PARTNERSHIP HEALTHPLAN of CALIFORNIA

*Eureka | Fairfield | Redding | Santa Rosa*

# PROVIDER NEWSLETTER

Fall 2017 | Volume 23 | Issue 3

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***Links to additional articles:***

**Pharmacy Department**
**Prescribing Naloxone**
https://goo.gl/u27f2Q
**The current PHC Formularies on our website:**
http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

**Compliance Department:**
**Compliance Privacy Policy & Procedure Updates**
https://goo.gl/IKO9zq

**Health Services Department:**
**Drug Medi-Cal**
https://goo.gl/QTVeoT
**Innovation Grants on Housing: Request For Proposals**
https://goo.gl/3NmGpn
**New Medi-Cal Non-Emergency Transportation Benefit**
https://goo.gl/RkHnwm
**Cross Cultural Connection: Cultural Competency Training for Providers**
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**Claims Department**
**Important Provider Notices:**
http://www.partnershiphp.org/Providers/Claims/Pages/Important-Provider-Notices-Medi-Cal.aspx
**Claims Modifier FAQs:**
https://goo.gl/Tr0rvh

**Member Services Corner**
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**Quality Department:**
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**Provider Relations Department**
**PHC Equipment Grant: Making a Difference**
https://goo.gl/q5utXB
**Interpretive Services Language Line:**
https://goo.gl/SwcBnx
**CHDP HIPAA Code Conversion & Claim Form Transition**
https://goo.gl/UWyVdh

## From the Desk of CEO Liz Gibboney

### Local Innovation Grants on Housing: Reducing Barriers to Care

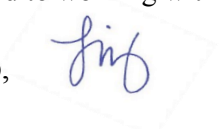
Access to care is not as simple as ensuring that our members are assigned to a PCP or can see a specialist when needed. There are many social factors, social determinants of health, which can impact access to care, homelessness being a significant factor.

In the beginning of July, we released a Request for Proposals (RFP) for the PHC Innovation Grants on Housing. The grant program seeks to address the critical housing and housing-related needs that affect the health and overall costs of health care for our 572,000 members. This one-time, $25 million, grant funding will support projects to expand access to housing for Medi-Cal members in our service area. The top two requirements are 1) funding projects that directly link to our community benefits goals of high quality care, healthy communities, and improving access to care, and 2) projects that will directly impact primarily PHC Medi-Cal beneficiaries.

We are seeking housing projects that reflect a collaborative process that involves community support, and where possible, projects that leverage existing local funds or other resources.

For those without housing, finding shelter outweighs ongoing health issues. By increasing access to housing, we, the community, can begin to address the physical and mental wellbeing of these members. As we begin to address our members social determinants of health, we will begin to realize our mission, *to help our members, and the communities we serve, be healthy*. We cannot accomplish our mission and goals alone, will take the entire community and we look forward to working with your community.

In Partnership,



For more information about the Local Innovation Grants on Housing, including questions and answers, visit the Community section on our website:
http://www.partnershiphp.org/Community/Pages/default.aspx

# From the Desk of Chief Medical Officer Robert L. Moore, MD, MPH

## Balancing Efficiency and Caring: Addressing More Than One Issue in a Visit

**Case Example** (Identifying Details Removed):

An established patient makes an appointment with her primary care provider to evaluate progressive shoulder pain, not getting better in spite of taking ibuprofen three times a day. The next available appointment was one month away with a new clinician working at the office. The patient accepted the appointment. By the time she is seen, she is starting to also have significant abdominal pain and weight loss.

When she arrives at the appointment, the medical assistant asks her why she is there, and she says she made the appointment for shoulder pain, but she now also is worried about the abdominal pain and weight loss. The doctor arrives and tells the patient that he has a policy of addressing only one problem per visit, and asks the patient to choose the problem. The patient decides to have the shoulder pain addressed. The physician diagnoses probable rotator cuff injury and prescribes physical therapy, telling her to continue taking the ibuprofen. The patient is advised to make a return appointment to have the abdominal pain addressed. She is given an appointment six weeks into the future.

The patient calls Partnership to complain and requests re-assignment to a new primary care provider. The case is referred for investigation as a potential quality of care issue to our peer review process.

**Comments on Limiting a Visit to One Complaint:**

In this particular case, the "policy" of only addressing one problem clearly led to a significant *quality of care* issue: potential missed diagnosis of NSAID-induced gastritis or peptic ulcer disease. In other cases we have observed from patient complaints, this "policy" may not harm a patient medically, but nonetheless represents a very non-patient-centric approach to patient care, resulting in what we characterize as a *quality of service* issue.

As clinicians, we have a duty not just to efficiency, keeping our schedule moving along, but to provide excellent quality of care, and to demonstrate respect and caring for these patients. Experienced clinicians know this and have developed mechanisms for maximizing both efficiency and caring/respect/excellent outcomes.

**Approach to the patient with multiple complaints:**

The *vast majority* of physicians and health centers in our network do an *excellent* job of balancing efficiency and caring. In a recent conversation about this topic with clinician leaders from throughout our 14 counties the following best practices emerged:

- **Agenda Setting** Develop a process for jointly setting an agenda for the visit. This may include a reminder of the length of the appointment, listing all issues that the patient would like to address, and then a brief review of these at the beginning of the visit, to *jointly* decide which complaints are the highest priority and which can be safely deferred until the next visit.
- **Continuity** Develop systems to maximize the continuity between the clinician and their team with their assigned patients. Continuity of care improves the efficiency of the acute visit as well as follow up visits. Our performance improvement team has worked with consultants to successfully help several PHC area practices improve continuity and reduce waiting time for appointments.
  For more information, see http://www.tantauassociates.com/ or http://www.aafp.org/fpm/2013/0900/p12.html .
- **Quick Follow Up** For patients with more complaints than can be addressed in one visit, schedule a follow-up visit to address unresolved issues *as timely as possible*, with instructions on what would constitute emergency escalation of symptoms.
- **Regular Appointments** For complex patients with many medical issues, schedule routine appointments at an interval that allows the clinician to address both the chronic diseases and new acute issues on a timely basis. This may be every two to twelve weeks, depending on the patient.
- **Adequate Staffing** Ensure sufficient clinician staffing to meet the needs of your assigned patients. If you are having challenges meeting the needs of your assigned patients due to clinician illness or attrition, reach out to our Provider Relations Department to let us know; there are several options to help balance supply and demand in cases like this, but we need to know about them.
- **Mentorship** Last, and perhaps most important, experienced clinicians should mentor new clinicians on how to address multiple issues effectively.

If someone in your office is allowing patients to bring up only one issue per visit, review these best practices with them. When PHC becomes aware of such complaints, we will forward them to the Medical Director or the office manager of the practice/health center to be addressed. PHC Regional Medical Directors or Quality Improvement staff can be resources for smaller practices if needed.

A key frame of mind we expect from our hardworking and dedicated clinician network**: PHC members may have limited options for open practices for primary care, but this does not excuse poor quality of service.** We expect our entire clinician network to provide high quality care, high quality service *and* to practice efficiency.

# Provider Newsletter

## 2017 Physician Satisfaction Survey Results

Thank you to those who participated in the annual PHC Physician Satisfaction Survey. The survey was conducted by an outside vendor during April and May 2017. Following are the results measuring overall satisfaction with PHC and satisfaction with our Utilization Management (UM) process. The percentages note responses for Strongly Agree or Agree with the survey statements.

Score from all surveys - **I am satisfied with the Plan - 95%**

**Specialty Physician specific UM questions:**

I know how to determine what requires a TAR – 94%

My TARs are approved in a timely manner – 96%

When my TARs are deferred or returned for information, I know what to resubmit – 93%

**PCP only UM question:**

I routinely receive consultative reports from the specialist for my patients – 79%

**Combined PCP and Specialist UM questions:**

PHC Formulary is helpful – 92%

I am satisfied with my interactions with the UM staff (RAFs, TARS, Care Coordination) – 96%

Satisfied with interactions with Chief Medical Officer/Regional Medical Director – 97%

Satisfied with interactions with PHC Pharmacy Department – 89%

I think the process for obtaining non-formulary prescriptions is reasonable – 63%

**Opportunities for further review and improvement:**

Consultative reports routinely received from specialists – 79%

Process for obtaining non-formulary prescriptions is reasonable – 63%

The Plan welcomes any and all feedback and suggestions for process improvement.

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## Online System for Reporting Provider Preventable Conditions

Federal legislation prohibits PHC from paying for treatment of Provider Preventable Conditions (PPCs), and payment adjustments may be applied. Providers must report the occurrence of a PPC that did not exist prior to the initiation of treatment directly to DHCS and PHC. PPC reporting is mandated for all PHC members.

**New reporting system:** As of July 1, 2017, PPCs must be reported to DHCS via a new secure online portal. Please see the instructions about using the portal, which includes a link to the online portal. The online portal replaces the one-page PPC reporting form (DHCS 7107). PHC network providers should also report PPCs directly to PHC via PQI@partnershiphp.org.

Please note that reporting PPCs for Medi-Cal beneficiaries to DHCS does not remove the requirement for reporting of adverse events and healthcare-associated infections (HAI) to the California Department of Public Health, pursuant to Health and Safety Code sections 1279.1 and 1288.55.

For more information, please visit the DHCS PPC Homepage: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx

Our PPC Policy: http://www.partnershiphp.org/Providers/Policies/Documents/Quality%20Improvement/MPQP1055.docx

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# Provider Newsletter

## Claims Mailing Addresses - Important Numbers

**Medi-Cal**

Attn: Claims Department

P.O. Box 1368

Suisun City, CA 94585-1368

**Partnership*Advantage***

Attn: Claims Department

P.O. Box 610

Suisun City, CA 94585-0610

**Healthy Kids**

Attn: Claims Department

P.O. Box 3172

Suisun City, CA 94585-3172

**PHC Care Coordination**

Asthma, Diabetes, ESRD & Growing Together Perinatal Programs - (707) 863-4276

## Protecting Member Confidentiality

Partnership HealthPlan of California places a high value on maintaining our members' confidentiality. We have developed a Confidentiality Policy to ensure that our members' medical and/or other personal health information is handled in a confidential manner to avoid unauthorized or inadvertent disclosure.

Please refer to the PHC Provider Manual for the full Confidentiality Policy.

## IT Corner: Provider Data

High quality provider data is a hot topic for health plans throughout the country. Studies have shown that most provider directories are only 60-85% accurate. Recent changes to government regulations have called for improvement in the timeliness, accuracy, and completeness of provider directory data, with potential stiff fines for non-compliance. In order to meet these requirements we are implementing some changes to our processes. We will require contracted groups and individual providers to attest to the accuracy of their data. This includes all facility or organizational-level data as well as the demographic data for all healthcare practitioners. We have partnered with a service to scrub (clean) the data that we have in our systems. We are also redesigning our internal provider systems to improve our processes for claims payment and authorization submission.

## Staying Healthy Assessment (SHA) Requirement

The SHA is the Department of Health Care Services' (DHCS's) ***Individual Health Education Behavior Assessment*** (IHEBA). The SHA was first developed in the late 1990s and updated in June 2013 in collaboration with Medi-Cal Managed Care Plans.

Plan providers are required to use and administer the SHA or another approved IHEBA tool to all Medi-Cal beneficiaries as part of the Initial Health Assessment (IHA) and periodically re-administer it according to contract requirements.

More details regarding the SHA policy letter and the questionnaires can be found on the DHCS website, link provided for your convenience. http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

A list of resources and trainings is available on the PHC website:
http://www.partnershiphp.org/Providers/HealthServices/Pages/SHA-Training-for-Providers.aspx

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