Medical Directors Forum

Primary Care Almanac (Leadership Version)

Detailed Notes

Spring 2025

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:
Lisa Ward, MD, Regional Medical Director, Santa Rosa office (Marin and Sonoma counties)
Colleen Townsend, MD, Regional Medical Director, Fairfield office (Napa, Solano and Yolo Counties)
Jeff Ribordy, MD, Regional Medical Director, Eureka office (Humboldt, Del Norte, Mendocino and Lake counties)
Brad Cox, DO, Regional Medical Director Redding Office (Trinity, Shasta, Tehama, Siskiyou, Modoc and Lassen counties)
Richard (Doug) Matthews, MD Regional Medical Director, Chico Office (Butte, Colusa, Glenn, Sutter, Yuba counties)
Matthew Morris, MD, Regional Medical Director, Auburn office (Placer, Nevada, Sierra, Plumas 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

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:

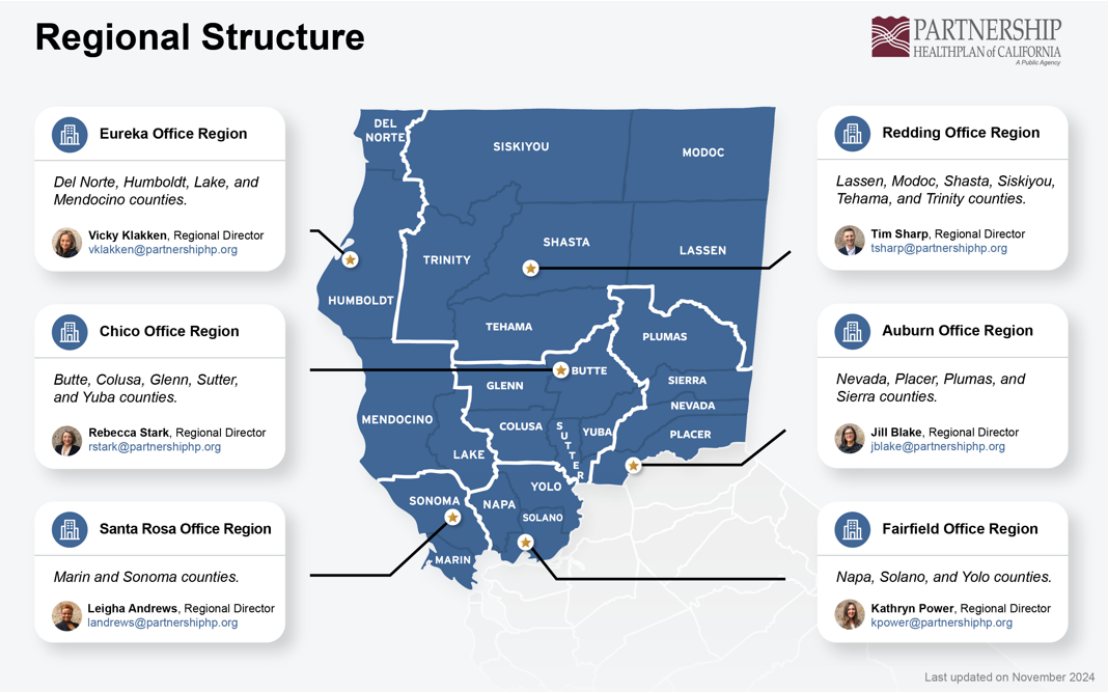
- Non-primary care specialists
- A hospitalist

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

Six Regional Offices

To better serve the needs of our large geographic area, we have divided up into six regions, each with a regional office with a regional director, a regional medical director, and a regional multi-department team. The following graphic shows the counties in each region.



Re-introducing Partnership Advantage

Background

In January 2023, the California Department of Health Care Services (DHCS), mandated that Medi-Cal managed care plans operate a Medicare Advantage Dual Special Needs Plan (D-SNP) designed to coordinate care and benefits for Medi-Cal members who qualify for Medicare. This requirement was designed to further DHCS's policy aims under the CalAIM (California Advancing and Innovating Medi-Cal) plan and required managed care plans to have an active D-SNP plan with enrollees by January 1, 2026.

In pursuance of this mandate, Partnership HealthPlan of California began the application process to the state and federal Centers for Medicare and Medicaid Services (CMS) in 2024 to have a D-SNP plan called Partnership Advantage (PA) ready to accept enrollment in October 2025 and initially operating in 8 counties: Del Norte, Humboldt, Mendocino, Lake, Sonoma, Marin, Napa and Solano.

A major part of that application process was the submission of a Model of Care (MOC) application —a blueprint outlining how health services are designed and implemented— that CMS requires every Medicare Advantage SNP plan to submit. The MOC application covers areas related to the description of the SNP population that will be served, care coordination, the provider network who will help deliver services to this population and quality measurement and performance improvement initiatives.

Some of the quality improvement initiatives and capturing of codes relevant to care acuity for this population are focused on the annual wellness visits (AWV) performed for this population.

Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV) is a preventive healthcare appointment designed for Medicare beneficiaries to assess their health, identify potential risks, and develop a personalized plan for maintaining their well-being. It is also an opportunity to conduct a HRA – a Health Risk Assessment.

Some Key Highlights

According to CMS guidance, an AWV is not a physical exam. A provider can complete a AWV for a member over a video visit or in the office. This AWV cannot take place within 12 months of Part B enrollment or a member's Initial Preventive Physical Examination (IPPE), also called the "Welcome to Medicare," exam. IPPE completion is not required before qualifying for a AWV. During the AWV exam the provider gathers the medical history, social history, routine measures, weight and body mass index, other vital signs, Advanced Care Planning and may include completion of a health risk assessment (HRA). An optional Social Determinant of Health (SDOH) HRA can be performed and an annual cognitive risk assessment is required. AWVs are performed annually.

In contrast, the IPPE (coded with HCPSC G0402) is a one-time in-person visit that must be provided within 12 months of the effective date of a beneficiary's Medicare Part B coverage. It includes the history usually collected at an AWV, but also must include a comprehensive physician exam. A screening EKG, often done as part of the IPPE, is also separately reimbursable once during the beneficiary's lifetime.

Some Key Highlights

- Just as with an AWV, a licensed physician or qualified non-physician (NP, PA, clinical nurse specialist) can provide the IPPE.
- A physician's office usually provides the service but facilities, such as a Hospital, SNF, Rural Health Center, FQHC and CAHs can bill for a IPPE.
- In addition to G0402, ICD 10 diagnostic codes also have to be reported.
- In addition to a typical Medical Hx, SH, risk factors, measurement of BMI, vitals, visual acuity and other factors deemed appropriate are done.
- Discussion of end of life planning, counseling and any referrals, EKG.

Similarities between AWV and IPPE

- Face-to-face
- Covered with opportunities for conducting an annual HRA and Advance Care Planning

Key Differences

- AWV is conducted annually and is an opportunity to also conduct a HRA, IPPE is done one-time within 12 months of effective date of a beneficiary's Medicare Part B coverage

What is the effective date of a beneficiary's Medicare Part B coverage?
A beneficiary's Medicare Part B coverage typically becomes effective the first day of the month following their enrollment, *meaning if they sign up during a given month, their coverage will start the following month*; however, if they enroll during their Initial Enrollment Period (IEP) within the first three months of turning 65, *coverage may start the same month they become eligible* (i.e. when they turn 65).

Why this is important
In the case of AWVs for new Partnership Advantage members, if the PA member had Medicare FFS for at least a year prior to their enrollment with PA, they would not be eligible for a IPPE, they would receive a AWV within a year of the enrollment into PA during which time a HRA can be completed (although this can be completed separately without a AWV).

If the PA member was purely Medi-Cal eligible prior and this will be their first enrollment into Medicare, then they should receive their IPPE instead of a AWV, and the HRA should be performed at that time.

How do members newly eligible for Medicare enroll?
To enroll in Medicare Part B, they can contact the Social Security Administration (SSA) by calling 1 (800) 772-1213, either to apply online through your My Social Security account or to mail in a completed application form (CMS-40B) during the Initial Enrollment Period (IEP), which typically begins three months before they turn 65. They can also visit a local Social Security office in person.

Key points about enrolling in Medicare Part B:

- Contact Social Security: This is the primary way to enroll in Medicare Part B.
- The best time to sign up is during their Initial Enrollment Period, which starts three months before they turn 65.

Credentialing Considerations for New and Locums Physicians

Locum tenens who provide services for fewer than 90 calendar days within a rolling 12-month period do not need to be credentialed. However, if they provide services at a site for more than 90 calendar days within a rolling 12-month period, they will need to be credentialed by the Partnership Health Plan of California.

The purpose of the practitioner credentials review is to ensure that participating practitioners meet the necessary qualifications – including experience, license, certification, privileges, professional liability coverage, and education – to deliver care that aligns with professionally recognized standards. This review also ensures compliance with Partnership policy and applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care, the Centers for Medicare and Medicaid Services, and the National Committee for Quality Assurance.

If you have any additional questions about credentialing Locum Tenens, please contact the credentialing department at Credentialing@partnershiphp.org

Resource:
Policy MPCR300 - Physician Credentialing and Re-credentialing requirements
Section VI. POLICY/PROCEDURE, B. Initial Credentialing Criteria, 8. Locum Tenens

Health Policy Updates

Legislative Roundup

340B Pharmacy-related bill:

California AB 1460 (Rogers, 2025) would prohibit pharmaceutical manufacturers from placing contract pharmacy restrictions on health care providers that utilize the federal 340B discount drug program to serve low-income communities. This legislation is sponsored by the California Partnership for Health and California Primary Care Association Advocates attempting to add **Section 127472** to the Health and Safety Code, to read:

A prescription drug manufacturer shall not engage in discriminatory practices that would impose additional conditions, prohibit, restrict, deny, or interfere with a covered entity's purchase or delivery of a drug eligible for discounts under the federal pricing requirements set forth in Section 256b of Title 42 of the United States Code, if the covered entity utilizes a specified pharmacy, including a contract pharmacy, that dispenses the drug to an eligible patient of the covered entity.

https://leginfo.legislature.ca.gov/faces/billVersionsCompareClient.xhtml?bill_id=202520260AB1460

Obstetrical related bills

California SB 669 (McGuire, 2025) would allow for a pilot project that designates a "standby perinatal unit" in a remote rural hospital. This model contrasts the standard model of continuous OB unit staffing used in hospitals. This pilot will provide an example of a solution that emphasizes a well-trained, capable local team of professionals who provide high-quality maternity and labor and delivery care. Emphasizing the training and systems required in this model, we have been able to garner support for SB 669 by all stakeholders.

A key part of advocating for this bill is that family physicians with specialized, supplemental OB training are critical to the success and sustainability of this staffing model in rural hospitals. Urban specialists may be unaware of the enhanced skills and experience that family physicians bring to rural settings; rural communities' needs are different than urban areas. Our current health systems, policy, and regulations are based on serving dense, urban populations with a broad network of resources. Urban specialists often drive the standard and models of care beyond the city limits. However, when an urban mindset drives solutions for rural areas, the unique rural circumstances and resources may not be fully considered.

California AB 55 (Bonta, 2025) would change the requirements related to licensing alternative birth centers in California. Medi-Cal requires that birth centers be licensed, but private patients may deliver in non-licensed facilities, which are often accredited by the Commission for the Accreditation of Birth

Centers (CABC). To our knowledge, only three licensed birth centers in California exist, compared to dozens of accredited birth centers. The state licensing requirements inherently promote inequitable access to birthing centers. This bill makes multiple changes in licensing requirements, which would allow many accredited birthing centers to start accepting Medi-Cal, making obstetric care more accessible in California

California SB228 (Cervantes, 2025): Requires greater oversight of the CPSP program by DHCS and CDPH. While the original version would have transferred responsibility of the program to DHCS, the new version does not do that, but does require DHCS to develop a training that all perinatal providers (not defined) must complete. It also mandates the use of a perinatal services data form to collect supplemental data, a proposal first suggested by the state auditor.

California AB1386 (Bains, 2025): Defines perinatal services as core services for Acute Care Hospitals and requires them to reopen services or submit evidence that they would be unable to do so. Likely exempts Rural Acute Care Hospitals that don't have surgery or anesthesia services. Doesn't get at underlying causes of OB unit closures.

California SB626 (Smallwood-Cuevas, 2025): Requires Medi-Cal managed care plans to ensure pregnant patients have care coordination and case management, and that they be screened for depression. This would also ensure support for mental health for these patients, and to report on the rates of use of these services on their public website, starting in 2026. The current local codes used by CPSP capture this data nicely, but any change to the use of national billing codes (without ensuring that CPT or HCPCS codes with more specificity are created by the American Medical Association), will make the specificity envisioned by this bill impossible. We believe a coalition that coordinates efforts to develop specific, prenatal case management codes accepted nationwide would improve access to data to assess and adapt perinatal services.

California SB32 (Pierson, 2025): Requires developing and implementing new standards of perinatal access. Since health insurers cannot control what hospitals do, this will not have any impact on the maternity access issue.

United States S. 380 (Hassan, 2025) is a bill which would allocate up to $20 million in grants to support development of training in obstetrical emergencies and newborn stabilization for rural hospitals without dedicated obstetrical units. Some grants would also support the implementation of telehealth services for such rural hospitals.

Federal Policy:

As part of the continuing resolution to continue to fund the government, Congress granted a several month (until September) extension for Medicare telehealth flexibilities and FQHC funding.

The Senate and House Subcommittees overseeing the Medicaid budget have both proposed sizable cuts in Medicaid. The details are in flux and will be reviewed at the in-person meetings.

State Policy:

State Budget Projection. Since the Trump administration has cut payments for overhead expenses in NIH grants, the UC system is projecting significant shortfalls which are affecting the overall fiscal situation in California. Simultaneously, the Cal State University system and Medi-Cal are running short of operating cash, which will need to be resolved as part of this year's budget cycle. This will make new spending all but impossible, and put current programs and state employee staffing at risk. Advocacy opportunities need to focus on initiatives not costing discretionary funds. For example, the California Academy of Family Physicians, at their lobby day, focused on preserving funding for Graduate Medical Education, known as Song-Brown funding.

DHCS has announced a "back to the office" at least 4 days per week initiative for summer, 2025, with some exceptions. This may prompt some staffing turnover in the months ahead.

Managed Care Tax (MCO Tax). Starting last 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

Due to DHCS delays in issuing regulatory instruction, the payments for 2024 were mostly made in December, as a one-time estimate, based on existing claims data.

Proposition 35 passed overwhelmingly in November which “permanently,” designated the MCO tax money to Medi-Cal provider rates and other purposes. It also adding a stakeholder process requirement. Of note, DHCS interprets Prop 35 as making the 2025 increases specified in statue (summarized above) inoperable. Instead, the stakeholders would need to approve the use of the Prop 35 funding.

The first meetings of the stakeholders have not yet happened, so it seems likely that regulatory guidance will also be delayed, like in 2024. The threat from the U.S. Congress to phase out MCO taxes nationwide may be weighing on the timeline for regulation from California.

POLST Registry

After a several-year wait, California Emergency Management Services announced on March 14 that a vendor for a statewide registry for the Physician Order for Life Sustaining Treatment (POLST) registry had been selected and that initial implementation is expected in the summer of 2025. The Coalition for Compassionate Care of California will be participating in the POLST Technical Advisory Committee mentioned below. For details, see https://emsa.ca.gov/polst/.

The planning and development work for the POLST eRegistry has been transitioned from the California Health and Human Services (CalHHS) Office of Technology and Solutions Integration (OTSI) to the Emergency Medical Services Authority (EMSA). This strategic shift will allow EMSA to maintain closer oversight of the project as it moves forward.

EMSA was previously engaged in the state procurement process to secure a vendor to begin the system build. This reflects the department’s commitment to maintaining project momentum while ensuring the right partner is selected to bring the POLST eRegistry to life.

Vendor and Timeline

The EMSA Request For Offer (RFO) was awarded on 3/14/25 to ServiceNow for the POLST platform. The rationale being that it is an enterprise service platform that will be utilized by all EMSA programs. Also, an RFO was issued instead of an Request For Proposal (RFP) because the Department of General Services Software Licensing Program (SLP) has an existing Licensing Procurement Agreement (LPA) that lists approved vendors for ServiceNow. The initial POLST functionality is expected to be available Summer 2025.

POLST Technical Advisory Committee

As part of the department’s ongoing commitment to stakeholder engagement, EMSA will be launching a dedicated POLST Advisory Committee and sent out engagement letters in February of 2025 for this important initiative.

The first meeting is scheduled for May 14, 2025, and will be held virtually from EMSA Headquarters, in Rancho Cordova. The department welcomes participation in this workgroup as the POLST program aims to ensure that seriously ill patients can make their wishes known about life-sustaining treatment and have those wishes honored across all healthcare settings.

Access to Maternity Care

Last year, another Northern California hospital maternity ward closed in the Partnership service area. The closure of the Mad River Hospital in Arcata (Humboldt County), leaves just 23 non-Kaiser hospitals with open maternity units in our 24-county service area. Now, there are 24 hospitals without maternity services across rural Northern California.

Last spring, Advancing Health in Rural California published a research paper by Harvard MPH student Sara Howard, describing the underlying drivers of the steadily worsening maternity care access crisis in rural California:

1. Birth volume has decreased by 20% in the past decade, which has cascading impacts on financing and operations for hospitals providing obstetric (OB) services.
2. Financial stability of rural hospitals is decreasing due to a variety of factors besides OB volume.
3. A trend toward RN training programs that focus on specialized care limits the foundation of cross-training experiences, which subsequently limits nurses' abilities to pivot into OB care when needed.
4. Regulatory barriers prevent flexibility in staffing models that could optimize the capacity for low volume rural hospitals to meet the local service needs
5. Statutory regulations on Alternative Birthing Centers prevent most of these centers from billing Medi-Cal, and consequently they are unable to serve the Medi-Cal population.
6. A pervasive shortage of trained maternity care providers, especially obstetrician-gynecologists (OB/GYNs), midwives, family physicians who do obstetrics (FP-OBs).

In Partnership's service area, 40% of births are covered by Medi-Cal. This rate grows to over 60% in smaller and rural counties. Partnership has a responsibility to participate in and lead actions that address this issue and help ensure our members receive the care they need.

Partnership has a wide range of working relationships with a diverse group of stakeholders whose collaboration can drive policy change and local initiatives to meet the maternity care needs of rural communities. The stakeholders include: county and state public health entities, hospitals, health centers, tribal health centers, Department of Health Care Services (DHCS) and our government regulators, elected government representatives, community-based organizations, the mental health delivery system, the trade organizations serving hospitals, health centers and Tribal health, and public-school systems.

Partnership holds a unique position to address complex, multi-faceted challenges like OB access and quality, with multiple interventions and projects across different domains, all working towards a common goal. Over the years, Partnership has had a key role of cross-sector collaboration and innovation to enact change, in order to improve health outcomes of the communities we serve. Our experiences in addressing opioid overuse, palliative care, substance use disorder treatment, transportation, pay for performance, social determinants of health, complex care management, and more, can be leveraged to address the large and complex maternal health problems in our service area.

Expanding access to safe and high-quality obstetrical care aligns with Partnership's mission: to help our members, and the communities we serve, be healthy. Safe, accessible, local maternity care serves the entire community. Building key local and regional partnerships improves both the quality of care and member satisfaction. These are foundational components of Partnership's strategic plan.

Improving access to high-quality maternity services in our service area requires a portfolio of synergistic interventions in these broad categories:

1. Policy changes: governmental, health plan, and local health systems
2. Educational programs that optimize local health care workforce capacity
3. Adjustment of reimbursement models to support diverse settings of care
4. Deepening community partnerships that reinforce collaboration
5. Better data collection and analysis to guide thoughtful decision making

Much has been accomplished in the two years since Partnership's focus on obstetrical access and quality began. This article summarizes key developments and activities, so our partners can see how they all fit together.

Policy Activities

Pending Bills: see policy updates above

CMA House of Delegates: Thanks to the efforts of the medical societies representing rural Northern California, the 2024 House of Delegates of the California Medical Association focused on two major policy issues: rural health equity and access to quality obstetrical services. The final list of 19 recommendations can be found on the CMA website.

There was general support for activities to support the rural health care delivery system and to improve rural OB access. Nonetheless, statements from some urban based physicians on the floor of the House of Delegates illustrated the lack of understanding of rural health care delivery systems, including the role of family physicians in providing obstetrical services in rural areas.

While strong evidence across several countries shows that closing hospital maternity units in rural hospitals increases adverse neonatal outcomes, some

urban-based medical leaders and policy makers express ambivalence to closure of rural OB units, believing that the safest place to deliver any baby is at a larger volume facility. The reality of long distances in rural areas and the effect of inclement weather on transportation may not be fully appreciated by urban-based physicians and policymakers. This is an important opportunity for medical societies in rural areas to speak up on issues affecting rural health care.

State Regulatory Activities

In February 2025, DHCS unveiled their “Birthing Care Pathway” framework, which lists several current and proposed interventions to improve quality and access to high quality OB services. One new activity to note is that dyadic services (mental health services provided to both the mother and baby/infant) are a reimbursable fee-for-service in all primary care settings, including health centers.

Also in the beginning of the year, DHCS was awarded a 10-year federal grant to reduce maternal mortality and improve health outcomes in several San Joaquin valley counties. The initiative, called “Transforming Maternal Health” will test the hypothesis that maternal outcomes can be dramatically improved with a new payment model that pays for quality outcomes instead of services provided.

Partnership Activities

Provider Recruitment

In late 2024, a survey of the Partnership network found that 33% of all positions for maternity care providers (including physicians, midwives, and nurse practitioners) are currently vacant and under active recruitment. This is higher than the vacancy rate for primary care in general, which is 26%. A vacancy is defined as a job opening in which active recruitment is underway, with exam room capacity and funding available to pay the clinician, if one is found.

Maternity care providers are eligible for Partnership’s recruitment incentive program. During 2024, three obstetrician/gynecologists, two family physicians with a focus on obstetrics, seven midwives/nurse practitioners, and two women’s health physician assistants (a total of 14 individuals) received signing bonuses.

While Partnership supports efforts to integrate midwives into hospital and community-based care for Medi-Cal members, midwifery workforce development efforts are stymied by external factors. Unfortunately, one of the two California training programs for nurse midwives (UC San Francisco) converted its program from a master’s program into a doctorate program (a longer, more expensive training program) and paused admission of new students for a year to prepare for the transition. This will lead to a decrease in new nurse midwives who complete training in California in the next few years.

The only remaining nurse midwife master's program is at California State University, Fullerton. Advocacy that reinforces existing training programs and expands training for midwifery and other obstetrics providers is vitally needed in California to meet the workforce needs of our communities.

Rural Nursing Education

In the summer of 2024, Christi Myers, the director of the registered nurse training program at Lassen College, highlighted the way that the program provides a well-rounded, hands-on training experience for registered nurses. Graduates of the program can practice in multiple hospital settings in rural hospitals. She presented this program at Partnership's annual Hospital Quality Symposium in August. Meyers stated that a close partnership between Lassen College and nearby Banner Lassen Hospital was a key to the strength of the program. Another highlight is a high-quality simulation lab for teaching hands-on skills using mannequins before trying them on patients. Partnership hopes that RN training programs in other rural community colleges will collaborate with nearby rural hospitals with the same goal: to produce well-trained nurses who are able to work in multiple settings in the hospital.

Several other community colleges in the Partnership region are working to develop such programs. Support by local medical societies and hospitals will be key.

Building Skills and Teamwork to Provide Safe OB and Newborn Care in Rural Areas

Partnership has identified three training programs related to obstetrical/newborn care, which are rarely available but important to be accessible in rural areas: Advanced Life Support in Obstetrics, Basic Life Support in Obstetrics, and custom neonatal airway training.

Advanced Life Support in Obstetrics (ALSO), developed by the American Academy of Family Physicians, is taught around the world. This intensive course offers teams actively providing obstetrical care the current knowledge and skills for managing obstetrical emergencies, including hands-on practice of manual skills that are needed in obstetrical emergencies, such as shoulder dystocia, vaginal breech delivery, and post-partum hemorrhage. The target audience is family physicians that provide active OB services, nurse midwives, licensed midwives, as well as nurses who work in a labor and delivery setting. This is a 6 to 10 hour online training is followed by 7.5 hours of in-person training. Inviting any local OB/GYNs to participate can build team communication skills and is encouraged.

Basic Life Support in Obstetrics (BLSO) is a variation of ALSO that targets first responders, doulas, physicians, and nurses that practice in the emergency department or outpatient setting. These individuals may be the only medical personnel available to assist with delivery in rural areas. The training includes material covering normal delivery and routine newborn care, as well as the basics of managing uncommon obstetrical emergencies. This is a 4 to 8 hour

online training followed by 7.5 hours of in-person training. The focus of the practice sessions can be adapted to meet the specific scope of the trainees.

Neonatal Airway Training is a custom advanced training for pediatricians, family physicians, emergency physicians, respiratory therapists, and inpatient pediatric physician assistants/nurse practitioners. This training builds on the foundations of the Neonatal Resuscitation Program (widely available) and includes hands-on practice mastering complex neonatal airway challenges that can be encountered in term and premature infants. The training focuses on using bag-valve mask, laryngeal mask airway, and video-enabled laryngoscopes. The training lasts about 2.5 hours. Partnership provides the hospital with a state-of-the-art video laryngoscope and includes a supply of disposable laryngoscope blades.

Partnership offers all three training programs in our rural service area, training physicians, midwives, doulas, nurse practitioners, and respiratory therapists. If you are interested in scheduling a training course in your community or hospital, please reach out to your local Partnership Regional Medical Director to be connected to our training coordinator.

Support for Doulas

Doula services became a Medi-Cal benefit in January 2023, with the number of contracted doulas in our region growing steadily. Doulas provide support and education for those who are to give birth. These services are especially important for pregnant individuals without their own support system or who need extra advocacy to gently assure that patient-doctor communication is optimized. Studies show that birthing persons from the vulnerable population (groups with higher rates of maternal mortality and serious maternal morbidity) who have doula care have better outcomes than those without doulas. Partnership aims to provide doula access for our perinatal members in each of the 24 counties we serve.

Partnership has three parallel strategies to develop a robust doula network: contracting with existing trained doulas, enhancing the integration of high-quality doula care into maternity care teams, and supporting efforts to train new doulas.

To connect with currently practicing doulas, Partnership staff reach out to individual doulas and doula groups to schedule information meetings that introduce the doulas to Partnership, the doula benefit, and other perinatal services offered by Partnership. These sessions provide a step-by-step overview of the process to contract and credential with Partnership. To expedite the enrollment process in the Medi-Cal system to onboarding doulas, the application for contracting and credentialing are processed simultaneously within Partnership.

Once contracting and credentialing are complete, Partnership schedules monthly trainings for doulas to learn about Partnership benefits and how to submit a claim. The Partnership Claims team works closely with newly

contracted doulas to facilitate timely and smooth claims and reimbursement processing.

In addition to direct outreach to doulas, we partner with community-based organizations, public health departments, clinical practices and hospitals to share information regarding the doula benefit. Partnership has sponsored informational doula gatherings and doula trainings on different clinical topics. Since Medi-Cal coverage of doula services is new, both Medi-Cal beneficiaries and hospitals/maternity care professionals are learning how doulas fit into the birthing care team. Partnership provides educational awareness activities directed at members, hospitals, and maternity care teams and collaborates with several county-based organizations to recruit and train new doulas.

Tribal Perinatal Support

Maternal and neonatal outcomes for American Indians in California are worse than outcomes for other ethnic groups. Partnership members who identify as single-race American Indians are more likely to reside in rural areas. Many reside in remote frontier areas with limited access to health care services. The closure of obstetrical units in many rural hospitals especially impacts our Tribal communities.

The Partnership service area includes 21 Tribal Health Clinics serving 51 federally recognized Tribes, more than any other managed care plan in California. Tribal health leaders and clinicians serve on Partnership's Board of Commissioners, Physician Advisory Committee, Quality Utilization Advisory Committee, and Community Advisory Committee.

As part Partnership's CalAIM portfolio, we launched a Tribal Perinatal Initiative, which provides grants to Enhanced Care Management (ECM) programs to support the case management needs of pregnant and post-partum Tribal members living in our service area. Major activities include grants to start new ECM programs with a focus on Tribal health and wellness, educational offerings targeting community health workers and case managers, and supporting local community collaboratives that connect Tribal members and hospitals to build a more responsive, understanding, and welcoming health system for Tribal members who are pregnant. Many Tribal health centers are participating, but the work has only just begun.

Quality Improvement Activities

Partnership's pay-for-performance programs that focus on prenatal and post-partum care quality are the longest standing and most effective perinatal incentive programs in California.

Until recently, the reimbursement rates for non-Health Center maternity care have been far below rates in Federally Qualified Health Centers, rural health centers, and Tribal health centers, which are reimbursed with different mechanisms. Matching a trend seen in primary care services in the Partnership

region, most prenatal and post-partum care has migrated to Federally Qualified Health Centers.

Partnership's Perinatal Quality Incentive Program (Perinatal QIP) incentivizes timely prenatal care, depression screening, vaccinations recommended in pregnancy, timely post-partum visits, and electronic clinical data exchange systems. Perinatal QIP staff visit prenatal practices regularly to provide individual feedback and information on perinatal programs and improvement activities. Educational content for perinatal providers includes in-person, real-time webinar, recorded webinar, and written materials, available on the Partnership website.

In addition, Partnership's Hospital Quality Incentive program (HQIP) includes many hospital quality metrics related to maternity and newborn care. A new measure incentivizes hospitals to implement or continue to include family physicians and midwives into the medical staff. A diverse medical staff model leads to a more sustainable workforce and allows community members more options in their care providers. As a result of these robust efforts, perinatal quality measures are among the highest performing in California.

Introducing Partnership HealthPlan Perinatal Services (PHPS)

Over the last several years, the California Department of Public Health has pulled back from overseeing the California Perinatal Services Program (CPSP). As a result in 2024, with significant input from our provider network, Partnership launched Partnership HealthPlan Perinatal Services (PHPS). This is an updated, nimble version of the CPSP program, that builds on the core strengths inherent to CPSP, while adding flexibility to expand access to perinatal services.

Building a stable, modern perinatal case management system offers a platform for high quality and optimal maternal care outcomes. Key changes include telehealth services for health education/case management, nutrition, behavioral health and medical care. We have expanded the types of eligible providers and are building the network of participating providers for services that are difficult to access, such as nutrition.

We are rolling out PHPS to the network, with perinatal provider meetings, review of applications, and updating our site review process. After this phase is complete, we will be aiming to fill network gaps for perinatal case management and setting up the infrastructure for ongoing enhancement of quality of care provided by the network.

Future Activities

Stabilizing access and quality of obstetrical services is a major strategic initiative of Partnership, as is evident from the host of high-impact activities noted above. While some great groundwork has been laid, much remains to be done on these projects.

We are committed to working with our partners to create new solutions and fortifying and spreading current successful practices to build safer, accessible maternal care services across Northern California.

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 are 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.

Key Framing Messages for Rural Health

1. People living in rural areas deserve high quality health care and good health outcomes.
2. In rural areas and frontier areas, Medicaid patients get services from the same providers as everyone else. Access and quality of care for everyone living there is the goal.
3. The needs of people in frontier areas are very different from those in cities with surrounding rural areas (like Redding and Eureka and Chico).
4. Policy-makers from urban areas/backgrounds often have implicit bias against those living in rural areas, leading to discrimination and structural inequities, sometimes called Structural Urbanism. Some aspects of this
    a. Statewide policies that work in urban settings but not rural or small county settings
    b. Not getting input of stakeholders from rural areas in the policy-

making process.
   c. Lack of awareness of the sociodemographic differences of populations outside urban and suburban areas.
5. In just about all areas of the health care delivery system, the relatively low volume of services means that fixed costs per services are higher than in urban areas. Thus, equal payments for the same service are inherently inequitable, whether these assumptions are at the federal, state or local level.

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.

Rural Health was Focus of 2024 CMA House of Delegates

The California Medical Association's 2024 House of Delegates made 14 recommendations related to rural health (see below). Notably missing was a recommendation to create a new rural health section or other grouping of rural physicians to directly advise the Board of Trustees. There was notable support for this idea, and further advocacy is warranted. Nonetheless, in an organization dominated by urban and suburban physician members, the passage of the recommendations below demonstrates a dedication to supporting physicians practicing in rural areas.

RECOMMENDATION 1: That CMA encourages the development of programs and financial assistance models that support increasing the number of physicians in rural areas by encouraging medical schools and residency programs to prepare, recruit, support and train rural health physicians. Substantial training should occur in non-hospital facilities, focus on the unique challenges and needs of the rural communities they serve, and ensure reduced barriers that prevent residents from participation in those opportunities.

RECOMMENDATION 2: That CMA supports increasing the number of culturally responsive physicians who are fluent in the languages that are predominant in populations living in local rural areas and supports access to and reimbursement for interpreting services for people who do not speak English as a first language.

RECOMMENDATION 3: That CMA supports increasing each state's visa waiver slots for physicians practicing in rural areas.

RECOMMENDATION 4: That CMA supports the continued development of integrated team-based care in rural areas that is led by physicians and includes advanced practice clinicians, registered nurses, pharmacists, social workers, behavioral health workers, in-home care workers, community health workers, and peer health workers, and that these teams and their patients have access to specialty consultation and treatment.

RECOMMENDATION 5: That CMA supports the permanent extension of all COVID-19 pandemic telehealth waivers and supports the ease of use, access to, and payment for patient-to-provider telehealth and provider-to-provider virtual consultation as an option to increase access to primary and specialty care in rural communities and acknowledges that significant investments in rural telehealth infrastructure, such as broadband and cellular access, must be made in order to effectively deliver telehealth care.

RECOMMENDATION 6: That CMA encourages the development of programs and comprehensive financial assistance models for rural facilities and physician practices to obtain the modern health information technology and medical equipment along with the technical and business training required to provide high quality care.

RECOMMENDATION 7: That CMA recognizes that the provision of preventative care services and care for chronic conditions can be particularly difficult and variable in rural and underserved areas and supports increased physician-led interventions to improve patient health outcomes.

RECOMMENDATION 8: That CMA encourages partnerships with

community-based organizations and expanding community engagement models to facilitate improving public health, health literacy and health care outcomes.

RECOMMENDATION 9: That CMA supports developing public health funding allocation models that account for the limitations small, local health jurisdictions have when competing in grant application processes. When available funding is sufficient, CMA supports all local health jurisdictions receiving a minimum baseline funding allocation, preferably in an amount no less than one full time equivalent position.

RECOMMENDATION 10: That CMA supports actions designed to promote rural access to health care, affordability of care, and high quality of care. This includes the authority of the appropriate governmental agencies to intervene when rural facilities, such as hospitals and physician practices, are being acquired by another party in a manner that could result in the discontinuation of key health care services in a community. CMA also encourages the timely notification of health facility sales and mergers to affected communities.

RECOMMENDATION 11: That CMA supports the development and evaluation of reimbursement and alternative payment models, including value-based payment programs as well as regulatory and reporting changes for small and rural practices, that are effective in rural areas and acknowledge the unique financial challenges of rural practice.

RECOMMENDATION 12: That CMA supports improved and equitable reimbursement and financial assistance models aimed at supporting rural healthcare facilities and physician practices.

RECOMMENDATION 13: That CMA supports investments in and payment for a wide variety of medical transportation options to connect rural residents to health services including but not limited to primary and specialty care services and associated ancillary services and return to their communities.

RECOMMENDATION 14: That CMA supports the collection of granular comprehensive race/ethnicity data, including mixed race individuals to reduce the undercounting of American Indians in rural and urban settings.

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 support of 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 any provider or facility caring for a Partnership member and makes recommendations for opportunities for improvement and/or corrective action plans. The definition and description of Corrective Action Plan (CAP) was recently redefined for clarity: "A CAP is a directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. 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. Pharmaceuticals 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.

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 or have them subscribe at http://eepurl.com/gjHOxb.

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

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. The link to the download of the Excel spreadsheet with the 34 different BP monitor options is here.

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 Medi-Cal Rx at (800) 977-2273.

Medical Equipment Distribution Program

The Partnership's Medical Equipment Distribution Services (PMEDS) program 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.

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, Social Workers, Health Care Guides, and Behavioral Health Clinical 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 from high-risk populations that transition from one care setting to another, have multiple unmanaged complex conditions, and/or for those who 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:
Southern Region Office
Fairfield, CA
CCHelpDeskSR@partnershiphp.org
Northern Region Office
Redding, CA
CCHelpDeskNR@partnershiphp.org
Eastern Region Office
CCHelpDeskEA@partnershiphp.org

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, Placer County (Roseville area), Plumas, Sierra, Siskiyou, Shasta, Solano, Trinity, Tehama, Sutter, Yuba	Vynca/Resolution Care	Phone: 707-442-5683
Butte, Glenn	Adobe Ca Medical Group	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	By the Bay Health	Phone: 415-444-9210
Marin	MarinHealth Medical Network	Pending
Sonoma	St. Joseph Home Care Network	Phone: 707-522-4307
Nevada and Placer (Grass Valley, Nevada City, Auburn)	Foothills Compassionate Care	Phone: 530-272-5739
Nevada and Placer (Truckee and North Lake Tahoe)	Tahoe Forest Hospice (Pending)	

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

Medi-Cal 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. Importantly, members are who drive themselves or own cars are not eligible.

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**.

If you as a **provider** are encountering problems or challenges, you can reach us by phone at **(866) 828-2303** (option 3), 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:

- Member reimbursements for travel expenses such as lodging, meals, parking and tolls
- Driver reimbursements for gas mileage reimbursement (GMR)
  - Driver/Payee credentials are managed in the software
  - Must supply current driver's license, registration, insurance and proof of attendance on facility letterhead (we also match trips to medical claims in leu of proof of attendance documents)
  - Members cannot be reimbursed directly and GMR is intended for transport via a private vehicle (Taxi rides, including Lyft and Uber, do not qualify for GMR)
- Taxi transportation (including Lyft)
- Wheelchair, Gurney/Litter, Ambulance or Air ambulance
  - These options require a Provider Certification Statement (PCS)
  - The PCS must be signed by the physician overseeing care and be fully completed
  - A copy of our PCS can be requested via email at transportationhelpdesk@Partnershiphp.org

Telemedicine Services

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. We have partnered with ConferMED for eConsult, TeleMed2U for adult specialty care and UC Davis for pediatric specialty care. Highlights are listed below.

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

eConsult: ConferMED

Partnership HealthPlan of California is contracted with the eConsult vendor, ConferMED. ConferMED can seamlessly integrate with office electronic health records to allow for peer-to-peer communication with 75% of the time the patients needs being addressed through consultation.

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 are listed in the table below.

If you are interested in learning more about ConferMED, contact Partnership's telemedicine team at telemedicine@Partnershiphp.org.

Adult Specialty Telemedicine

In “traditional” synchronous telemedicine, the patient is physically located in the PCP office and the specialist is remote (embedded clinics). The PCP office will coordinate the appointment, check vitals, and may require the PCP or another clinician to 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 begin utilizing services through TeleMed2U, contact our telemedicine program team at: telemedicine@Partnershiphp.org

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 which are being provided by "TeleMed2U" for a select set of specialties. More Information can be found here.

Physical Therapy was recently added in September as an offering through Direct-to-Member for Partnership members 5 years of age and older. Since its inception, there have been 446 completed visits across 25 providers, with consistent growth seen month-over-month. Examples of reasons for referrals thus far are listed.

Here is a quick reference of the Telemedicine Modalities available for **adults**:

Telehealth Modalities				
Specialties Offered*	Block Time	Open Scheduling	Direct Specialty Telehealth Services *	eConsult
Allergy & Immunology (all ages)			x	x
Cardiology			x	x
Dermatology (all ages)			x	x
Diabetes Care Program			x	
Endocrinology	x	x	x	x
ENT/ Otolaryngology			x	x
Gastroenterology		x	x	x
General Surgery				x
Geriatric Medicine				x
Gynecology				x
Hematology/ Oncology				x
HIV/ HEP C			x	
Infectious Disease	x	x	x	x
Medical Oncology				x
Nephrology	x		x	x
Neurological Surgery				x
Neurology		x	x	x
Neuropsychology				x
Nutrition (ages 3+)	x	x	x	
Obesity Medicine				x
Orthopedics				x
Pain Management				x
Physical Therapy (ages 5+)			x	
Psychiatry (ages 4+)	x	x	x	x
Pulmonology	x	x	x	x
Retinal Reading				x
Rheumatology	x	x	x	x
Urology	x		x	x
Vascular Surgery				x

Pediatric Specialty Telemedicine

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.

Here is the matrix of telemedicine services available for children:

Specialties Offered*	Block Time**	Direct Specialty Telehealth Services	eConsult
Adolescent	x	x	
Allergy & Immunology		x	x
Behavior and Development		x	
Cancer Center		x	
Cardiology	x	x	x
Dermatology		x	x
Endocrinology	x	x	x
ENT/ Otolaryngology		x	x
Gastroenterology	x	x	x
Genomic Medicine		x	
Gynecology (ages 15+)			x
Hematology/ Oncology		x	x
Infectious Disease		x	x
Neonatology		x	
Nephrology	x	x	x
Neurology	x	x	x
Neuropsychology			x
Neuromuscular Disease Medicine		x	
Ophthalmology		x	
Orthopedics		x	x
Pain Management		x	
Palliative Care		x	
Physical Therapy		x	
Psychiatry			x
Pulmonology	x	x	x
Retinal Reading			x
Urology	x	x	x

Diabetes Education and Nutrition Counseling

Diabetes education and nutrition counselling are important components of diabetes care that give 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. A new telemedicine nutrition vendor, *FoodSmart* will be contracted soon. 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

Follow Up Visits for Patients Seen at ED's with Mental Health or Substance Use Diagnoses

Partnership encourages PCPs to communicate on a regular basis with local ED's to support well-coordinated transitions of care and post-ED follow up care for all members.

PCPs should follow up with all assigned members who were seen in an ED with a Mental Health or Substance Use Diagnosis within 7 days of their ED event. Please schedule these members with appropriate follow-up services with a clinician who can address their mental health or substance use treatment

needs. It is important to code these visits appropriately on claims and encounters, using a mental health or substance use diagnosis aligned with their ED event, so that your work can be counted towards NCQA and DHCS behavioral health quality measures reported by Partnership and County Departments of Behavioral Health.

Many EHR's now include real-time Admission, Discharge, and Transfer (ADT) feeds which makes it possible for PCP's to monitor their assigned members' ED events and follow up in a timely manner. The Compass Rose module in Epic OCHIN is an example of this tool in an EHR. ADT feeds also include up-to-date contact information for members seen at the ED, which can streamline contacting for follow-up care.

Mild to Moderate Mental Health: Carelon Behavioral Health

Partnership contracts with a third party Mental Health administrator, 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. 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.

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 remain the only managed care plan in California to administer 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.x for Medication Assisted Therapy for Opioid Use Disorder
- F10. x for Medication Assisted Therapy for Alcohol Use Disorder

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

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

Online Behavioral Health Resources for Caregivers and Youth

Free Online Behavioral Health Resources for Caregivers and Youth are now available through the state's Children and Youth Behavioral Health Initiative (CYBHI).

BrightLife Kids (https://www.hellobrightline.com/ca-families/) - provides free behavioral health coaching to all California kids ages 0–12.

- No costs attached
- No insurance required
- No referrals needed
- Video or chat-based
- 1:1 coaching (diverse, bilingual coaches
- On-demand digital tools
- Care Guides to manage complex needs and provide referrals

Soluna (https://solunaapp.com) - is the all-in-one mental health app for California youth and young adults to de-stress, reset, and seek support.

- Always free
- Always anonymous
- Scheduled or drop-in 1:1 coaching (diverse, bilingual coaches)
- Interactive and engaging tools • Moderated community forum, self-support guides, and articles

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 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.brightheartheath.com/contact-us/

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

In addition to 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)
- Non-custom compression garments

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)

CalAIM: Enhanced Care Management and Community Supports

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 (CS) Services covered by Partnership include the following:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Transition Housing (ie post-hospitalization)
- Short-term Recuperative Care (Medical Respite)
- Respite Services
- Meals/Medically Tailored Meals
- Personal Care and Homemaker Services
- Day Habilitation *
- Sobering Centers *
  *(*established programs only)*

If you wish to refer a patient for consideration for ECM and/or CS services, have

your care coordinator contact:

- ECM: ECM@partnershiphp.org
- CS: CommunitySupports@partnershiphp.org.

Additional components of CalAIM of interest to Primary Care Providers:

1. A new *transitions of care* requirement, DHCS 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.

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 CHW 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.
4. Partnership has begun contracting with Supervising CHW providers. More information can be found here.
5. DHCS specified covered and non-covered services in their policy document.
6. 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 and RHCs: FQHCs and RHCs are unable to bill for CHW services per DHCS. Tribal health centers are eligible for a FFS payment for CHWs, but not their OMB rate.

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).

Genetic Testing for Pregnant People: What is covered?

Over the last few decades, antenatal testing for genetic disorders has grown from screening for Down syndrome (introduced in 1986) to screening for a variety of disorders. For our members, some are covered by DHCS, some are covered by Partnership, and others are not covered by either. State policy documents related to prenatal diagnosis are unclear in certain aspects. Here are some hints for sorting this out:

Universal Screening of Pregnant Persons:

(Lab bills DHCS, not Partnership)

By California law, every prenatal provider must offer every pregnant patient before 21 weeks gestation the option of participating in the California Prenatal Genetic Testing Program. This program covers screening tests, as well as counselling and follow-up studies if the screening test is positive. There is a specific "California Prenatal Screening Program Patient Booklet" that should be given to every pregnant patient to assist with their choice, as this booklet contains the privacy statement related to the test and a consent form, which must be brought to the lab that is drawing the test with the lab order (see below).

With appropriate counselling, most pregnant MediCal patients will accept prenatal testing. It is incorrect for providers to counsel patients to only do prenatal tests if they would consider getting an abortion if a genetic abnormality is encountered.

Routinely covered by the state prenatal screening program (detailed regulation can be found here).

a. Maternal Serum Alpha-fetoprotein MSAFP screening
    i. These test for Trisomy 21, Trisomy 18, Trisomy 13, Neural tube defects
    ii. Fetal translucency (ultrasound) in first trimester
b. Cell-free DNA (cfDNA) screening **CPT Code 81420,** Includes:
    i. Trisomy 21, Trisomy 18, Trisomy 13
    ii. Sex chromosome aneuploidies: Turner syndrome (XO), Klinefelter syndrome (XXY), Trisomy X, XYY.
c. If screening positive, covers amniocentesis or CVS procedure and resulting lab tests.

Additional notes on these tests:

a. Maternal Serum Alpha-fetoprotein MSAFP screening must be ordered with state-required on-line requisition form/consent; do NOT just order an Alpha Feto Protein (AFP) from your local lab; it is the wrong test. The MSAFP is ordered via an on line form (Cal Genetics portal) (takes 10 minutes for staff to fill out), then the form needs to be printed out form on special paper with bar codes, and handed to patient to bring to lab. We recommend against giving the form to the patient too early, as may lose the form or the test may be drawn too early. Thus, you will need a process to not miss the window 15-21 weeks. Results of the MSAFP are mailed; abnormal results are followed up with a phone call within a week.

   An electronic interface option is available with your electronic health record. You will need to apply to the CDPH-Prenatal Screening Program to get the process rolling. pns@cdph.ca.gov

   Fetal translucency (ultrasound) in first trimester is covered, but in reality, but with the cell-free DNA as a backup to the SMAFP, if the two tests are normal then the first trimester ultrasound is primarily used for dating; there isn't much additional sensitivity gained by doing the fetal translucency. Later a 20 week ultrasound screening for anomalies is standard of care.

Cell-free DNA (cfDNA) screening **CPT Code 81420, no TAR required**

(ordered through Quest, or drawn by any lab and sent to Quest or Natera; NOT Lab Corps). Can be ordered through portal in the process above.

There are a few special cases in which a specific cfDNA test is recommended as summarized in this chart:

Singleton vs Twins Screenability Guide

	Singleton		Twins	
Ovum Donor = No	**Trisomies**	All labs - YES	**Trisomies**	Quest & Natera - YES Revity - NO
	SCAs	All labs - YES	**SCAs**	Quest and Revity – NO and will show on mailer as "Not Reportable" Natera – YES if Monozygotic. NO if Dizygotic and will show on mailer as "Not Reportable"
Ovum Donor = Yes	**Trisomies**	All labs - YES	**Trisomies**	Quest – YES Natera & Revity – NO
	SCAs	All labs - YES	**SCAs**	All labs – NO and will show on mailer as "Not Reportable"

Last updated 5/6/2024

Other reasons patients cannot have cfDNA

- Malignancies
- Organ transplant
- Bone Marrow Transplant
- Triplets
- Any type of failed pregnancy (with a current viable fetus)—blighted ovum, vanishing twin, empty sac, twin demise.

Note- A patient with a known SCA is eligible for screening; however, there would be a higher rate of "inconclusive" results because it is unclear how to distinguish if the SCA is of maternal or fetal origin.

In some cases, a different cfDNA test can be ordered directly from a lab that carries these tests, instead of the tests that are part of the state Genetic Screening program

1. triplet pregnancies
2. mosaic aneuploidies

For advice on what test to order in these circumstances, we recommend you consult a skilled, state-certified genetic counsellor.

The lab will bill Partnership with the same 81420 code if this is required (no TAR is required, but overuse of commercial 81420 may trigger an audit of the ordering provider. Using a commercial cfDNA as a routine screening test or as a diagnostic test, reserving the Prenatal Screening Program for those who test positive buts the financial viability of the Prenatal Screening Program at risk.

Coming changes: In the spring of 2025, ACOG is expected to recommend adding DeGeorge syndrome to the recommended group of disorders screened for with cfDNA. CDPH and DHCS are expected to promptly make this addition to the state Prenatal Screening Program.

State Genetic Counselling Program. Patients with complex genetic histories or family histories of disorders should be seen by a Licensed, Certified Genetic Counsellor under the state prenatal diagnosis program. If they recommend specific testing that is not normally covered by DHCS or Partnership, they will assist with the prior authorization request process to facilitate approval by Partnership.

Partnership Covered Prenatal Genetic Tests: The four most common recessive carrier traits are covered without a TAR. Because there are several tests that sound similar, it is easy to accidently order a test that is not covered. Here is a list, with the correct codes:

1. Cystic Fibrosis (CF) Screening: The correct code for screening for CF carrier status in a person with no known history of CF or family history of CF is **81220**, which screens for the most common variants. If there is a known family history of CF or a personal history, one of three different codes would be appropriate (81221, 81222, 81223), depending on the scenarios (consulting a genetic counsellor is recommended).
2. Spinal Muscular Atrophy (SMA) Screening: The correct code for screening for SMA carrier status in a person with no known history or family history is **81329**. If there is a known family history of SMA or a personal history of SMA, one of two different codes would be appropriate (81336 and 81337), depending on the scenario (consulting a genetic counsellor is recommended.
3. Hemoglobinopathy screening (for sickle cell trait and thalassemia): For diseases of the alpha subunit of hemoglobin gene (alpha thalassemia), use **81257**. For diseases of the beta subunit of the hemoglobin gene (sickle cell trait or beta thalassemia), use **81361**.
4. Fragile X syndrome has some phenotypic symptoms, like mental delay, mental impairment, autism, or tremor/ataxia. Anecdotally, the rate is higher in sex workers and those who are incarcerated, associated with the underlying mental impairment. Unlike other genetic disorders, in which a specific base pair mutation is tested for, the test for fragile X is more specialized and more expensive (the CPT code which Partnership accepts without a TAR to test phenotypically abnormal individuals for Fragile X syndrome is **81243.** According to ACOG, testing for fragile X should only be

considered if there is a known family history of fragile X syndrome, or if the patient has an underlying neuropsychiatric disorder has been fully evaluated by a neurologist or other specialist with experience in neuropsychiatric evaluations. A blood test for Fragile X is a once in a lifetime test, and considering that the patient has intellectual impairment, they often don't know if they have been tested before. Previous medical records should be requested and reviewed if the patient or relative has care for their condition by another provider. State genetic counselors can assist with the decision making and if consulted they can order the Fragile X test.

Not covered by Partnership:

1. Other tests for autosomal recessive genes: Some lab vendors are recommending a broader screening of pregnant patients, covering a host of rarer recessive traits. There are a number of codes for these. They are currently NOT covered by Partnership or MediCal. There are some CPT codes for panels with many recessive traits, (**81443** for a very comprehensive screen and **81412** for Ashkenazi Jewish disorder analysis), but neither is covered by MediCal, and the price for 81443 is about $2500, getting close to the price for a whole genome sequence! There are other fishing expedition tests**: 81349, 81228, 81229**, "genome-wide analysis for constitutional chromosomal abnormalities"; none are covered by MediCal.

2. Tay Sachs disease is more common in these of Ashkenazi Jewish or French Canadian/Creole origin. Screening for Tay Sachs or other Ashkenazi Jewish disorders are not covered by Partnership or Medi-Cal, so a patient with a risk factor **should be seen by a state genetic counsellor first to fully assess the risk and for them to make a recommendation** for consideration of an exception, to cover the test although not ordinarily covered. Potential tests they might order include: 1. **81255**: for Tay Sachs itself; 2. **81412** for Ashkenazi Jewish disorder Analysis, Medicare cost about $2500; 3. **81443** the screening for over 100 recessive disorders, which does happen to include Tay Sachs and costs about $2500 (interesting that the price is the same with so many more tests).

3. Paternity testing is also never covered by Medi-Cal or Partnership. There are two options for paternity testing: a blood test and an amniocentesis. A blood test using cell free fetal DNA from the mother can now be used as early as 10-12 weeks, comparing the nonsense chromosomal patterns to determine paternity testing; the cost is $2000 (1-800-DNA center is one example). If an amniocentesis sample is used (if the patient is getting an amniocentesis for another reason, and an extra sample is collected at the same time) the cost of the analysis is $500. Again, the patient would be responsible for the cost of either test.

4. Test for mutations in the gene for Methyl Tetrahydrofolate Reductase (MTHFR). MTHFR gene analysis shows mutations in about 60% of the population (so really variations of normal), so is not particularly diagnostic. Medical geneticists never recommend this test for screening, and believe the psychiatrists who order the test

do not understand the genetics of MTHFR tests.

Locations of Genetic Testing in Northern California: Kaiser, Sutter, UC Davis, Marwan Ali (Folsom), UCSF

Partnership Updates

Prior Authorization Changes for CT/MRI

Treatment authorization requests (TARs) are no longer required for certain radiologic studies:

For adults aged 21 years and older:
• No TARs are required for CT scans of extremities, head, neck, or spine, for CT angiograms, or for screening CT colonograms.
• TARs continue to be required for CT scans of the chest, abdomen, and/or pelvis.
• No TARs are required for other MRI scans of the extremities, head, neck, or spine, for MR elastography, or for breast MRIs.
• TARs continue to be required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis.

For children aged 20 and younger:
TARs continue to be required for all CT and MRI scans. No changes noted.

For a detailed list of codes covered by this change, please see the important provider notice on the Partnership website.

Prior Authorization for PT, ST, and OT

No referral authorizations (RAFs) are required for Physical Therapy, Speech Therapy, or Occupational Therapy (PT, ST, and OT). However, a written order from the referring clinician is needed.

A therapist contracted with Partnership will not need to submit a prior treatment authorization (TAR) for members age 21 and over, for up to 12 visits in a rolling 12 month period. A TAR is required if more than 12 visits are requested, and will be evaluated based on progress and potential for further improvement after the first 12 visits.

TARs are still required for therapy services for children (under age 21) and for services provided in the home.

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

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 June of 2025. All electronic data interfaces from PCPs and other providers will need to be re-directed to HRP and tested in Spring of 2025. If you use a claims clearinghouse, they will do this testing for you.

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/Occupational Therapy/Speech 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
- Facility-based sleep studies
- Hospice and Palliative Care

Pearls on Referrals

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.

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 Shriner’s Hospital in Sacramento (for problems requiring specialized surgery), 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.

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.

Non-invasive Assessment for Liver Fibrosis:

While the definitive test for liver fibrosis is liver biopsy, these are uncomfortable, relatively expensive, and occasionally have serious complications. As a result, there are a number of algorithms for evaluating the likely severity of liver disease to predict who can be presumptively assumed to have minimal fibrosis or severe fibrosis, and who needs a biopsy to be sure. See the section of UpToDate "Noninvasive assessment of hepatic fibrosis: Overview of serologic tests and imaging examinations" for full details.

Who needs evaluation? Assessing level of fibrosis in patients with

- Chronic Hepatitis C
- Alcoholic Liver Disease
- Fatty Liver/Hepatic steatosis
- Other Liver Disease

The level of fibrosis determines best treatment options (like urgency for Hep C treatment), indicated surveillance (like for liver cancer), and prognosis.

The first step will generally be some sort of serologic test:

- Some level of abnormality of liver enzymes (AST, ALT, GTT) and liver biosynthesis (Platelets, Prothrombin time, Cholesterol level)
- Nonproprietary tests/panels: AST/Platelet Ratio, AST/ALT ratio, many others.
- Other (proprietary) serologic tests: FibroTest, Fibrosure, ActiTest.

Broadly, these tests will indicate one of the following:

- Probably no fibrosis
- Probably extensive fibrosis
- Intermediate result

These interpretations are then compared to the global clinical scenario to decide if a radiologic study would be helpful.

There are two types of radiologic studies to evaluate the level of fibrosis:

- Ultrasound-based tests, three variations, but generally use the term elastography and billed with code: 91200
- MRI-based test, called MR Elastography, billed with code 76391.

In both cases, special equipment is needed (a regular ultrasound machine or MRI scanner by itself cannot be used)

No prior authorization (TAR) is required for either test.

Within the hospitals contracted by Partnership, only a few offer either ultrasound-based elastography and/or MRI-based elastography. This list was confirmed a few months ago; please send us any updates you become aware of.

Bay Area Counties:

- Sutter Santa Rosa: (Sonoma) the outpatient imaging clinic only (not the hospital) for Fibroscan/Liver elastography
- Queen of the Valley Hospital (Napa): has ultrasound elastography only
- Sutter Davis (Yolo); has both ultrasound elastography and MRI elastography.
- Sutter Lakeside (Lake): has ultrasound elastography only

Northern Counties: the following two Oregon hospitals have ultrasound elastography:

- Asante in Medford, OR, for ultrasound elastography
- Asante in Grants Pass, OR, for ultrasound elastography
- Sky Lakes Medical Center in Klamath Falls, OR (unclear which)
- DDA/Enloe GI office in Chico for ultrasound elastography “referral for FibroScan”

Eastern Counties:

- Sutter Roseville (Placer County) has both ultrasound elastography and MRI elastography.
- Tahoe Forest (Nevada County): has ultrasound elastography only
- Rideout (Yuba County): has ultrasound elastography only

Tertiary Care Centers:

- UC Davis has both ultrasound elastography and MRI elastography.
- UCSF has both ultrasound elastography and MRI elastography.
- Mercy Sacramento: all Sacramento-based hospitals have ultrasound elastography; MRI elastography only at Elk Grove Location

Electro-diagnostic Studies

Electro-diagnostic studies such as Electro-encephalograms (EEGs), Nerve Conduction Studies, and Electro-myelograms (EMGs) are important diagnostic tools for different neurologic and other conditions.

It is ideal to make a *referral* to a specialist that conducts the actual test, asking for evaluation of the patient with consideration of performing an electro-diagnostic test if indicated (such as a neurologist or physical medicine/rehab specialist, for example). This allows the specialist to also bill for and be paid for their expert evaluation of the patient, for the purposes of ordering the correct test.

If the actual *test* is ordered without the referral, an incorrect test for that patient's specific condition may be ordered. For example, a patient with fibromyalgia usually does not need an EMG for diagnosis. If the EMG is ordered without a specialist referral, the specialist doing the study might determine that the EMG is not needed, but have no mechanism for reimbursement given the lack of a RAF.

If an eConsult, curbside consult, or telemedicine specialist - such as a neurologist - confers on the case and requests an electro diagnostic test, there is not a need for a second referral, but the prior consultation should be noted for the benefit of the staff doing the test and the specialist interpreting the test.

Your local specialists (where available) may have different preferences; you may want to reach out to them to determine what they prefer and let your clinical staff know. For example, if your local neurologist has shared a protocol for criteria for ordering a nerve conduction study with your office, you may be able to order the test directly if you follow that protocol.

Mobile Mammography

Partnership contracts with Alinea Medical Imaging to bring mobile breast cancer screenings to provider organization 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 is exploring new ways to improve breast cancer screening rates. Performance in this measure is expected to drop as the U.S. Preventive Services Task Force (USPSTF) lowered the recommended age for initiating breast cancer screening from age 50 years to 40 years in April 2024. We will be exploring access in our service region's fixed imaging sites as a mechanism to optimize access, in addition to mobile mammography offerings.

Public Health Data: County Profiles

County Profiles are an annual compilation of data from Partnership and from publicly available resources. They are under development and will be posted on the Partnership website in early May. Below are a few data elements that will be included.

Advance Directive Completion

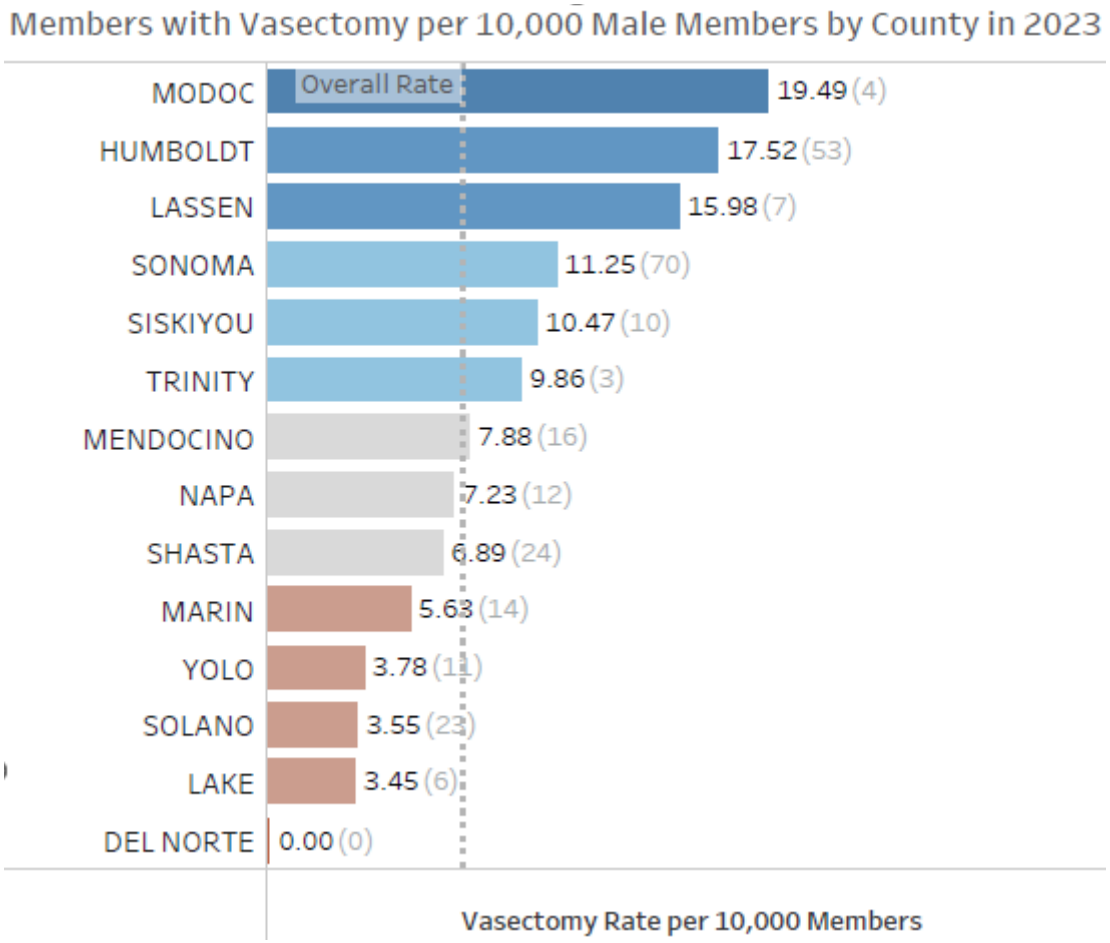
Data source: CG-CAHPS supplemental Data, from 2023 survey (Legacy counties only)

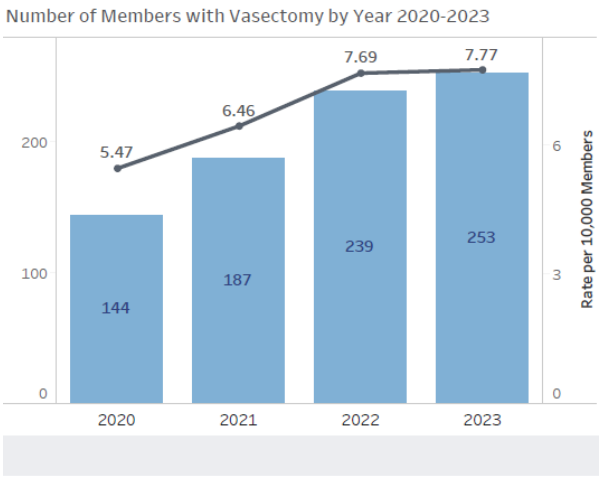
County - Advanced Directive

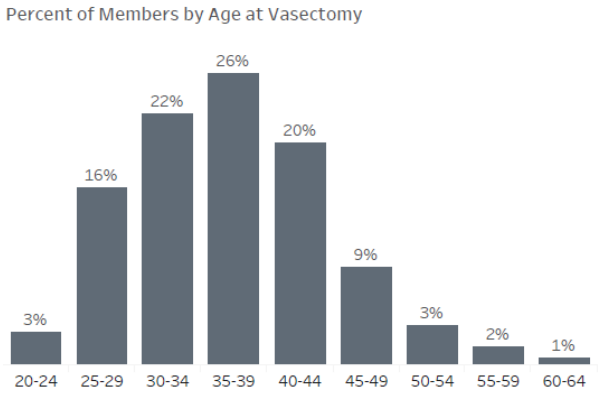
County	Q32 Did you fill out and sign an Advance Directive?			Q33 Did you talk about your Advance Directive with your medical decision maker or family?*			Q34 Did you give a copy of your Advance Directive to your doctor or your local hospital?*		
	Yes	No	Not Sure or Don't Remember	Yes	No	Not Sure or Don't Remember	Yes	No	Not Sure or Don't Remember
Del Norte	27.5%	58.0%	14.5%	63.2%	36.8%	0.0%	47.4%	31.6%	21.1%
Modoc	9.1%	81.8%	9.1%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Humboldt	13.3%	66.5%	20.2%	69.0%	27.6%	3.4%	64.3%	25.0%	10.7%
Marin	28.4%	54.2%	17.4%	52.3%	29.5%	18.2%	15.9%	61.4%	22.7%
Mendocino	8.3%	63.6%	28.1%	77.8%	0.0%	22.2%	33.3%	33.3%	33.3%
Trinity	21.6%	56.9%	21.6%	90.9%	0.0%	9.1%	90.9%	9.1%	0.0%
Yolo	22.6%	55.0%	22.4%	68.7%	13.1%	18.2%	38.4%	27.3%	34.3%
Napa	34.9%	45.6%	19.5%	80.4%	13.7%	5.9%	56.9%	35.3%	7.8%
Sonoma	26.3%	51.7%	22.0%	58.4%	28.0%	13.7%	30.7%	51.8%	17.5%
Siskiyou	26.7%	54.5%	18.8%	70.1%	27.8%	2.1%	55.6%	33.3%	11.1%
Lake	33.6%	52.7%	13.6%	62.9%	22.9%	14.3%	40.0%	34.3%	25.7%
Solano	25.1%	52.8%	22.1%	69.9%	21.3%	8.7%	55.7%	24.6%	19.7%
Lassen	18.2%	56.1%	25.7%	61.8%	27.6%	10.5%	65.7%	15.7%	18.6%
Shasta	23.8%	58.5%	17.7%	67.8%	20.0%	12.2%	51.3%	26.5%	22.2%

Vasectomy usage

Data source: Partnership Claims Data







Tobacco screening and referral rates

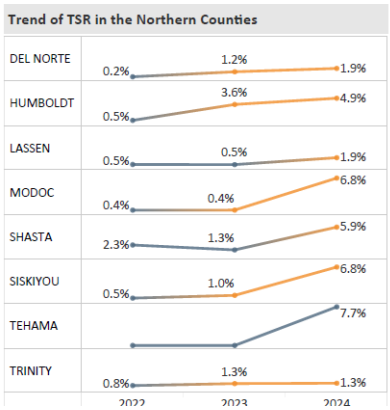
Data source: Partnership Claims data for Calendar Year 2024

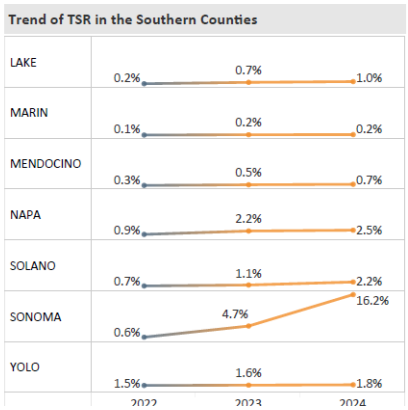
Screening for tobacco use and vaping, for well-child visits aged 12 and above. This should be linked to the CPT II code: 4004F. In practice this should be a screening for both tobacco and non-tobacco nicotine delivery devices (vaping), with appropriate counseling and referral afterwards but CPT codes only exist for tobacco use screening/counseling referral. This measure remains a PCP QIP as a unit of service measure.

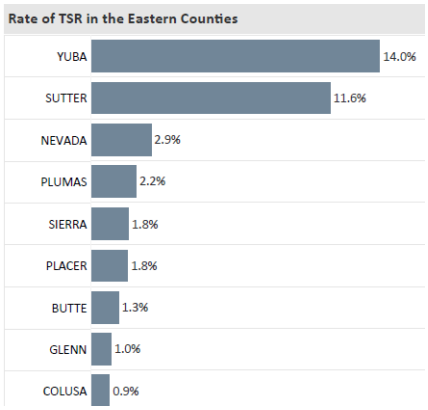
Of the many codes that could be used for tobacco screening, DHCS has selected four for tracking this: 99406, 99407, 4004F and 1036F. The .25 modifier is needed when 99406 or 99407 are provided in the same visit that an E&M code is used. Of these 4 codes, the **4004F is the most appropriate for use** in a typical well child visit, starting at age 12 and in adults well adult template or MA template.

- 99406.25: Smoking + tobacco use cessation counseling visit: 3-10min
- 99407.25: Smoking + tobacco use cessation counseling visit: >10 min
- 1036F: Current tobacco non-user.

- **Preferred: 4004F:** Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy or both) if identified as a tobacco user







Top PCPs with increased TSR rate from last year

	2022		2023		2024	
	Members with TSR	%	Members with TSR	%	Members with TSR	%
PEACH TREE HEALTHCARE					5,745	36.2%
BUTTE VALLEY HEALTH CENTER	1	0.1%	0	0.0%	261	34.1%
SRCH CARITAS CAMPUS	5	0.6%	126	14.0%	528	47.3%
HARMONY HEALTH MEDICAL CLINIC					1,570	29.1%
MT SHASTA HEALTH CENTER	2	0.6%	1	0.3%	132	29.3%
VISTA FAMILY HEALTH CENTER	29	0.3%	863	8.6%	3,902	37.0%
BURNEY HEALTH CENTER	9	1.0%	10	1.1%	231	29.4%
FALL RIVER VALLEY HC	7	0.8%	6	0.7%	256	27.4%
LASSEN MEDICAL CLINIC	29	1.4%	30	1.4%	1,791	27.5%
TULELAKE HEALTH CENTER	0	0.0%	2	0.2%	302	25.8%
SRCH LOMBARDI CAMPUS	16	0.2%	641	6.1%	4,188	30.5%
SRCH DUTTON CAMPUS	32	0.3%	699	7.3%	3,117	30.7%
BIG VALLEY HEALTH CENTER	1	0.3%	5	1.4%	87	24.4%
WEED HEALTH CENTER	3	0.2%	1	0.1%	318	20.6%
SRCH PEDIATRIC CAMPUS	8	0.1%	151	2.6%	1,031	18.7%
MED ASSOC INC CAMPOS TRAN	0	0.0%	1	4.2%	4	15.4%
PROVIDENCE MED GROUP HUMBOLDT	1	0.4%	63	29.2%	95	39.6%

Top PCPs with decreased TSR rate from last year

	2022		2023		2024	
	Members with TSR	%	Members with TSR	%	Members with TSR	%
FULL CIR CTR FOR INTEGRATIV	2	3.2%	9	12.3%	5	7.5%
CONCEPCION MARC	94	14.9%	94	14.4%	82	11.0%
REDWOOD RURAL HEALTH CENTER	8	0.3%	266	9.8%	263	7.8%
VIDA FAMILY HEALTH CENTER	6	3.2%	43	3.5%	38	1.6%
HUMBOLDT OPEN DOOR CLINIC	25	0.5%	9	1.7%		
SCOTT VALLEY RURAL HEALTH	3	0.5%	19	3.4%	10	2.0%
LIZARRAGA MIGUEL	73	16.9%	48	14.8%	29	13.4%
NORTHCOUNTRY CLINIC	28	0.5%	152	3.3%	6	2.3%
PATEL JAYESH	116	20.8%	233	31.0%	315	30.1%
LOFFLER-BARRY CHRISTINE	0	0.0%	5	3.0%	4	2.2%
WILLOW CREEK COMM HLTH CTR	6	0.4%	44	2.7%	57	1.9%
ROBERT RUSHTON MED OFFICES	0	0.0%	1	0.7%	0	0.0%
HARVEST PEDIATRICS	0	0.0%	15	1.5%	8	0.8%
CORRELL ALICJA	46	9.2%	98	15.3%	126	14.8%
SHASTA FAMILY CARE	0	0.0%	2	0.6%	0	0.0%
NORTHERN VLY INDIAN HEALTH	7	1.6%	4	0.8%	47	0.3%
MERCY LAKE SHASTINA COMM	3	0.5%	3	0.5%	0	0.0%

CT Scan Usage by Emergency Departments:

Data source: Partnership Claims Data, comparing 2022 to 2023
Trends: The trend has changed over the years; currently the highest rates are UC Davis Medical Center, Sutter Santa Rosa, and several Dignity hospital emergency rooms. The lowest rates were in Adventist system Emergency Rooms, Queen of the Valley Hospital, and several small rural hospitals.

Top 50 Hospitals by Number of ER Visits

Facility	% Visits with CT scan					% Change in % Visits with CT scan from Previous Year				
	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
MEDICAL CENTER UC DAVIS	14.9	17.8	19.0	18.6	20.9		19.82%	6.42%	-2.00%	12.48%
ROSA REG HOSP SUTTER SANTA	14.5	15.2	16.3	16.2	17.6		4.84%	7.43%	-0.55%	8.15%
HOSPITAL MERCY SAN JUAN	14.6	20.4	15.7	15.6	16.8		40.16%	-23.40%	-0.58%	8.15%
HOSPITAL MERCY GENERAL	14.6	15.3	14.2	14.5	14.4		4.93%	-7.34%	2.09%	-0.48%
COMMUNITY HOSP ST ELIZABETH	8.5	10.2	10.6	14.3	12.3		20.83%	3.65%	34.74%	-13.93%
CENTER REDDING MERCY MEDICAL	8.9	11.9	12.7	14.2	13.4		32.75%	7.18%	11.85%	-5.56%
SUTTER DAVIS HOSPITAL	10.7	12.5	12.9	13.5	13.6		17.35%	3.47%	4.03%	1.08%
HOSPITAL VACAVALLEY	10.8	12.2	14.0	13.2	14.7		12.42%	15.11%	-6.18%	11.89%
JOSEPH HOSP PROVIDENCE ST	10.9	12.5	12.6	12.9	14.1		14.14%	1.15%	2.63%	8.53%
HEALTH ENLOE	13.9	13.2	14.5	12.9	15.3		-4.86%	9.97%	-10.95%	18.26%
VALLEY HOSP PETALUMA	10.3	12.2	12.8	12.4	15.0		17.93%	4.83%	-2.86%	20.98%
MEDICAL CENTER NORTHBAY	9.4	11.0	12.9	12.2	14.6		15.97%	17.48%	-5.07%	19.45%
UCSF MEDICAL CENTER	4.7	12.2	13.0	12.2	10.7		156.88%	6.54%	-5.83%	-12.35%
MEMORIAL HOSP WOODLAND	9.8	11.0	12.8	12.2	10.1		12.26%	16.53%	-5.11%	-16.75%
KAISER VACAVILLE	11.0	10.3	10.9	11.8	6.6		-6.25%	5.19%	8.33%	-43.61%
KAISER S. SACRAMENTO	9.7	12.3	13.3	11.8	10.5		26.69%	7.74%	-11.46%	-10.80%
CENTER SAC SUTTER MEDICAL	10.4	10.5	12.1	11.6	12.0		0.26%	15.64%	-4.05%	3.25%
KAISER FOUND HSP SACRAMENTO	7.0	8.6	13.4	11.2	10.2		22.57%	55.88%	-15.89%	-9.53%
SONOMA VALLEY HOSPITAL	8.3	11.5	11.2	11.1	11.0		38.66%	-2.14%	-0.94%	-1.30%
LAKESIDE HOSP SUTTER	8.7	9.4	11.4	10.8	11.7		8.43%	21.24%	-5.28%	7.79%
MEDICAL CENTER MARINHEALTH	7.4	8.5	11.2	10.7	12.0		15.20%	31.58%	-4.48%	12.38%
MEDICAL CENTER FAIRCHILD	8.1	11.2	11.5	10.0	9.9		36.93%	3.24%	-13.37%	-0.57%
CTR MT SHASTA MERCY MEDICAL	8.9	10.4	8.9	9.7	10.3		16.18%	-14.32%	9.01%	5.72%
KAISER FOUND HOSP OAKLAND	10.0	9.2	11.4	9.2	7.5		-7.83%	23.42%	-19.43%	-18.74%
COMMUNITY HOSP MAD RIVER	8.0	9.0	10.5	9.0	9.9		12.87%	16.89%	-14.11%	9.69%
WOOD MEM HOSP PROVIDENCE RED	7.8	9.5	9.8	9.0	10.1		22.32%	2.82%	-7.82%	11.77%
COAST HOSPITAL SUTTER	10.5	11.7	12.9	8.8	10.1		10.92%	10.41%	-31.38%	14.35%
MEDICAL CENTER SKY LAKES	7.6	10.6	12.7	8.7	11.9		40.44%	19.58%	-31.37%	36.19%
CLEARLAKE ADVENTIST HLTH	6.3	8.6	9.2	8.4	9.4		36.74%	6.69%	-8.16%	11.53%
SUTTER SOLANO MEDICAL CENTER	5.7	7.2	7.6	8.4	9.3		27.58%	4.90%	10.71%	11.31%
KAISER MED CTR SANTA ROSA	6.4	5.2	7.7	8.4	8.4		-18.18%	47.24%	9.52%	-0.05%
HOSPITAL NOVATO COMMUN	5.9	8.2	8.4	8.4	8.9		38.94%	2.45%	-0.66%	6.33%
HOSPITAL TRINITY	7.4	10.3	8.3	8.3	6.6		38.51%	-19.73%	0.08%	-20.77%
MEMORIAL HOSP PROVIDENCE SR	7.5	7.8	8.4	8.2	10.2		3.99%	8.49%	-2.56%	24.29%
MEDICAL CENTER BANNER LASSEN	7.1	6.6	7.1	8.2	8.4		-6.86%	8.04%	14.56%	2.39%
MENDO COAST ADVENTIST HLTH	6.2	6.3	7.5	8.1	8.0		2.31%	19.21%	7.20%	-0.45%
ST HELENA ADVENTIST HLTH	7.0	8.7	9.7	7.8	6.3		24.75%	11.07%	-19.10%	-19.46%
MEDICAL CENTER SHASTA REG	6.4	7.7	8.7	7.8	7.1		19.42%	12.94%	-10.12%	-8.58%
KAISER VALLEJO	6.2	4.4	7.0	7.4	7.8		-28.52%	57.17%	5.36%	6.04%
KAISER FOUND HOSP SANRAFAEL	7.7	8.7	8.1	7.0	6.2		12.72%	-7.23%	-13.65%	-10.81%
QVMA MED CTR PROVIDENCE	6.6	7.1	8.3	6.9	9.3		7.79%	17.04%	-16.97%	33.88%
HOWARD MEM ADVENTIST HLTH	4.0	6.2	7.4	6.9	7.7		52.77%	19.89%	-7.22%	12.17%
UKIAH VALLEY ADVENTIST HLTH	5.8	6.8	7.3	6.7	7.7		18.51%	6.60%	-8.69%	14.91%
MEMORIAL HOSP MAYERS	6.9	5.8	6.8	6.5	6.3		-15.46%	16.86%	-4.53%	-3.76%
HEATH RIDEOUT ADVENTIST	13.6	15.5	11.7	6.2	5.6		13.49%	-24.57%	-46.91%	-9.24%
CENTER MODOC MEDICAL	5.4	5.0	5.3	5.9	5.7		-8.01%	5.18%	11.60%	-2.38%
HOSPITAL HEALDSBURG	7.1	6.4	7.8	5.7	6.4		-10.08%	22.15%	-27.05%	12.42%
MEDICAL CENTER ALAMEDA COUNTY	8.4	6.0	4.3	4.0	3.7		-28.48%	-28.57%	-6.86%	-6.51%
CHILDRENS HOSP OAKLAND	2.6	2.0	3.5	2.2	1.9		-23.06%	75.72%	-35.30%	-13.48%

Hospital Obstetrical Data:

Data source: California Hospital Quality Compare (data from CMQCC), 2023

				NTSV C-Section Rate			Breastfeeding Rate (CDPH)			Episiotomy Rate			VBAC Rate			Routinely Available	Certified Nurse Midwife Delivery Rate		Early Elective Delivery		
HOSPITAL NAME	Partnership Regional Office	County	City	Denom-inator	Score [%]	Rating	Denom-inato	Score [%]	Rating	Denom-inato	Score [%]	Rating	Deno m-inato	Score [%]	Rating	Yes/No	Denom-inato	Score [%]	Denom-inato	Score 9	Rating
Marin Health Medical Center	Santa Rosa	Marin	Greenbrae	520	17.9	Superior	1357	84.3	Above Average	1091	0.5	Above Average	194	40.2	Superior	Yes	1453	46.2	46	2.1	Below Average
Santa Rosa Memorial Hospital	Santa Rosa	Sonoma	Santa Rosa	258	20.5	Above Average				529	0.8	Above Averag	134	39.6	Superior	Yes	767	45.4	66	7.58	Below Average
Sutter Santa Rosa	Santa Rosa	Sonoma	Santa Rosa	501	23.4	Average				976	1.1	Average				No	1451	0.8			
Dignity Health Woodland Memorial Hospital	Fairfield	Yolo	Woodland	172	22.1	Average	449	80.4	Above Averag	332	0.9	Above Average				No	489	0	34	0	Above Average
NorthBay Medical Center	Fairfield	Solano	Fairfield	398	25.4	Below Average				875	0.7	Above Averag	219	18.3	Average	Yes	1326	0	97	0	Above Average
Providence Queen of the Valley Medical Center	Fairfield	Napa	Napa	234	20.5	Above Average	574	71.95	Average	544	1.5	Average	143	28.7	Above Average	Yes	797	0	51	1.96	Below Average
Sutter Davis	Fairfield	Yolo	Davis	449	14.5	Superior				989	1.4	Average	151	31.8	Above Average	Yes	1240	60.2			
Tahoe Forest Hospital	Auburn	Nevada	Truckee	147	16.3	Superior				246	1.2	Average				No	359	0	5	0	Above Average
Sutter Roseville	Auburn	Placer	Roseville	867	25.7	Below Average				1723	3	Average	336	15.5	Average	Yes	2477	0			
Dignity Health Sierra Nevada Memorial Hospital	Auburn	Nevada	Grass Valley	110	30	Below Average	313	90.1	Superior	215	4.2	Average				No	324	4.9			
Adventist Health Clear Lake	Eureka	Lake	Clearlake	38	15.8	Superior				92	2.2	Average				No	131	0	99	0	Above Average
Adventist Health Ukiah Valley	Eureka	Mendocino	Ukiah	228	18.9	Above Average	714	77.17	Above Average	501	1	Average	105	14.3	Average	Yes	701	50.1	44	0	Above Average
Sutter Coast	Eureka	Del Norte	Crescent City	63	17.5	Superior				146	2.1	Average				No	209	0			
Sutter Lakeside	Eureka	Lake	Lakeport	54	25.9	Below Average				138	1.4	Average				No	200	0			
Providence St. Joseph Hospital Eureka	Eureka	Humboldt	Eureka	217	24	Below Average	610	85.25	Above Average	457	5	Below Average	91	15.4	Average	Yes	660	15.6	53	0	Above Average
Mad River Community Hospital (closed Oct 31)	Eureka	Humboldt	Arcata	141	19.9	Above Average				255	1.6	Average				No	356	19.4	14	0	Above Average
Banner Lassen Medical Center	Redding	Lassen	Susanville	68	14.7	Superior				141	6.4	Below Average				No	197	0	23	0	Above Average
Dignity Health Mercy Medical Center Mount Sha	Redding	Siskiyou	Mount Shasta	53	18.9	Above Average	102	80.39	Above Averag	116	2.6	Average				No	156	0	11	9.09	Below Average
Dignity Health Mercy Medical Center Redding	Redding	Shasta	Redding	546	22.2	Average	1519	78.54	Above Averag	1126	2.3	Average				No	1688	0	89	2.25	Below Average
Dignity Health St. Elizabeth Community Hospita	Redding	Tehama	Red Bluff	189	21.7	Above Averag	519	74.95	Average	380	2.4	Average				No	540	16.1	53	0	Above Average
Fairchild Medical Center	Redding	Siskiyou	Yreka	49	32.7	Below Average				89	4.5	Average	27	22.2	Average	Yes	156	0	8	12.5	Below Average
Adventist Health Rideout Hospital	Chico	Yuba	Marysville	504	24.4	Below Average				1127	1.6	Average	275	10.5	Average	Yes	1705	0.1			
Oroville Hospital	Chico	Butte	Oroville			Not Rated			Not Rated			Not Rated					~500				Not Rated
Enloe Medical Center - Esplanade Campus	Chico	Butte	Chico	648	18.2	Superior	1729	87.45	Above Average	1408	0.5	Above Average	285	25.3	Above Average	Yes	1913	14.3	45	0	Above Average

2023 Partnership HealthPlan Hospital OB Quality Data

	NTSV C-section	Early Elective Delivery	Breastfeeding at discharge	Episiotomy Rate	VBAC rate	CNM delivery rate
Above Avg	<21.9%	<1%	>75%	<1.2%	>25%	>10%
Avg	22-23.6%	1-2%	70-75%	1.5 - 5.0%	10 - 25%	
Below Avg	>23.6%	>2%	<70%	>5.0%	<10%	<10%

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:

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 Guidelines. The updated version will be posted to our website in March. Here are the major changes:

In anticipation of Partnership Advantage, added references to Preventive Care for Medicare recipients. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.

The following services are available to both Medicare and Medi-Cal recipients:

- Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
- Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services.

Required Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services.

Updated existing guidelines include:

- Breast Cancer Screening by Mammography: The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned female at birth ages 40 to 74 years (Grade B).

- Osteoporosis in Postmenopausal Persons Assigned as Female at Birth, Screening: USPSTF Recommendation (January 2025) - Screen persons assigned as female at birth age 65 years and older with bone measurement testing to prevent osteoporotic fractures (Grade B). For postmenopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at: https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9 to determine the appropriate need for bone measurement testing (Grade B).

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.

Topical Fluoride Varnish for Children

DHCS added the CMS measure of 2 fluoride varnish applications per year for children ages 1 – 20 years to its Managed Care Accountability Set (MCAS) in MY2022. Partnership's very low performance on this measure in MY2023 is due to a data completeness issue with Denti-Cal data that Partnership receives from DHCS. Without complete Denti-Cal data, most of the fluoride varnish services completed in FQHC, RHC, and Tribal Health Dental Centers are not being counted towards this measure.

DHCS and Partnership have identified a work-around to this data issue: Dental Centers must use the ICD code Z29.3 (Encounter for prophylactic fluoride administration) combined with CDT codes (D1206 or D1208) when billing fluoride varnish services to Denti-Cal. **Please partner with Dental Center and Billing leaders in your health center to make this change to your coding workflows ASAP.**

For questions and technical assistance with issues around coding fluoride varnish services, please contact dentalsupport@partnershiphp.org.

Lead Screening Requirements

Pediatric lead poisoning occurs throughout California and continues to present a health risk, particularly for infants and young children. The Department of Health Care Services (DHCS) requires lead prevention education at every well-child visit between 6 months and 6 years of age and lead testing for all Medi-Cal enrolled children at 12 and 24 months, with catch-up testing to be performed up to the age of 6 (for those who were not previously tested or do not have lead testing results available).

The single most important strategy to get all your age-appropriate pediatric patients tested for lead exposure, is obtaining a capillary specimen in the exam room. Once the specimen is collected (ideally by the individual rooming the

patient, through a standing order), it can be run with a point of care testing device on-site (LeadCare II) or sent to a public health or commercial lab.

DHCS added the HEDIS measure of blood lead screening by age 2 to its Managed Care Accountability Set (MCAS) in MY2022. Performance on this measure was low before COVID and dropped during COVID. Despite 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 and MY 2023 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	**MY 2022 Lead Screening Rates** **Between ages 1 and 2**	**MY 2023 Lead Screening Rates** **Between ages 1 and 2**
Anthem Blue Cross (Region 1)	53%	50%
California Health and Wellness (Region 1)	40%	47%
Partnership (weighted overall)	44%	59%
National NCQA Medicaid Health Plan average	64%	63%

This notable improvement is the result of a number of improvement activities Partnership has undertaken in the past two years to support more universal lead screening:

- Blood lead screening is now a core measure for the PCP QIP.
- Supporting providers who wish to move to providing lead testing on site, using point of care devices.
- Ensure education for clinical practices include both information on, and the importance of, billing for lead testing
- 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.

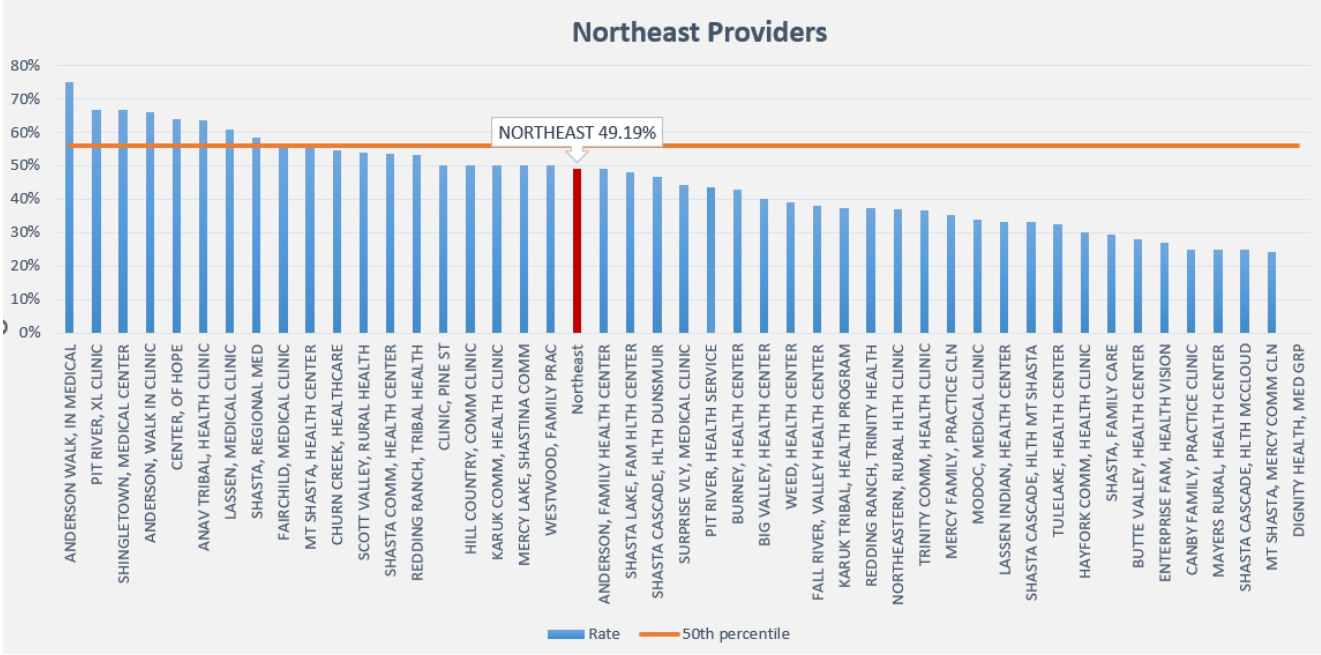
If you do not yet have Point of Care Lead testing units in your office, there may be some grant funding available within the Partnering for Pediatric Lead

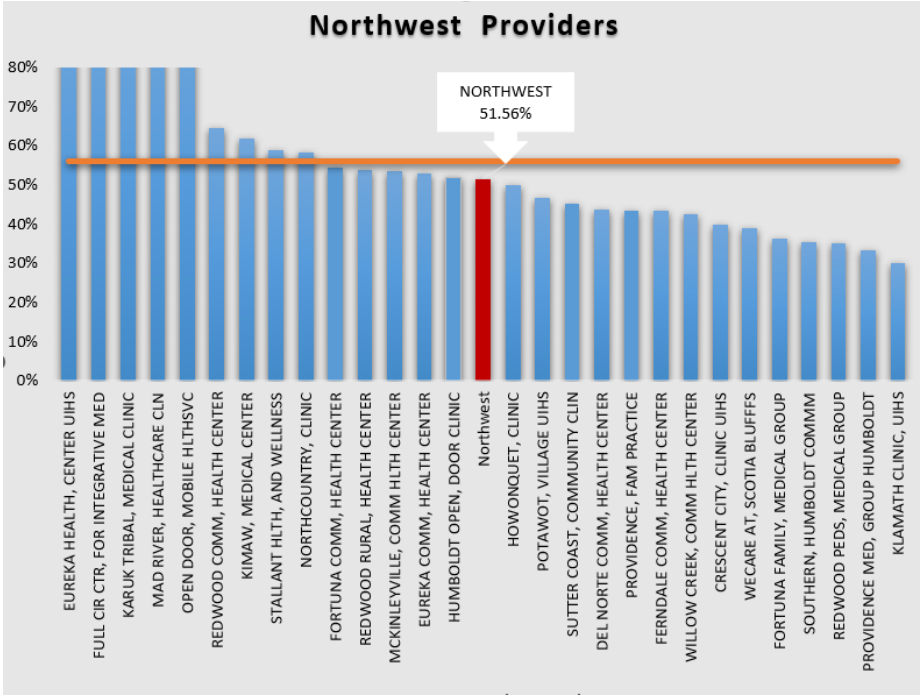
Prevention program. Contact us at leadPOC@partnershiphp.org or visit our website for more information.

Chlamydia Screening

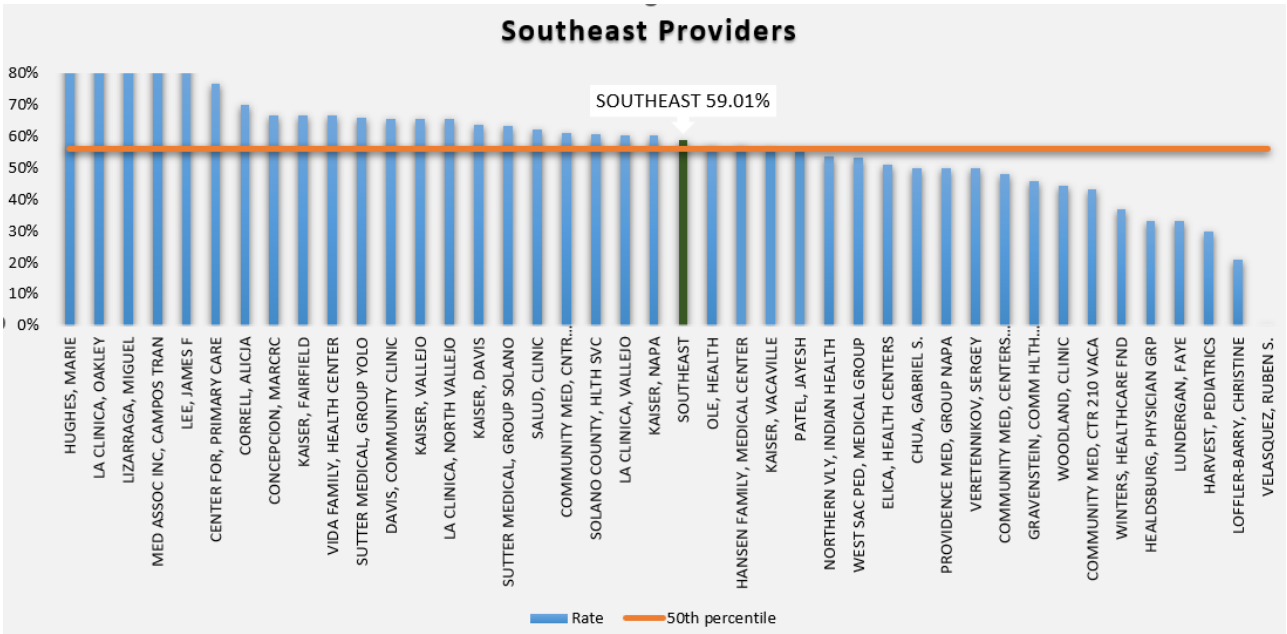
Chlamydia screening is being added to the Partnership pay for performance program in MY 2025, given ongoing DHCS sanctions for low Chlamydia screening rates in our Northeast and Northwestern regions. Within the PCP QIP, it is included in the core measure set for Pediatric practices and as a monitoring only measure for Family Medicine and Internal Medicine practices. The 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.

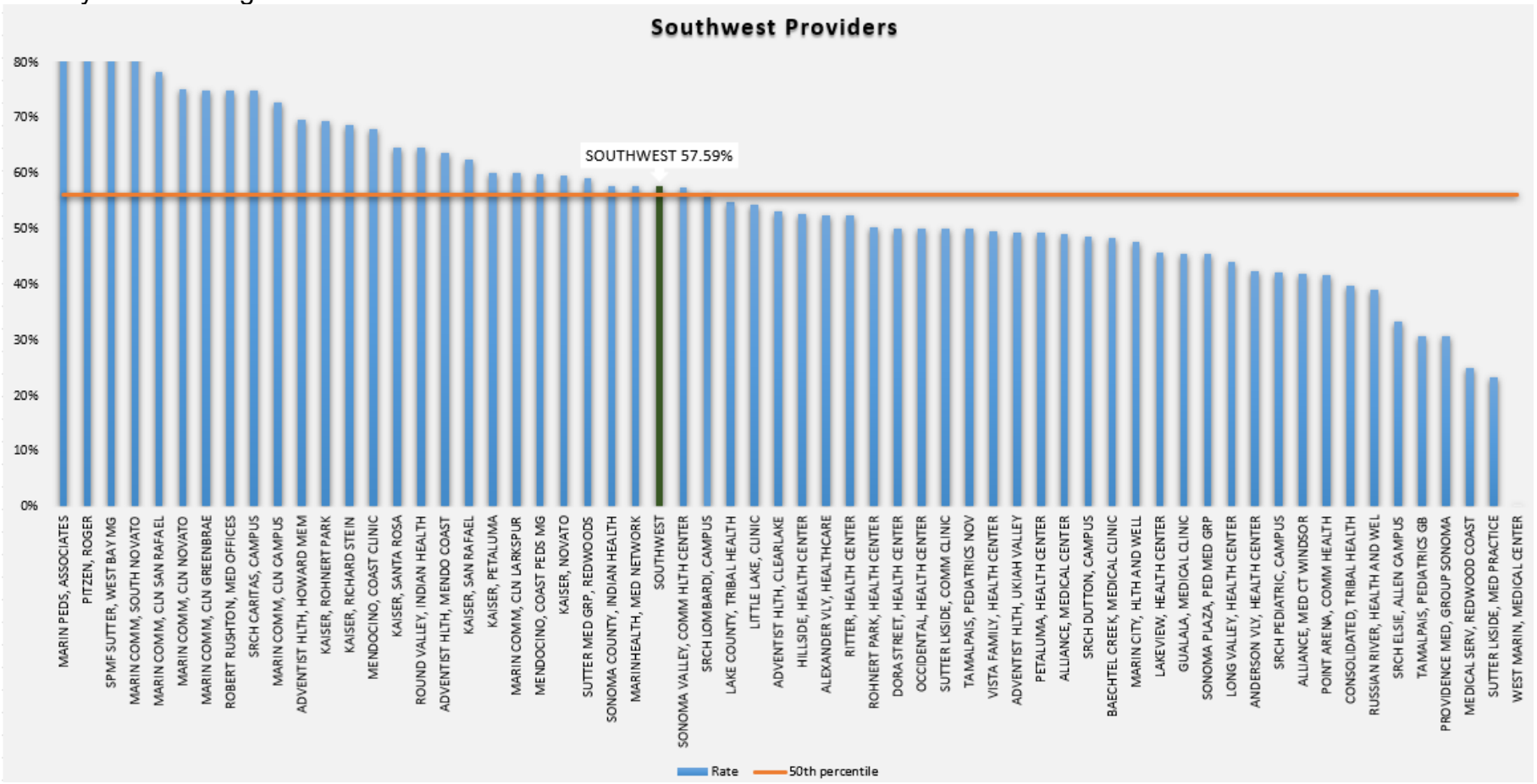




Chlamydia Screening Rates.



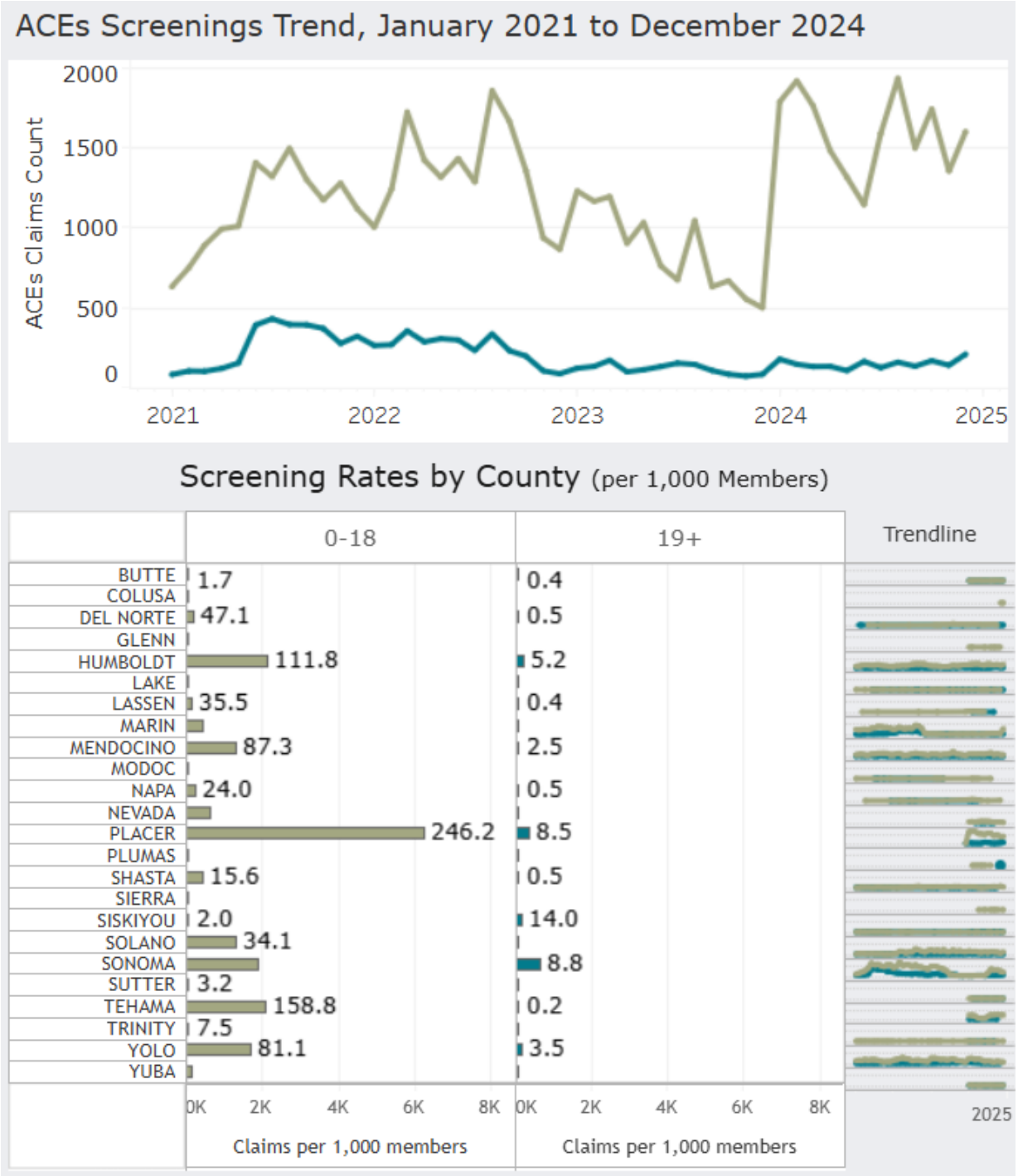
Chlamydia screening rates:



ACEs Screening

Screening for Adverse Childhood Events (ACEs) is a separately reimbursable service, to help gather data on the number of ACEs through billing data.

ACEs screening peaked in 2022 and has been declining since then.



FQHCs, RHCs, and Tribal Health centers are eligible for the supplemental payment for screening, 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 was 69% percent in Medicaid in 2023.

The overall rate for Partnership was 71% in 2023, which is between the 33rd and 66th percentile. We ask you all to create processes to allow strep testing even if visits are done virtually, such as sending them to a lab for testing, or dropping into the office for testing only.

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.

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.

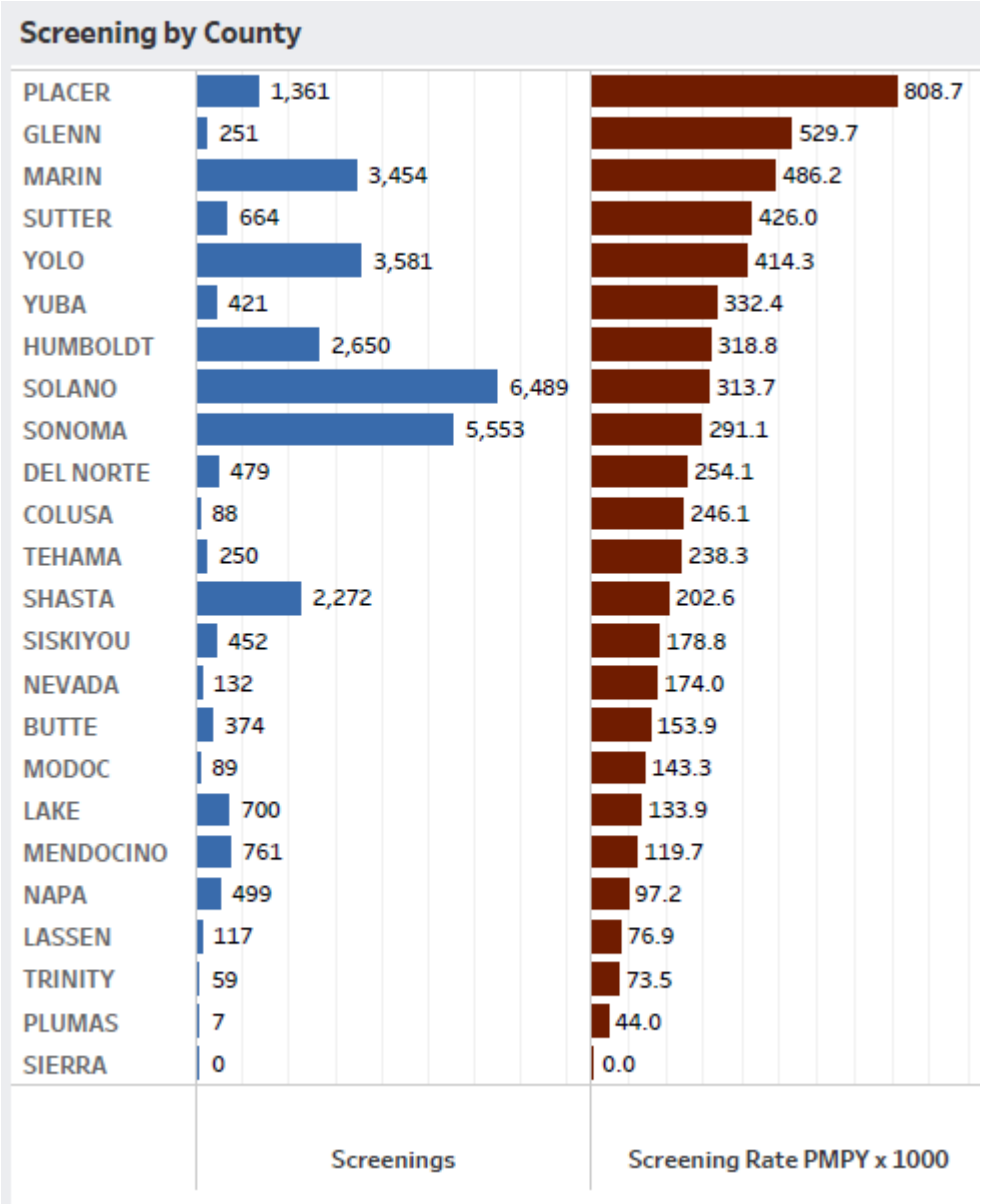
When autism screening is provided **in addition to** a comprehensive developmental assessment, both 96110 without a modifier and 96110.KX may be billed together.

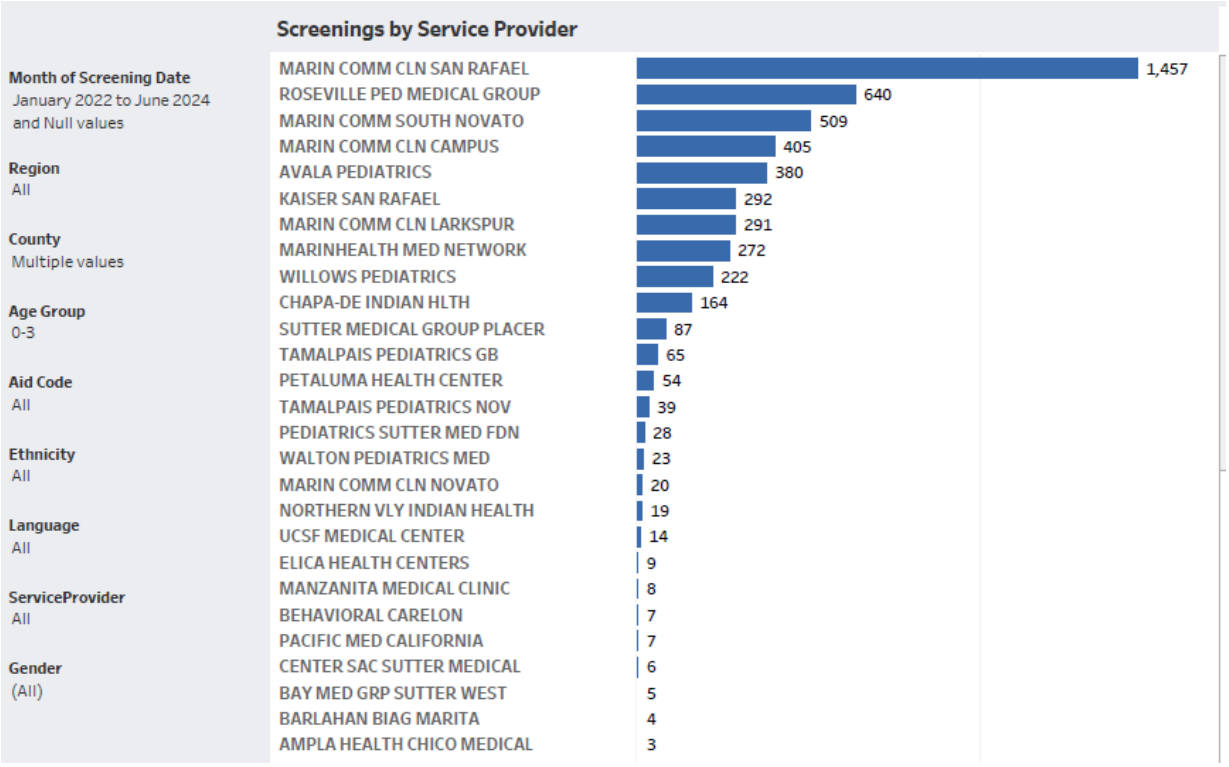
A comprehensive developmental screen is considered standard of care by the American Academy of Pediatrics, the American Academy of Family Physicians, CMS, NCQA, and DHCS. Please ensure your well-child visit process and templates include the use of a comprehensive tool such as the ASQ and documents this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

Developmental Screening Rate Data

Data source: Partnership Claims Data plus historical data file for expansion counties, January 2022 to June 2024


Screening by County
PLACER 1,361 808.7
GLENN 251 529.7
MARIN 3,454 486.2
SUTTER 664 426.0
YOLO 3,581 414.3
YUBA 421 332.4
HUMBOLDT 2,650 318.8
SOLANO 6,489 313.7
SONOMA 5,553 291.1
DEL NORTE 479 254.1
COLUSA 88 246.1
TEHAMA 250 238.3
SHASTA 2,272 202.6
SISKIYOU 452 178.8
NEVADA 132 174.0
BUTTE 374 153.9
MODOC 89 143.3
LAKE 700 133.9
MENDOCINO 761 119.7
NAPA 499 97.2
LASSEN 117 76.9
TRINITY 59 73.5
PLUMAS 7 44.0
SIERRA 0 0.0
Screenings
Screening Rate PMPY x 1000



Adult Guidelines

Colorectal Cancer Screening

Screening for colorectal cancer remains on the Managed Care Accountability Set (MCAS) along with the Primary Care Provider Quality Improvement Program, although Partnership's PCP QIP is now utilizing the NCQA MediCaid standards resulting in an increase in the benchmark targets. 2025 targets are currently set at 50th percentile for partial points and 75th percentile for full points, with the following measurement years benchmarks set to rise to 75th and 90th respectively. Members between the ages of 45 – 75 need to have an appropriate screening done for colorectal cancer.

While colonoscopies are ideal as they are good for every 10 years, access to colonoscopies continues to be limited while cases continue to rise in young adults. FIT testing can be done annually, and FIT/DNA (Cologuard) is good for every 3 years. To discuss bulk ordering for Cologuard, you can reach out to Exact Sciences at *phc@exactsciences.com* .

COPD Exacerbation Management

Key Points from the 2025 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. The duration of therapy should not normally be more than 5 days.
- Short-acting inhaled beta2-agonists, with or without short acting anticholinergics are recommended as initial treatment of 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.

Antibiotics, when indicated (increased sputum purulence plus increased dyspnea or sputum volume), can shorten recovery time, reduce the risk of early relapse, treatment failure, and hospitalization duration. Duration of therapy should normally be 5 days.

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 pharmacy consultation 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.**

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.

New Mandates on Tuberculosis

Starting January 1, 2025, AB 2132 will generally require a health care provider to offer a tuberculosis risk assessment and screening (if appropriate) to all adult patients seen in a setting where primary care services are provided.

These publications serve as helpful guides for tuberculosis screening and treatment:

- The California Department of Public Health (CDPH) –
  - Prevent Tuberculosis (TB) in 4 Steps: A Guide for Medical Providers
  - Risk Assessments

The first step of the risk assessment is to evaluate for potential symptoms of active TB:

1. Cough lasting longer than 2 weeks
2. Fevers or night sweats
3. Unexplained weight loss

An individualized diagnostic evaluation is needed to ensure that the patient does not have active TB.

The four risk factors for latent TB are:

1. Birth, travel, or residence of at least 1 month in a country with elevated TB rate
2. Immunosuppression
3. Close contact to someone with known active TB during lifetime
4. Homelessness or incarceration, current or past

Treatment is strongly recommended for patients diagnosed with latent TB infection.

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.

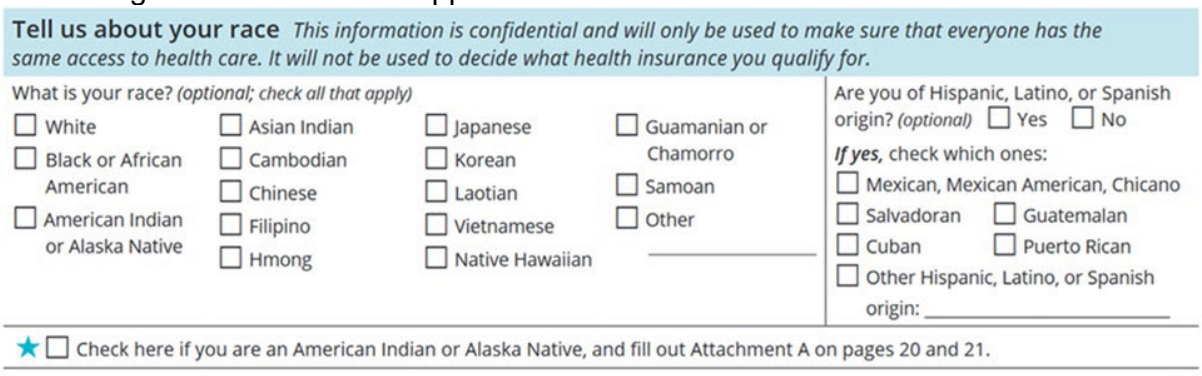
National Changes in Categorization of Race/Ethnicity

Two years ago, Partnership first stratified Quality Outcome data based on the race/ethnicity we received from DHCS. As noted in prior newsletters, this data showed that outcomes were much worse for the self-identified American Indian/Alaska Native (AIAN) population than for any other racial group. This prompted Partnership to launch a Tribal Engagement Strategy to build relationships with the 21 Tribal Health Centers and their associated 51 individual tribes, so that we can work together on improving health and wellness for the AIAN population.

Two months ago, while preparing a presentation for the Medi-Cal Managed Care Advisory Group about Partnership's Tribal Health Liaison, Yolanda Latham, I was looking through race/ethnicity data on our members, and comparing it to the official California Census data, and discovered something very concerning: The number of AIAN enrolled in Partnership seemed very low. After a little digging (details below), I discovered that the magnitude of the undercounting is somewhere between 213% and 900%, and may be even higher.

The reason for this is the way DHCS takes the race/ethnicity/tribal affiliation data from the official Medi-Cal application and uses an algorithm to assign a single race. The Medi-Cal application encourages individuals to choose all races that apply, in accordance with federal recommendations going back to 2000.

Page 4 of the Medi-Cal application:



Tell us about your race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

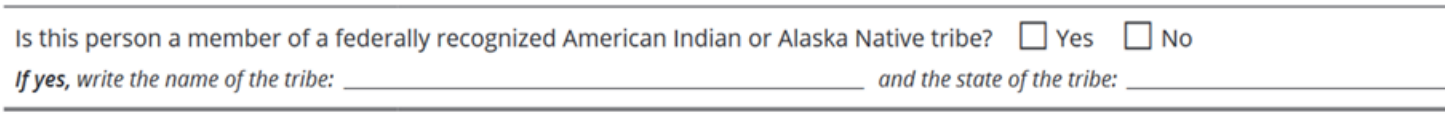
Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Page 20 of the Medi-Cal application



Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

The mechanism that DHCS uses to convey membership information to Partnership and other Medi-Cal Managed Care Plans is a file called the 834 file or membership file. This file lists just one single race-ethnicity category per enrollee. DHCS uses an algorithm to translate the application race and ethnicity responses to this single category.

While the exact algorithm is not publicly posted, it seems likely that if an AIAN also identifies as Hispanic or Latino, this trumped their AIAN status and they were assigned a Latino ethnicity. Additionally, if an enrollee identified both AIAN and any other racial status, they were classified as “other” or “mixed race,” a category with poor outcomes similar to the AIAN population, but as it is mixed with all other mixed-race individuals is completely non-actionable.

Here are three mechanisms used to estimate the scope of this undercounting:

1. Census Data

One way to estimate the scope of undercounting is to compare the proportion the Medi-Cal enrolled population identified as AIAN compared to California census data on AIAN ethnicity.

Official MediCal statistics show a total of 55,302 **(only 0.4% of all beneficiaries)** individuals enrolled in Medi-Cal as of July 2023 identified as AIAN (Medi-Cal Fast Facts).

In contrast, in the 2020 census, 1.6% of the California population identified as American Indian and Alaska Native race alone and an additional 2% of the population identified as American Indian or Alaska Native in combination with

some other race, for a total of 3.6% of the population categorized at AIAN alone or in combination. Even if we assume that the proportion of the AIAN population of California with Medi-Cal is the same as the non-Medi-Cal population (a highly unlikely assumption), **Medi-Cal is undercounting the AIAN population by as much as 9-fold**. Put another way, the true number is 900% higher.

Extrapolating the scope of the undercounting based on census data, as many as 495,000 MediCal beneficiaries would be categorized as AIAN alone or in combination, instead of just 55,302.

2. Tribal Health Centers

Confirmatory evidence of racial mis-categorization comes from the subset of Tribal Health Centers which **only** allow enrolled tribally affiliated members to be served. Of those Medi-Cal members served at these tribal health centers, 53% were categorized by Medi-Cal 834 data as **not** being AIAN. Meaning that the true number is 213% greater than the identified AIAN at Native-run health centers.
Extrapolating this underestimate would mean that the actual number of AIAN receiving Medi-Cal is about 118,000 individuals.

Why such a broad range?

The range of undercounting (from 213% to 900%) is so large partly because the U.S. Census groups together indigenous populations from Central American (such as the Maya and Aztec), South America and Canada into its totals. Of these groups, those who identify as indigenous from Central America is large and growing, resulting in a shift from the Latino Category to the indigenous/AIAN category. In contrast, indigenous people from outside the United States are not generally eligible to receive care at tribal Health Centers that are limited to tribal members.

The American Community Survey assesses race and ethnicity differently, in a way that likely does not include indigenous individuals from Central America in the AI/AN count, which lowers that count relative to the census estimate.

Impact of Undercounting

Official methods of categorizing race have a centuries-long history of being built on racist assumptions and bias. While I would like to think that the algorithm decisions that led to the undercounting of the AIAN in Medi-Cal were not intended to harm AIAN, such large scale undercounting has several important impacts.

First, it reinforces the perception that American Indians are no longer present in California, “erasure” is the term used by American Indian scholars and activists. In fact, in the past century, erasure was official U.S. government policy, as

tribes were “terminated” in the 1950s and 1960s, children kidnapped and taken away to boarding schools to “save the child by killing the Indian,” so the residual evidence of erasure reflects a lack of acknowledgement and sensitivity of this historical trauma.
Second, such profoundly faulty data leads to faulty analysis of health inequities. If the racial data used to calculate rates of quality indicators is biased and faulty, then the inferences drawn by stratifying data by race are hints of the underlying reality, but any sanctions or penalties tied to reducing such inequities by any specified quantity are statistically invalid.

Lastly, such significant undercounting impacts public health prioritization based on population affected, and thus potentially impacts funding allocated proportional to the AIAN population affected.

Major changes in the new U.S. Office of Management and Budget (OMB) Standards

The Updated 2024 OMB Standards for categorizing race/ethnicity move Latino/Hispanic to be a co-equal race/ethnicity category, instead of a carved-out ethnicity category. The Middle-eastern/north African population was carved out of the White category, so there will now be 7 major race/ethnicity categories, one of which is American Indian or Alaska Native, with a box to fill in details with the following language: “Enter, for example Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya etc.”

The most concerning aspect of the new OMB standard is the list of options for handling individuals who identify more than one race/ethnicity category. The three options identified are:

1. The “alone or in combination” approach mentioned earlier related to census data. There is some complexity to using this approach, but it substantially resolves the undercounting of the AIAN population and should be the starting point of data sharing and equity analysis. A key feature of this approach is that the total of all categories is greater than 100% as one individual may be two or more categories; this requires special statistical methods to avoid errors.

2. The “most frequent multiple responses” approach, in which the top combined categories are each presented with individual data. For example, in addition to each race ethnicity category alone, each combination is listed with the number of individuals. Some may be simple two-race categories (like black-asian) but more complex combinations are possible (like latino-black-white). This allows the most granular data analysis, and the numbers can be folded into the “alone or in combination” category. The sum of all individuals in all categories will total 100%.

3. The “multiracial” approach in which any individual who chooses more than

one race/ethnicity category is categorized as either “other” or “mixed.” This grouped category is impossible to analyze, so the “pure” race/ethnicity categories end up being the only way to look for health disparities. This appears to be the method currently used by DHCS, and it should be abandoned as soon as possible.

Partnership has urged DCHS should share the current detailed enrollment race/ethnicity/tribal affiliation data with all Medical Managed Care plans so they can better analyze and understand the inequities in their members. We request either the “alone or in combination” approach or the “most frequent multiple responses” approach (which can be combined to create “alone or in combination” groups. These two approaches would stop the undercounting of the AIAN population.

This granular race/ethnicity/tribal affiliation data will allow Managed Care Plans to re-run our disparity analyses and release an analysis of our findings. In addition, we can pass on this information to primary care practices to give them the complete and accurate data they need to identify and address health inequities.

As unintentional as it may be, the DHCS racial categorization algorithm is an example of structural racism that deserves to be addressed. With the increased emphasis on Health Equity at DHCS and CDPH, there should be a heightened sense of urgency to definitively address this issue. DHCS alignment with the OMB’s updated race and ethnicity data standards creates an opportunity to correct an issue that obscures AIANs and other small populations from the data.

One additional wrinkle is a recent increase in the willingness of individuals applying for MediCal to embrace their multiracial background. In the past, there were significant social and administrative pressures for individuals to self-identify one race on the Medi-Cal application. In contrast, newly eligible newborns now have “other/multiple race” as the largest single category of race even before the new OMB standards are implemented.

According to DHCS, one option for generating more accurate MediCal race data is to have beneficiaries individually go on-line to update their race selection. This is done through CalHEERS and BenefitsCal. Partnership has not confirmed that this will work, so if one of your patients uses this system to update their race, please let us know how it goes.

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 2025. Online options will be available. More details will be coming in the months ahead.

Health Inequity Measurement

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

<u>Major findings</u>:

A. The most important administrative measures for detecting racial inequities (compared to the white population) are the following HEDIS measures:
    a. Mammogram
    b. Colorectal Cancer
    c. Well Child Visit

<u>Mammogram Inequities</u>:
In all 4 regions of 2023, **American Indians** had lower rates of screening.
In just the Southeast region, **Pacific Islanders** also had low rates.

Colorectal Cancer:
In all 4 regions in 2023, **American Indians** had lower rates of screening.
In just the Northeast, the **Black** population had lower rates.
In just the Southwest, the **Pacific Islander** had lower rates.

Well Child Visits in 2023:
Northeast: Inequity in **Pacific Islander** population
Northwest: Inequity in **Pacific Islander and American Indian** populations
Southeast: Inequity in **Pacific Islander and Black** populations
Southwest: Inequity in just the **American Indian** population.

Other notable trends are evident in the CIS-10 Childhood immunization Measure:
Northeast: Inequity in **American Indian** population (0%) vs. 5% in white population. Rates in all ethnic groups very low with highest in Hispanic population (14%)
Northwest: No inequities
Southeast: No inequities
Southwest: Inequity in just the **American Indian** population (0%) vs. 26% in white population.

B. PCP QIP Equity Analysis

In 2024 there were 11 clinical measures; here are the plan-wide consolidated results (QIP denominator only)

- Breast Cancer screening: Only American Indian rate (45%) lower than white rate (47%)
- Cervical Cancer screening: Only American Indian rate (41%) lower than white rate (46%)
- Well Child/Adolescent Visits: Only the Black rate (45%) lower than the white rate (47%)
- Childhood Immunization (CIS-10): Only American Indian rate (7%) is lower than the white rate (13%)
- Colorectal Cancer Screening: American Indian (27%) and Black (32%) rates less than white rate (35%)
- Blood Pressure Control: American Indian (54%) and Black (60%) rates less than white rate (62%)
- Diabetes Good Control: American Indian (56%) and Black (59%) rates less than white rate (64%)
- Diabetes Retinal Eye Exam: Only American Indian rate (45%) is below white rate (46%)
- Adolescent Immunization (IMA-2): No inequities noted: white population performs the worst with just 22% complete.
- Lead Screening in Children: No inequities noted: white population performs the worst with 62% complete.

- Well child visit in the first 15 months of life: Only American Indian rate (36%) is below white rate (42%)

Summary by Race:

- Native American: Improvement in inequities from 10/11 have worse outcomes than the white population in 2022 to 8/11 in 2024
- Black/African American: Improvement in inequities from 5/11 have worse outcomes than the white population in 2022 to 4/11 in 2024

- No statically significant disparities: Hispanic, South Asian, East Asian, Southeast Asian, and Pacific Islanders.

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

Partnership's 2024 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 (EPT)

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. In May 2024, DHCS recalculated the final award amounts due to state budget revisions. All 27 awarded organizations remain as participants and the amount available for directed payment now totals: $12,930,240. Statewide, 199 of the 207 organizations remain in the program. 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 3 years to achieve the ambitious goals of the EPT program.

General Quality Updates

DHCS Quality Oversight

The accountable measures in the DHCS Managed Care Accountability Set (MCAS) for reporting year RY2026 (measurement year MY2025) 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

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Children's Health Domain Measures					
3	Child and Adolescent Well-Care Visits[*]	WCV	NCQA	Administrative	Yes
4	Childhood Immunization Status—Combination 10[*]	CIS-10-E	NCQA	ECDS	Yes
5	Developmental Screening in the First Three Years of Life	DEV-CH	CMS	Hybrid/Admin	Yes[iii]
6	Immunizations for Adolescents—Combination 2[*]	IMA-2-E	NCQA	ECDS	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

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Reproductive Health Domain Measures					
14	Chlamydia Screening	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*,ii	BCS-E	NCQA	ECDS	Yes
18	Cervical Cancer Screening	CCS-E	NCQA	ECDS	Yes

DataLink and ECDS Measures

Electronic Clinical Data Systems (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. NCQA has announced plans to convert all hybrid HEDIS measures to ECDS measures by 2029, which would replace chart sampling with the ECDS reporting standard. ECDS measures are indicated by a "-E" after the measure name.

<u>The following MY2025 ECDS measures (accountable and report only) require data collection using only ECDS data standards:</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)
- Childhood Immunization Series 10 (CIS-10-E) - **NEW to ECDS**
- Immunizations for Adolescents (IMA-2-E) - **NEW to ECDS**
- Breast Cancer Screening (BCS-E) - **NEW to ECDS**
- Cervical Cancer Screening (CCS-E) - **NEW to ECDS**
- Colorectal Cancer Screening (COL-E) - **NEW to ECDS**

In 2024-2025, Partnership is piloting use of an NCQA Certified Data Aggregator, DataLink, to collect data for its ECDS measures. DataLink ingests Continuity of Care Documents (CCD's) that are extracted from EHR's and posted on a Secure FTP site. For most EHR's, the CCD extraction process is a configuration task for the EHR administrator and can be automated. There is no charge to practices in Partnership's provider network for adopting DataLink.

In 2024, 38 practices in the Partnership network signed up for DataLink. We encourage you to participate in the 2025 pilot. For PCP QIP participants, please contact the QIP team at qip@partnershiphp.org to be included in the 2025 pilot if you are not already participating. For the Perinatal QIP, please contact the Perinatal QIP team at PerinatalQIP@partnerhsiphp.org to be included in the 2025 pilot if you are not already participating.

Facility Site Review

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

Each year, Partnership is required to perform a regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is separate and distinct from the survey administered for the PCP QIP Patient Experience Measure. The CAHPS survey is performed to capture accurate and complete information about member-reported experiences and specifically aims to measure how well plans are meeting covered member expectations. It also determines which areas of service have the greatest influence on member overall satisfaction and identifies areas of opportunity to improve the quality of care and service delivery.

The annual CAHPS survey results provide a retrospective performance on key National Committee for Quality Assurance (NCQA) ratings and composite measures. Typically, the regulated survey is conducted in February of each calendar year, and members are asked to share their experiences over the past six months, representing dates of service between the months of July and December of the prior year. Survey questions target member experiences and engagement with a physician, non-emergent clinical setting, health plan, and health plan delivery of covered benefits.

Similar to the Consumer Groups (CG-CAHPS) survey used in the PCP QIP Patient Experience measure, the CAHPS survey poses several core question topics. Table A is a comparison between the different survey types.

Table: A

	CAHPS Health Plan: Partnership	**CG-CAHPS Partnership Provider Network: Parent Organization**
Core Survey Topics		
Access to care	• Getting needed care • Getting care quickly	• Getting timely appointments, care, and information
Communication between patients and providers	• How well doctors communicate	• How well providers communicate with patients
Care coordination		• Providers' use of information to coordinate patient care
Customer service	• Health plan customer service	• Helpful, courteous, and respectful office staff

As a reminder, in January 2024, Partnership expanded its service area to include ten additional northern counties. These new counties will be included in the Measure Year (MY) 2024 survey sample but are not part of the MY 2023 survey results.

Table: I

Measure Attribute	ADULT Plan Performance				
	MY 2023 HEDIS QC Ranking	MY 2023 Plan Score	Plan Benchmark Target ≥33rd Percentile Ranking	RY 2024 Performance Compared to RY 2023	
				Status	Plan Score
Rating of Health Plan (% 8, 9, 10)	<5th	68.4%	Not Met	Decline	-5.4%
Rating of Health Care (% 8, 9, 10)	5th	66.9%	Not Met	Decline	-8.0%
Rating of Personal Doctor (% 8, 9, 10)	51st	82.8%	Met	Improvement	1.3%
Rating of Specialist Seen Most Often (% 8, 9, 10)	41st	81.0%	Met	No Change	-
Getting Needed Care (% Always or Usually)	7th	74.0%	Not Met	Decline	-2.4%
Getting Care Quickly (% Always or Usually)	<5th	68.1%	Not Met	Decline	-1.4%
Care Coordination (% Always or Usually)	11th	78.8%	Not Met	Decline	-7.8%
How Well Doctors Communicate (% Always or Usually)	48th	92.6%	Met	Decline	-0.3%
Customer Service (% Always or Usually)	18th	87.0%	Not Met	Decline	-1.6%

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Table: II

Measure Attribute	CHILD Plan Performance				
	MY 2023 HEDIS QC Ranking	MY 2023 Plan Score	Plan Benchmark Target ≥33rd Percentile Ranking	RY 2024 Performance Compared to RY 2023	
				Status	Plan Score
Rating of Health Plan (% 8, 9, 10)	45th	86.5%	Met	Improvement	1.8%
Rating of Health Care (% 8, 9, 10)	<5th	76.9%	Not Met	Decline	-3.5%
Rating of Personal Doctor (% 8, 9, 10)	55th	89.9%	Met	Decline	-0.6%
Rating of Specialist Seen Most Often (% 8, 9, 10)	21st	81.5%	Not Met	Decline	-3.7%
Getting Needed Care (% Always or Usually)	14th	77.1%	Not Met	Improvement	0.4%
Getting Care Quickly (% Always or Usually)	9th	78.9%	Not Met	Improvement	2.6%
Care Coordination (% Always or Usually)	22nd	80.4%	Not Met	Decline	-0.7%
How Well Doctors Communicate (% Always or Usually)	40th	91.4%	Met	Improvement	0.3%
Customer Service (% Always or Usually)	89th	91.2%	Met	Improvement	1.3%

The following are the questions that feed into the four composite measures.

Getting Needed Care

Q9 Easy for respondent to get necessary care, tests, or treatment
Q20 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

Q24 Customer service gave necessary information/help
Q25 Customer service was courteous and respectful

Primary Care Patient Experience Survey Results (2024)

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.

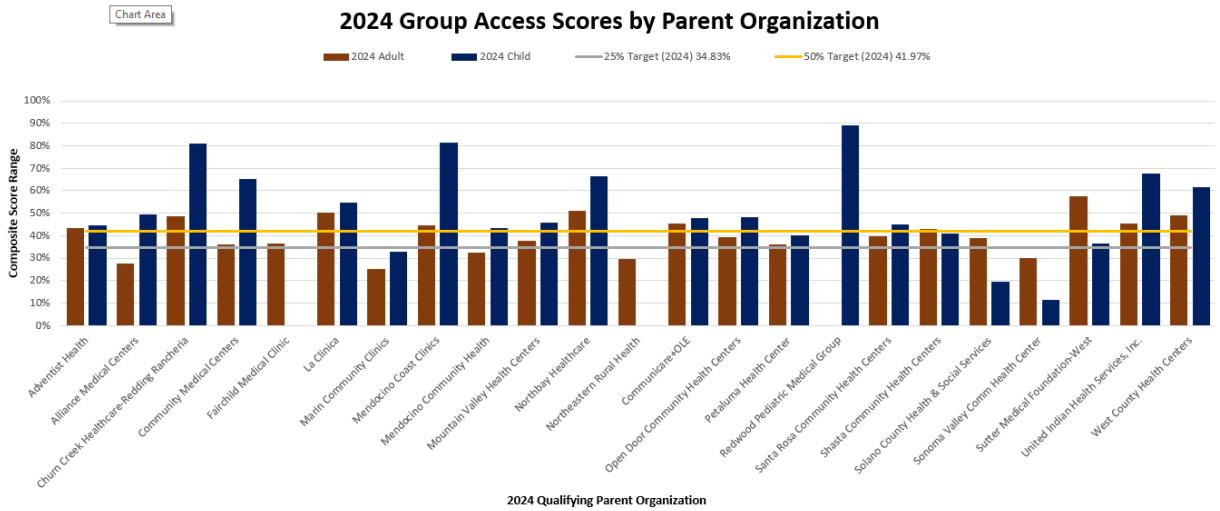
Two benchmarks are listed, for the 25th percentile and the 50th percentile based on our Partnership results.
Up to four results are noted for each PCP: Adult and Caregiver on behalf of child are the age categories, and Communication and Access are the two composite scores reported for each. Two other 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, Mendocino Coast Clinics, and Churn Creek Healthcare – Redding Rancheria

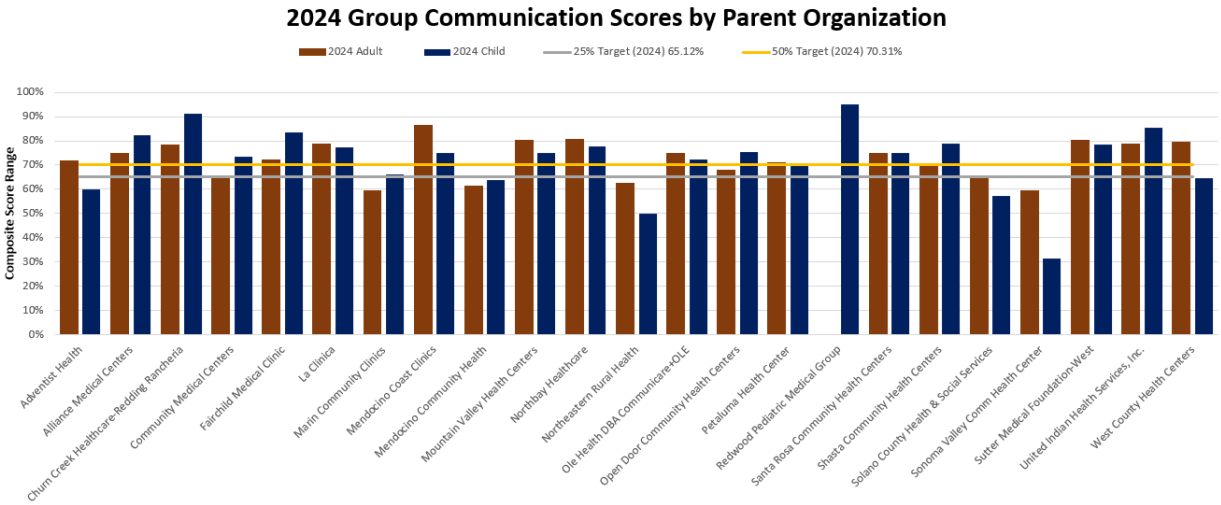
Highest scores for Adults: Sutter Medical Foundation West, La Clinica, NorthBay



Communications Scores:

Highest for Children: Redwood Pediatric Medical Group, Churn Creek Healthcare – Redding Rancheria, United Indian Health Services, Inc.

Highest for Adults: Mendocino Coast Clinics, NorthBay, Sutter West



Highlights of Supplemental CAHPS Questions

In 2023, Partnership administered an additional third-party, non-regulated CAHPS adult survey that included a 43-question survey mailed to a random member sample size of 5,000. Member participation offered a total of 678 survey completes, (678/5,000) a 13.6% response rate. Below are example

survey questions related to the patient/member benefits:

Question Attribute Benefit Literacy	
Q22. Which of the following resources do you prefer to use when you need to find information about your health benefits and coverage. ❑ Call the health plan's customer service department ❑ Look first in the health plan's member handbook ❑ My health plan's website ❑ Ask my provider or someone at my provider's office ❑ Other, please explain: _____	Response (n=678): ▪ *35.7% Ask provider or someone at my provider's office.* ▪ *29.1%: Call the health plan's customer service department.* ▪ *23.1%: My health plan's website.* ▪ *7.9%: Look first in the health plan's member handbook.* ▪ *4.2%: Other.*
Q23. Rating of understanding of benefits and coverage. ❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor	Response (n=678): ▪ *53%: Excellent or very good understanding of health benefits and coverage.* ▪ *47%: Fair or poor understanding of health benefits and coverage.*

Medi-Cal covered benefits are complex so it is optimal for staff to be familiar with these benefits to be able to direct the member for additional assistance.

Reflections on Improving 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 CAHPS 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, 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.

Pay for Performance Program for Primary Care (PCP QIP)

PCP QIP Overview

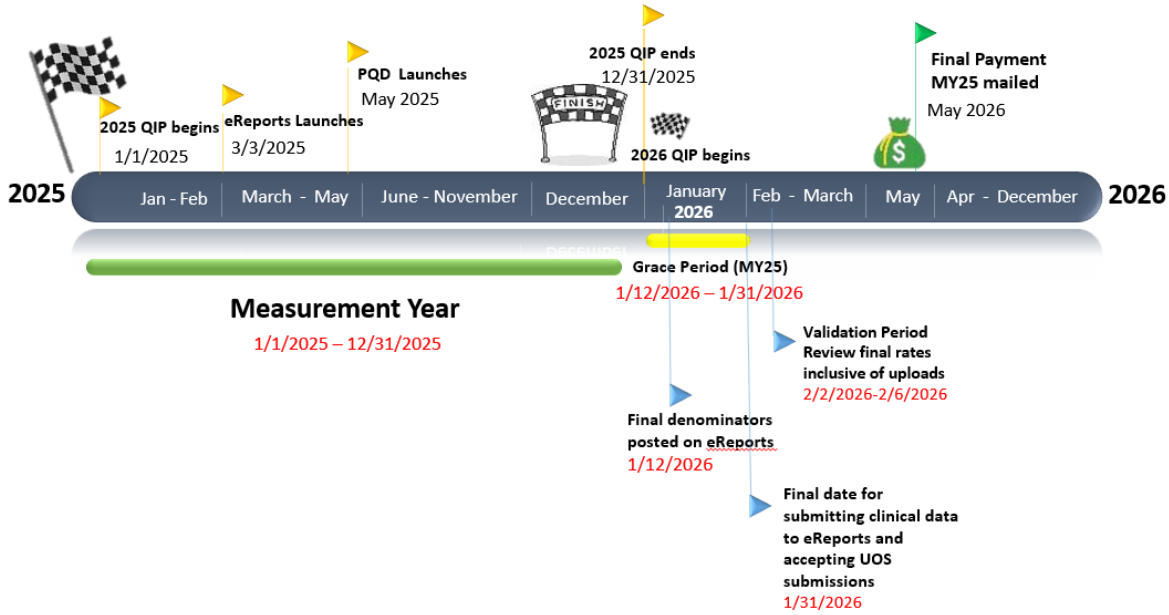
Partnership's PCP Quality Incentive Program (QIP) has been in place for more than 25 years, and has evolved over that time period. Designed in collaboration with our PCP provider network, the goal is to align Partnership and our Primary Care Providers on Quality Goals, and to transfer substantial resources 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 abridged specifications for the 2025 PCP QIP measurement year can be found here. The detailed specifications are housed in eReports. You can also request the detailed version from the PCP QIP team who will send the document via Secure email.

2025 PCP QIP Measurement Year Timeline Activities



PCP QIP Measure Sets

PCP QIP Measurement Year 2025 Changes and Updates

Clinical Domain:

- **New** for **Pediatrics**:
  - Chlamydia Screening (16-20yo)
    - The purpose of this new clinical measure is to incentivize providers for completing at least one chlamydia test for members 16-20 years of age during the measurement year.
  - Well-Child Visits in the First 15-30 Months of Life
    - The purpose of this new clinical measure is to incentivize providers for completing two or more well child visits between the child's 15 month and one (1) day birthday and 30-month birthday for members who turn 30 months of age during the measurement year.
- **New** for **Family Practice, Internal Medicine, and Pediatricss**:
  - Reduction of Healthcare Disparity (Participation is optional)
    - The purpose of this new clinical measure is to incentivize providers to reduce disparity in a race/ethnicity group within an assigned measure of focus during the measurement year.
- **New** **Monitoring** **Measures for Family Practice & Internal Medicine**:
  - Breast Cancer Screening (40-51yo)
    - The purpose of this new monitoring measure is to visualize the completion rate of mammograms for members 40-51 years of age on or between October 1, 2023, and December 31, 2025. The target is one or more mammograms per year.
  - Chlamydia Screening (FP: 16-24yo) (IM: 21-24yo)
    - The purpose of this new monitoring measure is to visualize the completion rate of chlamydia tests for members 16-24 years of age (FP) and 21-24 years of age (IM) during the measurement year. At least one test/member is the target.
- **New** **Monitoring** **Measures for Family Practice**:
  - Well-Child Visits in the First 15-30 Months of Life
    - The purpose of this new monitoring measure is to visualize the completion of well child visits between the child's 15 month and one (1) day birthday and 30-month birthday for members who turn 30 months of age during the measurement year. The target is at least two visits annually.
- **New** **Monitoring** **Measures for Pediatrics and Family Practice**:

- Topical Fluoride in Children
  - The purpose of this new monitoring measure is to visualize the completion rate of fluoride varnish applications in members 1-4 years of age during the measurement year. The target is at least two applications annually.

Non-Clinical Domain

- **Retired** from **Family Practice & Internal Medicine** – Risk Adjusted Readmission Rate (RAR)
  - Measure was retired due to the implementation of the new follow-up within seven days after Hospital Discharge measure.
- **New** for **Family Practice & Internal Medicine** – Follow-up within seven days after Hospital Discharge
  - The purpose of this new non-clinical measure is to incentivize providers to complete a clinical follow-up for members 18-64 years of age with a primary care provider, a hospital-based provider or specialist provider within seven days after discharge.
- **Change** for **Family Practice, Internal Medicine & Pediatrics** – Patient Experience
  - Added links to measure resources and member benefits located on the PCP QIP webpage.
  - Added a second survey and results example focusing on the member experience directly with their personal doctor.

Unit of Service

- **New** for **Family Practice, Internal Medicine & Pediatrics** – Academic Detailing
  - Providers can earn a $2500 incentive for scheduling and hosting academic detailing meetings with Partnership's Pharmacy team.
- **Change** from **Family Practice & Pediatrics** – Peer-Led Pediatric Group Visits
  - Expanded the qualifying pediatric well-child group visit to include both Well-Child Visits in the First 15 months of Life and Well-Child Visits in the First 15-30 Months of Life.
- **Retired** from **Family Practice & Pediatrics** – Dental Fluoride Varnish
  - Measure was retired due to the new monitoring Topical Fluoride in Children measure being added to the Core Measurement

Targets

- **Change** for **Family Practice, Internal Medicine & Pediatrics**
  - Partial Points raised to the 75th Percentile
  - Full Points raised to the 90th Percentile
  - Colorectal Cancer Screening thresholds increased to the 50th percentile for partial points and the 75th percentile for full points

- New measures are the exception and targets for full points are set at the 50th percentile. New measures are not eligible for partial points.

Pharmacist Visits to PCP sites

A new Unit-of-Service Measure

Most clinicians believe that they are diligently applying best practices when they manage the medications or their patients. As clinical leaders, you know that the only way to see if this is true or not is to look at **comparative data:** how do the prescribing patterns of your clinicians compare, in areas where there is consensus on standard of care?

Generating such comparative data is somewhat complex and nuanced. Fortunately, the Partnership pharmacy department has decades of experience with sorting through a high volume of prescription data and distilling this down to a few core important measures, at the individual prescriber level! When we meet with your team to review this data, we call this **academic detailing** (in contrast to the sales-oriented detailing performed by representatives of pharmaceutical companies).

The objective of Academic Detailing is to analyze Medi-Cal Rx prescription claims data to identify data-driven actionable opportunities for performance improvement of quality measures impacted by medication management. This is done by Sharing Medi-Cal Rx prescription drug data with our clinical leaders and quality improvement leaders of primary care organizations.

The data we provide at academic detailing includes: rates of adherence to national guidelines at the individual prescriber level as well as at your clinic site/organization level. In some cases, we can share gap lists of members who should be evaluated for eligibility for certain therapy, based on diagnosis data we have.
For patients with appropriate prescriptions provided by the PCP but who are not filling the medications regularly, we have compliance reports we will share.

Measures covered at Pharmacist Visits

- Asthma: appropriate use of controller medications
- Diabetes and Cardiovascular Disease: appropriate use of statins
- Controlling High Blood Pressure
- Blood sugar control for patients with diabetes

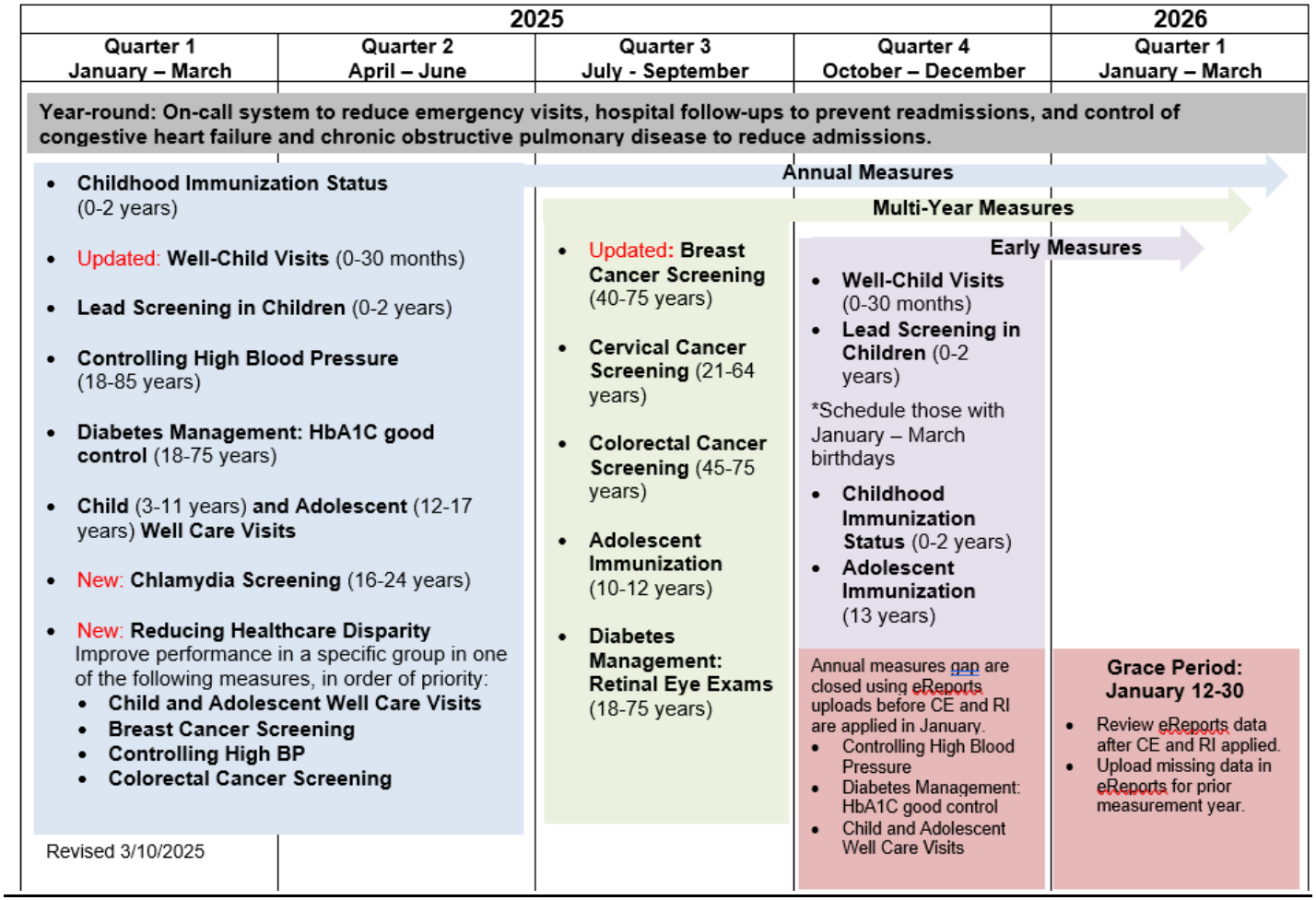
We know that you and your clinicians are busy, so **we are offering a bonus payment** through the PCP QIP for organizations that invite us to do this analysis and meet twice with your clinicians or clinical leaders. Reach out to the

pharmacy team to schedule your initial visit soon!

Email our director of pharmacy to let us know your availability!
Sleung@partnershiphp.org

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

Timeline for Addressing 2025 and 2026 PCP QIP Measures



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).

High priorities for immediate attention:

1. Children turning 2 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. Adolescents turning 13 years old in January through May: looking for opportunities to get their vaccines caught up, especially the second HPV vaccine.
3. Infants turning 15 months old 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 password 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.

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 3, 2025. 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.

With each new measurement year the PCP QIP hosts an eReports Kick Off Webinar. For the launch of the 2025 eReports, a Kick Off Webinar was held on February 24, 2025. You can find the PowerPoint presentation and link to the recorded webinar here on the PCP QIP Partnership webpage.

CLINICAL MEASUREMENT SET:

Cervical Cancer Screening Childhood Immunization Status - Combo 10 Comprehensive Diabetes Care - Retinal Eye Exams Colorectal Cancer Screening Lead Screening in Children Immunizations for Adolescents - Combination 2	MAR 03, 2025 - JAN 31, 2026
Comprehensive Diabetes Care - HbA1c Control (A1c) Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life Well-Child Visits in the First 15-30 Months of Life NEW	OCT 01, 2025 - JAN 31, 2026
Breast Cancer Screening Breast Cancer Screening 40-51 (monitoring) NEW Child and Adolescent Well Care Visits Chlamydia Screening NEW Topical Fluoride in Children (monitoring) NEW	JAN 12, 2026 - JAN 31, 2026

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.

Once launched, 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.

Important note about the launch of 2025 PQD and go-live activities for Partnership's new claims system, Health Rules Payor (HRP). Typically, PQD launches in May of each year; however, with the go-live of HRP taking place in late-summer, 2025 PQD will not be launching until Q3 2025. You will still be able to track your Clinical measure performance in

eReports. Please keep in mind eReports will be down for a short amount of time for cut-over activities. The PCP QIP team will be communicating timelines around HRP go-live activities as we get closer to launch.

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 2024. Added to the $4 PMPM base rate, the range of projected payouts is estimated 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 2023, the weighted average score was 66%, 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, 2024
- 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	> $230	< $160	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. Mandatory monthly meetings with an Improvement Advisor from Partnership.
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

Pediatric Well Visits: Required Training

Department of Health Care Services (DHCS) required all managed care plans to ensure network providers complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) specific training no less than every two years. In order to stay compliant with DHCS, Partnership HealthPlan of California is requesting all contracted medical groups/providers that provide services to members under the age of 21 to complete and return a signed attestation. To prevent duplicate efforts, if you are contracted with multiple managed care plans and have completed the training for all of them, you may share your training records and provide an attestation of completion. If you have not submitted an attestation for EPSDT training, please do so at your earliest convenience. If you have already submitted an attestation, please disregard this notice. For questions, please contact your Provider Relations representative.

Resources:

APL20-005:
https://www.dhcs.ca.gov/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

DHCS training materials: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-andTeens/Documents/DHCS-EPSDT-Provider-Training.pdf

Performance Improvement Online Trainings

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.
- 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.
- Improving Measure Outcomes Webinar Series: An overview of clinical measures including improvement strategies and tools.
- Incorporating Patient Experience in Quality Improvement Projects and Plans.
- 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.

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.

Partnership Measure Best Practices Documents

Each year Partnership updates and publishes measure best practices documents that cover the important details in each of the PCP QIP. Topics include Partnership tools available, supporting programs, outreach strategies, clinical process tips, and equity strategies. The documents were just updated for 2025 and now include the new chlamydia and dental fluoride measures.

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 blog post.

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

Upcoming trainings

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 clinical quality improvement teams who are doing the work.

Remaining 2025 sessions:

- April 9, 2025 - Breast and Cervical Cancer Screenings
- April 23, 2025 - Diabetes Control

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

Sierra Nevada Conservation & Wilderness Medicine Conference

We are excited to announce that the 2025 Sierra Nevada Conservation & Wilderness Medicine Conference will be held on September 5th-7th, at the UC Berkeley Forestry Camp in Meadow Valley, California! This is a remote venue. Cell service and Wifi are largely inaccessible. A landline is available for emergencies only.

We encourage all participants to stay in the rustic cabins (Gender separate bunk/dorm room style logging) or bring a tent and camp on site, though you can make other accommodations if you choose. RV and Trailer camping is not available at the conference venue.

This year's conference theme is ***THE HEAT IS ON: Wilderness Medicine's Response to Rising Temperatures.*** Join us as we delve into the unique, pressing healthcare challenges posed by climate-induced migration, including issues related to public health, infectious disease, mental health, and cross-

cultural competency. As always, our conference will also feature world class speakers and workshops on core wilderness medicine topics such as wound care, sports medicine, ultrasound in remote environments, and many more!

The schedule will feature world-class presenters, a keynote speaker, lectures and workshops relating to wilderness medicine and patient care in remote settings. This high-quality educational event is supported through the combined efforts of Plumas District Hospital, Plumas Health Care Foundation, and The UC Berkeley Forestry Camp. The conference is open to both healthcare and non-healthcare professionals, including students and residents. CME details will be released upon approval.

Tuition

We are a non-profit 501c3. We remain committed to making this event affordable for all registrants, in particular for medical students, residents and paramedics/EMTs with our sliding tuition scale, while preserving the quality experience that you have come to expect from our conference. **(2025 Conference details coming soon!)** These additions will not only enhance the learning experience but also provide more opportunities for hands-on training, skill development, and CME credits. The Tuition Fee is based on a sliding scale and includes all materials, *key note presentation, 4 lectures, interactive & hands on breakout sessions, and CME Credits (Excluding Non-Conference Attendees)*. The Facility Fee includes all lodging and camping fees, facilities, and six meals. The Facility Fee is a flat rate of $230, for each attendee (Our Cost).

Please see the facility & tuition rates for each registrant category below.

- **Physician or Doctoral Level** ($230 Facility Fee + $315 Tuition Fee)
- **Non-Doctoral Professional** ($230 Facility Fee + $215 Tuition Fee)
- **Resident Physician** ($230 Facility Fee + $65 Tuition Fee)

Student (Full-Time Current) ($230 Facility Fee + $15 Tuition Fee)

- **EMT or EMS professional** ($230 Facility Fee + $15 Tuition Fee)
- **Non-Conference Attendee** (Lodging and Meals only) ($230 Facility Fee)
- **Presenter/Faculty**

Camping and gender separate bunkhouse/dormitory style lodging will be available at the UC Berkeley Forestry Camp, conference venue. Registrants that choose to camp will be responsible for bringing their own camping equipment (Tent, sleeping bag, pads, lights). Conference attendees are also free to pursue and organize their own outdoor activities during free time on Saturday afternoon. Pets are not allowed. Credit or debit card transactions will be processed through Stripe. To pay by cash or check, mail to: Plumas Health Care Foundation, c/o Wilderness Conference, 1065 Bucks Lake Road, Quincy, CA 95971. **Cancelation Policy:** Cancelations received in writing more than four weeks prior to event will receive a full refund minus a refund processing fee. Cancelations received in writing two to four weeks prior will receive a

refund minus a $100.00 administrative fee. There will be no refunds for cancelations received within two weeks of the event. Please remember that canceling your registration does not automatically cancel your hotel and travel arrangements. Individuals are responsible for canceling their own hotel and travel reservations.

Registration coming soon!

CME DETAILS PENDING This event is fiscally sponsored by the Plumas Health Care Foundation with facilitation support from Plumas District Hospital. We depend on sponsors to help keep Conference tuitions affordable. We want to extend a big thank you to our Sponsors (More details coming soon) for partnering with us for 2025!

Questions? Contact us at **information@pdh.org**
Please check back for updates! You can also follow us on Facebook at ***www.facebook.com/SierraNevadaCWMC***

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.

3. If your organization offers dental services to Partnership members, relay the importance of using the Z29.3 ICD code along with the appropriate CDT code for all services including topical fluoride varnish application. Partnership is reliant on its heath center partners to improve the accuracy of fluoride varnish applications reported in the counties it serves. The Topical Fluoride in Children monitoring measure in the PCP QIP will allow you to confirm that you are correctly coding your fluoride varnish services for children ages 1-4 years.

4. 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.

5. 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 be willing to represent their community and their specialty on one of our partnership committees.

6. 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.

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.

Quality Leaders

1. Work with your Dental and Billing leadership to ensure that fluoride varnish applications within your Dental Center are coded using the Z29.3 ICD code along with the appropriate CDT code for all Partnership members 0 through 20 years.

2. When the 2025 Partnership Quality Dashboard goes live in Q3, 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.

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

4. Convene a group within your organization to prioritize annual activities to assess your patients' experience and prioritize interventions to improve this.

5. If you do not have a point of care Lead testing unit, consider applying for one from Partnership.

6. 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.

7. 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).

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

9. Review Partnership's preventative care dashboards within eReports, continually, throughout the year to assure no one is being missed. Prioritize patients who need final visits and immunizations early in the next measurement year to avoid missing numerator hits. Also review dose-level immunization data to identify frequently missed immunizations.