PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **October 9, 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) Karen Sprague, MSN, CFNP *(FF)* Candy Stockton, MD *(E)* Teresa Shinder, DO *(FF)* Brent Pottenger, MD *(FF)*	Darrick Nelson, MD *(R)* Karina Gookin, MD *(AU)* John McDermott, FNP *(C)* Malia Honda, MD *(E)*	Mills Matheson, MD *(OMM)* Melanie Thompson, DO *(MCC)* Danielle Oryn, DO *(AD)* Matthew Zavod, MD *(FF)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn* *MCC - Marin Community Clinics* *OMM - Office of Dr. Matheson* *AM – Ampla Health*
Members Excused:	Angela Brennan, DO Chester Austin, MD	Noemi Doohan, MD Michelle Herman, MD	Christina Lasich, MD Suzanne Eidson-Ton, MD	Chris Myers, MD Vanessa Walker, DO
Members Absent:	Brian Evans, MD Mustaffa Ammar, MD *(AM)*			
Visitor:	Dr. Derice Seid, Marin Community Clinics			
Partnership Staff:	Katherine Barresi, RN, Chief Executive Officer *(acting)* Patti McFarland, Chief Financial Officer Wendi Davis, Chief Operating Officer Vacant, Regional Director Mary Kerlin, Sr. Dir., Prov. Relations (PR) Lisa O'Connell, Director of Enhanced Health Services Doreen Crume, RN, N. Mgr. Care Coord. Stephanie Nakatani, Supervisor, Provider Relations Representatives Vicky Klakken, Dir., North Region Brigid Gast, RN, Dir. of CC	Robert Moore, MD, Chief Medical Officer Katherine Barresi, RN, Chief Health Services Officer Colleen Townsend, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Vacant, RN, Assoc. Dir. UM Strategies Sue Quichocho, Mgr., Quality Measurement Amy McCune, Manager of QI Programs Bradley Cox, MD, Northeast Region Medical Director James Cotter, MD, Associate Medical Director	Jeffrey Ribordy, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Marshall Kubota, MD, Region 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 Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	13/23 – PAC	Committee quorum requirements met (13).	10/09/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.A. Chief Executive Officer Administration Updates	**Partnership's Chief Operations Officer (COO) provided the following report on Partnership activities on behalf of Partnership's Chief Executive Officer.**
	• **Department of Health Care Services (DHCS) Updates**
	  • DHCS signaled that they are going to be starting the data pull process with certain provider types starting their trajectory towards the new minimum wage care law, SB525, that was passed, which requires minimum wage for covered care employees to be $25 per hour by June 2028. Many health centers quickly adjusted to raise the wage to $25 per hour preemptively. Partnership will be monitoring impacts to staffing in an already challenging environment for recruitment and retention.
	  • DHCS released the Community Reinvestments policy sending out the guidelines to MediCal Managed Care Plans (MCPs) requiring reinvestment of a certain about of base profits based on quality and financial measurement performance.
	  • Local health plans have been reinvesting in communities for many years, and there are concerns about credit being received for programs Partnership has already implemented.
	  • Local Health Plans of California (LHPC) conducted a poll spanning dates from 2019 to the present revealing health plans have invested $800 million back into the communities served. DHCS has suggested a reinvestment rate of five to seven percent, but Partnership has been investing roughly 20% and has questioned if credit will be received.
	  • Drafted language suggests DHCS is looking at the legal permissibility of having another shared governance structure for a decision-making authority body with regards to where these investments are made.
	  • Partnership will be working closely with financial partners and Finance Team to ensure firm and confirmed rates to project positive revenue.
	• **National Coalition for Quality Assurance Health Equity Accreditation (NCQA)**
	  • A mock audit with a consultant revealed Partnership would pass the measures needed to obtain NCQA Health Equity Accreditation.
	  • Partnership departments focus internally and with the provider network to ensure systems and processes are in place to achieve quality outcomes.
	
	Questions – None

I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services.**
	
	• **DHCS Updates**
	  • Dental data received from DHCS has not categorized all of the dental visits for Federally Qualified Health Centers (FQHC), tribal health clinics, and rural health clinics. Within the medical file, absent dental files, the data only shows if the appointment took place and not if fluoride was applied. Fluoride application is a Managed Care Accountability Set (MCAS) measure.
	  • Partnership has been aggressively working with DHCS to elevate the issue of missing data and measure accountability.
	  • Partnership proposed to DHCS three reporting regions to match MCAS regions to the financial reporting regions.
	• **Network Engagement**
	  • Partnership has been piloting events for new medical residents to welcome them to the communities.
	  • Partnership held the second tribal health convening with great attendance where the topics of workforce, behavioral health, tribal perinatal initiatives, data sovereignty, and public health were presented and discussed.
	• **California Medical Association (CMA)**
	  • CMA House of Delegates meeting will be held at the end of October highlighting rural health equity and reproductive and obstetrical (OB) access.
	  • CMA is often dominated by urban areas. Counties proposed having a rural health caucus within CMA for a forum to discuss rural health issues.
	  • OB access needs legislative advocacy; three proposals have been offered for consideration.
	  • Allowing alternative birthing centers to be accredited rather than licensed in order to be a contracted MediCal provider
	  • Allowing rural hospitals to have standby perinatal units without the need for continuous staffing but could be staffed when patients are there
	  • Training rural nurses to have a broad range of skills to be cross-trained in many areas.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Yolo, and Solano Counties presented a brief update on activities.** • LaClinica, Communicare+Ole in Napa, and Community Medical Centers have all recruited new providers. • Community Medical Centers CEO has announced retirement in November. • Doula applications for contracting and credentialing across the regions are increasing. • Drug Safe Solano hosted a medication assisted treatment (MAT) collaborative and invited all provider practices in the community as well as the local hospitals to have a discussion about how to bring together better access to MAT treatment. This will be an ongoing avenue for clinicians to get to understand from each other how they are prescribing, how to help individuals get through the systems and get access to MAT, and provide tools and support to primary care providers (PCP) and mental health professionals.
I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Partnership Santa Rosa will be hosting a fall meeting with FQHCs in the region to address any questions about the Quality Improvement Program (QIP). • E-Consults continue to fill gaps in specialty access. • Leigha Andrews joined Partnership as the new Region Director for Sonoma and Marin Counties.
I.C.3. Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Adventist Health Mendocino Coast in Fort Bragg had contracted a third party to run operations since 2020 and has sent a desire to restructure the terms of the agreement. Negotiations will take place over 60 days, but there is no additional information at this time. • The California Attorney General, Rob Bonta, has filed a lawsuit against Providence St. Joseph Hospital for denying emergency medical abortion care as required by California law. Although the patient was not a Partnership member, there are implications for all members of the community, and the outcome will be closely monitored.
I.C.4. Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, Colusa, Yuba, Plumas, Sierra, Nevada, and Placer Counties presented a brief update on activities.** • Jill Blake has joined Partnership as the Chico Office Region Director. • Oroville Hospital expansion is progressing with hopes for electrical switches for the electrical system to be placed on a generator by the end of the year in efforts to open a new hospital wing in 2025. • Orchard Hospital in Gridley, CA is linking up with Partnership Telemedicine for hospitals and clinics. • Recently held meeting with Sierra Nevada Memorial Hospital to build relationships with Chapa De clinics, providers, and the medical residency program. • Plumas District Hospital is in the process of building a skilled nursing facility (SNF) and working diligently on the building structure ahead of expected inclement weather in the winter months. Once opened, 30 beds will be available for the region. • Met with Healthy Rural California to discuss continued medical education efforts, focusing on underrepresented groups, including the American Indian Alaska Native population, to encourage all students in the region to consider careers in medicine. • Yuba-Sutter-Colusa Medical Society and Placer-Nevada County Medical Society have merged to become Sierra Foothills Medical Society. • Butte County is seeing an increase in advanced colorectal cancer. Partnership's Chico Medical Director will be meeting with other area providers to brainstorm ideas for addressing the issue through access to endoscopy and brining colorectal cancer screening rates closer to the national average of 70-80%.
I.C.5. Status Update, Regional Medical	**Partnership's Regional Medical Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Dignity Health Sierra Pacific Regional Cancer Center had a groundbreaking ceremony on September 24, 2024. The $70 million, 40,000 sqft facility will serve the Redding area and hope to attract more oncologists and bolster the cancer program to keep Redding patients close to home.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
II.A. Executive Member Highlight, Ms. Jennifer Lopez, Chief Financial Officer	**Ms. Jennifer Lopez, Partnership Chief Financial Officer, provided her background and introduced herself to PAC attendees.** Ms. Lopez joined Partnership as the Deputy Chief Financial Officer in March 2023 and has been appointed the Chief Financial Officer in October 2024 following the retirement of Ms. Patti McFarland. She has years of experience working in Medicaid for the California Department of Finance, previously overseeing all of the healthcare premium payments and setting healthcare premiums for MediCal across the state for several years. She is also familiar with Medicaid policy working alongside the legislature and on the social services side. DHCS is transforming MediCal and she understands many of the social service aspects through community support and had an opportunity to design some of those supports. Additionally, she previously worked for Local Health Plans of California (LHPC) as the Director of Finance were she advised CEOs and CFOs across the state on all financial matters related to Medicaid.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	**October 2024 PAC minutes were presented for approval.**	**MOTION:** Dr. Shinder moved to approve Agenda III.A as presented, seconded by, seconded by Nurse Sprague. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.B. ▪ III.B.1 ▪ III.B.2 ▪ III.B.4 ▪ III.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – October 2024 • Policies, Procedures, and Guidelines for Action Policy Summary October 2024 • Provider Engagement Group (PEG) Report - September 2024 • Credentials Committee Meeting – August 14, 2024	**MOTION:** Dr. Shinder moved to approve Agenda III.B.1, III.B.2, III.B.4 and III.B.5, as presented, seconded by Nurse Sprague. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.C	**Physician Advisory Committee Membership** Resignation of Dr. Melanie Thompson from PAC	**MOTION:** Dr. Zavod moved to approve Agenda III.C, as presented, seconded by Dr. Shinder. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.D	**Primary Care Physician (PCP) Quality Improvement Program (QIP) Proposal**	**MOTION:** Nurse Sprague moved to approve Agenda III.D, as presented, seconded by Dr. Shinder. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
IV. Old Business	
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	**Primary Care Physician Quality Improvement Program (QIP) Proposal** Summary of Proposed Measure Changes for Measurement Year 2025 Providers have the potential to earn a total of 100 points in four measurement areas. (A) Core Measurement Set Measures - 1) Clinical Domain 2) Appropriate Use of Resources 3) Access and Operations 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

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

2024 Measures	2025 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Care: HbA1c Control 7. Diabetes Management: Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children	**Family Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Diabetes Management: Eye Exams 9. Controlling High Blood Pressure 10. Immunizations for Adolescents – Combo 2 11. Well-Child Visits in the First 15 Months of Life 12. Lead Screening in Children 13. Chlamydia Screening in Women (both age groups: 16-24yo) – **Monitoring** 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. **Reduction of Inequity Adjustment (Participation is Optional)**
Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)	**Family Medicine & Internal Medicine:** 1. Ambulatory Care Sensitive Admissions 2. ~~Risk Adjusted Readmission Rate (RAR)~~ 3. Follow-up within 7 days after Hospital Discharge
Access and Operations	
All Practice Types: 1. Avoidable ED Visits 2. PCP Office Visits	**All Practice Types:** 1. Avoidable ED Visits 2. PCP Office Visits
Patient Experience	
All Sites: 1. Patient Experience	**All Sites:** 1. Patient Experience

2024 Measures	2025 Recommendations
Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Comprehensive Diabetes Care: HbA1c Control	**Internal Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Colorectal Cancer Screening
5. Controlling High Blood Pressure 6. Diabetes Management: Eye Exams	5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure 7. Diabetes Management: Eye Exams 8. Chlamydia Screening in Women (21-24yo) - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children 6. Chlamydia Screening in Women (16-20yo) 7. Well-Child Visits in the first 15-30 months of life 8. Topical fluoride in Children - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	**Programmatic Changes:** **I. Descriptions of Potential 2025 Measure Changes for Core Measurement Set** A. Change(s) to Existing Measures – Core Measurement Set i. Retire Risk Adjusted Readmission Rate (RAR) and replace with Follow-up within 7 days after Hospital Discharge. See rational in section I.B. B. Potential Additions as New Measures – Core Measurement Set i. Breast Cancer Screening (Family Practice & Internal Medicine: *Monitoring* for age group: 40-49yo) – In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024). Because members and providers are used to the recommendation to start at age 50 years, an adjustment period is indicated to allow member and provider to "get caught up" on screening of eligible members aged 40-49 years. For this reason, this new measure will be a monitoring measure only for 2025. All Primary Care Providers seeing members from the eligible population (all persons assigned as female at birth aged 40-74 years) should initiate screening now, in accordance with the guidelines. As the screenings are recommended for every other year, any screening done in 2025 will count for numerator compliance when the measure moves to an active measure in 2026 (anticipated). ii. Chlamydia Screening in Women (Family Practice: *Monitoring* for age groups: 16-24yo, Internal Medicine: *Monitoring* for age group: 21-24yo, Pediatrics: **Active** for age group: 16-20yo) – The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: "Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV". Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women) iii. Well-Child Visits in the first 15-30 months of life (Family Practice: *Monitoring* & Pediatrics: **Active**) – Members who turned 15 months and 1 day - 30 months old during the MY and had two or more well child visits. This measure will be separate from the W15. According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits. iv. Topical fluoride in Children (Family Practice & Pediatrics: *Monitoring*) – Age range will mirror HEDIS, 1-4yo, with a minimum of 2 applications per MY. This will be a 2025 monitoring measure for Family Medicine & Pediatrics. Topical fluoride varnish (TFV) application is recognized as one of the most effective strategies for preventing dental caries and improvement of oral health in all children (8). In addition to prevention, TFV has the potential to re-mineralize existing caries and halt the progression from caries to cavities. According to the CDC, the prevalence of untreated cavities (tooth decay) in the primary teeth of children (aged 2 to 5) from low-income households is about three times higher than that of children from higher income households. Young children are seen in primary care settings earlier and more frequently than in dental offices, making well child visits an ideal opportunity for early detection of caries and varnish application.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	v. Reduction of Inequity Adjustment – Participation is optional. Partnership HealthPlan of California (PHC) is actively engaged in HE initiatives that bring equitable awareness and result in improved quality performance within the 24 counties we serve. We highly encourage provider organizations to partner with us in these efforts and together, we can help move our communities toward equitable access to healthcare. In reviewing the performance of our clinical measures, we recognize there are underlying disparities among our member populations based on location, access and Social Determinants of Health (SDOH). To help our provider organizations with identifying and addressing disparities in their member populations, we have created the Disparity Analysis dashboard housed within eReports which promotes the identification of disparities across all PCP QIP clinical measures based on race/ethnicity groups. This new clinical measure will incentivizing participating sites with set dollar amount if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the main focus, followed by Childhood Immunization Status Combo 10, Immunization in Adolescents, Breast Cancer Screening & Colorectal Cancer Screening). The sites selected priority group must be performing below the 25th percentile in a particular measure of focus with the goal to improve performance by at least 20% or reaching the 50th percentile at the end of the measurement year. vi. Follow-up within 7 days after Hospital Discharge (Family Practice & Internal Medicine) – A readmission occurs when a patient is discharged from a hospital and then admitted back into a hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d). Inclusion of this measure and benchmark determination is supported in alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768). A follow up with a hospitalist, a primary care clinician or a specialist within a week after discharge from the hospital can help reduce readmissions back to the hospital. While this can be a struggle, a good strategy to attain this goal is to have a proper discharge summary which can be communicated with the follow-up provider. ***Questions*** **Will primary care clinics be expected to administer fluoride rather than dental offices?** This is a complicated measure because DHCS has held MCPs accountable for two dental fluoride varnish applications per year for all children under the age of 20, but there is also a separate standard related that requires four times per year, but most children only see the dentist twice in a year. DHCS is lacking this data. This measure is intended to address preventative dental care access. Partnership's CMO explained clinics have been providing treatment either in clinic or sending the treatment home with parents to administer. Partnership's Senior Director for Quality Improvement mentioned previous pilots where clinics were partnered with a registered hygienist in a primary care setting to teach medical assistants how to administer. The pilot revealed clinics preferred dental clinics administer because of access challenges in securing well child visits. Partnership could always go back to offering those in-services because we hired that registered hygienist to serve in the clinical quality side of our team, but it was not successful in some of the more rural health centers. Partnership's Medical Director reiterated the treatment could be done by a nurse and is not required of the physician.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	(B) Unit of Service Measures - Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites:	**All Sites:**
1. Advance Care Planning Attestations 2. Extended Office Hours	1. Advance Care Planning Attestations 2. Extended Office Hours
3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity 7. Blood Lead Screening 8. Dental Fluoride Varnish Use 9. Tobacco Use Screening 10. Electronic Clinical Data Systems (ECDS)	3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity ~~7. Dental Fluoride Varnish Use~~ 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS) 10. Early Administration of the 1st HPV Dose 11. Early Administration of Flu Initiation and Booster Doses 12. Academic Detailing

Descriptions of Potential 2025 Measure Changes for Unit of Service Measurement Set

A. Change(s) to Existing Measures – Unit of Service

i. Peer Led and Pediatric Group Visits – Expanding the qualifying pediatric well child group visit from exclusively Well-Child Visits in the First 15 Months to both Well-Child Visits in the First 15 Months and Well-Child Visits in the First 15-30 months of Life

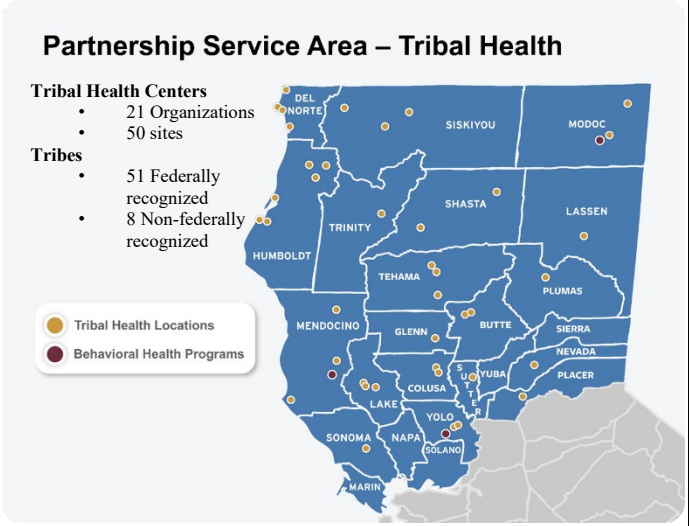
ii. Retired Dental Fluoride Varnish Use – In comparing Partnership's reporting to the State's DentiCal reporting, we have identified large gaps of discrepancies between the data. These discrepancies are not an accurate reflection of the services provided to the PCPs assigned patients and their overall performance. This is an opportunity for Partnership to continue to work with the State in ensuring we are receiving the most appropriate dental varnish application data for our members.

B. Additions as New Measures – Unit of Service

i. Academic Detailing - Medication management is an important component of disease state management, such as diabetes, hypertension, and asthma. Effective medication management requires the clinician and care team to have complete, accurate, and current data on pharmacy claims. PHC Pharmacy Academic Detailing partners clinicians with the PHC clinical staff to provide a review of actionable pharmacy claims data to address gaps in care such as medication non-adherence, suboptimal asthma medication therapy, and gap in statin therapy for people with diabetes and/or cardiovascular disease. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The purpose of this new unit of service measure is to incentivize provider organizations for hosting a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director.

AGENDA ITEM	DISCUSSION / CONCLUSIONS

V.A Undercounting of the American Indian Population	**Erasure**
	• Erasure of previous cultures and beliefs has occurred throughout history
	  ○ Settler or conqueror societies discount and eliminate the presence of indigenous peoples, cultures, and languages.
	  ○ Tools of erasure:
	  ▪ Massacre
	  ▪ Educational content
	  ▪ Framing in media/entertainment
	  ▪ Suppression of cultural practices
	  ▪ Suppression of language
	  ▪ Re-defining identity
	  ▪ Official census data collecting
	
	Consequences of Erasure
	• Lost with erasure:
	  ○ Cultural knowledge
	  ▪ Environmental stewardship practices
	  ○ History
	  ○ Religions, philosophies, and worldviews
	• Other consequences:
	  ○ Trans-generational trauma adversely impacts mental and physical health
	  ○ Loss of cultural identity impacts self-esteem
	  ○ Persistent discrimination
	
	Indigenous Erasure in the United States
	• Strategies for American Indian **erasure** have included:
	  ○ Genocide: large scale massacres of indigenous people
	  ○ Forcible removal of children to attend boarding schools, where they were not permitted to speak their native language
	  ○ Teaching of U.S. history that ignores Indian massacres
	  ○ Portrayal of American Indians in a stereotypical negative light in movies, TV
	  ○ Federal tribal termination policies of the 1950s and 1960s.
	  ○ 1870 Census definition of those of mixed Indian-white heritage, living off-reservations as white.



AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	

Systematic Undercounting of AI/AN

- In July, 2024 DHCS reported that, as of April 2024, there were:
- 14,981,547 Californians with Medi-Cal, but only 50,996 of them were classified as being Native American or Alaska Native:

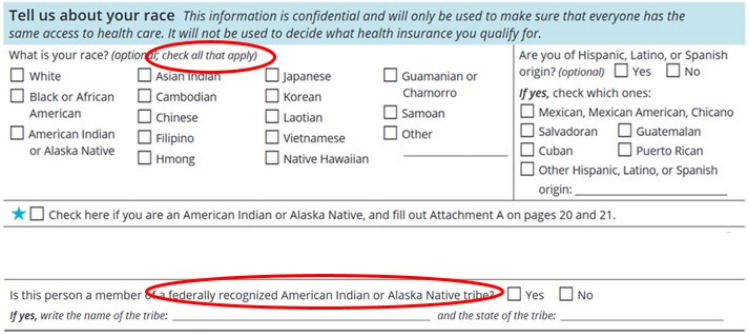
Race/Ethnicity	Number of Certified Eligibles	Percentage of Total
African-American	1,022,292	6.8%
American Indian/Alaskan Native	50,996	0.3%
Asian/Pacific Islander	1,393,671	9.3%
Hispanic	7,710,166	51.5%
Not Reported	2,408,724	16.1%
White	2,395,698	16.0%
Total	14,981,547	100.0%

Census Data Not Consistent with DHCS Data

- 2020 Census of the California population
  - 1.6% identified as AI/AN alone
  - Additional 2.0% identified as AI/AN in combination with some other race.
  - Total 3.6%
- If we assume the proportion of AI/AN with Medi-Cal is about the same as the population as a whole, then about 3.6% of the Medi-Cal population should be identified as AI/AN, not 0.3%.
- This represents a 12-fold undercounting. Put another way, the true number of AI/AN with Medi-Cal is 1200% higher than that presented by DHCS.
- This means the number of individuals state-wide with Medi-Cal who identify as fully or partly AI/AN is approximately 600,000 instead of 50,000.

Why is the DHCS number so low?

Better data is collected on 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.

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

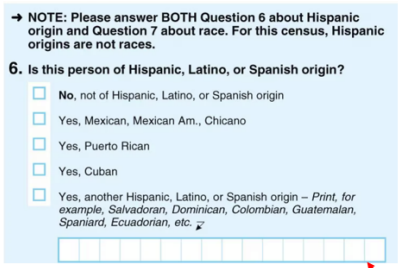
If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

DHCS Chooses One Race

- The membership file (834) DHCS sends to Health Plans associates just one race with each Medi-Cal enrollee. Of note Hispanic ethnicity is reclassified as a race.
- Here are the options:
  - White
  - Black
  - Hispanic (No subgroups included)
  - Asian Pacific Islander (specific subgroup is identified in membership file from 12 options)
  - Native American/Alaska Native
  - Unknown/Missing
  - Other
- The algorithm used by DHCS to determine which race is chosen is not transparent, but can be inferred.

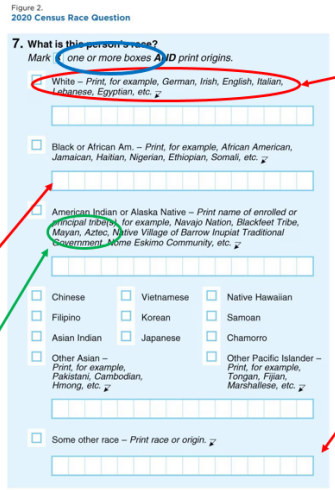
AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	

Race and Ethnicity in 2020 Census



Sixteen-letter maximum in text fields prevent describing more than one or two descriptions.

Indigenous individuals from outside the United States are encouraged to select a tribe, which classifies them in the American Indian category.



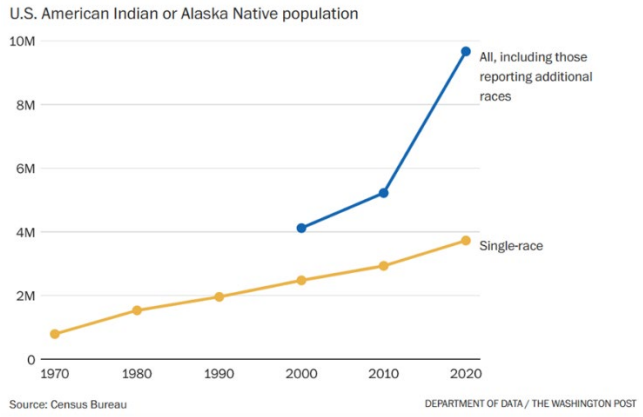
Multi-generation white Americans will write "American" instead of one or more groups from Europe/Middle East

Many Hispanics don't want to choose one of the race options, and so will write Hispanic or Mexican under some other race.

Examples

Medi-Cal Application	Census	DHCS Membership File
Race: AI/AN Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Yurok	Race: AI/AN and lists Yurok, Karuk, and Hupa tribes Ethnicity: non-Hispanic	Single Race: AI/AN Principle: Non-Hispanic ethnicity with only one race chosen.
Race: Other: Mexican Ethnicity: Hispanic: Mexican	Race: AI/AN: Aztec tribe Ethnicity: Hispanic: Mexican	Single Race: Hispanic Principle: Hispanic Status trumps any race choice
Race: White and AI/AN selected Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Round Valley	Race: White: German and AI/AN: Concow, Pomo (runs out of room so cannot include others) Ethnicity: non-Hispanic	Single Race: Other/Missing Principle: Non-Hispanic ethnicity with more than one race.

2020 U.S. Census



Sligly muddled counts of Native American origins

U.S. Native Americans, by self-reported origin, 2020

Search in table

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TRIBE OR ENTITY	SINGLE-ORIGIN	ALL
Aztec	387,122	583,981
Navajo Nation	315,086	423,412
Cherokee	214,940	1,513,326
Maya	180,359	300,519
Choctaw	69,454	255,557

Aztec and Maya added as specific Options in 2020

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	**Dividing up the AI/AN category** • Offering Aztec and Maya choices increased number of Latin American Indians identified • Increased self-identification of AI/AN mixed with other race • Census category of AI/AN might more properly be called Indigenous people of the Americas

Table 1.
American Indian and Alaska Native Alone and Alone or in Any Combination Regional Groups: 2010 and 2020

Regional group	Alone			Alone or in any combination		
	2010	2020	Percent change	2010	2020	Percent change
Alaska Native	120,260	133,311	10.9	166,120	241,797	45.6
American Indian	1,935,910	2,159,802	11.6	3,232,465	6,363,796	96.9
Canadian Indian	6,435	7,723	20.0	14,825	72,701	390.4
Latin American Indian	172,280	766,112	344.7	269,050	1,319,523	390.4

Note: The 2010 counts shown were created using 2020 processing and tabulation and may not match official counts from the 2010 Census. Information on suppression, confidentiality protection, nonsampling error, definitions and guidance on using the data are available at <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/detailed-demographic-and-housing-characteristics-file-a/2020census-detailed-dhc-a-techdoc.pdf>. The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and approved the disclosure avoidance practices applied to this release. CBDRB-FY23-POP001-0150.
Source: U.S. Census Bureau, 2010 Census special tabulation; 2020 Census Detailed Demographic and Housing Characteristics File A.

Another estimate of undercounting
The 2021 American Community Survey (a random sample from across the country) framed the questions differently, not including indigenous people from outside the United States. It calculated that 330,959 individuals have Medi-Cal, which is 660% higher than official estimates, but less than the 600,000 extrapolated from the U.S. Census.

Impact of undercounting AI/AN
- Erroneous framing in Native and non-Native populations
- Insufficient prioritization of policies
- Inequitable resource allocation
- Incorrect conclusions drawn from invalid data

Resolving Over Counting
- New OMB 2024 standard for categorizing race/ethnicity
  - Must be implemented by 2029 at the latest
  - The Middle-eastern/north African population was carved out of the white category.
  - Moves Latino/Hispanic to be a co-equal race/ethnicity category, instead of carved out ethnicity category
    - This will solve the Hispanic over counting issue
  - Anticipated result: Less Hispanic race, more of all other categories.
  - Official options for categorizing individuals who select more than one race
    1. "Alone or in combination" *(intermediate complexity, less granular analysis possible)*
    2. "Most frequent multiple responses" *(most complex to convey and analyze)*
    3. "Multiracial" categorized as "other" or "mixed" *(simplest but least useful for analysis)*
  - Tribal Consultation was not done to select the current method of conveying racial data.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	**DHCS Remedies** • Since it has such a large impact on the American Indian data, formal Tribal Consultation should be done before a decision is made. • Partnership recommends: o DHCS should adopt the "Alone or in combination" option for categorizing data. o Share detailed ethnicity data with Managed Care plans at least monthly. o Develop framework for analyzing racial disparities/inequities using more inclusive racial categories. • Urgency: o Undercounting is a health inequity, a form of structural racism. o New Federal Standards offer an opportunity to change the standard for sharing racial data. o Tribal consultation should be done early in this decision-making process, especially if there is significant controversy and major implications of the policy *DHCS announced a plan to offer data to the health plans through a new product called MediCal Connect, for which Partnership has enrolled for the pilot. The data is expected sometime in 2025. Partnership asked for a one-time, preliminary data feed for the raw data on multi-racial patients so Partnership data analytics team can begin to evaluate. These federal standards are beginning to come down and health centers will need to be mindful of electronic health records and the data contained.* ***Questions*** **Are Hawaiians considered AN/AI?** No. Hawaiian natives are classified with Pacific Islanders.
VI. Adjournment	
PAC adjourned at 9:02 a.m.	**Next PAC on Wednesday, October 9, 2024 at 7:30 a.m. Brown Act flexibilities have ended.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on 11/13/24
Date

Colleen Townsend MD
Colleen Townsend M.D., Committee Chairperson (Acting)

The foregoing minutes were APPROVED WITH MODIFICATION on _____
Date

_____
Colleen Townsend M.D., Committee Chairperson (Acting)