Quarterly Community Provider Network (CPN) Meeting
Contra Costa Health Plan

When:  
Time: 7:30 AM – 9:00 AM  
Date: January 27, 2015

Where:  
1350 Arnold Drive Ste 103  
Martinez, CA

The agenda for the meeting is as follows:

| I. | CALL TO ORDER and INTRODUCTIONS | Mary Berkery, RN |
| II. | REVIEW and APPROVAL of MINUTES from previous meeting | Mary Berkery, RN |
| III. | REGULAR REPORTS | |
| | • Medical Director’s Report/Health Plan Updates | Mary Berkery, RN |
| IV. | NEW BUSINESS | |
| | • Lipid Management Guidelines | D. Dooley, MD  
R. Cohen, MD |
| VI. | OTHER | |
| | • Provider Concerns | Mary Berkery, RN |

Unless otherwise indicated below, Contra Costa Health Plan – Community Plan hereby adopts all issues, findings, or resolutions discussed in the Agenda for Contra Costa Health Plan, dated January 27, 2015 and attached herein.

Our next scheduled meeting is:

Tuesday, April 28, 2015  
7:30 AM – 9:00 AM
CONTRA COSTA HEALTH PLAN  
West County  
Quarterly Community Provider Network (CPN)  
Meeting Minutes – January 20, 2015

Attending:  
CCHP Staff:  M. Berkery, RN, Co-Chair; D. Dooley, MD (Guest); L.M. Perez, CPCS  
CPN Providers: G. Aguilar, PA; A. Barocio, PA; K. Ceci, MD; O. Eaglin, PA; D. Fernandes, MD; P. Mack, MD; J. Mahony, MD; L. Tromba, PA; T. Wilson, DO; K. Winter, MD

<table>
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<tr>
<th>Discussion</th>
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<tr>
<td>I.</td>
<td>Agenda was approved with no revisions.</td>
<td>M. Berkery, RN</td>
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<tr>
<td>II.</td>
<td>Review and Approval of Minutes from October 21, 2014: Minutes were approved as presented.</td>
<td>M. Berkery, RN</td>
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| III. | Regular Reports:  
- Medical Director’s Report/Health Plan Updates  
  - Autism Referrals  
    - All autism referrals from CPN Network go directly to the CAAD Clinic (Clinic for ASD and ADHD Diagnoses) – phone # is (925) 370-5490 and fax # is (925) 370-5277  
  - Flu Vaccine Matrix – reviewed  
    - Be aware of flu, measles and pertussis (Public Health)  
    - Questions and Resources: http://www.cdph.ca.gov/HealthInfo/discond/Pages/Measles.aspx  
  - Breast reduction referrals  
    - Follow certain guidelines  
  - VerifPoint Credentialing Solutions (VCS)  
    - Contract with VCS to provide continual credentialing and recredentialing services for CPN Network since 2010  
    - VCS obtaining all expirable documents between credentialing cycles (additional service as of 10/1/14)  
    - Provider to comply by submitting to VCS requested information  
  - Podiatry Referrals  
    - Need prior authorization, no longer a Medi-Cal benefit  
  - Optometry  
    - No prior authorization needed, members could go to contracted optometrists  
  - Advance Directives  
    - Providers encourage to push on advance directives | M. Berkery, RN |
| IV. | New Business:  
- Lipid Management Guidelines  
  - CCHP practices every 1 to 2 years of adopting the best practices for pediatric and adult medicine, called Pediatric Prevention Guidelines from American Academy of Pediatrics, State requirement for Well Child Exams  
    - Recently adopted newest version, new recommendation routinely screen ALL children for Lipids Disease  
    - Advocating Lipids Disease be treated as other diseases which is lifelong monitoring  
    - Atherosclerosis is actually a lifelong condition that could start early in life depending upon both environmental and genetic factors  
    - New recommendation allowing to more persuasively influence family  
    - Educate family, follow the lipid and handle additional risk factors  
    - If there is a strong family history for early Atherosclerosis Disease or if there is a secondary risk | D. Dooley, MD |
factor such as diabetes, provider is to go ahead and screen as early as two (2) years of age with fasting lipid
- Do the at risk screening for the patients who have high risk, the obese children and 2-8 year olds with risk factors using fasting lipids
- Screening recommendation (change) non-fasting for 9-11 year olds
- Well Child Exams on ALL children should include blood pressure monitoring and checking BMI
- Risk Factors are basically coronary artery events, very high total cholesterol in the family or the child who has risk factors and smoking cigarettes
- Talk to family about concerns, conduct motivational interviewing about changing lifestyle and diet (important) and refer to interventions

**Dietary Supplements**
- Data came back neutral
  - Fish oil NOT recommended for adults anymore for HDL modifications
  - Vitamin E and Folic Acid NOT recommended

V. **Adjournment:**
Meeting adjourned @ 8:55 a.m.

*Next meeting – April 21, 2015*
CONTRA COSTA HEALTH PLAN  
East/Central County  
 Quarterly Community Provider Network (CPN)  
Meeting Minutes – October 28, 2014

Attending:  
CCHP Staff: J. Tysell, MD, Chair; R. Cohen, MD, Medical Consultant; M. Berkery, RN; J. Galindo, RN, PHN; L.M. Perez, CPCS  
CPN Providers: S.M. Chang, MD; N. Essa, MD; G. Graves, MD; S. Huerta, CPNP; A. Mahdavi, MD; C. Mayor, NP; T. Mostaghasi, MD; S. Sachdeva, MD; S. Shitivelman, MD; R. Tracy, MD; L. Yang, MD; J.G. Zimmerman, MD

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<td>J. Tysell, MD</td>
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<td>II.</td>
<td>Review and Approval of Minutes from July 22, 2014: Minutes were approved as presented. Rose Cohen, MD cardiologist at CCRMC and now working as a medical consultant for CCHP was welcomed.</td>
<td>J. Tysell, MD</td>
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<tr>
<td>III.</td>
<td>Regular Reports:</td>
<td>J. Tysell, MD</td>
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<td></td>
<td>• Medical Director’s Report</td>
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</table>
| | | - Health Plan continues to grow with Medi-Cal  
| | |   - Impacted services at CCRMC and clinics  
| | |   - May increase CPN and FQHC assignments  
| | | - 2014 year of added benefits (changes) for Medi-Cal recipients  
| | |   - Mental Health  
| | |     - Working with referring providers for coordination of care  
| | |     - Future substance use experience capability to the Access Line  
| | |   - Autism  
| | |     - Starting to get referrals from providers  
| | |     - Dr. Blaisch is active in this area and working with County pediatricians with assessments  
| | |     - Have criteria for patients who may be eligible for ABA (Applied Behavior Analysis)  
| | |     - Working with existing system to try not to interrupt appropriate care  
| | |     - Expecting better and faster capability than in the past  
| | |     - Health Plan will give updates  
| | | - Alcohol and Other Drugs substance use disorders for adolescent and adults  
| | |   - May become a Health Plan benefit  
| | |   - State is looking at coordinating services  
| | | - State Quarterly Meeting Update  
| | |   - Topics discussed include:  
| | |     - Homelessness – State looking at issues that impact health care costs and trying to partner with health plans in matching up services  
| | |     - Tobacco Cessation Program for adolescent – important to screen for tobacco use  
| | | - Governing Board – Board of Supervisors  
| | |   - Staff meets with the Board four times a year  
| | |   - Issues to be advanced to the Board, contact Provider Relations for Board Representative’s contact information  
| | | - Public Health - Ebola  
| | |   - There is no Ebola in Contra Costa County and the risk here remains very low  
| | |   - Providers are to screen patients’ travel history and be vigilant  
| | | - Concerns: http://cchealth.org/public-health/  
| | | - Prenatal Care  
| | |   - Continue to work on prenatal care and trying to improve postpartum and timeliness of prenatal care |
Meeting adjourned @ 8:49 a.m.

Provider bulletin was reviewed.

- Adolescent SHA
- Other:

- Adole
cent
SHA

Available in the packet.

- Flu Update

Help/Advice Hotline 1-800-NO-BUTTS

- Medi-Cal Members: call 1-800-NO-BUTTS

- Year

CCHP will cover your 10 minute counseling sessions per year.

- Needs Assessment: nicotine intake and nicotine therapy

- Smoking cessation can be assessed through the use of SHA.

- Medicaid members: use for patients 18

- For patients 20 years or older:

- New Business: Smoking Cessation

- Look forward to improved numbers this coming year.

- Education and compliance is important.

- Patients who do not have persistent asthma are not on controllers

- Prescribe aminophylline, theophylline, or similar.

- Measuring peak flow levels.

- HEDIS.

- For providers: contact Elise Hernandez, Health Educator

- Primary care system needs to be engaged.

- Developing a treatment of healthy hearts – involve a physical and medical component:

- Developing an algorithm with more clear steps necessary to

- Continuing to work on pediatric obesity

- Weigh Posthumus

- Medicaid

- Child Health Initiative

- Children's Health Initiative

- Other:

- Improvement in pediatricians to ensure all children visit their
Pediatrics and Atherosclerosis

To Screen or Not to Screen?

Diane Dooley MD
Rose Cohen MD

Critical questions

- What is the evidence that atherosclerosis and atherosclerosis-related target organ damage begin in childhood?
- What is the evidence that the presence of risk factors in childhood affects the development and progression of atherosclerosis and atherosclerosis-related target organ damage during childhood and adulthood?
**Natural History of Atherosclerosis**

**Stages of Atherosclerosis**

1. Risk factors for an acute event may promote plaque growth, plaque instability, thrombosis, or all three.
2. Thrombosis leads to acute event.

- Normal
- Fatty streak
- Fibrous plaque
- Complex vulnerable lesion
- Acute event

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>1. CRP/Inflammation</th>
<th>2. Hypertension</th>
<th>3. Diabetes</th>
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<tbody>
<tr>
<td>CRP</td>
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<td></td>
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<tr>
<td>HDL</td>
<td></td>
<td></td>
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<tr>
<td>Smoking</td>
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**Lipids and atherosclerosis**

Combined evidence from autopsy studies, vascular studies, and cohort studies strongly indicates that abnormal lipid levels in childhood are associated with increased evidence of atherosclerosis. Significant tracking of elevated lipid levels from childhood to adulthood.

- **Muscatine study**
  - 2367 children followed until 20-30 years old
  - TC >200 mg/dl
  - 70% of boys and 43% of girls qualify for intervention as adults

**Family risk factors**

- Parent, grandparent, aunt/uncle, or sibling with myocardial infarction, angina, stroke, coronary artery bypass graft/stent/angioplasty at <55 years in males, <65 years in females
- Parent with TC ≥ 240 mg/dl or known dyslipidemia
- Child has diabetes, hypertension, BMI >95thile or smokes cigarettes
Lifestyle Risk Factors

Secondary dyslipidemia

Screening Recommendations

At risk screening:
- Ages 2-6 years
- Family history + parent with dyslipidemia, any other risk factors or high-risk condition
- Fasting lipid profile

Routine screening:
- Ages 9-11 years, 18-21 years
- Screen with non-fasting lipids
- Repeat with fasting if abnormal
Critical questions

- What is the evidence that risk factors in childhood can be decreased?
- What is the evidence that a decrease in risk factors in childhood alters the development and progression of atherosclerosis and atherosclerosis-related target organ damage in childhood and adulthood?

Lowering Cardiovascular risks

- Identify biologic, familial and lifestyle risk factors
- Initiate improved lifestyle counseling
- Dietary counseling (Grade A)
- Lipid medications
  - LDL > 190 mg/dl
  - High level risk factors
  - TG > 500

Lifestyle Counseling

- Nutrition and Diet
- Physical Activity
- Tobacco Exposure
- High Blood Pressure
- Overweight and obesity
- Diabetes
Dietary Counseling

- Dietary counseling
  - Initiate Cardiovascular Health Integrated Lifestyle Diet (Child 1) or DASH diet
  - Elevated TG levels very responsive to weight loss, diet composition and exercise
  - Increase plant-based foods and fiber
  - Decreased sugar-sweetened beverages

Medications

- Statins
  - Myopathy
  - Hepatic enzyme elevation
  - Drug interactions (Cytochrome-450 system)
- Bile acid-binding sequestrants
  - GI side effects
- Niacin, fibrates
- Omega-3 fish oil
Table 5-2. EVIDENCE-BASED RECOMMENDATIONS FOR DIET AND NUTRITION: CARDIOVASCULAR HEALTH INTEGRATED LIFESTYLE DIET (CHILD 1)

CHILD 1 is the recommended first step diet for all children and adolescents at elevated cardiovascular risk.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Recommendation</th>
<th>Supportive actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Infants should be exclusively breastfed (no supplemental formula or other foods) until age 6 months.</td>
<td>Infants who cannot be fed directly at the breast should be fed expressed milk. Infants for whom expressed milk is not available should be fed iron-fortified infant formula.</td>
</tr>
<tr>
<td></td>
<td>Strongly recommend</td>
<td></td>
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<tr>
<th>Grade</th>
<th>Recommendation</th>
<th>Supportive actions</th>
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<tbody>
<tr>
<td>B</td>
<td>Continue breastfeeding until at least age 12 months while gradually adding solids; transition to iron-fortified formula until 12 months if reducing breastfeeding</td>
<td>Fat intake in infants younger than 12 months of age should not be restricted without medical indication. Limit other drinks to 100% fruit juice ≤ 4 oz/d. No sweetened beverages; encourage water.</td>
</tr>
<tr>
<td></td>
<td>Strongly recommend</td>
<td>Infants who cannot be fed directly at the breast should be fed expressed milk. Infants for whom expressed milk is not available should be fed iron-fortified infant formula.</td>
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<th>Recommendation</th>
<th>Supportive actions</th>
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<tbody>
<tr>
<td>B</td>
<td>Transition to reduced-fat (2% to fat-free) unflavored cow’s milk** (see Supportive Actions bullet 1)</td>
<td>Limit avoid sugar-sweetened beverage intake; encourage water.</td>
</tr>
<tr>
<td></td>
<td>Strongly recommend</td>
<td>Transition to table food with: Total fat 30% of daily kcal/EAR***, Saturated fat 8–10% of daily kcal/EAR, Avoid trans fat as much as possible, Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EAR, Cholesterol &lt; 300 mg/d.</td>
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Supportive actions:
- The fat content of cow’s milk to introduce at ages 12-24 months should be decided together by parents and health care providers based on the child’s growth, appetite, intake of other nutrient-dense foods, intake of other sources of fat, and potential risk for obesity and CVD.
- Limit 100% fruit juice (from a cup) no more than 4 oz/d.
- Limit sodium intake.
- Consider DASH-type diet rich in fruits, vegetables, whole grains, low-fat/fat-free milk and milk products; lower in sugar (Table 5-3).

* Toddlers 12-24 months of age with a family history of obesity, heart disease, or high cholesterol should discuss transition to reduced-fat milk with pediatric care provider after 12 months of age.
** Continued breastfeeding is still appropriate and nutritionally superior to cow’s milk. Milk reduced in fat should be used only in the context of an overall diet that supplies 30% of calories from fat.
*** EAR = Estimated Energy Requirements/d for age/gender (Table 5-1).
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Primary Beverage</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2–10 y</td>
<td>Fat-free unflavored milk</td>
<td>Grade A (Strongly recommend)</td>
</tr>
<tr>
<td></td>
<td>Limit/avoid sugar-sweetened beverages; encourage water</td>
<td>Grade B (Recommend)</td>
</tr>
<tr>
<td></td>
<td>Fat content:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Total fat 25–30% of daily kcal/EAR</td>
<td>Grade A (Strongly recommend)</td>
</tr>
<tr>
<td></td>
<td>- Saturated fat 8–10% of daily kcal/EAR</td>
<td>Grade A (Strongly recommend)</td>
</tr>
<tr>
<td></td>
<td>- Avoid trans fat as much as possible</td>
<td>Grade D (Recommend)</td>
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<td></td>
<td>- Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EAR</td>
<td>Grade D (Recommend)</td>
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<tr>
<td></td>
<td>- Cholesterol &lt; 300 mg/d</td>
<td>Grade A (Strongly recommend)</td>
</tr>
<tr>
<td></td>
<td>Encourage high dietary fiber intake from foods*</td>
<td>Grade B (Recommend)</td>
</tr>
<tr>
<td></td>
<td>Supportive actions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Teach portions based on EER for age/gender/activity (Table 5–1).</td>
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<td></td>
<td>- Encourage moderately increased energy intake during periods of rapid growth and/or regular moderate-to-vigorous physical activity.</td>
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<td></td>
<td>- Encourage dietary fiber from foods: Age plus 5 g/d.*</td>
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<td></td>
<td>- Limit naturally sweetened juice (no added sugar) to 4 oz/d.</td>
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<td></td>
<td>- Limit sodium intake.</td>
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<tr>
<td></td>
<td>- Support DASH-style eating plan (Table 5–3).</td>
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<tr>
<td></td>
<td>* Naturally fiber-rich foods are recommended (fruits, vegetables, whole grains); fiber supplements are not advised. Limit refined carbohydrates (sugars, white rice, white bread).</td>
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| 11–21 y  | Fat-free unflavored milk | Grade A (Strongly recommend) |
|          | Limit/avoid sugar-sweetened beverages; encourage water | Grade B (Recommend) |
|          | Fat content: |  |
|          |   - Total fat 25–30% of daily kcal/EAR | Grade A (Strongly recommend) |
|          |   - Saturated fat 8–10% of daily kcal/EAR | Grade A (Strongly recommend) |
|          |   - Avoid trans fat as much as possible | Grade D (Recommend) |
|          |   - Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EAR | Grade D (Recommend) |
|          |   - Cholesterol < 300 mg/d | Grade A (Strongly recommend) |
|          | Encourage high dietary fiber intake from foods* | Grade B (Recommend) |
|          | Supportive actions: |  |
|          |   - Teach portions based on EER for age/gender/activity (Table 5–1). |  |
|          |   - Encourage moderately increased energy intake during periods of rapid growth and/or regular moderate-to-vigorous physical activity. |  |
|          |   - Advocate dietary fiber: Goal of 14 g/1,000 kcal.* |  |
|          |   - Limit naturally sweetened juice (no added sugar) to 4–6 oz/d. |  |
|          |   - Limit sodium intake. |  |
|          |   - Encourage healthy eating habits: Breakfast every day, eating meals as a family, limiting fast food meals. |  |
|          |   - Support DASH-style eating plan (Table 5–3). |  |
|          | * Naturally fiber-rich foods are recommended (fruits, vegetables, whole grains); fiber supplements are not advised. Limit refined carbohydrates (sugars, white rice, white bread). |
Figure 9-2: DYSLIPIDEMIA ALGORITHM: TARGET TG (TRIGLYCERIDES)

**Note:** Values given are in mg/dL. To convert to SI units, divide results for total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C), and non-HDL-C by 38.6; for triglycerides (TG), divide by 88.6.

- **Fasting lipid profile (FLP) x 2**, average results:
  - TG ≥ 500 mg/dL → Consult lipid specialist
  - LDL-C ≥ 250 mg/dL → Consult lipid specialist

- **LDL-C ≥ 130, < 250 mg/dL:**
  - TG ≥ 100, < 500 mg/dL, < 10 y
  - ≥ 130, < 500 mg/dL, 10-19 y → **Target TG**

- **TARGET TG → Cardiovascular Health Integrated Lifestyle Diet (CHILD 1) → CHILD 2-TG diet (Table 9-8) + lifestyle modification with weight loss goal as needed × 6 months**

- **FLP**

- **TG < 100 mg/dL, < 10 y, < 130 mg/dL, 10-19 y**
  - Continue CHILD 2-TG + lifestyle change
  - Reassess q.12 m

- **TG ≥ 100, < 200 mg/dL, < 10 y, ≥ 130, < 200 mg/dL, 10-19 y**
  - Intensify CHILD 2-TG + weight loss
  - Increase dietary fish content***
  - Repeat FLP in 6 m

- **TG ≥ 200-499 mg/dL**
  - If LDL-C target achieved and non-HDL-C ≥ 145 mg/dL
  - Lipid specialist for drug therapy (statin+/- fibrates+/- niacin)
  - Consider omega-3 fish oil therapy

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* Obtain FLP at least 2 weeks but no more than 3 months apart.
** Per Table 9-5, use of drug therapy is limited to children ≥ 10 y with defined risk profiles.
*** The Food and Drug Administration (FDA) and the Environmental Protection Agency are advising women of childbearing age who may become pregnant, pregnant women, nursing mothers, and young children to avoid some types of fish and shellfish and eat fish and shellfish that are lower in mercury for more information, visit www.fda.gov/food/foodsafety/prodspecificinformation/Seafood/FoodbornePathogens/Contaminants/Methylmercury/ucm175664.htm.
Figure 9-1. DYSLIPIDEMIA ALGORITHM: TARGET LDL-C (LOW-DENSITY LIPOPROTEIN CHOLESTEROL)

**Note:** Values given are in mg/dL. To convert to SI units, divide results for total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C), and non-HDL-C by 38.6; for triglycerides (TG), divide by 88.6.

Fasting lipid profile (FLP) x 2*, average results

- **LDL-C ≥ 130, < 250 mg/dL** → **Target LDL-C**
- **TG ≥ 500 mg/dL** → **Consult lipid specialist**
- **LDL-C ≥ 100, < 500 mg/dL, 10 y**
- **≥ 130, < 500 mg/dL, 10-19 y** → **Target TG**

(see TG algorithm, Figure 9-2)

Exclude secondary causes
Evaluate for other risk factors (RFs)
Start Cardiovascular Health Integrated Lifestyle (CHILD 1) → CHILD 2-LDL (Table 9-8) + lifestyle change x 6 months***

**FLP**

LDL-C < 130 mg/dL
- → Continue CHILD 2-LDL
- → Repeat FLP q. 12 months

LDL-C ≥ 130 to 189 mg/dL
- Family history (FHx) (-)
- No other RFs
- → Continue CHILD 2-LDL
- Follow q. 6 m with FLP, FHx/RF update

LDL-C ≥ 190 mg/dL
- → Initiate statin therapy

(Tables 9-11 & 9-12)

LDL-C ≥ 160 to 189 mg/dL
- FHx (+) or 1 high-level RF or ≥ 2 moderate-level RFs
- → Initiate statin therapy

(Tables 9-11 & 9-12)

LDL-C ≥ 130 to 159 mg/dL
- + 2 high-level RFs or 1 high-level + ≥ 2 moderate-level RFs OR clinical CVD
- → Initiate statin therapy

(Tables 9-11 & 9-12)

Follow with FLPS, related chemistries per Table 9-12

- → LDL-C still ≥ 130 mg/dL, TG < 200 mg/dL, refer to lipid specialist for addition of second lipid-lowering agent; monitor per Table 9-12
- → In high LDL-C patients, if non-HDL-C ≥ 145 mg/dL, after effective LDL-C treatment, → Target TG (Figure 9-2)

* Obtain FLPS at least 2 weeks but no more than 3 months apart.
** Per Table 9-5, use of drug therapy is limited to children ≥ 10 y with defined risk profiles.
*** In a child with LDL-C > 190 mg/dL, and other RFs, trial of CHILD 2-LDL may be abbreviated.
Information for Providers

The CCHIP Provider Relations and Contracting Units compose a team of qualified professionals who meet the needs of our network providers. The Provider Relations and Contracting Units have over 150 years of combined clinical, credentialing, contracting, private practice and managed healthcare experience to support over 3000 Primary Care and Specialty providers in our two primary networks; the Community Provider Network and the Regional Medical Center Network. The Provider Relations and Contracting Units are committed to solving the concerns of our providers while delivering excellent customer service and training to our providers and their staff. CCHIP cares for over 100,000 members in Contra Costa County.

Options
- Join Our Network
- Provider Bulletins
- Newsletter
- Provider/Pharmacy Directory
- Preferred Drug List (PDL)
- Clinical Guidelines
- Interpreter Services
- SPD Training
- CPN Meetings
- FSR Tool
- Health Education Resources
- Case Management (CM) Programs

Forms and Resources
- Contact Information for Noncontracting Hospitals
- Immunization’s for a Healthy Pregnancy
- SBIRT:
  - Attestation Statement | AUDIT
  - AUDIT-C
  - Growing Up Healthy | Spanish
- Eligibility Verification Form (PDF | MS-Excel)
- Member Rights | Spanish
- Grievance Form
- Claims Tracer Sheet (MS-Excel | PDF)
- Sleep Study Requisition Form
- Prior Authorization Request (PA) form | Word

http://cchealth.org/healthplan/providers/ 1/15/2015
• Disease Management Program
• Pharmacy & Therapeutics Training Resources
• Provider Manual
• Contact Us

• Medication Prior Authorization Request (PA) form
• Erectile Dysfunction Medication Questionnaire and Prior Authorization Form
• Synagis Prior Authorization Request form
• Direct Member Reimbursement Form
• Disease Management Referral Form
• NDC Training
• POLST Form
• Formulary Addition Request Form
• Child Health & Disability Prevention Program (CHDP) Brochure
• Chronic Pain Management Policy
• Neurosurgical Referral Guidelines
• Pediatric Obesity Guidelines

Staying Healthy Assessment (SHA):
• Provider Training
• Attestation Statement
• Staying Healthy Assessment Forms

See more information designed specifically for health care providers.
October 24, 2014

Re: Verifpoint/Credentialing Solutions

To our contracted providers:

Contra Costa Health Plan (CCHP) has been contracted with VerifPoint/Credentialing Solutions to provide continual credentialing and recredentialing services for CCHP’s provider network since 2010. These activities further qualify and distinguish all CCHP’s Providers with regard to meeting the comprehensive quality assurance standards established by NCQA (National Committee for Quality Assurance) and URAC (Utilization Review Accreditation Commission).

As of October 1, 2014, CCHP has added an additional service to our agreement with Verifpoint/Credentialing Solutions for obtaining all expirable documents between credentialing cycles; such as licenses, liability coverage, DEA, etc. When requested, please comply by returning a CLEAR copy of the requested documents to VerifPoint/Credentialing Solutions’ office.

CCHP’s goal in adding this service is to eliminate numerous requests and phone calls from us for expired documents and to ensure credentialing documents remain current as required by NCQA and URAC. Thank you in advance for your cooperation.

If you have any questions, please contact Provider Relations at (925) 313-9500 or by e-mail to ProviderRelations@hsd.cccounty.us.

Sincerely,

Terri Lieder, MPA, CPCS, CPMSM
Director of Provider Relations and Credentialing
Breast Reduction Referral Guidelines for PCPs

In order to save members from making extra trips and visits, please note the following guidelines re: referring a member to a Plastic Surgeon for consultation for possible Breast Reduction surgery. Be sure the member has these requirements fulfilled before referring:

- If member is over 40, they must have had a mammogram within the last year that was negative for cancer. Ask the member to take a copy of the mammogram to the Plastic Surgery visit.
- Member must have a documented three-month trial of conservative measures. This may include:
  
  Analgesic/non-steroidal anti-inflammatory drugs interventions
  
  Physical therapy/exercises/posturing maneuvers
  
  Supportive devices (e.g. proper bra support, wide strap bras)
Your baby may be at risk for flu and whooping cough

Flu can be dangerous for you and your baby, causing:

- Low birth weight
- Premature birth
- Stillbirth
- Hospitalization

Whooping cough can also be dangerous for babies, causing:

- Coughing fits
- Gasping for air
- Serious lung infections
- Hospitalization

If you’re pregnant:

- Get flu vaccine as soon as possible and
- Whooping cough (Tdap) vaccine in your third trimester of every pregnancy

The protection you get from these vaccines passes to your baby during pregnancy. Your baby counts on you for protection.

Talk to your doctor for more information

California Department of Public Health, Immunization Branch

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IMM-1145 (12-14)
Regional Center of the East Bay Supported Atameda and Contra Costa Counties

Early Start Referral RCEB Intake Referral Line 510-618-6195; Fax 510-618-7763, Attn: El Intake

REFERRAL SOURCE: (Name of agency or individual) ___________________________ Phone ___________________________

CONSENT: Verbal or written consent by Parent / Legal Guardian is required prior to this referral.
Referral cannot be processed if this is not completed.

1. ______ Verbal consent has been obtained from parent / legal guardian for referral of child to: The Early Start Program at Regional Center of the East Bay and/or LEA, ______ and if eligible, they agree to participate.

OR

2. ______ I hereby give consent for my child to be referred to The Early Start Program at Regional Center of the East Bay and/or LEA, ______ and if eligible, I agree to participate. I also consent to the exchange of verbal or written information between the referral source and RCEB, and/or LEA to gather information needed for intake.

As parent or individual legally responsible for this child, I hereby give consent for the information gathered for intake referral purpose to be shared with the qualified specialists evaluating to determine eligibility for Early Start services.

Parent / Legal Guardian Signature ___________________________ Date ___________________________
Referral Form Completed By ___________________________ Date ___________________________

Person giving info ___________________________ Relation to child ___________________________ Phone ___________________________

Internal Use Only

Referral to
RCEB
SELP
Transition
ASAP [children 30+ months]

Child’s Name ___________________________ AKA ___________________________

Last ______ First ______ Middle ______

F ______ M ______ DOB ______ SSN ______ Ethnicity ______

Student # ___________________________ District / SELPA ___________________________

Lives with ______ Parent ______ Legal Guardian ______ Foster Family ______ Other ______

Name ___________________________
Address ___________________________
Phone ___________________________

Home Phone Work Phone Cell Phone

E-mail ___________________________
Best time to call: ___________________________

Other Contact Person
(Name / Relationship to Family) ___________________________
Address ___________________________ Phone ___________________________

If Child is a Court Dependent, Children & Family Services Worker’s Name & ID # ___________________________

Agency Address ___________________________
Phone ___________________________
Fax Phone # ___________________________

If foster child: Who holds educational rights? ___________________________
If not parents, have birth parents’ educational rights been terminated or limited? ______ Yes* ______ No
* Please provide written documentation

Birth parent: Name ___________________________ Phone ___________________________
Address ___________________________

Language(s) spoken in Child’s Home (%) ___________________________ Interpreter Needed? ______ Yes ______ No
Does family have interpreter? ______ Yes ______ No Name: ___________________________ Phone ___________________________

Early Start Interagency Referral-community

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Revised December 2014
MEDICAL & BIRTH INFORMATION
Birth Weight ____________ Gestational Age ____________ Apgars ____________
Hospital; Born: ____________ Transferred to: ____________
Birthplace (city & state) ____________
Hospital Days ______ Discharge Date ______ Medical Insurance? □ Yes □ No
Pediatrician ____________ Phone ____________
Insurer ____________ Medical Record # ____________
Current or Prior Services & Agency child is involved with ____________

Documents Requested :
Submit the following relevant documents for referred child; [X] only if attached.
□ Birth / Discharge Summary □ Current Medical Reports □ Genetic Report □ Court dependency report □ Surrogate parent documentation
□ Developmental Report □ Speech, OT, or PT Evaluation □ Verification of Adoption Status

Statement of Need: (please explain developmental needs)

EARLY START ELIGIBILITY CRITERIA. [determined via evaluation] Please check appropriate box. Please explain under Statement of Need [above].
1. _______ INFANT WITH ESTABLISHED RISK CONDITION resulting in developmental disability. (i.e. Down Syndrome, Cerebral Palsy, Intellectual Disability, Autism, Epilepsy)
2. _______ EXHIBITING SIGNIFICANT DEVELOPMENTAL DELAY
3. _______ (A) At high risk for developmental delay or disability, but have yet to manifest delays (due to multiple risk factors)- identify below

MEDICAL RISK FACTORS

| Prematurity less than 32 weeks gestation and/or low birth weight of less than 1500 gm. | Central nervous system infection. |
| Assisted ventilation for 48 hours or longer during the first 28 days of life. | Biomedical insult, including but not limited to: injury, accident or illness which may seriously or permanently affect developmental outcome. |
| Small for gestational age: below the third percentile on the National Center for Health Statistics growth charts. | Multiple congenital disorders which may affect developmental outcome. |
| Asphyxia neonatorum associated with a 5-min Apgar score of 0 to 5. | Prenatal exposure to known teratogens. |
| Severe and persistent metabolic abnormality, including but not limited to: Hypoglycemia, acidemia, and hyperbilirubinemia in excess of the usual exchange transfusion level | Prenatal substance exposure, positive infant neonatal toxicology screen, or symptomatic neonatal toxicity or withdrawal. |
| Neonatal seizures or non-febrile seizures during the first three years of life | Clinically significant failure to thrive, including but not limited to: weight persistently below the third percentile for age on standard growth charts, or less than 85% of the ideal weight for age, and/or acute weight loss or failure to gain weight with the loss of two or more major percentiles on the growth curve. |
| Central nervous system lesion or abnormality. | Persistent hypotonia or hypertonia, beyond that otherwise associated with a known diagnostic condition |

3. _______ (B) High Risk for a developmental disability also exists when the regional center determines that the parent of the infant or toddler is a person with a developmental disability.

Early Start Intake Coordinator ____________ Date ____________ Phone Number ____________

Early Start Interagency Referral-community
Page 2 of 2 Revised December 2014
HEALTH ADVISORY
JANUARY 23, 2015

MEASLES

SUMMARY:
Since late December 2014, 59 cases of measles have been confirmed in California. None of the cases to date is a Contra Costa County resident but other counties in the San Francisco Bay Area have reported cases. Secondary measles exposures have likely occurred in the region. We are advising clinicians to be vigilant and to report suspected measles cases immediately.

ACTIONS REQUESTED OF HEALTHCARE PROFESSIONALS:

- MASK upon entry all patients presenting with fever. If a mask cannot be tolerated, other means should be implemented such as placing a blanket loosely over the head of infants and young children.
- SUSPECT measles in a patient presenting with fever and rash, regardless of travel history.
- IMPLEMENT airborne precautions immediately, and mask and isolate suspect patients (negative pressure room if available). Do not use any regular exam room for at least 1 hour after a suspected measles patient has left the room.
- REPORT suspect measles cases immediately to Contra Costa Public Health at (925) 313-6740 during business hours or after hours to the Health Officer On-Call at (925) 646-2441. Do not wait for lab confirmation.
- TEST suspect patients with measles serologic testing (IgM and IgG) and nasopharyngeal, throat and urine specimens for polymerase chain reaction (PCR) and viral culture. To expedite testing and reduce delay in diagnosis, testing is available through the Contra Costa Public Health Laboratory (www.cchealth.org/laboratory)
- ADVISE patient to stay home with no visitors until contacted by Contra Costa Public Health.
- VACCINATE all patients born after 1956 who have not received two documented doses of MMR, unless contraindicated. Children routinely receive MMR at 12 months and 4-6 years but the second dose may be given one month after the first dose or later.
- CONFIRM staff immunity now. Healthcare workers exposed to a measles case may not work until they provide Public Health with documentation of two doses of MMR or immunity via serologic testing.

CLINICAL INFORMATION:

- Measles is an acute viral illness characterized by a prodrome of fever (as high as 105°F) and malaise, cough, coryza, and conjunctivitis, followed by a maculopapular rash.
- Prodromal symptoms typically begin 8-12 days after exposure. The rash usually appears 14 days (range 7-21 days) after exposure.
Measles - 1/23/2015

- Measles rash is red, blotchy and maculopapular and typically spreads from head to trunk to lower extremities.
- Persons with measles are usually considered infectious from 4 days before until 4 days after onset of rash.
- No specific treatment is available for measles. Administration of vitamin A for two days has been associated with reduced risk of mortality in children less than 2 years old.

Current Recommendations:

Testing

- Collect the following specimens for measles testing:
  1) 5 mL of blood in red top or serum separator tube;
  2) Throat or nasopharyngeal swab in viral transport media; and
  3) 10-40 mL of urine in a sterile cup
- Arrange testing at Contra Costa Public Health Laboratory by contacting (925) 370-5775. The laboratory submittal form is available at: http://cchealth.org/laboratory/

Infection Control

- Provide suspect patient with a surgical mask upon entry. If possible, isolate patient (in negative pressure room if available).
- Query and suspect patients with febrile illness and rash, especially those with international travel, exposure to international travelers (including theme parks and other international tourist attractions), or possible exposure to measles patient in the 3 weeks prior to symptom onset.
- Immediately implement airborne precautions for all suspect patients.
- Confirm staff immunity now. Healthcare workers exposed to a measles case may not work until they provide Contra Costa Public Health with documentation of two doses of MMR or immunity via serologic testing.
- Allow only healthcare workers with two documented doses of MMR or serologic evidence of immunity to enter the patient’s room. These healthcare workers should use a N95 respirator.
- Do not use any regular exam room for at least 1 hour after suspected measles patient has left.
- Make note of all rooms and common areas the suspect patient traveled so if diagnosis is confirmed, then exposed people can be identified to assess measles immunity.

CDPH healthcare facility infection control recommendations are available at:

Additional Questions:

Contra Costa Public Health Communicable Disease Programs can be reached at (925) 313-6740 after hours to the Health Officer On-Call at (925) 646-2441. More information is available at: www.cchealth.org/measles and http://www.cdph.ca.gov/HealthInfo/discond/Pages/Measles.aspx