PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (20)

Steve Gwiazdowski, M.D. (Chair)	Chris Myers, D.O.	John McDermott, FNP-PAC	Michele Herman, M.D.
Angela Brennan, D.O.	Christina Lasich, M.D.	Karen Sprague, MSN, CFNP	Mills Matheson, M.D.
Brent Pottenger, M.D.	Danielle Oryn, D.O.	Karina Gookin, M.D.	Mustafa Ammar, M.D.
Candy Stockton, M.D.	Darrick Nelson, M.D.	Malia Honda, M.D.	Teresa Shinder, D.O.
Chester Austin, M.D.	Derice Seid, M.D.	Matthew Zavod, M.D.	Vanessa Walker, D.O.

Partnership Executive Staff:

Sonja Bjork, Chief Executive Officer
Jennifer Lopez, Chief Financial Officer
Wendi Davis, Chief Operating Officer
Amy Turnipseed, Chief Strategy & Government Affairs Officer
Robert Moore, MD, MPH, Chief Medical Officer
Katherine Barresi, RN, Chief Health Services Officer
Mark Bontrager, Sr. Director of Behavioral Health
Tina Buop, Chief Information Officer

Regional Medical Directors	Region	Region Directors
Jeffrey Ribordy, MD	Eureka - Del Norte, Humboldt, Mendocino & Lake	Vicky Klakken
Bradley Cox, DO	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Tim Sharp
Colleen Townsend	Fairfield - Napa, Yolo & Solano	Kathryn Power
Lisa Ward, MD	Santa Rosa - Marin & Sonoma	Leigha Andrews
R. Doug Matthews, MD	Chico - Glenn, Butte, Sutter, Colusa & Yuba	Rebecca Stark
Matthew Morris, MD	Auburn - Plumas, Sierra, Nevada & Placer	Jill Blake

Kermit Jones, MD, Medical Director for Medicare Services
Jeffrey DeVido, MD, Behavioral Health Clinical Director
Mark Netherda, MD, Medical Director of Quality Improvement

Directors / Managers / Associate Directors

Nancy Steffen, Senior Director, Quality & Performance Improvement
Mary Kerlin, Senior Director, Provider Relations
Brigid Gast, RN, Senior Director, Care Management
Stan Leung, Pharm.D., Director., Pharmacy Services
Mohamed Jalloh, Pharm.D., Director of Health Equity
Lisa O'Connell, Director, Enhanced Health Services
DeLorean Ruffin, DrPH, Director, Population Health Management
Heather Esget, RN, Director of Utilization Management
Margarita Garcia-Hernandez, Director, Health Analytics
Kristine Gual, Director, Quality Measurement
Ledra Guillory, Senior Manager, Provider Relations Reps.
Amy McCune, Manager, Quality Incentive Programs
Sue Quichocho, Manager, Quality Measurement
Kevin Jarrett-Lee, RN, Assoc. Dir. of Utilization Management
Marshall Kubota, Associate Medical Director
Bettina Spiller, MD, Associate Medical Director
Teresa Frankovich, MD, Associate Medical Director

cc: Partnership Commission Chair
Kim Tangermann, Partnership Board Chair

FROM: PAC@partnershipHP.org
DATE: March 7, 2025

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

The Physician Advisory Committee will meet as follows and will continue to meet the second Wednesday of every month (July and December are tentative.) Please review the Meeting Agenda and packet, as discussion time is limited.

DATE: Wednesday, March 12, 2025 **TIME: 7:30 a.m. – 9:00 a.m.**

HOSTING LOCATIONS

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding
2525 Airpark Drive
Redding, CA

Partnership – Eureka
1036 5th Street
Eureka, CA

Partnership - Auburn
281 Nevada St.
Auburn, CA 95603

Partnership - Chico
2760 Esplande, Suite 130
Chico, CA 95973

Marin Community Clinic
3260 Kerner Blvd.
San Rafael, CA 94901

Sutter-Roseville
6 Medical Plaza
Roseville, CA 95661

Tahoe Forest Health Systems
10976 Donner Pass Rd., Suite 9
Truckee, CA 96161

Office of Dr. Mills Matheson
1245 S. Main St.
Willits, CA 95490

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

Please contact Partnership's Executive Assistant to the Chief Medical Officer with additional questions at (707) 863-4228, or e-mail pac@partnershiphp.org.

REGULAR MEETING OF PARTNERSHIP HEALTHPLAN OF CALIFORNIA'S PHYSICIAN ADVISORY COMMITTEE (PAC) - AGENDA

Date: March 12, 2025 Time: 7:30 – 9:00 a.m. Location: Partnership

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa Office
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding Office
2525 Airpark Drive
Redding, CA

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Eureka, CA

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1245 S. Main St.
Willits, CA 95490

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

PUBLIC COMMENTS			**Speaker**		**2 minutes**
			Speaker		**2 minutes**
This Brown Act meeting may be recorded. Any audio or video tape record of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.					
Welcome / Introductions					
I.		**STATUS UPDATES**	**LEAD**	**PG**	**TIME**
A.	**I**	**Chief Executive Officer Administration Updates**	**Ms. Bjork**		**7:35**
B.	**I**	**Chief Medical Officer Health Services Report**	**Dr. Moore**		**7:45**
C.	**I**	**Regional Medical Director Reports**	**LEAD**	**PG**	**TIME**
1	**I**	Napa, Yolo & Solano	**Dr. Townsend**		**7:55**
2	**I**	Marin & Sonoma	**Dr. Ward**		**7:58**
3	**I**	Del Norte, Humboldt, Mendocino & Lake	**Dr. Ribordy**		**8:01**
4	**I**	Glenn, Butte, Sutter, Colusa & Yuba,	**Dr. Matthews**		**8:04**
5	**I**	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	**Dr. Cox**		**8:07**
6	**I**	Plumas, Sierra, Nevada & Placer	**Dr. Morris**		**8:10**
II.	*I*	*NEW MEMBER INTRODUCTION*	*LEAD*	*PG*	*TIME*
III.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	**A**	**Review of February 12, 2025 PAC Minutes**	**Dr. Gwiazdowski**	**5**	**8:13**
B.	**A**	**Consent Review: Agenda Items III. B.1, B.2, B.5 and B.7** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Gwiazdowski**	**14 - 75**	**8:15**
1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – February 19, 2025** ***Acceptance of Draft Meeting Minutes:*** • Q/UAC Agenda • Q/UAC Activities & Minutes • Internal Quality Improvement Meetings February 11, 2025 Quality Improvement Update – February 2025 ***Special Presentations*** *(for reference only, not included in packet)* • 2023 Complex Case Management Program Evaluation Report • 2023 Complex Case Management Program Evaluation Presentation	**Dr. Gwiazdowski**	**14** **16** **30** **41**	**8:15**

<table>
<tr><th>III.</th><th>A</th><th>MOTIONS CONTINUED</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>B.</td><td>A</td><td>Consent Review: Consent Review: Agenda Items III. B.1, B.2, B.5 and B.7</td><td>Dr. Townsend</td><td></td><td>8:15</td></tr>
<tr><td>2</td><td>C</td><td>Policies/Procedures/Guidelines for Action
<table>
<tr><th colspan="2">Quality Improvement</th></tr>
<tr><td>MPQP1022</td><td>Site Review Requirements and Guidelines</td></tr>
<tr><td>MPQG1005</td><td>Adult Preventive Health Guidelines</td></tr>
<tr><td>MPQP1016</td><td>Potential Quality Issue Investigation and Resolution</td></tr>
<tr><th colspan="2">Care Coordination</th></tr>
<tr><td>MCCP2020</td><td>Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)</td></tr>
<tr><td>MCCP2021</td><td>Women, Infants and Children (WIC) Supplemental Food Program</td></tr>
<tr><td>MPCD2013</td><td>Care Coordination Program Description</td></tr>
<tr><th colspan="2">Utilization Management</th></tr>
<tr><td>MCUP3064</td><td>Communications Services</td></tr>
<tr><td>MCUP3103</td><td>Coordination of Care for Child Welfare-Involved Members</td></tr>
<tr><td>MPUG3011</td><td>Criteria for Home Health Services</td></tr>
<tr><td>MPUG3019</td><td>Hearing Aid Guidelines</td></tr>
<tr><td>MPUP3048</td><td>Dental Services (including Dental Anesthesia)</td></tr>
</table>
All versions linked within Policy Summary (See page 53)
• Policy Summary
• Detailed Synopsis of Changes</td><td></td><td>53
54</td><td>8:15</td></tr>
<tr><td>3</td><td>C</td><td>Pharmacy & Therapeutics Committee</td><td>Dr. Stan Leung</td><td></td><td></td></tr>
<tr><td>4</td><td>C</td><td>Provider Engagement Group (PEG) Report</td><td>Ms. Kerlin</td><td></td><td></td></tr>
<tr><td>5</td><td>C</td><td>Credentials Committee Meeting
• Summary, January 8, 2025
• Credentialed List, January 8, 2025</td><td>Dr. Netherda</td><td>59
62</td><td>8:15</td></tr>
<tr><td>6</td><td>C</td><td>Pediatric Quality Committee</td><td>Dr. Ribordy</td><td></td><td></td></tr>
<tr><td>7</td><td>C</td><td>Quality Improvement Health Equity Committee
• Meeting Minutes, January 21, 2025</td><td>Dr. Jalloh</td><td>65</td><td>8:15</td></tr>
<tr><td>C.</td><td>A</td><td>Physician Advisory Committee Membership
• Nomination of Dr. Brett Pottenger to Credentials Committee</td><td>Dr. Gwiazdowski</td><td>75</td><td>8:17</td></tr>
<tr><td>IV.</td><td>I</td><td>Old Business</td><td></td><td></td><td></td></tr>
<tr><td>V.</td><td></td><td>SPECIAL PRESENTATIONS</td><td>LEAD</td><td>PG</td><td>TIME</td></tr>
<tr><td>A.</td><td>I</td><td>Workforce Development Update</td><td>Mr. Lavine</td><td>76</td><td>8:20</td></tr>
<tr><td>VI.</td><td>I</td><td>ADJOURNMENT</td><td>LEAD</td><td></td><td>9:00</td></tr>
<tr><td></td><td></td><td>Next PAC on March 12, 2025 at 7:30 a.m.</td><td>Dr. Gwiazdowski</td><td></td><td></td></tr>
</table>

This agenda contains a brief description of each topic for consideration. Except as provided by law, no action shall be taken on any topic not appearing on the agenda.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular committee meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The committee has designated the Executive Assistant to the Chief Medical Officer as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection.

The Physician Advisory Committee Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all Partnership regional offices (see locations under the Meeting Notice). It can also be found online at the Physician Advisory Committee webpage, linked below.

https://www.partnershiphp.org/Providers/HealthServices/Pages/Physician-Advisory-Committee.aspx

In compliance with the Americans with Disabilities Act (ADA), Partnership meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Executive Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (707) 863-4228 or by email at pac@partnershiphp.org. Notification in advance of the meeting will enable Partnership to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

Land Acknowledgment: Partnership HealthPlan 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.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **February 12, 2025 - 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:	Steven Gwiazdowski, MD *(FF)* Angela Brennan, DO *(FF)* Teresa Shinder, DO *(FF)* Brent Pottenger, MD *(FF)* Michele Herman, MD *(FF)* Karen Sprague, MSN, CFNP *(FF)*	Matthew Zavod, MD *(FF)* Suzanne Eidson-Ton, MD *(FF)* Malia Honda, MD *(SR)* John McDermott, FNP *(C)* Derice Seid, MD *(MCC)*	Christina Lasich, MD *(OMM)* Mills Matheson, MD *(OMM)* Darrick Nelson, MD *(R)* Vanessa Walker, DO *(SH)* Chris Myers, MD *(E)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn*	*MCC Marin Community Clinics* *OMM Office of Dr. Matheson* *SH Sutter Health*
Members Excused:	Candy Stockton, MD Karina Gookin, MD	Mustaffa Ammar, MD			
Members Absent:	Chester Austin, MD	Danielle Oryn, DO			
Visitor:	Melanie Ridley				

Partnership Staff:	Sonja Bjork, Chief Executive Officer Jennifer Lopez, Chief Financial Officer Wendi Davis, Chief Operating Officer Leigha Andrews, 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, Director, Quality Measurement Isaac Brown, Director, Quality Management Mohamed Jalloh, Pharm.D., Director, Health Equity Megan Shelton, Project Manager, Quality Improvement DeLorean Ruffin, DrPH, 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	16/21 – PAC	Committee quorum requirements met (16).	02/12/25

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

I.A. Chief Executive Officer Administration Updates	**Partnership's Fairfield Regional Director provided the following report on Partnership activities on behalf of Partnership's Chief Executive Officer.**
	
	• The Physician Advisory Committee Chairperson, Dr. Steven Gwiazdowski, was presented with a plaque commemorating his honorable mention for an award from Association for Community Affiliated Plans (ACAP) for advocacy and leadership.
	• **Partnership submitted the Medicare application on February 12, 2025**, which includes information about the model of care, network, organizational structure, benefits, and services provided under the dual-eligible special needs program (D-SNP).
	  • If accepted, members may begin applying in October 2025.
	  • Coverage begins January 1, 2025 in eight counties within Partnership's network.
	• **Department of Health Care Services (DHCS) Audit Results**
	  • Partnership fared very well in the audit with only two or three findings. The final report will be released sometime in the spring.
	• **Monitoring Medicaid for Potential Administrative Changes**
	  • Partnership is keeping a close eye on policy developments, executive orders, presidential appointments, and other proposed federal changes that are likely to have big impacts on our healthcare delivery system and how our members receive care.
	  • Partnership's CEO is attending a meeting in Washington D.C. with the other safety net health plans advocating for Medicaid protections and to demonstrate to our congressional representatives how some of these proposed changes could negatively affect our vulnerable members.
	  • Federal Medical Assistance Percentage (FMAP) is how the federal government calculates the allocation of matching federal funds to the states for Medicaid programs. Any changes to this formula, such as reducing the percentage of the federal match, would likely have a sizable impact on how Medicaid is funded in all 50 states.
	  • Block grant changes could change the payment mechanism from the formula based on cost to a set amount of dollars per state that does not consider the specific needs of the population. Like FMAP, block grants have the potential to greatly reduce the amount of federal Medicaid funds that flow into California.
	  • Demonstration waivers, such as the 1115 waiver that allowed for 30 different programs under California Advancing and Innovating Medi-Cal (CalAIM), are pilots the state gets approved by the federal government to test changes and new programs to the Medicaid program. The federal government could revoke these waivers at any time, which -if implemented- could cause programs to halt operations and cancel those which have not started. Revoking these waivers would require California and other states to make difficult decisions to continue to fund if federal funds are not available.
	  • Partnership's Chief Financial Officer shared her prior experiences and wants the community to feel rest assured Partnership is prepared to face challenges as they come. Although nothing has been confirmed, it is important that the Physician Advisory Committee is tracking the potential risks that could potentially affect the health care delivery system.
	  • These trends are seen across the network.
	  • Patients are cancelling appointments or disenrolling from MediCal due to immigration related concerns.
	  • Increased no-show rates for appointments at clinics with significant immigrant populations.
	  • Increased demand for telehealth for privacy reasons
	  • Increased requests for 90 days of medication over monthly refills.
	  • Partnership is responding to trends in the following ways:
	  • Examining how to leverage and expand telehealth options
	  • Promoting transportation program to transport members to and from appointments
	  • Reactivating Member Resource page
	  • Training front-line staff to be familiar with rights to help members navigate legal resources
	
	Questions
	Will Medicare allow direct telehealth?
	Partnership will consult with policy analysts and follow up with an answer at a later time.

AGENDA ITEM	DISCUSSION / CONCLUSIONS

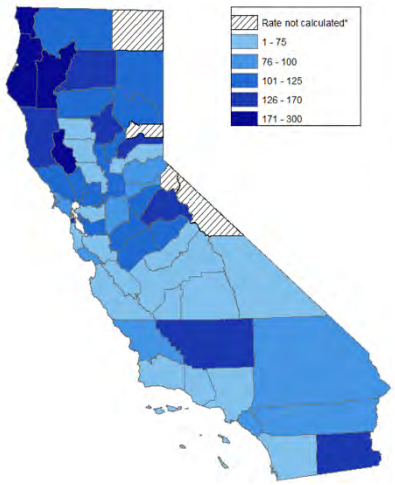
I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services.**
	
	• **State Government Actions**
	  • Senate Bill 228, sponsored by Senator Cervantes, would move responsibility for Comprehensive Perinatal Services Program (CPSP) from the California Department of Public Health (CDPH) to DHCS.
	  • Assembly Bill 55, introduced by Assembly Member Bonta, would change the licensing for requirements for alternative birthing centers, no longer requiring CPSP programs, and also change some other standards currently in place. There are only three licensed alternative birthing centers operating in California right now because the licensing requirements are so difficult to achieve.
	  • Senate Bill 669*, introduced by Senator McGuire, to allow standby perinatal units to discontinue the need for multiple obstetrical nurses and staff to be continuously staffed regardless of volume. Partnership has been working California Hospital Association to draft language and honored to have Senator McGuire's support. **At the time of February PAC meeting, the bill had not yet been assigned a number. SB669 was later assigned.*
	  • DHCS released the Birthing Care Pathway listing a large number of initiatives. Of note, dietic services will now be payable at a fee for service rate for pay per service (PPS) providers in addition to the PPS rate.
	• **Quality Improvement Updates**
	  • Identified mechanism to capture rates of dental fluoride treatment administered by Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal Health Center dental clinics.
	  • Special permission has been granted to allow diagnosis ICD-10 code Z29.3.
	  • Partnership will begin a large campaign with providers to begin billing for this code and will be holding a webinar for pediatric providers.
	  • Partnership has noticed a large decline in pediatric vaccinations rates, primarily for the influenza vaccine. The rates have continued to decline over the last two years. Any providers are welcome to contact Partnership's CMO to discuss insights on vaccine hesitancy and ways to improve rates.

I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • Solano County Health and Social Services appointed Emery Cowan as the new director. • Dr. Suzanne Eidson-Ton will be departing Communicare+Ole. A new CMO has not been selected. • Adventist Health is also in need of a CMO.
I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Marin Community Clinics and Alliance Medical Center are recruiting for a new CMO. • Vaccination rates have decreased. • Partnership's former Regional Medical Director, will be reducing hours and taking on the role of Associate Medical
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.** • Providence Gastroenterologists (GI) will only take referrals from Providence Primary Care Physicians (PCPs). • Specialty access in the are remains constrained. • Many rural clinics in Mendocino County are echoing concerns about Medicare funding and sharing apprehensions about rights and responsibilities in light of potential Immigration and Customs Enforcement (ICE) raids. The California Medical Association (CMA) provided guidance, but uncertainties remain. • Influenza A is spreading throughout the community. There have been more deaths caused by complications of the flu than there have been from COVID.
I.C.4. Status Update, Regional Medical	**Partnership's Regional Director for Glenn, Butte, Sutter, Colusa, Nevada, and Placer Counties presented a brief update on activities.** • Valley counties are experiencing substantial flooding. Oroville evacuated patients to Yuba and Sutter Counties. • Peach Tree Health in the Yuba-Sutter region appointed Michelle Woodward as interim Chief Administrative Officer. • Workforce Development is seeing an aging workforce in the area and concerned about access as providers may retire.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
I.C.5. Status Update, Regional Medical	**Partnership's Regional Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Delivered sleeping bags and tents to Tehama County. • Mountain Valley Health Center in Weed, CA will be closing down for renovations on March 15, 2025 and temporarily moving to Mount Shasta, CA. • Northeastern Rural Health Clinic in Lassen County is recruiting a new CEO. • The Shasta County Board of Supervisors is hiring a consultant to assess the physician workforce gap.
II.A New Member Introduction	**Partnership's new Santa Rosa Regional Medical Director introduced herself to the committee.** Dr. Lisa ward is Board Certified Family Physician who has been practicing in Sonoma and Marin Counties for 15 years. She has worked closely with Marin Community Clinics and Adventist Health and is happy to be at Partnership.
II.B New Member Introduction	**Partnership's new Auburn Regional Medical Director introduced himself to the committee.** Dr. Matthew Morris is originally from Oklahoma and went to Oklahoma State and then Oklahoma University for medical school. Dr. Morris served his residency at the University of Iowa. He is a Board Certified Family Physician with additional training in psychiatry. He served as the medical director for the Iowa Department of Corrections Healthcare System prior to moving to California. He is passionate about serving the underserved patient population. Upon moving to California, he was the CMO at Western Sierra Medical, an FQHC. He is passionate about serving the underserved patient population and continuing that work at Partnership.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	**January 2025 PAC minutes were presented for approval.**	**MOTION:** Dr. Herman moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Brennan. **ACTION SUMMARY:** [16] yes, [0] no, [0] abstentions.	02/12/25 Motion carried.
III.B. ▪ III.B.1 ▪ III.B.2 ▪ III.B.3 ▪ III.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – January 2025 • Policies, Procedures, and Guidelines for Action Policy Summary February 2025 • Pharmacy and Therapeutics Committee Minutes Approved Criteria, January 16, 2025 • Credentials Committee Meeting Minutes and Credentialed List, December 11, 2024	**MOTION:** Dr. Pottenger moved to approve Agenda III.B.1, III.B.2, III.B.3 and III.B.5, as presented, seconded by Dr. Zavod. **ACTION SUMMARY:** [16] yes, [0] no, [0] abstentions.	02/12/25 Motion carried.
III.C	• Dr. Suzanne Eidson-Ton's resignation from PAC	**MOTION:** Dr. Herman moved to approve Agenda III.C as presented, seconded by Dr. Brennan. **ACTION SUMMARY:** [16] yes, [0] no, [0] abstentions.	02/12/25 Motion carried
IV. A Old Business	*None*		

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Reducing Barriers to Hepatitis C Treatment in Humboldt County, An Innovative Approach to Person-Centered Care	**Dr. Malia Honda presented her California Health Care Foundation leadership fellowship Community Health Improvement Project (CHIP).** **Reducing Barriers to Hepatitis C Treatment in Humboldt County, An Innovative Approach to Person-Centered Care**



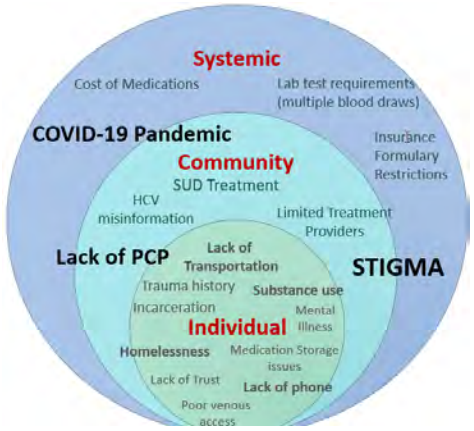
New cases of hepatitis C were disproportionately affecting younger people, especially those experiencing homelessness and addiction, as well as indigenous communities and people experiencing incarceration. Geographically, Northernmost California and other rural Northwestern regions were recognized as having some of the highest rates of new infection in the state, increasing every year. Humboldt County's Hep C rate is at least three times the state average and has increased significantly since 2000. With only two treatment providers in the county, physicians faced many challenges. Dr. Honda wanted to be part of the solution.

<u>Why we should care about Hepatitis C</u>
Curable – 97% cure rate
Cost-effective - $16K per person per year, $1.5B annually
Cases are Climbing.

Fifteen years ago, Hepatitis C accounted for nearly 50% of liver transplants in the US and treatment options were limited to aggressive medications that worked only half the time. Today, thanks to revolutionary drugs known as direct acting antivirals, it is a curable disease with only a few short months of treatment.

It is estimated that curing a single hepatitis C patient saves nearly $16K per year, which if we were to include all HCV+ patients in the US, equates to $1.5 billion in healthcare savings annually!

<u>Complexities of Challenges Facing Patient Care</u>



Dr. Honda first met Abbie in early 2020, when Abbie came to seek Hepatitis C treatment. It was not the first nor second time she had tried to get rid of this virus. Abbie was diagnosed several years prior but experienced a multitude of challenges every time she tried to get care. For insurance to approve the costly medications, she needed abdominal imaging, frequent and reliable follow-up, and numerous blood draws, where each time she felt guilty and ashamed because her scarred veins made it difficult for the lab team to obtain the needed samples. Dr. Honda recall yellow-tinged eyes and skin, and distended fluid-filled abdomen – signs of decompensated liver disease and a health system that had failed her. In that first visit, Dr. Honda learned much about Abbie's life and struggles with addiction, homelessness, trauma, and loss.

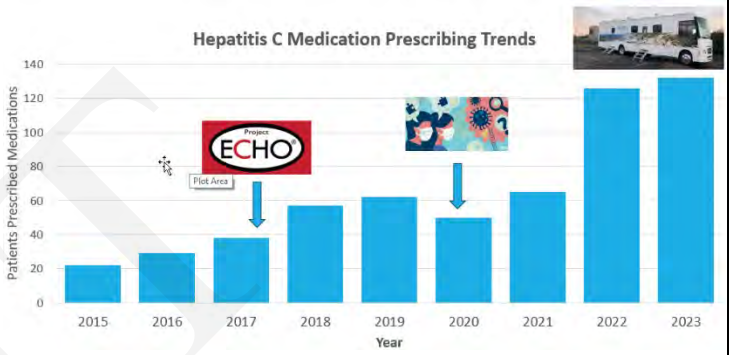
Without specialty care locally or any means to travel out of the area, treating her Hepatitis C and opioid use disorder were likely to be her best chances at survival. Dr. Honda ordered an updated set of labs and scheduled her a follow up appt, both knowing without a phone or car, the likelihood of her making it in were slim. The COVID lockdown occurred a few weeks later and she was lost to follow up amidst the chaos of those early pandemic months.

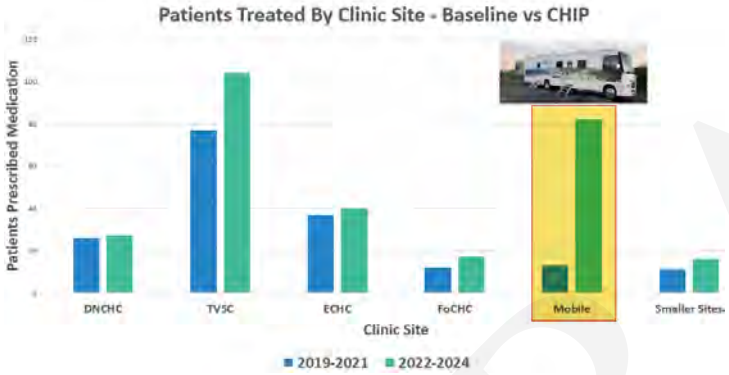
The challenges that Abbie faced are common. Complex barriers stacked against the people most affected by hep c are not solved by increased access alone. Ranging from large systemic barriers such as insurance formularies and medication cost – to more personal daily experiences of homelessness, substance use, incarceration, and mental illness. Expecting people to overcome these obstacles and show up to medical appointments is unrealistic. They deserve better. A way to challenge the usual model of care and a program designed that focused on what each person needs to be successfully treated was needed.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Reducing Barriers to Hepatitis C Treatment in Humboldt County, An Innovative Approach to Person-Centered Care, Continued	How Might We reduce transportation and access barriers for patients living with chronic Hep C by bringing screening and treatment services to places they are already seeking care? Dr. Honda received grant funding from the state in 2022 to build this person-centered program in collaboration with the county public health dept. The outcome objective was simple - increase treatment engagement by 50% within the first two years. **<u>Where do People Living with Hep C Engage in Care or Services?</u>** Given the strong association with injection drug use, Dr. Honda focused on partnering with agencies serving people experiencing homelessness and addiction – the local methadone clinic (AEGIS), mobile syringe exchange (HACHR), residential treatment centers, homeless shelters, and encampments. She conducted her CHIP interviews with county health officers, addiction specialists, street medicine experts, clinical staff, and many patients to inform her as the program that put patient needs and circumstances at the center of our delivery model was built. After obtaining buy-in and participation from these community organizations, her team developed several strategies to bring care out of our four clinic walls directly to patients. First, they expanded mobile clinic services to provide co-located care at the methadone clinic, where most clients access care daily and maintained hep c treatment access at other sites by ensuring all providers received training and mentorship if needed. In areas where the mobile clinic was not accessible, they leveraged telehealth with Dr. Honda and other dedicated providers to be available on-demand every day through video and phone visits. Arguably, one of the most impactful interventions was our peer HCV navigator, Susan (similar role to a Community Health Worker(CHW)) and the county public health hep c care coordinators. Collectively, they brought a depth of understanding and empathy for what patients were suffering with and were able to build a trusting relationship almost immediately. Susan's presence allowed people to bring their whole selves to the treatment process and address their needs with dignity and humanity - whether it be socks, a meal, or simply a listening ear – she was the link that was needed, and her impact is evident in our results. **<u>Results</u>** Dr. Honda used medication prescribing as the metric for treatment engagement – as this reflected a successful connection between patient and provider. Looking back over prescribing trends in the last decade, there was a small but significant increase in 2018, when we partnered with UCSF Project ECHO to increase treatment capacity and train and additional 25 local provider to treat hep c. We saw an expected dip in 2020 due to COVID the pandemic. ❖ *"I love that **you brought your office to the street**!"* ❖ *"I take the bus here every morning for **1.5 hours each way to get my methadone**. There is no way I would have gotten treated if you weren't here."* ❖ *"Thank you for **treating me like a person and not an addict**. I always worry about how I'll be treated when I go to doctors' appointments."*

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Reducing Barriers to Hepatitis C Treatment in Humboldt County, An Innovative Approach to Person-Centered Care, Continued	

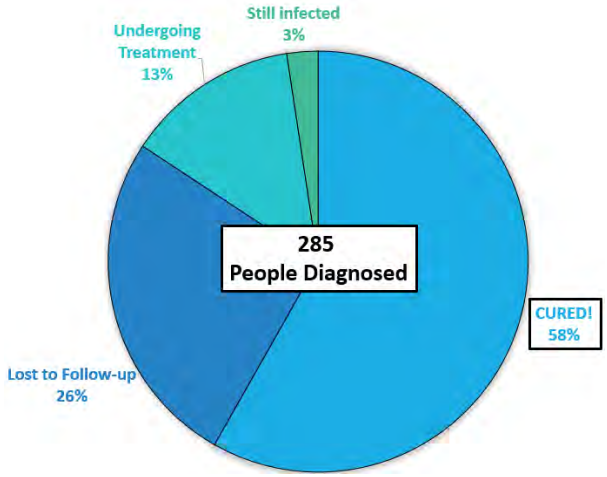
The outcome objective for this program was to increase treatment engagement by 50%; in 2022 and 2023, the numbers more than doubled! Without a doubt, the effort to reduce barriers to care was working.





This graph demonstrates a comparison of treatment numbers at different sites before and during the grant period. These first three sites have always been access points for hep c referrals, which stayed fairly consistent. The main takeaway is the profound increase in treatment through our mobile van services, which jumped from 13 patients in 2018-2020 to 82 patients in the last two years.

Clinically, the more relevant question is whether these patients successfully made it through treatment and were ultimately cured of their disease. Of the 285 people we've diagnosed since the program started, 58% have been cured, 13% are still undergoing treatment, and 3% have not yet engaged in treatment. 26% are people who started treatment but were unfortunately lost to follow up. Unable to be reached by phone and often with no address, they hope to run into them again through ongoing outreach efforts.



AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Reducing Barriers to Hepatitis C Treatment in Humboldt County, An Innovative Approach to Person-Centered Care, Continued	**Lessons Learned** • Every person treated is a HUGE success! • Power of Peer Navigation • Activism in Practice • CHIP Obstacles Abbie's story served as a good reminder that every person treated is a huge success. With the peer navigation paired with low barrier/on-demand access to care, Dr. Honda and the Open Door team have been able to extend the reach far beyond what was previously possible. The barriers are still there – many people still lack primary care, housing, transportation, and phones – but by linking to care through Hep C treatment, other doors may open to address these issues as well - "activism in practice." Dr. Honda and Open Door have encountered many obstacles in the last two years – staff turnover of several key players on our team as well as the organizations we collaborated with, invisible bureaucratic red tape, harsh weather conditions, and harsh state government policies negatively impact unhoused patients. Maintaining a consistent voice of purpose and vision; bringing stories like Abbie's out of the shadows and into our everyday line of sight, Dr. Honda's team remained motivated, found opportunities in hardship, and continued growing and learning together. **What is next?** There is still plenty of work to be done to eradicate Hep C from Humboldt County. Dr. Honda's CHIP was focused primarily on people experiencing homelessness and addiction. Dr. Honda received funding for $100K per year for three more years to reach other vulnerable populations disproportionately affected by hepatitis C. Dr. Honda works and live in the indigenous homeland of many native tribes, including Wiyot, Hoopa, Yurok, and Karuk, each with unique historical, cultural, and geographic complex barriers to care. Replicating our peer navigation/low barrier model may help build trust and address this pervasive inequity. Additionally, it is estimated that about 1 in 3 incarcerated individuals tests positive for Hep C. With the CalAIM Justice-Involved initiative in 2025, they will have the opportunity to expand treatment access for people experiencing incarceration. They are confident that with the current momentum and further expansion, they will curb the trajectory of Hep C rates in Humboldt County and improve the health of the community overall. Dr. Honda shared her gratitude to the following organizations and individuals: • Open Door Hep C Team • Community Partners • Patients (esp. Abbie) • CHCF Leadership Fellowship Cohort 22 • Leaders Among the Redwoods Pod • Her Family

VI. Adjournment	
PAC adjourned at 8:48 a.m.	**Next PAC on Wednesday, March 12, 2025 at 7:30 a.m. Brown Act flexibilities have ended.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____ _____

Date **Steve Gwiazdowski, M.D., Committee Chairperson**

The foregoing minutes were APPROVED WITH MODIFICATION on _____ _____

Date **Steve Gwiazdowski, M.D..., Committee Chairperson**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: Feb. 19, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville, CA 95901

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Jan. 15 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 17
2	*Acknowledgment and acceptance of draft* • Jan. 7 Internal Quality Improvement (IQI) Committee Meeting Minutes • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee Minutes • Jan. 21 Quality Improvement Health Equity Committee (QIHEC) Minutes • Nov. 19, 2024 QIHEC Approved Minutes			19 - 95
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:35	97 - 108
2	HealthPlan Update	Robert Moore, MD	7:40	--
III.	**Old Business**			
	None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:45	109
	Care Coordination Policies			
	MCCP2020 – Lactation Policy and Guidelines			111 - 118
	MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program			119 - 121
	Utilization Management Policies			
	MCUP3064 – Communication Services			123 - 125
	MPUG3011 – Criteria for Home Health Services			126 - 130
	MPUG3019 – Hearing Aid Guidelines			131 - 138
	MPUP3048 – Dental Services (including Dental Anesthesia)			139 - 144

	Item	Lead	Time	Page #
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			145 - 149
	Quality Improvement			
	MCQP1022 – Site Review Requirements and Guidelines – **NEW Attachment I** *begins on p. 467*	Rachel Newman, RN	7:48	151 - 496
	MPQG1005 – Adult Preventive Health Guidelines	Mark Netherda, MD	7:52	497 - 512
	MPQP1016 – Potential Quality Issue Investigation and Resolution		7:56	513 - 523
	Utilization Management			
	MCUP3103 – Coordination of Care for *Child-Welfare Involved* Members – **NEW TITLE**	Shahrukh Chishty	8:00	525 - 529
VI.	**Presentations**			
1	Care Coordination Grand Analysis • MPCD2013 – Care Coordination Program Description • Complex Case Management (CCM) Program Evaluation for CY 2023 (Report) *begins on p. 553* *Data presentation with Shivani Sivasankar of Health Analytics begins on p. 573*	Shannon Boyle, RN Shivani Sivasankar	8:04	531 - 600
2	PQI/PPC Annual Report	Robert Bides, RN	8:20	601 - 616
3	CY 2024 Site Review Report	Rachel Newman, RN	8:25	617 - 626
4	CY 2024 Physical Accessibility Review Survey (PARS) Report		8:30	627 - 631
5	D-SNP Model of Care	Kermit Jones, MD, JD Kimberly Robertello, PhD	8:35	633 - 650
VII.	**Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, March 19, 2025**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Feb. 19, 2025 / 7:30 a.m. – 9:04 a.m. Napa/Solano Room, 1st Floor

Voting Members Present:
Sara Choudhry, MD
Steven Gwiazdowski, MD, FAAP
Emma Hackett, MD, FACOG
Brandy Lane, PHC Consumer Member
Phuong Luu, MD
Brian Montenegro, MD
John Murphy, MD
Robert Quon, MD, FACP
Michael Strain, PHC Consumer Member
Chris Swales, MD
Randolph Thomas, MD
Jennifer Wilson, MD

Voting Members Absent: Meagan Mulligan, FNP-BC

Partnership *Ex-Officio* Members Present:
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Cotter, James, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Kerlin, Mary, Senior Director of Provider Relations
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Guests:
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MBA/MHA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chishty, Shahrukh, Sr. Mgr of Foster Care Programs, Behavioral Health
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)
Erickson, Leslie, Program Coordinator II, QI (scribe)
Garcia-Hernandez, Margarita, PhD, Director, Health Analytics, Finance
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Innes, Latrice, Manager of G&A Compliance, Grievance & Appeals
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Lopez, David, PR Representative, Provider Relations
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Robertello, Kimberly, PhD, Senior Medicare QI Program Manager, QI
Sivasankar, Shivani, Senior Data Scientist I, Health Analytics, Finance
Ward, Lisa, MD, Regional Medical Director (Southwest)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. The Jan. 15, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Jan. 7 Internal Quality Improvement (IQI) Committee • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee • Jan. 21 Quality Improvement Health Equity Committee (QIHEC) • Nov. 19, 2024 QIHEC (Approved Minutes)	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept the other minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, MBA/MHA, Director of Quality Management, QI*	• The PCP QIP Measurement Year 2024 closed on Jan. 31. Providers are still able to look at their figures and reach out with any concerns. One of the major tools we have for providers is our eReports and our PQD dashboards. Refreshing some of these tools for MY2025, however, will be delayed until our Health Rules Payor (HRP) launches later this year to replace AMISYS. Partnership will keep providers posted on these changes and will also provide trainings as needed. • The Quality Measure Score Improvement (QMSI) workgroup has been busy. Pediatrician and Associate Medical Director Terry Frankovich, MD, will conduct a noontime webinar April 3 on developmental screening tools and CPT codes. Register at https://partnershiphp.webex.com/weblink/register/rd35df7db5fe1ef3b888bd39bf2a5d02c • Two webinars focused on best practices in pediatric preventive care for ages 0-30 months and ages 3-17 years old are being offered in February. • Partnership has not been seeing the data on application of topical fluoride, and so we went to our providers and to the Department of Health Care Services (DHCS) to find out why. Director of Quality Measurement Kristine Gual will explain: o DHCS identified a systems issue and has given us a work-around coding fix that we are asking dental administrators to implement within their systems. Dental Centers must use ICD Z29.3 (encounter for prophylactic fluoride administration). Such treatments completed in Federally Qualified Health Centers, Rural Health Centers and Tribal Health Dental Centers count toward DHCS measure rates. The measure, for children ages 1-20 years old, requires a minimum of two fluoride varnish applications per year. For questions: contact dentalsupport@partnershiphp.org. • We have launched our annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This will be the first year the 10 "expansion" counties will be included. • Many organizations within Partnership are engaged in the statewide Equity Practice Transformation (EPT) program. Self-assessments are now happening around how each organization is doing on leadership, data, empanelment, and team-based care.	For information only: no formal action required. There were no questions for Isaac.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• Anyone who has a dental clinic is encouraged to immediately text or email your dental director to let them know the importance of using the Z29.3 code on every child who gets a dental fluoride varnish, • We have two new Regional Medical Directors who recently started with Partnership: Lisa Ward, MD, in Santa Rosa covering Marin and Sonoma counties, and Matthew Morris, MD, in Auburn, serving Placer, Nevada, Sierra, and Plumas counties. Welcome! • The Auburn office has just one conference room, which is booked out in conflict with Q/UAC, so Dr. Morris is here in Fairfield today. We hope soon to have a second conference room in Auburn. • Many persons have top of mind what is now happening in Washington, D.C. Partnership CEO Sonja Bjork, JD, Medical Director for Medicare Services Kermit Jones, MD, JD, and Director of Population Health DeLorean Ruffin, DrPH, recently took meetings with the Association for Community Plans, a national trade association representing 83 nonprofit health plans, including Partnership. Sonja reported that many proposals for cutting Medicaid are circulating in the Republican-controlled Congress, including an initiative proposed by a California Republican to prohibit coverage of undocumented individuals even if no federal dollars are involved. Also at risk are federal funds matching California's Prop. 35 Managed Care Organization (MCO) tax that is funding increases in Medi-Cal rates. Washington Democrats indicated to Sonja that they have little power to try and forestall cuts. Individuals and medical societies are encouraged to reach out to two Republican congressmen whose districts cover many of Partnership's counties: Doug LaMalfa (CA First) and Kevin Kiley (CA Third). • The State meanwhile is still putting forth many regulatory requirements. One will change the name of our Consumer Advisory Committee to the Community Advisory Committee, with a host of requirements that Partnership mostly already meets. This probably won't be finalized until the next Board of Commissioners' meeting. • Last week, the State released the details of a Community Reinvestment program wherein any health plan that earns a surplus on its Medi-Cal line of business must devote a portion of that to investing back in the community. This sounds good but is very detailed in who must review and sign off, including Partnership's Consumer Advisory Committee (CAC) and Quality Improvement Health Equity Committee (QIHEC), and every county's public health officer and behavioral health director. Moreover, plans must align with the CHIP (Children's Health Insurance Program) in each county as well as the State's quality strategy. There is much work to be done to operationalize all this. • The next round of CalAIM grant funding that was supposed to aid transitional rent and the justice-involved population is being delayed for some months. • Partnership favors three pieces of California legislation relating to obstetrical access: o Senate Bill 228 – Comprehensive Perinatal Services Program (Sabrina Cervantes, D-Riverside) moves the CPSP program from the California department of Public Health to the Department of Health Care Services (DHCS). There is now an opportunity to offer amendments. o Assembly Bill 55 – Alternative Birth Centers: Licensing and Medi-Cal Reimbursement (Mia Bonta D-Oakland) would ease some licensing requirements, now so difficult that only three such centers exist in California. Licensing is now required to accommodate Medicaid patients but not private patients, giving rise to access inequities.	There were no questions for Dr. Moore. *Meeting Postscripts:* • An "Updated Billing Instructions" flyer on dental codes is appended to these minutes with the consent of the Q/UAC chair and vice-chair. It will also be shared FYI in March committee packets. • Partnership's Board of Commissioners on Feb. 26 approved changing the name of the Consumer Advisory Committee to the Community Advisory Committee. • AB 55 was re-referred Feb. 26 to the Assembly's Committee on Health. • SB 669 was introduced Feb. 20 and may be acted upon on or after March 23. • Dr. Moore's February 2025 Medical Directors Newsletter was forwarded March 3 to Q/UAC clinicians.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	o SB 669 – Rural Hospitals: Standby Perinatal Medical Services (Mike McGuire, D-Healdsburg) would allow standby perinatal units such as that proposed by Plumas District Hospital.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	***Health Services Policies*** Care Coordination MCCP2020 – Lactation Policy and Guidelines MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program Utilization Management MCUP3064 – Communication Services MPUG3011 – Criteria for Home Health Services MPUG3019 – Hearing Aid Guidelines MPUP3048 – Dental Services (including Dental Anesthesia)	Motion to **approve as presented:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: March 12 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Clinical Compliance – Quality Investigations*		
MCQP1022 – Site Review Requirements and Guidelines	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document. Rachel went through the synopsis: note that although her team has been utilizing Attachment I for some time, DHCS still has not formally approved it. Dr. Gwiazdowski wondered at the State's need for such a long policy to cope with all its regulations. Dr. Moore said our contract necessitates it. He anticipates that DHCS will be similarly slow to provide oversight guidance to the MCPs re their contractual and regulatory responsibilities to CPSP, so we meanwhile are planning additional internal reviews of what we are referring to as the Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services equivalent to or substantially similar to the services once defined and overseen by the California Department of Public Health (CDHP).	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: March 12 PAC
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1005 – Adult Preventive Health Guidelines	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are added:** K. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services L. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/ **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • 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). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing,	There were no questions. Motion to **approve as presented:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth (this is a title change in what is a Grade D recommendation) Dr. Netherda went through the synopsis, adding that USPSTF on Jan. 14, 2025 confirmed that screening for osteoporosis in post-menopausal persons assigned female at birth is a Grade B recommendation. Dr. Netherda added "(currently under review)" after policy or grade recommendations that USPSTF is pondering, saying this will help guide him in his research for the next annual review of MPQG1005. Also, he may alphabetize the list within categories so users may more easily find topics of interest. Dr. Moote thanked Dr. Netherda for his hard work and said the changes will be presented in March meetings of the regional medical directors.	
MPQP1016 – Potential Quality Issue Investigation and Resolution	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** Timeframes amended throughout document to clarify "days" as "calendar days." **III.D. Corrective Action Plan is now redefined:** 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. **VI.C.1.a. addition:** The Investigator will begin an investigation within 30 days of receiving the PQI case referral. **VI.C.3.d.ii:** The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality. Dr. Netherda went through the synopsis, noting that it was Marshall Kubota, MD, who recommended that references to "days" be rewritten as "calendar days" where applicable. Some of the changes in the policy are	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: John Murphy, MD *Approved unanimously* Next Steps: March 12 PAC

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	in anticipation of what the Member Safety - Quality Investigations team thinks might be recommended by the DHCS auditor based on remarks heard in December. We added that coaching and counseling from a provider of concern's medical director might be enough to meet the requirements of An imposed CAP (e.g., if it's a physician assistant who has done something we think needs a better review, having that just being overseen by the medical director might be an adequate response). We will now track and tend more closely those providers who have had severity ratings that are higher than we would like. We score on a scale of zero to three. We will now better track those who are scored a two or higher to make sure that we are not seeing a repeat of whatever it was that initially triggered the investigation. That is the minimum of what we will do. John Murphy, MD, asked if the team can issue a CAP or if only the Peer Review Committee can. Dr. Netherda responded that the team can strongly recommend but the decision to impose a CAP is the responsibility of Peer Review because an actual CAP is considered a more serious trackable event. There were no other questions.	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Sr. Mgr, Foster Care Programs, Behavioral Health*		
MCUP3103 – Coordination of Café for *Child-Welfare* Involved Members – **NEW TITLE**	**This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." The name of the policy was updated to reflect the new "Child Welfare-Involved" language. Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy.** **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care." **Section VI.C.** A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights Shahrukh noted that this policy was revised to reflect the broadening definition from foster care to child welfare. There are several categories within that larger scope, including members in foster care, in addition	There were no questions. Motion to **approve as presented:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: March 12 PAC

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	to former foster youth, youth involved in the adoption process, youth placed with approved relatives and those engaged in family maintenance. Correspondingly, this policy title is updated. We indicated related policies and described in detail the role of the child welfare liaison who will support this work. Other than that, no other significant edits were introduced	
VI. Presentations		
Care Coordination Grand Analysis: • MPCD2013 – Care Coordination Program Description • Complex Case Management (CCM) Program Evaluation for CY 2023 (Report and Presentation) *Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance* and *Shivani Sivasankar, Senior Data Scientist, Health Analytics*	**Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated JD Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN **Updated JD for Behavioral Health Clinical Specialist-LCSW or LMFT to include:** Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes	

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	Protected Health Information (Page 17) Updated: The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer Shannon noted that Partnership's Care Coordination department is part of Health Services, is led by the Senior Director of Care Management and includes the care coordination director, regional associate directors, managers, case managers, social workers, and health care guides. Teams coordinate care and case management for members with care needs who are willing to participate, ensuring Partnership is the primary source of coverage or responsible for the benefit. Their responsibilities include assessing needs, coordinating services, and conducting outreach to target specific populations. The teams work in multidisciplinary care groups to meet members' needs, reduce duplication, and address challenges such as chronic illness, fragmented care, and complex health issues. The teams use evidence=based practices to create individualized care plans and interventions aimed at education, timely care access, and connecting members with resources to minimize care gaps during transitions and to achieve desired health outcomes. Shannon then went through the synopsis of changes to the Program Description. She noted that Care Coordination is growing fast: 11 new staff have recently been added. Robert Quon, MD, asked whether those job titles with "RN" after them must specifically be an RN or can they have higher licensure? Shannon said that those with the RN in their role title do need that licensure. Other roles do not require such licensure, and this is spelled out in the job descriptions within the Program Description. Shivani Sivasankar then presented the CCM Evaluation. The main objective was to assess the impact and see if there had been any increases in the appropriate usage of health and medical resources as well as any reduction in inappropriate utilization of healthcare resources. There were four steps to this data analysis. The first was focused on segregating the 255 members enrolled for CY 2023 into different case length analysis groups based on the number of days they were enrolled in the CCM program, and we tested the significant difference in average utilization metrics before enrollment, after enrollment and after program closure. The second step was focused mainly on the CCM group, and in the third step we identified significant factors that impact utilization metrics. In the fourth step, we compared the CCM group with the control group and tested significant difference in the utilization metrics. We only looked at three months after enrollment and three months after closure so that the utilization period was consistent across the three measurement periods. And then we determined eight different utilization metrics, and, for the case length analysis, we segregated the members into different case groups based on the number of months they were enrolled. The main purpose of this analysis was to see if the 40 members who were enrolled for less than one month had any significantly different results and if it made sense to exclude them from the next step of the analysis. Members that were enrolled for less than one month had a decrease in the number of unique drugs after enrollment compared to members who enrolled for just one to two months, whereas the number of unique drugs increased when compared to members who were enrolled for two to five months and from five to eight months. Specialty visits increased for members who were enrolled for less than one month, whereas it decreased after closure for members who were enrolled for more than eight months. Based on these results, their cases were not managed sufficiently and they were excluded from the next step of the analysis. Thus, 189 members were evaluated in the second step. Some of the key findings were they had lower visits after the end of the CCM program, lower inpatient visits, lower average inpatient days, lower PCP visits after the end of the program, higher specialty visits after the start of the program, and lower total allowed amount after the start and end of the program. However, we did not control for bias (third step) and we did not compare this to a control group (fourth step). In the third step, we identified significant parameters like gender, region, age group and risk level. And then we performed regression analysis to see if the significant parameters affected utilization metrics before enrollment and after closure.	

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	In the fourth step, we compared these 189 members against a control group of 517 members who were eligible for at least one month but did not enroll during this utilization period. There were no significant results without adjusting for covariates, but after adjusting, the ED visits in the CCM group significantly decreased after enrollment and after closure compared to the control group; the average inpatient day visits dropped more significantly in the CCM group after closure. Some of the key findings were that members enrolled in the CCM program had significantly lowered ED visits, which decreased by 11% after the start of the program and decreased 37% after the end of the program. Inpatient visits decreased by 60% after the end of the program. Average inpatient days decreased by 70% after the end of the program. Total allowed amount decreased by 57% after the start of the program and 71% after the end of the program. PCP and specialty visits both decreased significantly after closure. In conclusion, when compared to the control group, the CCM program was effective in reducing ED visits, average inpatient days, total allowed amount after the start and end of the CCM program; increasing PCP visits, specialty visits and unique medications after the start of the CCM program; reducing inpatient visits, specialty visits and number of unique drugs after the end of CCM program. It was not effective in reducing inpatient visits after the start of CCM; reducing readmissions after start and end of CCM; increasing PCP visits after the end of the CCM program. Before taking questions, Dr. Moore noted that this analysis is done annually in part to satisfy NCQA requirements. Jennifer Wilson, MD, asked what the difference was between "unique medications" and "unique drugs"? Shivani said she used the terms interchangeably. Dr. Kubota asked for more specifics on those 40 members who were excluded, and Dr. Moore answered. Dr. Gwiazdowski asked about the statistical methodologies used and a conversation ensued between him, Shivani and Dr. Moore, who said they could continue the discussion after the meeting. Dr. Montenegro was curious about specialty visits increases and decreases and what specialties were included. Shivani responded that although specific specialties were not tabulated in this analysis, they could be in future. Dr. Montenegro said he asked because certain specialties may have access issues, so an intervention might have an unintended consequence of overwhelming an already scarce specialty. Dr. Moore said it would be a good call-out to know, for example, if it were a gastroenterologist doing a colonoscopy or was it an endocrinologist to manage their diabetes. Dave Katz, MD, wondered if any data was collected o~~n~~n the patient and family experience and, if so, whether it was correlated with utilization data. Shannon replied that we do have a CCM survey after closure, but sometimes it will not be completed, especially in those CCM cases closed for lack of engagement. Dr. Moore commented that it would be interesting to learn why some become disengaged but that would be a different survey. **Jennfer Wilson, MD / Robert Quon, MD to approve both the Program Description and the Evaluation.**	
PQI/PPC Annual Report *Robert Bides, RN, Manager, Member Safety – Quality Investigations*	Robert said Potential Quality Issues (PQIs) are defined as possible adverse variations from expected clinical performance, care, and outcomes. His team investigates all PQIs to determine if there is an actual quality issue or if there is an opportunity for improvement. PQIs come from internal and external sources. Provider Preventable Conditions (PPCs) are a medical condition of complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. PPCs are reportable to DHCS. The Member Safety - Quality Investigations team initially reviews and scores PQIs for both providers and system issues on a zero (care is appropriate), one (minor opportunity for improvement), two (moderate opportunity for improvement), or three (significant opportunity for improvement) level. Those scoring Provider 2 or System 2 or above are referred to the confidential Peer Review Committee. The PRC in 2024 reviewed 16 PQI cases, nine in the last two quarters. Nine of the 16 resulted in CAPs to providers, including six focal	

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	reviews. Altogether, with the Investigations team that on a weekly basis both reviews and scores referred cases, 207 PQI cases were completed and closed in CY 2024. There were multiple providers with multiple PQIs; however, no significant treads emerged. As Dr. Netherda said in presenting the PQI policy today, providers or facilities given a rating of P2 or S2 or above will be monitored for at least a year. The top three referral sources in Q3/Q4 continued to be Grievance & Appeals (119), "other" (15), and Medical Directors (8). As expected, the number of PQI referrals increased 8% in 2024 above 2023 in part because of the 10-county expansion. This new "Eastern" region accounted for 40 (20%) of the 247 PQI cases referred in 2024. Q1/Q2 results were reported to this committee in August 2024. Today, we report Q3/Q4: 117 providers were involved in the 104 processed and closed PQIs. Of these 117, 64 were PCPs; 18 were specialists, and 31 were hospital or ER related. Once again, Shasta and Solano county-based practitioners/providers accounted for the most reviewed with 22 and 17, respectively. (This is both down from and a reverse of their Q3/Q4 2023 positions with 25 and 32, respectively.) There is no significant trend to report regarding the severity of cases reviewed. In 2024, just 9% (19 of 221 involved providers) were scored above a P1 or S1 compared with 11% (34 out of 302) in 2023 and 11% (16 of 149) in 2022. In Q3/Q4, only two PPC cases were reported to Partnership. (Dr. Moore commented at IQI Feb. 11 that he suspects more have occurred but that, although they may have been self-reported to DHCS as required, they were not reported to Partnership, as is also required.) Robert said we are doing outreach to hospitals to provide PPC education on reporting requirement. In conclusion, the number of Q3/Q4 2024 PQI referrals received (150) was significantly higher than the same period in 2023 (111). The Member Safety - Quality Investigations team has implemented more communication with providers of concern and continues to provide education to providers and facilities regarding the PQI process and PPC reporting. The team is also educating other Partnership departments. Dr. Wilson asked when looking at the PQI rates if cross referencing is done for access by county or region. Robert replied that this has not been done but he could ask the Health Analytics team to look at this for future reports. Dr. Wilson noted that Solano County has one of the highest numbers of PQIs (39 in 2024) but their access is likely poorer than Sonoma County, which accounted for 23 PQIs. She asked if access itself could be a reason behind many PQIs, and she also wondered if some PQIs occur because PCPs can hold on to a patient longer than they perhaps should because a higher level of care is not readily accessible. Dr. Netherda acknowledged that some PQIs do happen for this very reason but that access itself is not a PQI issue. Dr. Gwiazdowski, noting that some counties did not have a recorded PQI in 2024, wondered whether this indicates "best in breed" or that reporting is not being done as it should be. Robert replied that most of the PQIs do come through Grievance & Appeals, so if a member doesn't complain, we are not necessarily apprised that any issue exists. Dr. Moore added that if a county's denominator is low (e.g., Sierra only has a few hundred members and Modoc a few thousand), it is not surprising that no PQI data exists for them. "The biggest counties are Solano, Sonoma, Shasta, Humboldt, and they are all represented," he said. Colleen Townsend, MD, added that when a member complains about one thing that isn't a PQI and something else is involved that actually presents a PQI, we do look at that as well. Dr. Netherda reminded Q/UAC that this report is based on where the provider is, not where the member resides: a Modoc member might present a PQI but it involves a provider in a different county. Dr. Moore clarified, however, that the denominator is based on the member when the rates are compiled. Robert Quon, MD, asked Robert to talk about the "unable to determine" (UTD) rating and what cases those are likely to be. Robert replied that most recently, some involved behavioral health wherein records were more difficult to obtain. Closed UTD cases are referred back to the	

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	provider's site or system with a request that that oversight body looks into the issue(s). Dr. Quon cautioned that, from a regulatory standpoint, having such a bucket creates a high risk. Dr. Moore clarified that a closed case labeled UTD may be because Partnership has no contractual oversight that requires a response. Dr. Quon suggested "closed by the facility" or "referred to the facility for investigation" might be better labels. Dr. Netherda clarified that DHCS has accepted "UTD," and we are careful to make sure that when we say that, it's because we passed it off to somebody else: it went to the CDPH if it's a facility, for example, or it went to the Nursing Board. It didn't end with us. Dr. Quon suggested that in future we then say "referred to the Nursing Board" or other appropriate agency; then it is clear the HealthPlan is taking an action and maintaining oversight.	
CY 2024 Site Review Report *Rachel Newman, RN*	A Site Review (SR) has two components: the Facility Site Review (FSR) and the Medical Record Review (MRR), according to DHCS-approved tools and standards. The FSR is an assessment of a facility's physical site across Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control concerns according to DHCS-approved guidelines and tools. A FSR is conducted by a registered nurse/DHCS-certified site reviewer on Partnership's Clinical Compliance team at the point of initial contracting and up to three years thereafter. The reviewer will issue a Corrective Action Plan (CAP) if any of the domains fall below 80%. MMRs are generally done virtually. Overall, 2024 average FSR scores by county looked good, Rachel said. (She noted that some elements are evaluated on an "all or nothing" basis. If just one staff member isn't trained or otherwise compliant, the site fails on that element and a CAP must be issued. Those are the State's rules.) What sites missed the most were accurate Emergency Medication Dosage charts, which must list all stocked medications. Overall, all regions have opportunities to switch to height adjustable eye charts and to improve staff training both in cultural and linguistic requirements and in disability rights and provider obligations. The MMR of randomly selected records is conducted three to six months after an initial FSR has been completed. It is repeated up to every three years thereafter on format, documentation, coordination of care, pediatric preventive care, adult preventive care, and OB/CPSP preventive care (if applicable). If any of these domains score below 80%, a CAP is required for the entire review. Rachel noted that we are seeing an uptick in MMR CAPs since the release of the 2022 Site Review Tools and because reviewers have more measures to look at. All regions have opportunities for improvement in adult and pediatric preventive health. Partnership continues to offer extensive training provided by a Certified Site Review nurse for all new site review criteria. The Clinical Compliance team continues to educate sites during the SR exit interview on the Individual Health Assessment (IHA), blood lead screening and testing, developmental screening tools and other criteria as needed. Web-ex trainings on preventive criteria and the IHA are available on request, as is training on the former Child Health and Disability Prevention Program (CHDP) protocols that have now transitioned from the Department of Public Health to the Managed Care Plans. Virtual MMRs continue to be a more efficient use of time with providers. There were no questions for Rachel.	
CY Physical Accessibility Review Survey (PARS) Report *Rachel Newman, RN*	A PARS is an assessment of how well members who are seniors or persons with disabilities (SPD) can navigate a practice site. Areas evaluated during this review include the parking lot, exterior building, interior building, restrooms, and exam rooms. Sites are assigned a designation of basic or limited accessibility based on the review findings. Partnership's Provider Directory is updated regularly for members to see which facilities meet their accessibility needs. Primary Care, OB, and High-Volume Specialty offices receive this review. Provider sites are categorized into three types:	

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td></td><td>
<table>
<tr><th>Level of Access / Domains:</th><th>Definition</th></tr>
<tr><td>Basic
Parking
Exterior Building
Interior Building
Restroom
Exam room</td><td>Facility met all 29 critical elements used to identify a sites capability of accommodating SPD members.
*All domains besides Medical Equipment are of a passing score.</td></tr>
<tr><td>Limited
Missing one or more domains above</td><td>Demonstrates that the facility is deficient in one or more areas.</td></tr>
<tr><td>Medical Equipment
This is noted in addition to access level of Basic or Limited as appropriate.</td><td>PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient).
**This is noted in addition to level of Basic or Limited access as appropriate.</td></tr>
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A total of 174 sites were assessed across Partnership in 2024: 80 enjoy “basic” designation; 94 are deemed “limited.” An additional five PARS were done in Sacramento and Alameda counties for continuity of care. Partnership does not issue CAPs that would insist any practice site should mitigate a perceived PARS deficit because many practices do not own their physical plant.
There were no questions for Rachel.
</td><td></td></tr>
<tr><td>Dual Special Needs Plan (D-SNP) Model of Care
Kermit Jones, MD, JD, Medical Director for Medicare Services
and
Kimberly Robertello, PhD, Senior Medicare QI Program Manager</td><td>
The MOC is the framework we have to use both internally and externally by the Centers for Medicare and Medicaid Services (CMS) and NCQA to let them know the processes we are changing to get ready for the SNP, which goes live Jan. 1, 2026 in eight of our 24 counties. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. NCQA reviews for approval each SNP’s MOC based on standards and scoring criteria established by CMS. Trainings on MOC Elements 1 & 2 can be found at https://snpmoc.ncqa.org/static/media/SNPApprvl_MOC12_CY2026.f6ab25f8cbd947497fa8.pdf (Reference is to Contract Year and not Calendar Year.)
There are four MOC sections: divided by a description of the SNP population, the care coordination components we are looking to design internally and externally, the SNP provider network to guarantee access, and then the quality measurement and performance score improvement. Each section is divided into elements, and those elements contain numerous factors wherein we narrate all the points NCQA wants us to articulate how we are executing care coordination and quality performance improvement procedures. Based on those elements and factors, the SNP can score as many as 64 points. Based on percentages, we can receive a one-, two-, or three-year approval. We are on track for a three-year approval, based on our performance in the December 2024 mock survey with our consultant. Additional DHCS expectations above NCQA mandates can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf
Dr. Jones noted that SNPs are required in MOC 1 to describe potential members and our “Most Vulnerable Population” (MVP) subset too by a
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	deep dive into the demographics; understand who is housed and who isn't; understand the degree of their chronic diseases; understand age and language barriers. Health Analytics has identified a number of member risk factors: number of members age 65 and older, those with 5+ co-morbid conditions, those who do not speak English at home, those age 25 and older without a high school diploma, those living in poverty, and those more than 65 of age who are homeless. The MOC 2 is the Care Coordination section focusing on specific CMS and DHCS care requirements, including a Health Risk Assessment (HRA), and Individualized Care Plan (ICP), and an Interdisciplinary Care Team (ICT) of providers, a case manager for each member, and in some cases, a care giver for the member as well. The MOC 3 describes both our proposed PCP and broad specialty care network in the eight counties and the accessibility of said care. The MOC 4 defines how the D-SNP will track performance, guide improvement efforts, document, share information with stakeholders, and creative an incentive structure in those areas that need to improve. Partnership has identified five areas of focus for the D-SNP population: improving care coordination and delivery of services through direct alignment of the HRAT, ICP, and ICT ensuring access; enhancing care transitions; ensuring appropriate utilization and improving member engagement. Within these five focal areas are nine performance metrics: HRA, ICP, and ICT completion; member access to preventive/ambulatory health services at least once each year; diabetes care through controlling blood sugar; controlling high blood pressure; providing statin therapies for members with cardiovascular disease; medication adherence around cholesterol, and transitions of care through member engagement post-discharge. Kimberly spoke more about reporting and oversight that will start with an internal Quality D-SNP subcommittee to be created to address performance and any CAPs, up through IQI, Q/UAC. PAC and the Board of Commissioners. A Medicare Steering Committee will be focused on operations. Dr. Jones concluded the presentation by noting important dates and milestones. The MOC has been submitted to both NCQA and DHCS. In June, we will launch the QI D-SNP subcommittee. We are currently reviewing all Health Services policies, some of which were talked about today. Next steps include committee and work group meetings, building organization-wide infrastructure, and integrating D-SNP work into Medi-Cal functions where able. Chris Swales, MD, noted that medication adherence is something providers cannot control, and he finds it frustrating to be monitored about that. Dr. Moore clarified that medication adherence is not one of the quality metrics we will be placing in our pay-for-performance program. It is, however, a measure that as a health plan, we are responsible for as part of our NCQA Stars rating. There were no other questions.	
VIII. **Adjournment** – Q/UAC adjourned at 9:04 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, March 20.		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Feb. 11, 2025 / 1:30 – 3:33 PM

Members Present:
Andrews, Leigha, MBA, Regional Director, Southeast
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Director (Northwest)
Kubota, Marshall, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:
Ayala, Priscila, Director, Network Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bjork, Sonja, JD, Chief Executive Officer
Davis, Wendi, Chief Operating Officer
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Sharp, Tim, Regional Director, Northeast
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:
Biasotti, Danielle, RPhT, Assoc. Dir. ECM Ops, Enhanced Health Services
Bikila, Dejene, Manager of Data Science, Finance
Blake, Jill, Regional Director (Auburn)
Broadhead, Candi, Project Manager II, QI
Bushey, Lindsey, Project Manager I, QI
Chishty, Shahrukh, Sr. Mgr, Foster Care Programs, Behavioral Health
Cox, Bradley, DU, Regional Medical Director (Northwest)
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement, QI (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Erickson, Leslie, Program Coordinator II, QI (scribe)
Gual, Kristine, Director of Quality Measurement, QI
Hannah, Bethany, Administrative Assistant I, Health Equity
Harris, Matthew, Education Specialist, Provider Relations
Harris, Vander, Senior Health Data Analyst I, Finance
Isola, Brandy, Manager of Performance Improvement, QI (Chico)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination
Kim, Amanda, Improvement Advisor, QI (Redding)
Kung, Jen, Senior Health Data Analyst II, Finance
Lee, Donna, Manager of Claims, Claims
Moore, Jordan, Provider Education Specialist, Provider Relations
Moraghebi, Roudabeh, Manager of Health Analytics, Finance
Morris, Matthew, MD, Regional Medical Director (Auburn)
Muncy, Kellie, Manager of Change Management and Configuration, Configuration
Nguyen, Tom, Manager of Health Analytics, Finance
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Romero, Liz, Improvement Advisor, QI (Fairfield)
Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Stark, Rebecca, Regional Director (Chico)
Stokes, Sarah, Project Coordinator II, QI
Tryan, Tiffany, Improvement Advisor, QI (Redding)
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Vance, Brooke, Program Manager I, Network Services
Ward, Lisa, MD, Regional Medical Director (Southwest)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:31 p.m. Dr. Colleen Townsend introduced Partnership's two new Regional Medical Directors, Lisa Ward, MD, in Santa Rosa, and Matthew Morris, MD, in Auburn. Both physicians were present in Fairfield for the meeting. Approval of the Jan. 7, 2025 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee	Motion to approve IQI Minutes: Mark Netherda, MD Second: Isaac Brown Motion to accept other minutes: Mark Netherda, MD Second: Stan Leung, Pharm.D
II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies <u>Care Coordination</u> MCCP2020 – Lactation Policy and Guidelines MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program <u>Utilization Management</u> MCUP3064 – Communication Services MPUG3011 – Criteria for Home Health Services MPUG3019 – Hearing Aid Guidelines MPUP3018 – Health Services Review of Observation Code Billing MPUP3048 – Dental Services (including Dental Anesthesia) – ***pulled to audible a change*** <u>Transportation</u> - ***pulled*** MCCP2030 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls ***Non-Health Services Policies*** **Credentialing** – ***all but 500 and 700 pulled*** MPCR16 – Lactation Consultant Credentialing Policy MPCR17 – Standards for Contracted Primary Care *and Urgent Care* Physicians – **NEW TITLE** MPCR101 – Ensuring Non-discriminatory Credentialing and Re-credentialing Processes MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements MPCR500 – Ongoing Monitoring and Interventions MPCR700 – Assessment of Organizational Providers Anna Campbell and Leslie Erickson pulled Transportation and all Credentialing policies for formatting, content and other issues. Anna also pulled UM's MPUP3048 to audible a change at Section VI.A.: "Magellan" will be removed, and reference made instead to the DHCS-contracted pharmacy administrator. • MCCP2030 will be formally archived under Care Coordination and renamed as MPTP2503 under Transportation at March IQI. (Communications is now adding a Transportation page to the Provider Manual's Health Services section.) • Anna will review suggested urgent care language in MPCR17 for agreement with Utilization Management's MCUP3044 Urgent Care Services.	The CC and UM (but for MPUP3048) policies, were approved: Anna Campbell Second: Mark Netherda, MD Motion to **approve MPCR500 and MPCR700 as they would later be amended**: Isaac Brown Second: Mark Netherda, MD Motion to **approve an amended MPUP3048**: Anna Campbell Second: Marshall Kubota, MD <u>Next Steps:</u> Approved Health Services policies will go to the Feb. 19 Quality/ Utilization Advisory Committee (Q/UAC) and the March 12 Physician Advisory Committee (PAC) *Meeting Postscript:* MPCR500 and MPCR700 were approved at the Credentials Committee Feb. 12.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Network Services leadership noted that approval of MPCR500 and MPCR700 was essential to other items before the Credentials Committee on Feb. 12 and asked that IQI approve these two policies understanding that Leslie would fix the outstanding formatting and minor content issues. IQI agreed. (Brown/Netherda) Leslie fixed the issues and forwarded the corrected policies to Credentials Committee staff. Identified issues with the other Credentialing policies have been forwarded to appropriate staff to resolve, and these policies should come back to IQI in March.	
IV. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Clinical Compliance Inspection Team*		
MCQP1022 – Site Review Requirements and Guidelines	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document. There were no questions; however, Anna Campbell noted a discrepancy that was resolved with Rachel after the meeting: "CNM" and "LM" licensure was added to the list of who could become a Certified Master Trainer (CMT) and Certified Site Reviewer (CSR) and conduct both initial certifications and re-certifications. **The policy will proceed as amended to Q/UAC on Feb. 19.**	Motion to **approve as presented**: Mark Netherda, MD Second: Colleen Townsend, MD Next Steps: Feb. 19 Q/UAC March 12 PAC
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		
MPQG1005 – Adult Preventive Health Guidelines	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at	Motion to **approve as presented**: Colleen Townsend, MD Second: Isaac Brown Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are updated.** **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • 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). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth Dr. Netherda went through the synopsis and noted that the policy is also in accordance with California Assembly Bill 2132 on tuberculosis screening that went into effect Jan. 1. The Reference section is updated to reflect this. Dr. Moore thanked Dr. Netherda for his review of the United States Preventive Services Task Force (USPSTF) recommendations, which comprise this policy's Attachment A. Anna noted that, for Medi-Cal, policy section VI.A. states "An Initial Health Appointment (IHA) must be completed for all Members within 120 days of assignment to Partnership…" yet, the timeline for a first Medicare "adult well-care visit" is 12 months. Rachel added that "Medi-Medi" patients' records are not pulled for site review. **Dr. Moore said this apparent discrepancy would be investigated,** and he urged IQI to approve as-is; if necessary, the policy will be brought back. Isaac questioned how Partnership would know that "shared decision making" in breast cancer screening for gender diverse persons actually occurs. Dr. Moore said we wouldn't necessarily know or be able to capture this. Jennifer Durst suggested that all health centers might post "persons with breast tissue should be screened." **Dr. Moore said the QIP team could look into this.**	
MPQP1016 – Potential Quality Issue Investigation and Resolution	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** **III.D. Corrective Action Plan is now redefined:** 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. **VI.C.1.a. addition:** The Investigator will begin an investigation within 30 days of receiving the PQI case referral.	Motion to **approve as amended**: Marshall Kubota, MD Second: Anna Campbell Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.3.d.ii: The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality. Dr. Netherda went through the synopsis, noting that the track and trend VI.E.1. was proactively modified based on comments heard during the December 2024 DHCS audit. (There was no Corrective Action Plan (CAP) issued that mandated this change.) Dr. Kubota suggested that all time framed in "days" be clarified to read "calendar days," if that is in fact what is meant. **The friendly amendment was accepted.**	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Senior Manager of Foster Care Programs*		
MCUP3103 – Coordination of Care for Child Welfare-Involved Members – **NEW TITLE**	This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." • The name of the policy was updated to reflect the new "Child Welfare-Involved" language. • Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy. **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care." **Section VI.C.** A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights	Motion to **approve as presented**: Anna Campbell Second: Brigid Gast, RN <u>Next Steps</u>: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Shahrukh went through the synopsis, noting that "child welfare-involved" has several categories, including those in foster care and those in the process of being adopted. DHCS has approved these policy changes, she said. There were no questions.	
V. Presentations		
1. Care Coordination Grand Analysis • MPCD2013 - Care Coordination Program Description • Complex Case Management (CCM) CY 2023 Program Evaluation Report and Presentation *Brigid Gast, RN, Senior Director of Care Management* *Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance* *Shivani Sivasankar, Senior Data Scientist, Health Analytics*	Dr. Moore remarked that the National Committee on Quality Assurance (NCQA) requires us to present Grand Analyses on certain aspects of the Partnership program, and that these analyses append to the annual renewals of the Health Services departments' program descriptions. Brigid Gast, RN, made opening remarks as to Care Coordination's mission and scope before turning over the presentation to Shannon Boyle, RN, who presented the synopsis of changes to the Program Description. **Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated Job Description Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN **Updated Job Description for Behavioral Health Clinical Specialist-LCSW or LMFT to include:** Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes	Motion to **approve the Program Description as presented**: Isaac Brown Second: Mark Netherda, MD Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Protected Health Information (Page 17) Updated: The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Shivani Sivasankar prepared and presented the Complex Case Management (CCM) analysis for CY2023. The objective of this analysis was to determine the efficacy of the CCM program. This report reviewed and analyzed utilization metrics that evaluate member utilization such as ED visits, hospital stays, number of hospital days, PCP visits, specialty visits, number of medications and readmissions. The analysis is separated into four parts: 1. Case length analysis We included all eligible members enrolled in the CCM program during 2023 and evaluated the utilization metrics by the number of days the members were enrolled in the CCM program using ANOVA. Based on the analysis, it was determined that members who were enrolled for less than one month indicated their case was not managed as they had: lower unique medications after the start of CCM program compared to members who were enrolled for 1-8 months, higher specialty visits after the end of CCM program compared to members who were enrolled for more than eight months, and lower unique medications after the end of CCM program compared to members who were enrolled for 1-2 months. Thus, members who were enrolled for less than one month were excluded from the next analyses; 189 distinct members moved on to be included in the second analysis. 2. CCM group analysis We included eligible members enrolled in the CCM program for more than 30 days and evaluated the utilization metrics across three measurement periods: six months prior to CCM program enrollment, six months from the start of CCM services and, six months after the case has been closed to CCM using Paired T-Test. Based on the analysis, it was determined that the CCM program had made a significant impact on reducing ED visits, reducing inpatient visits, reducing average inpatient days, PCP visits and reducing Total Allowed Amount after the start and end of the program as well as increasing specialty visits after the start of the program. The disadvantage of this one group design is that there was no way to control bias (affects external validity) and there was no way to compare the individual differences between the control and CCM group (affects internal validity). 3. Identification of Significant Factors We also identified significant parameters (utilization metrics before enrollment, gender, age, region and risk level of the member) that impact utilization metrics after starting the CCM program and following CCM closure using regression analysis. 4. CCM group Vs Control Group Analysis We identified a control group which included eligible members who were not enrolled in any case management program and were matched to the distribution of risk factors (identified in the regression analysis) and eligibility months of the CCM group. The utilization metrics were compared between the members in the CCM group and members in the control group across the previously mentioned three measurement periods. We did not identify any significant results when we performed ANOVA without adjusting for any covariates. However, when we adjusted for all the significant covariates using ANCOVA, we determined that, when compared to the members in the control group, members enrolled in the CCM program had statistically significantly lower: ED visits, inpatient days and total amount for members after starting the CCM program as well as after the program closure; had higher: PCP visits, specialty visits	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	and unique number of medications after the start of the program; and had lower PCP visits, specialty visits, inpatient visits and unique number of medications after the end of the program. In conclusion, the CCM program, when compared to the control group was effective in many ways already identified. The CCM program, however, was not effective in reducing inpatient visits after the start of CCM, reducing readmissions after the start or end of CCM, and increasing PCP visits after the end of the CCM program. Anna asked questions about the total allowed amount, and Shivani answered. Dr. Moore commented that it was "good to hit triple digits" with 189 distinct members involved. There were no other questions or comments.	
2. Quality and Performance Improvement Update *Nancy Steffen, Senior Director for Quality and Performance Improvement*	• The grace period for the MY2024 PCP QIP has ended. The 2025 Preventive Care Dashboard launched Jan. 1 and is refreshed daily and accessible to those endeavoring to close any gaps. • With the pending launch of Health Rules Payor (HRP) in the second quarter this year, some other dashboards will be delayed. • Associate Medical Director and pediatrician Teresa Frankovich, MD, will host a developmental screening webinar at noon Thursday, Apil 3. This is to educate providers regarding both screening tools and CPT codes. • An "Improving Measure Outcomes: Pediatric Preventive Care" webinar occurred Feb. 10. A DHCS-approved flyer on Partnership's Health Babies Growing Together Program was distributed to providers and cited as a best practice. The flyer has been translated into Spanish, Russian, Tagalog, Hmong, and Punjabi. • Other best practices will be captured in future webinars. DHCS is expected to provide more guidance on dental fluoride, and Partnership will be sharing this with our providers. • The MY2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey has launched and will remain open through mid-May. This is the first such survey to include the 10 expansion counties. Related articles will appear in upcoming provider and member newsletters this spring. • We have had good retention of providers participating in the statewide Equity and Practice Transformation (EPT) Program. The Statewide Learning Collaboration (SLC) is meant to support participating practices awarded Provider Direct Payment Program (PDPP) funding. The EPT Practice Level Reporting was submitted to the Population Health Learning Center (PHLC) on Jan. 31. The next such upcoming "HEDIS®-like" data submission report is due July 31, covering CY2024.	*For information only.* Nancy thanked the Health Effectiveness Data Information Set (HEDIS®) team for their support to the EPT program.
3. D-SNP (Dual Special Needs Plan) Model of Care (MOC) *Kermit Jones, MD, JD, Medical Director for Medicare Services* and *Kimberly Robertello, PhD, Senior Medicare*	The MOC, which has been in development for about eight months, provides the basic framework under which the SNP will meet the needs of each of its enrollees after Jan. 1, 2026, go-live, Dr. Jones said. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. NCQA reviews for approval each SNP's MOC based on standards and scoring criteria established by the Centers for Medicare and Medicaid Services (CMS). Trainings on MOC Elements 1 & 2 can be found at https://snpmoc.ncqa.org/static/media/SNPApprvl_MOC12_CY2026.f6ab25f8cbd947497fa8.pdf (Reference is to Contract Year and not Calendar Year.) There are four MOCs. In MOC 1, Partnership lets both DHCS and CMS know that we understand the SNP populations to be served, including the homeless and other Most Vulnerable Populations (MVP). NCQA scores 16 elements, each including numerous factors to address clinical and non-clinical requirements, across MOC 1-4. Were Partnership to score 85-100% of possible points, we would receive a three-year approval, Kimberly said, adding that our performance on the December 2024 mock survey bodes well. Additional DHCS expectations above NCQA mandates can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf	There were no questions. Dr. Moore congratulated everyone on their hard work to date. Oversight will be reported up through our existing committee structure, including IQI, Q/UAC, PAC, and the Board of Commissioners.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
QI Program Manager	Dr. Jones noted that SNPs are required in MOC 1 to describe potential members and the MVP too by age, gender, race, ethnicity, and language spoken. Moreover, "granular" attention is paid to low, medium, and high-risk populations. A number of member risk factors have been identified in each of the eight counties (Del Norte, Humboldt, Mendocino, Lake, Sonoma, Napa, Solano, and Marin) that will initially participate: number of members age 65 and older, those with 5+ co-morbid conditions, those who do not speak English at home, those age 25 and older without a high school diploma, those living in poverty, and those more than 65 of age who are homeless. The MOC 2 is the Care Coordination section focusing on specific CMS and DHCS care requirements, including a Health Risk Assessment (HRA), and Individualized Care Plan (ICP), and an Interdisciplinary Care Team (ICT) of providers and a case manager for each member. All D-SNP members are required to receive case management services: they will be risk-stratified to identify how much engagement is likely to occur. The MOC 3 describes both our proposed PCP and broad specialty care network in the eight-county region and the accessibility of said care. The MOC 4 defines how the D-SNP will track performance, guide improvement efforts, document, share information with stakeholders, and course correct as needed along the way. Partnership has identified five areas of focus for the D-SNP population: improving care coordination and delivery of services through direct alignment of the HRAT, ICP, and ICT ensuring access; enhancing care transitions; ensuring appropriate utilization and improving member engagement. Within these five focus areas are nine performance metrics: HRA, ICP, and ICT completion; member access to preventive/ambulatory health services at least once each year; diabetes care through controlling blood sugar; controlling high blood pressure; providing statin therapies for members with cardiovascular disease; medication adherence around cholesterol, and transitions of care through member engagement post-discharge. These metrics don't necessarily relate to our NCQA STAR rating as a health plan, Kimberly noted; however, any failure to meet goals year-over-year could result in Correct Action Plan(s) (CAP). Kimberly spoke more about reporting and oversight and Dr. Jones of important 2025 dates. Partnership needs to be ready to manage prior authorizations in October 2025. Next steps include committee and work group meetings, building organization-wide infrastructure, and integrating D-SNP work into Medi-Cal functions where able.	
4. PQI/PPC Annual Report *Robert Bides, RN, Manager, Member Safety – Quality Investigations*	Robert defined both Potential Quality Issues and Provider Preventable Conditions before saying that the confidential Peer Review Committee as the investigating body that meets monthly, reviewed 16 PQI cases in 2024, nine of these in the last two quarters. Altogether, with the Member Safety Quality Investigations team that (on a weekly basis) first reviews and scores referred cases, 207 PQI cases were completed and closed in CY 2024. Outcomes are confidential so it is difficult to exemplify specifics. The top three referral sources in Q3/Q4 continued to be Grievance & Appeals (119), "other" (15), and Medical Directors (8). As expected, the number of PQI referrals increased in 2024 above 2023 in part because of the 10-county expansion. This new "Eastern" region accounted for 40 (20%) of the 247 PQI cases referred in 2024. In Q3/Q4, 117 providers were involved in the 104 processed and closed PQIs. Of these 117, 64 were PCPs; 18 were specialists, and 31 were hospital or ER related. Robert and Dr. Netherda each remarked that primary care clinicians are the most commonly reviewed. Once again, Shasta and Solano county-based practitioners/providers accounted for the most reviewed with 22 and 17, respectively. (This is a down from and a reverse of their Q3/Q4 2023 positions with 25 and 32, respectively.)	SugarCRM (the PQI documenting and processing system) will be updated from version 8 to 14.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	There is no significant trend to report regarding the severity of cases reviewed. In 2024, just 9% (19 of 221 involved providers) were scored above a P1 or S1 (minor opportunity for improvement either in practitioner performance or systems issue, respectively) compared with 11% (34 out of 302) in 2023 and 11% (16 of 149) in 2022. In Q3/Q4, only two PPC cases were reported to Partnership. Dr. Moore commented that he suspects more have occurred but that, although they may have been self-reported to DHCS as required, they were not reported to Partnership, as is also required. Robert said we are doing outreach to hospitals to provide PPC education on reporting requirement. In conclusion, the number of Q3/Q4 2024 PQI referrals received (150) was significantly higher than the same period in 2023 (111). The Member Safety Investigation team has implemented more communication with providers of concern and continues to provide education to facilities regarding the PQI process and PPC reporting.	
5. CY2024 Site Review Report *Rachel Newman, RN*	A Site Review (SR) has two components: the Facility Site Review (FSR) and the Medical Record Review (MRR). The FSR is an assessment of a facility's physical site across Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control concerns according to DHCS-approved guidelines and tools. A FSR is conducted by a registered nurse/DHCS-certified site reviewer on Partnership's Clinical Compliance team at the point of initial contracting and up to three years thereafter. The reviewer will issue a Corrective Action Plan (CAP) if any of the domains fall below 80%. Overall, 2024 average FSR scores by county looked good, Rachel said. (She noted that what sites missed the most is accurate Emergency Medication Dosage charts, which must list all stocked medications.) Dr. Moore commented that when viewed by region, however, some do not score as well as others. He asked why this is so. Rachel noted that the Chico region sites were short on Infection Control. She said she does not know how these practices were scrutinized by previous health plans; however, Partnership is strict: *all* office staff must be trained. If even one individual staff is not trained, the site fails. Overall, all regions have opportunities to improve in staff training in cultural and linguistic, staff training in disability rights and provider obligations, and having height adjustable eye charts. The MMR of randomly selected records is conducted three to six months after an initial FSR has been completed. It is repeated up to every three years thereafter on format, documentation, coordination of care, pediatric preventive care, adult preventive care, and OB/CPSP preventive care (if applicable). If any of these domains score below 80%, a CAP is required for the entire review. Rachel noted that we are seeing an uptick in MMR CAPs since the release of the 2022 Site Review Tools and because reviewers have more measures to look at. All regions have opportunities for improvement in adult and pediatric preventive health. Partnership continues to offer extensive training provided by a Certified Site Review nurse for all new site review criteria. The Clinical Compliance team continues to educate sites during the SR exit interview on the Individual Health Assessment (IHA), blood lead screening and testing, developmental screening tools and other criteria as needed. Web-ex trainings on preventive criteria and the IHA are available on request, as is training on the former Child Health and Disability Prevention Program (CHDP) protocols that have now transitioned from the Department of Public Health to the Managed Care Plans. Virtual MMRs continue to be a more efficient use of time with providers.	Rachel asked for thoughts on dropping reporting of annual average FSR scores by region because reviews are generally conducted only every three years. Dr. Moore suggested she instead include a three-year rolling report.

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td>6. CY2024 Physical Accessibility Review Survey (PARS) Report

Rachel Newman, RN</td><td>A PARS is an assessment of how well members who are seniors or persons with disabilities (SPD) can navigate a practice site. Areas evaluated during this review include the parking lot, exterior building, interior building, restrooms, and exam rooms. Sites are assigned a designation of basic or limited accessibility based on the review findings. Partnership's Provider Directory is updated regularly for members to see which facilities meet their accessibility needs. Primary Care, OB, and High-Volume Specialty offices receive this review. Provider sites are categorized into three types:

<table>
<tr><th>Level of Access / Domains:</th><th>Definition</th></tr>
<tr><td>Basic
• Parking
• Exterior Building
• Interior Building
• Restroom
• Exam room</td><td>Facility met all 29 critical elements used to identify a sites capability of accommodating SPD members.
*All domains besides Medical Equipment are of a passing score.</td></tr>
<tr><td>Limited
• Missing one or more domains above</td><td>Demonstrates that the facility is deficient in one or more areas.</td></tr>
<tr><td>Medical Equipment
• This is noted in addition to access level of Basic or Limited as appropriate.</td><td>PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient).
**This is noted in addition to level of Basic or Limited access as appropriate.</td></tr>
</table>

A total of 174 sites were assessed across Partnership in 2024: 80 enjoy "basic" designation; 94 are deemed "limited." An additional five PARS were done in Sacramento and Alameda counties for continuity of care. Partnership does not issue CAPs that would insist any practice site should mitigate a perceived PARS deficit because many practices do not own their physical plant.</td><td>Just 57 practice sites region-wide enjoy the noted additional medical equipment. Rachel suggested that providing such equipment to more sites might be appropriate via future grant programs.</td></tr>
<tr><td colspan="3">VI. Adjournment</td></tr>
<tr><td colspan="3">Dr. Moore adjourned the meeting at 3:33 p.m. IQI will next meet Tuesday, March 11, 2025.</td></tr>
<tr><td colspan="3">Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement
Approval Signature: Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair</td></tr>
</table>

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• Measurement Year (MY) 2024 ended at 5 pm on 01/31/2025. The first week of February is the Validation Period where providers will be able to review data in eReports for accuracy. Providers are strongly encouraged to review their year-end data closely during this period as this data is used to finalize point earnings. If a provider notifies Partnership of a calculation or point attribution error before this period concludes, and it can be substantiated, the final data will be corrected in time to coincide with the upcoming MY2024 payment. • Final stages for MY2025 eReports User Acceptance Testing are in progress. The official launch of eReports to all users is targeted for Monday, 03/03/2025. • The 2025 Preventive Care Dashboard launched 01/01/2025 and is refreshed daily.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• The 2025 PQD QIP Business Requirements Document is being finalized in preparation for development to begin in March. The go-live timing of 2025 PQD is pending finalization of HRP's (i.e. Partnership's new core claims system) launch this year. Go-live of PQD MY2025 QIP specific dashboards will be delayed beyond the typical May timeframe; as more specific timeline details are available; they will be shared with the provider network.
EREPORTS	• MY2025 HRP UAT is in progress, in preparation for a cut-over from Amisys to HRP later this year.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Partnership met with DHCS on 01/15/2025 to review MY2023 HEDIS rates for Partnership's legacy 14 counties. DHCS indicated that several reporting regions showed performance below the Minimum Performance Level (MPL) of the Medicaid 50th national percentile. As a result, Partnership is required to develop strategies and actions to address the performance issues noted below and submit to DHCS by 02/14/2025: o Both Northern and Southern regions showed underperformance in several pediatric measures like newborn well visits, developmental screening, and lead screening. o The Northern region underperformed in asthma medication ratio and A1c control. This is the first time the chronic disease domain has triggered mandated activities which means Partnership must conduct a root-cause analysis before identifying strategies and actions.

	○ The Northern region underperformed in the Reproductive Health & Cancer Prevention domains for chlamydia screening, breast and cervical cancer screening, and pre-natal care. • In the prior year, Partnership was required to develop strategies and actions for Behavioral Health measures due to underperformance in Follow-up for ED Visits for Mental Illness. However, MY2023 performance exceeded both state and regional averages which means Partnership is not obligated to conduct improvement projects, however the rates are below the Medicaid 50th percentile and still warrant on-going focus and activities to drive improvement.
QUALITY MEASURE SCORE IMPROVEMENT	• A Developmental Screening Webinar aimed at educating providers regarding developmental screening tools and CPT codes will be hosted by Dr. Frankovich on Thursday, April 3rd at 12pm. Dr. Frankovich is a pediatrician and one of the Partnership Medical Directors, based in the Eureka Region. • The *Health Babies Growing Together Program (*GTP*)* flyer was approved by DHCS and translated into Spanish, Russian, Tagalog, Hmong, Punjabi. Copies of the flyer will be distributed to providers and cited as a best practice during the upcoming *Improving Measure Outcomes: Pediatric Preventive Care* webinar on 02/10/2025. • Partnership is preparing to publish co-branded colorectal cancer screening guidelines flyers in collaboration with the American Cancer Society. Flyers will be available to distribute within practices.
IMPROVEMENT ACADEMY	• On 01/30/2025, an *ABCs of Quality Improvement* in-person training was held in Ukiah. There were 21 external attendees, representing 8 unique organizations. The next in-person training will be held on 03/25/2025 in Redding. • Two *Improving Measure Outcomes* webinars focused on Pediatric Preventative Care for Ages 0 – 30 months and Ages 3 – 17 years are being offered throughout February.
JOINT LEADERSHIP INITIATIVE (JLI)	• Spring sessions are in the process of being scheduled.
REGIONAL IMPROVEMENT MEETINGS	• Quarterly regional quality meetings in the Redding and Eureka regions are in the process of being scheduled for February. • The next Southeast Regional Quality meeting is scheduled for 03/13/2025 in Fairfield.

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE	• The MY 2024 CAHPS® regulated survey formally launched in February. The survey will remain open through mid-May. MY 2024 marks the first CAHPS® Regulated survey to include both legacy and expansion counties. • Member Experience / CAHPS® related articles will appear in both the Spring 2025 Provider Newsletter and the Summer 2025 Member Newsletter. • The 24/25 Organizational Goal dedicated to improving member experience and access has eight (8) goal milestones, with a mid-year status completion rate of 42.8%.

& ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS	• The QI CAHPS team is leading milestones 3 & 8, while also overseeing progress in all goal deliverables. Notable Milestone Status Updates: o Milestone #3 Focus - Activity in-process: The pilot strike-team concept utilizes real-time data sources to conduct proactive research, assessments, and enhancements aimed at reducing member dissatisfaction. The team is focused on closing benefit literacy gaps. Internal workgroup(s) are actively planning and executing activities the health plan can use to close these gaps. These activities are being informed by a survey recently completed across Population Health Management and Member Services leadership and staff. These staff are central to assisting our members daily. From this input, a quick-hit triage list of the most common member-asked questions was created. Notable survey results include the following top four topical areas: Providers (PCP, internist, pediatrician, etc.), Transportation, Coordination of Benefits – access to care issues, and Dental Service. o Milestone #8 Focus - Completed: Patient Experience- Unit of Service Measure Development (CG-CAHPS® Performance/Survey Option) in PCP QIP that includes adoption of at least one change to better align with Partnership's member experience and access improvement goals.
CAPACITY ENHANCEMENT GRANTS	• Background: For the first time in Partnership's 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health's contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health. • Grant Implementation Process: Upon acceptance into the program, provider organizations submitted progress reports approximately three (3) months after the initial payment was awarded, detailing outcomes of their proposed activities, spending breakdowns, number of Dignity patients seen since the reassignment, and feedback on the CEG program. Although most providers adhered to their originally proposed plans, deviations from proposed activities were allowed if providers summarized alternative fund use. Examples of activities funded include: o Staff-related interventions such as sign-on bonuses, additional hiring and retention activities, incentives to clinicians for increasing number of visits and locum employment. o Extended clinic hours, including weekends. o Clinic space expansions and associated equipment purchases. • Summary of Results: The CEG Program closed upon the distribution of the second and final installment of funding, totaling $1,441,857.50. The evaluation of the program is now complete. This grant offering was a commendable initiative aimed at addressing the disruption caused by Dignity Health's contract termination, while at the same time developing capacity within the Partnership Primary Care network to serve all our

members. The program management team successfully launched the grant under tight deadlines, processing applications and issuing payments promptly. However, discrepancies in provider reporting and limited member impact underscore the need for improved accountability and strategic alignment in future iterations. By strengthening evidence requirements, enhancing cross-departmental coordination, and leveraging established frameworks, future programs can achieve a greater and more sustainable impact for members and providers alike.

- At the Chief Medical Officer's (CMO) recommendation, the CEG PM team conducted a discrepancy analysis with one of the participants, Elica Health Centers.
    - The total number of Dignity member visits identified by Partnership matches the report provided by Elica Health Centers. However, their reported total is higher because Elica counted multiple visits by the same member, whereas Partnership counts only one visit per member.
- The table below shows the discrepancy between the data Partnership collected compared to the data the CEG providers reported. The green triangles represent the sum of multiple sites within an organization.
    - Of the 27,357 reassigned members, only 1,419 were seen during the program's duration (May - September 2024)
    - 47% of members stayed with newly assigned PCPs, while 35% returned to Dignity.
    - The remaining 18% are a combination of members who lost eligibility and were not assigned to a PCP, who had a PCP that was neither Dignity nor a CEG participant, or who temporarily became Direct members.

Parent Org	Number of Dignity Members Assigned May 2024	Total Dignity Members with Visits	Reported Number of Dignity Members Seen
Adventist Health	950	30	50
Ampla Health	957	19	50
Anderson Walk In Medical	1416	78	90
Colusa Medical Center	2406	0	700
Elica Health Centers	934	7	42
Greenville Rancheria	808	168	661
Mccloud Healthcare (formerly known as Shasta Cascade)	585	24	85
Mountain Valley Health Centers	1004	43	175
Northern Valley Indian Health	2072	97	1200
Ole Health DBA CommuniCare Ole	8920	560	4422
Pediatric Medical Associates	453	40	30
Prime Heathcare (Shasta Regional)	772	0	327
River Bend (aka Francisco L. Garcia, M.D.)	819	37	1033
Shasta Community Health Centers	1976	122	Unable to calculate approx. number of reported Dignity members seen
Tarichi Primary Care	1071	41	396
Western Sierra Medical Clinic	811	81	272
Winters Healthcare Foundation	1403	72	296
Total:	**27357**	**1419**	**9829**

EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	• To centralize efforts within Partnership and Exact Sciences, and to align with Colorectal Cancer Awareness Month in March, Partnership is offering a Cologuard ® multi-patient order program. This program eliminates the minimum patient count needed for each provider as Partnership will place one order on behalf of any provider that wishes to participate. Kits are being shipped mid-March. An open office hour was held on

	02/05/2025 to address any questions or concerns providers may have regarding the process.
EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). • Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding. o $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). o The EPT PM team is drafting a proposal for Executive review to use the remaining $1.2 Million for two areas of unmet need for low-performing Primary Care Physicians (PCPs); Leadership training and Support for replacing outdated Electronic Health Records (EHRs). • All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations contracted with Partnership from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS has recalculated the final award amounts, due to budget revisions. o Following the budget revisions, the dropout rate for the EPT cohort across the state is 5% and all twenty-seven (27) provider organizations sponsored by Partnership are currently enrolled and engaged in the program. o EPT practices that did not complete the below 2024 deliverables on 11/01/2024 have until 11/01/2025 to submit as a requirement to remain enrolled in the program: ▪ Empanelment and Access Milestone 1: Empanelment Assessment ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure. o PHLC sent EPT milestone deliverable reports to all MCPs and the following summarizes the progress of Partnership's sponsored provider organizations. ▪ 80% of submitted Empanelment and Access Milestone 1 deliverables were accepted; seventeen (17) practices submitted, and no submissions were rejected.

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28 % of submitted Empanelment and Access Milestone 2 deliverables were accepted; ten (10) practices submitted, and (4) submissions were rejected.
74% of submitted Data Governance & HEDIS Assessment deliverables were accepted; twenty (20) practices submitted, and no submissions were rejected.
52% of submitted Data Governance Policy & Procedure deliverables were accepted; thirteen (13) practices submitted, and one (1) submission was rejected.
85% of submitted Key Performance Indicator (KPI) deliverables were accepted; twenty-three (23) practices submitted, and no submissions were rejected.

The next EPT submission period will open on 05/01/2025 and the following deliverables will be due:

Year 2 PhmCAT
Data to Enable PHM Milestone 2: Implementation Plan
Stratified HEDIS-like measures
Key Performance Indicators (KPI) reports
All Rejected or unsubmitted 2024 EPT deliverables

By March 2025 DHCS will funnel EPT payment(s) through MCPs and EPT POs will receive their funding no later than 04/30/2025.

The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP.

To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance.
The EPT Practice Level Reporting was submitted to PHLC on 01/31/2025.
The upcoming HEDIS-like data submissions are as follows:
<table>
<tr><th>Report Number</th><th>Due Date</th><th>Reporting Period</th><th>Submission Cycle</th></tr>
<tr><td>Report 1</td><td>01/31/25</td><td>01/01/23 - 12/31/23</td><td>May 2025</td></tr>
<tr><td>Report 2</td><td>07/31/25</td><td>01/01/24 - 12/31/24</td><td>November 2025</td></tr>
<tr><td>Report 3</td><td>01/31/26</td><td>07/01/24 - 06/30/25</td><td>May 2026</td></tr>
<tr><td>Report 4</td><td>07/31/26</td><td>01/01/25 - 12/31/25</td><td>November 2026</td></tr>
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<td>LOCUM PILOT INITIATIVE</td>
<td>The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited grant program, whereby select provider organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period.

A total budget of $250,000 was approved; participants receive up to:

$45,000 when hiring a Physician.

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	○ $31,600 when hiring an Advanced Practicing Clinician. • The Grant is paid for in two installments: ○ 50% upon signing the agreement. ○ 50% upon completion of the four-week assignment and submission of a post-program survey. • Program Implementation and Participation ○ The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods are being carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. ○ Locum Providers are alleviating a backlog of well-child and adolescent visits (WCV) while enabling urgent care coverage, allowing patients to schedule visits with their preferred physician. • Provider Specific Updates ○ Hill Country Community Clinic: A Nurse Practitioner began their three-month in early December, with the expectation the schedule and pace will ramp up slowly. Weekly check-ins are being conducted and will continue until they have met the grant requirements; anticipated by end of January 2025. ○ Round Valley Indian Health: The Executive Director indicated they would utilize their current locum to complete the grant activities. A request to extend the grant agreement through May 2025 has been made with Non-Provider Contracting. A weekly email check-in is initiated with their HR and/or QI teams to monitor and encourage progress; the Executive Director communicated they will let Partnership know when the grant activities begin. ○ Community Medical Center: Completed the initial grant activities and was awarded an extension to fund their locum through December 2024 to continue focusing on well-child visits, including disparity groups. Initial efforts resulted in the completion of 272 visits. During the extension, an additional 345 patient visits have been completed, primarily well-child visits and acute care. ○ Pit River Health Service: The grant activities and final evaluation have been completed, and payment of the 2nd installment was made. Successfully completed 218 patient visits, primarily well-child visits.
MOBILE MAMMOGRAPHY PROGRAM	• Between 07/01/2024 to 12/31/2024, Partnership sponsored 43 Mobile Mammography events days with 24 provider organizations at 38 provider sites. (Note: This represents a small update (i.e. increase) versus what was reported in January's QI Update.)

Completed Event Days 07/01/2024 – 12/31/2024				
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**	**# of Completed Partnership Screenings**
ER	6	13	15	309
NE	7	8	10	235
NW	2	7	8	170
SE	2	3	3	75
SW	7	7	7	145
Plan Wide	**24**	**38**	**43**	**934**

- Two (2) event days in the Northwest Region were held at a Tribal Health Center in Humboldt County.
- One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
- One (1) event day in the Southwest Region was held at a Tribal Health Center in Mendocino County.
- Three (3) event days in the Eastern Region were held at a Tribal Health Center in Tehama County.
- Scheduling for Mobile Mammography events for Q3 (January – March 2025) continues. Upcoming confirmed events in February and March include:

Upcoming Event Days January through March 2025			
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
ER	1	1	1
NE	2	2	3
SE	2	2	2
SW	1	1	1
Plan Wide	**6**	**6**	**7**

PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM (PPLP)

- Applications to request a LeadCare ll Point of Care device continue to be open year-round and are readily available on our Lead Poisoning and Prevention provider facing webpage, along with related resources.
- Providers approved in Fall 2023, who received their devices in January – February 2024, are currently being evaluated to determine if they met the 2024 QIP 50th percentile goal of 62.79.

	• The program has developed a promotional strategy to communicate the importance of lead testing, highlight available resources, and emphasize year-round enrollment. Promotional materials, including links and QR codes to the provider-facing page, have been distributed to provider facing teams. • Outreach efforts are underway for providers with a denominator of 100+, who did not meet the 2024 QIP 50th percentile. Meetings are being scheduled to review the workflows, provide feedback based on 2024 best practices and address challenges. • PPLP continues to collaborate with: o QI - Performance Improvement Team: Developing 2025 Best Practices using 2024 program feedback. o Population Health Team & Butte County Public Health: Supporting CALAIM Bold Goal efforts to exceed the 50th percentile for children's preventative care measures; Butte County Public Health submitted their application for a LeadCare II device in December 2024, and an MOU is in progress. o Communications Team: Updating the Lead Poisoning and Prevention member-facing page with current resources.
QI TRILOGY PROGRAM	• Mid-year status updates for the 2024-25 QI Work Plan were received from Business Owners in January. A mid-year report will be shared with Quality Committees in March. • Initial notices for the 2025-26 QI Program Description were emailed to Business Owners on 02/10/2025. Submissions are due 03/03/2025.

D-SNP

ACTIVITY	UPDATE
Model of Care (MOC)	• The Quality Project Management team completed the formatting of the Dual Eligible Special Needs (D-SNP) Model of Care (MOC) and the corresponding MOC Matrices. The MOC, Department of Healthcare Services (DHCS) Matrix and the National Committee for Quality Assurance (NCQA) Matrix were submitted to the Regulatory and Compliance (RAC) team on 01/22/2025. RAC is expected to submit all MOC related documents by the 02/12/2025 deadline. • A summary presentation of the MOC is occurring at Quality Committees this month.
D-SNP Education	• A special webinar titled: “Capturing Patient Acuity through Coding” will be presented on 02/19/2025. The target audience for this webinar is network providers and coding support personnel within organizations in the eight D-SNP counties. CME/CE was offered and will continue as an opportunity for Enduring Learning Credit through the end of the calendar year.
CAHPS Survey Project – Medicare Product Line	• The Medicare CAHPS program is in development. Interviews with sister plans have been conducted and relationships established for ongoing exchanges to help inform the buildout. • CMS approved survey vendors have been identified and RFIs were sent; three responses were received. The CAHPS team has scheduled follow-up calls to continue discussions with the three vendors and consider whether a formal RFP will be necessary

	to identify and move forward with the preferred vendor. We will be prepared to contract with a vendor mid-2025.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **12/30/2024 TO 01/28/2025**	• PQI referrals received during this period: 22 with 16 of these cases referred from Grievance and Appeals, four from Utilization Management, and two from Medical Directors • 26 cases were processed and closed to completion. • PQI cases that are currently open: 88 cases • One new PQI case was reviewed at the Peer Review Committee (PRC) in January. There are currently seven cases awaiting PRC review.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **12/30/2024-1/24/2025**	• As of 1/29/2025, we have a total of 457 PCP and OB sites with an additional 31 reviews due to multiple check-6ins (totaling 488 reviews). **Primary Care and OB Reviews Completed in this reporting period:** **Region** / **# of FSR conducted** / **# of MRR conducted** / **# of FSR CAP issued** / **# of MRR CAP issued** Auburn / 3 / 1 / 0 / 1 Chico / 2 / 0 / 0 / 0 Eureka / 5 / 4 / 0 / 1 Fairfield / 0 / 0 / 0 / 0 Redding / 3 / 4 / 2 / 4 Santa Rosa / 3 / 1 / 0 / 1 New sites opened this period à • Chico – Sycamore Pediatrics • Eureka – New Life • Santa Rosa – MarinHealth Medical Network

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The HEDIS MY2024 Annual Audits are scheduled: o DHCS Managed Care Accountability Set (MCAS) – 02/13/2025 o NCQA Health Plan Accreditation (HPA) – 02/26/2025 • Preparation is underway to receive and integrate all data to support the HEDIS MY2024 regulatory required reporting; this includes all non-standard supplemental data sources that will require Primary Source Verification (PSV), which must be approved by both auditors. • A special W30+6 medical record review (MRR) project launched in mid-January 2025 and will conclude by 02/28/2025. This special project is focused on retrieving,

	abstracting, and overreading compliant medical records to supplement the W30+6 administrative rate for MY2024. • Continued preparation is underway to begin plan-wide reporting as required by both DHCS MCAS and NCQA HPA HEDIS auditors in MY2024 reporting. • Additionally, beginning in MY2024, County-Level Reporting directly to DHCS will be completed for all 24 counties using the over-sampling methodology recently communicated by DHCS in late 2024.
HEDIS® Program Overall	• Partnership held a series of meetings with DHCS's Data Team on 01/10/2025 and 01/24/2025, with the goal of improving data capture for the Dental Fluoride Varnish for Children (TFL-CH) MCAS measure. DHCS and Partnership are moving forward with a strategy to validate the completeness of the Denti-Cal data that DHCS has provided Partnership for MY2024, and to improve data capture and completeness of Denti-Cal data for the MY2025 MCAS cycle. • DHCS continues to share aspects of their plan to sanction MCPs at the county level for MY2024 MCAS performance below the MPL. DHCS has shared plans to allow MCPs to substitute all plan rates for MCAS hybrid measures within counties having an eligible member population below DHCS's threshold of 100 members; Partnership is awaiting guidance on whether this instruction also applies to administrative measures.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• Applicable teams will participate in a full scope Mock File Review with our consultant, Managed Healthcare Resources (MHR), in either April or May 2025. The purpose of the Mock File Review is to sustain file review performance and to ensure full compliance with the Must-Pass elements throughout the HPA Renewal Survey look-back period. This review will include files from Partnership and non-NCQA Accredited delegates. The Mock File Review will be based on the 2025 HPA Standards and Guidelines and will follow NCQA's 8/30 methodology. Upon completion of the Mock File Review, the NCQA Program Management Team will coordinate Corrective Action Plan (CAP) submissions and provide assistance to ensure the actions are addressed promptly and the file review elements are compliant before the start of the look-back period in September 2025 (except for Credentialing files, as that look-back period started September 2023).
NCQA Health Equity Accreditation (HEA)	• In preparation for Partnership's HEA Initial Survey scheduled on 06/17/2025, Business Owners are required to submit their annotated and bookmarked evidence by 03/28/2025. The NCQA Program Management Team hosted an evidence preparation training session on 01/23/2025 which provided guidance and tips on how to prepare and present evidence in a standardized manner. Business Owners are asked to follow the plan-wide preparation instructions to ensure consistency in Partnership's evidence to streamline the review by the NCQA surveyors. The NCQA Program Management Team shared evidence submission instructions to all Business Owners via email on 01/28/2025. This communication also included an Evidence Submission Tracker specific to their assigned standards.

	• As of January 2025, Partnership's HEA compliance rate is at 85.19%, receiving 23 points out of the 27 total applicable points available. The NCQA Program Management Team is working closely with the Business Owners to ensure all applicable evidence is revised to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations.

Partnership Policy & Procedure Updates

March 2025

Policy Number	Policy/Procedures/Guidelines	Version Links
	The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in ***February 2025.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed* ***Synopsis of Changes.***	
	Quality Improvement	
MPQP1022	Site Review Requirements and Guidelines *I. Facility Site Review Tool – Supplemental Facility · Mobile Unit · Street Medicine (New Attachment, All others no changes)*	C CD RD
MPQG1005	Adult Preventive Health Guidelines	C CD RD
MPQP1016	Potential Quality Issue Investigation and Resolution	C CD RD
	Care Coordination	
MCCP2020	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)	C CD RD
MCCP2021	Women, Infants and Children (WIC) Supplemental Food Program	C CD RD
MPCD2013	Care Coordination Program Description	C CD RD
	Utilization Management	
MCUP3064	Communications Services	C CD RD
MCUP3103	Coordination of Care for Child Welfare-Involved Members	C CD RD
MPUG3011	Criteria for Home Health Services	C CD RD
MPUG3019	Hearing Aid Guidelines	C CD RD
MPUP3048	Dental Services (including Dental Anesthesia)	C CD RD

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Feb. 19, 2025 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement – *Rachel Newman, RN, Manager, Clinical Compliance Inspection Team*			
MCQP1022 – Site Review Requirements and Guidelines	151 - 496 ***NEW*** *Attachment I begins on p. 467*	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document.	Provider Relations Health Services Compliance Grievance & Appeals
Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*			
MPQG1005 – Adult Preventive Health Guidelines	497 - 512	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 –	Health Services Claims Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are added:** K. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services L. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/ **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • 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). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth	
MPQP1016 – Potential Quality Issue Investigation and Resolution	513 - 523	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** Timeframes amended throughout document to clarify "days" as "calendar days." **III.D. Corrective Action Plan is now redefined:** 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.	Health Services Provider Relations Grievance & Appeals

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		VI.C.1.a. addition: The Investigator will begin an investigation within 30 days of receiving the PQI case referral. **VI.C.3.d.ii:** The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality.	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Senior Manager of Foster Care Programs*			
MCUP3103 Coordination of Care for *Child Welfare-Involved* Members ~~in Foster Care~~	525 - 529	This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." • The name of the policy was updated to reflect the new "Child Welfare-Involved" language. • Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy. **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care."	Health Services Claims Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.C. A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*			
MPCD2013 Care Coordination Program Description	519 - 540	**Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated JD Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN	Health Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Updated JD for Behavioral Health Clinical Specialist-LCSW or LMFT to include: Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes **Protected Health Information (Page 17) Updated:** The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer	

PHC (PARTNERSHIP HEALTHPLAN OF CALIFORNIA) MEETING SUMMARY
(Confidential – Protected by CA. Evidence Code 1157)

Committee: Credentials Committee
Date: January 8, 2025 7:01am
Members Present: Steven Gwiazdowski, MD*; Michele Herman, MD*; Madeleine Ramos, MD*; Bradley Sandler, MD*

PHC Staff:

Marshall Kubota, MD*; PHC Regional Medical Director; Robert Moore, MD, MPH, MBA, PHC Chief Medical Officer; Mark Netherda, MD*; Medical Director; Priscila Ayala*; Director of Network Services; Heidi Lee, Senior Manager of Systems and Credentialing; Ayana Shorter, Credentialing Supervisor; J'aime Seale, Credentialing Lead; Alex Lopez, Credentialing Specialist; Ashnilta Sen*, Credentialing Specialist; Elizabeth Rios*, Credentialing Specialist; Morgan Brambley*, Credentialing Specialist; Alisa Crews-Gerk*, Credentialing Specialist; Ashlee Grove*, Credentialing Specialist; Maegan Ojeda*, Credentialing Specialist; Mare-Paule Uwase*, Credentialing Specialist; Kelly Serpa*, Credentialing Specialist; Nolan Smith*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. PHC Regional Medical Director Marshall Kubota, MD called the meeting to order at 7:01am. Credentials Committee roll call taken by J'aime Seale. Dr. Kubota reminded everyone that all items discussed are confidential. a. Marshall Kubota, MD, PHC Regional Medical Director, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Dr. Kubota reminded the committee that all information discussed is confidential in nature.			
II. Review and approval of 12/11/2024 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for 12/11/2024 were reviewed by the Committee.	II. Summary were reviewed. A motion for approval of the Summary was made by Dr. Bradley Sandler,MD and seconded by Dr. Steven Gwiazdowski, MD. Meeting Summary were unanimously approved without changes.		1/8/2025
III. Old Business. a. Update on Provider	III. Old Business – a. Dr. Netherda brought to the attention of the committee information for a provider. Dr. Netherda stated that he reviewed the providers chart personally and was pleased with what he reviewed. He stated he has no concerns at this time.	III. Old Business a. Old Business for provider was reviewed by the committee. A motion to Approve chart review was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski, MD. Chart Review was unanimously approved without changes.		1/8/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Kubota referred the Credentials Committee to review the routine list of practitioners on pages 17-19	a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Dr. Bradley Sandler, MD and seconded by Dr. Madeleine Ramos, MD . The Committee unanimously approved the routine list.		1/8/2025
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Kubota referred the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list on pages 20-23. These practitioners are approved by Dr. Kubota pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the list practitioners was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski, MD. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		1/8/2025
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Alex Lopez. Alex explained the policies MPCR11 Credentialing of Community Health Worker (CHW) supervising providers, MPCR20 Medi-Cal Managed Care Plan Provider Screening and Enrollment, MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR700 Assessment of Organizational Providers all had minor revisions. The policies are consent calendar items.	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Dr. Steven Gwiazdowski, MD and seconded by Dr. Bradley Sandler, MD. The Committee unanimously approved the revised policies.		1/8/2025
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions Report.	a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report on page 53.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Dr. Madeleine Ramos, MD and seconded by Dr. Bradley Sandler, MD. The Committee unanimously approved.		1/8/2025
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring List on pages 54-55. Dr. Kubota reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Informational only*.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
VI. Review and Approval of Consent Calendar Items. a. Report of Long Term Care Facility, Hospital, and Ancillary provider list.	VI. Review and Approval of Consent Calendar Items. a. Dr. Kubota asked the Credentials Committee members to review the report of Long Term Care Facility, Hospital, and Ancillary provider list on page 56-57.	VI. Review and Approval of Consent Calendar Items. a/b. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski, MD. The Credentialing Committee unanimously approved.		1/8/2025
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 1/8/2025 respectfully prepared and submitted by Alex Lopez, Credentialing Specialist I

Chairman Signature of Approval _____ ***Date*** 1/8/2025

Marshall Kubota, M.D., PHC Credentialing Chairman

App. Ty	Full Name	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Adams, Kimberlee K.,FNP-BC	SPEC	Providence Medical Group,	Humboldt	Family Nurse P	American Nurse	05/13/2024	Yes	None	
I	Adejumo, Oluwayemisi L.,MD	SPEC	NBHG: Heart and Vascular	Solano	Interventional C	ABMS of Intern	10/20/2020	Yes	North Bay Medi	Active
I	Aggio, Julian D.,PA-C	SPEC	Oroville Comprehensive He	Butte	Physician Assis	National Comm	01/12/2024	Yes	None	
R	Aldrete, Jessica BCBA	BHP	Maxim Healthcare Sevices I	Yolo	BCBA	Behavior Analy	12/17/2021	Yes	None	
I	Astran, Melinda MD	PCP	Peach Tree Healthcare - PC	Yuba	Family Medicin	ABMS of Famil	07/14/2000	Yes	Admitting Agre	None
I	Au, Veronique L.,MD	SPEC	Peach Tree Clinic - Spec	Yuba	Urgent Care	ABMS of Emerg	11/29/2005	Yes	John Muir Medi	Active
I	Auble, Daniel W.,AUD	Allied	Kenwood Hearing Centers	Sonoma	Audiology	None		No	None	
I	Avila, David MD	PCP	Marin Community Clinic: Ca	Marin	Pediatrics	Confirmed per A		No	Admitting Agre	None
R	Bernas, Janina RD	Allied	Ole Health	Napa	Registered Diet	Commission of	12/08/2020	Yes	None	
I	Brewer, Rachael M.,FNP-C	SPEC	TeleMed2U	Yolo	Family Nurse P	American Acad	07/13/2018	Yes	None	
I	Brown, Allison R.,PA-C	PCP	Pediatric Medical Associate	Placer	Physician Assis	National Comm	07/14/2022	Yes	None	
I	Buenrostro Contreras, Karen BCBA	BHP	Pantogran LLC dba Center	Yolo	BCBA	Behavior Analy	11/18/2024	Yes	None	
I	Burton, Noelle A.,PA-C	SPEC	Sierra Medical Partnership	Placer	Physician Assis	National Comm	02/26/2015	Yes	None	
I	Canavesio, Lindsey T.,AGACNP-BC	PCP	Adventist Health St Helena	Napa	Adult Gerontolo	American Nurse	10/17/2014	Yes	None	
I	Carr, Brandon PA-C	SPEC	Bright Heart Health Medical	Solano	Physician Assis	National Comm	05/24/2024	Yes	None	
I	Celosse, Karin Psy.D	BHP	Burnett Therapeutic Service	Napa	Clinical Psycho	None		No	None	
I	Chacon, Claret BCBA	BHP	Pantogran LLC dba Center	Solano	BCBA	Behavior Analy	12/13/2021	Yes	None	
I	Chait, Lois RD	Allied	TeleMed2U	Yolo	Registered Diet	Commission of	06/01/1975	Yes	None	
R	Chandrasekaran, Prathibha MD	SPEC	Dr. Prathibha Chandrasekar	Shasta	Gastroenterolo	ABMS of Intern	11/06/2002	Yes	Admitting Agre	None
I	Chrysofakis, Grigorios MD	SPEC	Sierra Hematology & Oncol	Solano	Hematology an	None		No	Mercy Hospital	Active
I	Concello, Heidi E.,PT	SPEC	Selah Women's Health	Shasta	Physical Thera	None		No	None	
I	Corbeil, Courtney R.,DO	SPEC	TeleMed2U	Yolo	Rheumatology	ABMS of Intern	11/07/2019	Yes	Admitting Agre	None
R	Dacy, Tara L.,SUDRC	W&R	Aegis Treatment Centers, L	Shasta	Wellness and R	California Subs	12/17/2024	Yes	None	
I	Damasco, Genevive P.,RD	Allied	La Clinica/ Great Beginning	Solano	Registered Diet	Commission of	10/05/2024	Yes	None	
I	Danforth, Amanda Doula	SPEC	Amanda Danforth DBA Butt	Nevada	Doula	None		No	None	
I	Davis, Joanna L.,LM	SPEC	Harmony Health Medical Cli	Yuba	Licensed Midwi	None		No	None	
I	Dawod, Yaser T.,MD	SPEC	TeleMed2U	Yolo	Pulmonary Dise	ABMS of Intern	11/16/2021	Yes	Admitting Agre	Active
R	Dhanda, Paula R.,MD	SPEC	Specialty Care and Surgery	Lake	Gynecology	None		No	Sutter Lakeside	Courtesy
R	Dhugga, Gurpreet S.,MD	SPEC	Gurpreet S. Dhugga M.D.	Solano	Internal Medicir	ABMS of Intern	08/26/1998	Yes	Sutter Solano M	Active
R	Di Gregorio, Allison BCBA	BHP	Autism Behavior Services Ir	Yolo	Behavioral Hea	Behavior Analy	08/31/2017	Yes	None	
I	Diles, William S.,AUD	Allied	Kenwood Hearing Centers	Sonoma	Audiology	None		No	None	
I	Dolan, Debora D.,SLP	Allied	Burger Physical Therapy an	Solano	Speech & Lang	None		No	None	
I	Donaldson-Fletcher, Katherine M.,CNM	SPEC	Planned Parenthood Northe	Solano	Certified Nurse	American Midw	01/01/2021	Yes	None	
I	Doyle, Paige L.,RD	Allied	Sierra Medical Nutrition The	Nevada	Registered Diet	Commission of	06/26/2023	Yes	None	
R	Duncan, Corinne N.,AGPCNP-BC	PCP	Santa Rosa Community Hea	Sonoma	Adult-Gerontolo	American Nurse	10/23/2024	Yes	None	
I	Ejigu, Desalegn FNP-C	PCP	Onsite Primary care and Nu	Yolo	Family Nurse P	American Acad	07/02/2018	Yes	None	
R	Fordham, Kimberly J.,MD	BOTH	Adventist Health Clearlake	Lake	Family Medicin	ABMS of Famil	07/12/2002	Yes	Adventist Healt	Active
I	Freschl, Guille E.,MD	PCP	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Famil	07/01/2024	Yes	Admitting Agre	None
I	Frey, Kendall N.,Doula	Allied	Kendall Frey	Nevada	Doula	None		No	None	
R	Giglio, Anita L.,RD	Allied	Ole Health	Napa	Registered Diet	Commission of	04/01/1984	Yes	None	
I	Greene, Elexus RADT	W&R	Archway Recovery Services	Fairfield	Wellness and R	California Cons	05/24/2024	Yes	None	
I	Greve, Robert D.C.	SPEC	Robert L. Greve, DC	Shasta	Chiropractor	None		No	None	
R	Groves-Rehwaldt, Katrina C.,MD	BOTH	Bright Heart Health Medical	Solano	Family Medicin	ABMS of Famil	07/10/1992	Yes	Admitting Agre	None
I	Guy, Cascillas M.,MD	SPEC	North Pacific Cardiology	Humboldt	General Surger	Confirmed per A		No	Mad River Com	Active
I	Hajek, Jaima R.,BCBA	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analy	10/10/2022	Yes	None	
I	Harwood, James W.,MD	SPEC	Providence Medical Group,	Sonoma	General Surger	ABMS of Surge	05/30/1986	Yes	Santa Rosa Me	Active
R	Hassani, Ali MD	PCP	NBHG: Center for Primary C	Solano	Internal Medicir	ABMS of Intern	08/18/2014	Yes	Admitting Agre	None
R	Heckert, Catherine A.,FNP	PCP	La Clinica - North Vallejo	Solano	Family Nurse P	American Nurse	01/01/2015	Yes	None	
I	Henderson, Claire Doula	SPEC	Doula Sisters, LLC	Humboldt	Doula	None		No	None	
I	Hicks, Nicole A.,PA-C	SPEC	Enloe Specialty Physicians	Butte	Physician Assis	National Comm	12/03/1999	Yes	None	
R	Holloway, Aaron S.,PA-C	PCP	Northeastern Rural Health C	Lassen	Physician Assis	National Comm	09/14/2020	Yes	None	
I	Holloway, Leah PA-C	PCP	Oroville Medical Clinic	Butte	Physician Assis	National Comm	01/12/2024	Yes	None	

App. Ty	Full Name	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Huffman, Jasmine D.,SUDCC II	W&R	Aegis Treatment Center LL	Humboldt	Wellness and F	California Subs	12/28/2023	Yes	None	
I	Hyde, Lauren BCBA	BHP	Kyo Autism Therapy LLC, fk	Yolo	BCBA	Behavior Analy	05/14/2022	Yes	None	
I	Iupe, Emily BCBA	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	12/27/2023	Yes	None	
R	Jackson, Scott A.,SLP	Allied	NorthBay Healthcare Ear, N	Solano	Speech & Lang	None		No	None	
I	Jackson-Tross, Danielle FNP-BC	PCP	ReSolution Care, PC	Solano	Family Nurse P	American Nurse	06/20/2017	Yes	None	
R	Jacobs, Joshua S.,MD	SPEC	Allergy & Asthma Medical G	Solano	Allergy & Immu	Previously Boa	08/11/1997	No	Admitting Agre	None
I	Janes, Donald N.,Jr., MD	SPEC	ODCHC - Telehealth & Visit	Humboldt	Urgent Care	None		Not Applica	Admitting Agre	None
I	Jose, Jessil K.,FNP-BC	SPEC	Sacramento Ear Nose and T	Yolo	Family Nurse P	American Nurse	02/09/2009	Yes	None	
I	Kashchy,Dakota BCBA	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analy	05/31/2022	Yes	None	
I	Kelly, Jessica BCBA	BHP	Jessica Kelly	Humboldt	BCBA	Behavior Analy	09/24/2021	Yes	None	
R	Khan, Akbar DO	SPEC	Revive Pain and Spine Cen	Yolo	Pain Medicine	AOB Physical M	10/08/2017	Yes	NBHG	Active
I	Khan, Asfandyar MD	SPEC	Dignity Health Medical Grou		General Surger	None		No	Sierra Nevada I	Active
I	Khanna, Vikram MD	PCP	La Clinica Oakley	Solano	Family Medicin	ABMS of Family	07/13/2001	Yes	Admitting Agre	None
R	Kindlespire, Kandyce C.,BCBA	BHP	Center for Social Dynamics	Yuba	Behavioral Hea	Behavior Analy	06/09/2020	Yes	None	
I	King, Deidra BCBA	BHP	Pantogran LLC dba Center	Yolo	BCBA	Behavior Analy	01/31/2011	Yes	None	
I	Komari, Vishuvardhan R., MD	SPEC	Noel Serrano, MD	Solano	SNFist	ABMS of Intern	08/11/2015	Yes	Admitting Agre	None
I	Lalchandani, Ram N.,MD	SPEC	Sierra Hematology & Oncol	Solano	Hematology an	None		No	Mercy San Jua	Active
R	Larumbe Smith, Stephanie K.,CNM	SPEC	CommuniCare Ole - Davis C	Yolo	Certified Nurse	American Midw	07/01/2021	Yes	None	
R	Limvarapuss, Chainarong MD	SPEC	Solano Hematology Oncolo	Solano	Medical Oncolo	ABMS of Intern	11/04/1998	Yes	Sutter Solano M	Active
R	Loffler-Barry, Christine MD	PCP	Napa Valley Medical Group,	Napa	Pediatrics	ABMS of Pedia	10/09/1996	Yes	Queen of the V	Active
R	Long, Richard J.,MD	SPEC	John Muir Specialty Medical	Solano	Urology	ABMS of Urolo	02/29/2000	Yes	John Muir Medi	Active
I	Lopez, Christina PA-C	SPEC	Enloe Orhopaedic and Trau	Butte	Physician Assis	National Comm	09/10/2024	Yes	None	
I	Ludlow, Catherine A.,FNP-BC	SPEC	The Cardiovascular Center	Shasta	Family Nurse P	American Nurse	09/01/1997	Yes	None	
I	Madsen, Kimberly H.,RD	Allied	Ceres Community Project	Sonoma	Registered Diet	Commission of	10/01/1992	Yes	None	
I	Marquez, Tiffany BCBA	BHP	Peak Potential ABA, LLC	Solano	BCBA	Behavior Analy	11/24/2020	Yes	None	
I	McCain, Krystal S.,PA-C	PCP	UIHS - Potawot Health Villa	Humboldt	Physician Assis	National Comm	02/15/2018	Yes	None	
I	McCurry, Meghan D.,DO	PCP	Consolidated Tribal Health F	Mendocino	Family Medicin	ABMS of Family	07/31/2024	Yes	Admitting Agre	None
I	McGinley, Pearl L.A.c	SPEC	Pearl McGinley, L.A.c	Solano	Acupuncture	None		No	None	
R	Meux, Mary K.,MD	PCP	CommuniCare Ole - Davis C	Yolo	Family Medicin	ABMS of Family	07/17/2004	Yes	Admitting Agre	None
R	Mitchell, James D.,MD	SPEC	NBHG: NorthBay Cancer Ce	Solano	Radiation Onco	ABMS of Radio	06/02/2009	Yes	John Muir Medi	Consulting
R	Mohebati, Arash MD	SPEC	John Muir Health Center Me	Sacramento	General Surger	ABMS of Surge	02/23/2010	Yes	John Muir Medi	Active
R	Mojica, Laura L.,NP	PCP	Redwood Pediatric Medical	Humboldt	Nurse Practitior	None		No	None	
I	Morton, Heather R.,PMHNP-BC	SPEC	Ampla Health Marysville Me	Yuba	Psychiatric Mer	American Nurse	08/04/2023	Yes	None	
I	Mualuko, Mueni C.,AGPCNP-BC	PCP	Northeastern Rural Health C	Lassen	Adult-Gerontolc	American Nurse	03/28/2014	Yes	None	
I	Mullen, Netanya M.,DO	SPEC	Netanya Mullen DO	Shasta	Neonatal-Perin	None		No	Mercy Medical	Active
I	Murphy, Michael D.,MD	PCP	Southern Humboldt Commu	Humboldt	Internal Medicir	Meets MPCR #		No	Admitting Agre	None
R	Narayan, Geetha MD	SPEC	Nagarathna G. Manjappa M	Napa	Nephrology	ABMS of Intern	11/13/1984	Yes	Queen of the V	Active
I	Nedic, Meghan MD	PCP	Northern Valley Indian Healt	Butte	Pediatrics	None		No	Admitting Agre	None
R	Ngai, Tiffany MD	SPEC	Providence Medical Group,	Sonoma	Infectious Dise	ABMS of Intern	11/15/2018	Yes	Providence Sar	Active
I	Nnoka, Maureen N.,PMHNP-BC	W&R	Ujima Hope Solano	Solano	Psychiatric Mer	American Nurse	07/19/2022	Yes	None	
I	Nutting, Larry L.,MD	PCP	Pediatric Medical Associate	Yolo	Pediatrics	ABMS of Pedia	10/09/1996	Yes	Sutter Medical	Active
I	O'Neil, John C. MD	SPEC	J. Cole Recovery Homes In	Solano	Wellness and F	None		No	Admitting Agre	None
R	Owoeye, Olatunde O.,FNP-C	PCP	Adventist Health Clearlake	Lake	Family Nurse P	American Acad	09/26/2017	Yes	None	
I	Padilla, Patricia G.,MD	PCP	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Family	07/14/1989	Yes	Admitting Agre	None
R	Paquette, Justin MD	SPEC	Justin Paquette, MD	Napa	Neurological Su	None		No	Admitting Agre	None
I	Patel, Karuna D.,PT	Allied	Karuna D. Patel / Turtle Rat	Solano	Physical Therap	None		No	None	
R	Patel, Vishal G.,MD	SPEC	Providence Medical Group,	Sonoma	Interventional C	ABMS of Intern	11/05/2014	Yes	Santa Rosa Me	Active
R	Peterson, Robert K.,MD	SPEC	NBHG: Ortho Surg A Northt	Solano	Orthopaedic Su	ABMS of Ortho	07/13/2000	Yes	Admitting Agre	None
R	Pettis, Robert M.,MD	SPEC	Adventist Health Mendocino	Mendocino	Otolaryngology	ABMS of Otolar	06/05/2006	Yes	Adventist Healt	Active
I	Ponce, Aniel Psy.D	BHP	Burnett Therapeutic Service	Napa	Clinical Psycho	None		No	None	
I	Poulsen, Megan M.,PA-C	PCP	Alliance Medical Center	Sonoma	Physician Assis	National Comm	12/21/2023	Yes	None	
R	Purkey, Hannah Claire G.,MD	PCP	SCHC: Anderson Family He	Shasta	Family Medicin	ABMS of Family	07/07/2020	Yes	Admitting Agre	None

App. Ty	Full Name	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Raj, Vikram DO	SPEC	Peach Tree Clinic - Spec	Yuba	Urgent Care	None		No	Adventist Healt	Active
I	Rao, Shravan MD	SPEC	John Muir Cardiovascular M	Solano	Cardiology	None		No	John Muir Medi	Provisional
R	Rodriguez Moreno, Jose I.,MD	SPEC	Asante Physician Partners:	Siskiyou	Neurology	ABMS of Psych	09/19/2022	Yes	Rogue Regiona	Active
R	Rojas, Heather R.,FNP-C	SPEC	Shriners Hospitals for Childr	Yolo	Family Nurse P	American Acad	05/01/2012	Yes	None	
I	Rose, Jessica L.A.c	SPEC	Jessica Curl	Mendocino	Acupuncture	None		No	None	
R	Rosenthal, Ellen G.,MD	PCP	Marin Community Clinic: Ca	Marin	Internal Medicir	ABMS of Intern	08/24/1994	Yes	Admitting Agre	None
R	Rothermund, Heather M.,SUDRC	W&R	Empire Recovery Center	Shasta	Wellness and R	California Subs	11/06/2024	Yes	None	
I	Saechao, Cheng H.,PA-C	SPEC	Peach Tree Clinic - Spec	Yuba	Physician Assis	National Comm	12/14/2021	Yes	None	
R	Shah, Saurin MD	SPEC	Bay Area Surgical Specialis	Solano	Thoracic & Car	ABMS of Thora	06/10/2016	Yes	John Muir Medi	Active
R	Sidhu, Navpreet S.,MD	PCP	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Family	08/06/2020	Yes	Admitting Agre	Active
I	Silverman, Ira J.,MD	SPEC	Northeastern Rural Health C	Lassen	Obstetrics and	ABMS of Obste	12/09/1983	Yes	Admitting Agre	None
R	Singh, Paramvir MD	SPEC	Paramvir Singh, MD Inc.	Shasta	Gastroenterolo	ABMS of Intern	11/03/2004	Yes	Admitting Agre	None
I	Singh, Sharanjit MD	PCP	Ampla Health Marysville Me	Yuba	Internal Medicir	ABMS of Intern	08/22/2017	Yes	Adventist Healt	Active
I	Stratigakes, Vanessa A.,PT	Allied	Burger Physical Therapy an	Solano	Physical Thera	None		No	None	
I	Stuart, Jeanee Iona SUDRC	W&R	Archway Recovery Services	Solano	Wellness and R	California Subs	05/13/2024	Yes	None	
I	Taubman, Bridget BCBA	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	12/02/2024	Yes	None	
I	Tello, Maryori Y.,RD	SPEC	TeleMed2U	Yolo	Registered Diet	Commission of	11/11/2017	Yes	None	
I	Thompson, Darren R.,DO	PCP	SCHC: Shasta Community H	Shasta	Family Medicin	None		No	Admitting Agre	Active
I	Virk, Navneet MD	SPEC	Sierra Hematology & Oncol	Solano	Hematology	ABMS of Intern	11/17/2011	Yes	Mercy San Jua	Active
I	Ward-Dyer, Jasmine C.,OT	SPEC	Burnett Therapeutic Service	Napa	Occupational T	None		No	None	
I	Weber, Kevin J.,MD	SPEC	Glenn Medical Center - Fam	Glenn	Orthopaedic Su	Confirmed per A		No	Admitting Agre	None
I	White, Tesheima BCBA	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analy	07/05/2020	Yes	None	
I	Xu, Jennifer W.,MD	SPEC	Capital Allergy & Respirator	Placer	Allergy & Immu	None		No	Admitting Agre	Active

MEETING Minutes

Meeting & Project Name: Quality Improvement & Health Equity Committee (QIHEC)

Date: 1/21/2025 **Time**: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Monika Brunkal, Anna Campbell, Dawn Cook, Nicole Curreri, , Heather Esget, Ledra Guillory, Bethany Hannah, Mohamed Jalloh Amanda Kim, Vicky Klakken, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Robert Moore, ,Lilian Morino, Rachel Newman, Hannah O'Leary, Katheryn Power, Sue Quichocho, Manleen Randhawa, Denise Rivera, Dorian Roberts, Leila Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Liat Vaisenberg, Vicquita Velazquez, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Isaac Brown, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller Margarita Garcia-Hernandez, Brigid Gast, Nisha Gupta, Tony Hightower, Latrice Innes, Mary Kerlin, Rachel Newman, Mark Netherda, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Edna Villasenor

External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC						
Eugene Durrah	Solano County	County						
Suzanne Edison-Ton, MD Chief Medical Officer	Communicare+ Ole	FQHC						
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System						
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department						
TBD	Providence	Health System	X					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System						
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X					
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X					
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department						
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X					
Tiffani Thomas	Solano County	Local	X					

Case Manager	Superior Court	Government						
Brandon Thornock	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X					

***FQHC= Federally Qualified Health Center

*****Members who do not attend at least half of meetings will be considered for removal per vote of committee.

Agenda Topic	Notes	Action Item
Agenda Item 1 **Introductions**	A. Dr. Jalloh introduced Bethany Hannah as the new coordinator for the QIHEC meeting. He then conducted a roll call for external advisory members to mark their attendance. B. Quorum was met by having 9 members present.	
Agenda Item 2 **Renaming QIHEC**	A. Dr. Jalloh introduces two options for renaming QIHEC; Option 1: HEART (Health Equity Advisory Committee for Reform and Transformation) or Option 2 IDEA (Inclusion Diversity, Equity, and Access) or Option 3: No change.	1. No motion was made to change the name at this time.
Agenda Item 3 **CMO Partnership Health Plan Updates.** Speaker: Dr. Moore	A. Medicare Advantage product using the name Partnership Advantage. • The plan will be 8 counties: Dell North, Humbolt, Mendocino, Lake, Sonoma, Marin, Napa and Solano in the initial phase. • Low enrollment expected initially, somewhere between 3000 and 8000 members. • Scheduled to submit our bid in the next month or so to CMS. • Working on developing a network between these 8 counties. B. 10 counties have successfully transitioned to the whole child model. • There is a large amount of care management and care coordination is now the responsibility of our partnership team. C. Announced that they would be sanctioning several health plans across the state for below average quality performance in a series of metrics.	

Agenda Topic	Notes	Action Item
	• The methodology for this is problematic if a measure is sanctionable if it's below average, therefore more than half of all health plans are subject to these sanctions. • Over half of the sanctions for dental Fluoride measure are reliant upon data from DHS, we are lacking the data, as a result Partnership has appealed that sanction. D. A big issue for the Partnership is to undergo a couple of major system updates. • The first major system update is the claims processing system, which is scheduled for within the next 6 months (HRP). • The second major system update is a change to the utilization management care coordination population health care system (JIVA)	
Agenda Item 5 **Community Updates from ALIADOS and HANC.** Speaker: Arlene Pena	A. ALIADOS: Health Equity Dashboard • Arlene Pena shares that starting this year they are working on the development of a health equity dashboard as well as provide training to health centers on how to utilize the dashboards. • The dashboard is built into the population health management system, and they have started breast cancer screening and controlling high blood pressure. • Arlene stated that their next step is to build in some statistical analysis onto the dashboard. • Next steps are to develop cervical cancer screening and colorectal cancer screening and then roll out well child visits and immunizations next. She stated there is some grant funding to build in some geo mapping into the dashboard to look visually briefly at what regions have a lower rate of compliance for those measures. B. HANC: No Updates.	

Agenda Topic	Notes	Action Item
Agenda Item 6 **Meeting minutes** Speaker: Dr. Jalloh	A. Meeting minutes were distributed the morning of the QIHEC Meeting, therefore committee members were unable to review them. B. Dr. Jalloh called for a motion for approval, but no one had time to review, therefore they will be reviewed and approved at the next QIHEC meeting in March.	1. Review and approve Nov and January QIHEC Meeting minutes
Agenda Item 7 **Grand Analysis: Disparity Analysis (Language Stratification)** Speaker: Dr. Jalloh	A. This analysis was completed for data measurement year 2023. o This data included 14 counties; data may be changing this upcoming year when we are able to do the analysis based on the year 2024. o All studied linguistic groups (English Spanish, Russian, Tagalog) met minimum performance level (MPL) for prenatal and postnatal care. o Spanish, Russian, Tagalog groups did not meet minimum performance level for Controlling Blood Pressure but there waws no statistically significant difference when compared to English group. o The Tagalog group was the group that had numerically higher rates of poor hemoglobin control when compared to the English group. B. Vietnamese group had significantly lower rates of WCV when compared to English speaking community o Preliminary goal is to increase the well care visit rate of Vietnamese speaking population by 12% in SE region and to have all underperforming regions achieve 50th percentile (MPL) in 12 to 24 months. C. Observations of Language Disparities in Communities: o Jeremy Plumb (North Bay) shared that the Spanish-speaking population is facing significant disparities in diabetes management and Medicare. He emphasized the need for outreach and education as key interventions. o Dr. Jalloh asked if Partnership can support this community, and Jeremy confirmed that outreach and education would be critical. o Wendy Starr suggested exploring the Promotores Program (community health workers from within the Hispanic community) for outreach, especially with Spanish-speaking individuals. She shared her experience	

Agenda Topic	Notes	Action Item
	with the program in Humboldt and Del Norte counties, noting that it's informed and effective because it comes from within the community. D. Arlene Pena supported this, suggesting combining community health workers with mobile health units to reach vulnerable communities, especially in the current political climate. Language and Acculturation Considerations: o Dr. Moore raised concerns about ensuring cultural sensitivity when addressing language disparities. He noted that acculturation impacts outcomes differently—sometimes improving, sometimes worsening them. He cautioned against assuming language disparities are solely based on language, suggesting acculturation should be respected without interference. Dr. Jalloh agreed. E. Dr. Candy Stockton stressed the importance of considering the political climate when designing outreach efforts to avoid exposing vulnerable populations, particularly undocumented individuals, to risk D. Concerns About Outreach Events: o Dr. Candy Stockton warned that targeted outreach events for specific populations could inadvertently put participants at risk due to the political climate, potentially making them targets. o Dr. Kubota highlighted that language disparities often overlap with concerns related to fear among non-primary English speakers due to the political climate. He suggested that this issue should be treated separately, emphasizing that some Hispanic communities have a lower rate of grievances and appeals, which is problematic and hasn't changed over time. o Dr. Kubota also noted that the Partnership's member handbook is being revised and stressed the importance of ensuring it is accessible and understandable for non-English speakers, particularly regarding cultural and language nuances. F. Communication and Feedback:	

Agenda Topic	Notes	Action Item
	o Dr. Jalloh emphasized the need to gather direct feedback from non-English-speaking members and to involve communities in the design of communication materials. He suggested hosting indirect focus groups for this purpose. o Denise Whitsett from TNT shared that they have recently started a patient advisory committee and are actively recruiting members from their community for input. They are committed to ensuring the community's voice is heard. o Arlene Pena mentioned that several health centers in the Aliados network have patient advisory councils and emphasized the importance of balancing engagement without tokenizing individuals. She also mentioned some community-based organization (CBO) projects that might offer opportunities for Partnership. o Dr. Candy Stockton shared an example of a translation issue she encountered when trying to translate documents into Moong for an older Moong-speaking family. She explained that the family was unable to read or write in Moong, highlighting the issue of non-written literacy in some non-English-speaking immigrant populations	
Agenda Item 8 **Health Equity Integration Policy** Speaker: Dr. Jalloh	A. A preliminary draft is being refined with internal staff over the next 6-9 months, aiming to guide health centers and systems in integrating health equity. o IHI Health Equity Organization Readiness Assessment and Diversity Assessment ▪ The tool encourages organizations to assess how well equipped they are for addressing health disparities. o Organizations should look to have staff, leadership, and governing bodies resemble the community they are serving. o REAL/SOGI Data Collection and Non-Stigmatizing Practices: ▪ Organizations should follow guidelines for collecting Race, Ethnicity, and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) data in a sensitive, non-stigmatizing manner.	A. Further discussion on ensuring accessible communication materials and involving community members in feedback and design will be prioritized.

Agenda Topic	Notes	Action Item
	○ Medical Documentation, Clinical Score Tool, and Medical Device Update ▪ Organizations should evaluate clinical score tools to ensure they don't reinforce health disparities, with recommendations for alternative tools. ○ Arlene Pena proposed considering AI's impact on patient care.	
Agenda Item 9 **Disparity Discussions: Prenatal and Postpartum Care in AI/AN** Speaker: All	A. Partnership Goals: • The partnership's goal is to send DHCS an annual report outlining key efforts to address disparities. B. Categories of Activities to Address Disparities: Dr. Jalloh explained that these three categories will be the focus of a recurring cycle of discussions: Policy Changes, Key Activities, and Community Engagement. **Prenatal/Postpartum Disparities in AI/AN:** **A. Policy Discussion (PPC – PRE-Post AI/AN):** *Policies to be Evaluated with their corresponding IQI/QUAC dates:* • April 2025: MCP2026 Diabetes Prevention Program • June 2025: MPXG5008 Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing; MPXG5009 Lactation Clinical Practice Guidelines • August 2025: MCUG3118 Prenatal and Perinatal Care; MCUP3119 Sterilization Consent Protocol • September 2025: MCUP3050 Medication Abortion in First Trimester • November 2025: MCNP9006 Doula Service Benefit *A motion was made to approve the review and feedback process for these policies to address disparities.* 1st Motion: Denise Whitset 2nd Motion: Candy Stockton, MD	A. Share Updated Draft with interested QIHEC members and Partnership Staff Members B. Motion to approve the policies chosen to review and provide timely feedback to policies to help address corresponding disparities. 1st Motion: Denise Whitset 2nd Motion: Candy Stockton, MD • Motion from the committee to add pediatric guidelines to list of policies to review. 1st Motion to approve: Arlene Pena • 2nd Motion: Tifanni Thomas • Anna Cambell will send the details for the pediatric guidelines policy. Policy #: MCQG1015

Agenda Topic	Notes	Action Item
	F. All feedback is due by March. Addition of Pediatric Guidelines: - *A Motion to Add Pediatric Guidelines:* 1st Motion: Arlene Pena 2nd Motion: Tifanni Thomas	
Disparity Discussions: Well-Care Visits in Rural Community	**Well-Child Visit Disparities in Rural Community** QI/PHM Intervention Review: • Community Engagement: Amanda Smith shared that Partnership's Growing Together Program incentivizes well-child visits by offering gift cards to parents. o Program Details: The program incentivizes parents to access care for their children or perinatal care. Gift cards are given when parents bring their child for well-child visits. o No recommendations or motions were made	
Disparity Discussions: Controlling Blood Pressure in AA Community	Blood Pressure Control for Tribal and African American Communities: - Community Health Workers (CHWs): Partnership will explore integrating CHWs into community settings such as churches, barbershops, beauty salons, etc. A. IPP Grant: A grant was approved to pilot this initiative. B. Community Suggestions: • Churches, libraries, Parent Teacher Associations • Recreation centers • LGBTQ community centers, day labor centers	• The group will continue to work on integrating community health workers into various organizations throughout the year to improve health outcomes in targeted communities.

Agenda Topic	Notes	Action Item
Agenda Item 10 **Next Meeting** Speaker: Dr. Jalloh	Next Meeting: March 18th, 2025, 7:30 a.m. – 9:00 a.m.	

AGENDA ITEM: III.C.
DATE: 03/12/2025

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 03/12/2025

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Brett Pottenger, Medical Director, Solano County Health and Social Services, volunteers to serve as a Credentials Committee voting member.

His appointment as a voting member is recommended.

Physician Advisory Committee Workforce Development Update

David Lavine

Associate Director of Workforce Development

March 12th, 2025

Presentation Focus Areas

Provider Network
Needs assessment

Programs & Initiatives

Data Analysis

Strategies

Understanding Landscape

Contacts

- CEOs / Executive Directors
- COOs
- CMOs / Medical Directors
- HR Directors/ Recruiters
- Specialty Providers

Organization Type

- FQHCs / RHCs
- Hospitals / Hospital Based Clinics
- Tribal Health Clinics
- Private / Small group practices

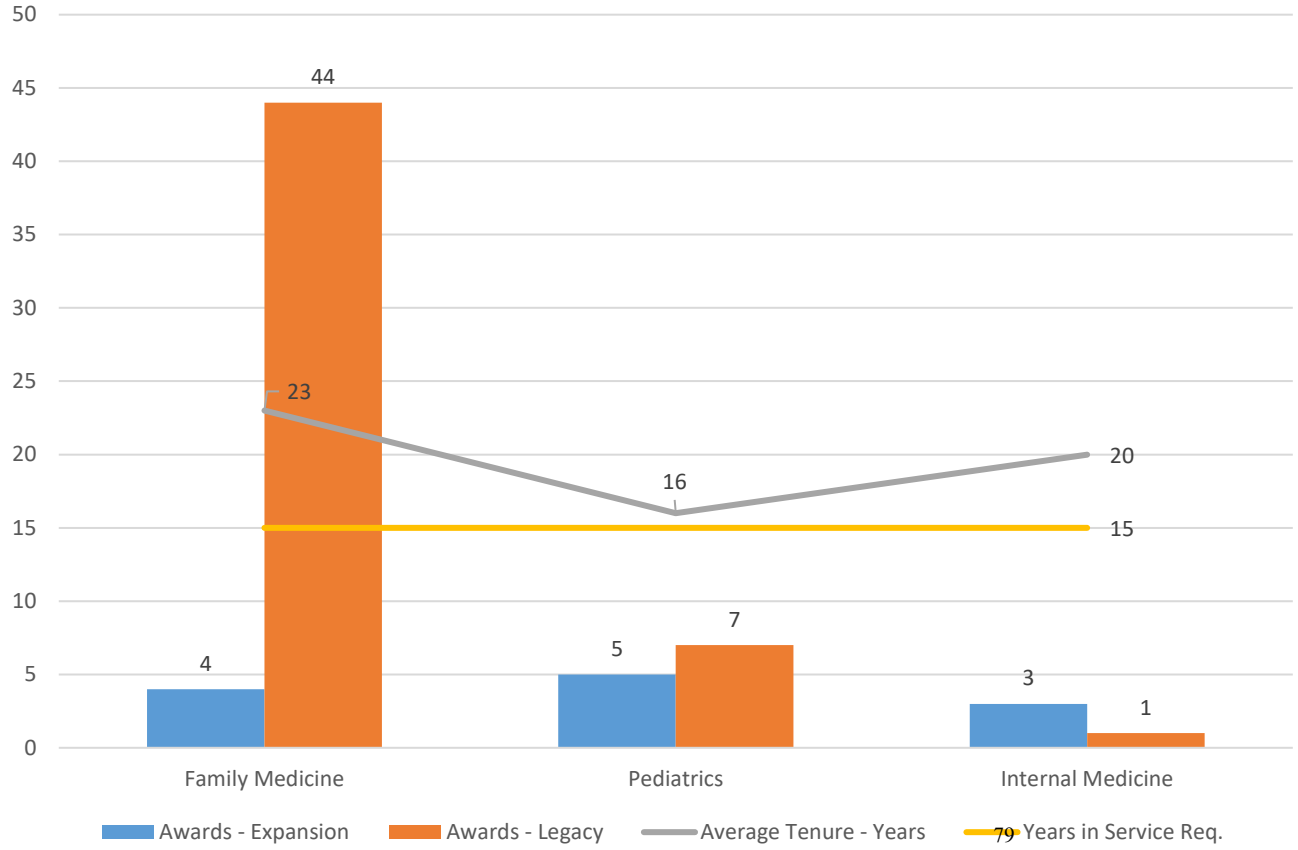
Recommendations From Provider Network

- Support to retain long-practicing and key clinicians to our network.*
- Support to hire primary care providers to Northern California, including perinatal clinicians.*
- Emphasis on retaining regional residency program graduates.*
- Support high-need specialists in certain geographic areas.
- Support expansion of health careers pathway and training programs.*

*Current Partnership programs/initiatives addressing recommendations

Provider Retention Initiative (PRI)

The Provider Retention Initiative (PRI), established in 2024, incentivizes additional years of service, aiming to preserve institutional knowledge, foster clinical leadership, and create mentorship opportunities. This initiative helps to ensures that an emerging generation of providers can learn from and train with experienced health professionals, strengthening the foundation of our network.



Highlights

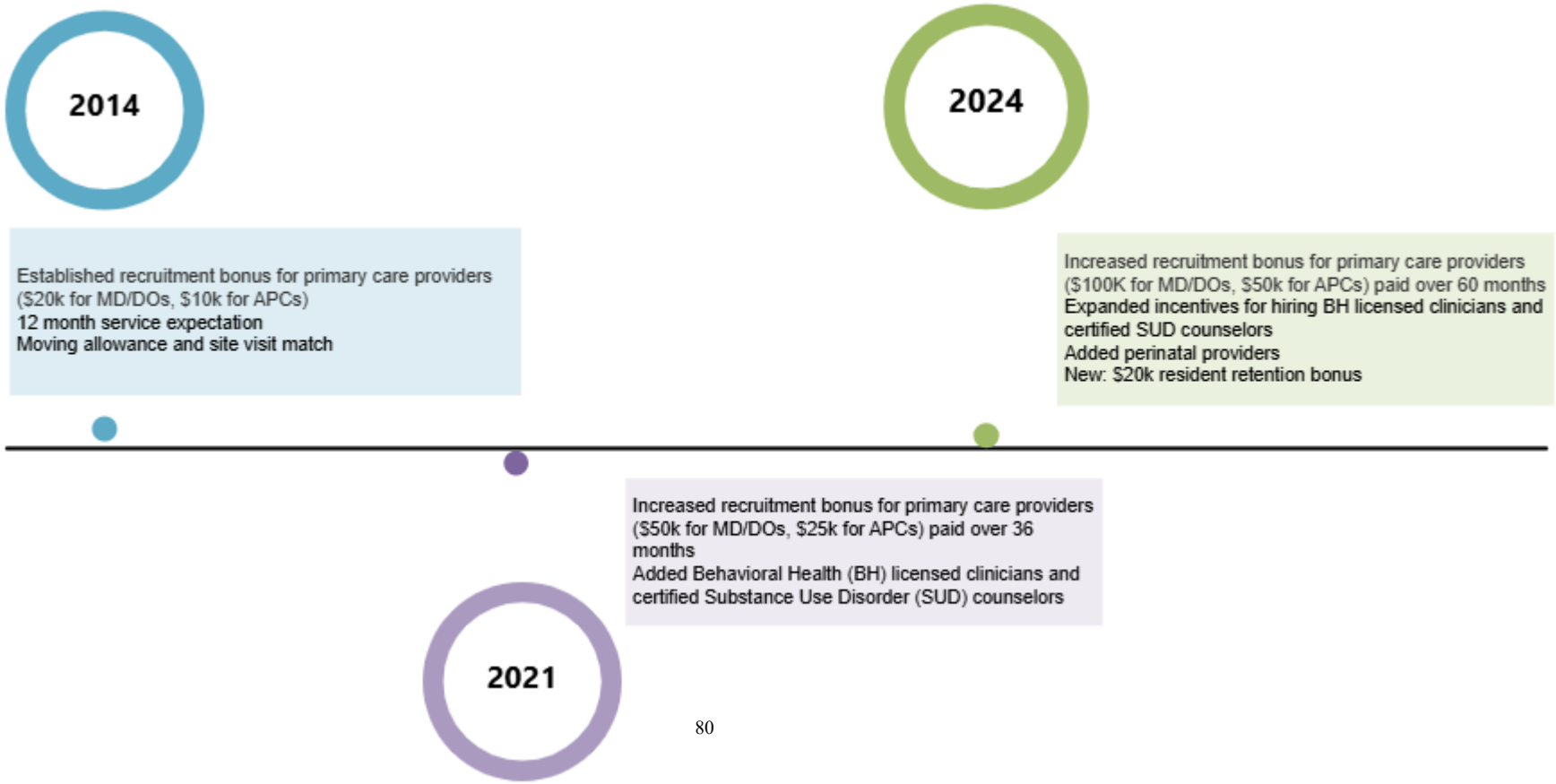
Awards (payable over 36 months)
- $45,000 physicians
- $30,000 APCs

64 total awards approved
- 42 physicians
- 22 APCs

Program extended through June 2025, including newly eligible clinician types:
- OB/GYN and Psychiatry

Provider Recruitment Program (PRP)

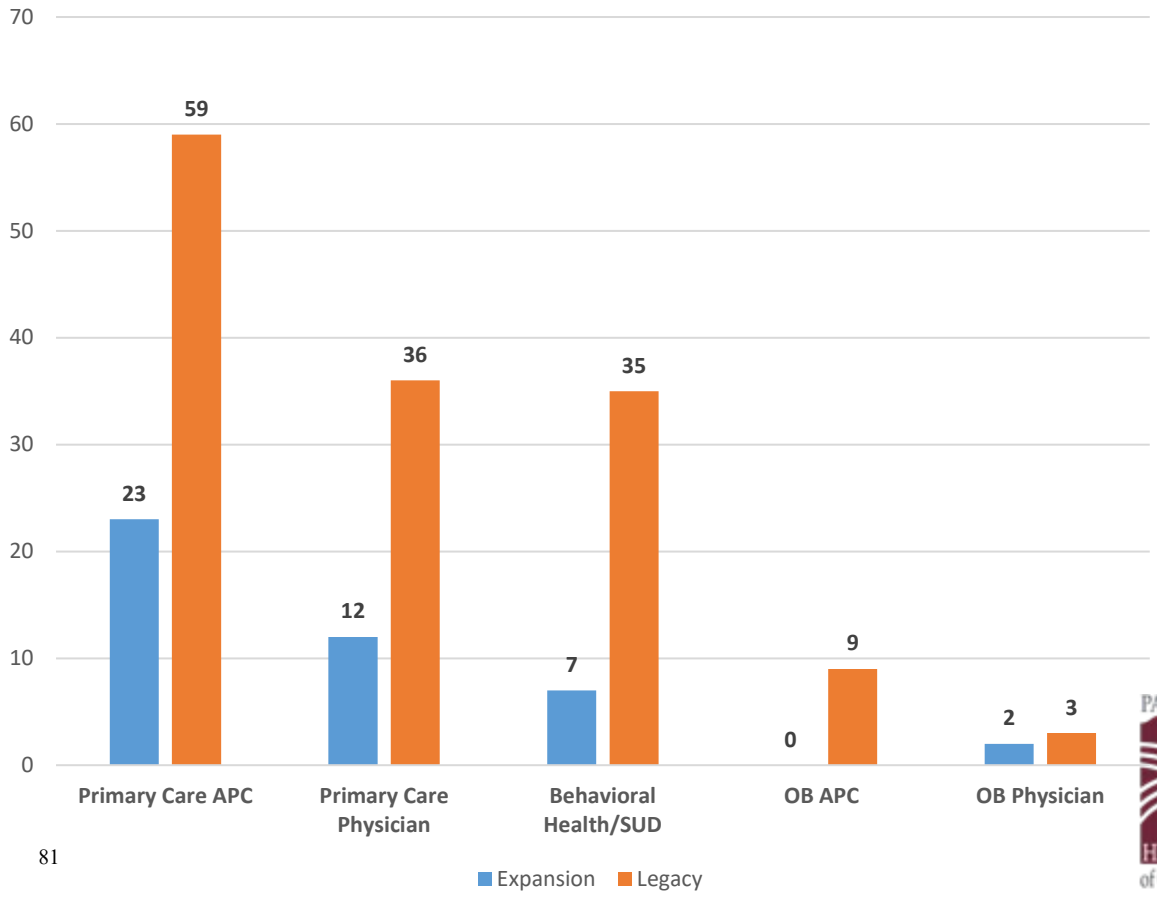
Launched in 2014, the Provider Recruitment Program (PRP) supports our network in recruiting and retaining high-quality health care professionals to improve access to care for Partnership members. Since its inception, the PRP has grown to include new incentives, expanded provider eligibility, and other key improvements to better serve our communities.



2024/2025 Physician Recruitment Program (PRP)

2024 – YTD	
Physicians	**53**
• OB/GYN	4
• FP/OB	1
• Family Medicine	32
• Internal Medicine	4
• Pediatrics	12
APCs	**91**
• Women's Health PAs	2
• Women's Health NPs/Nurse Midwives	7
• Family Medicine	78
• Internal Medicine	3
• Pediatrics	1
BH Clinicians	**42**
Total	**186**

Award Year	Count (average)
2014 – 2023	706 (**86 per year**)
2024 – YTD	186 (**160 in 12 months**)



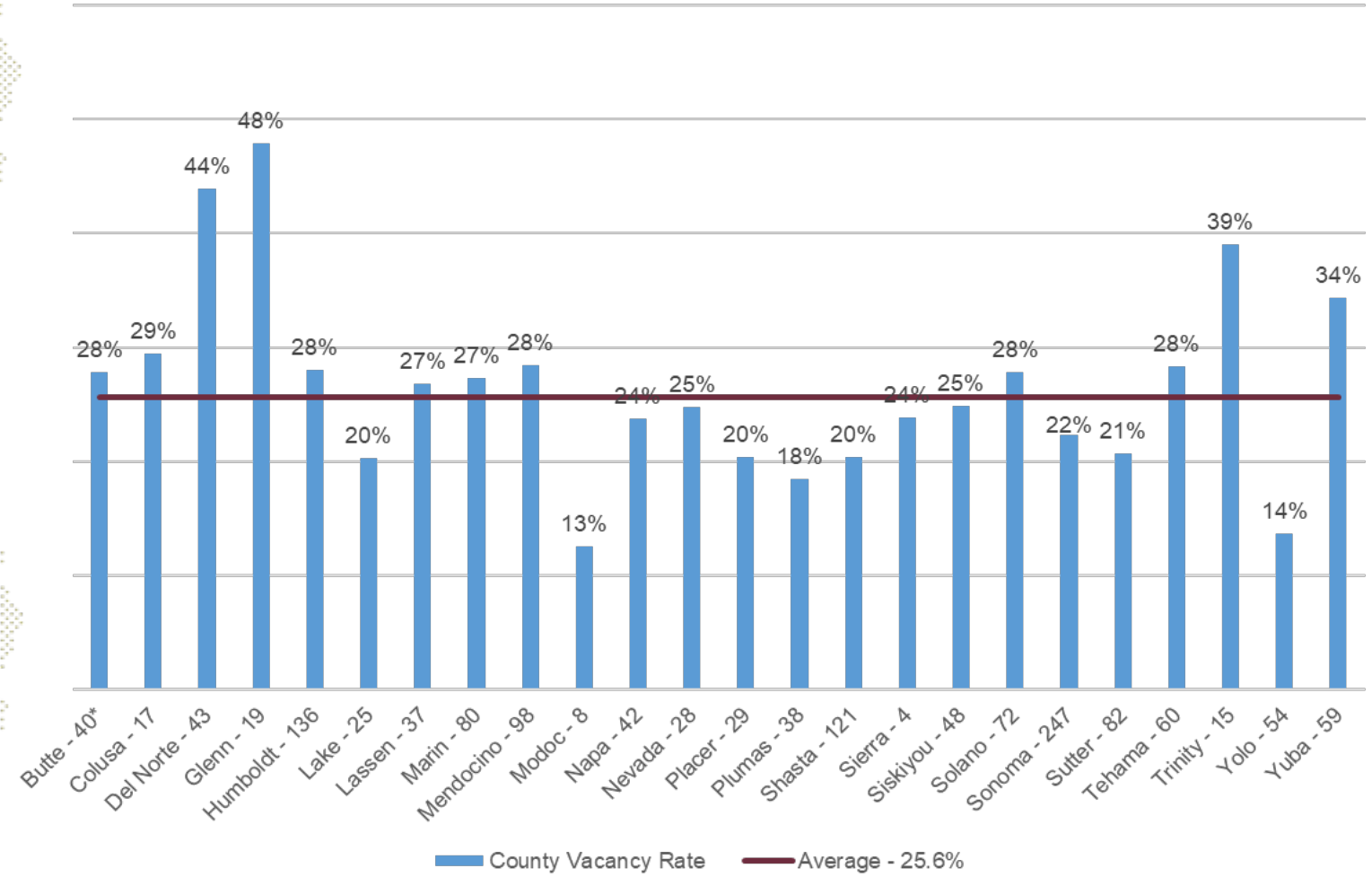
2024 Primary Care Provider Vacancy Rate Survey

Scope	• Organizations with at least 500 Partnership members assigned to their practice sites
Focus	• Identify staffing gaps by comparing current PCP numbers to the desired staffing levels for each organization
Purpose	• Collect data to inform access - related strategic planning. Vacancy rate is different from the number of PCPs that are needed to fully meet the needs of the population
Who	• 107 total organization respondents, 87% response rate • 24 counties represented

Findings	• 25.6% Primary Care Provider (PCP) Vacancy Rate
	• 88% actively recruiting primary care providers
	• Vacancy rate represents 359 Total FTE:
	  • 204 physician
	  • 155 NP/PA
	• 33% Obstetrics (OB)/ Prenatal Vacancy Rate
	• 49% respondents (52 organizations) provide prenatal care
	• Vacancy rate represents 83 Total FTE:
	  • 49 physician
	  • 34 NP/PA

PCP Vacancy Rate Survey

Other than the three highest counties (**Del Norte, Glenn, Trinity)** and three lowest counties (**Modoc, Plumas, Yolo)** all counties had vacancy rates at or greater than 20%, with a slight trend for higher vacancy rates in rural counties compared to suburban counties



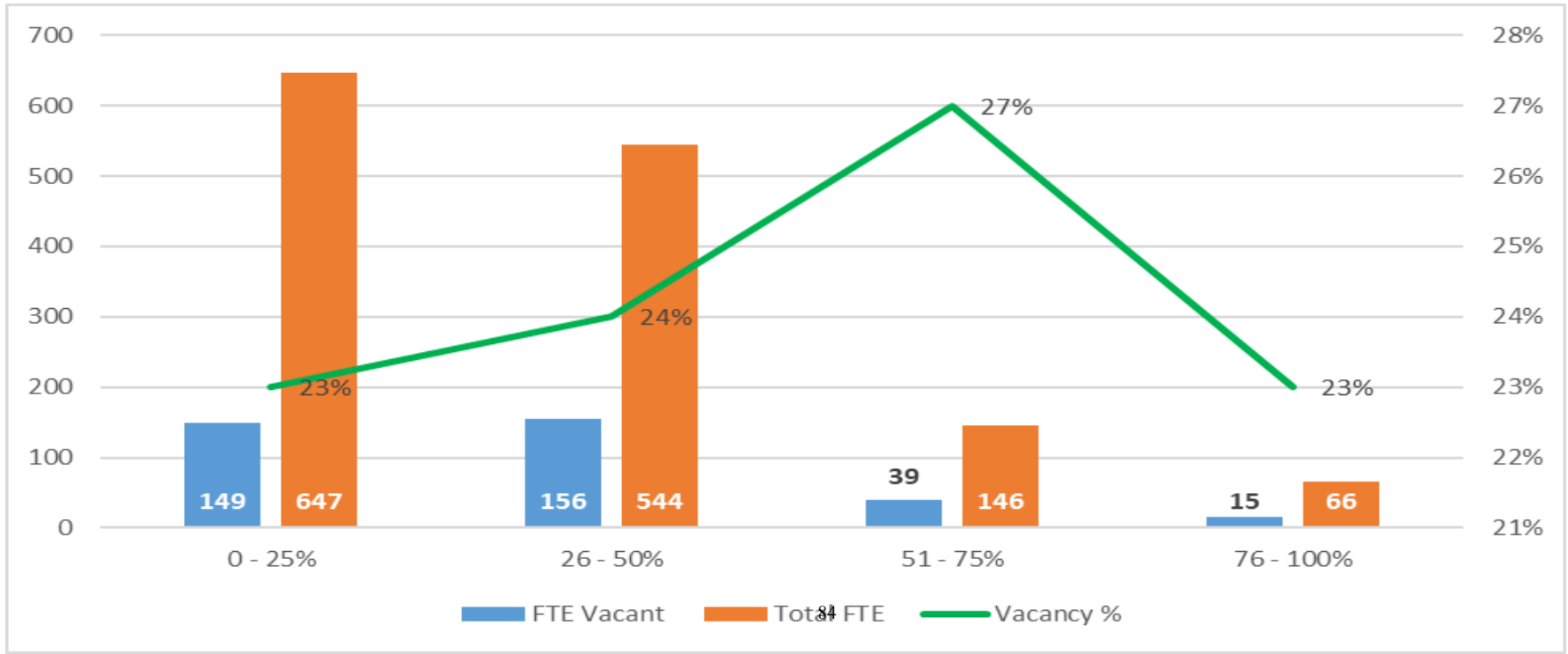
Insights
25.6% 2024 Vacancy Rate (Legacy Counties – 25.2%)
24.5% 2022 Legacy Counties Vacancy Rate
28% Physician and 23% APC vacancy rate
88% are actively recruiting primary care providers
33% Obstetrics (OB)/ Prenatal Vacancy Rate
2022 Total Vacant FTE – 296 (167 physicians and 129 APCs)
2024 Total Vacant FTE – 359 (204 physicians and 155 APCs)

*County and total FTE (working and vacancies)

PCP Vacancy Rate Survey - Rural Insights

Rural survey insight based on the US Census Bureau definition. Of our 24 counties, Modoc, Plumas, Sierra and Trinity are entirely rural. Only Yolo, Marin, and Solano have rural populations under 10%.

Rural	Counties
0 - 25%	Solano, Marin, Yolo, Sonoma, Placer, Napa, Sutter, Butte
26 - 50%	Yuba, Humboldt, Shasta, Lake, Glenn, Colusa, Del Norte, Nevada, Mendocino
51 - 75%	Tehama, Siskiyou, Lassen
76 - 100%	Sierra, Modoc, Plumas, Trinity



Key Barriers: PCP Vacancy Rate Survey Responses

Barrier
Location: cited as the common barrier, including: Rurality of the area Lack of community amenities (e.g., schools, healthcare, career options for partners/spouses)
Revenue: Reduced relative reimbursements w/increasing costs
Housing: Lack of adequate or affordable housing, including high costs of living
Talent: Difficulty attracting applicants despite marketing efforts, with positions receiving little to no interest. A shortage of qualified candidates and reluctance to work full-time.

Next Steps

2025 VACANCY RATE SURVEY

PRP / PRI EFFECTIVENESS ANALYSIS

ONGOING NEEDS ASSESSMENT

Questions

Rural Specialty Access Survey

Scope	• Survey distributed to physician specialists inside and outside of our provider network
Focus	• Gather data to guide strategic planning related to specialty access
Purpose	• Analyze trends in the specialty physician workforce. Understand the current challenges organizations and specialists are facing

Who	• Surveyed physicians:
	  • 35 practicing in 17 different specialties
	  • 4 retired in 3 specialties
	• Met with Shasta County hospital executives
	• Follow-up interviews completed with 17 physicians representing 11 specialties
	(Allergy Immunology, Dermatology, Gastroenterology, General Surgery, Neurology, Obstetrics/Gynecology, Orthopedic Surgery, Podiatry, Pulmonology, Radiation Oncology, and Vascular Surgery)

Counties Served	• Butte • Humboldt • Lake • Mendocino • Shasta
Findings	• **Validated that specialists believe access to care has worsened over time. Without significant intervention they believe access will continue to worsen**

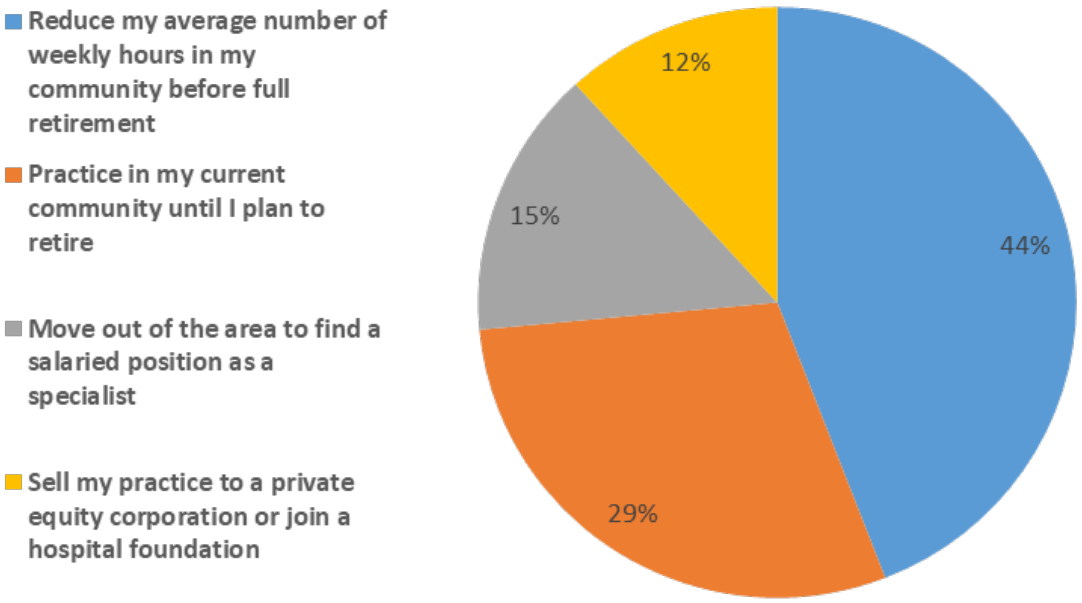
PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Specialty Access Survey Insights:

"What motivates you to practice medicine in your community?"

- About 60% of survey respondents cited the overwhelming needs of the community and positive impact they can make in their patients' lives as the key motivating factor to continue to practice medicine
- About 40% of respondents cited hometown, family, social connections, and love of the geographic area as other reasons specialists remain in the community
- 57% of survey respondents have been practicing for at least 20 years

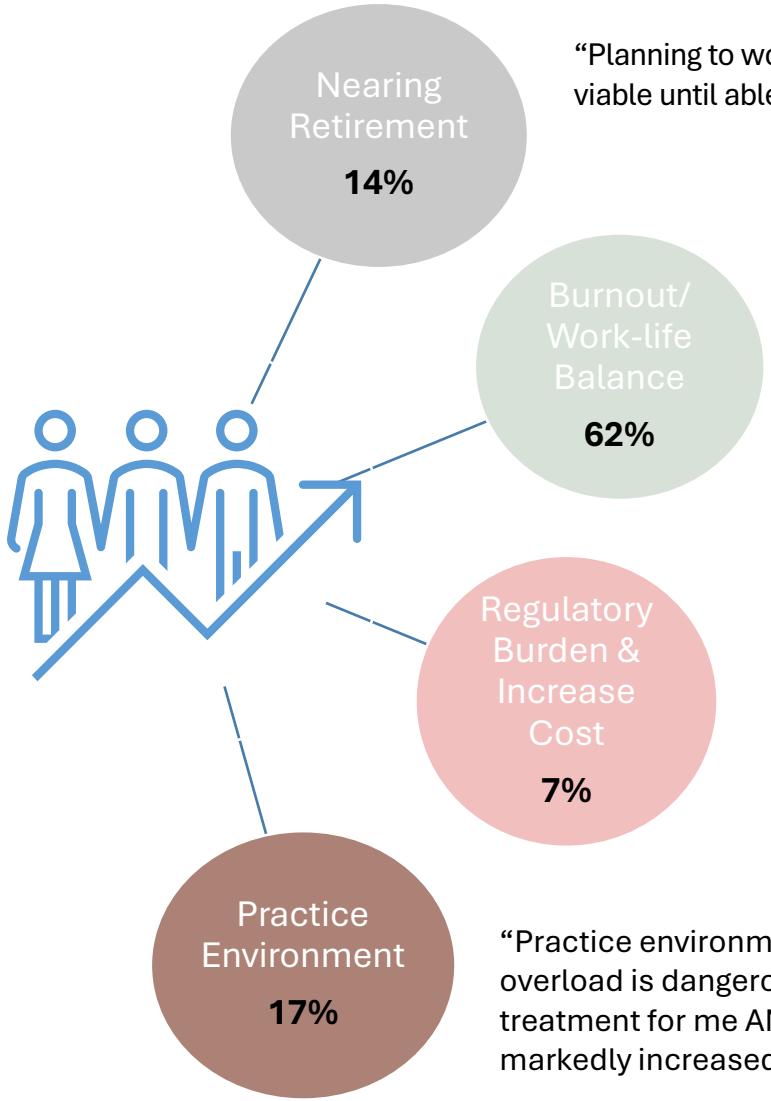
"What are your plans for the future?"



- 70% plan to change their practice status before they fully retire
- 60% plan for the change to occur in the next 5 years

Specialty Access Survey Insights:

Respondents shared reasons why they plan to change their practice status in the next 5 years



"Planning to work enough to keep practice viable until able to recruit replacements"

"I'm working longer hours, spending time away from my family to pay off loans and debts and provide for my family like I didn't expect"

"My income before expenses has not improved in the last 8-9 years (in actual non-inflation adjusted dollars) but my costs have doubled"

"Practice environment makes duties undoable & the overload is dangerous. Non-competitive pay & poor treatment for me AND the nursing staff has resulted in markedly increased turnover"

Well-Managed Benchmark: Specialty

Question: how do our rural specialty access findings relate to our specialty utilization data and physician demographics?

	BUTTE	COLUSA	DEL NORTE	GLENN	HUMBO..	LAKE	LASSEN	MARIN	MENDO..	MODOC	NAPA	NEVADA	PLACER	PLUMAS	SHASTA	SIERRA	SISKIYOU	SOLANO	SONOMA	SUTTER	TEHAMA	TRINITY	YOLO	YUBA
ALLERGY/ IMMUNOLOGY	38%	6%	15%	6%	37%	26%	18%	28%	31%		125%	2%	5%		6%		4%	59%	44%	5%	4%	13%	45%	3%
OTOLARYNGOLOGY	48%	19%	62%	39%	23%	54%	13%	25%	26%	25%	50%	17%	34%	9%	25%	27%	15%	27%	38%	24%	30%	11%	24%	21%
UROLOGY	59%	540%	32%	54%	27%	55%	13%	44%	45%	28%	113%	25%	27%	36%	28%	67%	18%	48%	46%	35%	30%	26%	29%	27%
GASTROENTEROLOGY	84%	47%	54%	43%	26%	78%	15%	81%	71%	16%	139%	87%	57%	32%	38%	122%	18%	99%	69%	47%	27%	32%	56%	50%
NEUROLOGY	77%	92%	28%	54%	48%	35%	44%	50%	33%	53%	59%	51%	39%	72%	85%	90%	40%	50%	37%	94%	51%	44%	38%	76%
PULMONARY DISEASE	164%	125%	47%	137%	39%	90%	62%	74%	168%	40%	95%	268%	141%	337%	118%	274%	46%	141%	146%	129%	80%	94%	59%	147%
ORTHOPEDIC SURGERY	55%	21%	54%	43%	42%	41%	43%	60%	67%	36%	69%	54%	28%	54%	71%	107%	76%	49%	50%	19%	32%	70%	29%	24%
ONCOLOGY/HEMATOLOGY	82%	74%	68%	87%	61%	99%	34%	67%	75%	18%	155%	63%	77%	56%	42%	67%	26%	177%	118%	67%	78%	46%	58%	51%
CARDIOVASCULAR DISEASE/INTERNAL MEDICINE	137%	185%	49%	121%	47%	151%	62%	122%	93%	49%	158%	33%	53%	51%	85%	85%	48%	106%	116%	75%	67%	98%	42%	57%
NEPHROLOGY	129%	151%	35%	216%	31%	89%	39%	83%	38%	117%	197%	54%	52%	59%	40%	338%	56%	113%	61%	131%	783%	49%	45%	76%
OPHTHALMOLOGY	571%	115%	62%	196%	106%	176%	48%	70%	200%	133%	378%	33%	49%	44%	141%	131%	56%	168%	91%	69%	109%	120%	59%	65%
GENERAL SURGERY	87%	62%	186%	128%	151%	199%	97%	101%	202%	77%	121%	45%	47%	64%	76%	126%	139%	66%	88%	29%	90%	76%	46%	37%

Specialties excluded (based on effectiveness of telehealth):

- Rheumatology
- Dermatology
- Endocrinology

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Regional Specialty Network Physician Demographics

Northern California has the highest median age for physicians according to Department of Health Care Access and Information (HCAI) data. As these clinicians retire, access challenges will worsen.*

Partnership Specialty Network Data (excluding telehealth conducive specialties)	**Partnership Regions**						
	Eureka (Del Norte, Humboldt, Lake, Mendocino)	**Redding** (Lassen, Modo, Shasta, Siskiyou, Tehama, Trinity)	**Chico** (Butte, Colusa, Glenn, Sutter, Yuba)	**Auburn** (Nevada, Placer, Plumas, Sierra)	**Santa Rosa** (Marin, Sonoma)	**Fairfield** (Napa, Solano, Yolo)	**Overall** (24 counties – 12 specialties)
Physicians	162	139	245	208	274	309	1337
Median Physician Age	57	61	51	49	56	52	53
% Physician Retirement Age	33%	34%	22%	14%	25%	22%	25%
% Physicians Retirement Age in 5 Years	**45%**	**50%**	31%	25%	**40%**	33%	38%

*https://hcai.ca.gov/wp-content/uploads/2023/02/Research-Data-Center-Annual-Report-January-2023-1.pdf

Redding Region:
Specialty Network Physician Demographics / Well-Managed Benchmark -

	Allergy/Immunology	Gastroenterology	Nephrology	Hematology / Oncology	Pulmonary Disease	Neurology	Otolaryngology
24 County Benchmark	34%	69%	117%	95%	135%	59%	34%
Lassen	**18%**	**15%**	39%	34%	62%	44%	48%
Modoc	**0%**	**16%**	117%	**18%**	40%	53%	**25%**
Shasta	**6%**	38%	40%	42%	118%	85%	**25%**
Siskiyou	**6%**	**18%**	56%	26%	46%	40%	**15%**
Tehama	**4%**	27%	783%	78%	80%	51%	30%
Trinity	**13%**	32%	49%	46%	94%	44%	30%
Physicians	1	7	5	8	6	10	4
Median Physician Age	68	54	65	53	68	54	59
% Physicians Retirement Age	**100%**	29%	**60%**	25%	**50%**	0%	25%
% Providers Retirement Age in 5 Years	**100%**	**43%**	**80%**	38%	**67%**	30%	**50%**

Chico Region:
Specialty Network Physician Demographics / Well-Managed Benchmark

	Allergy/Immunology	Gastroenterology	Nephrology	Hematology / Oncology	Pulmonary Disease	Neurology	Otolaryngology
24 County Benchmark	34%	69%	117%	95%	135%	59%	34%
Butte	38%	84%	129%	82%	164%	77%	48%
Colusa	**6%**	47%	151%	74%	125%	92%	**19%**
Glenn	**6%**	43%	216%	87%	137%	54%	39%
Sutter	**5%**	47%	131%	67%	129%	94%	**24%**
Yuba	**3%**	50%	76%	51%	147%	76%	**21%**
Physicians	**1**	14	9	8	10	7	7
Median Physician Age	43	53	56	44	52	64	58
% Physicians Retirement Age	0%	29%	33%	13%	30%	**43%**	29%
% Providers Retirement Age in 5 Years	0%	29%	**44%**	13%	30%	**57%**	**43%**

Eureka Region:
Specialty Network Physician Demographics / Well-Managed Benchmark -

	Allergy/Immunology	Gastroenterology	Nephrology	Hematology / Oncology	Pulmonary Disease	Neurology	Otolaryngology
24 County Benchmark	34%	69%	117%	95%	135%	59%	34%
Del Norte	**15%**	54%	35%	68%	47%	28%	62%
Humboldt	37%	26%	31%	61%	39%	48%	**23%**
Lake	26%	78%	89%	99%	90%	35%	54%
Mendocino	31%	71%	38%	75%	168%	33%	26%
Physicians	**3**	10	10	10	14	8	5
Median Physician Age	54	66	65	50	55	51	58
% Physicians Retirement Age	0%	**60%**	**40%**	0%	21%	0%	20%
% Providers Retirement Age in 5 Years	33%	**80%**	**60%**	10%	36%	13%	**40%**

Key Barriers – Survey Responses

Barrier	Rural Specialty Access Care	Primary Care Provider Vacancy
Location: cited as the common barrier, including: Rurality of the area Lack of community amenities (e.g., schools, healthcare, career options for partners/spouses)	**X**	X
Revenue: Reduced relative reimbursements w/increasing costs	**X**	X
Housing: Lack of adequate or affordable housing, including high costs of living		X
Talent: Difficulty attracting applicants despite marketing efforts, with positions receiving little to no interest. A shortage of qualified candidates and reluctance to work full-time.	**X**	X
Burnout: Challenging Practice Environment	**X**	

Provider Feedback: What can help with specialty care?

Recommendations from specialty providers to help improve access to care -
Strengthening PCP-Specialist Collaboration: Encouraging better communication and coordination between primary care physicians and specialists can improve patient care and reduce unnecessary referrals.
Expanding Primary Care Access: Increasing the availability of primary care services in the region can help reduce the strain on specialists and improve overall patient outcomes.
Support for Community Health Centers: Helping community health centers, rural health clinics and/or tribal health entities hire specialists directly, or collaborate with existing specialty groups, can expand access to care in underserved areas.
Recruitment Programs: Establishing targeted recruitment programs for specialty providers could help address workforce shortages and improve care access.
Multi-Stakeholder Coalitions: Forming coalitions with various stakeholders (hospitals, medical societies, health centers, community organizations) to focus on specialty access and rural health care needs can drive systemic change and ensure long-term solutions.
Targeted Rural Incentives: Augmenting financial incentives for rural specialty care can make it more attractive for specialists to practice in these areas.

Next Steps

FEASIBILITY ANALYSIS OF SPECIALTY ACCESS STUDY RECOMMENDATIONS

ONGOING NEEDS ASSESSMENT

COALITION BUILDING TO RAISE AWARENESS ABOUT THE SCOPE OF THE CHALLENGE – REGIONAL MEDICAL SOCIETIES, HEALTH CARE FOUNDATION PARTNERS, HOSPITAL PARTNERS, COMMUNITY HEALTH CENTERS, TRIBAL HEALTH, ETC.

Questions

Pathway Programs and Activities

Past

- Funding for region's medical residency program feasibility studies
- Grant/seed funds provided for APP residency/fellowship programs
- Quarterly meetings with regional medical residency programs
- Funding for UC Davis APP student housing in Humboldt County

California Medicine Scholars Program

AvenueM
Roadmap to Your Career in Medicine

Now

- Solidifying partnership activities and support with UC Davis California Medicine Scholars Programs – AveM, COMPADRE, etc
- Supporting UC Davis Medical School Branch Campus planning in Chico
- Hosting engagement opportunities with region's medical residency programs and residents
- Driving expansion and continued adoption of APP residency/training programs in collaboration with the California Health Care Foundation
- Establishing partnerships with region's community colleges and career and technical education entities relating to nursing and allied health professions
- Direct engagement with local health career exploration and scholarship activities
- Ongoing support of wilderness medicine conference

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Questions