CONTRA COSTA
HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan

When: **Time: 7:30 AM – 9:00 AM**
Date: July 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**	James Tysell MD
IV.	**NEW BUSINESS**	
	• **CCHP Updates** • **Disaster Preparedness (Contra Costa County EMS)**	James Tysell MD Lisa Vajgrt—Smith RN, BSN, MPH, CPH
VI.	**OTHER**	
	• **UM Question and answer** • **Provider Concerns**	James Tysell MD CCHP Staff
VII.	**ADJOURNMENT**	

Our next scheduled meeting is:

October 18, 2016

CONTRA COSTA HEALTH PLAN

West County

Quarterly Community Provider Network (CPN)

Meeting Minutes – April 19, 2016

Attending:

CCHP Staff: Jose Yasul, MD, Mary Berkery, RN, Christine Gordon, RN, BSN, PHN; Maria Tesolin, Clerk

CPN Providers: D. Fernandes, MD; K. Kaminski, PA; P. Mack, MD; M. Ogawa, MD; K. O'Hearn, CPNP; R. Paterson, PA; A. Wallach, MD; G. Aguilar, PA; K. Ceci, MD; O. Eaglin, PA; R. Harrison RN, NP; K. Winter, MD; L. Trombla, PA.

Guests: O. Omotoso MD, MPH

Discussion		Action	Accountable
	Meeting called to order @ 7:44 A.M.		M. Berkery, RN
I.	Agenda was approved with no revisions.		M. Berkery, RN
II.	**Review and Approval of Minutes from January 19, 2016:** Minutes were approved as presented.		M. Berkery, RN
III.	**Regular Reports:** Legislative Updates Handout SB 493 - Pharmacist Provider Status Legislation Dr. Yasul reviewed the new policies and the impact on CCHP Providers. • Declares all licensed pharmacists as healthcare providers who have the authority to provide health care services. • Allows pharmacists to administer drugs when ordered by a prescriber (including injection). • Provide consultation, training and education about drug therapy. • Perform patient assessments. • Independently initiate and administer immunizations to patients three years of age and older (if certain training requirements are met). • Order and interpret tests of drug therapies. Handout AB 15 - End of Life Benefit Dr. Yasul acknowledged the sensitivity and controversy surrounding AB 15, the new legislation permitting adults who meet certain qualifications to make a request for an aid-in-dying drug. A future meeting will be scheduled to discuss in detail the particulars and address provider inquiries in reference to AB 15. He reported the following: • Requires the signature of 2 providers. • The patient must self-administer the drug (orally). • Hospital patients must be discharged, to self-administer at home. • CCHP will pay for the drug. Palliative Care – Changes to the PDL • Naloxone has been added to the formulary for commercial plan members. (Effective May 2016). • Reduction/limit methadone as step therapy for long term opiate therapy. • CCHP pharmacy will run monthly analysis – to identify members seeking opiates from 3 or more providers. Those members will be referred to case management for follow up. • CCHP Pharmacy plans to place limits on the amount and length of opioid prescriptions beginning at the initial prescription. Heavy discussion and many provider inquiries about Naloxon in relation to addiction. Dr. Yasul offered to conduct an *Naloxone In-Service* at LifeLong or West County Health Center, the providers agreed to have it at West County Health Center. Dr. Saffier referred providers to videos available online. Prior Authorizations Optometry and Ophthalmology services do not require a prior authorization.		J. Yasul, MD

IV.	**New Business:** CCHP Updates Disease Management Program Online The program for adult diabetes and pediatric obesity, offers referrals and education to both providers and patients/families faced with these conditions. Community Providers may access the Disease Management Program referral form on the website provider section under "forms and resources" or contact Lourdes Jensen, RN at (925) 313-6968. Gastric Bypass Surgery (GBS) Consultation Referral Form A mental health evaluation is required prior to a GBS consult. GBS consult may be approved if there aren't any findings from the mental health evaluation. Members must meet the BMI values, and be at least 18 years of age. Although panniculectomy is not a covered benefit, providers are encouraged to refer any requests to Dr. Yasul or Dr. Tysell for review. Dashboard scores. Dr. Yasul reviewed the 2015 Dashboard chart. CCHP performance level is above 60%. Adult Vaccine CCHP adult members may go to Walgreens and Rite Aid for vaccines. CCHP Audit DHCS & DMHC will conduct a joint audit of the CCHP on May 9th.		J. Yasul, MD
	Adjournment: Meeting adjourned @ 9:10 A.M.		M. Berkery, RN

Next meeting July 19, 2016

	CCHP Medi-Cal HEDIS Measures	2016 CCHP	2016 La Clinica	2016 Lifelong	2015 MPL	2015 HPL	2015 Medi-Cal Mean
WCC	BMI %ile calculated for children	80.05%	60.87%	78.95%	51.27%	85.61%	77.41
	Nutrition counseling given for children	72.68%	56.52%	57.89%	51.98%	79.56%	69.98
	Physical activity counseling for children	71.58%	47.83%	57.89%	44.16%	71.53%	60.19
W34	*Yearly well child visit 3-6 yr.	78.14%	46.67%	60.00%	65.54%	83.75%	72.28
CIS	*Combo 3 immunizations	73.97%	46.15%	72.00%	66.19%	81.25%	70.98
PPC	*First trimester prenatal	86.13%	100.00%	82.35%	77.44%	91.73%	81.9
	Postpartum visit 21-56 days	68.13%	66.67%	58.82%	55.47%	72.43%	61.29
LBP	Avoiding Use of Imaging for Low Back Pain	82.30%	70.59%	81.69%	71.82%	82.86%	80.3
CCS	*Cervical cancer screening	58.15%	86.67%	42.11%	54.33%	73.08%	58.96
CDC	Diabetes Eye Exam 2 yrs.	51.94%	43.75%	31.81%	47.06%	67.74%	53.98
	*Diabetes HbA1c testing	86.17%	87.50%	95.24%	83.19%	91.94%	86.98
	Diabetes HbA1c(>9%) (lower is better)	41.50%	81.25%	72.72%	49.89%	29.68%	40
	Diabetes HbA1c (<8%)	50.24%	25.00%	27.27%	40.00%	58.58%	49.76
	Diabetes Nephropathy screen or treatment	88.83%	81.25%	100.00%	77.95%	87.70%	83.72
	Diabetes BP <140/90	60.44%	75.00%	63.64%	56.45%	76.64%	64.74
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	41.08%	50.00%	52.38%	22.00%	40.38%	29.77
IMA-1	Immunizations for Adolescents: Combo 1	70.75%	55.00%	70.59%	63.79%	87.71%	70.56
CBP	*Controlling High Blood Pressure	57.11%	66.67%	52.94%	49.88%	70.32%	60.73
MMA	Medication Management for People with Asthma 50%	55.56%	66.67%	42.86%	47.41%	67.24%	
	Medication Management for People with Asthma 75%	30.83%	30.77%	25.00%	23.72%	43.38%	28.14
ACR	All-Cause Readmissions (lower is better)	15.52%	10.04%	9.87%			
	All-Cause Readmission, SPDs	19.70%	9.33%	20.00%			
	All-Cause Readmission, Non SPDs	12.22%	10.39%	1.56%			
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	339.74	9.82	10.90	304.73	460.08	311.54
	Ambulatory Care - Emergency Department Visits per 1000 Member Months	55.65	2.15	2.75	50.67	83.68	47.25
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	86.96%	86.30%	84.53%	84.87%	92.01%	86.15
	Monitoring for Patients on persistent Medications - Digoxin	74.76%	66.67%	100.00%	49.35%	61.04%	54.03
	Monitoring for Patients on persistent Medications - Diuretics	86.26%	78.05%	83.16%	84.66%	91.78%	86.3
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months[2]	94.42%	91.00%	93.13%	94.23%	98.17%	94.26
	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years[2]	83.56%	78.74%	75.44%	85.41%	92.93%	86.86
	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years[2]	86.20%	80.55%	85.08%	88.89%	95.88%	88.67
	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years[2]	83.95%	76.13%	75.70%	87.25%	94.91%	86.51

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

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

*included in default algorithm

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

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

ACIP votes down use of LAIV for 2016-2017 flu season

Media Statement

For Immediate Release: Wednesday, June 22, 2016
Contact: Media Relations (http://www.cdc.gov/media),
(404) 639-3286

CDC's Advisory Committee on Immunization Practices (ACIP) today voted that live attenuated influenza vaccine (LAIV), also known as the "nasal spray" flu vaccine, should not be used during the 2016-2017 flu season. ACIP continues to recommend annual flu vaccination, with either the inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV), for everyone 6 months and older.

ACIP is a panel of immunization experts that advises the Centers for Disease Control and Prevention (CDC). This ACIP vote is based on data showing poor or relatively lower effectiveness of LAIV from 2013 through 2016.

In late May, preliminary data on the effectiveness of LAIV among children 2 years through 17 years during 2015-2016 season became available from the U.S. Influenza Vaccine Effectiveness Network. That data showed the estimate for LAIV VE among study participants in that age group against any flu virus was 3 percent (with a 95 percent Confidence Interval (CI) (http://www.cdc.gov/flu/about/qa/vaccineeffect.htm) of -49 percent to 37 percent). This 3 percent estimate means no protective benefit could be measured. In comparison, IIV (flu shots) had a VE estimate of 63 percent (with a 95 percent CI of 52 percent to 72 percent) against any flu virus among children 2 years through 17 years. Other (non-CDC) studies support the conclusion that LAIV worked less well than IIV this season. The data from 2015-2016 follows two previous seasons (2013-2014 and 2014-2015 (http://www.cdc.gov/media/releases/2015/s0226-acip.html)) showing poor and/or lower than expected vaccine effectiveness (VE) for LAIV.

How well the flu vaccine works (or its ability to prevent flu illness) can range widely from season to season and can be affected by a number of factors, including characteristics of the person being vaccinated, the similarity between vaccine viruses and circulating viruses, and even which vaccine is used. LAIV contains live, weakened influenza viruses. Vaccines containing live viruses can cause a

stronger immune response than vaccines with inactivated virus. LAIV VE data before and soon after licensure suggested it was either comparable to, or better than, IIV. The reason for the recent poor performance of LAIV is not known.

Vaccine manufacturers had projected that as many as 171 million to 176 million doses of flu vaccine, in all forms, would be available for the United States during the 2016-2017 season. The makers of LAIV had projected a supply of as many as 14 million doses of LAIV/nasal spray flu vaccine, or about 8 percent of the total projected supply. LAIV is sold as FluMist Quadrivalent and it is produced by MedImmune, a subsidiary of AstraZeneca. LAIV was initially licensed in 2003 as a trivalent (three-component) vaccine. LAIV is currently the only non-injection-based flu vaccine available on the market.

Today's ACIP vote could have implications for vaccine providers who have already placed vaccine orders. The ACIP recommendation may particularly affect pediatricians and other vaccine providers for children since data from recent seasons suggests nasal spray flu vaccine accounts for about one-third of all flu vaccines given to children. CDC will be working with manufacturers throughout the summer to ensure there is enough vaccine supply to meet the demand.

CDC conducts vaccine effectiveness (VE) studies each season to estimate flu vaccine effectiveness. Today's ACIP vote highlights the importance of measuring and evaluating the effectiveness of public health interventions, which can have significant implications for public health policy. The change in the ACIP recommendation is an example of using new available data to ensure public health actions are most beneficial. Influenza is a serious disease that causes millions of illnesses, hundreds of thousands of hospitalizations, and thousands or tens of thousands of deaths each year. While the protection offered by flu vaccines can vary, the flu shot's overall VE estimate of 49 percent suggests that millions of people were protected against flu last season.

Today's ACIP recommendation must be reviewed and approved by CDC's director before it becomes CDC policy. The final annual recommendations on the prevention and control of influenza with vaccines will be published in a CDC Morbidity and Mortality Weekly Report (MMWR), Recommendations and Reports (http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html) in late summer or early fall.

CDC has recommended an annual influenza vaccination for everyone ages 6 months and older since February 24, 2010. CDC and ACIP briefly had a preferential recommendation for nasal spray vaccine for young children (during 2014-2015); however, during the 2015-2016 season, influenza vaccination was recommended without any preference for one vaccine type or formulation over another.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (http://www.hhs.gov/)

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HEALTH ADVISORY UPDATE
JUNE 6, 2016
ZIKA VIRUS

SUMMARY:
In May 2015, Zika virus started circulating in the Western Hemisphere. The first locally-acquired case in the Americas was reported in Brazil. Zika virus is transmitted by the bite of infected *Aedes aegypti* and *Aedes albopictus* mosquitoes, which are aggressive day biters and also vectors of Dengue, Chikungunya, and Yellow Fever viruses. Transmission of the virus has been reported in Mexico, the Caribbean, Central America, South America and some South Pacific Islands and US territories. We know that Zika is most commonly transmitted through mosquito bites, but it can also be transmitted from a man to his sex partners and from a pregnant woman to her infant. More information can be found at: cdc.gov/zika

CURRENT SITUATION

- On January 15, 2016, the Centers for Disease Control and Prevention (CDC) began issuing travel advisories (http://wwwnc.cdc.gov/travel/notices) for people, particularly pregnant women, traveling to places where ongoing local Zika virus transmission has been documented.
- To date, NO local transmission has been documented in the continental United States; however, cases of Zika virus have been reported among travelers returning back to United States.
- Public Health can facilitate diagnostic testing (testing is unavailable commercially) and works to mitigate the risk of local transmission (the mosquito vectors do not currently exist in Contra Costa but surveillance is on-going).

Actions Requested of Healthcare Professionals:

1. **Suspect Zika** (also consider Dengue and Chikungunya) in travelers with acute onset of fever, maculopapular rash, arthralgia, myalgia or conjunctivitis within 2 weeks after return from a place with local Zika transmission and persons with acute onset of the same symptoms if they also report recent unprotected sex with a man who has known Zika infection Suspect Zika.
2. **Report** suspected cases of Zika virus with appropriate symptomology and Zika exposure history/travel history to Contra Costa Public Health by phone at 925-313-6740, and by faxing the 'Zika Case History Form' to 925-313-6465. The 'Zika Case History Form' can be found here: http://cchealth.org/cd/pdf/Zika-Case-History-Form.pdf
3. **Test** patients with appropriate symptomology and Zika exposure history/travel history by arranging testing through Contra Costa Public Health. See Laboratory Testing. The 'Laboratory Requisition Form' can be found here: http://cchealth.org/laboratory/pdf/lab_test_form.pdf
4. **Advise** patients to avoid mosquito bites and potential sexual transmission. Refer travelers, particularly pregnant women, to CDC Travel Advisories for current information about Zika virus and prevention. http://wwwnc.cdc.gov/travel/notices

CURRENT RECOMMENDATIONS:

REPORTING/ SURVEILLANCE

- Report suspected cases of Zika virus to Contra Costa Public Health by phone at 925-313-6740, and by faxing 'Zika Case History Form' (http://cchealth.org/cd/pdf/Zika-Case-History-Form.pdf) to 925-313-6465.
- Inform and screen pregnant women who traveled or lived in areas with Zika virus transmission in the past 2 to 12 weeks while pregnant. (http://www.cdc.gov/mmwr/volumes/65/wr/mm6512e2.htm?s_cid=mm6512e2_w.htm)
- Evaluate fetuses and infants of women infected with Zika virus during pregnancy for possible congenital infection and microcephaly. All infants born to women with laboratory evidence of possible Zika virus infection require ongoing monitoring; data will be maintained in the U.S. Zika Pregnancy Registry (http://www.cdc.gov/mmwr/volumes/65/wr/mm6507e1.htm?s_cid=mm6507e1_w.htm)

TESTING

- Testing is recommended for the following exposure groups:
  - **Symptomatic travelers** with acute onset of fever, maculopapular rash, arthralgia, or conjunctivitis within 2 weeks after return from a place with local Zika transmission.
  - **Asymptomatic pregnant women:** 1) with history of travel to a place with local Zika transmission 2) reporting recent unprotected sex with a man who has known Zika exposure and who was symptomatic. Testing should be performed between 2 and 12 weeks after return from travels or sexual exposure.
  - **Infants/Neonates with:** 1) possible congenital Zika virus infection 2) born to a mother with a positive or inconclusive laboratory result
  - **Symptomatic sexual partners of travelers:** Persons reporting recent sex with a man who has known Zika exposure should be tested according to similar guidance as above.

- NO testing will be provided for asymptomatic non-pregnant persons (male or female) regardless of travel history to Zika affected country.

- Submit specimens to Contra Costa Public Health with the 'Laboratory Requisition Form': http://cchealth.org/laboratory/pdf/lab_test_form.pdf

  2500 Alhambra Ave., Room 209, Martinez, CA 94553
  Phone: 925-370-5775
  Fax: 925-370-5252

- Refer to table for specimen collection guidance

CLINICAL SPECIMEN COLLECTION BY ZIKA EXPOSURE GROUP			
	LABORATORY DIAGNOSTIC METHOD		
	RT-PCR	SEROLOGY (IgM AND PRNT)	HISTOPATHOLOGY IMMUNOHISTOCHEMICAL STAINING
SYMPTOMATIC	• SERUM (2mL) OR CSF (1mL) COLLECTED WITHIN 7 DAYS OF ONSET • URINE (2mL) COLLECTED WITHIN 21 DAYS OF ONSET • AMNIOTIC FLUID (2mL) COLLECTED IF AN AMNIOCENTESIS IS PERFORMED	• SERUM OR CSF COLLECTED > 3 DAYS AFTER ONSET NOTE: ALL IgM + SPECIMENS WILL BE REFLEXED TO PRNT TESTING DUE TO POTENTIAL CROSS-REACTIVITY WITH OTHER FLAVIVIRUSES	N/A
POSSIBLE CONGENITAL ZIKA VIRUS INFECTION (NEONATE)	• UMBILICAL CORD BLOOD (1mL) COLLECTED WITHIN 2 DAYS OF BIRTH • SERUM (2mL) • CSF (1mL), IF COLLECTED FOR OTHER STUDIES NOTE: IF MOTHER NOT ALREADY TESTED DURING PREGNANCY, COLLECT BLOOD WITH INFANT		COLLECT MULTIPLE TISSUES BOTH COLD FORMALIN FIXED AND FROZEN TISSUES (0.5-1.0 cm) • PLACENTAL TISSUE • UMBILICAL CORD TISSUE OTHER FETAL TISSUE (FETAL DEMISE) TISSUES FROM MULTIPLE ORANGS – BRAIN, EYE, SPINAL CORD
ASYMPTOMATIC (PREGNANT WOMEN ONLY)	N/A	SERUM (2mL) COLLECTED BETWEEN 2-12 WEEKS AFTER ENTRY INTO US	N/A

- Storage & shipment of specimens (clinical laboratory processing department)
  - Serum and CSF samples should be stored and shipped cold at 4-8°C
  - Amniotic Fluid and tissues should be stored and shipped frozen. If ≥ 72 hours, all specimens should be frozen and ship on dry ice.

TREATMENT

- There is no specific treatment for Zika infection; clinical guidance is to provide supportive care including rest, fluids, and use of analgesics and antipyretics (after Dengue has been ruled out).

PREVENTION

- There are no vaccines to prevent Zika infection.
- Travelers to regions with known Zika virus transmission should monitor CDC travel alerts (http://wwwnc.cdc.gov/travel/notices) and for pregnant women, consider postponing travel.
- Preventing mosquito bites is the main control measure to avoid becoming infected (http://www.cdc.gov/features/stopmosquitoes/).
- Male partners with Zika virus exposure can pass the infection to his sex partner(s). Condoms can reduce the risk of Zika transmission. Counsel patients about pregnancy planning and the timing of pregnancy after possible exposure to Zika virus. CDC MMWR Interim Guidelines for Prevention of Sexual Transmission of Zika Virus: http://www.cdc.gov/mmwr/volumes/65/wr/mm6512e3.htm?s_cid=mm6512e3_w.htm

RESOURCES

- CDC Zika Health Advisories (CDCHAN-00389, 00388 and 00385) http://emergency.cdc.gov/HAN/index.asp
- CDC COCA Call (April 12, 2016): Updated Interim Zika Clinical Guidance for Reproductive Age Women and Men, Sexual Transmission of Zika, and the U.S. Zika Pregnancy Registry http://emergency.cdc.gov/coca/ppt/2016/coca-call-april12-zika-virus-clinical-guidelines_508.pdf
- CDC COCA Call (January 26, 2016): Zika Virus – What Clinicians Need to Know? slides posted at: http://emergency.cdc.gov/coca/ppt/2016/01_26_16_zika.pdf
- Up-to-date transmission map: http://www.cdc.gov/zika/geo/index.html).

More information at: cdc.gov/zika, cchealth.org/providers/ and cchealth.org/mosquito-borne-illnesses/

Intravenous (I.V.) Sedation and General Anesthesia Guidelines for Dental Procedures

Patient selection for conducting dental procedures under I.V. sedation or general anesthesia utilizes medical history, physical status, and indications for anesthetic management. The dental provider in consultation with an anesthesiologist is responsible for determining whether a Medi-Cal beneficiary meets the minimum criteria necessary for receiving I.V. sedation or general anesthesia. The provider must also submit a *Treatment Authorization Request* (TAR) prior to delivering I.V. sedation or general anesthesia. However, a TAR is not required prior to delivering I.V. sedation or general anesthesia as part of an outpatient dental procedure in a nursing facility or any category of intermediate care for the developmentally disabled. Additionally, the dental provider must meet the requirements for chart documentation, which includes a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports, the indication for I.V. sedation or general anesthesia and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure.

Criteria Indications for I.V. Sedation or General Anesthesia

Behavior modification and local anesthesia shall be attempted first. If this fails or is not possible, then sedation shall be considered.

If the provider documents both number one and number two below, then the patient shall be considered for I.V. sedation or general anesthetic.

1. Failure of local anesthesia to control pain.
2. Failure of conscious sedation, either inhalation or oral.

If the provider documents any one of numbers three through six then the patient shall be considered for I.V. sedation or general anesthetic.

3. Failure of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff).
4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due to immature cognitive functioning.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order: conscious sedation via inhalation or oral anesthetics, I.V. sedation, then general anesthesia.

Patients with certain medical conditions such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders (continuous warfarin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.