PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: Physician Advisory Committee
Date / Time: April 10, 2024 - 7:30 to 9:00 a.m.

Brown Act flexibilities have ended. Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:
Steve Gwiazdowski, MD *(Chair) (FF*
Angela Brennan, DO *(FF)*
Suzanne Eidson-Ton, MD *(FF)*
Theresa Shinder, MD, *(FF)*
Karen Sprague, MSN, CFNP *(FF)*
Candy Stockton, MD *(E)*
Chris Myers, MD, *(E*
Malia Honda, MD, *(E)*
Darrick Nelson, MD *(R)*
Danielle Oryn, DO *(A)*
Mills Matheson, MD *(OMM)*
Melanie Thompson, DO *(MCC)*
Karina Gookin, MD *(SR)*
Brian Evans, MD *(TF)*
Noemi Doohan, MD *(CC)*
Jonathan McDermott, FNP *(BC)*

FF Fairfield
SR Santa Rosa
E Eureka
R Redding
BC Butte County Public Health
MCC Marin Community Clinics
AM Ampla Health
A Aliados Health
TF Tahoe Forest
RS Sutter-Roseville
CC CenCal Health
OMM Office of Dr. Matheson

Members Excused:
Dr. Vanessa Walker
Dr. Chester Austin

Members Absent:
Dr. Matthew Zavod

Visitor:

Partnership Staff:
Sonja Bjork, Chief Executive Officer
Patti McFarland, Chief Financial Officer
Wendi Davis, Chief Operating Officer
Lynn Scuri, Regional Director
Mary Kerlin, Sr. Dir., Prov. Relations (PR)
Lisa O'Connell, Associate Director of Housing and Incentive Programs
Doreen Crume, RN, N. Mgr. Care Coord.
Stephanie Nakatani, Supervisor, Provider Relations Representatives
Vicky Klakken, Mgr, North Region
Brigid Gast, RN, Dir. of CC
Robert Moore, MD, Chief Medical Officer
Katherine Barresi, RN, Chief Health Services Officer
Colleen Townsend, MD, Regional Med. Director
Mark Netherda, MD, Medical Director for Quality
Jeffrey DeVido, MD, Behavioral Health Clinical Dir.
Stan Leung, Pharm.D., Director, Pharmacy Services
Debra McAllister, RN, Assoc. Dir. UM Strategies
Sue Quichocho, Mgr., Quality Measurement
Amy McCune, Manager of QI Programs
Bradley Cox, MD, Associate Medical Director
James Cotter, MD, Associate Medical Director
Jeffrey Ribordy, MD, Northern Region Medical Director
R. Doug Matthews, MD, Eastern Region Medical Director
Marshall Kubota, MD, Regional Medical Director
Teresa Frankovich, MD, Associate Medical Director
Nancy Steffen, Dir., Quality & Perf. Improvement
Heather Esget, RN, Director, Utilization Mgmt. (UM)
Kevin Jarret-Lee, RN, Assoc. Dir. of UM
Kristine Gual, Mgr. of Performance Improvement
Isaac Brown, Director, Quality Management
Mohamed Jalloh, Pharm.D., Director, Health Equity
Megan Shelton, Project Manager, Quality Improvement
Monika Brunkal, RPh, Interim Director, Population Health
David Lavine, Assoc. Dir. of Workforce Development

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC acting Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	18/21 – PAC	Committee quorum requirements met (18).	04/10/2024

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer Administration Updates	**Partnership's Chief Health Services Officer provided the following report on Partnership activities on behalf of Partnership's Chief Executive Officer (CEO).** • **Department of Health Care Services (DHCS) Transitional Care Services** • Under the umbrella of Population Health Management for all Medi-Cal managed care plans (MCP) for which plans are responsible for having staff assist in the discharge planning as members move across care settings. • MCPs are to be more actively involved in the hospital discharge planning process. • Includes members in an acute-care setting as well as members who are in a skilled nursing facility (SNF) or long-term care facility (LTC). • There will not be one approach applied to all situations, and multiple models of care are proposed. • Partnership will heavily lean on the relationships with Primary Care Physician (PCP) community clinics that have robust connections with area hospitals and SNFs to assist with member transitions. • Partnership is actively communicating to DHCS the successes of its own Transitional Care Services implemented after the implementation of an innovation grant awarded in 2015, such as those with children and youth within the California Children's Services (CCS) and Whole Child Model (WCM). • DHCS is still developing expectations for MCPs for this policy. • **DHCS Foster Care Changes** • Partnership cares for the physical health care needs for more than 8,000 youth. • As part of Partnership's new contract with the state for the expansion, a Foster Care Liaison has been hired to better serve those members. • The Foster Care Liaison will work closely with county welfare agencies, probation, and mental health, to help coordinate care and answer questions about appointments, especially those within the first 120 days. • Beginning 2025, Partnership will be coordinating with county welfare agencies under the template released by DHCS. • Partnership has begun having early conversations working with some of the other stakeholders with regards to giving feedback to ensure that the policy document is really meaningful and aligns with some of the other broader principles under the Medi-Cal transformation. • **Dignity Contract Updates** • Despite many efforts to renew with Dignity Health, the contract expired April 1, 2024. • Partnership hopes a future agreement will be possible to bring Dignity back in-network. • Partnership appreciates all of the community health center support to care for those members who have been reassigned. • Dignity Health requested rates far exceeding the limits of Partnership's ability to pay without risk to the financial stability of the entire organization and network of providers. • Members whose primary coverage is Medicare are not affected in addition to any other members who have Partnership as secondary coverage. • Partnership's Care Coordination department is working to assist members with their care and answer any questions regarding the transition. • More than 17,000 members qualify for continuity of care with their Dignity providers based on certain criteria such as • Patients in cancer treatment receiving chemotherapy • Scheduled surgeries • Members with multiple comorbidities and medication needs • Pregnant members • Members who have the most medical vulnerability • Providers may visit Partnership's online services under eligibility to view members who have been approved for Dignity Continuity of Care. ***Questions/Comments:*** Who is available for specialty care for Partnership members? Partnership has mapped out providers and coordinated with Transportation to address gaps. Telehealth is also available for certain conditions. Members or providers are welcome to call Care Coordination for more information on Continuity of Care for any Partnership member experiencing a transition.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services activities.** • **Regional Medical Directors' Forums** • Partnership welcomes Medical Directors, Clinical Leads, Administrators, Executive Leads, Directors, and Quality Improvement Managers to attend this annual training covering information about new programs, major Partnership and state policy updates, mental health and Substance Use Disorder (SUD) treatment updates, data review, Public Health issues, and Primary Care Physician Quality Improvement Program updates. Each forum will take place from 9 a.m. - 2 p.m. each Friday through May 3, 2024 in various locations. • **California Conference of Local Health Officers (CCLHO) Meeting** • Partnership hosted a meeting with Public Health Officers during the CCLHO spring conference. • Health plans are encourage to work closely with County Public Health offices to plan public health priorities. • Furnished the first view of Partnership's county-specific annual data report which was well received and will be posted online with minor changes at later date. • Discussed several initiative related to maternity and pediatric care with focus on well-child visits and timely vaccinations, which aligns with several counties' maternal and child health five-year plans. • Although there were six reported cases of the measles at the time of the meeting, there is little concern about a larger outbreak throughout California. • California Department of Public Health (CDPH) is focusing on Substance Use Disorder (SUD) as a top priority, especially for alcohol. Hemp was also added for concerns about chemical marijuana added to foods without accurate labeling. • **Breakthrough in Latent Tuberculosis Treatment** • Partnership's Pharmacy team identified 366 patients who had started but not complete treatment for latent tuberculosis by evaluating the state database for pharmacy prescriptions, which is not currently imported into the database for Public Health infrastructure, creating a blind spot for Public Health Officers. • The information was shared with county public health officers to import the data into CalREDIE. • Partnership will send another list of those who have completed and have not completed in the near future. • There are four new regimens that reduce the treatment time from nine months to one month, but there has been no way to determine if patients completed their prior treatments; having this list will help reach patients to complete treatment and assist Public Health departments to eradicate tuberculosis from California. • **Upcoming Hospital Quality Symposium** • Annual meeting for hospitals in Partnership's network to be held August 5, 2024 in Anderson and August 7, 2024 in Fairfield. • Invitations will be sent at a later date. • The keynote speaker will be Arianna Campbell, Master of Public Health (MPH) and Physician Assistant, Certified (PA-C), who is the principal investigator for the Bridge to Treatment program related to Substance Use Disorder (SUD). • The importance of prescribing buprenorphine in the emergency department will be a topic for discussion. • **Quality Improvement Updates** • Partnership is in the midst of dispensing the second round of point-of-care lead-testing devices to practices as an intervention for detection at practices. • There are 22 provider organizations (about 10% of practices) engaged in the ColoGuard bulk ordering process and are accepting additional interested practices. • Partnership is working on a cervical cancer screening pilot in which users self-swab; five sites are testing. • This testing has been used in other countries and is waiting on recommendation for implementation throughout the United States. • There are upcoming Improving Measure Outcomes webinars in April for pre-natal care and cervical cancer and sexually transmitted infection (STI) screening. • ABCs of Quality Improvement will be held in Chico on May 1, 2024. • The North Coast Clinic Network will conduct training on incorporating the patient experience and quality improvement projects and plans.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
I.B. Chief Medical Officer Health Services Report, Continued	• **Equity Practice Transformation Updates** • There are 27 primary care sites participating. • The first deadline for self-assessment will be the first week of May 2024. • Partnership will assist sites in completing the assessment, which may be used by Department of Health Care Services (DHCS) to front-load the funding based on the assessment. • Dollars administered can be used to work on subsequent milestones. • **Change Healthcare** • Partnership is closely monitoring how the Change Healthcare cyber-attack will affect annual Healthcare Effectiveness Data and Information Set (HEDIS) measures due to a lack of data during this time. The final upload has been announced for April 24, 2024. • The IT Department does not yet have complete data on the number of providers affiliated with Change Healthcare. • Partnership's CEO will ask National Committee for Quality Assurance (NCQA) for an extension of two weeks to allow more data to be released, but approval is uncertain. ***Questions/Comments –*** Dr. Gwiazdowski shared that he attended an internet security meeting where it was mentioned Change Healthcare had additional attacks from a splitter group after the initial cyber-attack. Partnership's Chief Financial Officer explained many hacker groups have a loose affiliation of people who own the encryption and decryption software, similar to a contractor and subcontract, in which they agree to split the ransom fee. In the case of Change Healthcare, the head group received the funds but did not pay the others who still have access to the information. Concerns remain those who were not paid will threaten to release the protected information. Change Healthcare received the decryption to resume work, but there may be an additional data leak and a second ransom request paid to prevent it. This is an unusual case that may have implications for future hacker groups since most times the ransom is paid and the threat is resolved. Companies will be hesitant to pay ransom fees if threats remain after doing so. These ransom requests are for several million dollars. The systems are backed up, and Change Healthcare is working through the process, there is still risk of potential data breach. Dr. Gwiazdowski also added the importance of securing accounts with individual, unique passwords rather than the same one for multiple logins. Adding two-factor authentication provides an additional layer of protection against hacking. Dr. Doohan thanked Partnership for the Public Health Officers' meeting she attended and asked more information about how to request a data analysis offered. Partnership's CMO answered a form needs to be completed by a county's Public Health Officer for the information being requested to ensure someone with a background in interpreting data is available to review it.
I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for the Southeast Counties presented a brief update on activities.** • **Area Updates** • Staffing is relatively stable across Napa, Solano, and Yolo Counties. • Providence lost a primary care provider who shifted to specialty care offering weight management and working closely with bariatric surgeons. • Partnership regularly communicates recruitment and retention incentives to practices to assist in hiring and keeping more clinicians. • Working closely with doula programs for the recruitment of doulas throughout the southeast and other regions. • Doula Doula has a great model of care for training to share with others interested. • Napa Solano Medical Society released annual scholarship information which targets individuals with ties to Napa and Solano counties. Many applicants are area medical students who wish to stay in this region or are from this region and wish to return.

AGENDA ITEM	DISCUSSION / CONCLUSIONS

I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Southwest Counties presented a brief update on activities.**
	
	• **Area Updates**
	  • Working with Aliados Health and other in Sonoma County are looking to elevate the use of e-consults, which is clinician-to-clinician communication between a primary care provider and specialist to reduce the need for a face-to-face patient visits with the specialist, an estimated reduction as high as 70%. Patient no-shows for visits are also greatly reduced.
	  • There is a large shortage of physical therapists in Sonoma County.
	  • Encouraging physicians to attend the upcoming Partnership Regional Directors Meetings.
	  • Physical therapy (PT) shortages continue to be an issue in Sonoma County.
	  • President of Adventist Health Clear Lake announced resignation.
	  • Continued issues in specialty access emphasize the use and need for consults in order to reduce number of necessary face-to-face visits. Consults eliminate about 705 of the cases that would usually require a face-to-face visit with a specialist.

I.C.3. Status Update, Regional Medical	**Partnership's Regional Medical Director for the Northwest Counties presented a brief update on activities.**
	
	• **Area Updates**
	  • The non-contracted status of Dignity Health greatly affect obstetrical care in the region as they provide the majority of all care. Partnership is submitting continuity of care requests for eligible pregnant members, but care for newly pregnant members will be challenging.
	  • Dignity Health also purchased MD Imaging, the largest radiology provider in the area, limiting access to radiology services such as mammography.
	  • Other providers in the area have agreed to fill gaps for mammography screening by offering set days to Partnership members.
	  • A new ophthalmologist is moving into the region after completing a corneal fellowship and should arrive in the summer.
	  • Dr. Eva Smith, a long-time provider in Tribal health, will retire in June. Dr. Smith was the driving force in implementing addiction treatment and getting prescribing practices under control. She will be missed throughout the communities she served.

I.C.4. Status Update, Regional Medical	**Partnership's Regional Medical Director for the Northwest Counties presented a brief update on behalf of Regional Medical Director for the Eastern counties.**
	
	• **Medical Education**
	  • Medical Education Clubs have been implemented throughout high schools in Glenn County to encourage education and careers in the medical and paramedical fields. Healthy Rural California is a partner in these efforts.
	  • Chico State is also working with high school students for interest in paramedical education. UC Davis partners to provide further training to clear the pathway for high school students moving into college, then on to medical school, and finally return to positions as physicians in the local areas.
	  • Dr. David Canton of Butte County Public Health and Dr. Mark Servis, vice dean for Medical Education and leader of the Office of Medical Education at UC Davis School of Medicine, held a meeting with Healthy Rural California and local leadership on April 2, 2024 to discuss ways to instill more medical education in rural communities in Northern California. There is potential for a branch campus at UC Davis within the next 10 years or less, depending on how the program develops.
	  • Four medical students were matched for residency into the Health Rural California program. Hopes are to meet the residents and acclimate them to the area in hopes of staying in the community long-term.
	• **Provider Updates**
	  • The non-contracted status of Dignity Health greatly affects the areas of Grass Valley and Nevada City, CA. Partnership is working with a variety of clinics to ensure care for affected members. Gastroenterology (GI) and other specialty access is constrained. Looking to fill in gaps with telehealth where possible.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
I.C.4. Status Update, Regional Medical, Continued	• **Provider Updates** • The non-contracted status of Dignity Health greatly affects the areas of Grass Valley and Nevada City, CA. Partnership is working with a variety of clinics to ensure care for affected members. Gastroenterology (GI) and other specialty access is constrained. Looking to fill in gaps with telehealth where possible. • Visited with Harmony Health Medical Clinic and Family Resource Center that recently brought on several new staff members including physicians, nurse practitioners, and midwives to work in the newly contracted birthing center. • Visits held with Colusa and Glenn Counties and scheduled with Sierra and Plumas County in May, where emergency medical services (EMS) and ambulance transportation has been a large concern.
II.A. Committee Member Highlight, Dr. Noemi Doohan, Lake County Public Health	**Dr. Noemi Doohan, Lake County Public Health Officer, shared information about her background and current focus.** Dr. Doohan is known to her friends as Mimi, nicknamed by her parents who were European immigrants. She has been married to her husband, Jim, for 32 years. They share two grown children. She started her career as a molecular biologist, obtaining her PhD in molecular biology at the University of California Santa Barbara where she did seminal work in epigenetics in yeast. She attended Stanford Medical School to receive her Medical Degree. She trained in Family Medicine at Contra Costa Regional Medical Center in Martinez, CA. Her husband is a professor in Santa Barbara, California, where she focused on starting her practice. At the same time, she started a non-profit called Doctors Without Walls (SBDWW), which provides street medicine in Santa Barbara. SBDWW was founded out of her private practice and was one of the first street medicine programs in California. The all-volunteer members practiced with backpacks, for which Dr. Doohan's practice served as the dispensary. Dr. Doohan is no longer affiliated with SBDWW, but the program is still going strong, and she remains interested in street medicine. Practicing full-scope Family Medicine was challenging in her community. Dr. Doohan did not have the opportunity to continue practicing OB work, but she is passionate about OB and proud of the work Partnership has been doing to address OB access throughout Northern California. She believes in the importance of expanding OB services beyond the OB specialty to include other types of clinicians to improve access. She began hospitalist work as a full-scope family doctor and continues work as a hospitalist. She worked for Adventist Health from 2014 to 2019 and then started a family medicine residency program for Ukiah Valley Medical center under then CEO, Glen Matthews. Partnership HealthPlan was instrumental in providing the effort with an innovation grant. The residency program is still going strong in the years since she departed. Additionally, Dr. Doohan started another street medicine program in Ukiah. She then was appointed as the Mendocino County Public Health Office in August 2019 after receiving her masters of public health degree from the University of Massachusetts Amherst. The COVID-19 pandemic began just months later, which was an experience that further shaped her career. After the first year of the pandemic, Dr. Doohan left for San Diego to work the front lines at the Chula Vista Family Medicine Residency Program near the border of Mexico. She worked in a Federally Qualified Health Center (FQHC) called the San Ysidro Health Center as well as the Chula Vista Hospital at a time before vaccines were available. Having the experience of being a Public Health Officer and working on the frontlines during the pandemic was impactful on a personal and professional level. From there, she stepped into the role at Lake County Public Health as the Public Health Officer, which had been filled on a part-time basis for two years prior. Dr. Doohan is the first full-time health officer for Lake County since the pandemic. Public Health Officers are now working on recovery and what that looks like. Many are working in rural communities where there may have been gaps in coverage for communicable diseases. In Lake County, the focus is on hepatitis C and trying to get visibility on the rates of active cases. Prior to the pandemic, there may have been more consistent data, but COVID pulled focus; and Public Health Departments are now catching up. Dr. Doohan is now taking her passion for street medicine and making a student documentary film focusing on encampment resolution. Governor Newsom provided millions of dollars for encampment resolution, but as they are resolved, there have to be places for those persons to relocate. She is interested in how they are resolved and how medical care can be provided. During those challenging transitions, there is now data to show that it can be deadly when people move out of encampments and will focus efforts there.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A. Approval of Minutes	March 2024 PAC minutes were presented for approval.	**MOTION:** Dr. Eidson-Ton moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Herman. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions. Motion carried.	04/10/24
III.B.1 III.B.2 III.B.4 III.B.5	**Consent Calendar Review** Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – March 21, 2024 Policies, Procedures, and Guidelines for Action - Policy Summary April 2024 Provider Engagement Group Minutes – March 7, 2024 Credentials Committee Meeting – February 14, 2024	**MOTION:** Dr. Herman moved to approve Agenda III.B.1, III.B.2, III.B.4 and III.B.5, as presented, seconded by Dr. Eidson-Ton. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions. Motion carried.	04/10/24
V.A Hospital Quality Improvement Program	Hospital Quality Improvement Program Measurement Set Proposal, Measurement Year 2024 – 2025 Measure 2: 7-Day Follow-up Clinical Visit (Risk Adjusted Readmissions) – language will be added to allow registered nurses (RNs) to determine whether a patient's care needs to be seen by a primary care physician and within what time-frame. Measure 8: Expanding Delivery Privileges – Year two will be removed to be reworked and added a later time.	**MOTION:** Dr. Eidson-Ton moved to approve Agenda V.A, as modified at PAC, seconded by Dr. Herman **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions. Motion carried.	04/10/24
V.B Perinatal Quality Improvement Program	Perinatal Quality Improvement Program Measurement Set Proposal, Measurement Year 2024 - 2025	**MOTION:** Dr. Eidson-Ton moved to approve Agenda V.B, as presented, seconded by Dr. Shinder. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions. Motion carried.	04/10/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Hospital Quality Improvement Program Measure Set Proposal	**The Hospital Quality Improvement Program was presented for potential changes in measures.**

Summary of Approved Measure Set for Measurement Year 2024

(A) HQIP Measurement Set

Providers have the potential to earn a total of 100 points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Programmatic Changes:

I. Descriptions of Potential 2024 Measure Changes for Core Measurement Set

A. Change(s) to Existing Measures

1. Remove Measure 9: Measure Hepatitis B / CAIR Utilization

Rationale: Recording immunizations in the California Immunization Registry (CAIR) is now a requirement from the State of California for all hospitals. Therefore a measure to incentivize hospitals to use the registry is no longer needed.

B. Potential Additions as New Measures

1. Measure 2: 7-Day Follow-up Clinical Visit (Risk Adjusted Readmissions)

We are suggesting that a 7-day Clinical Follow-up Visit measure to be created in the Risk Adjusted Readmissions Domain. This would be for both large and small hospitals. Suggesting to remove RAR measure for Small size hospitals to only have a focus on the new measure while large hospitals would focus on both. Points would be distributed by hospital size.

Rationale: Evidence shows that patients who have follow-up visits within 7 days of discharge from a hospital do not readmit to the hospital as frequently as those who have no follow-up or a delayed follow-up appointment with a primary care doctor or specialist. Incentivizing hospitals for connecting their patients to follow-up care is a key tool to helping reduce readmissions.

Measure Summary

For assigned members 18 to 64 years of age, the percentage of acute inpatient and observation stays for which the member received follow-up within 7 days of discharge. Follow-up visits may include in person, telephone, and telehealth visits done at the hospital or outpatient setting. Clinical visits include those with a patient's primary care provider, other specialist, mental health professional, or a hospitalist/hospital based clinician in a hospital discharge visit. Visits with a nurse or a case manager would not count towards the denominator for this measure.

Targets

Baseline data will be gathered and analyzed to determine the appropriate targets for this measure.

Points for Hospital Advisory Committee Consideration:

1. Should our age range include pediatrics and newborns?
2. Would stepdown to a SNF be included or excluded from numerators and denominators?

Key:

New Measure || Change to Measure Design || ~~Measure removed~~

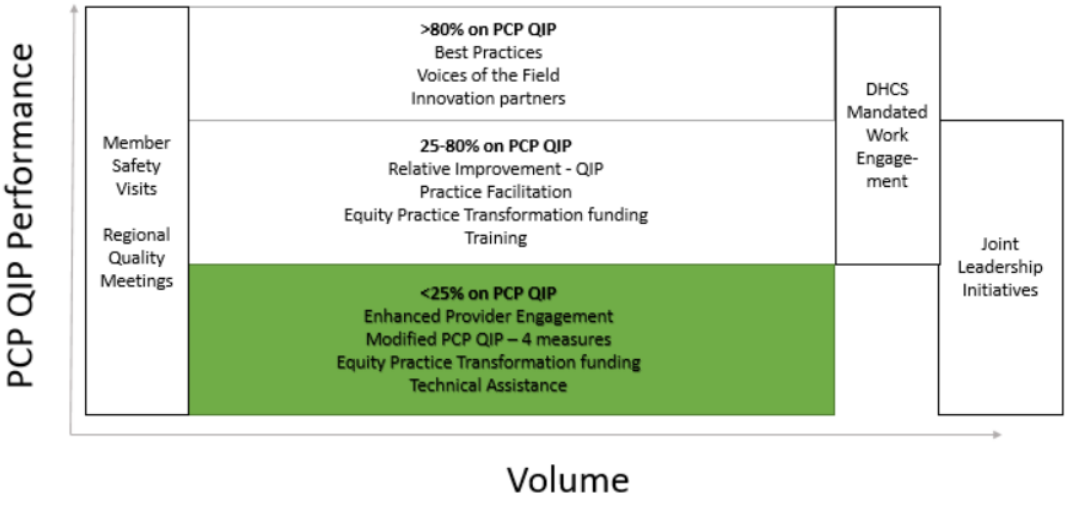
2023 Measures	2024 Recommendations
Clinical Domain	
Risk Adjusted Domain 1. Risk Adjusted Readmissions **Palliative Care Domain** 2. Palliative Care Capacity **Clinical Domain** 3. Elective Delivery Before 39 Weeks 4. Exclusive Breast Milk Feeding Rate 5. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 6. Vaginal Birth After Cesarean (VBAC) **Patient Safety Domain** 7. CHPSO Patient Safety Organization Participation 8. Substance Use Disorder, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 9. Hepatitis B/CAIR Utilization 10. QI Capacity **Patient Experience Domain** 11. Hospital Quality Improvement Platform 12. Cal Hospital Compare-Patient Experience 13. Health Equity	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Increasing Mammography Capacity **Patient Safety Domain** 10. CHPSO Patient Safety Organization Participation 11. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** ~~12. Hepatitis B/CAIR Utilization~~ 12. QI Capacity 13. Hospital Quality Improvement Platform **Patient Experience Domain** 14. Cal Hospital Compare-Patient Experience 15. Health Equity

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Hospital Quality Improvement Program Measure Set Proposal, Continued	**2. Measure 8: Expanding Delivery Privileges** **Rationale:** This measure is intended to increase the number of family physicians and midwives who are allowed to perform deliveries in the hospitals, which also respects the preferences of women in the community for midwifery care to be performed not just in the home. Increasing the number of family physicians performing deliveries should result in a greater continuity of care between family practitioners and the hospitals. This expansion of the clinicians available for labor and delivery services may help reduce the on-call frequency, and/or responsibility for clinicians on call at the hospitals for these services. Obstetrical privileges for family physicians may also serve as an attractor for qualified family physicians for areas with primary care shortages. **Measure Requirements** Year 1 – Hospitals' medical staff bylaws will allow qualified family physicians and midwives to perform deliveries in the hospitals. Year 2: Evidence that family physicians (non-resident) and/or midwives are on staff with privileges to perform deliveries in the hospitals. Hospitals with existing family physicians / midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital. **3. Measure 9: Increased Mammography Capacity** **Proposed Measure:** We are proposing to introduce a measure to increase capacity for diagnostics and screening for breast cancer through the HQIP. Hospitals would be able to determine the best way to increase their capacity, which may include expanding the available appointment hours, and hosting mobile mammography clinics. **Rationale:** According to the CDC, "Cancer is the second leading cause of death in the United States, and breast cancer is one of the most commonly diagnosed cancers in women. The risk of breast cancer increases with age. About 83% of breast cancer diagnoses each year are among women aged 50 or older." Increasing the access to mammograms is a powerful tool to help screen more women for breast cancer. Detecting cancers early increases the probability of curative treatment of the disease. Therefore, this measure is designed to encourage hospitals to increase capacity for mammography services. **Measure Specifications** Hospitals can be incentivized by increasing access/capacity to mammography by increasing breast cancer diagnostics and screening access/capacity by at least 5 to 10%. **Measure Requirements** **Large Hospitals and Small Hospitals with access to mammography:** Full Points = 10 Points: Increase access/capacity for breast cancer diagnostics and screening by 10% over previous year's baseline average. Partial Points = 5: Increase access/capacity for breast cancer diagnostics and screening by 5-9.9% over previous year's baseline average. **Tiny Hospitals without access to mammography:** Full Points = 10 Points: Host at least 1 mobile mammography clinic during measurement year with at least 25 exams conducted for Partnership members.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.B Perinatal Quality Improvement Program Measure Set Proposal	**Perinatal Quality Improvement Program was presented for potential changes in measures.** **I. Summary of Proposed Measures** (A) Core Measurement Set Measures Participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers who provide quality and timely prenatal and postpartum care to PHC members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed with PCPs and OB/GYNs in mind and includes the following measures: 1) Timely Immunization Status - Tdap and Influenza Vaccine; 2) Timely Prenatal Care 3) Timely Postpartum Care. (B) Electronic Data Measure DataLink allows for data exchange from Provider Electronic Health Records to PHC in order to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems. The measure for electronic clinical data systems (ECSD) may change to require all providers to go through a multi-step process to submit data to Partnership via secure file transfer protocol (SFTP) for the depression screening tool. The data would then go through a multiple-step process with the HEDIS team for primary source verification. DataLink is not yet an approved HEDIS aggregator, but will obtain the data for Partnership. NOTE: Measure details and specifications to be finalized in June 2024, pending DataLink pilot results and contracting. **PQIP FY 2023-24 Descriptions of Measures and 2024-25 Proposed Changes** A. Clinical Measures 1) Prenatal Immunization Status - The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy (i.e. within 40 weeks of delivery date). $37.50 (Tdap) $12.50 (Influenza) 2) Timely Prenatal Care -Timely prenatal care services rendered to pregnant PHC members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. Alternatively, timely prenatal care services rendered to pregnant PHC members at 14 or more weeks of gestation. - $100 (<14 weeks gestation) or $25 (>14 weeks gestation) 3) Timely Postpartum Care -Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforces the importance of routine preventive health care. Two Timely postpartum care services rendered to Partnership members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery. - $25 (1st visit) $50 (2nd visit) B. Electronic Data Measure *Proposed: DataLink Implementation* - DataLink implementation for monthly timely prenatal data is optional to PHC Perinatal QIP participating providers.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A and V.B Questions and Comments Hospital Quality Improvement Program Measure Set Proposal Perinatal Quality Improvement Program Measure Set Proposal	***Questions/Comments for HQIP and PQIP*** **PQIP** Dr. Gookin expressed concern about the first visit required by 21 days. Dr. Townsend explained the intent is have the first visit before three weeks and the second visit done before three months. If a baby is seen after 21 days and before 84 days, credit can be received for the second visit, but not the first. Dr. Townsend expressed the importance of seeing the birthing parent and child early to screen for interventions that may be needed for post-partum depression (PPD) or breastfeeding support. **HQIP** Partnership's CMO furthered that pediatrics would not be included in the HQIP due to taking months to receive the correct identification numbers which greatly reduces the rate of accuracy. He added excluding skilled nursing facilities from the denominator functionally works out the same, but does change the threshold Partnership will choose. Dr. Gwiazdowski asked about the newborn six-digit temporary identification number and if that could be used in lieu of the nine-digit permanent identification number or if there is something in the process that does not allow it. Partnership's CMO responded that the amount of work and time for newborn identification number to be sorted out makes including newborns in the HQIP ineffective. Dr. Herman commented on the post-hospital seven-day requirement and the exclusion of nurses for follow-ups. She explained much of that information can be shared at the nursing level to allow the nurses to choose if it should be elevated to a primary care provider. Partnership's CMO believed this was a good point to consider as the measure develops. Dr. Shinder also expressed support for nurses to be part of the follow-up care. Partnership's CMO then suggested amending the HQIP to allow a nursing visit if the committee members desired that change. Partnership would need to have a code to define that appointment for proper billing. Dr. Gwiazdowski commented on measure eight for year two that there has to be family physicians and/or midwives on staff with privileges to be able to perform deliveries in hospitals. He speculated that might force hospitals to recruit or accept a penalty if no one applies. Dr. Townsend answered that one of the barriers is that many hospitals to do not allow privileging of family physicians or certified nurse midwives (CNMs) for performing labor and delivery support. The intent is to encourage hospitals to be more open to medical staff for a broader swath of capable clinicians to provide those services. The measure is meant to be an incentive rather than a penalty in efforts to encourage hospitals to recruit midwifery and family physicians to complement those OB services. Most hospitals are actively recruiting for those roles. Dr. Eidson-Ton expressed the two-year timeline for changing the bylaws to allow those privileges is a short amount of time because there is no guarantee the hiring committee will hire those individuals and have them comfortable performing deliveries. She agrees with incentivizing the hiring, but acknowledges it will likely take longer than two years to successfully implement. Dr. Doohan added one of the issues in the bylaws will be who can proctor that new provider. Bylaws will often say a family doctor has to proctor a family doctor, but it there are no family doctors performing deliveries, there is no one to proctor them. Having some specificity that the bylaws must be changed to also include how those new providers will be proctored will be necessary. Those providers will likely require proctoring by OB/GYNs, which will likely be challenged. Dr. Doohan agreed with Dr. Eidson-Ton that the timeline is too short. Dr. Moore recommended focusing on year one for now and reevaluating year two at a future time since it would not take effect until 2025. Dr. Gwiazdowski summarized the HQIP measure eight for year two would be removed while year one will be kept. Changes to proposed HQIP measures that were approved by PAC: Measure 2: Follow up visit after hospitalization: add RN to list of clinicians who may see patients at this follow up visit. Measure 8: Section addressing year 2 is remove

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report	**Partnership's Manager for Quality and Manager of Performance Improvement presented strategies for improving quality.** Partnership has taken a multi-faceted approach to motivate change and improve quality through physician engagement, member safety, trainings, joint-leadership meetings, member incentives, recognition, and comparative data. Several engagement have taken place at practices all throughout Northern California. **Coaching and Collaboration with Providers**



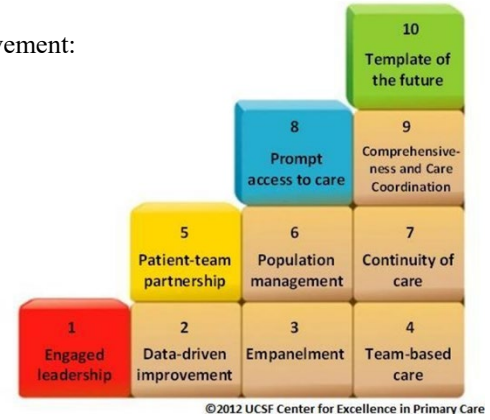
AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report	**JLI year-over-year Comparison % PCP QIP Points Earned**

JLI Provider	MY2019	MY2021	MY2022	MY2023	Sparkline
Adventist	38.3	47.4	53.4	48.4	
Fairchild Medical Clinic	56.3	45.3	50.6	56.7	
La Clinica	48.9	54.2	65.3	70.5	
Mendocino Community Health	58.2	47.1	62.6	67.2	
OLE Health	57.0	73.0	78.1	83.2	
Open Door	39.1	45.8	59.3	71.1	
Santa Rosa Community Health	59.0	82.1	86.0	79.7	
Shasta Community Health	34.6	51.7	60.6	68.9	
Solano County Health	27.0	34.7	41.1	39.2	
Planwide	43.9	51.6	56.6	57.6	

*Ole Health line represents Ole Communicare in MY 2023

JLI Comparison % PCP QIP Points Earned

JLI Provider	MY2019	MY2023	Points Change
Adventist	38.3	48.4	10.1
Fairchild Medical Clinic	56.3	56.7	0.4
La Clinica	48.9	70.5	21.6
Mendocino Community Health	58.2	67.2	9.0
OLE Health	57.0	83.2	26.2
Open Door	39.1	71.1	32.0
Santa Rosa Community Health	59.0	79.7	20.7
Shasta Community Health	34.6	68.9	34.3
Solano County Health	27.0	39.2	12.2
Plan-wide	**43.9**	**57.6**	**13.7**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report, Continued	**Background Information** Partnership reported several HEDIS measures performing below average in DHCS's Managed Care Accountability Set (MCAS) for Measurement Year 2021. This ultimately resulted in Partnership receiving a Corrective Action Plan (CAP) from DHCS in the fall of 2022. Additionally, Partnership aims to become a highly rated NCQA accredited health plan, of which clinical quality measure performance is a significant rating component. **DHCS CAP Resulted in Two New Tactical Strategies:** 1) Modified PCP QIP for Low Performing Providers: Develop and implement consequences for Primary Care Provider (PCP) Organizations (POs) with persistent low performance in PHC's PCP QIP. I. Reduction of QIP clinical domain measure set from 10 to 4 measures II. Required Executive meeting with PO's Board III. Required participation in Enhanced Provider Engagement coaching with PI team 2) Enhanced Provider Engagement: I. Completion of a Needs Assessment tool; II. Partnership summary and recommendation for impactful quality interventions, based on Needs Assessment; III. Coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance **What is the Modified PCP QIP?** The Modified PCP QIP is intended to leverage the resources and infrastructure of the PCP QIP to center the strengths of PCPs with persistent low performance. • Reduced measure set to focus efforts on 4 key measures, reflecting PHC's highest priorities in measure improvement: 1. Well-Child Visits in the First 15 Months of Life 2. Child and Adolescent Well Care Visits 3. Breast Cancer Screening 4. Cervical Cancer Screening • Each of the 4 measures carry 25% of the total available points. • Provider performance is evaluated annually for continued inclusion **Groupings – Enhanced Provider Engagement** Pilot – Four Providers and Assessment **Phase 1 – 11 Providers, Greater than 1000 Members, Less than 25% of QIP Clinical Points, Modified QIP** • 81% Engagement • 73% Completed Needs Assessment • 54% Executive Board Meeting • 73% Coaching/Technical Assistance • 73% Equity and Practice Transformation Grant phmCAT and Application, 27% Funding  **Measure versus Foundational Building Blocks**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report, Continued	**Enhanced Provider Engagement Success Story** • On site completion of Needs Assessment with members of practice's Quality, Clinical, Operations, and Administrative teams • Spread of successful best practices identified with PDSA's completed with Improvement Advisor • Improvement Advisor and Medical Director trained four clinical groups on QIP measures and best practices during another on site visit at practice • Continuous staff training and communication • Practice used internal team challenges and prizes to motivate each other towards meeting measure benchmarks • Special events for members completing services – raffles, food **Practice improved PCP QIP performance and graduated to full QIP in 2024** **Clinical Points Comparison** Characteristics of practices that improved: existing quality program with dedicated resources, were able to quickly align with Partnership QIP Characteristics of practices that didn't improve: frequent leadership transitions or overextended leaders, lack of dedicated quality resources/time or resources pulled into other functions, infrastructure and fiscal challenges, especially vulnerable populations (i.e.: Ritter). We anticipate a longer engagement to help these practices improve. Some practices were achieving points on chronic disease measures which are a more engaged cohort by definition – M-QIP access measures are more challenging. Suspended practices did not engage with Partnership in 2023, despite multiple outreach efforts. Since the suspensions, we have seen engagement improve, there will be heavy coaching supports to help these practices return to the Modified QIP.

Parent Organization	2022 Scores	2023 Scores	Difference
PO 1	25.5%	81.6%	56.2%
PO 2	9.4%	61.2%	51.8%
PO 3	12.0%	38.0%	26.0%
PO 4	0.0%	13.0%	13.0%
PO 5	18.6%	30.5%	11.9%
PO 6	15.5%	25.0%	9.5%
PO 7	0.0%	0.0%	0.0%
PO 8	6.8%	0.0%	-6.8%
PO 9	7.0%	0.0%	-7.0%
PO 10	9.0%	0.0%	-9.0%
PO 11	19.0%	0.0%	-19.0%
Average Non-weighted Change			**11.5%**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report, Continued	**Did Warning Work? Phase 2** **Phase 2 – 12 Providers, Greater than 500 Members, Less than 33% of QIP Clinical Points, On the bubble** • 75% Engagement • 66% Needs Assessment or phmCAT • 42% EPT Funding • **Phase 2 QIP Scores**

Parent Organization	2022 Scores	2023 Scores	Difference
PO 1	16.1%	47.4%	31.3%
PO 2	20.0%	49.0%	29.0%
PO 3	17.1%	39.2%	22.1%
PO 4	1.4%	19.2%	17.7%
PO 5	23.0%	37.0%	14.0%
PO 6	17.0%	30.1%	13.1%
PO 7	0.0%	10.0%	10.0%
PO 8	0.0%	9.0%	9.0%
PO 9	0.0%	9.0%	9.0%
PO 10	19.0%	27.8%	8.8%
PO 11	28.0%	33.5%	5.5%
PO 12	8.0%	7.0%	-1.0%
PO 13	32.3%	30.1%	-2.1%
Average Non-Weighted Change			**12.8%**

Evaluation Decision

- Evaluation: Enhanced Provider Engagement initiative met expectations.
  - 81% Engagement Phase 1
  - 73% Assessment/phmCAT for Phase 1 and Phase 2 (80% Work plan Goal)
- Decision: Adjust and Continue into 2024-25

Lessons Learned

- Many of these groups have foundational problems. Those problems have to be solved before a more measure specific approach is effective
- Engagement works – Some require in-person meeting
- Some disconnect between senior leaders/Boards and their organizations. Some were very engaged and some were likely part of the leadership challenges
- Smaller measure set can situationally help. COVID is another example
- Working with tribal health requires adjustments – pace of decisions/change, communication method, differing measure sets, competing priorities, etc**.**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.C Primary Care Physician Engagement Report, Continued	**What's Coming Next?** • Equity Practice Transformation funding – 27 provider organizations over 5 years • East Region engagement – Practice Facilitation, JLI's, training • Continuation/Adjustment of Enhanced Provider Engagement **Concluding Thoughts on Provider Engagement** • Engagement is a major driver of quality performance • Ties in with Partnership's brand of close relationships with practices and members • Long term commitment to partner with practices to build QI capacity
VI. Adjournment	
PAC adjourned at 9:02 a.m.	**Next PAC on Wednesday, June 12, 2024 at 7:30 a.m. Brown Act flexibilities have ended.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on 05/08/2024
Date

Colleen Townsend, M.D., on behalf of Committee Chairperson

The foregoing minutes were APPROVED WITH MODIFICATION on _____
Date

Colleen Townsend, M.D..., on behalf of Committee Chairperson