Agenda

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

When: **Time: 7:30 AM – 9:00 AM**
Date: April 19th, 2016

Where: **West County Health Center**
13601 San Pablo Ave, San Pablo, CA
Room A-1194

Attention! Please enter by the side door (on San Pablo Ave.)

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**	
	• **Legislative Updates** 1. Pharmacists prescribing OCPs 2. End of life Benefit 3. Palliative Care	Jose Yasul MD
IV.	**NEW BUSINESS**	
	• **CCHP Updates** 1. CCHP involvement locally and regionally with Opioid prescribing crisis 2. CCHP reminders and Health Education mailings to patients 3. Medi-Cal performance Dashboard	Jose Yasul MD
VI.	**OTHER**	
	• **UM Question and answer** • **Provider Concerns**	Jose Yasul MD/CCHP Staff
VII.	**ADJOURNMENT**	

Our next scheduled meeting is:

July 19th, 2016

CONTRA COSTA HEALTH PLAN
West County
Quarterly Community Provider Network (CPN)
Meeting Minutes – January 19th 2016

Attending:
CCHP Staff: M. Berkery, RN, Maria Tesolin, Jose Yasul, MD

CPN Providers: D. Fernandes, MD; K. Kaminski, PA; P. Mack, MD; J. Mahony, MD; A. Wallach, MD; G. Aguilar, PA; K. Ceci, MD; O. Eaglin, PA; R. Harrison RN, NP; K. Winter, MD.

Guests: Vi Ibarra

Discussion		Action	Accountable
	Meeting called to order @ 7:40 A.M.		M. Berkery, RN
I.	Agenda was approved with no revisions.		M. Berkery, RN
II.	**Review and Approval of Minutes from October 27th, 2015:** Minutes were approved as presented.		M. Berkery, RN
III.	**Regular Reports:** • 2015 Adult Preventative Care guidelines update. Behavioral Health: • CCHP data from March 2014 to September 2015 reviewed. • Patient Accounting received 6,964 Behavioral Health Screening Forms from MH Access Line. Out of the 6964 claims, 2175 had CCHP claims in PSP which is 31% of the total referrals. • Mental Health referral forms available online. Complex Patient Case Management Program: • New non-emergency transport program will provide transportation (bus passes, taxi service) for patients to and from medical appointments. • The specifics are still in progress. Heart Failure Guidelines: • Study results effective. Colorectal Cancer: • Power Point presentation of FIT screening test. • Colonoscopy is not always a requirement. • Refer to patient insurance and/or patient preference. Ophthalmologist: • Does not require a prior authorization. Immunization: • Handout SB277 California's New School Vaccine Law. • 2015 - 2016 Immunization matrix distributed.		Dr. Jose Yasul

IV.	**New Business** Contra Costa California Community Care Coordination Collaborative (7Cs) A grant funded program that conducts roundtable meetings which offer a forum for agency representatives to conduct care coordination on behalf of children with special needs, birth through five years, and their families. Meetings are held monthly in both West County and Central/East. Parental consent must be obtained prior to referring; consent forms and referrals distributed. Online Information: Provider Directory: http://cchealth.org/healthplan/provider-directory.php Info about Health Leads: Through our partnership with Health Leads USA, we connect patients at West County Health Center with needed services and resources addressing underlying socioeconomic issues that affect health. http://cchealth.org/centers/health-leads.php To be a clinic partner: https://healthleadsusa.org/get-involved/business-development/ Adult: http://cchealth.org/healthplan/pdf/provider/Mental-Health-Adult-Referral-MR393.pdf Child: http://cchealth.org/healthplan/pdf/provider/Mental-Health-Child-Youth-Referral-MR395.pdf		Vi Ibarra J. Yasul, MD
	Adjournment: Meeting adjourned @ 8:50 A.M.		M. Berkery, RN

Next meeting April 19th , 2016

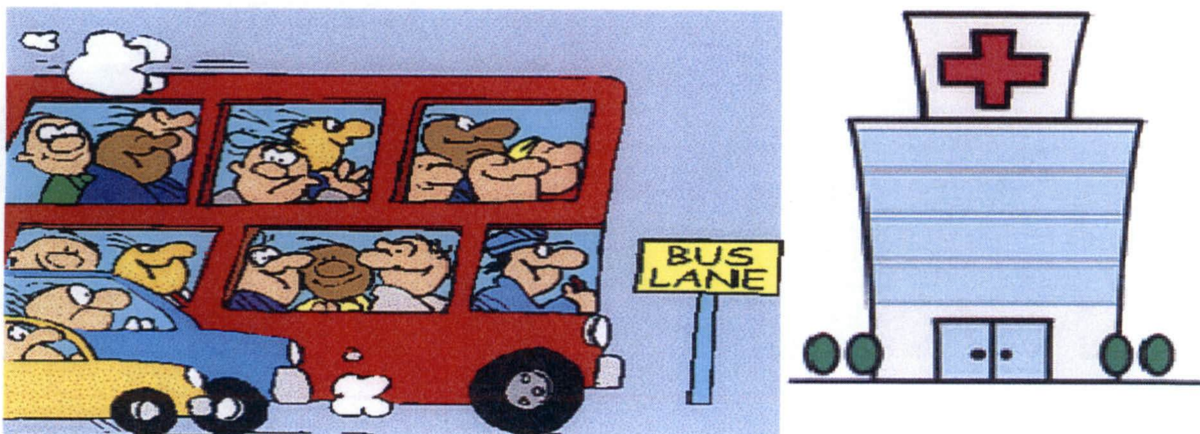
CCHP To Cover Transportation Costs To Appointments For Some Medi-Cal Members

Under a new benefit, Contra Costa Health Plan will now pay some Medi-Cal members to take a taxi, bus, para-transit or special van to get to medical appointments. The benefit, which is being required of all managed Medi-Cal plans in the state, went into effect April 1, 2016.

CCHP members with Medi-Cal may now have some transportation costs covered for getting to and from medical appointments. In order for children and people under 21 to qualify, the services must be covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Additionally, dialysis patients, cancer patients receiving chemotherapy or radiation therapy, prenatal patients and those under CCHP case management can be eligible. The member must also demonstrate a need for this service.

The Health Plan asks that members arrange for rides five days before their appointments—or call CCHP as soon as possible if it's an urgent appointment. Patients need to call **855-222-1218** for CCHP authorization. The new benefit is separate from transport services from an ambulance, litter van or wheelchair van.

CCHP Chief Executive Officer, Patricia Tanquary, said the new benefit will help patients get the care they need in a timely way. Many patients miss appointments because they can't afford transportation.



CPN Provider Bulletin – Immunizations Update

As a contracted provider for CCHP, the plan fully expects that you will provide vaccination services to our adult members. With that said, the plan realizes that there may be times when a certain vaccine is unavailable for administration in the office. For this reason, CCHP has expanded vaccination services available at Walgreens and Rite Aid stores throughout the county. Effective May 1st, 2016 the following vaccines will be available to all CCHP members age 19 and over as a pharmacy benefit:

• **Immunizations (Vaccines)**		
****Use of all vaccines must be based on the guidelines published by the Centers for Disease Control and Prevention (CDC)****		
Haemophilus B Vaccine	ACTHIB	**AL:** >18 years old **QL:** 3 fills per lifetime
Hepatitis A Vaccine	HAVRIX	**AL:** >18 years old **QL:** 2 fills per lifetime
Hepatitis B Vaccine	ENGERIX B	**AL:** >18 years old **QL:** 3 fills per lifetime
Hepatitis A+B Vaccine	TWINRIX	**AL:** >18 years old **QL:** 3 fills per lifetime
Human Papilloma Virus Vaccine	CERVARIX, GARDASIL, GARDASIL 9	**AL:** 19-26 years old **QL:** 3 fills per lifetime
Influenza Vaccine	FLUZONE, FLUZONE QUAD, FLUMIST, FLUVIRIN, FLUCELVAX, AFLURIA, FLULAVAL	**AL:** >18 years old (>65 years old for high dose flu) **QL:** 1 fill per 270 days
Measles/Mumps/Rubella Vaccine	MMR	**AL:** >18 years old **QL:** 2 fills per lifetime
Meningococcal Vaccine	BEXSERO, MENVEVO, MENOMUNE, MENACTRA, TRUMENBA	**AL:** >18 years old **QL:** Bexsero, Menactra, and Menvevo (2 fills per lifetime), Menomune (1 fill per lifetime), Trumenba (3 fills per lifetime)
Pneumococcal Vaccine	PREVNAR 13, PNEUMOVAX 23	**AL:** >50 years old **QL:** Prevnar 13 (1 fill per lifetime), Pneumovax 23 (2 fills per lifetime)
Rabies Vaccine	IMOVAX, RABAVERT	**AL:** >18 years old
Tetanus/Diphtheria Vaccine	TENIVAC	**AL:** >18 years old
Tetanus/Diphtheria/Pertussis Vaccine	ADACEL, BOOSTRIX	**AL:** >18 years old
Varicella Vaccine	VARIVAX	**AL:** >18 years old **QL:** 2 fills per lifetime
Zoster-vaccine, live attenuated	ZOSTAVAX	**AL:** must be at least 60 years old **QL:** 1 fill per lifetime
AL = age limit, QL = quantity limit		

News Release

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

FOR IMMEDIATE RELEASE
February 01, 2016
PH16-005

CONTACT: Orville Thomas
(916) 440-7259

California Department of Public Health Reminds Public to Guard Against Mosquito Bites

SACRAMENTO – The California Department of Public Health (CDPH) Director and State Public Health Officer Dr. Karen Smith today advised that although there is no evidence of mosquitoes carrying Zika virus in California, people should always take steps to avoid mosquito bites, including removing standing water and wearing insect repellent when necessary. Californians should also be advised of international travel alerts for the countries where Zika virus is circulating.

"Although no one has contracted Zika virus in California, mosquito bites can still be harmful and the public should take steps to protect themselves," said Dr. Smith. "Help reduce the risk of mosquito bites by removing standing water from around your home and wearing mosquito repellant when appropriate."

As of January 29, 2016, there have been six confirmed cases of Zika virus in California, all of which were contracted when traveling in other countries with Zika virus outbreaks in 2013 (1), 2014 (3) and 2015 (2). CDPH will continue monitoring for any confirmed cases in California and will provide weekly updates every Friday. To protect patient confidentiality, specific locations of infected patients cannot be disclosed.

Zika virus is primarily transmitted to people by *Aedes aegypti* and *Aedes albopictus* mosquitoes, the same mosquitoes that can transmit dengue and chikungunya viruses. These mosquitoes—which are not native to California—have been identified in 12 California counties, although there are no known cases where the mosquitoes were carrying the Zika virus in this state. The six confirmed cases of Zika virus in California were acquired in other countries.

The Centers for Disease Control and Prevention (CDC) have issued a travel alert (Level 2-Practice Enhanced Precautions) for people traveling to regions and certain countries where Zika virus transmission is ongoing: American Samoa, Brazil, Colombia, Costa Rica, Curacao, El Salvador, French Guiana, Guatemala, Haiti, Honduras, Martinique, Mexico, Nicaragua, Panama, Paraguay, Suriname, Venezuela and Puerto Rico.

People traveling to these and other countries with known Zika virus risk should take steps to avoid being bitten by mosquitoes, including:

- Use insect repellents containing DEET, picaridin, IR3535, oil of lemon eucalyptus, or para-menthane-diol for long lasting protection. If you use both sunscreen and insect repellent, apply the sunscreen first and then the repellent. Pregnant women

and women who are breastfeeding can and should choose an EPA-registered insect repellent and use it according to the product label

- Wear long-sleeved shirts and long pants
- Use air conditioning or window/door screens to keep mosquitoes outside. If you are not able to protect yourself from mosquitoes inside your home or hotel, sleep under a mosquito bed net
- Help reduce the number of mosquitoes outside by emptying standing water from containers such as flowerpots or buckets

The CDC and CDPH have also issued guidance for pregnant women recommending they avoid countries where Zika virus is circulating. Pregnant women who cannot avoid travel to these countries should talk to their health care provider and take steps to avoid mosquito bites. The CDC and CDPH have also provided guidance for physicians on the evaluation of pregnant women and infants who may have been exposed to Zika virus.

Most people infected with Zika virus will not develop symptoms. If symptoms do develop, they are usually mild and include fever, rash and eye redness. If you have returned from an affected country and have fever with joint pain, rash within two weeks, or any other symptoms following your return; please contact your medical provider and tell the doctor where you have traveled. While there is no specific treatment for Zika virus disease, the best recommendations are supportive care, rest, fluids and fever relief.

There is concern that Zika virus may be transferred from a pregnant woman to her baby during pregnancy or delivery. Preliminary reports suggest that Zika virus may cause microcephaly (a condition in which an infant's head is significantly smaller than the heads of other infants of the same age and sex). This possibility has not been confirmed and is being actively investigated. CDPH has requested that health care providers report suspected Zika virus disease or associated conditions of microcephaly to local health departments. Local health departments will report cases to CDPH, which is coordinating referral of any specimens to CDC for diagnostic testing.

For more information on Zika virus disease and other mosquito-borne illnesses, please visit the CDPH Zika virus information webpage.

www.cdph.ca.gov

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Health Advisory

March 4, 2016

Warning Regarding Misuse and Abuse of Prescription Opioids

This Health Advisory is being issued to bring attention to an alarming trend and national epidemic of misuse and abuse of prescription opioids and sedatives. As our communities and families face the devastation of loss associated with addiction and misuse of these prescription medications we call attention to the need for health care professionals to be aware of the scope of this epidemic and new guidelines for prescribing.

Nationally, each year, prescription narcotics result in more fatal overdoses than heroin and cocaine combined. Add to this that the second leading cause of fatal overdoses are prescription sedatives — medicines like Xanax and Ativan, and we are compelled to recognize and address the unintended consequence that may result from the misuse of these medications. Parallel with this trend is a resurgence in overdoses related to heroin abuse.

Data from the California Department of Public Health reveals that there were 53 accidental drug overdose deaths in 2003 in Contra Costa County. In 2008 there were 84 and in 2013 there were 113. Of profound concern is the trend that underlies these occurrences. What we are experiencing in our County is, tragically, mirrored across the Nation. Information from the Centers for Disease Control and Prevention reveals that the death rate from drug overdose has more than doubled since 2000 and on a national level has claimed the lives of nearly 500,000 individuals during this same time period. In 2014 there were 47,055 deaths from drug overdose, more than any previous year on record. Drug overdose has now replaced automobile accidents as the number one cause of accidental death among individuals age 25-64. http://www.cdc.gov/mmwr/pdf/wk/mm6450.pdf

According to the Centers for Disease Control and Prevention, prescription opioid sales in the United States increase by 300% between 1999 and 2010. *CDC Vital Signs MMWR 2011:60(43); 1487-1492*. Between 1999 and 2013 the number of deaths attributed to opioid pain relievers had increased by 400%, http://www.cdc.gov/nchs/deaths.htm

A Call to Action:

Counties, health systems and community partners across the greater bay area are galvanized in their efforts to address this epidemic. Closer to home, the Alameda-Contra Costa Medical Association together with local public health agencies, health insurers, community partners and health care provider organizations are calling for Emergency Departments, Urgent Care Centers and Primary Care clinicians to adopt a set of guidelines for prescribing opioids. These guidelines are intended to help balance the need for the treatment of pain with the very real risk of drug dependency, abuse and addiction. Electronic copies of the guidelines and other helpful information can be downloaded from www.EastBaySafeRX.org.

The guidelines are also attached here for reference. In addition, health systems are expanding the availability of drug treatment programs, medication assisted treatment, and drug counseling services.

Prescription drug abuse is a complex social problem that requires new dialogue, innovative solutions and the engagement of our health care community. Launched in May 2015, East Bay Safe Prescribing Coalition brings together stakeholders across sectors, including physicians, pharmacists, schools, law enforcement agencies, public health officials and concerned community members to design and implement local strategies for prevention and awareness. Efforts by regional health care delivery systems and health insurers have shown positive results in reducing the number of prescriptions for opioid-based pain medication. In addition, the Contra Costa MEDS (Medication Education and Disposal Safety) Coalition is a community based effort that has engaged multiple sectors, communities and partners to advance awareness and develop local strategies to help prevent the misuse of prescription medication. Individuals interested in joining coalition efforts are encouraged to contact Coalition chair, April Rovero, at 925-980-5490.

Individuals seeking confidential assistance with drug abuse treatment can contact 1-800-662-HELP (4357). Individuals can also contact the Contra Costa Behavioral Health Department at 1-800-846-1652, Monday-Friday 8:00am to 5:00. Providers or the Public can also contact the California Poison Control Center at: 1-800-222-1222. More information can be found at: http://www.samhsa.gov/prescription-drug-miuse-abuse or from the CDC at http://www.cdc.gov/drugoverdose/states/state_prevention.html

WILLIAM B. WALKER, MD
HEALTH SERVICES DIRECTOR

DAN PEDDYCORD, RN, MPA/HA
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HEALTH ALERT

APRIL 7, 2016

OPIOID OVERDOSES POSSIBLY RELATED TO COUNTERFEIT NORCO CONTAINING FENTANYL

SUMMARY:

Contra Costa Public Health received 2 reports of opioid-related overdoses in March 2016 possibly associated with ingestion of counterfeit Norco prescription pain pills being sold on the streets. Elsewhere in California, including Sacramento County, dozens of patients have been reported with overdoses due to counterfeit pills which contained the synthetic opioid fentanyl instead of the active ingredients of Norco (acetaminophen and hydrocodone).

Actions Requested of Healthcare Professionals:

1. **REPORT suspected and confirmed drug poisoning cases** to Contra Costa Public Health at 925-313-6740 or after hours 925-646-2441 including:
   a. Emergency Department visits due to opioid overdoses
   b. All deaths due to opioid overdoses

   Medical records should be sent via confidential fax to 925-313-6465.

2. **CONSIDER** toxicology screening specific for fentanyl in cases of severe overdoses.

3. **WARN** clients and patients against taking prescription-like pills that are not prescribed by a health care provider and dispensed by a pharmacy. Counterfeit Norco pills containing fentanyl are very difficult to distinguish from actual Norco pills. Fentanyl is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.

ADDITIONAL QUESTIONS:

Contra Costa Public Health can be reached at 925-313-6740 or after hours 925-646-2441. Our confidential fax number is 925-313-6465.

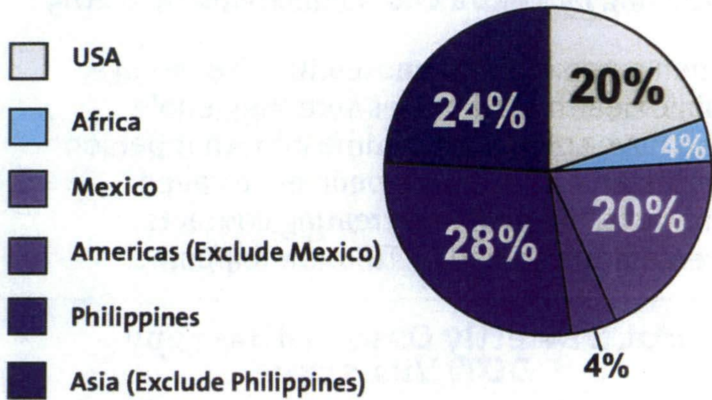
TUBERCULOSIS in Contra Costa County 2015

46 Number of People Diagnosed with TB Disease in 2015

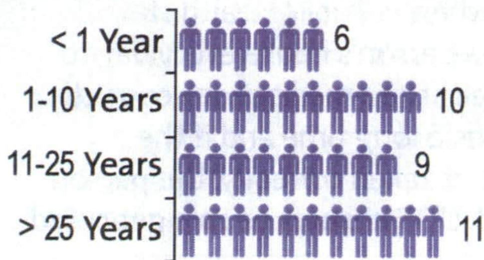
4.1 TB Disease Rate per 100,000 People in Contra Costa

5.5 TB Disease Rate per 100,000 People in California

Origin of People with TB Disease, 2015



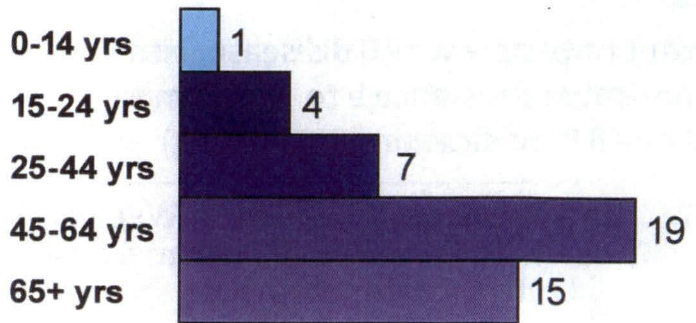
Length of Time in US for Foreign-Born People with TB Disease, 2015



If a person comes from a country with a high rate of TB, that person is more likely than other Contra Costa residents to have latent TB infection. Five to 10 percent of people with latent TB will go on to get sick with TB disease – sometimes many years later.

Tuberculosis (TB) is a disease caused by bacteria that is passed from person to person through the air. Not everyone who becomes infected with TB will become sick: most people will get what is called latent TB. This means they have the TB bacteria in their body but their immune system is keeping the bacteria under control. People with latent TB do not have any TB symptoms and cannot pass on the disease, but they are at risk of getting sick with TB disease in the future if their immune system can no longer keep the TB bacteria under control. Both TB disease and latent TB are treatable and curable!

Age Distribution of People with TB Disease, 2015



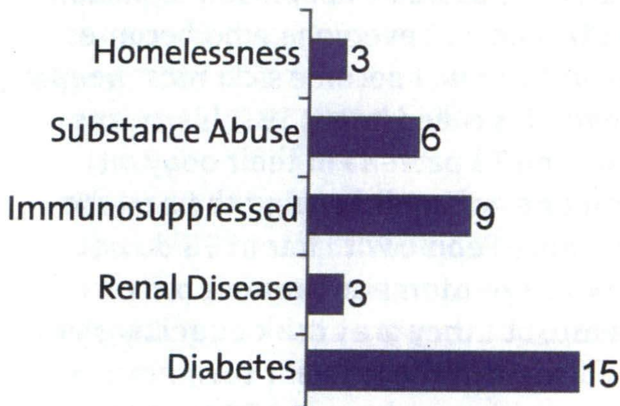
Older people are more likely to get sick with TB disease. They can have latent TB for many years and then get sick as their immune system weakens.

For more information, call the Contra Costa Public Health Tuberculosis Program at 925-313-6740 or visit cchealth.org

CONTRA COSTA HEALTH SERVICES

TUBERCULOSIS in Contra Costa County 2015

Risk Factors for People with TB Disease, 2015

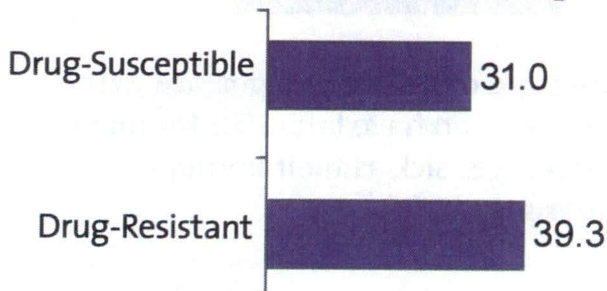


Almost half of people with TB disease in 2015 had a risk factor that made them more vulnerable to TB disease. These risk factors can also complicate TB treatment.

Drug Resistance

Percent of people with TB disease with demonstrated resistance to one or more first-line TB medications. (2010-2014)

Median Treatment Length in Weeks for Those who Completed Treatment in Contra Costa, 2010-2014



Treatment of drug-resistant TB takes longer and requires using medications that can have more harmful side effects. Treatment of patients with multi-drug resistant TB (resistance to the two most effective, first-line medications) can take more than twice as long as standard TB treatment.

The number of patients with confirmed active TB represents only a fraction of the patients that we follow in the TB Program.

Average number of contacts exposed by a person with contagious TB in 2015

Total number of contacts identified for screening by Contra Costa Public Health in 2015

When a person is diagnosed with TB disease, Public Health staff makes sure the people who have spent a lot of time with that person get tested for TB. These people are called "contacts." Testing and treating contacts prevents the spread of TB to more people.

Total Directly Observed Therapy (DOT) Visits, 2015

Public Health staff also provide Directly Observed Therapy (DOT) to people with TB. DOT is a service where a Public Health staff member goes to a person's house every day to make sure they take their medications correctly. TB treatment takes a long time and if the medications are not taken correctly, the person may not be cured. DOT ensures people get cured.

Prepared by Contra Costa Health Services, Public Health Communicable Disease Programs. Data obtained from the Contra Costa Public Health Tuberculosis Program and the California Department of Public Health Tuberculosis Control Branch.

CONTRA COSTA
HEALTH SERVICES

PATRICIA TANQUARY, MPH, PhD
Chief Executive Officer

JAMES TYSELL, MD
Medical Director

A Culture of Caring

ADMINISTRATION

595 Center Avenue, Suite 100
Martinez, California 94553
Main Number: 925-313-6000
Member Call Center: 877-661-6230
Provider Call Center: 877-800-7423

Se Habla Español

Free Webinar & CE Credits: Smoking Cessation and Pregnancy

The California Smokers' Helpline is pleased to host this free webinar, *How to Talk with Patients about Smoking Cessation and Pregnancy*, on **Wednesday, April 20th from noon to 1pm PST.**

The relationship between pregnancy and smoking is a significant concern among health professionals. Smoking during pregnancy can cause low birth weight, sudden infant death syndrome (SIDS), learning and behavior problems, and lung problems. Quitting smoking while pregnant can increase the chance of having a healthy baby. This webinar will address key strategies to help pregnant smokers to quit.

The following continuing education credits are being offered for this course: CA BBS, APA, CCAPP, CAADE, and CME.

This course is designed for primary care providers and behavioral health professionals interested in the most current research surrounding smoking cessation and pregnancy.

Objectives

At the conclusion of this activity, participants should be able to:

- Discuss the evidence regarding tobacco use among pregnant women
- Talk with patients or clients about the relationship between pregnancy and tobacco cessation
- Identify and implement evidence-based treatment for treating tobacco dependence

To sign up:

Call **California Smokers' Helpline Communications Department** at (858) 300-1010.

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR.
Governor

March 30, 2016

To: CCLHO
CHEAC
Communicable Disease Controllers

Dear Colleagues,

Thanks to everyone's extraordinary efforts during the Ebola response, we were able to rapidly mobilize and incorporate CDC recommendations for travel screening. Fortunately, the acute response to Ebola is no longer needed and targeted travel screening for Ebola exposure can end.

As we transition away from the acute Ebola crisis, to remain vigilant and build upon the existing infrastructure created for Ebola response, CDPH strongly recommends that:

- Effectively immediately, healthcare providers cease inquiring about recent travel focused solely on Ebola affected countries.
- Instead, all patients should receive and have documented a recent travel screening history especially those patients with fever, rash, and/or acute respiratory symptoms. The travel history should be incorporated into a patient's routine intake and screening.
  - This may provide an early warning for new and re-emerging infectious diseases.
  - If feasible, we strongly encourage the travel history be incorporated into Electronic Medical Records to trigger screening and facilitate documentation.
  - If new diseases emerge that require screening and acute triage, a system will already be in place to document travel history and any needed algorithm for isolation during patient care may be more easily incorporated into the patient intake form.
- Healthcare and emergency medical service providers maintain situational awareness of travel-related infectious diseases.

CDPH will keep you abreast of any emerging diseases that require specific screening through HAN releases, statewide calls and updates on the website. For all other non-acute, travel-related diseases that should be considered for patients with a travel

CDPH Center for Infectious Diseases, MS 7300 • 1616 Capitol Avenue • Sacramento, CA 95814
(916) 445-0062 • (916) 445-0274 FAX
Internet Address: www.cdph.ca.gov

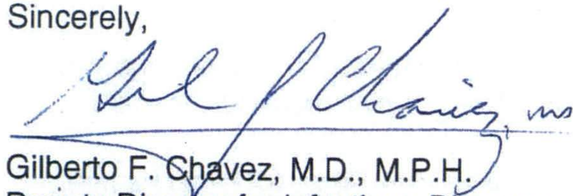
history, please refer to the CDC traveler's health webpage available at: http://wwwnc.cdc.gov/travel.

CDPH would like to ask you to please share this information widely with all healthcare providers in your jurisdiction. It is important that healthcare providers adopt this recommendation uniformly.

Thank you for all your dedication and hard work with the Ebola response and your continued diligence in protecting the public's health from infectious diseases. Let us use this as an opportunity to ensure all patients receive a travel history so we are prepared for the next acute disease response.

If you have any questions please contact Dr. Neha Shah at neha.shah@cdph.ca.gov or (510) 620-3056.

Sincerely,



Gilberto F. Chavez, M.D., M.P.H.
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Screening and Early Diagnosis of Colorectal Cancer

Caroline Peck, MD, MPH, FACOG

State Chronic Disease Director

California Department of Public Health

October 15, 2015

Colorectal Cancer 2014

- 4th most common cancer: 14,260 cases
- 2nd leading cause of cancer deaths in Californians (5,265 deaths) exceeded only by lung cancer (12,690 deaths)
- Colorectal cancer (CRC) is only diagnosed at an early stage in 43% of cases, as compared to 65% of breast and 80% of prostate cancer cases

California Cancer Facts & Figures 2014

California Department of Public Health

CRC Screening Performance Measure

Office of the Patient Advocate Report Card 2015-16

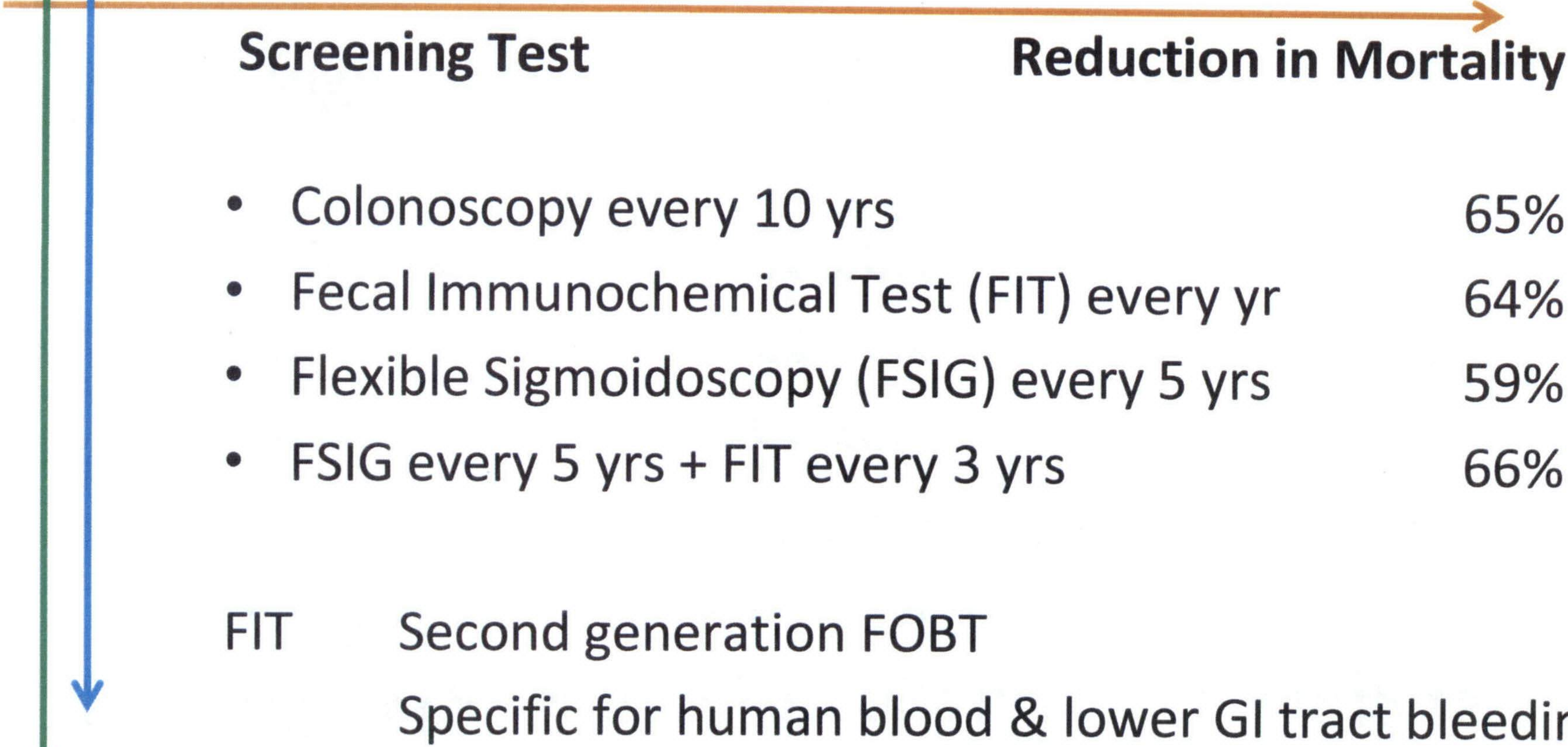
HEDIS Measure for Colorectal Cancer Screening

	% eligible who are screened
HMO	*60-80%*
PPO	*50-60%*
Medical Groups	*20-80%*
Healthy People Goal	*70.5%*

www.opa.ca.gov

CDPH California Department of PublicHealth

Screening Tests Decrease CRC Mortality



U.S. Preventive Services Task Force Colorectal Cancer Screening Guidelines - adults from 50 – 75 yrs

Ann Intern Med 2008;149:659-669

CDPH Recommends

All health care systems adopt **FIT** as the first line screening test for CRC

"First FIT"

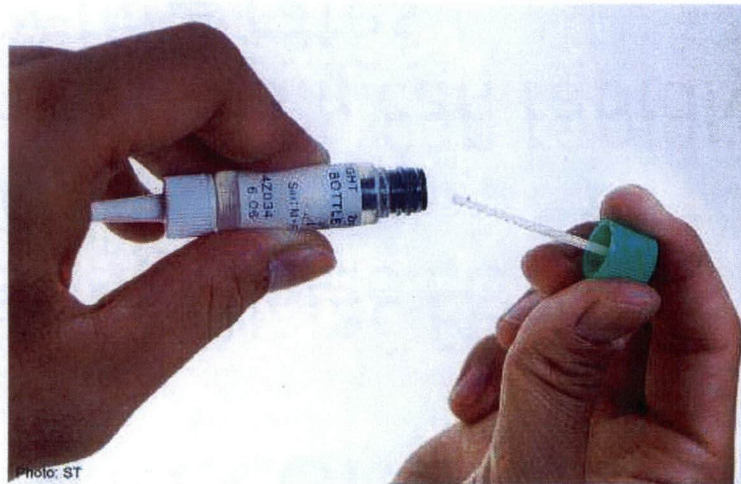
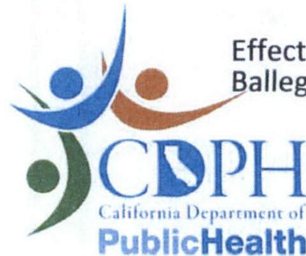


Photo: ST

CDPH
California Department of
PublicHealth

Why Recommend FIT?

- Preferred to guaiac FOBT, FSIG, and colonoscopy
- If Kit sent by mail, can rapidly increase CRC screening rates
- Saves $191 per person screened
- For every dollar spent on a FIT screening program over the lifetime of an individual, 11% is saved in treatment costs
- Colonoscopy not cost saving



Effect of Rising Chemotherapy Costs on the Cost Savings of Colorectal Cancer Screening; I Lansdorp-Vogelaar, M van Ballegooijen AG Zauber, JDF Habbema, EJ Kuipers; J Natl Cancer Inst 2009;101:1412-1422.

Advantages of FIT

- No risk of bowel perforation (less invasive)
- No bowel preparation or sedation needed
- Results not influenced by foods or medications
- Picked up during an office or lab visit, or mailed to patient
- Sample collected at home
- Easier to access and lower cost compared to other CRC screening tests

CRC Screening Rate Increase of 31% in 1 Year Using FIT

Best Practice!

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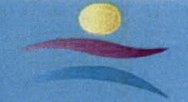
Quality Improvement Project



- CRC screening rate of 17% in 2012
- Identified as a priority by Quality Improvement (QI) Committee
- QIP Goal: increase CRC screening rate
- Used Plan-Do-Study-Act model
- Involved a multidisciplinary team
- Used EHR, data analytics, new clinic protocols/procedures, patient education
- Involved Community Partners

Inreach

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- Huddles/pre-visit planning

Preventive Medicine (Ecw, Andrew - 12/12/2013 03:30 PM, EST) *

Pt. Info Encounter Physical Hub

Preventive Medicine
- Daily Huddle
- Post Visit Summ
- Tobacco Cessati
- *Peds NHC antic
- Asthma Educatic
- PNTL AFP
- PNTL Vaginitis
- PNTL UTI
- Project Dulce Cl
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- Project Dulce Ba
- Diabetic Teachir
- FPACT Handouts
- FPACT Medicatic

Daily Huddle

Symptom	Presence	Notes
Reviewed: Everythin		
Notes:		
Reviewed Labs		
Reviewed DI		
Reviewed HME		
Needs FIT		Yes
Needs Pap		
Needs Mammogram		
Needs Immunization		
Reviewed Referrals		
Reviewed last note		
Timestamp:		
Nothing to prep, chai		

Notes Browse ... Clear Select Default... Clear All...

Assessments Custom Treatment

CDPH California Department of PublicHealth

Inreach

- eCW Alerts expanded point of service information application added to EMR
- Patients due for CRC screening identified

eCW Alerts

Alerts | Opps

Ecw,Alex (age:65)

DM, HTN, 10y CVD risk: Insufficient data

A1C:	none	
LDL:	none	
Microalb:	none	
Foot exam:	none	
Optho:	none	Ref: none
A.L.L.:	Asa Statin Ace/Arb	
BP:	1/1/00	-1/-1
BMI	none	
CRC:	none	Pend: none
PHQ2/9:	none	
Imms due:	Zoster,PCV13,Flu,Tdap	
Tobacco:	Not assessed	

Updated: seconds ago

eCW Alerts

Alerts | Stats | Opps

Cancer Screening Opportunities

Today Last Wk Last 30 Days

	Addressed
Liu	100% (5 of 5)
Oshrin	100% (5 of 5)
Shoukry	100% (4 of 4)
McFarland	85% (6 of 7)
Tasher	83% (5 of 6)
Held	77% (7 of 9)
Catling	75% (3 of 4)
Guffey	75% (3 of 4)
Nejati	75% (3 of 4)
Vishtell	71% (5 of 7)
Carlos	66% (2 of 3)
Laverdiere	66% (4 of 6)
Shanks	66% (2 of 3)
Thiermann	66% (2 of 3)
Ayon Martinez	62% (10 of 16)
Louie	60% (3 of 5)
Tantod	60% (3 of 5)
Page	57% (4 of 7)
Rodarte	57% (4 of 7)
Bagnasco	50% (3 of 6)
Ede	50% (2 of 4)
Hastanan	50% (2 of 4)
Muchnik	50% (5 of 10)
Miller	40% (2 of 5)
Patrick	40% (2 of 5)
Samorano	40% (4 of 10)
Chen	33% (2 of 6)
Juarez	33% (2 of 6)
Nakamura	22% (2 of 9)
Jackson	10% (1 of 10)
Allen	0% (0 of 1)
Cherry	0% (0 of 1)
McCarberg	0% (0 of 1)
Willis1	0% (0 of 2)

Last update:02/24/2015 at 11:16AM
Last accessed:02/24/2015 at 11:17AM
(Updated every 10 minutes)
(Mouse over to show your needs...)

Organization-Wide Reports

Huddle Reports shared monthly at each site with providers and leadership

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Care Transformation Report Card
Organization Wide
August 2014

Organization Wide Pre-Visit Planning (Huddles)
Period for: 08/01/2014-08/31/2014
Standard: 75%

Site	Value
El Cajon	75.73%
Elm	87.48%
Grand	93.96%
Lakeside	89.90%
Pauma	98.82%
Peds/ Prenatal	80.48%
Temecula	76.18%
Valley Parkway	87.21%
Org. Wide	82.46%

Outreach

Use community health center registry to identify patients due for CRC screening

orhood Healthcare Registry *(Last data update: 2/23/2015)*
y] [Dashboard] [Trends]

Filter: Needs CRC screening | Facility: Elm | Provider: (any) | Search
Insurance: (ignore) | Account#: | ☑ Hide Done/Suppressed | ☐ For export | ***850 records retrieved.***

Provider	Insurance	Dx	BP	A1C	LDL	On Ace/Arb / Statin	Smoker : date - Counselled	Last Appt	Next Appt	#ER F/Us	CVD Risk	FIT	Dulce	Glucose	INR	Needs
Christie,Patricia	Medicare FQHC - Valley Parkway	DM	144 / 86 : 6/9/2014	8.5 : 10/15/2013	142 : 10/15/2013	Y/Y	N : 2/15/2015 - N	6/9/2014	7/15/2014	1	46.4%		1	233	1/1/00	BP,A1C,LDL,FIT
No NHC,PCP	HN Medi-Cal VMG/Elm	DM, HTN	127 / 91 : 1/23/2015	11.7 : 1/19/2015	165 : 1/19/2015	Y/N	Y : 1/23/2015 - 01/19/2015	1/23/2015	3/16/2015	0	39.8%		1	421	1/1/00	FIT
Hastanan,Carol	Humana MEDICARE ADVANTAGE HMO/VMG	DM, HTN	121 / 60 : 2/3/2015	7 : 2/13/2015	164 : 2/13/2015 (non-hdl)	N/Y	N : 2/16/2015	2/3/2015	3/13/2015	0	36.8%		0	0	1/1/00	pneumo,FIT
Chen,Margaret	Communicare MEDICARE HMO	HTN	147 / 74 : 12/4/2014		104 : 5/17/2012	N/Y	N : 12/4/2014	12/4/2014	1/12/2015	0	31.1%		0	0	1/1/00	pneumo,FIT
Nakamura,Melanie	CHG Medi-Cal Elm	DM, HTN	140 / 76 : 3/27/2014	7.2 : 4/2/2014	126 : 4/2/2014	Y/Y	N : 3/27/2014	4/2/2014		0	30.7%		1	0	1/1/00	BP,A1C,LDL,FIT,Mammo
Negron,Caroline		DM, HTN	158 / 98 : 1/6/2015	9.3 : 1/3/2015	999 : 1/3/2015	Y/Y	N : 12/9/2014 - 08/26/2014	1/3/2015	1/3/2015	0	30%		0	0	1/1/00	FIT
Schultz,James	Medi-Cal FQHC Elm	DM	142 / 84 : 2/17/2015		107 : 12/26/2014	Y/Y	Y : 2/17/2015 - 12/30/2014	12/31/2014	2/24/2015	0	29.9%		0	141	1/1/00	A1C,FIT
Dodge,Geraldine		DM, HTN	155 / 72 : 12/16/2014	6.3 : 12/6/2014	75 : 12/6/2014	N/N	N : 12/16/2014	12/16/2014	12/19/2014	0	29.5%		0	0	1/1/00	FIT
Hastanan,Carol	HN Medi-Cal VMG/Elm	DM, HTN	128 / 74 : 2/6/2015	9.3 : 12/18/2014	96 : 12/18/2014	Y/N	N : 2/6/2015	2/6/2015	3/5/2015	0	27.8%		1	286	1/1/00	FIT
Chen,Margaret	Medi-Cal FQHC Elm	DM, HTN, CVD	162 / 74 : 2/19/2015	6.2 : 2/19/2015	105 : 2/19/2015	Y/Y	N : 2/19/2015	12/4/2014	2/19/2015	1	27.4%		0	0	2/19/15	pneumo,FIT,Mammo
Butler,Rachel		DM	141 / 69 : 2/19/2015	8.7 : 2/19/2015	999 : 2/19/2015	Y/Y	N : 2/19/2015	12/20/2014	2/19/2015	0	27.3%		0	199	1/1/00	FIT
Cook,Lisa	HN Medi-Cal VMG/Elm	HTN	157 / 92 : 12/3/2014		168 : 12/6/2014	Y/Y	N : 12/3/2014	12/6/2014	2/23/2015	0	26.1%		0	0	1/1/00	pneumo,FIT
Chen,Margaret	Molina Medi-Cal Elm	DM	158 / 92 : 2/4/2015	10.8 : 2/4/2015	205 : 2/4/2015	N/Y	Y : 2/4/2015 - 12/24/2014	2/4/2015	3/26/2015	0	24.7%		0	231	1/1/00	FIT,Mammo
Nakamura,Melanie	Medicare FQHC - Elm	HTN	152 / 76 : 2/3/2015		108 : 1/10/2015	Y/N	N : 2/3/2015	2/3/2015		0	23.3%		0	0	1/1/00	FIT,Mammo
x-Sharma,Minu	CHG Medi-Cal Elm	HTN	142 / 66 : 12/2/2014		269 : 12/2/2014 (non-hdl)	N/N	Y : 12/2/2014 - 04/23/2013	12/2/2014		0	22.4%		0	0	1/1/00	FIT,Mammo
Nakamura,Melanie	Medicare FQHC - Elm	HTN	157 / 91 : 1/26/2015	5.4 : 5/8/2014	78 : 2/16/2015	Y/N	N : 1/26/2015 - 05/08/2014	1/26/2015	2/23/2015	0	20.6%		0	0	1/1/00	pneumo,FIT

Screening Rate Increase

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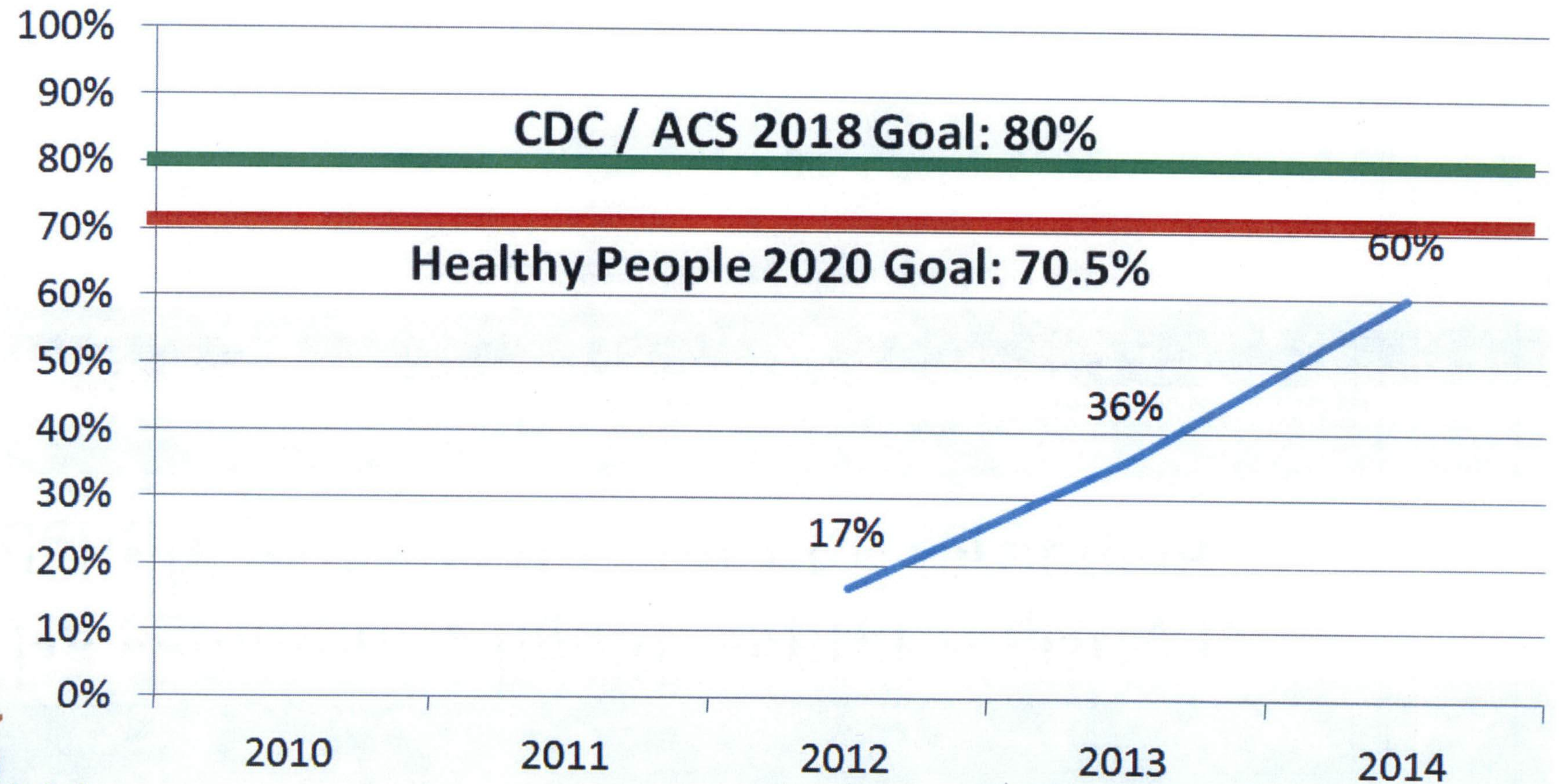
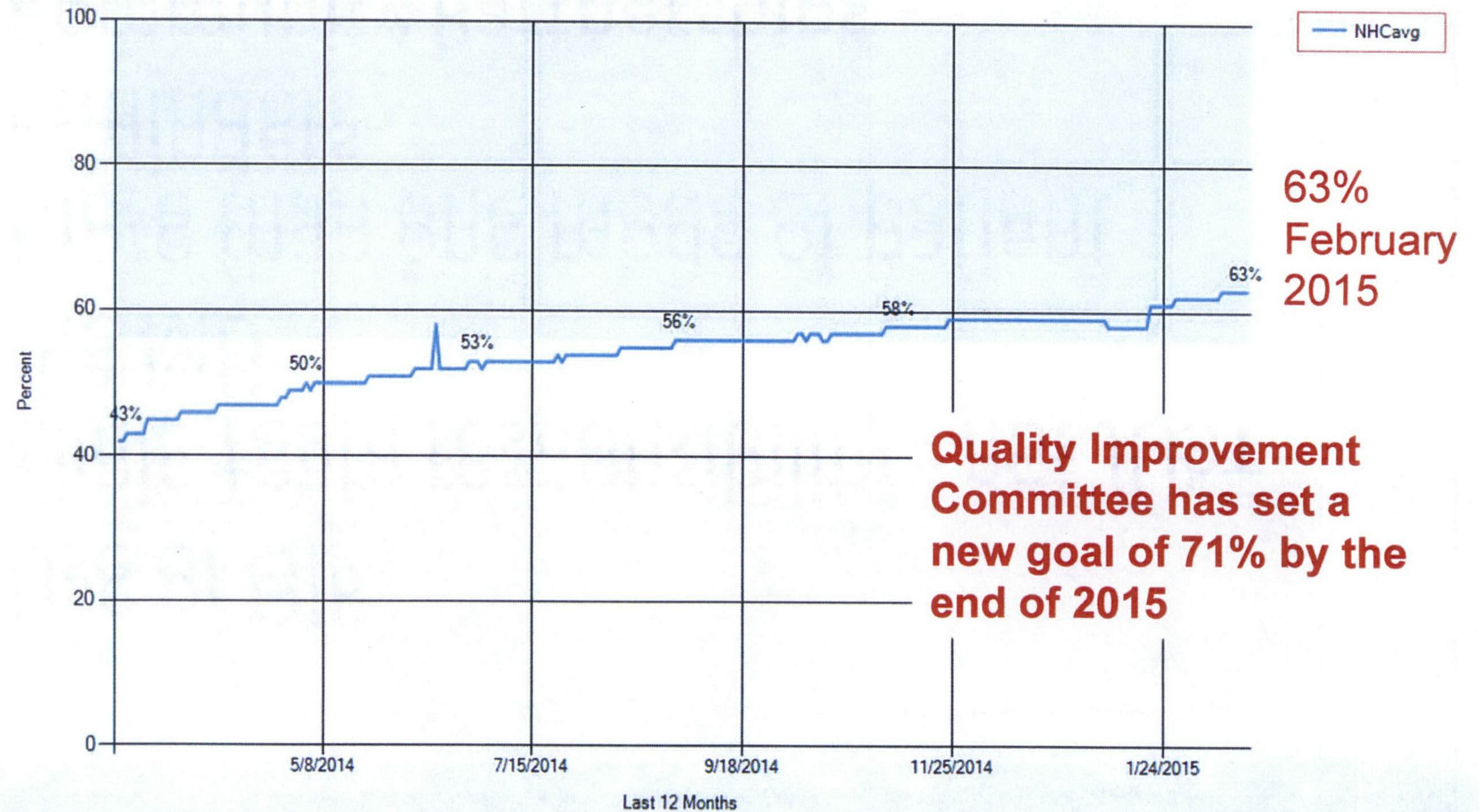


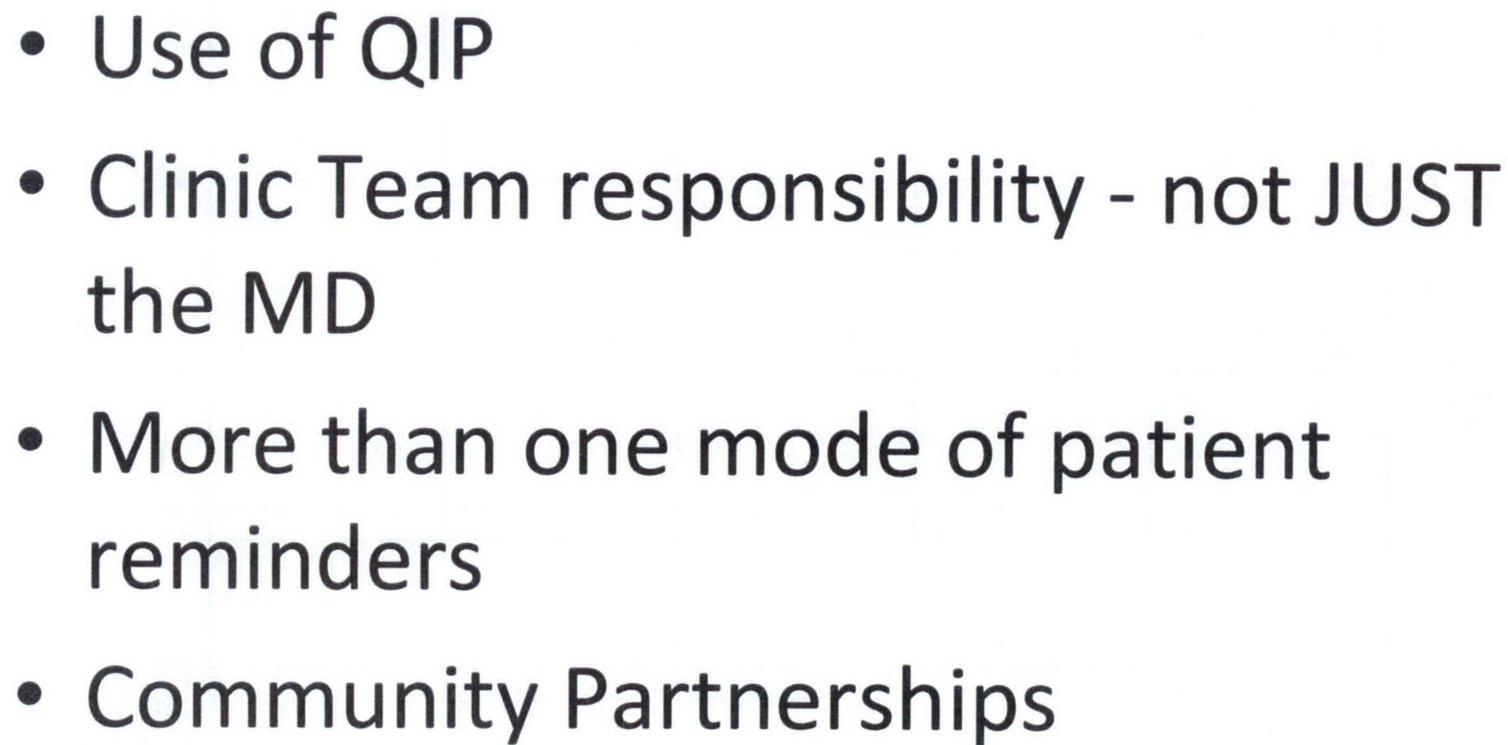
Screening Rate Increase



63% February 2015

Quality Improvement Committee has set a new goal of 71% by the end of 2015

Keys to Success



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CDPH
California Department of Public Health

QIP Impact on other Measures

- Culture of Quality
- Systems Approach

- Improvement in:
  - Breast and Cervical Cancer Screening Rates
  - Blood Pressure Control
  - Diabetes Control
  - Smoking Cessation Counseling

CDPH can provide....

CRC Resources:

- 'What Role does the Primary Care Provider Play?' webinar with 1.5 AMA PRA Category 1 Credits
- Primary Care Evidence-Based ToolBox
- Expert speakers for Provider or Medical Director meetings, Grand Rounds, etc.

http://www.cdph.ca.gov/programs/Pages/C4P.aspx

Summary

- CA CRC screening rates not ideal
- CRC is Preventable, Treatable, Beatable
- FIT Kit reimbursement by Medi-Cal ~ $17
- FIT screening program can be cost saving
- Culture of quality leads to better health outcomes for patients and better performance on more than just CRC screening measure

Thank You

For more information contact:

California Colon Cancer Control Program (C4P)

Sandra Robinson

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916-552-9891

california pharmacists association

CSHP | CALIFORNIA SOCIETY OF HEALTH-SYSTEM PHARMACISTS
Partners in Medication Management

Pharmacist Provider Status Legislation
SB 493 (Hernandez) Summary

Now that the pharmacist provider status bill has been signed by the Governor, many pharmacists are asking: "*what does this bill do for me*?" SB 493 grants all pharmacists certain authorities in all practice settings that had previously been limited to inpatient settings or integrated systems. The bill also establishes a new "Advanced Practice Pharmacist" recognition. This recognition can be granted when specified experience and/or certification requirements are met. The Advanced Practice Pharmacist recognition is not mandatory, but it does allow pharmacists to provide additional services. Below is a summary of SB 493's changes, which take effect January 1, 2014, though some provisions require regulations by the Board of Pharmacy and will not take effect until those regulations are approved.

- Declares pharmacists as healthcare providers who have the authority to provide health care services.
- Authorizes *all licensed pharmacists* to:
  - Administer drugs and biologics when ordered by a prescriber. Previously, this was limited to oral and topical administration. SB 493 allows pharmacists to administer drugs via other methods, including by injection.
  - Provide consultation, training, and education about drug therapy, disease management and disease prevention.
  - Participate in multidisciplinary review of patient progress, including appropriate access to medical records.
  - Furnish self-administered hormonal contraceptives (the pill, the patch, and the ring) pursuant to a statewide protocol. This authority is similar to the existing emergency contraception protocol. Once a statewide protocol is adopted by the Board of Pharmacy, it will automatically apply to all pharmacists.
  - Furnish travel medications recommended by the CDC not requiring a diagnosis.
  - Furnish prescription nicotine replacement products for smoking cessation pursuant to a statewide protocol if certain training, certification, recordkeeping, and notification requirements are met. Once a statewide protocol is adopted by the Board of Pharmacy, it will automatically apply to all pharmacists.
  - Independently initiate and administer immunizations to patients three years of age and older if certain training, certification, recordkeeping, and reporting requirements are met. A physician protocol is still required to administer immunizations on children younger than three years of age.
  - Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, in coordination with the patient's primary care provider or diagnosing prescriber.
- Establishes an Advanced Practice Pharmacist (APP) recognition, and authorizes APPs to:
  - Perform patient assessments.
  - Order and interpret drug therapy-related tests in coordination with the patient's primary care provider or diagnosing prescriber.
  - Refer patients to other healthcare providers.
  - Initiate, adjust, and discontinue drug therapy pursuant to an order by a patient's treating prescriber and in accordance with established protocols.
  - Participate in the evaluation and management of diseases and health conditions in collaboration with other healthcare providers.
- Requires pharmacists seeking recognition as APPs to complete any *two* of the following three criteria:
  - Earn certification in a relevant area of practice, such as ambulatory care, critical care, oncology pharmacy or pharmacotherapy.
  - Complete a postgraduate residency program.
  - Have provided clinical services to patients for one year under a collaborative practice agreement or protocol with a physician, APP pharmacist, CDTM pharmacist, or health system.

Assembly Bill No. 15

CHAPTER 1

An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life.

[Approved by Governor October 5, 2015. Filed with Secretary of State October 5, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 15, Eggman. End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill, until January 1, 2026, would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish specified forms to request an aid-in-dying drug, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby creating a crime and imposing a state-mandated local program, and a final attestation for an aid-in-dying drug. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

This bill would prohibit a provision in a contract, will, or other agreement from being conditioned upon, or affected by, a person making or rescinding a request for the above-described drug. The bill would prohibit the sale, procurement, or issuance of any life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for any policy or plan contract, from being conditioned upon or affected by the request. The bill would prohibit an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person assisted the qualified individual by preparing the aid-in-dying drug so long as the person did not

assist with the ingestion of the drug, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct of a health care provider provided for by the bill. The bill would make participation in activities authorized pursuant to its provisions voluntary, and would make health care providers immune from liability for refusing to engage in activities authorized pursuant to its provisions. The bill would also authorize a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the act while on the premises owned or under the management or direct control of that prohibiting health care provider, or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

This bill would make it a felony to knowingly alter or forge a request for drugs to end an individual's life without his or her authorization or to conceal or destroy a withdrawal or rescission of a request for a drug, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request a drug for the purpose of ending his or her life, to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions is to be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among other things, suicide or homicide.

This bill would require physicians to submit specified forms and information to the State Department of Public Health after writing a prescription for an aid-in-dying drug and after the death of an individual who requested an aid-in-dying drug. The bill would authorize the Medical Board of California to update those forms and would require the State Department of Public Health to publish the forms on its Internet Web site. The bill would require the department to annually review a sample of certain information and records, make a statistical report of the information collected, and post that report to its Internet Web site.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

CCHP Involvement in Combating the Opioid Epidemic

Changes to the CCHP formulary:

- Addition of naloxone to the formulary for commercial plan members:
  - Naloxone remains carved out for MediCal members, but has been added to the formulary for commercial plan members. Prescribers may send a prescription to Walgreens for the naloxone pre-filled syringe, and Walgreens has agreed to give the member (free of charge) a nasal atomizer.
- Removal of methadone as required step therapy for long acting opiate therapy.
- Addition of duloxetine (without PA requirements)
- Addition/creation of pharmacy utilization criteria for non-opioid analgesic agents.
- Implementation of claims processing logic that prevents inappropriate controlled substance refills.

Reporting metrics, ongoing projects, and case management:

- Every month, the CCHP pharmacy unit analyzes all claims data for polypharmacy and possible drug seeking behavior. Any CCHP member with opiate claims from 3 or more providers and/or opiate prescriptions filled at 3 or more pharmacies is referred to the CCHP case management department for follow-up. The case management team contacts the member's PCP, notifying them of the possible aberrant behavior and follows up as needed.
- All CCHP clinical pharmacists have access to CURES and run a report for all controlled substance PA requests.
- Given the importance of the opioid epidemic, the CCHP pharmacy unit is beginning work on a large project to combat opioid abuse. This move by the health plan is inspired by other hugely successful implementations such as our Northern neighboring health plan, Partnership. Partnership covers approximately 500,000 lives in 14 California counties with some of the highest levels of opioid overdoses, and through a multi-pronged approach they have been able to drastically reduce opioid abuse. Specific to CCHP, the pharmacy unit has future plans to:
  - Place limits on the amount and length of opioid prescriptions starting at the root, when prescribers are writing the prescriptions.
  - Educate and pull together the community for support in the upcoming project.

Program attendance/involvement:

- Attended the joint Alameda Contra Costa Medical Association (ACCMA), East Bay Safe Prescribing Coalition kickoff event and educational series on long acting opiates. Will continue to attend events and change CCHP policies as necessary.
- Attended CCRMC Safe Opioid Prescribing and Review Committee. Will continue to attend, and will plan on coordinating with committee to align the CCHP pain management policy with the CCRMC policy.
- Active member of the Contra Costa County Public Health Opiate Task Force – helped draft the opiate public health advisory released in March 2016, and will continue to work with public health to improve access to naloxone and curb addiction/overdose.

Current Preventive Reminders and other Health Education Mailings
As of April 2016

All documents are produced in both English and Spanish.

Health Sense member newsletter. Three times a year.

Disease Management Programs: Quarterly educational and informational packets sent to members who qualify for our Diabetic and Pediatric Obesity programs.

Reminders:

- Mammography due
- Cervical Cancer Screening due
- Annual testing for members on ACEI/ARB or diuretics due
- Annual flu shot due
- Self-management tools sent monthly to members with new asthma referrals
- Tobacco cessation resources sent monthly to members who self identify as smokers when completing a Health Risk Assessment

CONTRA COSTA
HEALTH PLAN

Prior Authorization Request Form for Mental Health Evaluation
[Prior to Gastric Bypass Surgery (GBS) Consultation]

(This form is valid for the Mental Health evaluation, which is required prior to GBS consult. GBS consult **may be** approved if there are no significant findings from the Mental Health evaluation)

Patient's Name: ______________________________ Date of Request: ________________

ID#: ______________________________ Birthdate: ________________

HEIGHT: ________ WEIGHT (most recent): ________ Date weighed ________ BMI: ____________

Requesting Provider Name (Print): ______________________________ Date Last Seen: ______________

SIGNATURE: ____

Morbid obesity can be a health danger because of the associated increased prevalence of cardiovascular risk factor such as hypertension, hypertriglyceridemia, hyperinsulinemia, diabetes mellitus and low levels of high-density lipoprotein (HDL) cholesterol. Conservative and dietary treatments include low (800-1200) calorie and very low (400-800) calorie diets, behavioral modification, exercise and pharmacologic agents. When these less drastic measures have failed or are not appropriate, providers may request, (upon meeting the criteria listed below) a consultation for obesity surgery.

Must meet 1 or 2 (see Table 1 for BMI values)

1. ☐ BMI over 40 with or without comorbidities
2. ☐ BMI 35-39.9 with presence of any of the following severe obesity-related comorbidities likely to be alleviated by surgery:
   a. Life-threatening cardiovascular disease.
   b. Life-threatening pulmonary disease.
   c. Clinical significant obstructive sleep apnea.
   d. Uncontrolled diabetes mellitus.
   e. Severe neurological or musculoskeletal problems.

Life Threatening comorbidities include documented sleep apnea, cardiomyopathy of obesity, and Pickwickian syndrome. Other obesity-related comorbidities include symptomatic degenerative joint disease demonstrated on x-ray with orthopedic recommendation for weight loss, symptomatic ventral hernia, difficult to control diabetes or hypertension, some cases of lower back pain, severe lower extremity edema with ulceration, stress incontinence, amenorrhea, etc.

MUST MEET ALL CRITERIA BELOW*

	Date	**Indicate date completed for each item:**
1.		1. Weight control efforts within the past year documented by PCP, which indicates member has made a serious effort to change eating and lifestyle in the last year, as shown by documented participation in a weight loss program, including exercise. Patient or PCP must also provide a narrative summary of weight control efforts.
2.		2. A dietary consultation and at least one follow up visit 30-60 days after initial consult, performed within the last 6 months by an approved Health Plan Registered Dietician, are required to assess present eating patterns (binge eating, bulimia, etc.) and ability to comprehend and cope with the post-surgical dietary restrictions. *Purpose of both the dietary assessment and the weight loss program include educating members in healthy eating styles, assessing if they can lose weight without surgery, counseling on the effects of surgery, and connecting them to their PCP who can follow them after surgery.*
3.		3. Participation in a support program, such as Food Addicts in Recovery Anonymous (www.foodaddicts.org) or WeightWatchers (www.weightwatchers.com), within the past 6 months for a period of at least 3 months of regular attendance ($\geq$ 3 meetings per month).
4.		4. Documented failure to sustain weight loss from more conservative methods, such as diet management programs or other similar programs within the past year.
5.		5. Has no specifically correctable cause for obesity, e.g. an endocrine disorder: (FBS) or hemoglobin A_1C within the past 6 months _______, (TSH) and lipids within the past year _______
6.		6. Obesity for a duration of at least 5 years.
7.		7. Monthly weight checks for the past 6 months.

Confirm the following:

8. Yes ☐ No ☐ Presence of active peptic ulcer disease (PUD).
9. Yes ☐ No ☐ Presence of advanced kidney or liver disease,
10. Yes ☐ No ☐ Has attained full growth (at least 18 years of age or documentation of completion of bone growth).
11. Yes ☐ No ☐ Uses illegal drugs, abuses prescription medications, or drinks excessive amounts of alcoholic beverages.
12. Yes ☐ No ☐ Presence of endocrinologic, psychiatric/Mental Health or substance abuse disorder.
13. Yes ☐ No ☐ Client has a clear and realistic understanding of available alternatives and how their lives will be changed after surgery, including the possibility of morbidity and eventually mortality, and a credible commitment to make the life changes necessary to maintain the body size and health achieved.
14. Yes ☐ No ☐ Presence of contraindications to the surgery including major life-threatening disease not susceptible to alleviation by the surgery, uncontrolled substance abuse, severe psychiatric/Mental Health impairment and demonstrated lack of compliance and motivation.
15. Yes ☐ No ☐ Client understands that, in general, surgery to remove excess skin resulting from weight loss (e.g., panniculectomy, abdominoplasty) is not a covered benefit.

***<u>After</u> meeting above criteria, Contra Costa Health Plan (CCHP) will authorize a Mental Health evaluation to rule out any mental disease or disorder and to determine the patient's ability to comply with post-op dietary and/or physical limitations and restrictions. Based on the findings of the Mental Health evaluation, CCHP will determine if an initial GBS consult is appropriate.**

Table 1

Body Weights in Pounds According to Height and Body Mass Index

*Each entry gives the body weight in pounds (lbs.) for a person of a given height and body mass index. Pounds have been rounded off. To use the table, find the appropriate height in the left-hand column. Move across the row to a given weight. The number at the top of the column is the body mass index for the height and weight.

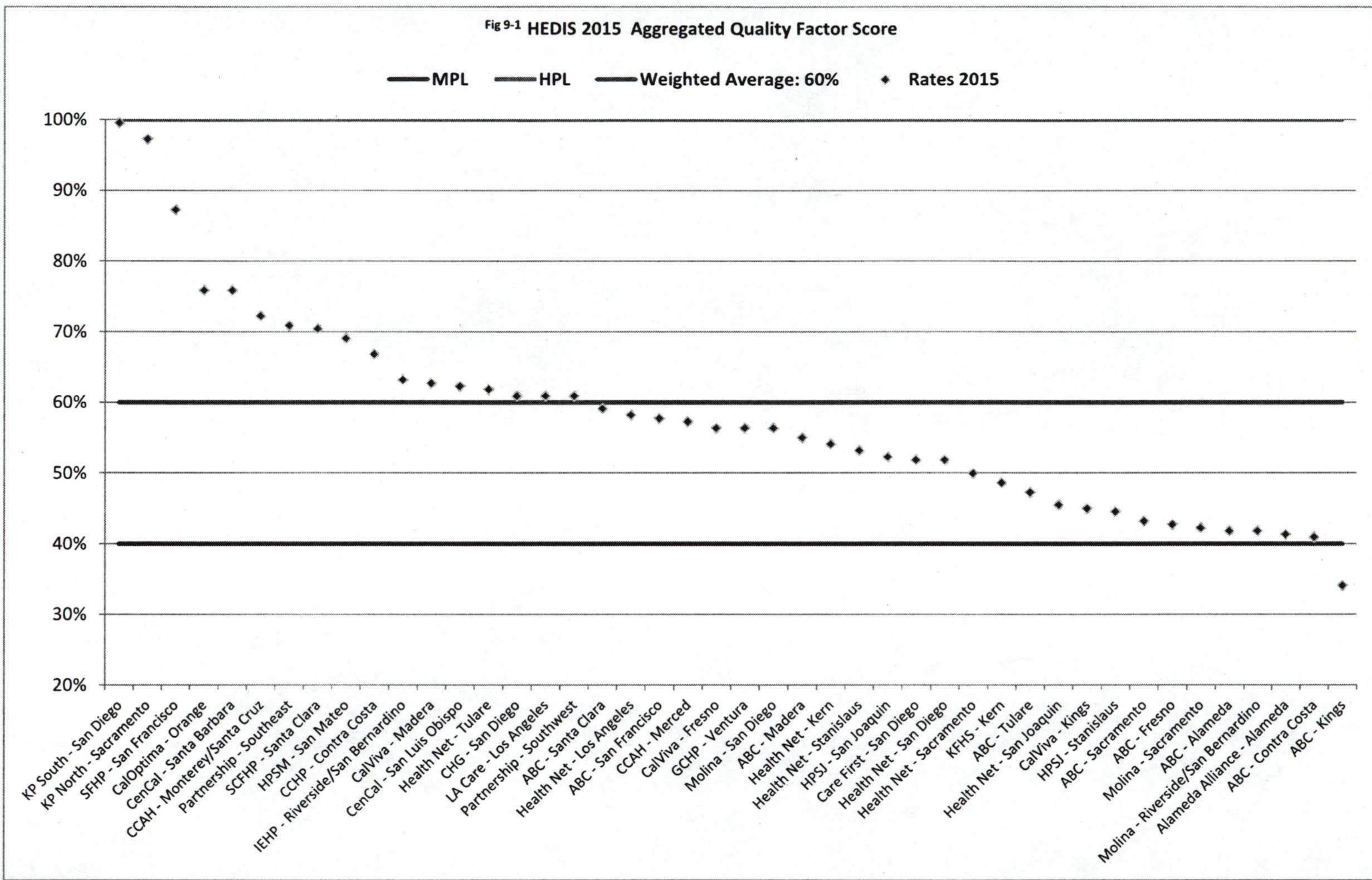
Body Mass Index	25	30	35	36	37	38	39	40	41	42	43	44	45	50
Ht. (in)	Body Weight (lbs)													
58	119	143	167	172	176	181	186	191	195	200	205	210	214	238
59	124	149	174	179	184	188	193	198	203	208	213	218	223	248
60	127	153	178	183	188	194	199	204	209	214	219	224	229	255
61	132	159	185	191	196	201	207	212	217	222	228	233	238	265
62	136	163	190	196	201	206	212	217	223	228	234	239	245	272
63	141	169	198	203	209	214	220	226	231	237	243	248	254	282
64	146	176	205	211	217	223	228	234	240	246	252	258	264	293
65	150	180	210	216	222	228	234	240	246	252	258	264	270	300
66	154	187	218	224	230	236	243	249	255	261	268	274	280	311
67	159	191	223	229	236	242	248	255	261	268	274	280	287	319
68	165	198	231	238	244	251	257	264	271	277	284	290	297	330
69	169	203	236	243	250	257	263	270	277	284	290	297	304	338
70	175	210	244	251	258	265	272	279	286	293	300	307	314	349
71	179	214	250	257	264	271	279	286	293	300	307	314	321	357
72	185	221	258	266	273	281	288	295	303	313	317	325	332	369
73	189	226	264	272	279	287	294	302	309	317	324	332	340	377
74	195	234	273	281	288	296	304	312	319	327	335	343	351	390
75	199	239	279	287	294	302	310	318	326	334	342	350	358	398
76	205	246	287	296	304	312	320	328	337	345	353	361	370	411

Adapted from Bray, G.A. Gary, D.S.. Obesity, Part 1. Pathogenesis. West J. Med 1988; 149:429-41

Medi-Cal Managed Care Performance Dashboard

Released December 15, 2015

QUALITY: HEDIS 2015



Note: The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as percent of the National High Performance Level (HPL, the 90th percentile of NCQA national Medicaid level). This is an annual calculation.

The High Performance Level of AQFS is 100% (represents the 90th percentile of NCQA national Medicaid level). The Minimum Performance Level of AQFS is 40% (represents the 25th percentile of NCQA national Medicaid level). The statewide weighted average is 60%.

Note: Data in this dashboard is preliminary and subject to change

	CCHP Medi-Cal HEDIS Measures	2013 CCHP	2014 CCHP	2015 CCHP	2013 RMC	2014 RMC	2015 RMC	2013 CPN	2014 CPN	2015 CPN	2013 KSR	2014 KSR	2015 KSR	2015 MPL	2015 HPL	2015 Medi-Cal Mean	BLUE CROSS	CCHP Overall improvement (if positive) from last year (in percentage points)	CCHP Percent improvement (if positive) from last year	CCRMC Overall improvement (if positive) from last year (in percentage points)	CCRMC Percent improvement (if positive) from last year
WCC	BMI %ile calculated for children	56.20%	62.29%	69.34%	55.80%	74.43%	85.29%	43.79%	40.37%	41.32%	82.89%	90.32%	92.59%	41.85%	82.46%	77.41	55.32%	7.05%	11%	10.86%	15%
	Nutrition counseling given for children	55.96%	59.37%	67.64%	50.28%	69.41%	79.41%	52.94%	40.99%	44.31%	76.32%	83.87%	88.89%	50.00%	77.47%	69.98	55.79%	8.27%	14%	10.00%	14%
	Physical activity counseling for children	46.23%	50.85%	66.67%	44.75%	63.01%	79.41%	33.33%	27.95%	41.92%	76.32%	83.87%	88.89%	41.67%	69.76%	60.19	46.99%	15.82%	31%	16.40%	26%
W34	*Yearly well child visit 3-6 yr.	73.31%	74.75%	79.81%	70.59%	71.20%	78.75%	73.42%	73.78%	75.61%	82.98%	87.50%	89.66%	65.97%	82.69%	72.28	66.87%	5.06%	7%	7.55%	11%
CIS	*Combo 3 immunizations	84.47%	74.70%	77.86%	76.12%	81.12%	72.25%	78.18%	64.00%	72.00%	96.67%	80.00%	89.66%	66.67%	80.86%	70.98	68.29%	3.16%	4%	-8.87%	-11%
PPC	*First trimester prenatal	86.86%	83.45%	85.89%	85.71%	81.93%	90.36%	88.80%	84.73%	85.39%	87.50%	90.32%	69.01%	77.80%	93.10%	81.9	72.27%	2.44%	3%	8.43%	10%
	Postpartum visit 21-56 days	62.53%	60.34%	67.15%	63.87%	61.85%	67.47%	60.00%	57.25%	58.43%	62.50%	61.29%	76.06%	56.18%	74.03%	61.29	43.70%	6.81%	11%	5.62%	9%
LBP	Avoiding Use of Imaging for Low Back Pain	92.06%	87.85%	87.31%	90.88%	85.60%	84.60%	92.26%	88.10%	83.57%	94.52%	93.94%	99.51%	72.15%	84.03%	80.3	S	-0.54%	-1%	-1.00%	-1%
CCS	*Cervical cancer screening	66.04%	54.99%	55.47%	62.44%	46.40%	50.78%	58.70%	49.48%	53.92%	85.14%	96.88%	87.50%	54.50%	75.96%	58.96	48.38%	0.48%	1%	4.38%	9%
CDC	Diabetes Eye Exam 2 yrs.	51.09%	51.34%	55.10%	52.94%	53.74%	52.90%	45.37%	43.00%	52.22%	54.17%	56.67%	78.38%	46.25%	68.04%	53.98	45.94%	3.76%	7%	-0.84%	-2%
	*Diabetes HbA1c testing	85.40%	84.43%	83.98%	85.49%	85.41%	83.33%	84.26%	80.00%	85.56%	87.50%	90.00%	86.49%	80.18%	91.73%	86.98	81.27%	-0.45%	-1%	-2.08%	-2%
	Diabetes HbA1c(>9%) (lower is better)	40.39%	41.61%	41.26%	40.39%	37.72%	36.23%	36.11%	53.00%	56.67%	50.00%	40.00%	37.84%	53.76%	30.28%	40	42.40%	0.35%	1%	1.49%	4%
	Diabetes HbA1c (<8%)	49.88%	48.18%	44.17%	47.06%	51.25%	47.10%	60.19%	41.00%	35.56%	41.67%	43.33%	45.95%	38.20%	59.37%	49.76	46.64%	-4.01%	-8%	-4.15%	-8%
	Diabetes Nephropathy screen or treatment	82.00%	83.94%	82.52%	82.75%	83.99%	80.43%	75.93%	80.00%	84.44%	91.67%	96.67%	94.59%	75.67%	86.86%	83.72	79.15%	-1.42%	-2%	-3.56%	-4%
	Diabetes BP <140/90	59.37%	61.31%	60.44%	57.25%	65.48%	64.13%	54.63%	50.00%	45.56%	81.25%	60.00%	72.97%	53.28%	75.18%	64.74	52.30%	-0.87%	-1%	-1.35%	-2%
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	43.27%	44.09%	47.06%	38.27%	45.30%	52.36%	46.49%	37.86%	33.68%	46.15%	77.27%	54.05%	20.20%	38.66%	29.77	NA	2.97%	7%	7.06%	16%
IMA-1	Immunizations for Adolescents: Combo 1	71.61%	73.24%	72.51%	66.67%	73.12%	70.21%	67.30%	69.94%	69.75%	90.00%	82.26%	79.63%	61.70%	86.46%	70.56	70.87%	-0.73%	-1%	-2.91%	-4%
CBP	*Controlling High Blood Pressure	51.34%	53.28%	64.23%	50.36%	56.03%	65.23%	45.26%	35.05%	50.63%	75.00%	84.38%	79.25%	48.53%	69.79%	60.73	49.71%	10.95%	21%	9.20%	16%
MMA	Medication Management for People with Asthma 50%	56.90%	43.46%	59.10%	48.02%	54.98%	54.97%	41.06%	52.50%	44.54%	85.32%	0.58%	87.94%	47.88%	66.96%		51.38%	15.64%	36%	-0.01%	0%
MMA	Medication Management for People with Asthma 75%	33.95%	22.79%	37.92%	24.32%	31.90%	34.41%	16.91%	25.36%	21.26%	64.68%	0.00%	67.73%	24.55%	43.08%	28.14	28.73%	15.13%	66%	2.51%	8%
ACR	All-Cause Readmissions (lower is better)	16.99%	12.29%	16.98%	17.37%	12.13%	17.58%	16.56%	12.45%	14.52%	14.69%	13.20%	7.14%				16.77%	-4.69%	-38%	-5.45%	-45%
	All-Cause Readmission, SPDs	19.48%	13.05%	21.17%	19.38%	12.82%	22.58%	21.03%	13.02%	15.96%	14.06%	15.08%	4.76%					-8.12%	-62%	-9.76%	-76%
	All-Cause Readmission, Non SPDs	12.72%	9.50%	10.68%	13.48%	9.32%	10.48%	8.59%	10.66%	11.70%	15.04%	8.45%	14.29%					-1.18%	-12%	-1.16%	-12%
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	217.23	246.81	257.12	166.26	255.18	255.01	185.03	257.06	259.32	293.81	209.48	259.08	314.03	467.26	311.54	201				
AMB	Ambulatory Care - Emergency Department Visits per 1000 Member Months	60.94	53.25	56.21	63.4	68.49	65.11	50.81	52.61	49.26	24.9	18.04	41.89	52.33	82.27	47.25	59.90				
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	83.77%	86.52%	85.55%	87.83%	87.73%	84.50%	80.22%	82.73%	83.57%	72.36%	100.00%	94.33%	85.76%	92.01%	86.15	80.22%	-0.97%	-1%	-3.23%	-4%
MPM	Monitoring for Patients on persistent Medications - Digoxin	85.71%	95.45%	77.11%	100.00%	97.30%	82.46%	81.25%	85.71%	63.64%	61.54%	0/0	66.67%	88.89%	95.65%	54.03	NA	-18.34%	-19%	-14.84%	-15%
MPM	Monitoring for Patients on persistent Medications - Diuretics	83.68%	85.11%	84.60%	87.06%	85.83%	83.96%	82.75%	82.51%	81.49%	72.17%	100.00%	92.20%	85.69%	92.07%	86.3	81.74%	-0.51%	-1%	-1.87%	-2%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months[2]	86.74%	94.62%	93.94%	94.65%	95.77%	92.47%	85.81%	91.77%	92.57%	53.89%	98.21%	98.90%	95.92%	98.53%	94.26	93.77%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years[2]	76.18%	86.07%	84.21%	81.67%	85.70%	82.88%	73.49%	83.40%	82.31%	58.27%	94.36%	90.13%	86.07%	93.58%	86.86	85.36%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years[2]	77.96%	86.71%	86.56%	81.03%	83.56%	84.20%	78.69%	87.37%	86.07%	67.02%	94.94%	94.46%	87.78%	95.19%	88.67	88.50%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years[2]	74.86%	83.44%	83.80%	77.90%	80.13%	81.90%	75.44%	82.42%	81.44%	66.67%	93.59%	93.41%	85.83%	94.42%	86.51	87.31%				

*included in default algorithm

below Minimum Performance Level (MPL), national Medicaid 25th percentile

above High Performance Level (HPL), national Medicaid 90th percentile

Bad data

[2] CAP measures are below MPL but do not require Improvement Plan

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