paper charts, and was shut down for a week or more while dealing with the issue.	For information only, no formal action required.	11/11/20
II.A1. Committee Member Highlight	PHC's Director of Pharmacy Services shared some of his background with the Committee. Born in Hong Kong, Dr. Leung came to this country when he was six years old. Having five siblings already established in the Bay Area, his father immigrated the family. Members of this extended family were all highly educated, though childless. Along with his immediate family, all of his relatives were in the chrysanthemum business and maintained their own greenhouses. Initially, the floral business had a lot of enjoyable times. That ended when he was put to work when he was in the fourth grade. While his friends did sports or other fun activities after school, he went home to labor. Life became a routine of school, work, studies, and eat and sleep at his young age. The positive for him was being able to spend that time with his parents. However, it was manual labor and being exposed to the seasonal temperatures. This lasted until he was ready for college when he applied to UC Davis, with hopes of leaving the "nest". Fortunately, he was accepted, and pursued his studies in biochemistry. His time at college brought about lifelong friends, and is where he met his wife. He was asked by a peer about volunteering in the lab of the dermatology department during his senior year. At this point, he was still uncertain of his professional direction, but spent one year volunteering at the lab. Dr. Leung's first regular employment was at a company called Ciba, a subsidiary of Syntex, where he worked with one of the first nonsteroidal anti-inflammatory drugs (NSAIDs), which is now known as Naproxen. While working at the facility, the drug (Anaprox) was freely given to anyone experiencing pain, which was considered a benefit, since the drug was rather expensive at the time. After one year, the professor he worked under at the UC Davis lab asked if he would like to return. Since a generic of Anaprox was coming out and the fate of the company was unsure, he opted to return to the UC Davis lab. In addition to his previous professor, he also worked for a rheumatologist. Their studies included the effects of certain antibodies on blood clotting, which he found really interesting. Being a rheumatologist, the physician would be invited to conferences. One of these was sponsored by the manufacturer of Ultram, now known as Tramadol. This event introduced Dr. Leung to the many perks a sponsored conference can entail, which included a high-priced hotel, meals, and late-night room service. He truly felt spoiled, and the experience gave him a new appreciation of what doctors may be offered. His professor asked if		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A1. Committee Member Highlight, Continued	he would like to be a grad student, but, grant funding was running low at that time. Being one of two people remaining in the lab, he was left feeling uneasy with the prospects of continuing that line of work. Dr. Leung's wife was going through pharmacy school at that time, and suggested he apply, which he did and was accepted. In retrospect, he believes he was destined to be a pharmacist. When he and his brother were young, they would playact as doctor, him being the assistant. But, after a period of time, he determined that he did not want to be taking orders like that. Fast-forward to adulthood, his brother is a physician and Dr. Leung is taking prescription orders from physicians. In 1998, he graduated from pharmacy school, with his first job at an outpatient Kaiser pharmacy, filling prescriptions along with others. Standing in one place several hours at a time, filling prescriptions on a non-stop basis, he felt part of an assembly-line. After three months, he decided to pursue his career elsewhere and walked into Walgreen's, which happened to be hiring. He worked many different shifts at Walgreen's, including graveyard, which he found interesting. Working in the San Jose area, he heard of an armed, takeover robbery at one of the Walgreen's stores. Though the incident turned out to be a fake story, it ended his working graveyard shifts and got him placed in a busier store in Watsonville to manage. Walgreen's was his first opportunity to work with Medi-Cal patients, starting at a store in Palo Alto, which serviced those who were affluent, and those who were not. After approximately twelve years, he moved on to Safeway, where he had the opportunity to work behind the scenes, establishing a program for vaccinations, one for medication therapy management, along with some pharmacist directed services. The position also oversaw stores in Hawaii. Though the experience was good, his trips did not allow for any personal time to enjoy the island scenery. During his time at Safeway, he was introduced to PHC through a meeting with staff regarding services that Safeway could provide. In 2015, Safeway merged with Albertson's and the parent investment company determined that Dr. Leung's team was not of value. Employees across the nation in that capacity were suspended. His unemployment lasted a few weeks when he found a position at Central California Alliance for Health in Santa Cruz, a sister health plan of Partnership. After a few months, PHC's previous Pharmacy Services Director reached out to him regarding working for the HealthPlan, which was part of Dr. Louie's exit strategy before retirement. After the interview process, Dr. Leung accepted the position, which was five years ago. This change has been very positive for him. Dr. Leung has three children, two of whom are in college. When he includes his home, he equates the three to having a triple mortgage. He also took on a four-legged child, a 70 pound Labrador who is a joy for the family, though has no concept of the fall time change and wakes him up at 5am every morning. He and his wife have been married for 22 years.	For information only, no formal action required.	11/11/20

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.B. Quality/ Utiliz. Advisory Committee (Cmt), II.B.1. Major Depression in Adults CPG, II.C. Pharmacy & Therapeutics Cmt, II.E. Credentialing Committee	There were no items pulled from the Consent Calendar for further discussion. *(Post-meeting correction – The new pharmacy policy, Medical Drug TARs [MCRP4068] will not be withheld for the DHCS Pharmacy Carve-Out, but will be published as of this meeting's approval date.)*	**MOTION:** Dr. Gwiazdowski moved to approve Agenda Items (II.B., II.B.1., II.C. and II.E.) as presented, seconded by Dr. Bosworth. **ACTION SUMMARY:** [11] yes, [0] no, [0] abstentions. Motion carried.	11/11/20
II.G. Committee Membership	PHC's CMO presented the membership recommendations for the Pharmacy & Therapeutics (P&T) Committee. Dr. Kent Blakely with Petaluma Health Center is interested in participating on the P&T Committee. Dr. Olea, pharmacist, and Dr. Gilliam, physician, are recommended for resignation. Of note, the scope of pharmacy and therapeutics will be changing significantly after the Pharmacy Carve-Out.	**MOTION:** Dr. Matheson moved to approve Agenda Item II.G. as presented, seconded by Dr. Gwiazdowski. **ACTION SUMMARY:** [11] yes, [0] no, [0] abstentions. Motion carried.	11/11/20
IV.A. Pharmacy & Therapeutics (P&T) Committee Highlights	PHC's Director of Pharmacy Services (Pharmacy Director) presented a few highlights from the P&T Committee meeting in October. • New Treatment Authorization Request (TAR) policy (MCRP4068) – The new policy reflects changes from pharmacy benefit medications to those that will be filled through the DHCS benefit. The TAR language and processes reflect those changes. • Language of how PHC staff will review the TARs after the carve-out was also addressed, along with terms relevant to the pharmacy benefit type of operations. For intravenous (IV) infusion drugs that have been approved by the U.S. Food and Drug Administration (FDA) for self-administration, PHC pharmacy staff will review appropriateness on a case by case basis. • Criteria for hyaluronic acid has been updated to reflect both orthopedic and rheumatology guidelines.	For information only, no formal action required.	11/11/20
IV.B. Status Report – Pharmacy Carve-Out	Partnership's Pharmacy Director shared that Magellan Medicaid Administration, Inc. (Magellan) is the DHCS contractor for processing pharmacy claims and administrative services under the Medi-Cal Rx-Pharmacy program. They will also provide a 365 day, 24/7 call center, a secure provider portal, along with an e-prescribing platform (Surescript.) Magellan will also provide the initial review of the TARs. If unable to approve a TAR, they will recommend a denial. The Department of Health Care Services (DHCS) makes the final decision on TAR denials. Once the final decision is determined, DHCS will return the TAR to Magellan for completion of the process (distribution of member and prescriber letters.) The turnaround for this process is expected to take place within 24 hours. PHC will be following this turnaround to ensure they adhere to that timeline.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS
IV.B. Status Report – Pharmacy Carve-Out, Continued	The scope of the carve-out includes all medications (including specialty medications and compounds) that are dispensed from a pharmacy and billed through the pharmacy benefit area considered part of the Medi-Cal Rx. Along with those medications are select medical supplies that are covered (insulin syringe, diabetic testing supplies, inhaler-spacers, and peak flow meters), glucometer systems (as long as the strips are covered), along with enteral formulas, which will be dispensed through a pharmacy and paid through Medi-Cal Rx. Physician administered drugs, which are administered and billed as a medical benefit, are not subject to Medi-Cal Rx and will continue as they are currently. The Medi-Cal Rx formulary is referred to as the Contract Drug List (CDL) by DHCS. Included in the Committee's meeting packet are several hyperlinks that directs the user to the Medi-Cal CDL, along with other affiliated services (CDL on-line search tool, Medi-Cal Rx Subscription Service, Magellan Provider Portal, and the Medi-Cal Rx Transition Policy.) The link to the Medi-Cal CDL opens up to a page with four documents in pdf format. The user can check for the generic medication alphabetically. If the drug is not listed, a TAR would be required. There is also a link that allows the user to search for the medication. The system will pull up therapeutic alternatives for drugs not listed. Anyone can sign up for the Medi-Cal Rx Subscription Service, which will send out bulletins, updates, and alerts. Once clinicians sign up and get access, they can utilize the Magellan Provider Portal for the Medi-Cal Rx. The portal includes the member's eligibility status, drug formulary information, and providers can submit authorizations, TARs, and attachments directly to Magellan. This type of service has been very limited previously. However, signing up on the portal can be a bit tricky. Magellan requires that each provider site designate an administrator to oversee and manage the portal access. Each clinician is required to register for access, and support staff, nurse practitioners, etc. under that clinician can be added under the clinician's National Provider Identifier (NPI) number. PHC's CMO shared that, having tested the link, the CDL online search tool is very smart in terms of offering alternative medications, and useful for providers who need to search for a drug. Partnership's Pharmacy Director noted that many prescribers currently use the Surecript electronic prescribing system. Currently, PHC's Pharmacy Benefits Manager (PBM) sends the formulary information, eligibility, and historical pharmacy claims through their database into Surescript. Prescribers connecting directly to Surescript under the Medi-Cal Rx will be able to check for eligibility, coverage of the drug and if a TAR is required, along with the historical prescription record for that member. The Medi-Cal Rx Transition Policy defines how continuity of prescriptions will be handled when the carve-out takes place. Medi-Cal will allow managed care claims without a TAR to pay for 180 days. If PHC has a prescription that was paid for within the past 12 months, which did not require a prior authorization TAR and is not covered under Medi-Cal, DHCS will allow to pay for 180 days. Each time a member presents that prescription to a pharmacy to fill (even though the prescription will pay), it will initiate an alert to the pharmacy that a change in medication or TAR is required. The physician is also to receive the alert message, but DHCS has not been clear on how that will occur. If there is a PHC claim that has a TAR, but the drug is not covered by Medi-Cal, DHCS will honor the TAR until the end-date of the TAR, or they will honor no later than one year after the approval date of the TAR. If a TAR was approved January 2020, DHCS would stop payment on the TAR January 2021. This is a significant concern currently being raised with DHCS by PHC staff. Ending the TAR at the time of transition would create a lot of disruption for the member. For certain chronic medical conditions (i.e. diabetes or asthma) Medi-Cal Rx will provide a five year extension on that TAR, but only if the medication was approved with the TAR. Also of note, during the transition period, prescribers and pharmacies will receive a notification each time a non-CDL drug is filled, requesting the prescriber to change the drug or submit a TAR. At PHC, an internal process is being developed to:

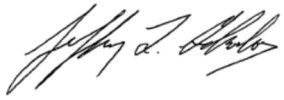
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
IV.B. Status Report – Pharmacy Carve-Out, Continued	• Monitor what prescription claims at the pharmacy are being denied • If a TAR is submitted, track down the event process as much as possible (i.e. when the prescription is not being filled), to mitigate the abandonment of that prescription. PHC's CMO asked the Committee's Chair how Kaiser Permanente will be handling the Medi-Cal Rx system, which is in addition to Kaiser's usual formulary. The Committee's Chair noted that he is currently unaware of how Kaiser will integrate the two. Most Kaiser physicians would not be familiar with TARs in general, so it raises a lot of questions. Partnership's Pharmacy Director shared that staff has been in communication with Kaiser regarding this change, and some operational changes Kaiser is committed to making. One of the challenges for them will be differentiating regular Kaiser members from those who are Partnership members, where the prescription will be billed to the PBM. They have recognized that prescriptions filled for PHC members assigned to Kaiser will need to be billed to Magellan. If a rejection is received from Magellan, Kaiser will work with the prescriber (or an internal team), to submit a prior authorization. Kaiser can also utilize the secure provider portal to submit TARs. The Committee's Chair will take this information back to the pharmacy team at Kaiser Vacaville to determine what is being planned. He also recognized a lot of potential issues if the TAR process is left to physicians, as that is not built into the existing workflow. Partnership's Pharmacy Director advised that the current grievance process for a denied prescription allows members or prescribers to appeal and request a secondary review. That process is initiated by contacting PHC. When Medi-Cal Rx goes into effect, members will no longer have the right to appeal a decision, but can initiate the grievance through the State Fair Hearing process by contacting Magellan. Prescribers can also initiate an appeal process on behalf of members, which would have a quicker turnaround time. Language and timeframes describing grievances and appeals has not yet been included under the Medi-Cal Rx information.	For information purposes only, no formal action required.	11/11/20
IV.C. Discussion Topic: Workflow Options for Connected Devices	PHC's CMO advised that, as part of the distribution of medical devices pilot, staff is looking into options for connected devices. These are not just the self-use devices patients would have in their home, but connected devices to a local device (i.e. Smartphone) or the patient's electronic health record. The key is not the technology, but the workflows, four of which are included in the meeting packet. There are few providers who have piloted the workflows. The workflow selected by the provider will determine the type of device used. The workflows and pathways were highlighted. • No Home Devices – The sample of this workflow showed what is currently being done for patients with known or suspected hypertension. There are two flows, one for a virtual visit, the second pathway for an in-office visit. In the office, the blood pressure is checked by a medical assistant, rechecked if it is elevated, and if uncontrolled, the clinician responds by determining what type of intervention is needed. If a virtual visit occurs without a blood pressure (BP) check, there is no way for the physician to determine if an intervention is required. • Unconnected Home Monitor – This scenario requires the patient to recall the information from the device or document it. The virtual visit flow is similar to that of an in-office visit, with some exceptions.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS
IV.C. Discussion Topic: Workflow Options for Connected Devices, Continued	The medical assistant would call ahead to the patient to retrieve the BP information, viewing it on screen. Of note, the current Health Resources and Services Administration (HRSA) requirements still require visualization of the digital results, which is not a requirement of the National Committee for Quality Assurance (NCQA) or PHC. Both pathways include the potential intervention by the physician if the patient's BP is uncontrolled. • Basic Connected Home Monitor with primary care provider (PCP) Managing – In a home-monitoring situation, the patient checks their BP at home and periodically sends that information to the PCP office. That information needs to be attached to the correct patient chart (unless connected to the electronic chart), and referred to clinical staff for evaluation. If the BP appears to be uncontrolled, the clinician needs to intercede. The office and virtual visits are similar to the Unconnected Home Monitor flow, with the main difference being in the series of steps with the home-monitoring, even in the absence of a clinician visit. Of note, Medicare covers the service at a small rate, using a specific code when billing. However, Medi-Cal does not cover that code. Even if PHC covered the code, Federally Qualified Health Centers (FQHCs), Rural Health Centers, and other Prospective Payment System (PPS) providers are not reimbursed for the code. Ultimately, the provider needs to assess this flow for unreimbursed work output. • Connected Home Monitor with Intermediate Organization Support – This model is being used by several vendors, and the flow for office and virtual visits is similar to previous pathways. The home-monitoring flow begins with the patient checking their BP. The BP data is uploaded to a Smartphone, which is then uploaded to the internet. From there, the vendor reviews the information via artificial intelligence, which determines if the patient's BP is out of range. If out of range, there is an initial contact with the patient by a non-physician to assess the circumstances (i.e. medication not taken, the person has become homeless.) The assessment may lead to some intervention, including contacting the patient's PCP. This flow takes a lot of the work out of the hands of the PCP and places it into the hands of the vendor. Under current circumstances, there are few registered dieticians available. This model's pathway includes those services, though not widely used by PHC providers. Factors to consider when choosing a model were reviewed. These include: 1) Office staffing 2) Clinician autonomy / clinician acceptance in embracing the model 3) Patient/clinician relationship versus the new case management with vendor team – There may be an increased benefit if a relationship between clinician and case manager (CM) is developed. But, that may detract from the patient / clinician relationship and the continuity and quality of the relationships. Will that CM be with the vendor long term, as a physician would be? 4) Efficacy in improving BP control – Available studies have not shown one model to be preferred over another. A home BP monitor requires oversight by the physician office or vendor. Otherwise, there is little improvement for the patient. 5) What is the effect on the overall office productivity and workflow? – If time required by medical assistants and clinicians exceed the benefit, the model is inefficient for the practice. 6) Who pays the vendor or extra staff? – This is a critical component to consider. Since BP control is a QIP measure that PHC pays for, perhaps clinics not doing well should invest in a vendor service to increase their measurement performance. If PHC pays for the service, they would need to consider reducing or eliminating the funds associated with that QIP measurement. Determining who would pay for the service is a bit complex. 7) The availability of extra counseling not readily available in the physician's office. The discussion was opened up to the Committee for comments on where their practices are at with connected devices.

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
IV.C. Discussion Topic: Workflow Options for Connected Devices, Continued	Dr. Matheson offered that his practice will continue their current process. Patients are encouraged to take their BP at home, which they record and bring into the practice for review. Changes to the medication are made when indicated. This system reflects the second flow, Unconnected Home Monitor. The Committee's Chair acknowledged that Kaiser Permanente (KP) is also adhering to the second flow. There are different methods to the flow, but essentially the same. KP has started to assess devices and operability with its system. What is currently being used is more in terms of health education, versus clinical management. However, the models presented better explains how connected devices can be used. There has been increased concern around patients with uncontrolled blood pressure. By adding a layer of connectivity, KP physicians could get their patients under better control. Issues with staff and paying an outside vendor arise, but so do concerns when a patient is lost due to uncontrolled blood pressure. Kaiser has been looking at what is patient versus physician-centric. Dr. Herman shared that La Clinica has concerns around involving outside vendors who may give their patients advice about different monitoring levels. There is also the concern around privacy issues with health information. The issue of insufficient staffing for ongoing monitoring of a telemetry model, where data is coming in outside of specific visit times, is also a concern. La Clinica would prefer tying this type of information by report to a telemedicine or in-person visit, analyzing the data at that time, and would prefer the flexibility of not going strictly electronic. Also, she believes La Clinica is moving toward a more patient centric approach by giving them devices and allowing them to monitor. But, that does not mean the outside vendor needs to be added, or having a non-stop flow of numbers coming into the practice. In comparison to a vendor, there have been times when home health nurses are on-site at a patient's home and contact the practice with vital signs that do not require reporting. There are also circumstances where the home health nurse counters instructions that have been developed between the physician and patient over a period of time. PHC's SE Regional Medical Director offered that better access to self-monitoring, with information of what can result when blood pressure is uncontrolled, gives the patient more control of their outcome. Dr. Hunter shared that Epic has a way for patients to enter their blood pressure readings via My Chart. He uses that information when making decisions on a patient's care, but the BP results cannot be used for reporting purposes. Dr. Bosworth concurred with the previous comments. However, with the first model, he believes there are benefits not stated. There is value in determining compliance, medication side effects, education, and using that visit to facilitate home monitoring and follow-up. Shasta Community Health Centers is trying to move toward the second model and is exploring ways to get the data automatically into their system, allowing them to have control. He would be hesitant to engage an outside vendor at this point, without first having more feedback and understanding of the workflow. PHC's CMO thanked the Committee for their input, which was very helpful.	For discussion purposes only, no formal action required.	11/11/20

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
IV.D. Additional Business – December Committee Meeting	The Committee's Chair reported that the Committee will not convene in December.	The Committee will not convene in December. The next regularly scheduled meeting will be in January	11/11/20
Adjournment	The Committee adjourned at 9:03 AM Respectfully submitted: Linda Largent		

The foregoing minutes were APPROVED AS PRESENTED on: January 13, 2021
Date



Jeffrey Gaborko, M.D., Committee Chairman

The foregoing minutes were APPROVED WITH MODIFICATION on: _____
Date

_____
Jeffrey Gaborko, M.D., Committee Chairman