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: May 9, 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, May 14, 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

Sutter-Roseville
6 Medical Plaza
Roseville, CA 95661

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

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

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: May 14, 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

Partnership – Eureka Office
1036 5th Street
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6 Medical Plaza
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Office of Dr. Mills Matheson
1245 S. Main St.
Willits, CA 95490

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**		**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**		**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**	**OFFICE PRACTICE UPDATE**	**LEAD**		**TIME**
A	**I**	**LaClinica** Dr. John Murphy, Chief Medical Officer	**Dr. Murphy**		**8:13**
III.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	**A**	**Review of April 9, 2025 PAC Minutes**	**Dr. Gwiazdowski**	**5**	**8:28**
B.	**A**	**Consent Review: Agenda Items III. B.1, B.2, B.3, B.5 and B.6** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Gwiazdowski**	**23 - 97**	**8:30**
1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – April 16, 2025** ***Acceptance of Draft Meeting Minutes*:** • Q/UAC Agenda • Q/UAC Activities & Minutes • Internal Quality Improvement Meetings April 8, 2025 Quality Improvement Update – April 2025	**Dr. Gwiazdowski**	**23** **25** **35** **45**	**8:30**

<table>
<tr><th>III.</th><th>A</th><th>MOTIONS FOR APPROVAL CONTINUED</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>B.</td><td>A</td><td>Consent Review: Agenda Items III. B.1, B.2, B.3, B.5 and B.6</td><td>Dr. Gwiazdowski</td><td>--</td><td>8:30</td></tr>
<tr><td>1</td><td>C</td><td><u>Special Presentations (for reference only, not included in packet)</u>
Utilization Management/Pharmacy Grand Analysis
• MPUD3001 – Utilization Management Program Description
• Annual (2024) Utilization Management Program Evaluation – NCQA UM Standard 1 Element B
• Supplemental TAR Report to the 2024 UM Program Evaluation
Population Health Management
• Population Needs Assessment Initial Findings & Report</td><td>Dr. Gwiazdowski</td><td>N/A</td><td>8:30</td></tr>
<tr><td>2</td><td>C</td><td><u>Policies/Procedures/Guidelines for Action</u>
<table><tr><th colspan="2"><u>Policies/Procedures/Guidelines for Action</u>
Clinical Practice Guidelines</th></tr><tr><td>MPQP1006</td><td>Clinical Practice Guidelines</td></tr><tr><td>MPXG5001</td><td>Clinical Practice Guidelines for the Diagnosis & Management of Asthma</td></tr><tr><td>MPXG5002</td><td>Clinical Practice Guidelines for Diabetes Mellitus</td></tr><tr><th colspan="2">Utilization Management</th></tr><tr><td>MCUP3121</td><td>Neonatal Circumcision</td></tr><tr><td>MPUP3014</td><td>Emergency Services</td></tr><tr><td>MPUP3026</td><td>Inter-Rater Reliability Policy</td></tr><tr><td>MPUP3051</td><td>Long Term Care SSI Regulation</td></tr><tr><td>MPUD3001</td><td>Utilization Management Program Description</td></tr><tr><th colspan="2">Population Health Management</th></tr><tr><td>N/A</td><td>Population Needs Assessment</td></tr><tr><th colspan="2">Pharmacy Operations</th></tr><tr><td>MCRP4065</td><td>Drug Utilization Review (DUR) Program</td></tr><tr><td>MPRP4034</td><td>Pharmaceutical Patient Safety</td></tr></table>
All versions linked within Policy Summary (See page 57)
• Policy Summary
• Detailed Synopsis of Changes</td><td></td><td>57
58</td><td>8:30</td></tr>
<tr><td>3</td><td>C</td><td>Pharmacy & Therapeutics Committee
• Meeting Summary, April 10, 2025
• Approved Criteria</td><td>Dr. Stan Leung</td><td>61
74</td><td>8:30</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, March 12, 2025
• Credentialed List, March 12, 2025</td><td>Dr. Netherda</td><td>83
89</td><td>8:30</td></tr>
<tr><td>6</td><td>C</td><td>Pediatric Quality Committee
• Meeting Minutes, November 13, 2024
• Meeting Minutes, February 4, 2025</td><td>Dr. Ribordy</td><td>92
95</td><td>8:30</td></tr>
<tr><td>7</td><td>C</td><td>Quality Improvement Health Equity Committee</td><td>Dr. Jalloh</td><td></td><td></td></tr>
<tr><td>C.</td><td>I</td><td>Physician Advisory Committee Membership
• Solicitation for Chairperson</td><td>Dr. Gwiazdowski</td><td>--</td><td>8:33</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>Partnership County Level Profile Review</td><td>Dr. Moore</td><td>--</td><td>8:35</td></tr>
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VI.	I	ADJOURNMENT	LEAD		9:00
		Next PAC on June 11, 2025 at 7:30 a.m.	**Dr. Gwiazdowski**		

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: **April 9, 2025 - 7:30 to 9:00 a.m.**

Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

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

Partnership Staff:	Sonja Bjork, Chief Executive Officer	Robert Moore, MD, Chief Medical Officer	Jeffrey Ribordy, MD, Region Medical Director
	Jennifer Lopez, Chief Financial Officer	Katherine Barresi, RN, Chief Health Services Officer	R. Doug Matthews, MD, Region Medical Director
	Wendi Davis, Chief Operating Officer	Colleen Townsend, MD, Region Medical Director	Marshall Kubota, MD, Region Medical Director
	Leigha Andrews, Regional Director	Mark Netherda, MD, Medical Director for Quality	Teresa Frankovich, MD, Associate Medical Director
	Mary Kerlin, Sr. Dir., Prov. Relations (PR)	Jeffrey DeVido, MD, Behavioral Health Clinical Dir.	Nancy Steffen, Dir., Quality & Perf. Improvement
	Lisa O'Connell, Director of Enhanced Health Services	Stan Leung, Pharm.D., Director, Pharmacy Services	Heather Esget, RN, Director, Utilization Mgmt. (UM)
		Vacant, RN, Assoc. Dir. UM Strategies	Kevin Jarret-Lee, RN, Assoc. Dir. of UM
	Doreen Crume, RN, N. Mgr. Care Coord.	Sue Quichocho, Mgr., Quality Measurement	Kristine Gual, Director, Quality Measurement
	Stephanie Nakatani, Supervisor, Provider Relations Representatives	Amy McCune, Manager of QI Programs	Isaac Brown, Director, Quality Management
		Bradley Cox, MD, Northeast Region Medical Director	Mohamed Jalloh, Pharm.D., Director, Health Equity
	Vicky Klakken, Dir., North Region	James Cotter, MD, Associate Medical Director	Megan Shelton, Project Manager, Quality Improvement
	Brigid Gast, RN, Dir. of CC		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	14/20 – PAC	Committee quorum requirements met (14).	04/09/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer Administration Updates	**Partnership's Chief Medical Officer (CMO) provided the following Partnership activities on behalf of Partnership's Chief Executive Officer (CEO).** **Monitoring Changes to Medicaid** • House and Senate proposing Medicaid cuts different in scope. Reconciliation is in process. • California sees funding shortfalls for Cal State and University of California schools as well as MediCal. • State is moving forward with all programs with no planned changes until definitive guidance is available.

I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services.**
	
	• **Legislative Update**
	  • Senate Bill 669, SB669 Rural hospitals: standby perinatal medical services, introduced by Senator McGuire, progressed through health committees with unanimous support.
	  • Assembly Bill 55, AB55 relating to alternative birth centers, introduced by Assembly Member Bonta, progressed through health committees with unanimous support.
	• **Partnership Activities**
	  • Joint Leadership Initiative (JLI) meetings have been planned between Partnership and Oroville Hospital, WellSpace Health, Western Sierra Medical Center, and Ampla Health.
	  • JLI meetings are ongoing with Fairchild Medical Center, Shasta Community Health Center, OpenDoor Health, Adventist Mendocino, Adventist Lake, and Mendocino Community Health Center.
	  • Spring Regional Medical Directors Forums are underway.
	  • Partnership plans to distribute Primary Care Provider Quality Incentive Program (PCP QIP) payments by the end of May.
	  • Cervical Cancer self-swab approved by NCQA with new CPT code. Partnership hosted and recorded a webinar with key details.

I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • In Solano County, continue to emphasize collaborative efforts with Federally Qualified Health Centers (FQHCs) regarding well-child care. • Working with Solano County for a Kindergarten Round Up health fair. • In Yolo County, the residency teaching site with CommunicareCare+Ole in West Sacramento is in need of more patient volume, but in this community, there is a more limited demand for providers. Working with CommunicareCare+Ole to optimize their panel/assignment management and collaboration with local practices. • Birth Equity Week is being celebrated in both Yolo and Solano Counties with community events sponsored and attended by Partnership.
I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Three mobile mammography events held in March, including health centers under a modified QIP. Additionally, education provided for Diabetes and Colorectal Cancer Screening. Working to replicate these events with Marin Health. • Outreach to community based organizations (CBO) to-build relationships in working towards enhanced care management (ECM) and California Advancing and Innovating Medi-Cal (CalAIM) integration in area clinics. • Supporting new clinical leaders after significant leadership turnover at four local health centers. Exploring options for onboarding in Partnership's QIP. • Supporting a pilot with UC Davis and Aliados for Advanced Practice Clinician (APC) fellowships to bring APCs to local health centers. • Established Santa Rosa Local Engagement Team (LET) meetings.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
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.** • Humboldt Medical Society involved in activities for growing local providers in working with high school and college students up thru college through a number of programs encouraging local youth to enter the health care fields and return to rural communities. • Dr. Antoinette Martinez, physician at United Indian Health Service, works with UC Davis in a program called RuralPRIME – placing medical students in rural areas to encourage them to practice in these communities. She also leads the state's first post-graduate education program to help prepare Native American students for medical school at UC Davis, called The Huwighurruk Health Postbaccalaureate Program. Huwighurruk is pronounced hee-way-gou-duck. In the Wiyot language, huwighurruk means plants, grass, leaves and medicine.
I.C.4. Status Update, Regional Medical	**Partnership's Regional Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.** • Plumas County Hospitals and clinics handed introduced to new Auburn Region Medical Director. • Visits in Taylorsville (population 150), confirm interest in support for Government subsidized medical insurance and care. • Plans in works to meet with Peachtree Clinics in Yuba/Sutter with new leadership, Tracie Riggs CEO and Dr. Kamara Graham as interim CMO.

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.**
	• Shasta Regional Medical Center
	  • Has capacity for more patients and is asking for more Partnership members.
	  • Emergency ambulance transfers are going to Mercy Medical Center 25% percent of the time for pediatrics, neonatal intensive care unit (NICU) needs, and level-2 traumas. Attempting to determine reasons and speculate patient requests may be a reason.
	  • Emergency department wait times have improved.
	  • Reviews for inpatient services are improving as several patients have left positive reviews.
	  • Hired two cardiologists, one gastroenterologist, and potentially an orthopedic specialist in the near future.
	  • Partnership is assisting with provider education, quality incentive work, and site visits.
	• Rolling Hills Clinic
	  • Opening site in Red Bluff, CA on Main Street one year from now.
	  • Plans to visit site soon.
	• Mayers Memorial Hospital has hired a new Medical Director.

I.C.6. Status Update, Regional Medical	**Partnership's Regional Director for Plumas, Sierra, Nevada & Placer presented a brief update on activities.**
	• Plumas County
	  • Seneca Hospital has broken ground on new 45,000 square foot hospital set to open 2027.
	  • Plumas District Hospital is opening new 36-bed skilled nursing unit in Summer 2025.
	• Nevada County
	  • Sierra Nevada Family Medicine Residency filled their two residency spots (one from University of Wisconsin and one from Florida State University).
	• UC Davis has applied for a grant opportunity that would allow for medical students from their three-year program to rotate with Sierra Nevada Memorial Hospital, Western Sierra Medical Center, and Chapa De Indian Health.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	**March 2025 PAC minutes were presented for approval.**	**MOTION:** Dr. Pottenger moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Brennan. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	04/09/25 Motion carried.
III.B. III.B.1 III.B.2	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – March 2025 • Policies, Procedures, and Guidelines for Action Policy Summary March 2025	**MOTION:** Dr. Shinder moved to approve Agenda III.B.1, III.B.2, III.B.4, III.B.5 and III.B.7, as presented, seconded by Ms. Sprague. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	04/09/25 Motion carried.
	Cultural & Linguistic Program Description was pulled for a brief discussion to explain the new trilogy documents contained within the program description. The following documents were highlighted: • Cultural & Linguistic Program Description • Cultural & Linguistic Program Evaluation • Cultural & Linguistic Program Workplan A separate motion was taken to approve after discussion.	**MOTION:** Dr. Brennan moved to approve Cultural & Linguistic Program Description after it was pulled for a brief discussion, seconded by Dr. Herman. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	04/09/25 Motion carried.
III.B.4 III.B.5 III.B.7	• Provider Engagement Group (PEG) Report Summary, March 18, 2025 • Credentials Committee Meeting Minutes and Credentialed List, February 12, 2025 • Quality Improvement Health Equity Committee Minutes and Credentialed List, March 18, 2025		
III.D	**Hospital Quality Incentive Program Proposal** Measurement Year 2025-2026	**MOTION:** Dr. Brennan moved to approve Agenda III.D as presented, seconded by Dr. Herman. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	04/09/25 Motion carried
III.E	**Perinatal Quality Incentive Program Proposal** Measurement Year 2025-2026	**MOTION:** Dr. Pottenger moved to approve Agenda III.E as presented, seconded by Ms. Sprague. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	04/09/25 Motion carried

IV. A Old Business	*None*
AGENDA ITEM	**DISCUSSION / CONCLUSIONS**
III.D Hospital Quality Incentive Program Proposal, Measurement Year 2025-2026	**Partnership's Program Manager for the Hospital Quality Incentive Program (HQIP) presented proposed changes for measurement year 2025-2026.** **Hospital Quality Incentive Program (HQIP) Measurement Set** Providers have the potential to earn a total of 100 points in six domains: 1) Readmissions 2) Advanced Care Planning 3) Clinical Quality 4) Patient Safety 5) Operations/Efficiency 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set. **Programmatic Changes:** I. Descriptions of Potential 2025-26 Measure Changes for Core Measurement Set A. Change(s) to Existing Measures for 2025-26 1. **Palliative Care Measure 3:** Remove references to the Palliative Care Quality Collaborative (PCQC) **Rationale:** PCQC dissolved in March 2025. A note was added mid-year to the 2024-25 specifications to reflect change, but change is needed for this year. Hospitals will use data from their inpatient electronic medical records (EMR) to report to Partnership. **Measure Requirements for X-Large hospitals with > 100 beds** Required to provide the following to Partnership: Part 1. Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2025 – June 30, 2026 Part 2. Rate of consults who have completed an Advance Care Directive or have a signed POLST to be included in the report described in Part 1: • Numerator: Anyone with an Advance Directive or POLST status in the hospital's inpatient EMR and on the palliative care service at either the time of consult or the time of discharge. • Denominator: Patients with a palliative care consult recorded in the hospital's inpatient EMR and on the palliative care service, discharged alive from July 1, 2025 – June 30, 2026. Part 3. Submit Attestation form Appendix II showing inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician

2024-25 Measures	2025-26 Recommendations
Risk Adjusted Domain	**Risk Adjusted Domain**
1. Risk Adjusted Readmissions (RAR)	1. Risk Adjusted Readmissions (RAR)
2. 7-Day Follow-up Clinical Visit (RAR)	2. 7-Day Follow-up Clinical Visit (RAR)
Palliative Care Domain	**Palliative Care Domain**
3. Palliative Care Capacity	**3. Palliative Care Capacity**
Clinical Domain	**Clinical Domain**
4. Elective Delivery Before 39 Weeks	4. Elective Delivery Before 39 Weeks
5. Exclusive Breast Milk Feeding Rate	5. Exclusive Breast Milk Feeding Rate
6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate	6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate
7. Vaginal Birth After Cesarean (VBAC)	7. Vaginal Birth After Cesarean (VBAC)
8. Expanding Delivery Privileges	**8. Expanding Delivery Privileges**
9. Increasing Mammography Capacity	**9. Doula Support**
Patient Safety Domain	**10. Increasing Mammography Capacity**
10. CHPSO Patient Safety Organization Participation	**11. Vaccines For Children Enrollment**
11. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)	**Patient Safety Domain**
Operations / Efficiency Domain	12. CHPSO Patient Safety Organization Participation
12. QI Capacity	13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)
13. Hospital Quality Improvement Platform	**Operations / Efficiency Domain**
Patient Experience Domain	14. QI Capacity
14. Cal Hospital Compare-Patient Experience	15. Hospital Quality Improvement Platform
15. Health Equity	**Patient Experience Domain**
	16. Cal Hospital Compare-Patient Experience
	15. **Health Equity**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Hospital Quality Incentive Program Proposal, Measurement Year 2025-2026, Continued	**2. Measure 8: Expanding Delivery Privileges:** Since we have moved into the second year of this measure and it is a multi-phase measure, it is suggested to replace "phase one" language with "phase two' language: **Measure Specification:** In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity. **Measure Requirements** This multi-phase measure began with Phase One in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With Phase One completed in 2024-25, this measure moved into Phase Two for the 2025-26 HQIP Measurement Year starting July 1, 2025. **Phase Two Requirement:** Hospital's that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges. **3. Revise Health Equity Measure: Switch from an annual report on Health Equity to submission of CMS Health Equity Attestation as written below:** **Measure Specifications** Partnership recognizes that health equity work can be very diverse and take many forms and Hospitals are being asked by multiple agencies to be committed to health equity. Since all hospitals need to report to CMS on health equity, rather than ask organizations to produce additional proof of their health equity work, Partnership has decided to reduce the administrative burden on hospitals by aligning our measure with CMS requirements. Hospitals may now report their health equity work to Partnership by submitting the same documentation submitted to the Centers for Medicare & Medicaid Services (CMS) for the Hospital Commitment to Health Equity Measures. **Measure Requirements** Hospitals shall submit a copy of their most recent CMS program attestation for the Hospital Commitment to Health Equity Measure to earn points for this measure. The attestation should cover part of the HQIP measurement year. **Target** Full Points: 5 Points earned for submitting current CMS Health Equity Attestation that meets all five domains. **Exclusions** Very Small sized hospitals with less than 25 Licensed General Acute beds are excluded from participation in this measure.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.E Perinatal Quality Incentive Program Proposal, Measurement Year 2025-2026	**Partnership's Program Manager for the Perinatal Quality Incentive Program (PQIP) presented proposed changes for measurement year 2025-2026.**

I. Summary of Current and Proposed Measures and/or Measure Changes

(A) Core Measurement Set Measures
Participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed with PCPs and OB/GYNs in mind and includes the following measures: 1) Timely Immunization Status - Tdap and Influenza Vaccine; 2) Timely Prenatal Care; and 3) Timely Postpartum Care.

(B) Electronic Data Measure
DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP in order to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems.

PQIP FY 2024-25 Descriptions of Measures and 2025-26 Proposed Changes

A. CLINICAL MEASURES *NO CHANGES BEING MADE IN 2025-26*

Key:
New Proposed Measures || Change to Measure Design

Prenatal Immunization Status - The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy.

Timely Prenatal Care - Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.

Alternatively, timely prenatal care services rendered to pregnant Partnership members at 14 or more weeks of gestation.

Current FY2024-25 Measures	Proposed FY2025-26 Measures
ECDS & Clinical Domains	
Perinatal Medicine:	**Perinatal Medicine:**
1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care	1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments Monitoring

Timely Postpartum Care - Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforces the importance of routine preventive health care.

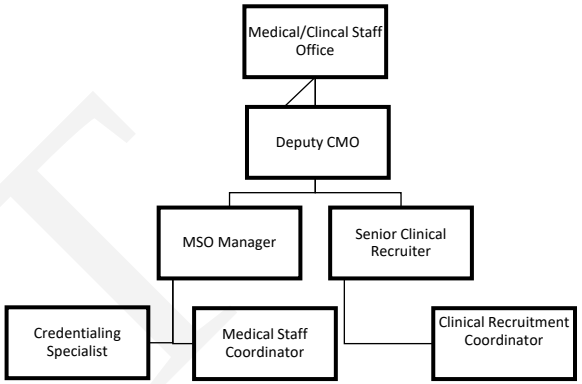
AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.E Perinatal Quality Incentive Program Proposal, Measurement Year 2025-2026, Continued	**B. Electronic Data Measure** **Proposed change: ECDS DataLink Gateway Measure 1** DataLink contracting was incentivized in the 2024-25 measurement year. This year, the ECDS measure would become a *Gateway Measure* requirement for perinatal providers to receive incentive dollars. Some providers may have completed this during the 2024-25 measurement year. However, if a perinatal provider did complete a contract and implementation with DataLink during the 2024-25 measurement period, they must complete all *Implementation Phases* and *Participation Requirement Steps* below by June 30, 2026 in order to be eligible for incentive payment in the 2025-26 measurement year. **C. Proposed Monitoring Measure 6: Timely Comprehensive Assessments** During the 2025-26 Measurement Year, Partnership will be monitoring claims data looking for members receiving full psychosocial, nutrition, and behavioral health assessments each trimester of pregnancy and once postpartum (up to 1 year after delivery). This measure is a monitoring only measure, without any incentive dollars attached to the measure. This measure may be developed into an incentive measure in future years. **D. Measure Incentive Breakdown**

Measure	Incentive Per Submission	Measure Requirement
Gateway Measure: ECDS: DataLink Implementation	**None.** Requirements must be met to be eligible to receive PQIP incentive dollars.	DataLink contracting and implementation completed by June 30, 2026.
Prenatal Immunization Status	$37.50 (Tdap) $12.50 (Influenza)	The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy (i.e. within 40 weeks of delivery date).
Timely Prenatal Care	$100 (<14 weeks gestation) $25 (≥14 weeks gestation)	Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. Alternatively, timely prenatal care services rendered to pregnant Partnership members at 14 or more weeks of gestation.
Timely Postpartum Care	$25 (1st visit) $50 (2nd visit)	Two Timely postpartum care services rendered to Partnership members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.
Monitoring Measure: Timely Comprehensive Assessments	**None.** This measure is a monitoring only measure with no incentive amounts attached.	Partnership will monitor the use of timely comprehensive assessments through claims data and potentially site audits.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**Dr. Darrick Nelson, Physician Advisory Committee voting member and Chief Medical Officer of Shasta Community Medical Center in Redding, CA presented their efforts to retain and recruit for improved workforce development.** ***Disclosures*** *Darrick Nelson, MD – No financial interest, arrangement or affiliations with commercial organizations that may have a material interest in the subject matter of this presentation.* *Dorothy Bratton, PA-C – No financial interest, arrangement or affiliations with a commercial organization that may have a material interest in the subject matter of this presentation.* **Objectives** 1.**Educate Attendees on SCHC's MSO Framework**: Provide a detailed overview of the MSO's structure and its role in clinician recruitment, onboarding, and retention. 2. **Encourage Adoption of Creative Retention Plans**: Inspire attendees to consider implementing long-term appreciation incentives, such as sabbaticals, to foster clinician well-being and loyalty. 3. **Demonstrate the Effectiveness of Performance-Based Incentives**: Present data or case studies showing the impact of SCHC's three incentive programs on clinician performance and patient outcomes. 4. **Share Best Practices for Loan Repayment Program**s: Offer actionable insights into setting up internal loan repayment systems and supporting clinicians in accessing state and national programs. 5. **Foster Discussion on Workforce Sustainability**: Engage attendees in a conversation about the challenges and solutions for sustaining a strong healthcare workforce in underserved areas. **About Shasta Community Health Center** • Mission: To provide high-quality healthcare to the community with compassion and understanding • Located in Redding, California • Founded in 1988 • Federally Qualified Health Center (FQHC) **Services Offered:** • Primary Care • Women's Health • Urgent Care • Pediatrics • Behavioral Health • Specialty Services • Dental Care • Integrated Behavioral Health • Chiropractic and Acupuncture

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**Patient Volume (2024)** • Unique Patients: 36,400 • Total patient visits: 159,559 **About SCHC Clinicians** • 83 FTE (full-time equivalents) • Approx. 95 individual clinicians **Sites** • 6 fixed sites across 3 towns and 77 square miles • 1 Mobile van • 1 Homelessness outreach team • 1 Respite house **Costs to Replace a Physician** Recruiter Fees $50, 000 Advertising & Marketing $10,000 Lost Revenue @ $82, 000/month Over 6 months $492,000 Sign-on bonus $35,000 Relocation $15,000 **AT LEAST** **$602,000** **Other Indirect Costs** • Reduced productivity of new or temp replacement • Impact on remaining staff morale • Onboarding costs, revenue, licensing credentialing • Replacing experience with inexperience

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**<u>The Kite String as a Metaphor for a Medical Staff Office</u>** **What does the kite string do? Hold the Kite Down?** In reality, it holds the kite up. A kite can only soar high because of its string. The string provides connection, confidence, and support, keeping it stable even against strong winds **<u>The String That Keeps Clinicians Soaring</u>** **The string symbolizes:** • **Support**: Robust onboarding, mentorship, and accessible leadership • **Stability**: Work-life balance, recognition, and fair policies • **Guidance**: Growth opportunities and career development *A strong string ensures our clinicians stay engaged, effective, and fulfilled.* **What happens when the string breaks?** When clinicians feel unsupported, they: • Face burnout and frustration • Lose connection with organizational goals • Ultimately drift away for other opportunities *Retention is not a cost—it's an investment in keeping our team strong and soaring.* 

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**Medical Staff Office (MSO)** **Top Ten Functions of MSO:** 1. Clinician Recruiting 2. Clinician Credentialing 3. Onboarding 4. Licensing and Certification 5. Patient templates, Time off management 6. Coverage scheduling, Clinical Team Associate 7. Continuing Medical Education (CME) program management 8. Loan repayment program(s) 9. Incentive & Retention management 10. Ongoing Engagement  **Senior Clinical Recruiter: A Concierge Service** • Review Candidate CV • Phone Screen candidate • Present Candidate to CMO and DCMO • Coordinate with MSO for Site Visit • Maintain Close Contact with Candidate • Ensure candidate arrives safely and knows where to go on day of site visit • Tour candidate during site visit • Follow up with candidate after site visit • Determine salary range with HR • Prepare offer letter • Send offer letter to recruiter or directly to candidate • Coordinate with Credentialing to begin • Process any sign-on bonuses • Work with MSO to coordinate onboarding day • Communicate weekly with candidate during credentialing process to give updates • Help with housing needs for new clinicians if needed • Meet new clinician on first day • Onboard & train new clinician over 2-week period **Touch base weekly with new clinicians after arrival at SCHC to ensure they feel supported with the goal of long-term retention, 2:10:30**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**MSO Manager** • MSO Staff Management • Retention bonus management & tracking • Loan repayment verification & tracking • Recruitment efforts • Locums • Inter-department communications: staffing needs • Tracking of recruitment, hiring and retention steps • Development of new programs relating to recruitment and retention • MSO budget and purchases • Scheduling, credentialing & privileging, CME approval & tracking **Medical Staff Coordinator Lead** • Manages Clinician schedules • Manages Schedules of covering Clinical Team Associates* • Monitors staffing balance • Creates patient schedule templates • Communicates with department managers • Blocks clinician schedules for time-off • Manages Locums Tenens schedules • Manages Urgent Care evening and weekend schedules • After hours call schedule **Clinical Team Associate (CTA)--***A Satisfaction and Retention Position* • CTA is typically a NP/PA • Hybrid work from home position • 80% work from home ▪ 66% of time covering indirect care ▪ 33% doing telehealth visits (8 per day) • 20% in office managing their own panel • Covering inboxes for clinicians on vacation • Covering tasks and refills for departed clinicians • Clinicians returning from vacation report less in-box dread **Credentialing Analyst** • Initiates credentialing new hires • Manages ongoing credentialing and privileging • Manages ongoing peer-review • Manages all licenses and certifications • Manages CME program • Manages professional association reimbursements • Monitors NPDB, ongoing • Books travel, lodging and processes reimbursements for site visits **Clinical Recruitment Coordinator** • Supports Clinical Staff Recruiter • Facilitates communication between internal departments • Facilitates communication between external recruitment firms • Facilitates communication with candidates • Coordinates site visit and interview schedules • Manages hospitality, lunch, dinner • Communicates with candidate regarding site visit schedule • Coordinates on-boarding schedule • Meets with clinicians on day 1

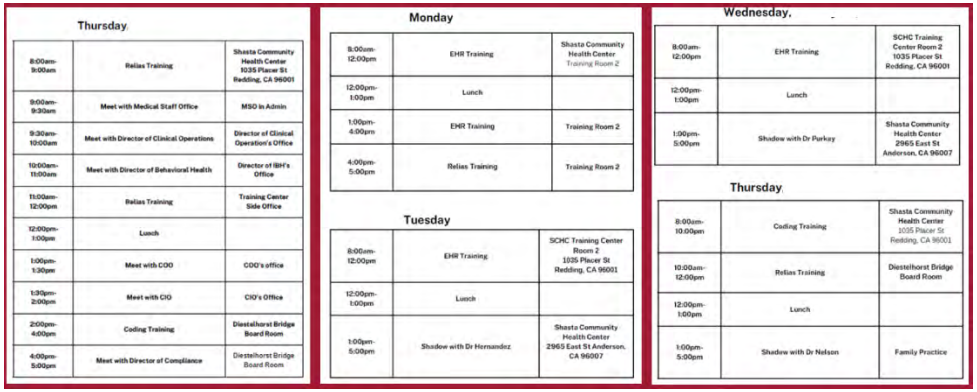
AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	

Site Visit Agenda for Prospective Hire

- For candidates outside the area, we generally fly them (+1) to Sacramento or Redding.
- Put them up in a local nice hotel near the famous Sundial Bridge.
- Prefer a Friday or Monday site visit so they can use the weekend to explore the area
- We cover additional nights if desired

Sample Two Week Onboarding Schedule

8:00am-8:30am	Welcome	Shasta Community Health Center 2965 East St Anderson, CA 96007
8:30am-9:30am	Meet with Medical Director	Medical Director's Office
9:30am-10:30am	Meet with Center Manager	Center Manager's Office
10:30am-11:00am	Meet with HIS Manager	Anderson's Conference Room
11:00am-12:00pm	Meet with Director of Quality	Anderson's Conference Room
12:00pm-1:00pm	Lunch	
1:00pm-1:30pm	Meet with Director of Billing	Shasta Community Health Center 1035 Placer St Redding, CA 96001 John's Office
1:30pm-2:00pm	Meet with Clinical Pharmacist	Clinical Pharmacist'sOffice
2:05pm-2:35pm	Meet with CMO, Dr Darrick Nelson	CMO's Office
2:45pm-5:00pm	Relias Training	Training Center Side Office
10:00am-11:00am	Meet with Recruiter	Shasta Community Health Center 1035 Placer St Redding, CA 96001
11:00am-12:00am	Review of Shasta Community Health Center Benefits with Benefits administrator	HR Office in Admin
12:00pm-1:00pm	Luncheon with Senior Management & key staff	Sundial Bridge Boardroom
1:00pm-2:00pm	Leadership Interview	CMO's Office in Administration
5:15pm	Dinner with Senior Management	TBD


Thursday

8:00am-9:00am	Relias Training	Shasta Community Health Center 1035 Placer St Redding, CA 96001
9:00am-9:30am	Meet with Medical Staff Office	MSO in Admin
9:30am-10:00am	Meet with Director of Clinical Operations	Director of Clinical Operation's Office
10:00am-11:00am	Meet with Director of Behavioral Health	Director of IBH's Office
11:00am-12:00pm	Relias Training	Training Center Side Office
12:00pm-1:00pm	Lunch	
1:00pm-1:30pm	Meet with COO	COO's office
1:30pm-2:00pm	Meet with CIO	CIO's Office
2:00pm-4:00pm	Coding Training	Diestelhorst Bridge Board Room
4:00pm-5:00pm	Meet with Director of Compliance	Diestelhorst Bridge Board Room

Monday

8:00am-12:00pm	EHR Training	Shasta Community Health Center Training Room 2
12:00pm-1:00pm	Lunch	
1:00pm-4:00pm	EHR Training	Training Room 2
4:00pm-5:00pm	Relias Training	Training Room 2

Tuesday

8:00am-12:00pm	EHR Training	SCHC Training Center Room 2 1035 Placer St Redding, CA 96001
12:00pm-1:00pm	Lunch	
1:00pm-5:00pm	Shadow with Dr Hernandez	Shasta Community Health Center 2965 East St Anderson, CA 96007

Wednesday

8:00am-12:00pm	EHR Training	SCHC Training Center Room 2 1035 Placer St Redding, CA 96001
12:00pm-1:00pm	Lunch	
1:00pm-5:00pm	Shadow with Dr Parkey	Shasta Community Health Center 2965 East St Anderson, CA 96007

Thursday

8:00am-10:00pm	Coding Training	Shasta Community Health Center 1035 Placer St Redding, CA 96001
10:00am-12:00pm	Relias Training	Diestelhorst Bridge Board Room
12:00pm-1:00pm	Lunch	
1:00pm-5:00pm	Shadow with Dr Nelson	Family Practice

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**Incentives at Shasta Community Health Center** **SCHC Short- Term Incentives** • Not everyone is incentivized monetarily • Some value time off or work-life balances • Some value recognition • Some value autonomy • Some value professional development opportunities **Frequent and Short-Term Incentives** **1. Quality and Citizenship** a) Incentivizes completing charts, tasks, peer review, document review timely b) Has 3-4 quality measures determined by CMO annually c) Assessed and paid quarterly, up to $5,000 per quarter Maximum of 20 points - $250 per point Up to $5,000 per quarter Clinicians usually earn between 10-20 points Q3, 2024 Average Payment = $3,450 **2. Access Incentive** a) Incentivizes clinicians to take extra patients above a daily threshold b) Assessed and paid quarterly, $50 per patient over threshold daily **3. Continuity Incentive** a) Incentivizes clinicians to do more ½ days per week in primary care continuity clinics b) Assessed and paid quarterly, between $5,000-$9,000 depending on number of half days of continuity clinic completed per week Daily Encounter Thresholds by Role: FM MD/DO = 17 FM NP/PA = 15 Peds = 19 OB = 16 Urgent Care = 20 Chiro = 30 PMHNP = 12 Mobile Van = 14 Payment is $50 for each billable encounter over daily threshold

Family Medicine Clinician Bonus Rubic 2024

Citizenship and Quality Measures					
Panel Size (0-3) (double QE points if no panel)	<80%	80-89%	90-100%	>100%	
Citizenship (0-5) (1 point each)		**Timely Documentation = 2 points**	**Task Completion**	**PAQ Completion**	**Chart Review**
		≥90% in 24 hours	≤72 hours	≤72 hours	≥90%
Quality Measures (0-12) (3 points each)	**0**	**1**	**2**	**3**	
Statin Therapy	<70%	70-80%	80-90%	90-100%	
Colorectal Cancer Screening	**<32.8%**	**32.8 - 40.22%**	**40.23 - 50%**	**>50%**	
Cervical Cancer Screening	<57%	57-61%	61 - 66%	≥66%	
Ischemic Vascular Disease	<70	70-80	80-90%	>90%	

Notes:

- Quality measure scores now based upon rolling 12-month period.
- Targets for Blood lead screening, colorectal and cervical are based on achieving QIP 50th percentile (1), QIP 75th percentile (2), **and QIP 90th percentile (3)**
- Targets for statin therapy and ischemic vascular disease are based on achieving at/above organizational performance as of **10/31 (1), 2022 UDS national performance (2), or stretch goal of 90% (3).**

Quarterly Board Report

Summary Q1, 1/1/2024 – 3/31/2024

• Number of extra patients	446
• Total Incentive Paid	$22,300
• Total Expected Revenue	$133,800

Summary Q2, 4/1/2024 – 6/30/2024

• Number of extra patients	479
• Total Incentive Paid	$23,950
• Total Expected Revenue	$143,700

Summary Q3, 7/1/2024 – 9/30/2024

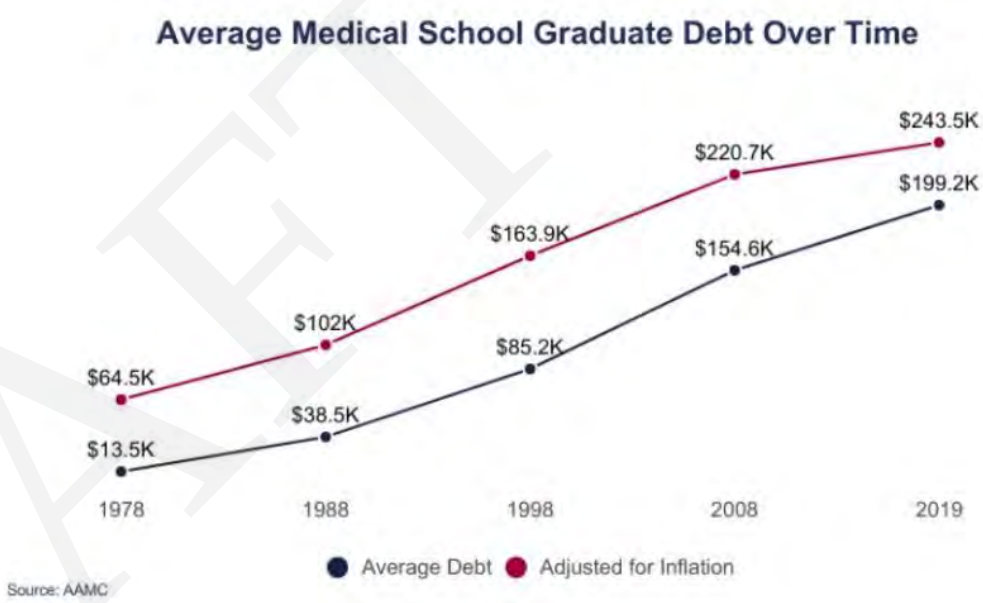
• Number of extra patients	399
• Total Incentive Paid	$19,950
• Total Expected Revenue	$119,700

Summary Q4, 10/1/2024 – 12/31/2024

• Number of extra patients	361
• Total Incentive Paid	$18,100
• Total Expected Revenue	$108,300

AGENDA ITEM	DISCUSSION / CONCLUSIONS

V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**Continuity Incentive: Burnout is Real**
	
	At Shasta Community Health Center there are several alternative schedules and clinical activities clinicians can do to help mitigate clinician burnout.
	
	• Alternative schedules e.g., 2 -12s and 2 - 8s
	• 32 hours per week, 24 hours continuity, 8 hours "elective" such as:
	  • Urgent Care
	  • Gender Health
	  • Homelessness Clinics
	  • Precepting Residents or Fellows
	  • GYN clinics,
	  • Well-child only clinics
	  • Medication Assisted Treatment, and so on
	
	***The Unintended Consequence: Diminishing Access to Primary Care Continuity Clinics*
	
	To qualify, clinician (only FM or IM) must already be doing at least 6 half days per week in Primary Care continuity clinic.
	1. If clinician does 7 half-days per week for 9 weeks out of a 12-week quarter, bonus is $5,000 per quarter.
	2. If clinician does 8 half-days per week for 9 weeks out of a 12-week quarter, bonus is $7,000 per quarter.
	3. If clinician does 9 half-days per week for 9 weeks out of a 12-week quarter, bonus is $9,000 per quarter.
	
	There are a few clinicians that earn some level of bonus each quarter, and we have observed that many are very judicious with how they spend their time off.
	
	SCHC Long-Term Retention Incentive
	
	Eligibility - an employee must be a salaried clinical provider and have one of the following licenses.
	• Physician – Medical Doctor (MD), Doctor of Osteopathic Medicine (DO)
	• Advanced Practice Providers – Nurse Practitioner (NP), Physician Assistant (PA)
	• Dentist – Doctor of Dental Surgery (DDS), Doctor of Medicine in Dentistry (DMD)
	
	Retention Incentive
	
	Beginning 2025, and after 7 years of service:
	$10,000* per year
	Between years 10-15, $10,000/yr plus one fully paid* 28-day sabbatical
	(Must commit to staying one year after returning from sabbatical)
	
	Between years 15-20 years:
	$10,000/yr Plus another fully paid* 28-day sabbatical
	(Must commit to staying one year after returning from sabbatical)
	
	* $ and sabbatical pay are prorated to FTE effort

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Investing in Clinicians for the Long Run: Shasta Community Health Center's Multi-faceted Retention and Recruitment Approach, Continued	**The Burden of Debt** **According to the AMA, the average medical school student loan debt is around $200K. "a figure that can play a factor in their first position out of residency."** *(AAPA: "PA student loan debt is $112k")* *(BLS: NP student loan debt $129K)* **Internal Loan Repayment** **Annual application February each year** • >$100k in debt, $25,000 in loan repayment • <$100k in debt, $12,500 in loan repayment • 2-year service commitment required • SCHC "gross-up" of payment. SCHC pays the taxes. • Assist with applying for external loan repayment  **Future of SCHC** • Reduction of use of recruitment firms • One-year onboarding plan • Leveraging professional social networks • Understanding multi-generational work-life balance expectations • Improved marketing materials • Ongoing clinician engagement • Clinician retreats ***Questions about this presentation can be directed to Dr. Darrick Nelson at*** danelson@shastahealth.org

VI. Adjournment	
PAC adjourned at 9:03 a.m.	**Next PAC on Wednesday, May 14, 2025 at 7:30 a.m.**

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: April 16, 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* • March 19 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 17
2	*Acknowledgment and acceptance of draft minutes of the* • March 11 Internal Quality Improvement (IQI) Committee • March 18 Quality Improvement Health Equity Committee (QIHEC) • Feb. 27 Member Grievance Review Committee (MGRC)			19 - 30 31 - 46 47 - 52
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	53 - 64
2	HealthPlan Update	Robert Moore, MD	7:45	--
III.	**Old Business**			
	Early Policy Reviews to Accommodate D-SNP Implementation Schedule – *refer to updated 2025 calendar under FYI, p. 293; early renewals are highlighted in green*	Robert Moore, MD	7:55	--
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	8:00	65
	Proposed 2025-2026 Quality Incentive Program Measure Summaries – *direct questions to Troy Foster* • Hospital QIP and Perinatal QIP *Note that these were approved at the Physician Advisory Committee (PAC) April 9*			67 - 73
	Quality Improvement Policies			
	MPQP1006 – Clinical Practice Guidelines			75 - 79
	MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma			81 - 83
	MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus			85 - 87

	Item	Lead	Time	Page #
	Utilization Management Policies			
	MCUP3121 – Neonatal Circumcision			89 - 90
	MPUP3014 – Emergency Services			91 - 98
	MPUP3026 – Inter-Rater Reliability Policy			99 - 101
	MPUP3051 – Long Term Care SSI Regulation			103 - 104
V.	**New Business – Discussion Policies**			
	None		--	--
VI.	**Presentations**			
1	UM/Pharmacy Grand Analysis • MPUD3001 – Utilization Management Program Description – *synopsis of changes begins on p. 105* • Annual (2024) Utilization Management Program Evaluation – NCQA UM Standard 1 Element B • Supplemental TAR Report to the 2024 UM Program Evaluation	Tony Hightower, CPhT Andrea Ocampo, Pharm.D	8:05	109 - 149 151 – 172 173 - 180
2	Population Needs Assessment – *presentation begins on p. 285*	Hannah O'Leary, MPH, CHES	8:25	181 - 292
VII. FYI	**Pharmacy Operations Update –** *refer any questions to Stan Leung, Pharm.D*			293
	Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*			295 - 299
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, May 21, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, April 16, 2025 / 7:33 a.m. – 8:58 a.m. Napa/Solano Room, 1st Floor

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

Partnership *Ex-Officio* Members Present:	Kubota, Marshall, MD, Associate Medical Director
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Leung, Stan, Pharm.D, Director of Pharmacy Services
Cox, Bradley, DO, Regional Medical Director (Northeast)	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
DeVido, Jeff, MD, Behavioral Health Clinical Director	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Frankovich, Terry, MD, Associate Medical Director	Randhawa, Manleen, Senior Health Educator, Population Health
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Hightower, Tony, CPhT, Associate Director, UM Regulations	Ruffin, DeLorean, DrPH, Director of Population Health
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Watkins, Kory, MBA-HM, Director, Grievance & Appeals
Katz, Dave, MD, Associate Medical Director	

Partnership *Ex-Officio* Members Absent:	Kerlin, Mary, Senior Director of Provider Relations
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	O'Connell, Lisa, Director, Enhanced Health Services
Cotter, James, MD, Associate Medical Director	Spiller, Bettina, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Thornton, Aaron, MD, Associate Medical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives	

Guests:	Hoang, Hanh, PR Representative II, Provider Relations
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Isola, Brandy, Manager of Performance Improvement (Chico)
Brown, Isaac, MBA/MHA, Director of Quality Management, QI	Jarrett-Lee, Kevin, RN, Associate Director of UM
Brunkal, Monika, RPh, Associate Director, Population Health	Matthews, Richard "Doug," MD, Regional Medical Director, Chico
Campbell, Anna, Health Policy Analyst, Utilization Management	Morris, Matthew, MD, Regional Medical Director, Auburn
Cunnigham, Aryana, Policy Analyst, Care Coordination	Nakatani-Phipps. Stephanie, Lead Senior Provider Relations Rep, PR
Devan, James, Manager of Performance Improvement (Redding)	Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
Erickson, Leslie, Program Coordinator II, QI (scribe)	O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Garcia-Hernandez, Margarita, PhD, Director, Health Analytics	Smith, Christine, Community Health Needs Liaison, Population Health
Grupe, Michele, Mgr of First Five Commissions, Behavioral Health	

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 7:33 a.m. The March 19, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • March 11 Internal Quality Improvement (IQI) Committee • March 18 Quality Improvement Health Equity Committee (QIHEC) • Feb. 27 Member Grievance Review Committee (MGRC)	Motion to **approve the Q/UAC minutes:** Robert Quon, MD Second: Chris Swales, 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 *Nancy Steffen, Senior Director of Quality and Performance Improvement, QI*	• Q/UAC may remember that last month we talked about pediatric measures: topical fluoride, developmental screening, well-child visits. This month, it might be helpful to highlight adult measures. o On cervical cancer screening: Southeast Regional Medical Director Colleen Townsend, MD, has been working with Provider Relations to inform providers about cervical cancer self-swab options through our laboratory vendors, including in an April 1 webinar with the Women's Health and Perinatal workgroup. The National Committee for Quality Assurance (NCQA) will allow inclusion of the new CPT code for HPV self-swab and the high-risk HPV lab test value set for Health Care Effectiveness Data Information Set (HEDIS®) starting this current measurement year, (MY) 2025. o The Chronic Disease workgroup observed Colorectal Cancer Awareness Month in March by meeting with an American Cancer Society representative who shared national statistics on colorectal cancer disparities. The workgroup together with the ACS co-branded an educational flyer that Provider Relations has distributed throughout our network. ▪ We've been looking at ways from a process standpoint to help support our provider organizations in completing a bulk order for Cologuard from Exact Sciences. Q/UAC will recall an evaluation of an intervention that Partnership conducted about 18 months ago with select provider organizations: we got great returns, including custom marketing materials with provider logos, help getting direct ship of those kits to our members, and help getting word to our providers to ensure timely screenings. ▪ We have worked with Exact Sciences to remove the minimum patient order requirement, and we are seeing a new wave of work underway. Kits went out in March to five of our larger organizations. We anticipate good results as we have seen in our prior pilots, and we are starting to plan a second multi-patient order phase for July through September. This is important to note because it will certainly help those providers focused on their QIP measures for 2025, of which colorectal cancer screening is a key measure. A note to anyone working on this measure: this is a limited time only offer. • In HEDIS®, as you know, we've been focused in the last several months on data completeness under key measures, in particular the Department of Health Care Services' (DHCS) Managed Care Accountability	For information only: no formal action required. There were no questions. Dr. Moore remarked that the 100% award on our D-SNP MOC submission is a great achievement. He congratulated everyone involved whose efforts got us to a three-year review cycle.

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	Set (MCAS) measures. o In completing a data inventory of both Short/Doyle Mental Health and Substance Use Disorder service claims that DHCS provides, we have gained a better onset of data flow to better represent county department behavioral health services that are billed through Medi-Cal. ▪ We looked at 2023 and 2024 data because the State has been focused on making this more readily available to the health plans to more completely evaluate performance under FUA (follow-up after ED visit for substance use) as well as FUM (follow-up after ED visit for mental health). We still have a significant gap in data completeness representing MY 2024. This is something we are diligently tracking with the help of our Health Analytics team. We will report status back to DHCS's chief data officer with whom we have been cultivating an ongoing dialog for this measure as well as for topical fluoride. • Q/UAC will recall that Partnership has our Consumer Awareness of Health Providers and Systems (CAHPS®) "Member Experience" survey, now in the field for both our adult and child populations. We are seeing an increase in the rate of response for both populations at this time in the measurement year. We anticipate further increase in response rate as our survey vendor begins implementing phone follow-up protocols. This includes a combination of one reminder call and three automated calls with live agents available of members pick up and opt in to complete the survey verbally by phone either in English or in Spanish. These calls will continue through the end of April. o The CAHPS® outcomes influence our Medicaid star ratings, so we look at this in combination with our quality outcome performance and the NCQA Health Plan Accreditation measure set. Certainly, DHCS looks at this as well, although they administer a separate survey on behalf of the health plans and evaluate us from that survey result. • The Center for Medicare and Medicaid Services (CMS) has informed Partnership that we have earned a high score on the Dual-Eligible Special Needs Plan (D-SNP) Model of Care (MOC) submitted earlier this year, such that we have earned the highest possible review cycle of once every three years, rather than every one or two years. This is a huge achievement. (Many first-time D-SNP health plans can anticipate a one-year cycle for review and updates on the MOC, or even a request for revision.) o The MOC is a foundational element in standing up our D-SNP effective Jan. 1, 2026, and articulates how we will deliver this new product line with a focus on quality and case management/care management, and the way we evaluate our population on an ongoing basis to serve and meet their needs.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• As you know, we continue to track two pieces of California legislation related to obstetric access: o Senate Bill 669 would allow small, rural hospitals the option of having a standby perinatal unit. This bill sponsored by the Senate Pro Temp Mike McGuire has passed out of committee with no opposition. Democrats, Republicans, nurses, doctors, everybody is in favor, so it's just sailing through. That's good. o AB55 is akin to a sister bill that would change the licensing requirements for alternative birth centers. There was some testimony there, but it did pass out of committee with unanimous support as well. Both bills are now in appropriations.	*Meeting Postscript:* • The Board of Commissioners meets in retreat at the end of this month and may discuss options to help meet State budget shortfalls.

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	• Partnership's Joint Leadership Initiative helps our larger health centers who have opportunity for improving their quality scores. Existing sites are Fairchild, Shasta, Open Door, Adventist Mendocino and Lake, Mendocino Community Health Center, and Solano County Family Health Services. In our new regions, we are adding four locations: Ampla Health, Western Sierra, Well Space, and Oroville Hospital. We have the space because we have successfully "graduated" some provider organizations. • The Regional Medical Director meetings are in full swing, We have just two more: one in Santa Rosa April 25, and one in Marysville May 2. The detailed notes have two versions: the leadership version, and the clinician version. They will be posted and placed in the newsletter to Medical Directors. • At the federal level, the House and Senate are proposing different sized Medicaid cuts with different assumptions and different scopes. There is conflicting information. If there are large cuts, then the State must respond what its plan will be, and that will take several months. The soonest that any changes could happen would likely be September/October, assuming the Feds come up with some large cuts. In the meantime, the State is on a trajectory to not change anything. They have regulatory authority to do quite a bit. Many of the waivers they have extend until later in the Trump presidency or even past that; however, regulatory authority does not equal funding. If funding decisions are required, will core services be cut to preserve the extra things they added? In the end, that decision will be made by the Finance Department and the Governor. o California has been having some funding issues: both the Cal State and University of California systems are facing some significant shortfalls exacerbated by the cuts in federal funding for grants. Then it becomes a question of do we curtail enrollment at the UCs or close campuses versus cut Medi-Cal? It is unlikely campuses will close or enrollment cut. o The State is going full speed ahead on all initiatives they have ordered the health plans to do, including diversity, equity and inclusion training for the network. Health Equity Officer Mohamed Jalloh, Pharm.D is leading Partnership's effort. If any organization is already doing their own DEI, they are invited to show it to him, and he will certify it. It will be an issue in some conservative areas when doctors there are asked to do this mandatory training. That will be an issue. *Q/UAC Conversation:* Dr. Jalloh added: DHCS has made it very clear that we should continue business as usual for the DEI training. Some health plans have already had the forethought to maybe change the name of it because they recognize "DEI" can be triggering, while others have kept it the same. We are exploring the best option because we want to make the decision based on what we think is best for our community versus just trying to react or pro-act based upon what the federal government is saying. The good news is that the State is not going to hold Partnership accountable for a certain percentage of people completing it. The State will hold us accountable to *distribute* the training to our practitioners. The State has said they want us to provide annual completion rates. We asked if there is a threshold they want. They weren't clear. They did say they wanted everyone to be provided the training within 90 days of being contracted. Dr. Moore added that DHCS has not answered 'do you want us to de-certify providers that refuse to do this training?'	• The April 2025 Medical Directors Newsletter was published and then distributed via email to Q/UAC members on April 30. • Senior Director Member Services and Grievance & Appeals Edna Villasenor will provide Leslie with hard copy Member Newsletters. They will be mailed to Q/UAC members after May 13.

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	Conversation ensued with Q/UAC members asking if there is any regulatory risk or downside to calling "DEI" by another name. (Dr. Jalloh suggested "cultural community connection training.") Dr. Moore liked Dr. Jalloh's term. He cautioned, however, that some will chafe at the mandate itself, and that Partnership still needs a clear answer to 'what happens if I don't do it?' Dr. Jalloh sees no risk with a name change, provided the documentation when submitted reflects the original intent of DHCS's All Plan Letter. Stven Giazdowski, MD, cautioned that some "recalcitrants" might well see through any terminology change and then call into question Partnership's integrity. Q/UAC Consumer Member Michael Strain commented on the recently published Member Newsletter. "It was a good thorough read," he said. "When you get to your DEI issue, in the back, there's one paragraph that's translated into six different languages. There are articles on doula services, on family care services, so any member who reads this already get the idea of inclusion and diversity and equity. It's underlying in the messages we get. For me, it was a pleasure to get this thing that says Partnership is taking care of me as a person. The information we hear here (at Q/UAC) and the work you guys do filters down to the members. We get it; we get the number of services and what's available, how to get help, how to get help when you have a complaint. All sorts of things are filtered down from our agenda to the members. There's even a short article by one of our members about the difference between Medicare and Medi-Cal. It's informative." Dr. Moore said he too is proud of this publication that comes out twice each year. He directed Leslie to obtain hard copies for the Q/UAC members.	
III. Old Business –		
Early Policy Reviews to Accommodate D-SNP Implementation Schedule *Robert Moore, MD Chief Medical Officer*	In preparing for our D-SNP Medicare product line going live Jan. 1, 2026, we have existing Medi-Cal policies that need to be minorly adapted to apply and some new Partnership Advantage-only policies that need to go through IQI/Q/UAC/PAC before the September/October timeframe. We are moving many policies that we normally see in September, October, November to May, June, August. We were not planning on having a July meeting. but we may need to for the new policies. This month is light because we are having trouble finishing some policy updates. The next three months will be busy, but then it could be lighter towards the end of the year.	*Meeting Postscript:* • IQI will meet July 8 to consider 8-10 or more new policies that will require much internal discussion. Q/UAC will entertain these policies on Aug. 20.
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	Proposed 2025-2026 Quality Incentive Program Measure Summaries – Hospital and Perinatal QIPs ***Health Services Policies*** <u>Quality Improvement</u> MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guideline for Diabetes Mellitus <u>Utilization Management</u>	The two QIP measure summaries were approved at the Physician Advisory Committee (PAC) on April 9 Motion to **approve slate as presented without MPUP3014:** Steven Gwiazdowski, MD

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	MCUP3121 – Neonatal Circumcision MPUP3014 – Emergency Services – ***pulled for discussion*** MPUP3026 – Inter-Rater Reliability Policy MPUP3051 – Long Term Care SSI Regulation **Steven Gwiazdowski, MD, pulled MPUP3014** to question how Claims adjudicates for an instance not listed in this policy (e.g., animal bites) as warranting emergent or urgent care. Robert Quon, MD, asked why any list of conditions is included at all, rather than leaving it to the determination of the Emergency Department. John Murphy, MD, concurred, saying that diagnosis comes after evaluation: a person presenting with a sore throat might have a peritonsillar abscess or a person complaining of belly pain, peritonitis. Dr. Moore acknowledged that conditions, if not evaluated, can progress. He added he did not recall how this policy was initially configured and why. He promised to investigate and asked the Q/UAC to pass the policy today as presented, knowing that answers will be forthcoming in the next 12 months. Meanwhile, he said the "standard is what a lay person would consider an emergency." Partnership is "lenient" on this if a member has sought care out of state, although Partnership had denied claims. Jeff Ribordy, MD, commented that members and ED staff alike should know that a sports physical, whether in- or out-of-state, does not rise to the occasion of emergency care. Randy Thomas, MD, pointed out that Section III.A.1 still uses gender noun and pronoun. **It is now amended to read** "Placing the health of the member (or, in the case of a pregnant *person,* the health of the member and/or *the* unborn child) in serious jeopardy…"	Second: Randy Thomas, MD *Approved unanimously* Motion to **approve MPUP3014 as amended:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: May 14 PAC *Meeting Postscript:* Subject Matter Experts (SMEs) later determined that more D-SNP changes are needed on MPXG5002, and so that policy will be pulled from May 14 PAC consideration.
V. New Business – Discussion Policies – None		
VI. Presentations		
Utilization Management/ Pharmacy Grand Analysis: • MPUD3001 – UM Program Description • Annual (2024) UM Program Evaluation – NCQA UM Standard 1 Element B	Tony "kicked things off" with a summary of the UM Program Description before turning to the Evaluation and Supplemental Treatment Authorization Request (TAR) Report. MPUD3001 is a comprehensive description of our UM program, which includes both our UM and Pharmacy teams. The document is broken down by our program purpose, which provides the reader high level description of the functions of the UM department. We go through our program objectives, which outlines how our UM program operates within the various regulatory frameworks that we are accountable for, including but not limited to both DHCS and NCQA compliance. We outline in our program structure, the roles and responsibilities of both our clinical staff, which includes our medical directors, our nurses and our pharmacists, as well as the roles and responsibilities of our non-clinical staff, which includes our data coordinators, pharmacy technicians, project coordinators, program managers, and our health services analyst. We give a description of our oversight committees, which does include Q/UAC. We then go into our program scope both for UM and for Pharmacy, as well as the benefits and services our teams evaluate. We provide an outline of the mental health services that Partnership provides, including our Specialty	Motion to **approve the MPUD3001 as presented:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* **Q/UAC also unanimously accepted the UM Evaluation**: Robert Quon, MD Second: Randy Thomas, MD Next Steps: May 14 PAC Dr. Gwiazdowski asked for

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• Supplemental TAR Report to the 2024 UM Program Evaluation *Tony Hightower, CPhT, Associate Director, UM Regulations* and *Andrea Ocampo, Pharm.D, Clinical Pharmacist, Pharmacy*	Mental Health Services (SMHS) that are currently delegated to Carelon, as well as our interfacing for specialty mental health services through our referrals to the county mental health plans. We provide an outline of our residential substance use disorder (SUD) Wellness & Recovery benefit that we manage. We outline the behavioral health treatments for our members under the age of 21. And then we go into a description of our UM process, the factors we consider when making decisions for UM requests, which includes the pre-authorization of services. We outline our referral management process referring members to specialty services. Then we go into various TAR reviews, concurrent review, our SNFs, sub-acute, and LTAC and recap reviews. We outline UM's role in the discharge planning process and our process for retrospective reviews on services already rendered to our members. We outline our timeliness requirements for both DHCS and NCQA. The PD further outlines our process for Inter-Rater Reliability (IRR) to ensure that our application of criteria is consistent across the entire scope of our team. The PD describes our external communication process, including our determination letters or notices of action, and a description of our translation services available to our members. We currently delegate inpatient services with four of our hospital partners within our service area. This year, we did update how we define medical necessity. A bulk of our work lies in keeping our program structure updated because our teams have been evolving so rapidly over the past couple of years. In the communication section, we made key updates to the non-discrimination statement to align with specific guidance that we received from DHCS. *There were no questions on the PD, and Dr. Moore called for a motion to accept it as presented before Tony and Andrea went on to the Evaluation and Supplemental TAR Report.* Tony noted the 2024 evaluation of the UM program structure looks at our clinical staffing ratios as well as our TAR-to-staff ratios. The program scope, looking at how we maintain our policies in accordance with both DHCS and NCQA requirements, is evaluated and how we conduct our provided medical services is analyzed. We look at timeliness for our TARs according to DHCS and NCQA requirements. We do a deep dive at our application of criteria, both our monthly and quarterly IRR processes as well as providing an annual assessment of the appropriate level of care through our over- and under-utilization activities. We look at the participation of senior level physicians in our interfaces with committees, the PAC, Q/UAC, and, for our Pharmacy team, the Pharmacy & Therapeutics Committee. For our UM clinical staff ratios, we set a threshold at 20% for our nursing-to-medical director ratios. We exceeded our threshold in Quarter 4 because of ramping up staffing as a result of the 10-county expansion. As a result of that staffing ratio deviation, we will be looking at resetting it for calendar year 2025 to better reflect the structure of our teams going forward. UM processed a total of 344,695 TARs in 2024, a 40% increase above calendar year 2023. When we look at our TAR-to-staff ratio for the UM team month over month, we did have deviations from the 20% threshold target across the board because of the increase in staff or increase in TAR volume that we encountered in January 2024. It was a bit of a rocky year for the UM team.	clarity on the number of UM TARs denied. Dr. Moore noted that 1,240 were medical necessity denials, adding that the most common administrative denial occurs when no TAR is required but is submitted anyway. These are automatically denied.

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	Andrea said that, similar to the UM department, Pharmacy's 2024 TAR volume significantly increased primarily due to the 10-county expansion. We received 10,758 Pharmacy TARS in 2024, a 43% increase above 2023. We continually monitor our TAR-per-pharmacist and TAR-per-technician ratios month-to-month to assess for adequate staffing. Both exceeded our 20% month-to-month threshold January through March. Pharmacy leadership continues to quarterly monitor TAR timeliness and IRR to assess impacts. Tony noted that every year we measure UM participation in our advisory committees. In 2024, quorum was achieved at every single meeting of Q/UAC, P&T, and PAC. That's a big "thank you" to our external partners for participating. Unfortunately though, UM did not meet timeliness goals for the areas of urgent concurrent, urgent pre-service, non-urgent pre-service and post-service requests because of volume and onboarding/training new staff. The good news is that, moving through 2025, the UM team has turned the corner and things are getting back on track. Andrea said Pharmacy achieved an overall timeliness rate of 99% in 2024: when broken down by category, timeliness goals were not met for urgent pre-service requests, which have a 72-hour turnaround time, but they were met for non-urgent pre-service and post-service requests. Some workflow changes have been implemented just to mitigate risks for our timeliness for our urgent requests, including identifying and flagging gene therapy requests at data entry as these tend to require external reviews. Pharmacy also hired some permanent technician staff in Quarter 4 2023/Quarter 1 2024 to address the staffing gaps created by the TAR volume increase. Pharmacy experienced a 90% concurrence rate for all IRR reviewer types. This confirms that our reviewers are consistently and accurately applying evidence-based clinical review criteria. Tony said level of care summarizes our over- and under-utilization activities conducted across the organization to evaluate the services that are requested from the plan. Our evaluation of over/under is performed by various groups – which includes but is not limited to our QI department via the analysis of our HEDIS® data, the conduction and maintenance of the IQI and Q/UAC, through the site review process and then through QI's annual access and availability grand analysis process – as well as the day-to-day UM process weighing potential over under utilizations when we are conducting our UM reviews. The UM department utilizes Change Healthcare's product InterQual® for our external criteria for evaluating UM requests. InterQual is reviewed, discussed, and evaluated annually: that review is coming up in a couple of months with a real time demonstration of how we work through that. UM also leverages medical guidelines, Medicare criteria, various state policy letters and national treatment guidelines in making these decisions. Andrea noted Pharmacy criteria and pharmaceutical drug classes are reviewed in collaboration with external and internal stakeholders on an annual basis, as required by NCQA, and Partnership's P&T and PAC committees. The criteria are selected, reviewed, updated or modified based on feedback from Partnership staff and committees, external providers, state policy letters, national treatment guidelines, such as NCCN (National Comprehensive Cancer Network), among other sources.	

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	Tony said UM internally analyzes data and also looks at external data sources to ensure that the program is operating according to how described in the program description. UM measures both our practitioner experience as well as our member experience. (Partnership on an annual basis surveys both our network providers as well as our members with various questions on how services are being rendered by the program. This includes questions specific to the UM team.) Every year, we work with Provider Relations and Grievance & Appeals in gathering that data, analyzing it and looking for any potential corrective actions or process improvement opportunities that we may identify. Tony said he was "extremely happy" in evaluating the survey results from our network PCPs as well as our specialists. (In years, past, we have had areas that have fallen below the 90% threshold that we have set for ourselves.) This year, for all UM-related questions within that survey we did exceed that 90% threshold. "It is also extremely encouraging that the survey did include our new providers within the new 10-county service areas," Tony added. Andrea said that the Member Experience portion is evaluated via the annual Grievance & Appeals PULSE Report. Although there was an overall increase in Partnership's membership and total number of grievance cases related to the UM process in 2024, we did see a decrease in the number of grievances per 1,000 members when compared to 2023 figures. The primary issue reported in 2024 was access related, with the majority being associated with the RAF and TAR processes. For both, many member concerns alleged providers delayed requests. When investigated, the G&A team did not find any discernible trends. Both the Pharmacy and UM departments provided a TAR supplemental report: this includes a breakdown of each department's respective TAR numbers by category and TAR status type. They also provided a summary breakdown of the percentage of TARs that were approved, modified approved, denied, and administratively denied, and a summary of the percentage of appeals received that were upheld or overturned. Tony summarized that both UM and Pharmacy teams faced challenges in calendar year 2024, largely driven by our expansion and the rapid influx or work that we saw as a result of that expansion. In conclusion, the UM program functions effectively, has a solid program structure, maintains a comprehensive policy library, and receives robust guidance and support from the senior level physicians via both our internal and external committees. As a result, no significant changes will be required for our UM program this year.	
Population Needs Assessment *Hannah O'Leary, MPH, CHES, Manager of Population Health*	This annual report is a compilation of preliminary 2024 findings pulled from various data sources (e.g., local community needs assessments, Partnership claims data, HEDIS® scores, CAHPS® data, etc.) and fulfills NCQA and other regulatory requirements. The 100-page document will be posted on Partnership's external website after the Board of Commissioners considers it this summer. Assessments of our 24 counties identified various social determinants of health, including economic instability, lack of access to quality healthcare, neighborhood and built environment challenges, limited access to quality education, and social/community context challenges (e.g., higher rates of adverse childhood experiences). Data sources further revealed income inequities and food deserts as part of social determinants of health concerns; disparities in health outcomes among marginalized groups; transportation	There were no questions. <u>Next Steps</u>: May 14 PAC Health education sessions around tobacco prevention will roll out in 2025. One has already occurred. Dr. Moore noted that the PNA

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	concerns; 118 wildfires among the environmental concerns; chronic hypertension, depression, and tobacco use in adults, and chronic anxiety, trauma/stress, and depression in our child members. Health disparities across differing rachial/ethnic groups were found in specific measures: controlling high blood pressure; child and adolescent well care visits; Hemoglobin A1c control for diabetes; and pre- and post-natal care visits. Partnership took dozens of actions on these issues in 2024, including the following: • Addressed organizational structure, social and environmental needs, health disparities, and health education/culture and linguistic needs • Hired new regional medical directors for the new Auburn region and the Santa Rosa office too • Created community health needs liaisons team via the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) modalities • Offered grant funding to address housing concerns • Awarded more than $52M in grants to more than 100 Cal-AIM (California Advancing and Innovating Medi-Cal) providers to build capacity in such programs as Enhanced Care Management and Community Supports services • Increased workforce opportunities, including member scholarships to support careers in healthcare, social work and other related fields • Rolled out the new Asthma Emergency Department Visit Outreach Program Campaign • Helped schools expand the use of behavioral health workers • Continued Alinea Medical Imaging contract for mobile mammography services • Conducted a six-month Cervical Cancer Screening Self-Swab pilot • Continued provider recruitment and retention programs • Continued to strengthen collaborative relationships with local Tribal Health providers • Created member-facing videos on several topics to help educate members on mental health, vaccines, and other health issues • Conducted Member/Community informative sessions in both English and Spanish	is an integration of what is happening everywhere with our members and concrete action in the Population Health Management department (such as the incentives offered to pregnant members to go to their prenatal visits) and therefore meets a regulatory need. "Hidden in there are gems of amazing projects that are really well run and have a major impact," Dr. Moore said of the "well-written" 100+ page report, adding that the Executive Team has reviewed many projects/programs in detail. Time permitting, some of these programs may be presented to Q/UAC this fall.
VII. FYI Attachments and Adjournment		
Pharmacy Operations Update – *refer questions to Stan Leung, Pharm.D*		
Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*		
Q/UAC adjourned at 8:58 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, May 21		

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, April 8, 2025 / 1:30 – 2:51 PM

Members Present: Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer 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 Campbell, Anna, Policy Analyst, Utilization Management Esget, Heather, RN, BSN, ACM, Director of Utilization Management 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 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 Ruffin, DeLorean, DrPH, MPH, Director of 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: Andrews, Leigha, MBA, Regional Director (Southwest) Ayala, Priscila, Director, Network Services Bjork, Sonja, JD, Chief Executive Officer Brunkal, Monika, RPh, Assoc. Dir., Population Health Davis, Wendi, Chief Operating Officer	Garcia-Hernandez, Margarita, PhD, Director of Health Analytics Kerlin, Mary, Senior Director, Provider Relations Klakken, Vicki, Regional Director (Northwest) Matthews, Richard "Doug," MD, Regional Medical Director (Chico) Sharp, Tim, Regional Director (Northeast) Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Guests: Armstead, Jay, Program Manager II, QI Arrazola, Kelcie, Lead Trainer, Provider Relations Beltran-Nampraseut, Athena, CPhT, Program Manager, QI Bikila, Dejene, Manager of Data Science, Finance Booth, Garnet, Senior Program Manager, Provider Relations Broadhead, Candi, Project Manager II, QI Brito, Alex, Senior Health Data Analyst, Finance Clark, Kristen, Manager of Quality & Training, Member Services 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) Foster, Troy, Program Manager II, QI (QIPs) Grupe, Michele, Mgr of First Five Commissions, Behavioral Health Gual, Kristine, Director of Quality Measurement, QI Harris, Matthew, Education Specialist, Provider Relations Harris, Vander, Senior Health Data Analyst I, Finance Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn) Jamali, Shahrzad, Improvement Advisor, QI (Chico)	McCune, Amy, Manager of Quality Incentive Programs, QI Moore, Jordan, Provider Education Specialist, Provider Relations Nguyen, Tom, Manager of Health Analytics, Finance Ocampo, Andrea, Pharm.D. Clinical Pharmacist, Pharmacy O'Leary, Hannah, MPH, Manager of Population Health, Pop Health Ooten, Lisa, Pharm.D, Clinical Pharmacist, Pharmacy Payumo, Desiree, RN, Supervisor of Inpatient Nurses, UM Rathnayake, Russ, Senior Health Data Analyst I, Finance Rhorer, Jeanelle, Supervisor of Configuration, Configuration Robertello, Kimberly, Senior Medicare QI Program Manager, QI Roberts, Dorian, Sr. Mgr of PR Representatives, Provider Relations Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast) Sackett, Anthony, Project Manager II, QI (CAHPS®) Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance Smith, Christine, Community Health Needs Liaison, Population Health Stark, Rebecca, Regional Director (Chico) Stokes, Sarah, Project Coordinator II, QI (HEDIS®) Trosky, Renee, Manager of Provider Relations Compliance Ungaro, Chloe, Senior Program Manager, Provider Relations Vaisenberg, Liat, Associate Director of Health Analytic, Finance

Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination	Vance, Brooke, Program Manager I, Network Services
Lee, Donna, Manager of Claims, Claims	Vij, Namita, Program Manager II, Enhanced Health Services
Lee, Heidi, Senior Manager, Network Services	Ward, Lisa, MD, Regional Medical Director (Southwest)
Lopez, Rosalee, Manager of UM Operations, UM	Wellander, Emily, Improvement Advisor, QI
LoPilato, Courtney, Project Coordinator I, Administration	Williams, Joanie, RN, Supervisor of Inpatient Nurses, UM

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 1:33 p.m. Approval of the March 11, 2025 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Feb. 27 Member Grievance Review Committee (MGRC)	Motion to approve IQI Minutes: Brigid Gast, RN Second: Isaac Brown Motion to accept other minutes: Marshall Kubota, MD Second: Stan Leung, Pharm.D
II. Old Business –		
Early Policy Reviews to Accommodate D-SNP Implementation Schedule *Robert Moore, MD Chief Medical Officer*	In preparing for our Dual-Eligible Special Needs Plan Medicare product line "Partnership Advantage" going live Jan. 1, 2026, we have policies that need to be minorly adapted to apply and some new PA-only policies that need to go through IQI/Q/UAC/PAC before the September/October timeframe. We are moving many policies that we normally see in September, October, November to May, June, August. We were not planning on having a July meeting, but we may need one for the new policies. This month is light because we are having trouble finishing some policy updates. The next three months will be busy, but then it could be light on policies towards the end of the year. Please review the updated policy timeframe list included as FYI at the end of today's meeting packet. Direct questions and issues to Leslie Erickson, together with a note that your policies have been reviewed for D-SNP applicability. Medical Director for Medicare Services Kermit Jones, JD, MD, encouraged anyone with such questions should reach out to him, Anna Campbell, and/or Kimberly Robertello. Realize, however, that they are not subject matter experts for all specific departments. Dr. Moore reiterated that although the underlying rules differ, our front line work needs to be integrated. Some Medi-Cal benefits may not be covered by Medicare but we still might offer them to D-SNP enrollees, so some policies may present editing difficulties. UM's MPUG3002 – Acupuncture Services Guidelines passed April 9 at PAC may serve as a model how to "thread the needle." See https://public.powerdms.com/PHC/documents/1850078	*Meeting Postscript:* IQI will meet July 8 to consider 8-10 or more new policies that will require much internal discussion. Q/UAC will entertain these policies on Aug. 20.
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies Quality Improvement MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus Utilization Management		Motion to **approve as presented but for the three pulled policies:** Mark Netherda, MD Second: Marshall Kubota, MD Next Steps:

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	MCUP3121 – Neonatal Circumcision MPUP3014 – Emergency Services MPUP3026 – Inter-Rater Reliability Policy MPUP3051 – Long Term Care SSI Regulation ***Non-Health Services Policies*** <u>Credentialing</u> MPCR4B – Identification of HIV/AIDS Specialists MPCR13 – Credentialing of Pain Management Specialist MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist MPCR13B – Buprenorphine Prescriber Credentialing – ***pulled for discussion*** MPCR13C – Osteopathic Manipulation Treatment Credentialing MPCR19 – Skilled Nursing Facility Providers (SNFists) Credentialing Policy MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements – ***pulled for discussion*** MPCR600 – Range of Actions to Improve Practitioner Performance MPCR601 – Fair Hearing and Appeals Process for Adverse Decisions – ***pulled for discussion*** MPCR800 – Delegation of Credentialing and Re-credentialing Activities <u>Provider Relations</u> MPPR203 – Provider Enrollment Status Guidelines MPPR209 – Provide Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions **Anna Campbell pulled three policies to ask questions.** First, should Credentialing polices be marked for Partnership Advantage? Manager of Provider Relations Compliance Renee Trosky agreed they could be. Doctors Moore, Mark Netherda, Marshall Kubota, and Jeff DeVido discussed whether **MPCR13B** is even still necessary and agreed that it is. They rewrote the Purpose Statement and the Policy/Procedure sections, and IQI agreed to these amendments. The policy now reads **V. Purpose**: This policy sets the standards for primary care physicians (PCPs) and non-physician clinicians who may be designated as "~~Suboxone~~ *Buprenorphine* prescribers" and thus eligible to treat patients for substance use disorder without a referral who are assigned to other primary care clinicians. This policy also sets standards for specialist physicians and non-physician specialist clinicians who want to treat patients for substance use disorder without a referral. **VI.B Policy Procedure is dropped altogether and VI.A. is amended**: For purposes of billing and directory listing and to treat patients without requiring a referral, in order to be recognized as a Buprenorphine Prescriber, the physician or non-physician clinician must hold a valid DEA (Drug Enforcement Agency) certificate. Anna suggested **Attachment B of MPCR304** needed editing: references to "Provider Relations" need to be changed to "Network Services" as that business unit handles Credentialing policies. This document is attached to five different policies. Rather than bring all the policies back, Dr. Moore agreed that Attachment B can be brought back on its own to IQI May 13. Anna also noted that this policy defines "allied health practitioners" one way but **MPCR601** lists a different set of credentials. **Dr. Moore noted that MPCR601 is incorrect** and must be changed: Physician Assistants and Nurse Practitioners are not "allied health practitioners." **MPCR304 is further edited** to drop reference to All Plan Letter (APL) 23-034 from Section VI.B.4.i. The References section also needs updating. Anna will send changes to Heidi Lee and Leslie Erickson.	Health Services policies will go to the April 16 Quality/Utilization Advisory Committee (Q/UAC) and the May 14 Physician Advisory Committee (PAC) **MPCR13B is approved as amended**: Mark Netherda, MD Second: Jeff DeVido, MD **MPCR304 is approved as amended**: Anna Campbell Second: Kermit Jones, MD, JD Attachment B should come back in May. **MPCR601 is approved as amended**: Marshall Kubota, MD Second: Anna Campbell *Meeting Postscript:* All Credentialing policies – save MPCR17 on today's discussion calendar – passed the Credentials Committee April 9.

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	More discussion ensued on MPCR601's listing of "practitioners." Policy **Definitions Section III.C is thus amended**: Licensed Independent Practitioners (LIP) (includes MD, DO, DPM, DC, DDS, LAc), clinical PA and NP, CRNA, CNM, Mental Health Practitioners (MHP) (includes MFCC, LCSW, LMFT, PhD) and Allied Health Providers (AHP) (PT, OT, Speech and Language Therapists and Optometrists, Audiologists, and Registered Dieticians) that are credentialed by Partnership to perform services specified in their contract. Dr. Netherda mentioned QI policy MPQG1011 passed at PAC Jan. 8 defines "Non-Physician Medical Practitioners" (NPMP), and Dr. Moore said we should agree on either "NPMP" or "non-physician clinician" going forward. He would prefer the latter, should it jibe with National Committee on Quality Assurance (NCQA) nomenclature. Anna has modeled some UM policies after MPQG1011 definitions, so these too might need to be changed in the next review cycle. Program Manager (Network Services) Brooke Vance noted that NCQA refers to NPs as NPs and in no other terms.	
IV. New Business – Discussion Policies		
Policy Owner: Credentialing (Network Services) – *Presenter: Heidi Lee, Senior Manager, Network Services*		
MPCR17 – Standards for Contracted Primary Care *and Urgent Care* Physicians – **NEW TITLE**	**This policy is being reviewed today to encompass Urgent Care physicians, and so "Urgent Care" is being added to the policy title. An OpEx/PMO committee has been created and authorized to review this policy and Utilization Management's MCUP3044 – Urgent Care Services from a contracting perspective and to resolve inconsistencies between the two policies. These policies should come back to IQI later this year.** **II. Impacted Depts:** Provider Relations is added. **III. Definition added:** Urgent Care – according to the American Academy of Urgent Care Medicine, Urgent Care is "the provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness and injury". (Definition of Urgent Care Medicine [Internet]. Available from: http://aaucm.org/about/urgentcare/default.aspx). While urgent care providers may also be the first to diagnosis chronic diseases such as diabetes or asthma, they refer patients to a primary care provider for the management of these conditions. Primary Care Providers may provide urgent care for their assigned continuity patients, as part of primary care. A clinician, who provides *only* urgent care services, without being assigned primary care patients, must meet the credentialing standards for Urgent Care providers. **V. Purpose Statement is updated.** Some physicians apply to be credentialed as a primary care physicians who have not completed a residency in a primary care specialty. This policy sets standards to ensure adequate quality of care for all members assigned to credentialed PCPs. To describe the credentialing and re-credentialing requirements for the following types of practitioners contracted with Partnership HealthPlan of California. (Partnership) Primary Care (PCP) Urgent Care (UC) **VI. Policy Procedure Section C is added.** Urgent Care Providers To be credentialed for contracted Urgent Care Services, or for performing only Urgent Care Services within a Primary Care setting, General Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine or Emergency	Motion to **approve as presented**: Marshall Kubota, MD Second: Mark Netherda, MD Next Steps: April 9 Credentials Committee *Meeting Postscript:* MPCR17 did not pass the Credentials Committee April 9 and should come back to committees in May.

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	Medicine or practicing under privileges granted when credentialed as a PCP under MPCR17. 2) An NP or PA practicing within their scope of practice. Pediatric Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine, Pediatrics, or Emergency Medicine or practicing under privileges granted when credentialed as a PCP under MPCR17. 2) An NP or PA practicing within their scope of practice. Adult Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine, Internal Medicine, or Emergency Medicine or practicing under privileges granted when credentialed under MPCR17. 2) An NP or PA practicing within their scope of practice. **IX. Position Responsible for Implementing Procedure is updated** to the Director, Network Services. Heidi emphasized and Dr. Moore reiterated that this policy has to do with credentialing and not contracting. There were no questions; however, this policy could come back to IQI later this year.	
V. Presentations		
1. QI Update *Nancy Steffen, Senior Director, Quality Improvement and Performance*	• The Women's Health and Perinatal workgroup under Regional Medical Director Colleen Townsend, MD, and Provider Relations hosted a webinar April 1 to inform providers about cervical cancer self-swab options through their laboratory vendors. NCQA now has a new code for this screening, which we will now apply to our Healthcare Effectiveness Data Information Set (HEDIS®) measure. • Our Chronic Disease workgroup, together with Provider Relations, has sponsored a Colorectal Cancer educational flyer throughout our provider network. "Chronic disease" is part of our accreditation set. Partnership is facilitating a multi-patient Cologuard order on behalf of providers, removing the 200-patient minimum requirements. Kits started shipping March 24. • Partnership's Behavioral Health leadership is working closely with our counties on innovative ways to affect positive changes for mental health service data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are now in the field for both our adult and our child populations. Response rates are thus far favorable. Telephone interviewing begins April 11.	*For information only. No action is required.* There were no questions.
2. Proposed 2025-2026 Quality Incentive Program Measure Summaries – HQIP and PQIP *Troy Foster, Program Manager II, QI*	Troy noted that current Hospital QIP measures will continue for MY 2025-2026, although changes will be made to palliative care capacity, expanding delivery privileges, and health equity. "Doula Support" and "Vaccines for Children Enrollment" are added to the Clinical Domain. 3. The Palliative Care Quality Collaborative (PCQC) dissolved in March. Hospitals will use data from their inpatient EMRs to report to Partnership. Measure requirements for "x-large hospitals" (100 or more beds) are changing. 4. The multi-phase Expanding Delivery Privileges is moving into its second year. "Phase 1" language will be replaced with "Phase 2" language. Hospitals are now required to actively recruit, grant privileges, and demonstrate evidence of family physicians' and nurse midwives' clinical activity. (Doctors Moore and Kubota noted that those who do not complete Phase 1 by July 1, 2025 cannot participate in Phase 2. Dr. Moore advised Troy to make this clear in the specifications.) 5. The health equity measure is switching from an annual report to submission of a Center for Medicare and Medicaid (CMS) Health Equity Attestation.	There were no questions for Troy. <u>Next Steps</u>: • PAC is scheduled to vote on these measure proposals April 9. • Q/UAC will see these proposals on its April 16 consent calendar.

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	6. It is suggested to add a multiple-phased Doula Support measure similar to that of Expanding Delivery Privileges to encourage hospitals to allow doulas to support birthing parents during delivery. 7. It is suggested to add a measure incentivizing hospitals to enroll in the cost saving Vaccines for Children program offered by the California Department of public Health (CDPH). Troy noted that Clinical Domain measures of the Perinatal QIP are not changing. The Electronic Clinical Data Systems (ECDS) measure, however, is becoming a "gateway" measure. If a perinatal provider did not complete a contract and implementation with DataLink during the 2024-2025 measurement period, they must complete all implementation phases and participation requirement steps by June 30, 2026 to be eligible for incentive payments in the 2025-2026 measurement year. • "Timely Comprehensive Assessments" is proposed as a new monitoring measure. During the~~y~~ 2025-2026 MY, Partnership will be monitoring claims data looking for members receiving full psychosocial, nutrition, and behavioral health assessments each trimester of pregnancy and once postpartum (up to one year post-delivery).	
3. UM Pharmacy Grand Analysis • MPUD3001 – UM Program Description • 2024 UM Program Evaluation • Supplemental TAR Report *Tony Hightower, CPhT, Assoc. Dir., UM Regulations,* and *Andrea Ocampo, Pharm.D, Clinical Pharmacist*	Tony "kicked things off" with a summary of the UM Program Description before turning to the Evaluation and Supplemental Treatment Authorization Request (TAR) Report. MPUD3001 is a comprehensive description of our UM program, which includes both our UM and Pharmacy teams. The document is broken down by our program purpose, which provides the reader high level description of the functions of the UM department. We go through our program objectives, which outlines how our UM program operates within the various regulatory frameworks that we are accountable for, including but not limited to both DHCS and NCQA compliance. We outline in our program structure, the roles and responsibilities of both our clinical staff, which includes our medical directors, our nurses and our pharmacists, as well as the roles and responsibilities of our non-clinical staff, which includes our data coordinators, pharmacy technicians, project coordinators, program managers, and our health services analyst. We give a description of our oversight committees, which does include Q/UAC. We then go into our program scope both for UM and for Pharmacy, as well as the benefits and services our teams evaluate. We provide an outline of the mental health services that Partnership provides, including our Specialty Mental Health Services (SMHS) that are currently delegated to Carelon, as well as our interfacing for specialty mental health services through our referrals to the county mental health plans. We provide an outline of our residential substance use disorder (SUD) Wellness & Recovery benefit that we manage. We outline the behavioral health treatments for our members under the age of 21. And then we go into a description of our UM process, the factors we consider when making decisions for UM requests, which includes the pre-authorization of services. We outline our referral management process referring members to specialty services. Then we go into various TAR reviews, concurrent review, our SNFs, sub-acute, and LTAC and recap reviews. We outline UM's role in the discharge planning process and our process for retrospective reviews on services already rendered to our members. We outline our timeliness requirements for both DHCS and NCQA. The PD further outlines our process for Inter-Rater Reliability (IRR) to ensure that our application of criteria is consistent across the entire scope of our team. The PD describes our external communication process, including our determination letters or notices of action, and a description of our translation services available to our members. We currently delegate inpatient services with four of our hospital partners within our service area.	Motion to **approve MPUD3001 as presented together with accepting the Evaluation and TAR Supplemental Report**: Stan Leung, Pharm.D Second: Kermit Jones, MD, JD Next Steps: April 25 Q/UAC May 14 PAC

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	This year, we did update how we define medical necessity. A bulk of our work lies in keeping our program structure updated because our teams have been evolving so rapidly over the past couple of years. In the communication section, we made key updates to the non-discrimination statement to align with specific guidance that we received from DHCS. Tony noted the 2024 Evaluation of the UM program structure looks at our clinical staffing ratios as well as our TAR-to-staff ratios. The program scope, looking at how we maintain our policies in accordance with both DHCS and NCQA requirements, is evaluated and how we conduct our provided medical services is analyzed. We look at timeliness for our TARs according to DHCS and NCQA requirements. We do a deep dive at our application of criteria, both our monthly and quarterly IRR processes as well as providing an annual assessment of the appropriate level of care through our over- and under-utilization activities. We look at the participation of senior level physicians in our interfaces with committees, the PAC, Q/UAC, and, for our Pharmacy team, the Pharmacy & Therapeutics Committee. For our UM clinical staff ratios, we set a threshold at 20% for our nursing-to-medical director ratios. We exceeded our threshold in Quarter 4 because of ramping up staffing as a result of the 10-county expansion. As a result of that staffing ratio deviation, we will be looking at resetting it for calendar year 2025 to better reflect the structure of our teams going forward. UM processed a total of 344,695 TARs in 2024, a 40% increase above calendar year 2023. When we look at our TAR-to-staff ratio for the UM team month over month, we did have deviations from the 20% threshold target across the board because of the increase in staff or increase in TAR volume that we encountered in January 2024. It was a bit of a rocky year for the UM team. Andrea said that, similar to the UM department, Pharmacy's 2024 TAR volume significantly increased primarily due to the 10-county expansion. We received 10,758 Pharmacy TARS in 2024, a 43% increase above 2023. We continually monitor our TAR-per-pharmacist and TAR-per-technician ratios month-to- month to assess for adequate staffing. Both exceeded our 20% month-to-month threshold January through March. Pharmacy leadership continues to quarterly monitor TAR timeliness and IRR to assess impacts. Tony noted that every year we measure UM participation in our advisory committees. In 2024, quorum was achieved at every single meeting of Q/UAC, P&T, and PAC. That's a big "thank you" to our external partners for participating. Unfortunately though, UM did not meet timeliness goals for the areas of urgent concurrent, urgent pre-service, non-urgent pre-service and post-service requests because of volume and onboarding/training new staff. The good news is that, moving through 2025, the UM team has turned the corner and things are getting back on track. Andrea said Pharmacy achieved an overall timeliness rate of 99% in 2024: when broken down by category, timeliness goals were not met for urgent pre-service requests, which have a 72-hour turnaround time, but they were met for non-urgent pre-service and post-service requests. Some workflow changes have been implemented just to mitigate risks for our timeliness for our urgent requests, including identifying and flagging gene therapy requests at data entry as these tend to require external reviews. Pharmacy also hired some permanent technician staff in Quarter 4 2023/Quarter 1 2024 to address the staffing gaps created by the TAR volume increase. Pharmacy	

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	experienced a 90% concurrence rate for all IRR reviewer types. This confirms that our reviewers are consistently and accurately applying evidence-based clinical review criteria. Tony said level of care summarizes our over- and under-utilization activities conducted across the organization to evaluate the services that are requested from the plan. Our evaluation of over/under is performed by various groups – which includes but is not limited to our QI department via the analysis of our HEDIS® data, the conduction and maintenance of the IQI and Q/UAC, through the site review process and then through QI's annual access and availability grand analysis process – as well as the day-to-day UM process weighing potential over under utilizations when we are conducting our UM reviews. The UM department utilizes Change Healthcare's product InterQual® for our external criteria for evaluating UM requests. InterQual is reviewed, discussed, and evaluated annually: that review is coming up in a couple of months with a real time demonstration of how we work through that. UM also leverages medical guidelines, Medicare criteria, various state policy letters and national treatment guidelines in making these decisions. Andrea noted Pharmacy criteria and pharmaceutical drug classes are reviewed in collaboration with external and internal stakeholders on an annual basis, as required by NCQA, and Partnership's P&T and PAC committees. The criteria are selected, reviewed, updated or modified based on feedback from Partnership staff and committees, external providers, state policy letters, national treatment guidelines, such as NCCN (National Comprehensive Cancer Network), among other sources. Tony said UM internally analyzes data and also looks at external data sources to ensure that the program is operating according to how described in the program description. UM measures both our practitioner experience as well as our member experience. (Partnership on an annual basis surveys both our network providers as well as our members with various questions on how services are being rendered by the program. This includes questions specific to the UM team.) Every year, we work with Provider Relations and Grievance & Appeals in gathering that data, analyzing it and looking for any potential corrective actions or process improvement opportunities that we may identify. Tony said he was "extremely happy" in evaluating the survey results from our network PCPs as well as our specialists. (In years, past, we have had areas that have fallen below the 90% threshold that we have set for ourselves.) This year, for all UM-related questions within that survey we did exceed that 90% threshold. "It is also extremely encouraging that the survey did include our new providers within the new 10-county service areas," Tony added. Andrea said that the Member Experience portion is evaluated via the annual Grievance & Appeals PULSE Report. Although there was an overall increase in Partnership's membership and total number of grievance cases related to the UM process in 2024, we did see a decrease in the number of grievances per 1,000 members when compared to 2023 figures. The primary issue reported in 2024 was access related, with the majority being associated with the RAF and TAR processes. For both, ~~,~~a~~nn~~y member concerns alleged providers delayed requests. When investigated, the G&A team did not find any discernible trends. Both the Pharmacy and UM departments provided a TAR supplemental report: this includes a breakdown of each department's respective TAR numbers by category and TAR status type. They also provided a summary breakdown of the percentage of TARs that were approved, modified approved, denied, and administratively denied, and a summary of the percentage of appeals received that were upheld or overturned.	

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	Tony summarized that both UM and Pharmacy teams faced challenges in calendar year 2024, largely driven by our expansion and the rapid influx or work that we saw as a result of that expansion. In conclusion, the UM program functions effectively, has a solid program structure, maintains a comprehensive policy library, and receives robust guidance and support from the senior level physicians via both our internal and external committees. As a result, no significant changes will be required for our UM program this year.	
4. Population Needs Assessment *Hannah O'Leary, MPH, CHES, Manager of Population Health*	This annual report is a compilation of preliminary 2024 findings pulled from various data sources (e.g., local community needs assessments, Partnership claims data, HEDIS® scores, CAHPS® data, etc.) and fulfills NCQA and other regulatory requirements. The 100-page document will be posted on Partnership's external website after the Board of Commissioners considers it this summer. Local external community needs assessments of our 24 counties identified various social determinants of health, including economic instability (e.g., food insecurity, disparities n access to social services), lack of access to quality healthcare (e.g., provider shortage), neighborhood and built environment challenges (e.g., 118 wildfires and lack of affordable housing, lack of transportation), limited access to quality education, and social/community context challenges (e.g., higher rates of adverse childhood experiences). Data sources further revealed income inequities and food deserts as part of social determinants of health concerns; disparities in health outcomes among marginalized groups; transportation concerns; chronic hypertension, depression, and tobacco use in adults, and chronic anxiety, trauma/stress, and depression in our child members. Health disparities across differing rachial/ethnic groups were found in specific measures: controlling high blood pressure; child and adolescent well care visits; Hemoglobin A1c control for diabetes; and pre- and post-natal care visits. In 2024, our Southern Region had the highest rates of accessing Specialty Mental Health Services, indicating members with serious persistent mental illness are accessing services at a higher rate than in other reporting regions. Both breast cancer and cervical cancer screening rates continue to underperform in the northern counties. Partnership took dozens of actions on these issues in 2024, including the following: • Addressed organizational structure, social and environmental needs, health disparities, and health education/culture and linguistic needs • Hired new regional medical directors for the new Auburn region and the Santa Rosa office too • Created community health needs liaisons team via the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) modalities • Offered grant funding to address housing concerns • Awarded more than $52M in grants to more than 100 Cal-AIM (California Advancing and Innovating Medi-Cal) providers to build capacity in such programs as Enhanced Care Management and Community Supports services • Increased workforce opportunities, including member scholarships to support careers in healthcare, social work and other related fields • Rolled out the new Asthma Emergency Department Visit Outreach Program Campaign • Helped schools expand the use of behavioral health workers • Continued Alinea Medical Imaging contract for mobile mammography services • Conducted a six-month Cervical Cancer Screening Self-Swab pilot, and are encouraging providers to adopt this method in 2025	There were no questions. Health education sessions around tobacco prevention will roll out this year. Motion to **accept the PNA as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: April 16 Q/UAC May 14 PAC

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	• Continued/continuing to support services for maternal and child health, including our Growing Together program • Continued provider recruitment and retention programs to preserve institutional knowledge and clinical leadership • Continued to strengthen collaborative relationships with local Tribal Health providers • Dedicated a community resource page for all 24 counties • Created member-facing videos on several topics to help educate members on mental health, vaccines, and other health issues • Conducted Member/Community informative sessions in both English and Spanish	
FYI Disseminations		
Pharmacy Operations Update – *refer questions to Director of Pharmacy Services Stan Leung, Pharm.D.*		
Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:12 p.m. IQI will meet next on Tuesday, May 13, 2025.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MPH, MBA* *Chief Medical Officer and Committee Chair*		

QI DEPARTMENT UPDATE
APRIL 2025
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY INCENTIVE PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER (PCP) QIP	• All preliminary reporting and provider review periods for Measurement Year (MY) 2024 have been completed. The QIP team is processing final scores and payments, which includes validation and Executive review for approval to distribute payments. • Final payments are estimated for distribution by the end of May 2025.
PALLIATIVE CARE QIP	• Payment for the July – December 2024 period is in progress. Payment is targeted for distribution by the end of May 2025. • The data registry, Palliative Care Quality Collaborative (PCQC), has dissolved as of 04/01/2025. The Palliative Care QIP team is discussing with participants how to proceed in MY2025.
PERINATAL QIP (PQIP)	• The proposed measure set for MY2025-2026 will be presented at April quality committee meetings. • The proposed changes for MY2025-2026 are as follows: o Sharing EMR data via Partnership's certified HEDIS Data Aggregator (DAV), Datalink, will be added as a Gateway measure for the ECDS measure. o A new monitoring measure is proposed to capture Timely Comprehensive Assessments. This measure will be developed in collaboration with our Member Safety Inspections team.
ENHANCED CARE MANAGEMENT (ECM) QIP	• Payment for Q4 2024 is underway with distribution planned for April.
HOSPITAL QIP (HQIP)	• The proposed measure set for MY2025-2026 will be presented at April quality committee meetings. • The proposed changes for MY2025-2026 are as follows: o Remove the PCQC requirement from the Palliative Care Capacity measure for Extra Large Hospitals o Move the Expanding Delivery Privileges measure to Phase II o Add a new Doula Support measure and a new Vaccines for Children Enrollment measure.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• The 2025 Business Requirements Document (BRD) for PCP QIP dashboard updates has been approved and turned over to the EDW team for development. 2025 PQD will launch with HRP (i.e. new core claims system) data in Quarter 3.
EREPORTS	• 2025 eReports HRP UAT remains in progress.

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 submitted new strategies and actions within the pediatric, chronic disease, and reproductive health and cancer prevention domains on 03/14/2025. Progress updates will be provided to DHCS in June and October this year. Several strategies and actions include: o Academic detailing sessions from Partnership's Pharmacy team encompassing medication-based best practices for conditions including asthma, statin therapy, controlling high blood pressure, diabetes, and opioid disorder. o Expediting newborn enrollment and primary care provider selection through Labor & Delivery engagement or through perinatal care. o Education and training on use of Z29.3 diagnosis code for fluoride application in dental practices to increase administrative capture of fluoride application for children. o Increasing use of in-office lead screening • Partnership continues to work with provider partners on the two required Performance Improvement Projects (PIPs) under behavioral health and pediatric disparities. o The BH PIP is in collaboration with Open Door Community Health Centers tracking transitions of care for patients who present in the Emergency Department for mental health events and require follow-up. o Pediatric Disparity PIP piloted a project with NorthBay (Solano) that involved Partnership Health Pop Health staff contacting birth parents shortly after the birth to assure connection with primary care provider of choice. NorthBay providing information to birthing parents was a huge help and boosted call connection/reach rates significantly. The W15 PIP Workgroup is now exploring additional delivery hospitals to expand this pilot and continue to test the efficacy of this strategy to improve W15 measure performance.
QUALITY MEASURE SCORE IMPROVEMENT	• The Women's Health and Perinatal workgroup with Dr. Townsend and Provider Relations hosted a webinar on 4/1 to inform providers about cervical cancer self-swab options through their laboratory vendors. • The Chronic Disease workgroup hosted a representative from the American Cancer Society. The representative shared national statistics on Colorectal Cancer disparities and educational resources for the team. • The Chronic Disease workgroup also sponsored a Colorectal Cancer educational flyer with our provider network through Provider Relations. This flyer was co-branded between Partnership and the American Cancer Society. See subsequent section titled, EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS for additional program level activities. • Partnership has received approval from DHCS to send reminders to members who had a 1st dose of HPV vaccine but have not received a second dose and are eligible per the adolescent immunizations measure.

Improvement Academy	• The final ABCs of Quality Improvement session was held in Redding on 03/25/2025. There were 43 attendees from 15 unique parent organizations. Feedback through the post-training survey was largely positive (72% extremely satisfied and 28% satisfied). 72% of respondents indicated this was their first time attending this event. • Status update on the *Improving Measure Outcomes* webinar series: o **02/12/2025 Preventative Care for Children Ages 0-30 Months** – 79 attendees from 36 unique organizations o **02/26/2025 Preventative Care for 3-17 Year Olds** – 55 attendees from 33 unique organizations o **03/12/2025 – Chronic Disease and Colorectal Cancer Screening** – 67 attendees from 45 unique organizations o **03/26/2025 – Perinatal Care and Chlamydia Screening** o **04/09/2025 – Breast and Cervical Cancer Screening** o **04/23/2025 – Diabetes Control**
Joint Leadership Initiative (JLI)	• 2025 sessions are currently being scheduled: • Ampla Health • Adventist Health – in process • Fairchild Medical Center – 07/01/2025 • Mendocino Community Health Center – targeting Summer 2025 • Open Door Community Health Centers – 06/26/2026 • Shasta Community Health Centers – 04/14/2025 • Solano County Family Health Services – 5/06/2025
Regional Improvement Meetings	• Redding and Eureka meetings will be held in June 2025 and invites will go out in May. • Chico and Auburn meetings are being planned for the summer. • Fairfield region will meet May 20, 2025

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 & Org Goals – FY 24/25 Member Experience and	**CAHPS Survey Fielding Timeline – Measurement Year 2024** The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) regulated survey for Measurement Year 2024 remains active in the field.

Survey Methodology	Launch Date	Status
• First survey questionnaire	• 02/14/2025	• Complete
• First reminder letter	• 02/21/2025	• Complete
• Second survey questionnaire	• 03/21/2025	• Complete
• Second reminder letter	• 03/28/2025	• Complete
• Begin telephone interviewing	• 04/11/2025	• Complete
• End telephone interviewing/data collection	• 04/25/2025	•

ACCESS | *ORG GOALS – FY 25/26 MEMBER EXPERIENCE*

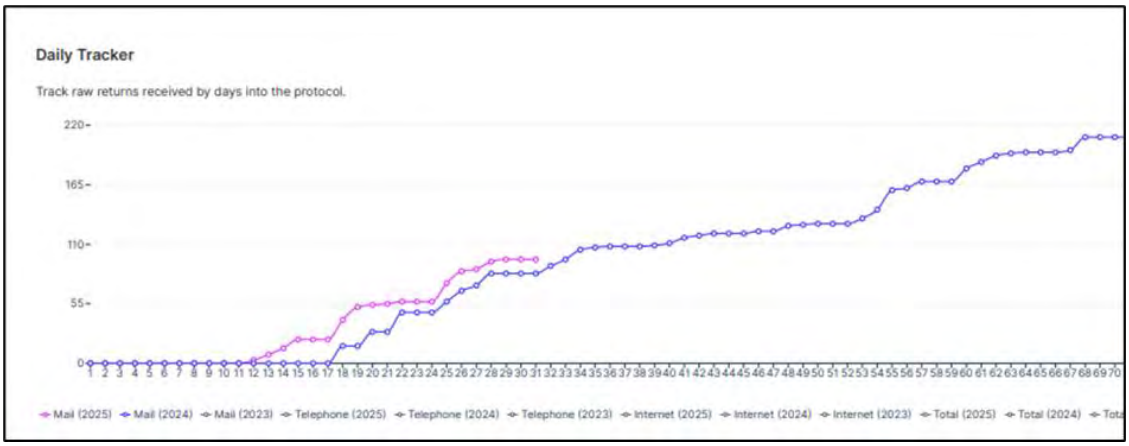
Preliminary Mail Response Rate Trends and Outreach Strategy

Mail response rates remain steady for both Adult and Child populations, with a slight increase compared to 2024. As part of a strategy to improve response rate, the CAHPS® team increased the Child sample size this reporting year – from 4,125 to 5,000. This larger sample size may be a contributing factor to the increased rate shown in the table below. The combined results indicate strong participation across both populations.

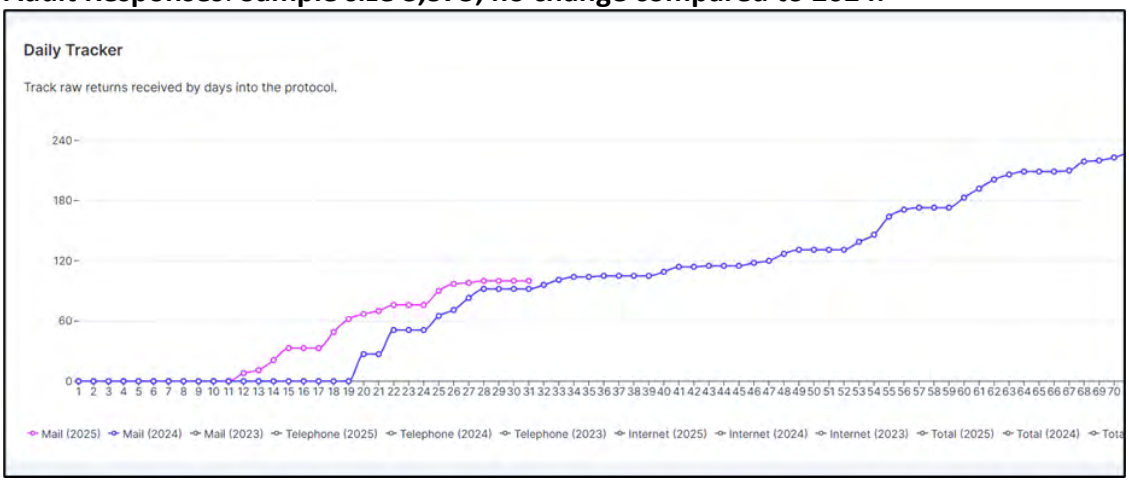
We anticipate a further increase in response rates as the survey vendor begins implementing phone follow-up protocols. These will include a combination of one reminder call and three automated calls, with live agents available to survey members in both English and Spanish formats.

Modality: Mail

Child Responses – Sample size 5,000; an increase from 4,125 in 2024.



Adult Responses: Sample size 3,375; no change compared to 2024.



	FY 2024/25 Organizational Goal #4 Progress Update: Access to Care & Member Experience Improvement The 2024-25 Org Goal #4 focuses on Access to Care and Member Experience Improvement. All goal contributors are focused on completing the remaining milestone activities during the last fiscal quarter of this period. As of this month, we have achieved a 61% completion rate for 8 milestones.
EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	**Program Overview and IPIP Funding Allocation** 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 in Initial Planning Incentives Payments (IPIP) funding. Of this amount: • $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). • In the past month, the Executive team approved the use of the remaining $1.2 Million in IPIP funding for two areas of unmet needs for low-performing Primary Care Physicians (PCPs): 1) Leadership training and 2) Support for replacing outdated Electronic Health Records (EHRs). • $900K will be allocated to the development and implementation of the PCP Leadership training which will be led by the PMO/OpEx team. • $300K will be allocated to support replacing outdated EHRs, a grant program which will be led by the QI Program and Project Management team. **PDPP Participation and Deliverable Requirements** 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. Accepted provider organizations span Partnership's sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhance Provider Engagement (EPE) program. DHCS has recalculated the final award amounts, due to budget revisions. • Following the budget revisions, the dropout rate for the EPT cohort across the state is 5%. All twenty-seven (27) provider organizations sponsored by Partnership remain enrolled and engaged in the program. • EPT practices that did not complete the 2024 deliverables, by the 11/01/2024 due date, have until 11/2025 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. • 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 • All templates and rubrics for the May 2025 deliverables are available on PHLC's milestone page in the link below. https://pophealthlearningcenter.org/milestones-and-deliverables/#may-25 • As of 03/25/2025, DHCS has not funneled EPT payments to Partnership. EPT POs are still expected to receive their funding no later than 04/30/2025. **Statewide Learning Collaborative** 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. EPT practices are diligently working on their May 2025 deliverables due on 05/01/2025. PHLC is hosting office hour sessions to help EPT practices learn more about population health best practices, work through implementation challenges, and prepare for deliverables submission. • Office hour topics include: EPT deliverables portal review, PhmCAT support sessions, Data implementation, Data Exchange Framework (DxF) bootcamp, and Access. • EPT practices and MCPs are welcome to register for any office hour sessions on PHLC's event calendar page linked below https://pophealthlearningcenter.org/eventcalendar/
LOCUM PILOT INITIATIVE	**Overview of the QI Locum Pilot** 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 was designed as a limited grant program, whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Track 1.

Track 1 Summary and Funding Model

A total budget of $250,000 was approved for Track 1 with some funding remaining, given progress since kick-off; participants have received up to:

- $45,000 when hiring a Physician.
- $31,600 when hiring an Advanced Practicing Clinician.

The Grant was paid 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 were carried out asynchronously through January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician.

Track 1 Provider Specific Status Updates

Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements.

Round Valley Indian Health received an amendment to their agreement to extend their grant offering through May 2025 and are working towards completing their grant requirements.

Track 2 Planning and Executive Review

Track 2 is currently under Executive review and proposed for implementation in FY 25/26. This offers strategic opportunities to address provider shortages, enhance health care quality, and improve patient outcomes. By allocating targeted funding to support temporary staffing, this initiatives aims to;

- Strengthen provider networks
- Increase access to care
- Drive measurable improvements in member health experiences.

If approved, it would expand the scope of the Locum Pilot as follows.

- Grant funding would be provided to eligible PCPs to support six (6) locum providers for 16-week assignments to increase provider capacity, reduce appointment backlogs, and improve HEDIS and preventive care measures.
- Total proposed funding: $576K, equating to $32K per month for each participating provider (up to six total).

<table>
<tr><td></td><td>

Edits to the application and agreement are currently in progress, pending executive approval.
QI Performance Improvement (PI) managers are identifying provider organizations that may be potential candidates for Track 2 participation.

</td></tr>
<tr><td>Mobile Mammography Program</td><td>
Upcoming Event Days (FY Q3)
<table>
<tr><th colspan="4">Upcoming Event Days
01/01/2025 – 03/31/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Chico</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Eureka</td><td>2</td><td>6</td><td>6</td></tr>
<tr><td>Fairfield</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Redding</td><td>5</td><td>5</td><td>6</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>4</td><td>4</td></tr>
<tr><td>Plan Wide</td><td>14</td><td>17</td><td>18</td></tr>
</table>

Scheduling for Mobile Mammography event days for FY Q4 (April – June 2025) is currently in progress.

</td></tr>
<tr><td>Partnering For Pediatric Lead Prevention Program (PPLP)</td><td>
LeadCare II Device Access and Evaluation
Partnership has continued its Partnering for Pediatric Lead Prevention program (PPLP) that funds point-of-care lead testing devices for practices. Applications are now available year-round. Details can be found on the PLPP page on Partnership's website. https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Lead-Poisoning-and-Prevention.aspx

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 benchmark.

Promotion and Outreach Efforts
To raise awareness and encourage ongoing participation, the program launched a promotional campaign emphasizing the importance of lead testing, promoting year-round enrollment and highlighting available resources. Promotional materials, including direct links and QR codes, have been shared with provider-facing teams.

Target outreach efforts are also underway for providers with a denominator of 100 or more who did not meet the 2024 QIP 50th percentile. Meetings are being scheduled to review the workflows, provide recommendations based on 2025 best practices and address any challenges.
</td></tr>
</table>

Exact Sciences: Promoting Colorectal Cancer Screenings	**March Cologuard Initiatives Removes Order Barriers** Partnership facilitated a multi-patient Cologuard order on behalf of providers aligned with Colorectal Cancer Awareness Month (March), removing the 200 patient-minimum requirement. Five provider organizations participated. Preshipment letters and calls are underway, kits shipped on 03/24/2025. An open office hour webinar was held on 02/11/2025 with Exact Sciences to address provider questions. Custom marketing materials with the provider logos, along with additional outreach support were provided by Exact Sciences. A second multi-patient order is planned for July – September to align with QIP's timeline for addressing 2025 and 2026 PCP QIP measures. Providers may submit orders from 07/21/2025 – 08/18/2025. An open office hour webinar will be held on 07/23/2025 with Exact Sciences to address provider questions. Pre-shipment patient notification letters will be mailed and live pre-shipment notification calls will begin on 09/22/2025. Orders are expected to ship on 09/29/2025.

QI Trilogy Program	• The FY 2025/26 QI Program Description is on track to be finalized by 04/28/2025
	• Upcoming deliverables for the remaining QI Trilogy documents are as follows:
	  • 2024/25 QI Work Plan (Final Updates) - submissions due: 05/12/2025
	  • 2024/25 QI Program Evaluation – submissions due: 05/30/2025
	  • 2025/26 QI Work Plan – submissions due: 06/18/2025

D-SNP

ACTIVITY	UPDATE
Project Tracker	• Quality is participating in tracking all D-SNP related projects in the shared Partnership Advantage Ops Project Tracker. Updates are submitted monthly by all Quality department leaders for any D-SNP related work.
HEDIS	• Baseline state Medicare data was evaluated for prospective D-SNP members in the eight county Partnership Advantage region to estimate future HEDIS performance. This data addresses HEDIS measure performance in preventative care/screenings and chronic condition management.
CAHPS Survey Project – Medicare Product Line	• No major updates to report at this time.
MOC Training (Internal and External)	• To comply with regulatory requirements in 2026, two Model of Care (MOC) training courses are being developed with collaboration from Quality, the Office of the Chief Medical Officer (CMO) and Training & Development (T&D) teams. One training is for external providers and the second is for Partnership personnel. The external MOC training will be required for member-facing employees of any contracted organization to complete annually beginning in 2026. The external MOC training will be hosted on Rival, a recently contracted platform used for Partnership's upcoming Health Equity training.

	Provider Relations will manage communications to providers and tracking of training completion. • Partnership personnel will complete the internal MOC training as part of their onboarding or as assigned in early 2026. T&D plans to host the Partnership employee training as part of its Learning Management System (LMS).

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **02/26/2025 TO 03/26/2025**	• 25 PQI referrals were received with 16 coming from Grievance and Appeals, 4 from Utilization Management, 3 from Medical Directors, and 2 from other sources. • 24 cases were processed and closed. • 97 PQI cases are currently open. • 2 cases were discussed at Peer Review Committee (PRC) on 03/19/2025 and there are 5 cases awaiting PRC review. • Upgrading of the SugarCRM PQI application (processing, documentation, and tracking system) has started with an anticipated completion date in May 2025.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **02/24/2025 TO 03/28/2025**	• As of 04/01/2025, we have a total of 461 PCP and OB sites with an additional 31 reviews due to multiple patient check-in locations (totaling 492 reviews). **Primary Care and OB Reviews:** **Region** / **# of FSR conducted** / **# of MRR conducted** / **# of FSR CAP issued** / **# of MRR CAP issued** Auburn: 1 / 1 / 1 / 1 Chico: 5 / 3 / 1 / 3 Eureka: 4 / 3 / 0 / 2 Fairfield: 3 / 2 / 3 / 2 Redding: 1 / 1 / 1 / 1 Santa Rosa: 9 / 9 / 1 / 4 Out of Area: 0 / 1 / 0 / 0 New sites opened this period → • Ampla Health North Chico Medical • Orchard Hospital Medical Specialty Center • West Sacramento Primary Care • UC Davis • Sutter Health

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
HEDIS® Program Overall	• Partnership completed an inventory of Short/Doyle Mental Health and Substance Use Disorder service claims sent by DHCS to Partnership that represent County Department of Behavioral Health services billed to Medi-Cal in 2023-2024. Partnership still experiences significant data completeness issues with County DBH service data, particularly for services from Q4 2024. The lack of complete 2024 Behavioral Health service data will impact MY2024 HEDIS performance on the Follow Up after ED Visit for Mental Health (FUM) and Follow Up After ED Visit for Substance Use (FUA) measure sets. The inventory was sent to DHCS's Chief Data Officer and Chief Quality and Medical Officer on 03/13/2025. • Partnership also continues its engagement with the DHCS Data Team to address data completeness issues within the DHCS Monthly Claims Data Feed files around the Topical Fluoride for Children (TFL-CH) measure; and around coordination of education campaign efforts around coding best practices for fluoride varnish application services using the ICD code Z29.3 3 (encounter for prophylactic fluoride administration) with CDT and CPT service codes. • Partnership has begun engagement with an external consultant with expertise in data validation and data exchange between DHCS, managed care payers, and provider networks. The engagement will continue through 2025 and will focus on identifying and addressing data completeness issues within Partnership's array of supplemental data sources; and on strengthening the validation tools and methodologies used by the HEDIS, PCP QIP, and internal stakeholder teams.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA)	• NCQA releases updates to the current HPA and HEA Standards and Guidelines three (3) times a year in November, March, and July. These changes include corrections, clarifications, policy changes and regulatory changes. The March updates were released on 03/31/2025 and have been shared with the applicable Business Owners. • Each year, NCQA releases proposed updates to the Standards and Guidelines. NCQA asks Health Plans to provide their feedback and/or comments on the proposed changes. This comment period is known as Public Comments. NCQA released the proposed updates to the 2026 HPA Standards and Guidelines on 02/25/2025. Applicable Business Owners were asked to review the proposed changes and indicate if they Support, Do Not Support, or Support the Changes with Modifications by 03/21/2025. The NCQA Program Management Team provided a plan-wide response to NCQA by the 03/25/2025 due date. • Proposed updates to the 2026 HPA Standards and Guidelines include:

Standard Category	Type of Change	Standard/Element
QI	New Element	QI 2C, 4A
PHM	Revised	PHM 1A, 1B, 2A, 3B, 3C, 4B, 6B

<table>
<tr><td></td><td>
<table>
<tr><td></td><td>New Element</td><td>PHM 3A, 3D</td></tr>
<tr><td rowspan="3">NET</td><td>Revised</td><td>NET 1A, 1D, 3C, 5A, 5C, 5E, 5F, 5H, 5I</td></tr>
<tr><td>New Factor</td><td>NET 2B</td></tr>
<tr><td>New Element</td><td>NET 2D</td></tr>
<tr><td rowspan="3">UM</td><td>Revised</td><td>UM 1A, 1B, 5A, 5B, 5C, 5D, 11B</td></tr>
<tr><td>New Factor</td><td>UM 1A, 3A,</td></tr>
<tr><td>New Element</td><td>UM 1B, 1C, 1D, 1E, 1F, 13E</td></tr>
<tr><td>ME</td><td>Retire</td><td>ME 5C</td></tr>
</table>
Proposed updates to the 2026 HEA Standards and Guidelines are scheduled for release in April or May 2025.
</td></tr>
<tr><td>NCQA HPA</td><td>The HPA Mock Renewal Survey is scheduled for 10/27-30/2025. The purpose of the HPA Mock Renewal Survey is to assess Partnership’s readiness, address identified gaps and develop action plans for meeting compliance when preparing for Partnership’s HPA Renewal Survey scheduled for 09/22/2026.
An evidence preparation training session will be held the week of 06/23/2025. Other details, including a tentative timeline for submission of the Year 1 evidence, timing for the distribution of the final report and results, and submission of an Action Plan, were reviewed and discussed during the February/March Business Owner Check-in meetings.</td></tr>
<tr><td>NCQA HEA</td><td>Partnership’s HEA Initial Survey is scheduled for submission on 06/17/2025.
As of March 2025, Partnership’s HEA compliance rate is 86.21%, receiving 25 points out of the 29 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.
An Introductory Call with our Accreditation Survey Coordinator (ASC) from NCQA was held on 03/20/2025. The purpose of the call was for NCQA to learn more about Partnership and review the survey process.
Business Owners submitted their annotated and bookmarked evidence by the 03/28/2025 due date, with a few exceptions. These exceptions include documents identified on the Evidence Submission Tracker with later dates due to committee review, publication and distribution of newsletters, and select delegation activities.</td></tr>
</table>

Partnership Policy & Procedure Updates

May 2025

Policy Number	Policy/Procedures/Guidelines	Version Links
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **April 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		
MPQP1006	Clinical Practice Guidelines	C CD RD
MPXG5001	Clinical Practice Guidelines for the Diagnosis & Management of Asthma	C CD RD
MPXG5002	Clinical Practice Guidelines for Diabetes Mellitus	C CD RD
Utilization Management		
MCUP3121	Neonatal Circumcision	C CD RD
MPUP3014	Emergency Services	C CD RD
MPUP3026	Inter-Rater Reliability Policy	C CD RD
MPUP3051	Long Term Care SSI Regulation	C CD RD
MPUD3001	Utilization Management Program Description	C CD RD
Population Health Management		
N/A	Population Needs Assessment	CD
Transportation		
MCRP4065	Drug Utilization Review (DUR) Program *(Internal Policy)*	C CD RD
MPRP4034	Pharmaceutical Patient Safety	C CD RD

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)
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MPUD3001 Utilization Management Program Description	109 -147	Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 2:** Under Program Objectives, added the definition of "medically necessary" and provided examples of service types that would require medical necessity review. **Page 2:** In the Program Staff description for the CMO, added the Senior Director of Care Management position as a collaborator. **Pages 3 and 4:** In the assigned responsibilities for the Medical Director of Medicare Services, added that this physician assists with coverage in UM and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities. **Page 6:** Added Program Staff description for the new position of Senior Director of Care Management. **Page 6:** Updated the direct report for the Director of Utilization Management to be the Senior Director of Care Management. Also added that the Director of UM coordinates with the new EHS department. **Page 7:** Updated title to Director of Enhanced Health Services (formerly Director of Utilization Management Strategies). Updated for CalAIM language in assigned responsibilities, including Street Medicine. Removed responsibility for regularly attending meetings with facilities, and added responsibilities related to expertise in housing services. **Page 8:** Updated title to Associate Director of Enhanced Health Services (formerly Director of Enhanced Care Management Operations). Updated for CalAIM language in assigned responsibilities. **Page 8:** Removed Program Staff description for Associate Director of Housing and Incentive Programs. **Page 9:** Updated Program Staff description for Associate Director of Utilization Management Regulation to better describe delegation oversight process. **Page 9:** Added new Program Staff description for Senior Manager of Justice Involved Programs – RN	NCQA team Compliance 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)
		Page 10: Updated Program Staff description for Manager of Long Term Support Services (LTSS) – RN to specify that this position has the authority to make decisions on coverage not relating to medical necessity. **Page 10:** Updated title to Clinical Manager, Enhanced Health Services- RN for position previously described as Clinical Manager, CalAIM Justice Liaison, ECM Program. Responsibilities were reorganized. Justice responsibilities went to new Staff description for Senior Manager of Justice Involved Programs – RN. This position will work with EHS leadership to manage and evaluate the CalAIM program. **Page 11:** Updated title to Clinical Supervisor of Enhanced Health Services- RN for position previously described as Supervisor of UM Strategies. No change in responsibilities. **Pages 14-15:** Added new Program Staff description for Program Manager I – (LTSS) **Pages 14 – 16**: Updated terminology to describe CalAIM or EHS as appropriate to our new Enhanced Health Services department. **Page 17:** In the Committee description for PAC, added non-physician clinicians as part of the voting membership. **Page 18:** In the Committee description for QUAC, added committee function for Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives **Page 18:** In the Committee description for QIHEC, added "grievance and appeal data" to the list of items the committee will analyze, Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer." **Page 19:** In the Committee description for SUIQI, added Senior Director of Behavioral Health and Senior Manager of Behavioral Health as committee members. **Page 19:** Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer."	

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		Pages 22-23: Updated County Mental Health Plan (MHP) term to be County Behavioral Health Plan (BHP) per state guidance. **Page 28:** Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer." **Pages 30-31:** Updated language regarding alternative formats and auxiliary aids in the No Cost Linguistic Services section. Added reference to MCND9002 Cultural and Linguistic Program Description for more information. **Page 31:** Added definition of medical necessity to Denial Determinations section. **Page 31:** Added that denial determinations may occur "When out-of-network services are not clinically appropriate." **Page 33:** Added "Member utilization data" and "Provider prescribing data" to the list of data collection activities for UM analysis and reporting. **Page 34:** In the Statement of Confidentiality section, added that confidentiality statements signed by QUAC and PAC members are "securely stored" in QI files. Also added description of Partnerships Privacy Office responsibilities and a statement on how Partnership maintains administrative structure, reporting procedures, due diligence procedures to protect PHI. **Page 34:** In the Non-Discrimination Statement section, added expanded language per DHCS to describe national origin as including "limited English proficiency (LEP) and primary language" and sex as including "sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes."	

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, April 10, 2025 / 7:30am – 10:00am PT

Practicing Members Present:
Jay Shubrook, DO
Kirsten Balano, PharmD
Lilia Vargas-Toledo, RN
Phillip Nguyen, PharmD, BCACP, BCGCP

PHC Members Present:

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

Medical Directors:
Jeffery Ribordy, MD, MPH
Mark Glickstein, MD
Mark Netherda, MD

Director of Pharmacy, Committee Secretary & Acting Chair:
Stan Leung, PharmD

Pharmacists:
Lisa Ooten, PharmD
Erin Montegary, PharmD
Lynette Rey, PharmD
Susan Becker, PharmD, BCPS
Kathleen Vo, PharmD

Invited Guests Present:
Dede Damasco, CPhT
Donell Colvin, CPhT
Mohamed Jalloh, PharmD

Department AA's:
Janet Ramos

IT Ops & Systems:
Jose Puga
John Lemoine

Practicing Members Absent:
Antonio Olea, PharmD

PHC Members Absent:
Richard Matthews, MD
Aaron Thornton, MD
Dave Katz, MD
Colleen Townsend, MD
Bettina Spiller, MD
James Cotter, MD, MPH
Marshall Kubota, MD
Teresa Frankovich, MD
Bradley Cox, DO
Kermit Jones, MD
Jeffrey DeVido, MD
Andrea Ocampo, PharmD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	• Introductions • Housekeeping (Announcement: Meeting is being recorded)	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Yes 4 out of 5 members attended Minutes: Approved	*Presented by Stan Leung, PharmD*	N/A
II. Standing Agenda			
1. PHC Update	PHC Updates provided by Dr. Moore: *State and Federal Level Updates:* There has been significant activity in the government sector. In Sacramento, there is a current budget shortfall, prompting the California Governor to request an emergency loan to support Medi-Cal through the remainder of the fiscal year. The source of the shortfall is unclear and likely multifactorial. One possible factor is that it is related to medications being more expensive, but it's difficult to confirm as there has not been a thorough audit on the Medi-Cal RX finance side that I've seen. Additionally, both the Cal State and University of California systems are experiencing financial shortfall. They've implemented hiring freezes and staff layoffs. And that was before the recent Federal changes that are now impacting grant funding for the UC system. Those are two of the four main pillars funded by the State, the others being prisons and the K-12 education. Going into this May season, because last year was a good year in the stock market, the State tends to have its income tax revenue more highly related to the performance of the stock market of the previous year, they will have some wiggle room. Still, back in January, out of caution about what might be happening at the Federal level, the governor recommended no new programs, but no particular cuts either. It will be interesting to see what the May revision reveals when they get a better idea of what the tax revenue picture looks like, and what the governor proposes just in terms of the programs. My best guess is that, in absence of some major change coming from the Federal government, they'll probably more or less hold the course on the Medi-Cal side. There have been some cuts to the	*Presented by Robert Moore, MD, MPH, MBA*	N/A

	public health departments throughout the country. And in California right now, many health departments are backfilling to cover the costs of the decreased funding from the Federal government for their public health for the short term, but that might potentially lead to some shortfalls and staff devoted to vaccination and infectious disease. We met with our public health colleagues a couple weeks ago and they were very concerned about that. So that is what is happening at the State level. At the Federal level, the House and the Senate are debating how much to cut from Medicaid and there is a big delta between the two, $880 billion vs. $5 billion. There is a debate over how that is going to play out but there is certainly a lot of concern about potential changes. But until those financial changes wind their way through Federal, the State isn't making any particular plans, at least publicly about any changes in what they will do with Medicaid. For the State, their words are full speed ahead. They're not slowing down any of their current initiatives and not making any changes, not relabeling DEI programs, anything at all in those realms. Things may change, but currently they are sticking to their current programs. *Partnership Updates:* Within Partnership, we are in the midst of the final stretch of the multi-year process of having some new computer systems for our core claim system and for our care management system. And those are taking a lot of energy and a lot of initiatives that require IT changes are sort of on pause. One of the changes affecting the pharmacy department is that we are going to be moving the physician administered drugs (PADs) to our care management TAR processing system, even prior to changing to a new system. So that's going to be a lot of work for the pharmacy department and I much appreciate the team. I have confidence that they will do well with that even though it's going to be a lot of work for everybody, so much appreciate that. Lastly, there is one bill pending in the California legislature which would make some changes in the way the 340B requirements are. There's a number of pharmaceutical companies that have unilaterally stopped supplying 340B medications to contract pharmacies, and that happened across the country. A number of other states have banned that practice so California is working on doing that as well in a bill that's pending in the legislature.		

2. Additional Updates	PHC Updates: Building on what is currently happening in Washington regarding tariffs-many of you may be aware there is a 90 day pause-I recently read an article about the potential impact of these tariffs on pharmaceuticals. This could be quite significant, as we import a large portion of active pharmaceutical ingredients from abroad, mainly from China and India. Over the last couple of years, we have heard a lot about shortages, often stemming from supply issues in China and India. With the new tariffs being imposed on those ingredients, the situation becomes even more challenging. Even if we are able to build and develop domestic manufacturing facilities for drugs, we still rely heavily on those imported active pharmaceutical ingredients. There are a few potential outcomes. First, we will likely see an increase in prices. Second, ongoing supply issues. And third, if other countries with lower tariffs step in to export active pharmaceutical ingredients, there is the added concern of quality control-especially if those countries are not customarily supplying these ingredients to the U.S. Another key impact is that the price increases will primarily affect generic drugs rather than brand-name medications. Brand-name drugs tend to have larger profit margins, allowing manufacturers to absorb some of the added costs. In fact, many major manufacturers have indicated that the anticipated impact on brand-name drugs would be minimal for this reason. However, generic drugs operate on much smaller margins, making it harder for them to remain competitive. As a result, we may see price increases-or, if prices can't keep pace with rising manufacturing cost, certain drugs may be withdrawn from the market altogether. We have already seen instances of this in recent years particularly with inhalers, due to pricing challenges-not necessarily due to tariffs but still relevant in terms of price issues. It is definitely something to monitor closely as these new tariffs take effect. Lastly, tariffs could also have an impact on medical equipment. I came across a report, as you know Mexico exports about 70%. of medical equipment to the U.S., including key items like infusion pumps and ultrasound machines. If tariffs are imposed on these products and no exclusions are granted, we could see disruptions in supply and cost issues, which would certainly pose challenges for hospitals and healthcare providers. These are just a few of the developments we're keeping an eye on. While there is currently a 90-day pause, it is still uncertain how things will unfold with this administration.	*Presented by Stan Leung, PharmD*	N/A

3. Managing Pain Safely Report	Managing Pain Safely is our own internal program to monitor opioid medication use. There are a couple things we are tracking. Even though we carved out the pharmacy benefit to Medical RX, we still keep up our monitoring with the Medical RX data. We will go over the graphs shown which are trends starting from February of 2024. In the first graph we measure the opioid prescription count. As you can see we have been trending down in terms of that opioid number from 9,000 prescriptions in February 2024 to 8,200. Our Rx count per member per month (PMPM) also shows a slight decrease. You can also see in the third graph to the right how that percentage compares again to the starting period of February 2024. In a one-year comparison we decreased about 5%. You can see the other trend lines in terms of how the percentage of prescription opioids compare to our starting period of 2024. You can see the red lines, some of it is 5% and that is somewhat normal when you are taking in the denominator, a few percentage points is expected. Where we would need to take action is if we see something like 20-30% increase from our baseline. This is just a demonstration of the things that we continue to monitor for opioid safety. The next graphs are for the new start opioid prescriptions. One thing we do is monitor the new start opioid prescriptions and the graph on the left illustrates our starting point with the county expansion and it's interesting that the graph shows a spike up but we will have to check with the health analytics team because this is per 1000 members per month. When you compare the baseline, this is a longer look back. This is from January 2023. It was 8.4 prescriptions or new starts per 1000 members per month, and we're about 8.3 right now. So currently we're at the same level as we were when Medical RX started. So the new start is something that we also monitor again when we see a spike in that percentage of increase compared to our baseline, then that's when we will do some investigation and certainly take actions if needed. On the second page, the graph displays dose escalation. This looks at several things and across several levels: under 50 MEDs, 50-90 MEDs, 90-120 MEDs, 120-200 MEDs and above 200 MEDs. Most of the increase occur in the group receiving less than 50 MEDs, as shown in the bottom portion of the graph highlighted in red, orange, and blue. Fortunately, the majority of patients remain below 90 MEDs, although we do observe some fluctuations with that particular dose escalation. You can see on the bottom graph with the red, orange and blue, most of	*Presented by Stan Leung, PharmD*	N/A

	the increase that is seen occurs at the less than 50 MED levels. It shows that most of the people are below that 90 MED, but there's still some fluctuations with that particular dose escalation. The graph on the upper right corner where you see the trend lines, you'll see how those compare in terms of dose escalation from February 2023 to current. And those numbers are slightly off, we are checking with health analytics on that. The numbers are about 40% in terms of dose stable and those are the orange lines and then the dose escalation and de-escalating is about 30 %. We are checking with our health analytics team to verify that. Based on the numbers that we have, if you add up all the utilizers on the bottom left graph, stratify those according to escalating, deescalating and stable, it's about 40% that are stable. The other 30% is escalating. Lastly, the graph at the bottom shows our monitoring for the concurrent opioid, benzodiazepine and muscle relaxants for February 2023 to current. As of February 2025, we have 315 members who are concurrently using an opioid and either a benzodiazepine or a muscle relaxant. You can see where we're at in terms of how we trend month by month in terms of concurrent users. It is interesting that in the month of June it does spike up about 12-13%, but it went back down in about three months and currently, at least compared to our baseline in early 2023 were about 11% below or reduction in terms of the concurrent users.		

4. DUR Update	DUR - Fraud and Abuse of Controlled Substances (F&A) The following was presented: • To assess potential fraud and abuse of opioids, PHC developed a program to monitor members who received prescriptions for opioids from 4 or more prescribers and 4 or more pharmacies. • A biannual retrospective review of pharmacy claims was conducted to identify members with fills for opioids during the prior 180 days. • To identify possible fraud and abuse by the member, claims were evaluated for early refills; short-term fills vs chronic stable fills; whether the fills were paid for by insurance vs paid out of pocket, use of providers and/or pharmacies that were far from the member's immediate geographic area; and prescriptions from multiple prescribers with different scopes of practices. • To identify possible fraud and abuse by the prescriber, claims were evaluated for prescribing of large quantities and/or high-doses; frequency of early refills authorized; and providing non-specialty care for patients who live more than 100 miles from the prescriber's office. • To identify possible fraud and abuse by the pharmacy, claims were evaluated for frequency of dispensing of early refills, dispensing of large quantities of controlled substances and dispensing to members who live more than 50 miles from the pharmacy. • If there were concerns of potential fraud and abuse, additional investigation was done to verify that there were no extenuating circumstances that contributed to the appearance of possible fraud and abuse. • A review of pharmacy claims between 7/1/24 to 12/31/24 identified 36,776 members who filled opioids during the 180 day period. Of these members, 24 members were identified with 4 or more prescribers and using 4 or more pharmacies with 11 members meeting the inclusion criteria. • Further investigation of these 11 members did not identify fraud or abuse by these members. No incidences of potential fraud and abuse by the prescribers and the pharmacies were identified. • For the next DUR round, we will consider focusing on members who receive large quantities of opioids and/or members who are on high MEDs to identify potential fraud and abuse, including potential drug diversion activities.	*Presented by Lynette Rey, PharmD*	N/A

	DUR Interim Summary for Concurrent use of Opioids and Benzodiazepines (COB) The following was presented: • PHC implemented a prescriber fax intervention for members recently started on concurrent use of opioids and benzodiazepines, with the intent of minimizing concurrent use. • A monthly retrospective review of pharmacy claims was conducted to identify members with concurrent fills for opioids and benzodiazepines who were newly started on either an opioid or benzodiazepine in the prior 30 days. • Concurrent use was defined as overlapping fills for both a benzodiazepine and an opioid for 15 or more cumulative days within a 30 day look back period. • A review of pharmacy claims between 7/1/2024 to 12/31/2024 identified 3,879 members who filled a benzodiazepine and an opioid during this period. 505 members were identified as possibly just starting on concurrent opioid and benzodiazepine use. • After applying exclusion criteria, and further analysis, 26 members were identified as just starting concurrent use. • Letters were faxed to the 61 respective prescribers during the measurement period. • The outcome of the response to the prescriber letters were evaluated 90 days post intervention. o 26 members identified as newly started on concurrent opioids and benzodiazepines. o 13 members no longer had concurrent fills for opioids and benzodiazepines. o 13 members continued who concurrent use of opioids and benzodiazepines. ▪ 4 members continued concurrent use, with either a dose reduction or a reduction in the day supply prescribed ▪ 7 members continued concurrent use with no change ▪ 2 members continued concurrent use with an increase in dose or quantity • This DUR will be continued for a total of 12 months. The final findings will be compared with a control group to determine if the intervention was beneficial.	*Presented by Lynette Rey, PharmD*	N/A

5. Drug Benefit Review

The classes for this quarter's review are:

- Antihistamine, Nasal, Cough and Cold, Respiratory, Misc.
- Anti-Infective Agents
- Genitourinary Agents

No changes proposed to the Vaccines, Toxoids, Immunizations, Allergenic Extracts, Misc. Agents.

All actions at right were approved by the committee as presented, unless otherwise noted as "*approved as modified*".

All changes will be effective 07/01/2025 unless otherwise noted.

Presented by Susan Becker, PharmD, BCPS and Erin Montegary, Pharm D

Class Reviews:

- Antihistamine, Nasal, Cough and Cold, Respiratory, Misc.
  - Updates to the following were presented, with approved action shown at right.
    - benralizumab, (Fasenra™)

Presented by Erin Montegary, PharmD, BCPS

Antihistamine, Nasal, Cough and Cold, Respiratory, Misc. Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J0517	benralizumab injection, 1 mg (Fasenra™)

7/1/2025

- Anti-Infective Agents
  - Updates to the following were presented, with approved action shown at right.
    - ceftazidime and avibactam, (Avycaz™)
    - daptomycin, (Cubicin™)
    - daptomycin (hospira), not therapeutically equivalent to J0878
    - daptomycin (baxter), not therapeutically equivalent to J0878
    - daptomycin (xellia), not therapeutically equivalent to j0878 or j0872
    - daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873
    - dalbavancin, (Dalvance™): removal of TAR and addition of dose and frequency limits

Presented by Susan Becker, PharmD, BCPS

Anti-Infective Agents Class Review, Approved Actions:	
HCPCS	**Drug**
Removal of TAR Requirements	
J0878	Injection, daptomycin, 1 mg (Cubicin™)
J0877	Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg
J0874	Injection, daptomycin (baxter), not therapeutically equivalent to J0878, 1 mg
J0873	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg
J0875	Injection, dalbavancin, 5 mg (Dalvance™)
Removal of Claim Limits &/or Requirements	
J0714	Injection, ceftazidime and avibactam, 0.5 g/0.125 g (Avycaz™)

7/1/2025

		Addition of Claim Limits &/or Requirements J0875 — Injection, dalbavancin, 5 mg (Dalvance™) **TAR Criteria Updates (see attached criteria for details)** J0872 — Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg	
	• Genitourinary Agents o Updates to the following were presented, with approved action shown at right. ▪ lumasiran, (Oxlumo™)	*Presented by Susan Becker, PharmD, BCPS* **Genitourinary Agents Class Review, Approved Actions:** **HCPCS** — **Drug** **TAR Criteria Updates (see attached criteria for details)** J0224 — Injection, lumasiran, 0.5 mg (Oxlumo™)	7/1/2025
	In addition to the scheduled class reviews, PHC presented the following: • Updates to Endocrine and Metabolic Agents: o Histrelin implant, (Supprelin LA™) o leuprolide acetate for depot suspension, (Fensolvi™) o triptorelin, extended-release, (Triptodur™) • Updates to Neuromuscular Agents: o delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™)	*Presented by Erin Montegary, Pharm D* **Ad hoc Updates** **HCPCS** | **HCPCS Description (brand)** | **Approved Action** J9226 | Histrelin implant, 50 mg (Supprelin LA™) | Updates to current criteria (see attached criteria for details) J1951 | Injection, leuprolide acetate for depot suspension, 0.25 mg (Fensolvi™) | Updates to current criteria (see attached criteria for details) J3316 | Injection, triptorelin, extended release, 3.75 mg (Triptodur™) | Updates to current criteria (see attached criteria for details) J1413 | Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™) | Updates to current criteria (see attached criteria for details)	7/1/2025

- New HCPCS code review – listed at right, listed in 2 sections:
  - 1st time HCPCS code for drug (other than unclassified code)
  - HCPCS code changed but no change in coverage requirements for the drug itself.
  - Codes were announced as benefits by DHCS on 4/4/2025, with an effective date of 4/1/2025.

Presented by Susan Becker, PharmD, BCPS

New HCPCS codes (no prior code or was previously unclassified		
HCPCS	HCPCS Description	Requirements
J1271	Injection, doxycycline hyclate, 1mg	NTR, no limits
J2804	Injection, rifampin, 1mg	QL: 1200 units/day
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	TAR
J9054	Injection, bortezomib (boruzu), 0.1 mg	TAR
J9161	Injection, denileukin diftitox-cxdl, 1mcg	TAR
Q2057	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	TAR
C9302	Injection, zanidatamab-hrii, 2mg	TAR
C9303	Injection, zolbetuximab-clzb, 1mg	TAR
C9301	Obecabtagene autoleucel, up to 410 million cd19 carpositive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	TAR
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	TAR
Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	TAR
Q5149	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	TAR
Q5150	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	TAR
J1072	Injection, testosterone cypionate (azmiro), 1 mg	TAR
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	TAR
J1808	Injection, folic acid, 0.1 mg	NTR, no limits
C9304	Injection, marstacimab-hncq, 0.5 mg	TAR (we expect this to be carved out)

4/1/2025

J7521	Tacrolimus, granules, oral suspension, 0.1 mg	NTR, no limits	
J9038	Injection, axatilimab-csfr, 0.1 mg	TAR	
C9300	Injection,indigotindisulfonate sodium, 1 mg	NTR, no limits	
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	TAR	

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	**HCPCS Description**	**Requirements & prior code**
J2865	Injection, sulfamethoxazole 5mg and trimethoprim 1mg	NTR, no limits *(same prior code S0039)*
J1938	Injection, furosemide, 1mg	NTR, no limits *(same as prior code J1940)*
J1308	Injection, famotidine, 0.25 mg	NTR, no limits *(same prior code S0028)*
J1299	Injection, eculizumab, 2 mg	TAR *(same as prior code J1300)*
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	TAR *(same as prior code Q5139)*
J0281	Injection, aminocaproic acid, 1 gram	NTR, no limits *(same prior code S0017)*

- Consent items not needing Committee vote: These are codes where configuration changes have been decided internally for processing efficiency and mirror the State's billing requirements, and that change is not a negative change. Changes to billing requirements shown at right.

Consent Items		
HCPCS	**HCPCS Description**	**Changes to Biling Requirements**
J0911	Instillation, taurolidine 1.35mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	TAR required

N/A

II. <u>Old Business</u> **a. Policy Updates**	• All Policies below submitted for consent with additions, changes and minor reorganization of content, improved wording and updating of references. 1) MPRP4034 and MPRP4034 Attachment A & B: Pharmaceutical Patient Safety, Prescriber and Member Letter: *Added additional information to the recall policy. With addition of the pharmacy benefit for Medicare Advantage plans, notification will be provided for class one and two recalls for pharmacy dispensed drugs and PAD (physician administered drug) drugs when withdrawn from the market completely.* 2) MPRP4065: Drug Utilization Review (DUR) Program: *Changes made to align with the start of the D-snip program. Added additional elements to comply with the pharmacy requirements for a Part D program.*	*Presented by Stan Leung, PharmD*	5/14/2025
<u>IV. New Business</u>	None		
<u>V. Additional Items</u>	None		
<u>VI. Adjournment</u>	Meeting adjourned at 9:20am		

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	• Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype. • Eosinophilic granulomatosis with polyangiitis (Churg-Strauss or EGPA)
Exclusion Criteria	• Monotherapy use (benralizumab is add on therapy to the current asthma treatment regimen) • Benralizumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, reslizumab or tezepelumab
Required Medical Information	Must submit clinical documentation to substantiate the following per diagnosis: For severe eosinophilic asthma: ~~Must be used for FDA approved indications and dosages~~ 1) Patient has a diagnosis of severe asthma with an eosinophilic phenotype and has a blood eosinophil counts equal to or greater than 150 cells/µL 2) Patient has persistent uncontrolled asthma despite at least 3 months of compliant use of high-dose inhaled corticosteroid (ICS) combined with long-acting β2 agonist (LABA) (ICS-LABA) as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline b. At least two exacerbations in the previous year. c. A history of Emergency Department (ED) visits requiring use of oral/systemic corticosteroids and/or hospitalization in the past year 3) Reduced lung function at baseline [pre-bronchodilator FEV1 below 80% in adults, and below 90% in adolescents] State the specific dosage form that will be administered during the medical office visit: a. Fasenra™ Autoinjector pen (may be administered by patient or caregiver with proper training) OR b. Fasenra™ Prefilled syringe (administered by health care provider) For eosinophilic granulomatosis with polyangiitis (Churg-Strauss or EGPA) 1) Member has a history, or the presence of an eosinophil count of more than 1000 cells/µL (or a blood eosinophil level of higher than 10 percent of total leukocyte count). 2) Member has two or more of the following disease characteristics of EGPA: a. Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation b. Neuropathy c. Pulmonary infiltrates d. Sinonasal abnormalities e. Cardiomyopathy f. Glomerulonephritis g. Alveolar hemorrhage h. Palpable purpura i. Anti-neutrophil cytoplasmic antibody (ANCA) positivity 3) Member has had at least one relapse (requiring an increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with Fasenra or has refractory disease.

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

Age Restriction	Asthma: 6 years and older ~~Must be 12 years of age or older.~~ EGPA: 18 years and older
Prescriber Restriction	None
Coverage Duration	Prefilled syringes: 3 doses (3 months) to allow administration of loading doses and for self-administration training with the goal of transitioning to the autoinjector pen for maintenance treatment at home (provided by the pharmacy). Autoinjector pens: 1 time dose for training & observation of self-administration technique.
Other Requirements & Information	Benralizumab (Fasenra™) is available for self-administration in the form of an auto-injector and is typically administered by the member or a caregiver at home. As soon as the maintenance dose is established and member or caregiver can be trained for self-administration, Fasenra™ autoinjector should be provided to the member by a pharmacy for administration at home whenever possible. Prefilled syringes: Requests will be approved for up to 3 months, if the healthcare provider prefers to administer the loading dose for new start requests, by obtaining it though the practice until maintenance dose and safety of self-administration is determined. Autoinjector pens: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J0517	Injection, benralizumab, per 1 mg (Fasenra™ auto-injector pen & Fasenra™ prefilled syringe)	Asthma: 30 mg subcutaneously every 4 weeks x 3 doses, and then once every 8 weeks thereafter. EGPA: 30 mg subcutaneously every 4 weeks Maximum Dose: 30 mg (30 HCPCS units)

Unless otherwise specified as having renewal requirements, criteria apply to new starts. Renewals require documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

APPROVED

PA Criteria	Criteria Details
Covered Uses	• Complicated skin and skin structure infections (cSSSI) caused by susceptible isolates of the following Gram-positive bacteria: *Staphylococcus aureus* (including methicillin-resistant isolates), *Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus dysgalactiae subsp. equisimilis*, and *Enterococcus faecalis* (vancomycin-susceptible isolates only) • *Staphylococcus aureus* bloodstream infections (bacteremia), including those with right-sided infective endocarditis, caused by methicillin susceptible and methicillin-resistant isolates.
Exclusion Criteria	• Pneumonia • Left-sided infective endocarditis • Infections in which IV treatment is not indicated
Required Medical Information	All Diagnoses: 1) Trial and failure or medical reasons why preferred daptomycin products billed with the following codes: J0878, J0877, J0874 and J0873 cannot be used. ~~1)~~2) Culture and Sensitivity lab report(s) when appropriate ~~2)~~3) Patient Med Allergy list if relevant ~~3)~~4) Treatment history for same infection ~~4)~~5) Clinic notes (or hospital admit and discharge) with assessment and plan Complicated skin and skin structure infections: 1) Documentation of trial and failure (or contraindication) to oral antibiotics appropriate to treat condition, such as: • Doxycycline • Minocycline • SMZ/TPM (Septra DS) • Erythromycin • Penicillins • Cephalosporins • Linezolid MRSA (either cSSSI or bacteremia) 1) IV treatment must be indicated 2) Documentation of failure, or reasons why vancomycin cannot be used 3) An Infectious Disease consult may be required
Age Restriction	≥ 1 year
Prescriber Restriction	None
Coverage Duration	Duration depends on diagnosis and treatment plan

Other Requirements & Information	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

<table>
<tr><th>Product</th><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr>
<td>~~Cubicin~~
Daptomycin</td>
<td>~~J0878~~
J0872</td>
<td>~~Injection, daptomycin, 1 mg~~
Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg</td>
<td>Weight based dosing, administered once every 24 hours
<table>
<tr><th>Age</th><th>cSSSI
(7-14 days)</th><th>Bacteremia
(2-6 weeks)</th></tr>
<tr><td>>17 yrs</td><td>4mg/kg</td><td>6mg/kg</td></tr>
<tr><td>12-17 yrs</td><td>5mg/kg</td><td>7mg/kg</td></tr>
<tr><td>7-11 yrs</td><td>7mg/kg</td><td>9mg/kg</td></tr>
<tr><td>2-6 yrs</td><td>9mg/kg</td><td rowspan="2">12mg/kg</td></tr>
<tr><td>1-<2 yrs</td><td>10mg/kg</td></tr>
</table>
</td>
</tr>
</table>

Note: the following daptomycin products do not require a TAR:
J0878: Injection, daptomycin, 1 mg (Cubicin™)
J0877: Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg
J0874: Injection, daptomycin (baxter), not therapeutically equivalent to J0878, 1 mg
J0873: Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Treatment of primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels.
Exclusion Criteria	History of kidney or liver transplant. History of extrarenal systemic oxalosis.
Required Medical Information	Clinical documentation confirming: 1) Diagnosis of PH1 by: a. Genetic test to confirm mutation of alanine-glyoxylate aminotransferase (AGXT) gene, OR b. Liver biopsy demonstrating absent or decreased alanineglyoxylate aminotransferase (AGT) enzyme activity, if genetic test is unable to confirm mutation. 2) Baseline metabolic screening: a. 24-hour urinary oxalate excretion >0.7 mmol/1.7 3mm2/day, OR b. Urinary oxalate-to-creatinine ratio greater than upper limit of normal (ULN) for age, OR c. Elevated urinary excretion of glycolate. ~~3) Estimated glomerular filtration rate (eGFR) >30 ml/1.73 mm2/min.~~ ~~4)~~3) Trial and failure to at least 3-month therapy of pyridoxine (vitamin B6) at maximum tolerated dose (up to 20 mg/kg/day). 4) Current weight. 5) For members over the age of 9 and with eGFR >30ml/1.73mm^2/min: documentation of a trial and failure, or reasons why self-administered nedosiran (Rivfloza) cannot be used.
Age Restriction	None
Prescriber Restriction	Prescribed by (or in consultation with) an endocrinologist, nephrologist, or urologist
Coverage Duration	Initial: 6 months. Renewal: 12 months upon documentation of positive clinical treatment response when compared to pre-treatment baseline.
Other Requirements & Information	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units		
J0224	Injection, lumasiran, 0.5mg	Maximum dose: 6 mg/kg in a single date of service. Example: 80 kg patient would be billed as no more than 960 HCPCS units (480 mg).		
		Weight	Loading Dose	Maintenance Dose
		< 10kg	6mg/kg SC once monthly for 3 doses	2mg/kg SC once monthly
		10 to <20kg	6mg/kg SC once monthly for 3 doses	6mg/kg SC once every 3 months
		≥20kg	3mg/kg SC once monthly for 3 doses	3mg/kg SC once every 3 months

Unless otherwise specified as having renewal requirements, criteria apply to new starts and documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

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PA Criteria	Criteria Details
Covered Uses	• Central precocious puberty (CPP) • Gender incongruence; puberty suppression
Exclusion Criteria	Peripheral precocious puberty
Required Medical Information	Documentation of the following must be submitted per diagnosis: Central Precocious Puberty 1. Specialist consult notes documenting diagnosis of CPP and treatment plan. 2. Baseline height and weight, growth velocity, bone age test results (within the past year). ~~1.~~3. Documentation of trial and failure, or contraindication to, PHC's preferred GnRH agonist, Lupron Depot. Gender Incongruence; Puberty Suppression: 1. Evaluation by a mental health professional or other health care professional who has the appropriate experience and training in treating gender dysphoria. 2. Confirmation of the following: a. Well-documented gender dysphoria/gender incongruence. b. Stability of relevant medical and mental health. 3. Documentation that member has experienced puberty development to at least Tanner stage 2. 4. Documentation that pubertal changes have negatively affected member's psychological or social functioning due to increased gender dysphoria. 5. Documentation of trial and failure, or contraindication to, PHC's preferred GnRH agonist, Lupron Depot.
Age Restriction	~~2 years and older~~ -Central Precocious Puberty: ≥1 yr and ≤11 yrs for females; ≤12 yrs for males -Gender incongruence: adolescents who have experienced puberty development to at least Tanner stage 2.
Prescriber Restriction	-Central Precocious Puberty: Endocrinologist -Gender incongruence: Endocrinologist or other specialist with appropriate training and experience treating gender incongruence in adolescents.
Coverage Duration	-Central Precocious Puberty: 12 months, until the resumption of puberty is desired. Renewal requests require current bone age, growth velocity, height, weight and clinic notes with assessment of pubertal progression. Gender incongruence: 12 months. Renewal requests require documentation of positive response from treatment and continued medical necessity.
Other Requirements & Information	~~With renewal requests: current bone age, growth velocity, height, weight and clinic notes with assessment of pubertal progression.~~ Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3316	Injection, triptorelin, extended release, 3.75 mg	22.5 mg once every 24 weeks.
J9226	Histrelin implant (supprelin la), 50 mg	50 mg implant inserted every 12 to 24 months.
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	45 mg once every 6 months.

Unless otherwise specified as having renewal requirements, criteria apply to new starts. Renewals require documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

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PA Criteria	Criteria Details
Covered Uses	Treatment of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene.
Exclusion Criteria	1. Treatment or use for anything other than DMD 2. Prior administration of delandistrogene moxeparvovec-rokl (Elevidys™) 3. Deletions in exon 8 and/or exon 9 in the DMD gene 4. Concurrent use with exon skipping therapies
Required Medical Information	1. Documented diagnosis of Duchenne muscular dystrophy with medical records detailing the clinical course and confirming a mutation of the DMD gene. a. Genetic mutation test results must be submitted with request. ~~a.~~b. Skeletal muscle biopsy results characterizing dystrophin by western blot and immunohistochemistry may be required, such as in the case of genetic testing showing a variant of uncertain significance, or a clinical course and laboratory findings deviating from the traditional trajectory of DMD. ~~b.~~c. For mutations in exons 1-17, provider must attest that they are aware of the increased risk for severe myositis associated with these mutations. 2. Baseline Serum Creatine Kinase level with laboratory reference range. ~~2.~~3. Documentation of ambulatory status in the medical records AND as evidenced by North Star Ambulatory Assessment (NSAA) score of ≥1 (or equivalent on another recognized scale) completed within the 3 months prior to TAR submission. ~~3.~~4. Documentation of anti-AAVrh74 total antibody titers <1:400 using a Total Binding Antibody enzyme linked immunosorbent assay (ELISA) completed within the 30 days prior to TAR submission. ~~4.~~5. Documentation of baseline liver function tests, platelet counts, left ventricular ejection fraction (LVEF) and troponin I levels completed within the 30 days prior to TAR submission. Elevidys administration should be postponed until acute liver disease has resolved or been controlled. ~~5.~~6. Documentation that the member does not have any signs or symptoms of infection. ~~6.~~7. Concurrent use corticosteroids (prednisone, prednisolone, deflazacort (Emflaza™), vamorolone (Agamree™) etc.) at a stable dose for at least 12 weeks, unless contraindicated or intolerant. Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	Ages 4 ~~5 years old only~~ years and older

Prescriber Restriction	Prescribed by, or under supervision and monitoring of a neurologist or a provider who specializes in the treatment of Duchenne muscular dystrophy
Coverage Duration	Once per lifetime
Other Requirements & Information	Requests for use in members ~~over the age of 5 or~~ who are considered non-ambulatory: See PHC criteria document ***Case-by-Case TAR Requirements and Considerations.*** Prescriber must attest or otherwise document member will receive prophylactic prednisolone (or glucocorticoid equivalent) (in addition to baseline corticosteroid dose) one day prior to Elevidys™ infusion and for 60 days following therapy to monitor liver function.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™)	$1.33x10^{14}$ vector genomes per kg (vg/kg) of body weight (or 10mL/kg) Supplied in 10ml vials packaged into single dose kits ranging from 10 to 70 vials per kit.

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

Committee: Credentials Committee
Date: 03/12/2025 7:00am
Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Madeleine Ramos, MD*; Bradley Sandler, MD*; Brent Pottenger, MD

PHC Staff: Mark Netherda, MD; Medical Director for Quality Improvement; Marshall Kubota, MD*; PHC Regional Medical Director; Robert Moore, MD*, MPH, MBA, PHC Chief Medical Officer; Jeffery Ribordy, MD*; Medical Director; Lisa Ward, MD* Medical Director; Matthew Morris 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 Team Lead; Nolan Smith*, Credentialing Specialist; Alex Lopez Credentialing Specialist; Marie Paule Uwase, Credentialing Specialist; Morgan Brambley, Credentialing Specialist; Ashlee Grove, Credentialing Specialist; Ashnilta Sen, Credentialing Specialist; Cori Berumen, Credentialing Specialist; Alisa Crews-Gerk, Credentialing Specialist; Maegan Ojeda, Credentialing Specialist.

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership HealthPlan Medical Director for Quality Improvement Mark Netherda, MD called the meeting to order at 7:00am. Credentials Committee roll call taken by J'aime Seale. Dr. Netherda reminded everyone that all items discussed are confidential. a. Dr. Mark Netherda, MD reminded The Credentials Committee of who the voting members are, and voting is restricted to Non-Partnership staff. Dr. Netherda reminded the committee that all information discussed is confidential in nature.			
II. Review and approval of February 12, 2025 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for February 12, 2025 were reviewed by the Committee.	II. Summary were reviewed. A motion for approval of the Summary was made by Dr. Bradley Sandler and seconded by Dr. Steven Gwiazdowski. Meeting Summary were unanimously approved without changes.		03/12/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
III. Old Business. a. No Old Business to report.	III. Old Business – a. No Old Business to report.	III. Old Business a. No Old Business to report.		03/12/2025
IV. New Business a. Review and Approval of Routine Practitioner List.	IV. New Business a. Dr. Netherda referred to the Credentials Committee to review the routine list of practitioners on pages 10-12 of the meeting packet. Dr. Gwiazdowski commented on probation provider being listed on the routine list. Dr. Kubota explained that providers who are recommended approval with monitoring are usually listed on the routine list. Dr. Gwiazdowski suggested that for future meetings only "clean" staff recommended approvals be listed and to add a name to the header of the list for approvals only. Dr. Kubota stated staff can move forward with the suggestion and recommended staff recommended approvals with monitoring will not be added to the list. A motion for approval of the routine list with future changes was made by Dr. Gwiazdowski.	IV. New Business a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Dr. Steven Gwiazdowski and seconded by Dr. Brent Pottenger. The Committee unanimously approved the routine list with changes to further lists presented.		3/12/2025
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Netherda referred to the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list on pages 13-27 of the packet. These practitioners were approved by Dr. Marshall Kubota, Regional Medical Director Pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the listed practitioners was made by Dr. Madeline Ramos and seconded by Dr. Michele Herman. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		3/12/2025
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by J'aime Seale, Credentialing Team Lead. J'aime Seale explained that policy MPCR 302 – Behavioral and Mental health Practitioner Credentialing and Re-Credentialing Requirements was pulled from today's	c. The Committee reviewed the Revised Policies presented. A motion to approve the revised policies was made by Dr. Bradley Sandler and seconded by Dr. Brent Pottenger. The Committee unanimously approved the revised policies presented.		3/12/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	meeting due to further changes needed from Partnership's IQI Department. The following Policies: MPCR16 – Lactation Consultant Credentialing Policy, MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Verification, MPCR400 - Provider Credentialing and Re-credentialing Verification Process and Record Security, MPCR601 – Fair Hearing and Appeal Process for Adverse Decisions and MPCR701 – Ancillary Care Services Providers Credentialing and Re-credentialing Requirements are Consent Calendar Changes and are the policies presented for the committee to make a motion on.			
d. CR5 Semi-annual Evaluation – Information Only	d. Dr. Netherda referred the Credentials Committee to review the CR5 Semi-annual Evaluation of Practitioner Specific Member Complaints for the period of October 1, 2024 through December 31, 2024 (3 months). Summary of Findings: Number of Potential Quality Issues (PQI) is 23. Number of Complaints from Grievance and Appeals (G&A) 23. Per Dr. Kubota's review there were a total of 1 practitioner involved with 3 complaints. No trend or significant clinical or services issues were identified as a result no further action is needed at this time. *Information Only.*	d. *Information Only.*		3/12/2025
e. Probation Provider	e. Dr. Netherda explained to the Credentials Committee a probation provider found. The provider was placed on three-years' probation effective 3/17/2023 until an anticipated end date of 6/18/2026 by the Medical Board of California due to gross negligence. Dr. Ramos asked what kind of monitoring Partnership will be doing during the provider's probation. Dr. Netherda informed Dr. Ramos that Partnership will follow the Medical Board of California's monitoring of the provider. The provider will be added to Network Services Department's Monthly Monitoring list to keep track of MBOC monitoring changes.	e. The Committee reviewed the probation terms for the provider. A motion to approve with monthly monitoring was made by Dr. Madeleine Ramos and seconded by Dr. Bradley Sandler. The Committee unanimously approved.		3/12/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
f. Probation Provider	f. Dr. Netherda explained to the Credentials Committee that a provider was placed on four-years' probation effective 3/16/2024 until anticipated end date of 2/15/2028 by the Medical Board of California. The provider was charged with gross negligence. The provider will be added to Network Services Department's Monthly Monitoring list to keep track of MBOC monitoring changes.	f. The Committee reviewed the probation terms for the provider. A motion to approve the provider with monthly monitoring was made by Dr. Brent Pottenger and seconded by Dr. Bradley Sandler. The Committee unanimously approved.		3/12/2025
g. Probation Provider	g. Dr. Netherda explained to the Credentials Committee that a provider was placed on five-years' probation on 11/8/2019 due to negligence by Medical Board of California. Provider failed to document treatment plan, failure to keep complete records and improper delegation of physician responsibilities. Medical Board of California also took over administrative action imposed by New York State agency. Provider successfully completed probation on 11/7/2024. Due to the probation being completed, Dr. Pottenger requested the agenda recommendation be updated to approve without monitoring.	g. The Committee reviewed the probation terms for the provider. A motion to approve the provider without monitoring was made by Dr. Bradley Sandler and seconded by Dr. Brent Pottenger. The Committee unanimously approved.		3/12/2025
h. Probation Provider	h. Dr. Netherda explained to the Credentials Committee the provider's license was placed on five-years probation effective 8/19/2021 due to gross negligence in the care and treatment of a patient. The provider was also additionally placed on a two-year probation to run concurrently with their five year probation order effective 2/16/2024. Dr. Gwiazdowski stated to Dr. Netherda that due to the amount of cases he does not feel comfortable approving with monitoring. Dr. Gwiazdowski asked how the committee would move forward in this type of situation. Heidi Lee, Network Services Credentialing Manager explained Partnership Healthplan's policy on denying a provider credentialing. Dr. Gwiazdowski then stated perhaps it would be better to get further information from the Medical Board of California. Dr. Kubota informed the committee that Partnership Staff can reach out to MBOC for further	h. The Committee reviewed the information for the provider and made a motion to defer the provider until the April 2025 meeting to allow for more information from the Medical Board of California. A motion to defer to April 2025 meeting was made by Dr. Steven Gwiazdowski and seconded by Dr. Michele Herman. The Committee unanimously approved.	4/9/2025	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	information. Dr. Gwiazdowski set a motion to defer the provider until the April 2025 to allow for more information to be received from the Medical Board of California.			
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 460.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Dr. Bradley Sandler and seconded by Dr. Steven Gwiazdowski. The Committee unanimously approved.		3/12/2025
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring List on pages 461-462. Dr. Netherda reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Informational only*.		3/12/2025
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a/b/c. Review and Approval of Consent Calendar Items	a. Dr. Netherda asked the Credentials Committee members to review the report of Long Term Care Facility, Hospital, and Ancillary provider list on page 463. b. Dr. Netherda directed the Credentials Committee members to review the Fourth Quarter Delegated Audits for Carelon Behavioral Health, Woodland Clinic, DHMG – North State, Mercy Medical Group, Lucile Packard Children's Hospital, Palo Alto Medical Foundation, SEBMF-CPN, Sutter Medical Group of the Redwoods, Sutter West Bay Medical Group, Mills Peninsula Medical Group, University of California Davis Health, UCSF Medical Group and Vision Service Plan (VSP) on pages 465-482. c. Dr. Netherda also directed the Credentials Committee	a/b/c. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Dr. Michele Herman and seconded by Dr. Bradley Sandler. The Credentialing Committee unanimously approved.		3/12/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	member to review the Annual Delegated Audits for Dignity Health, Lucille Packard Children's Hospital and Sutter Bay Medical Foundation on pages 483-485.			
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 3/12/2025 respectfully prepared and submitted by J'aime Seale Credentialing Team Lead.

Chairman Signature of Approval _____ ***Date*** ***3/12/2025***_____

Mark Netherda, M.D., Partnership HealthPlan Credentialing Chairman

App. Ty	Full Name	Provider Type Cd	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
I	Abdou, Rami MD	SPEC	NorthBay Healthcare Ear, N	Solano	Otolaryngology	ABMS of Otola	06/01/2018	Yes	Northbay Medic	Active
I	Abrams, Aaron S.,PT	Allied	Burger Physical Therapy	Yolo	Physical Therap	None		No	None	
I	Addiego-Hutton, Megai	BHP	California Psychcare, Inc db	Sacramento	BCBA	Behavior Analy	10/18/2020	Yes	None	
R	Alota, Ofelia C.,MD	PCP	Solano County Family Healt	Solano	Pediatrics	ABMS of Pedia	11/01/2005	Yes	Admitting Agree	None
R	Alston, Gerald A.,MD	BOTH	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Family	07/08/1994	Yes	Admitting Agree	None
I	Anand, Amar MD	SPEC	Amar Anand, MD DBA Integ	Solano	Neurology	ABMS of Psych	09/11/2023	Yes	Sutter Solano M	Active
I	Angulo, Armando BCB	BHP	California Psychcare, Inc db	Sacramento	BCBA	Behavior Analy	01/03/2025	Yes	None	
I	Arik, Tali MD	SPEC	Providence Medical Group,	Humboldt	Cardiology	None		Not Applica	Admitting Agree	None
I	Arthur, Susan Doula	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		Not Applica	None	
I	Baldwin, Polly F.,MD	PCP	Marin Community Clinic: Ca	Marin	Family Medicin	ABMS of Family	07/11/2003	Yes	Admitting Agree	None
I	Barrow, Jade K.,CRNA	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	12/22/2006	Yes	Admitting Agree	Active
R	Barton, Shannon R.,SL	Allied	Northern California Children	Yolo					None	
I	Beard, Amie RADT	W&R	Humboldt Recovery Center	Humboldt	Wellness and R	California Cons	12/03/2024	Yes	None	
I	Berliner, Susan R.,NP	PCP	McCloud Healthcare Clinic	Siskiyou	Nurse Practitior	None		No	None	
R	Bhaduri, Aditi B.,MD	SPEC	TeleMed2U	Yolo	Endocrinology,	ABMS of Intern	10/28/2005	Yes	Admitting Agree	None
I	Boddy, Nathaniel PA-C	SPEC	Enloe Digestive Diseases C	Butte	Physician Assis	National Comm	09/17/2024	Yes	None	
R	Bogdanova, Maria A.,F	PCP	Elica Health Centers-Halyar	Yolo	Physician Assis	National Comm	09/04/2018	Yes	None	
R	Braatz, Steven E.,MD	SPEC	Northeastern Rural Health C	Lassen	Obstetrics and	ABMS of Obste	12/07/1990	Yes	Banner Lassen	Active
R	Bratton, Dorothy A.,PA	PCP	SCHC: Shasta Community I	Shasta	Physician Assis	National Comm	09/07/2006	Yes	None	
I	Brown, Julius L.,CRNA	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	06/22/2023	Yes	Admitting Agree	Active
R	Buller, JuanCarlos MD	PCP	Ole Health	Napa	Family Medicin	ABMS of Family	07/14/2000	Yes	Admitting Agree	None
I	Bunter, Rachel M.,SUI	W&R	Ford Street Project - Ukiah I	Mendocino	Wellness and R	California Subs	06/27/2024	Yes	None	
I	Cabral, Ica BCBA	BHP	California Psychcare, Inc db	Sacramento	BCBA	Behavior Analy	04/19/2021	Yes	None	
I	Cahalin, Daniel BCBA	BHP	Pantogran LLC dba Center	Yolo	BCBA	Behavior Analy	05/31/2014	Yes	None	
R	Carlton, Samuel R.,MD	PCP	Northeastern Rural Health C	Lassen	Family Medicin	ABMS of Family	07/12/2002	Yes	Banner Lassen	Active
I	Carroll, Laquisha M.,FI	PCP	Solano County Family Healt	Solano	Family Nurse P	American Acad	07/29/2015	Yes	None	
R	Cassel, Kathleen M.,M	PCP	UIHS - Klamath Health Cen	Del Norte	Family Medicin	ABMS of Family	07/13/2001	Yes	Admitting Agree	None
R	Catalano, Rebekah BC	BHP	Best Behavior, LLC	Shasta	BCBA	Behavior Analy	09/30/2011	Yes	None	
I	Cavaness, Hilary E.,BC	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analy	05/31/2019	Yes	None	
I	Chang, Charles Y.,MD	SPEC	John Muir Specialty Medical	Solano	Urology	ABMS of Urolog	02/28/2017	Yes	John Muir Medi	Provisio
I	Charles, Edson CRNA	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	06/14/2022	Yes	Admitting Agree	None
I	Chiaji, Kairis Doula	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	
I	Chin, Aimmee L.,MD	PCP	Adventist Health Ukiah Valle	Mendocino	Family Medicin	ABMS of Family	07/08/2020	Yes	Adventist - Ukia	Provisio
R	Choate, Jennifer J.,MD	SPEC	Providence Medical Group,	Humboldt	Hematology	ABMS of Intern	06/17/1980	Yes	St. Joseph Hos	Active
R	Choudhry, Aditi MD	SPEC	John Muir Health Cancer M	Solano	Hematology	ABMS of Intern	10/24/2019	Yes	John Muir Medi	Active
R	Comer, Kristy BCBA	BHP	Autism Spectrum Therapies	Yolo	BCBA	Behavior Analy	08/31/2014	Yes	None	
I	Conners, Lori L.,FNP	PCP	Adventist Health Howard M	Mendocino	Nurse Practitior	None		No	None	
I	Cumbie, Elaine RD	Allied	TeleMed2U	Yolo	Registered Diet	Commission of	10/01/1982		None	
I	Dailey-Glenn, Dana Dc	SPEC	Empowered Doula Service	Sonoma	Doula	None		Not Applica	None	
R	De Capua, Jerome DC	SPEC	Jerome De Capua D.C.	Humboldt	Chiropractic	None		No	None	
I	de la Garza, Elizabeth	BHP	Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	05/31/2019	Yes	None	
R	De Rouchey, Louis E.,I	PCP	Fairchild Medical Clinic (PC	Siskiyou	Family Medicin	Meets MPCR#1	07/13/1990	No	Fairchild Medic	Active
R	DeCastro, Marlon C.,M	BOTH	Providence Medical Group,	Sonoma	Internal Medicir	ABMS of Intern	08/20/2002	Yes	Admitting Agree	None
I	Dellinger, Oscar D.,MI	SPEC	Compass Palliative Care	Solano	Hospice and Pa	ABMS of Intern	10/05/2012	Yes	Admitting Agree	None
I	DeNicola, Sarah Rose	SPEC	Wild Rose Wellness	Sonoma	Doula	None		Not Applica	None	
R	DeZerega-Thomson, K	Allied	Northern California Children	Yolo	Occupational T	None		No	None	
I	Dhandha, Maulik M.,MI	SPEC	Pacific Skin Institute	Yolo	Dermatology	ABMS of Derma	07/20/2021	Yes	Admitting Agree	None
I	Dhillon, Ajitpal S.,PA-C	SPEC	Yuba City Dermatology & SI	Sutter	Physician Assis	National Comm	10/01/2015	Yes	None	
I	Diller, Antonia F.,DC	SPEC	Active Care Chiropractic, Fc	Humboldt	Chiropractic	None		No	None	
R	Dittrich, Heidi F.,FNP-C	PCP	Petaluma Health Center	Sonoma	Family Nurse P	American Acad	08/02/2021	Yes	None	
R	Dodge, James F.,DO	PCP	CommuniCare Ole - Davis C	Yolo	Family Medicin	ABMS of Family		Yes	Admitting Agree	None
R	Downie-Allman, Fanne	PCP	Fortuna Family Medicine Inc	Humboldt	Nurse Practitior	None		No	None	
R	Drill, Celia BCBA	BHP	Positive Change Behavioral	Lake	Behavioral Hea	Behavior Analy	01/31/2013	Yes	None	
R	Eastman, Wilfred W.,Jr	SPEC	Fairchild Medical Clinic Spe	Siskiyou	Orthopaedic Su	Previously Boa	07/21/1989	Yes	Fairchild Medic	Active
R	Eigelberger, Monica S.	SPEC	John Muir Health Center Me	Sacramento	General Surger	ABMS of Surge	10/11/2005	Yes	John Muir Medi	Active
R	Emerson, Sherilyn BCE	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analy	03/04/2022	Yes	None	
R	Falk, Jennifer S.,PA-C	SPEC	John Muir Specialty Medical	Solano	Physician Assis	National Comm	11/24/2010	Yes	None	
R	Febuary, Yuki A.,RD	Allied	Ole Health	Napa	Registered Diet	Commission of	07/28/2020	Yes	None	
R	Ferrer, Gerrard F.,DO	SPEC	Providence Medical Group,	Sonoma	Neurology	ABMS of Psych	09/10/2004	Yes	Santa Rosa Me	Active
I	Fine, Celina PA-C	PCP	Marin City Health & Wellnes		Physician Assis	National Comm	12/20/2023	Yes	None	
R	Fisk, Darsie L.,PT	Allied	Northern California Children	Yolo	Physical Therap	None		No	None	
I	Frieze, Erika A.,Psy.D	BHP	Bridges of the Mind Psychol	Solano	Psychology	None		No	None	
I	Fuqua, Charles S.,PT	SPEC	Burger Physical Therapy	Solano	Physical Therap	None		No	None	
I	Fusaro, Michael E.,CR	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	12/03/2015	Yes	Admitting Agree	Active
R	Galdieri, Devin BCBA	BHP	Trumpet Behavioral Health-	Humboldt	Behavioral Hea	Behavior Analy	04/25/2021	Yes	None	
R	Gibb, Gregory N.,MD	SPEC	Gregory Gibb, MD	Humboldt	Ophthalmology	ABMS of Ophth	05/08/1983	Yes	Redwood Mem	Active
I	Glatt, Andrew H.,MD	PCP	MRCH: Mad River Healthca	Humboldt	Internal Medicir	Meets MPCR#1	08/21/1996	Yes	Admitting Agree	None
I	Godinez, Erik S.,BCBA	BHP	Positive Behavior Supports	Yolo	BCBA	Behavior Analy	07/30/2024	Yes	None	
I	Gohil, Dipali S.,PT	Allied	Burger Physical Therapy	Sacramento	Physical Therap	None		No	None	
R	Golergant, David MD	PCP	Lake County Tribal Health S	Lake	Pediatrics	ABMS of Pedia	10/12/1994	Yes	Admitting Agree	None
I	Gonzales, Eric CRNA	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	12/15/2008	Yes	Admitting Agree	None
R	Gonzalez, James N.,M	SPEC	James Gonzalez MD	Shasta	Surgery	ABMS of Surge	06/06/1995	Yes	Shasta Region	Active
R	Greig, Christina K.,MD	BOTH	Solano County Family Healt	Solano	Wellness and R	None		No	Admitting Agree	None
I	Grewal, Rupinder K.,FI	SPEC	Capital Pediatric Cardiology	Yolo	Family Nurse P	American Acad	09/25/2023	Yes	None	
R	Griner, Karen SLP	Allied	Northern California Children	Yolo	Speech & Lang	None		No	None	
R	Grover, Rhett D.,DO	PCP	SCHC: Shasta Community I	Shasta	Family Medicin	ABMS of Family	08/03/2007	Yes	Admitting Agree	None
R	Gutermuth, Angela M.,	Allied	Redding Rancheria: Trinity I	Trinity	Physical Therap	None		No	None	
R	Haberstock, Keith R.,S	Allied	Northern California Children	Yolo	Speech & Lang	None		No	None	
I	Haney, Devan PA-C	PCP	Hill Country Comm Clinic-R	Shasta	Physician Assis	National Comm	07/02/2024	Yes	None	
R	Harleman, Anna G.,RD	Allied	Ole Health	Napa	Registered Diet	Commission of	12/21/2003	Yes	None	
I	Hatch, Heather M.,PT	Allied	Burger Physical Therapy	Solano	Physical Therap	None		No	None	

App. Ty	Full Name	Provider Type Cd	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
R	Hawley, Mitchell L.,DP	SPEC	SCHC: Shasta Community I	Shasta	Podiatry	None		No	Mercy Medical (	Courtesy
R	Hazelton, Tracy M.,PA-	PCP	Lake County Tribal Health S	Lake	Physician Assis	National Comm	12/21/1995	Yes	None	
I	Hettema, Amanda L.,C	SPEC	Enloe Women's Services (S	Butte	Certified Nurse	American Midw	05/01/2024	Yes	None	
I	Hoffman, Tawnya I.,PA	PCP	Sutter North Brownsville Fa	Yuba	Physician Assis	National Comm	07/19/2007	Yes	None	
I	Holcomb, Alyssa BCBA	BHP	Pantogran LLC dba Center		BCBA	Behavior Analy	06/05/2024	Yes	None	
I	Holt, Justin C.,OD	SPEC	Anderson Eye Care (Ridge	Shasta	Retinal Myopatl	None		No	Admitting Agree	None
I	Hughes, Jan M.,PA-C	PCP	MRCH: Mad River Health C	Humboldt	Physician Assis	National Comm	11/09/2001	Yes	None	
I	Ingram, Corinne A.,SU	W&R	Empire Recovery Center	Shasta	Wellness and R	California Subs	10/11/2024	Yes	None	
I	Johansen, Kevin H.,MI	PCP	Tahoe Forest MultiSpecialty	Nevada	Family Medicin	ABMS of Family	12/02/2024	Yes	Tahoe Forest H	Provisio
I	Johnson, Brian K.,FNP	PCP	Adventist Health Howard M	Mendocino	Family Nurse P	American Acad	07/01/2011	Yes	None	
R	Johnson, Heidi L.,FNP-	PCP	Trinity Community Health C	Trinity	Family Nurse P	American Acad	06/29/2018	Yes	None	
R	Kassis, Michael D.,PT	Allied	Solano Sports Physical The	Solano	Physical Thera	None		No	None	
I	Keyashian, Brian J.,MI	SPEC	Bay Area Surgical Specialis	Solano	Vascular Surge	ABMS of Surge	05/21/2018	Yes	John Muir Medi	Active
R	Khabbaz, Melissa BCB	BHP	Autism Learning Partners	Humboldt	BCBA	Behavior Analy	06/10/2021	Yes	None	
R	Ko, Stephanie DPM	SPEC	Petaluma Health Center	Sonoma	Podiatry	None		No	Petaluma Valle	Affiliate
I	Kooyman, Douglas CR	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	12/21/2010	Yes	Admitting Agree	Active
I	Kor, Matthew J.,MD	PCP	Sutter Lakeside Medical Pra	Lake	Family Medicin	ABMS of Family	07/27/2022	Yes	Sutter Lakeside	Provisio
R	Kosinski, Anthony P.,M	SPEC	Providence Medical Group,	Sonoma	Obstetrics and	ABMS of Obste	11/12/1999	Yes	Petaluma Valle	Active
R	Krause, Andrea L.,OT	Allied	Northern California Children	Yolo	Occupational T	None		No	None	
R	Krupitskaya, Yelena MI	SPEC	John Muir Health Cancer M	Solano	Medical Oncolo	ABMS of Intern	11/12/2009	Yes	John Muir Medi	Active
R	Ladika, Courtney C.,M	PCP	ODCHC - Telehealth & Visit	Humboldt	Family Medicin	ABMS of Family	07/13/2011	Yes	Admitting Agree	None
R	Lai, Stella MD	SPEC	Providence Medical Group,	Sonoma	Neurology	ABMS of Psych	09/11/2017	Yes	Santa Rosa Me	Active
I	Lawrence, Jennifer G.,	PCP	Sutter Lakeside Community	Lake	Family Medicin	ABMS of Family	07/12/1996	Yes	Sutter Lakeside	Provisio
I	Levitan, Sarah H.,CNM	SPEC	OLE Health	Solano	Certified Nurse	American Midw	07/01/2012		None	
R	Lewis, Shaelah E.,FNP	PCP	Long Valley Health Center	Mendocino	Family Nurse P	American Acad	06/30/2021	Yes	None	
I	Long, Tavy BCBA	BHP	Behavior Frontiers, LLC	Placer	BCBA	Behavior Analy	01/29/2024	Yes	None	
I	Long, Zsofia B.,MD	SPEC	Capital Pediatric Cardiology	Yolo	Pediatric Cardi	None		No	Admitting Agree	None
R	Lopes, Shawne J.,LAc	Allied	Pivot Acupuncture & Integra	Solano	Acupuncture	None		No	None	
R	Losada, Catherine FNP	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurs	12/23/2012	Yes	None	
R	Lumia, Charlin A.,LMF	BHP	Burnett Therapeutic Service	Napa	Behavioral Hea	None		Not Applica	None	
R	MacLeamy, Patrick D.	BHP	Dr. Patrick D. macLeamy, P	Sonoma	Behavioral Hea	None		No	None	
I	Malik, Risha B.,MD	SPEC	WellSpace Health Oak Park	Placer	Endocrinology,	ABMS of Intern	10/01/2023	Yes	Admitting Agree	Active
I	Mangiaracina, Michael	PCP	Tahoe Forest MultiSpecialty	Placer	Physician Assis	National Comm	09/09/2004	Yes	None	
R	Manley, Shannon L.,FN	PCP	Healdsburg Physician Grou	Sonoma	Family Nurse P	American Nurs	02/28/2019	Yes	None	
R	Matsuda, Rikako PT	Allied	Northern California Children	Yolo	Physical Thera	None		No	None	
R	Matthews, Bonnie J.,SI	W&R	Ujima Family Recovery Sen	Solano	Wellness and R	California Subs	09/03/2024	Yes	None	
I	McCullough, Andrea P	PCP	Long Valley Health Center	Mendocino	Family Medicin	ABMS of Family	07/10/1998	Yes	Admitting Agree	None
I	McDonald, Sabra M.,P	Allied	Burger Physical Therapy	Placer	Physical Thera	None		No	None	
I	Mendez, Natalie RD	PCP	TeleMed2U	Yolo	Registered Diet	Commission of	05/03/2019	Yes	None	
R	Mentock, Shannon MD	PCP	Petaluma Health Center	Sonoma	Family Medicin	ABMS of Family	07/13/2020	Yes	Petaluma Valle	Active
I	Meyer, Stevie BCBA	BHP	Family First	Butte	Behavioral Hea	Behavior Analy	05/08/2024	Yes	None	
R	Michel, Christina D.,SL	Allied	Northern California Children	Yolo	Speech & Lang	None		No	None	
R	Miguel Yen, Maria A.,M	SPEC	TeleMed2U	Yolo	Nephrology	ABMS of Intern	11/04/2010	Yes	Admitting Agree	None
R	Miles, Matthew S.,MD	SPEC	SCHC: Shasta Community I	Shasta	Infectious Dise	ABMS of Intern	10/30/2007	Yes	Shasta Region	Active
R	Miranda, Anna M.,PT	Allied	Northern California Children	Yolo	Physical Thera	None		No	None	
R	Nelson, Catherine BCE	BHP	Learning Solutions Kids, Inc	Placer	Behavioral Hea	Behavior Analy	08/31/2018	Yes	None	
R	Nguyen, Katie T.,SLP	Allied	Northern California Children	Yolo	Speech & Lang	None		Not Applica	None	
R	Okada, Stephanie M.,(	Allied	Northern California Children	Yolo	Occupational T	None		No	None	
R	Okwandu, Gift O.,FNP-	PCP	ODCHC - Eureka Communi	Humboldt	FNP-C	American Acad	07/14/2020	Yes	None	
R	Orellana, Melinda J.,MI	PCP	Redding Rancheria Tribal H	Shasta	Family Medicin	Meets MPCR#1	11/08/2013	No	Mercy Medical (	Active
I	Otto, Sara C.,BCBA	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analy	05/16/2020	Yes	None	
R	Ozokwere, Marresa C.	PCP	ODCHC - Eureka Communi	Humboldt	FNP-C	American Acad	06/22/2018	Yes	None	
I	Pagano, Katelyn M.,OT	Allied	Southern Humboldt Commu	Humboldt	Occupational T	None		No	None	
I	Panteloglow, Christina	BHP	Autism Intervention Professi	Placer	BCBA	Behavior Analy	01/22/2022	Yes	None	
I	Parashar, Pavan MD	SPEC	ReSolution Care, PC	Solano	Hospice and Pa	ABMS of Intern	11/07/2016	Yes	Admitting Agree	None
I	Patel, Nandlal M.,MD	SPEC	Wound MD PC	Solano	Preventive Med	None		No	Admitting Agree	None
I	Perdomo, Ana J.,FNP-	PCP	Peach Tree Healthcare - PC	Yuba	Family Nurse P	American Acad	10/19/2022	Yes	None	
I	Pers, Susan S.,PA-C	SPEC	Planned Parenthood Northe	Contra Costa	Physician Assis	National Comm	05/26/2020	Yes	None	
I	Peters Oyefeso, Talatu	PCP	Round Valley Indian Health	Mendocino	Physician Assis	None		No	None	
R	Pezold, Michael L.,MD	SPEC	Providence Medical Group,	Sonoma	Vascular Surge	ABMS of Surge	07/13/2021	Yes	Santa Rosa Me	Active
I	Phillip, Nimeka N.,MD	PCP	Adventist Health Ukiah Valle	Mendocino	Family Medicin	ABMS of Family	07/24/2019	Yes	Adventist - Ukia	Provisio
R	Ploss, David R.,MD	SPEC	Adventist Health Ukiah Valle	Mendocino	Cardiovascular	Meets MPCR#1	11/10/1995	No	Adventist - Ukia	Active
I	Pring, Kindra BCBA	BHP	Maxim Healthcare Services,	Solano	BCBA	Behavior Analy	10/16/2024	Yes	None	
I	Putnam, Emily L.,Psy.D	BHP	Bridges of the Mind Psychol	Solano	Psychology	None		No	None	
R	Rivas, Adrianna E.,OT	Allied	Northern California Children	Yolo	Occupational T	None		No	None	
I	Rodriguez, Cassandra	PCP	Western Sierra Medical Clin	Nevada	Physician Assis	National Comm	12/17/2024	Yes	None	
R	Rousselot, Anthony M.	PCP	UIHS - Potawot Health Villa	Humboldt	Physician Assis	National Comm	01/09/1995	Yes	None	
R	Ryan, Jenna BCBA	BHP	Best Behavior, LLC	Shasta	BCBA	Behavior Analy	09/30/2011	Yes	None	
I	Safford, Daniel PT	Allied	Burger Physical Therapy	Yolo	Physical Thera	None		No	None	
R	Salas, Dimarrah BCBA	BHP	Center for Social Dynamics	Contra Costa	Behavioral Hea	Behavior Analy	10/04/2021	Yes	None	
I	Samuels, Jason PA-C	SPEC	Sacramento Ear Nose and T	Yolo	Physician Assis	National Comm	09/27/2024	Yes	None	
I	Sanders, Khristie H.,PT	SPEC	Burger Physical Therapy	Solano	Physical Thera	None		No	None	
R	Sanders, Laurie G.,BC	BHP	Laurie G. Sanders, M.S, BC	Humboldt	Behavioral Hea	Behavior Analy	06/30/2004	Yes	None	
R	Sandoval, Katherine FI	BOTH	Sutter Coast Community Cli	Del Norte	Family Nurse P	American Acad	02/04/2019	Yes	None	
I	Santana, Maria J.,PA-(	PCP	Ampla Health Arbuckle Med	Colusa	Physician Assis	National Comm	02/26/2004	Yes	None	
I	Sato, Sara BCBA	BHP	Kyo Autism Therapy LLC, fk	Yolo	BCBA	Behavior Analy	09/30/2011	Yes	None	
I	Sayd, Nicole RD	Allied	TeleMed2U	Yolo	Registered Diet	Commission of	12/26/2023	Yes	None	
R	Schwarz, Ronit OT	Allied	Northern California Children	Yolo	Occupational T	None		No	None	
R	Schwarz, Suzie Q.,PA-	PCP	Sutter Coast Community Cli	Del Norte	Physician Assis	National Comm	07/18/2013	Yes	None	
I	Scruggs, Cora H.,PT	Allied	Burger Physical Therapy	Solano	Physical Thera	None		No	None	
R	Seal-Mayr, Elli R.,OT	Allied	Northern California Children	Yolo	Occupational T	None		No	None	

App. Ty	Full Name	Provider Type Cd	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
R	Serrano, Noel MD	SPEC	Noel Serrano, MD	Solano	SNFist			No	Admitting Agree	None
R	Sethi, Parminder S.,MI	SPEC	John Muir Specialty Medical	Solano	Urology	ABMS of Urolo	02/29/2000	Yes	John Muir Medi	Active
R	Shah, Sanket S.,PA-C	SPEC	TeleMed2U	Yolo	Physician Assis	National Comm	08/12/2010	Yes	None	
I	Sharif, Hamdia Doula	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	
I	Shelley, Raymond BCE	BHP	Autism Learning Partners	Yolo	BCBA	Behavior Analy	07/09/2021	Yes	None	
I	Shelton, Dania M.,Dou	SPEC	Dania Shelton CMCPM Mer	Butte	Doula	None		No	None	
R	Shende, Urmila A.,MD	PCP	Petaluma Health Center: Rc	Sonoma	Pediatrics	ABMS of Pedia	10/08/1997	Yes	Admitting Agree	None
R	Shoemaker, Dane A.,A	BOTH	Providence Medical Group,	Sonoma	Acute Care Nur	American Nurse	11/02/2012	Yes	None	
R	Simpson, Brooke A.,SL	Allied	Northern California Children	Yolo	Speech & Lang	None		No	None	
I	Smiley, Claire F.,PT	Allied	Burger Physical Therapy	Solano	Physical Thera	None		No	None	
R	Smith, Jerome C.,MD	PCP	Sonoma Valley Community	Sonoma	Pediatrics	ABMS of Pedia	10/16/2001	Yes	Sonoma Valley	Courtes
R	Smith, Robert J.,DC	SPEC	Hill Country Comm Clinic-R	Shasta	Chiropractic	None		No	Admitting Agree	None
I	Snyder, Garrett M.,MD	SPEC	Santa Rosa Orthopaedic M	Sonoma	Orthopaedics	ABMS of Ortho	07/25/2013	Yes	Admitting Agree	None
I	Sobczynska, Katarzyn	PCP	Adventist Health Clearlake	Lake	Pediatrics	ABMS of Pedia	10/16/2007	Yes	Adventist Healt	Provisio
R	Spinka, Paul J.,MD	SPEC	Dignity Health - Mercy Fami	Shasta	Gastroenterolo	ABMS of Intern	11/09/1995	Yes	Mercy Medical	Active
R	Stokes, Kusum MD	SPEC	Providence Medical Group,	Humboldt	Gastroenterolo	ABMS of Intern	11/19/1985	Yes	St. Joseph Hos	Active
I	Streufert, Aaron M.,FN	PCP	New Life, LLC	Mendocino	Family Nurse P	American Nurse	02/13/2013	Yes	None	
I	Sumner, Sarah BCBA	BHP	Pantogran LLC dba Center		BCBA	Behavior Analy	08/03/2022	Yes	None	
I	Sweeney, James PT	Allied	Burger Physical Therapy	Placer	Physical Thera	None		No	None	
R	Tabrizi, Payam MD	SPEC	Providence Medical Group -	Sonoma	Orthopaedic Su	ABMS of Ortho	07/11/2004	Yes	Admitting Agree	None
R	Tang, Tianyi MD	SPEC	John Muir Health Cancer M	Solano	Hematology an	None		No	John Muir Medi	Active
I	Thai, Linh C.,PT	Allied	Burger Physical Therapy	Yolo	Physical Thera	None		No	None	
I	Thiara, Jagmohan S.,P	SPEC	Ampla Health Marysville Me	Yuba	Psychiatric Mer	American Nurse	04/24/2019	Yes	None	
I	Thiel, Glenn W.,DO	PCP	WellSpace Health Oak Park	Placer	Family Medicin	American Oste	06/01/2021	Yes	Admitting Agree	None
I	Tran, Michael L.,MD	SPEC	Acadia Pain Management G	Sonoma	Pain Medicine	Previously Boa	09/15/2001	No	Admitting Agree	None
R	Turrill, Mark MD	SPEC	Providence Medical Group,	Lake	Medical Oncolo	ABMS of Intern	11/09/1995	Yes	Sutter Lakeside	Active
I	Uribe, Ysabel Doula	SPEC	Ysabel Uribe	Siskiyou	Doula	None		No	None	
R	Vazquez, Sarai BCBA	BHP	Burnett Therapeutic Service	Napa	Behavioral Hea	Behavior Analy	08/31/2017	Yes	None	
R	Villers, Tanya L.,FNP-(	PCP	Northeastern Rural Health (	Lassen	Family Nurse P	American Acad	01/18/2018	Yes	None	
R	Vincent, Pamela L.,MD	SPEC	Bright Heart Health Medical	Solano	Neurology	Meets MPCR #		No	Admitting Agree	None
I	Viswanathan, Anjana F	Allied	Burger Physical Therapy	Solano	Physical Thera	None		No	None	
R	Vos, Amber L.,FNP-BC	SPEC	Sutter Coast Community Cli	Del Norte	Family Nurse P	American Nurse	10/28/2011	Yes	None	
R	Wade, Jonie K.,FNP-C	PCP	Redding Rancheria Tribal H	Shasta	Family Nurse P	American Acad	07/24/2017	Yes	None	
R	Wagner, Michael V.,M	SPEC	Providence Medical Group-	Napa	Obstetrics and	ABMS of Obste	12/09/1989	Yes	Queen of the V	Active
R	Wagoner, Kathryn B.,R	W&R	Archway Recovery Services	Solano	Wellness and R	California Cons	02/10/2022	Yes	None	
R	Walker, Peri A.,SLP	Allied	Northern California Children	Yolo	Speech & Lang	None		Not Applica	None	
R	Walker, Sukhjit K.,PA-(	SPEC	Shriners Hospitals for Child	Yolo	Physician Assis	National Comm	04/22/2019	Yes	None	
R	Watson, Lorena A.,FNI	BOTH	Lake County Tribal Health C	Lake	Family Nurse P	American Nurse	09/05/2012	Yes	None	
I	Webster, Maxine M.,A(	SPEC	Adventist Health Mendocinc	Mendocino	Adult Gerontolo	American Acad	09/14/2017	Yes	None	
R	Wexler, Ann M.,MD	SPEC	Solano Hematology Oncolo	Solano	Hematology	ABMS of Intern	11/14/2007	Yes	Sutter Solano M	Active
I	Whitaker, Dakoda BCE	BHP	Pantogran LLC dba Center	Solano	BCBA	Behavior Analy	12/11/2024	Yes	None	
I	Wilkin, Tangerine S.,SI	W&R	Empire Recovery Center	Shasta	Wellness and R	California Subs	10/11/2024	Yes	None	
I	Womack, Allison Psy.D	BHP	Bridges of the Mind Psychol	Solano	Psychology	None		No	None	
I	Yaminifar, Anoush FNI	PCP	Ampla Health Chico Medica	Butte	Family Nurse P	American Acad	03/02/2023	Yes	None	
I	Yang, Ronald H.,MD	PCP	La Clinica Oakley	Solano	Internal Medicir	ABMS of Intern	08/26/1998	Yes	Admitting Agree	None
R	Yates, Adam BCBA	BHP	Best Behavior, LLC	Shasta	BCBA	Behavior Analy	09/30/2011	Yes	None	
R	Zamary, Kirellos R.,MI	SPEC	Providence Medical Group,	Sonoma	Surgery	ABMS of Surge	04/24/2018	Yes	Santa Rosa Me	Active
R	Zumwalt, Benjamin R.,	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurse	01/30/2020	Yes	None	

MEETING AGENDA

Meeting / Project Name: The Pediatric Quality Committee

Objective of Meeting: To provide expert clinical guidance regarding WCM/CCS policy, procedures, Care Coordination and best practices for PHC Members.

Date: NNovember 13th, 2024 **Time**: 1:00 to 3:00 PM

Locations: Partnership HealthPlan of California
- **4665 Business Center Drive, Fairfield, CA 94534 |** Napa / Solano Conference Room – 2nd Floor (Host site for WebEx videoconference)
- **2525 Airpark Drive, Redding, CA 96002 |** Whiskeytown Conference Room
- **1036 5th St. Suite E., Eureka, CA 95501 |** Sue-meg Conference Room

Please see your calendar invitation for WebEx link.

If you are calling-in to the meeting, please dial **844-621-3956** Meeting ID: 2632 153 6115 Videoconference Password:5BPqfpy5PE7

PHC Attendees:

Jeff Ribordy, MD, MPH-**Committee Chair/Med. Director, WCM** Robert L. Moore, MD, MPH, MBA-**Vice Chair/CMO** Katherine Barresi, RN, BSN, PHN,CCM-**Acting CEO** / **Chief Health Services Officer** Stan Leung, Pharm.D, **Director of Pharmacy Services** Amy Turnipseed - Senior Director, Ext. & Regulatory Affairs Brigid Gast, RN, MSN, NEA-BC - SSr. Director of Care Coordination Doreen Crume, RN - Case Management Supervisor	Heidi Lee - Provider Systems Manager Mary Kerlin - Senior Director of Provider Relations Mohamed Jalloh Pharm.D. - Director of Health Equity Monika Brunkal, RPh – Assoc. Dir. Population Health Nicole Hartigan, MSN, RN – Assoc. Dir. Care Coordination Suzanne Trepoy Papadopoulos, RN, MSMHC – Supervisor of Case Management Teresa Frankovich, MD, MPH, FAAP - Assoc. Med. Director Vanessa Diaz - Senior Provider Relations Lead Wendi Davis, Chief Operating Officer
Advising Members:	
Annapurna Vishnubhotla, RN, Endocrinology, CHO Brenda Harris, RN, PHN Siskiyou County Carey Venglarcik, MD Shasta Community Health Center Carol Miller, MD, Marin CCS Caryl Greenwood, MN, PHN, Shasta County Cheryl Losado, RN, PHN, Napa County CCS Deborah Ard, RN, MSN, PHN, Lassen County R. Jennifer Olson, MD, CHO, Irene Jimenez, PHN, Solano County James Huang, MD, UCSF Katherine Estlin, MD Humboldt County CCS Med. Consultant	Lael Lambert, MSN, PHN, Marin County Lauren Burchfield, BSN, RN, PHN Humboldt County CCS Lorna Boland, RN, Modoc County Marcie Jo Cudziol, RN, PHN, MPA- Trinity County HHS Mary Ann Limbos, MD, Yolo CCS and Dep. Health Officer Paulomi Shah, DO, Sonoma CCS Shandi Fuller, MD, Solano CCS Sharon Convery, PHN - CCS Administrator for Mendocino Stephanie Holliday, PHN – Humboldt County Steven Gwiazdowski, MD, NorthBay Neonatology Assoc. Victoria Morgese, MD, Napa County CCS
Other Members:	
Carlene Bramlett, Trinity County Gina Pasquinelli, Sonoma County CCS Jaime Ordonez, Yolo County CCS Jennifer Hathaway, LVN – Siskiyou County Laura Farnetti – Trinity County Public Health, Program Coord. II Linda Singler, Shasta County	Meredith Wolfe, Humboldt County CCS Naomi Underwood, Trinity County Norma Williams, Del Norte County CCS Rachael Eddis –Trinity County Public Health, Admin Clerk Shonda Smith – Lassen County CCS Program Assistant

Topic	Notes
1) Introductions, Roll Call & Objective of Meeting 1:00 to 1:10 p.m. *10 minutes Speakers:* ***Jeff Ribordy, MD***	- Dr. Ribordy welcomed everyone and shared that this would be the last meeting of the year.
2) Review & approve PQC minutes from last meeting **August 7, 2024** ***Pages 3 - 9*** 1:10 to 1:15 p.m. *5 minutes Speaker:* ***Jeff Ribordy, MD***	- The meeting PQC minutes from 8/7/2024 were reviewed. Dr. Shaw approved them and they were seconded by Lauren Burchfield.
3) Minutes from previous Family Advisory Committee **Meeting of August 27, 2024** ***Pages 10 - 17*** 1:15 to 1:25 p.m. *10 minutes* Speaker: ***Nicole Hartigan, MSN, RN***	-The next FAC meeting will take place next week on 11/19/2024. - There was an update from the August meeting. Alyssa D Feliipo presented on transition to adulthood, tips for parents, health insurance, benefits, legal options and other resources. The presentation is available to share. An ongoing challenge was shared. Family members were struggling to navigate the family portal when the member turns 12.Dr Ribordy added that data exchange issues are not exclusive to CCS members but is a wider issue among many providers. PHC is working with MS and RAC discover alternatives to reduce the portal access barriers. This is a work in progress and nothing is finalized yet. Transportation success and challenges were also shared. Family members were educated on how to escalate issues, for example travel reimbursement. Another success included access to care with a pediatric dental in Sonoma county. Wait time was within 2 months. -Transportation Benefit escalation pathways were discussed as well as the FAC stipend update and updates regarding the WCM Transition.
4) Policy Review-MCQG1015 Pages 18 - 31 1:25 to 1:40 p.m. *15 minutes Speaker:* ***Jeff Ribordy, MD***	- Policy was reviewed. Dr. Ribordy shared that there are no major changes. A new immunization schedule was added however, it is not drastically different. The policy was approved by Dr. Shah, Lauren Burchfield 2nd - Dr. Shah asked about adolescent sports medicine. She had heard of rise in increased cardiac death and asked if there were any preventative measures in the works.Dr. Ribordy stated that the AAP has guidelines for screenings, but it is a good discussion to be had. One issue of note was that they are often happening at the schools or in urgent care instead of done by the PCP. Some local school used chiropractors and he has had ongoing discussions regarding this - SRCH has been talking about creating better tools for this as they have noticed that sometimes sports physicals are not done during the well child checkup.SRCH was asked to please send information if they do come up with new tool.
5) WCM MOU & Transitions Update 1:40 to 2:00 p.m. *20 minutes Speakers:* ***Brigid Gast, RN***	- PHC had a meeting with the expansion counties. DHCS shared that all deliverables have been received and approved, 2 more will be sent out at end of the year. PHC has been reviewing COC requests. As of date, 23000 providers statewide have been reviewed. PHC is continuing to be supportive of developing meaningful access to care. PHC has been taking a proactive outreach to providers based on member utilization data. The process includes contacting eligible providers and entering into a COC provider agreement for members. The communication pathways are shared with members and it has been successfully utilized in over 10 counties. - There have been some MOU updates and several WCM MOU drafts are coming. PHC is continuing to discuss and touch base with counties as needed. - Dr. Ribordy stated that CMS net access for expansion counties was given prior to January 1st and asked if MOUS are viewable on CMS net. - Lauren B. shared that it is complicated and it may be an issue of limited access for PHC, however, eligibility should be available to view.OUs are supposed to be viewable. Lauren B shared that it's complicated. General notes are made according to their own process and PHC may have limited access however, eligibility should be in there and viewable.

Topic	Notes
6) MediCal RX Update 2:00 to 2:10 p.m. *10 minutes* *Speaker:* ***Stan Leung, Pharm.D***	- As of January 31st,2025, TAR requirements for all members 21 and under will be reinstated. This may impact CCS kids. On October 31st, PHC released a bulletin with the 90 day countdown. This was sent to providers. PHC will meet with DHCS in December to continue discussion around this. Members will need tars for certain meds however, DHCS has said they will implement a CCS panel authorization policy. CCS providers would be exempt for most items, causing less impact. There will be an excluded product list for less commonly used medications and these will still need a TAR. - The topic of grandfathering was asked about. For example, If mbr was new to CCS or had been already receiving the medication what would happen? It was shared that DHCS didn't comment on this. It is suspected that there will most likely be a COC process for a limited amount of time.
7) CalAIM Update *2:10 to 2:20 p.m. 10 minutes* *Speaker:* ***Katherine Barresi, RN***	For CalAIM, as of Jan 1 25, DHCS changed to ECM RAF process for some. CCS and WCM members are eligible for presumptive authorization for ECM. This will only will apply to local health and CCS paneled providers in PHC's network. PHC is working to implement this with IT, Claims, OPS and PR. This is not formalized yet by DHCS. That will come after start date. PHC will be rolling out more info on this soon. - There was a proposal from DHCS for a 115 B waiver- transitional rent. This not approved yet. The waiver would allow for transitional rent assistance for up to 6 months for qualifying mbrs. There is potential for CCS members to qualify. Most members qualifying would be county specialty mental health and there is limiting criteria for eligibility. One potential issue would be needing to be able to have a match for the member. - Dr Shah asked a question regarding the presumptive eligibility. She asked if they would be eligible if a provider or CBO identifies them? It was shared that members could qualify on that day, meaning managed care plans would have to start paying before getting an authorization. Katherine clarified that this would not be true for all providers. It would only apply to CCS providers and local health at this time. Dr. Shah asked who would do it. Katherine responded that it would be paneled providers already contracted with PHC. She also shared that the State created a statewide ECM RAF template with hopes to create better access. Dr. Shah asked if there is a list of paneled providers and Katherine shared that PHC has 0 at this time.
8) DHCS CCS Advisory Group Update 2:20 to 2:30 p.m. 10 minutes *Speaker:* ***Katherine Barresi, RN***	In last month's October meeting, CCS Performance & timelines were discussed. Katherine shared the CCS redesign road map from Jan 1 2025- 2028. She also shared demographic data and enrollment data.There are 6 selected measures. The presentation will be shared with the group. -The Subcommittee discussed measure specifications. A concern was that Rural counties with smaller populations might have some of these measures suppressed because patients will be easily identifiable. -Brigid presented a COC overview and shared that PHC has collaborated with Placer County to share information. She added that we have reviewed APL draft language and the APL draft will be released shortly as well as revisions to follow. There are ongoing discussions surrounding this.
9) Questions and New Topics 2:30 to 3:00 p.m. *30 minutes* *Speakers:* ***All***	- Dr Shah commented on annual reviews, noting that specialty care centers are doing telehealth visits, and that they won't make a child medically eligible unless there is an in person visit due to concerns of the member not receiving appropriate care. -Dr. Ribordy added that he is also seeing this in pediatrics and adults. He stated this has been a large issue since Covid. - Lauren B. agreed at least once in person visit a year is necessary for appropriate care. **Next Meeting – February 4, 2025 1:00 – 3:00 PM**

MEETING AGENDA

Meeting / Project Name: The Pediatric Quality Committee

Objective of Meeting: To provide expert clinical guidance regarding WCM/CCS policy, procedures, Care Coordination and best practices for PHC Members.

Date: February 04, 2025 **Time**: 1:00 to 3:00 PM

Locations: Partnership HealthPlan of California
- **4665 Business Center Drive, Fairfield, CA 94534 |** Napa / Solano Conference Room – 2nd Floor (Host site for WebEx videoconference)
- **2525 Airpark Drive, Redding, CA 96002 |** Whiskeytown Conference Room
- **1036 5th St. Suite E., Eureka, CA 95501 |** Sue-meg Conference Room

Please see your calendar invitation for WebEx link.

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PHC Attendees:

Jeff Ribordy, MD, MPH**-Committee Chair/Med. Director, WCM** Robert L. Moore, MD, MPH, MBA**-Vice Chair/CMO** Katherine Barresi, RN, BSN, PHN,CCM-**Chief Health Services Officer** Stan Leung, Pharm.D, **Director of Pharmacy Services** Brigid Gast, RN, MSN, NEA-BC - **Sr. Director of Care Coordination** Shannon Boyle, RN- **Manager of CC Regulatory Performance**	Shari Roll, LCSW- **Social Worker II** Jaronna Jackson- **Program Manager I** Luis Atayde- **Project Coordinator I** Breanne Lea- **Project Coordinator I**
Advising Members:	
Brenda Harris, RN, **PHN Siskiyou County** Carol Miller, MD, **Marin CCS** Lauren Burchfield, BSN, RN, **PHN Humboldt County CCS** Dep. Health Officer Paulomi Shah, DO, **Sonoma CCS** Shandi Fuller, MD, **Solano CCS** Stephanie Holliday, PHN – **Humboldt County** Victoria Morgese, MD, **Napa County CCS**	
Other Members:	
Linda Singler, **Shasta County** Shonda Smith – **Lassen County CCS Program Assistant** Jessica Johnson, PHN- **Butte County** Cynthia Hawes-**Butte County** Cheryl Mosbacher- **Placer County CCS PHN Supervisor** Jessica Hamon, MPH- **Placer County Program Manager**	Carmen Barsottie- **Nevada County** Alyssa Soto- **Lassen County** Charlene Weiss-**Nevada County Director of Nursing** Janet Peck- **Butte County CCS Program Manager** Dustin Douros- **Nevada CCS MTU**

Topic	Notes
1) Introductions, Roll Call & Objective of Meeting 1:00 to 1:10 p.m. *10 minutes Speakers: **Jeff Ribordy, MD***	Dr. Ribordy welcomed the attendees and noted that there may be several new faces with the addition of the expansion counties.Roll call was taken at this time.
2) Review & approve PQC minutes from last meeting ***Pages 3 - 9*** 1:10 to 1:15 p.m. *5 minutes Speaker: **Jeff Ribordy, MD***	The meeting minutes from November 13th,2024 were reviewed and approved with a few minor edits to include removal of a duplicate sentence and correction of a misspelled name.
3) Minutes from previous Family Advisory Committee ***Pages 10 - 17*** 1:15 to 1:25 p.m. *10 minutes* Speaker: ***Nicole Hartigan, MSN, RN***	Nicole was unable to attend the meeting due to scheduling conflicts so Shari Roll, and LCSW and facilitation of the FAC meetings shared some highlights: - Butte county introduced a new CCS representative, Janet Peck. -Member services presented to the group and discussed topics including the new mobile app. Family members were asked for their input on the user experience and were given a questionnaire to fill out. -Population Health gave am upate on their Healthy Babies Program, which looks at developmental milestones. - Outreach has begun for Eastern region counties, including notification letters as well as HRAs beginning to be sent out. -There was discussion surrounding transportation. They have recently iplemented a texting feature for rides which should be an easier process and reduce the call volume for transportation staff. The minutes from this meeting will be forwarded for review. Nicole and other management are actively meeting with the transportation team to navigate concerns. -Future topics were discussed and it was noted that the Grievance and Appeals department will be present at the next meeting on February 25th. Additionally, a future topic presented was the issue of concerns over lack of OT and PT providers in Siskiyou County. Dr. Ribordy asked who would be the point of contact if anyone has a member that would like to join. Shari stated that the FAC is actively recruiting new family members and the best way to contact the FAC team would be through their email : FAC@partnershphp.org. This email address is also listed on the flyers on Partnership's website. Dr. Miller requested for the flyer to be sent out. It was agreed that the flyer would be sent out along with the complete minutes from today's meeting. The Stipend program was also discused with the following updates: Policy “ADM 21 - Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, QIHEC and Q/UAC Committees” and its attachment has been updated. The compensation rate for members of the Family Advisory Committee (FAC) is as follows: 1) $100.00 compensation for all FAC meetings attended for which a committee member must travel to a meeting at a Partnership location. 2) $50.00 compensation for all FAC meetings for which a committee member attended virtually. Family member committee members attending FAC meetings virtually will receive $100.00 in compensation. 3) FAC committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate. 4) FAC committee members who use public or group transportation (e.g. taxi, paratransit, etc) to get to meetings, may request a transportation reimbursement in lieu of a mileage reimbursement.

Topic	Notes
4) WCM MOU & Transitions Update 1:25 to 1:45 p.m. *20 minutes* *Speakers: Brigid Gast, RN*	Brigid provided several updates on the WCM transition. -All deliverables sent to DHCS so far have been approved, some key ones being the 30,60 and 90 day notices. -23,000 providers statewide have been reviewed to date. -Partnership has participated in high risk case conferences with the counties as well as a community town hall with Alta. This was attended by community members, providers and PHC staff. -Several WCM MOUs were sent over in their final draft and discussions with the counties are ongoing.
5) DHCS CCS Advisory Group Update 2:20 to 2:30 p.m. *10 minutes* *Speaker: Katherine Barresi, RN*	Katherine was not able to attend today's meeting due to scheduling conflicts. Brigid provided updates on her behalf. -DHCS shared the WCM program priorities, including TOC, CCS performance measures, CCS compliance monitoring, and the WCM APL. The next meeting is April 9th,2025
9) Questions and New Topics 2:30 to 3:00 p.m. *30 minutes* *Speakers: **All***	-Stan Leung discussed the pediatric reintegration. Starting January 31st 2025, For members 21& up TARS would be required again for medications. If the mbr previously had the RX, there will be a 60 COC. CCS panneled providers will be exempt from this for most RX. -Carol Miller asked about the status of ECM and CS providers that were pediatric friendly. Brigid responded that the issue was not discussed at the last DHCS advisory meeting but PHC is hoping to get more information on this at the next meeting. Carol shared her concerns about there not being a suffient amount of providers to meet members needs. Brigid stated that EHS oversees this and has been working with our PR department to get the right providers contracted for this. She also suggested it would be possible to have them join the next meeting to provide more specific details on the provider network. -Dr. Shah updated us with the news that Lisa is retiring on March 17th. Joanna King, previously from Alameda county will be filling her position. She will be responsible for some CCS, MTU and newborn/HRIF kids for the CCS program. -Dr. Ribordy closed the meeting by adding that if anyone has any topics they think of and would like discussed at the next meeting, they can reach out to him. **Next Meeting – May 14th,2025 1:00 – 3:00 PM**