



Agenda

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

When: Time: 7:30 AM – 9:00 AM
Date: January 20, 2015

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

Attention! Please enter by the side door if front door is locked!

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 | |
| | <ul style="list-style-type: none"> Medical Director's Report/Health Plan Updates | Mary Berkery, RN |
| IV. | NEW BUSINESS | |
| | <ul style="list-style-type: none"> Lipid Management Guidelines | D. Dooley, MD R. Cohen, MD |
| VI. | OTHER | |
| | <ul style="list-style-type: none"> Provider Concerns | Mary Berkery, RN |
| VII. | ADJOURNMENT | |

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 20, 2015 and attached herein.

Our next scheduled meeting is:

Tuesday, April 21, 2015
7:30 AM – 9:00 AM

CPN Quarterly Meeting

CONFIDENTIAL – Protected by California Evidence Code 1157

CONTRA COSTA HEALTH PLAN
 East/Central County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – January 27, 2015

Attending:

CCHP Staff: M. Berkery, RN, Co-Chair; D. Dooley, MD and R. Cohen, MD (Guests); J. Galindo, RN, PHN; B. Flowers, RN; L.M. Perez, CPCS

CPN Providers: C. Akera-Dow, MD; S.M. Chang, MD; N. Essa, MD; G. Graves, MD; S. Huerta, CPNP; A. Mahdavi, MD; C. Mayor, NP; B. Monday, BCBA; J. O'Meany, PA; H.E. Risgalla, MD; S. Sachdeva, MD; J. Sequeira, MD; S. Shtivelman, MD; W. Taft, MD; R. Tracy, MD; J.G. Zimmerman, MD

| Discussion | Action | Accountable |
|---|--------|--------------------------------|
| Meeting called to order @ 7:45 a.m. | | M. Berkery, RN |
| I. Agenda was approved with no revisions. | | M. Berkery, RN |
| II. Review and Approval of Minutes from October 28, 2014: Minutes were approved as presented. | | M. Berkery, RN |
| III. Regular Reports: <ul style="list-style-type: none"> • Medical Director's Report/Health Plan Updates <ul style="list-style-type: none"> ▪ Autism Referrals <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Follow certain guidelines ▪ VerifPoint Credentialing Solutions (VCS) <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Need prior authorization, no longer a Medi-Cal benefit ▪ Optometry <ul style="list-style-type: none"> - No prior authorization needed, members could go to contracted optometrists ▪ Advance Directives <ul style="list-style-type: none"> - Providers encourage to push on advance directives | | M. Berkery, RN |
| IV. New Business: <ul style="list-style-type: none"> • Lipid Management Guidelines <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> - 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 | | D. Dooley, MD/ R. Cohen, MD |

| | | | |
|----|--|--|--|
| | <ul style="list-style-type: none"> - If there is a strong family history for early Atherosclerosis Disease or if there is a secondary risk 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 <ul style="list-style-type: none"> • Dietary Supplements <ul style="list-style-type: none"> ▪ Data came back neutral <ul style="list-style-type: none"> - Fish oil NOT recommended for adults anymore for HDL modifications - Vitamin E and Folic Acid NOT recommended | | |
| V. | Adjournment: Meeting adjourned @ 8:50 a.m. | | |

Next meeting – April 28, 2015

CONTRA COSTA HEALTH PLAN
 West County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – October 21, 2014

Attending:

CCHP Staff: J. Tysell, MD, Chair; M. Berkery, RN; J. Galindo, RN, PHN; L.M. Perez, CPCS

CPN Providers: G. Aguilar, PA; H. Anesoir, MD; A. Barocio, PA; K. Ceci, MD; O. Eaglin, PA; D. Fernandes, MD; K. Kaminski, PA; P. Mack, MD; J. Mahony, MD; L. Trombla, PA; A. Wallach, MD; K. Winter, MD

| Discussion | Action | Accountable |
|--|--------|---------------|
| Meeting called to order @ 7:40 a.m. | | J. Tysell, MD |
| I. Agenda was approved with no revisions. | | J. Tysell, MD |
| II. Review and Approval of Minutes from July 15, 2014: Minutes were approved as presented. | | J. Tysell, MD |
| III. Regular Reports: <ul style="list-style-type: none"> • Medical Director's Report <ul style="list-style-type: none"> ▪ Health Plan continues to grow with Medi-Cal <ul style="list-style-type: none"> - Impacted services at CCRMC and clinics - May increase CPN and FQHC assignments ▪ 2014 year of added benefits (changes) for Medi-Cal recipients <ul style="list-style-type: none"> - Mental Health <ul style="list-style-type: none"> o Working with referring providers for coordination of care o Future substance use experience capability to the Access Line - Autism <ul style="list-style-type: none"> o Starting to get referrals from providers o Dr. Blaisch is active in this area and working with County pediatricians with assessments o Have criteria for patients who may be eligible for ABA (Applied Behavior Analysis) o Working with existing system to try not to interrupt appropriate care o Expecting better and faster capability than in the past o Health Plan will give updates - Alcohol and Other Drugs substance use disorders for adolescent and adults <ul style="list-style-type: none"> o May become a Health Plan benefit o State is looking at coordinating services ▪ State Quarterly Meeting Update <ul style="list-style-type: none"> - Topics discussed include: <ul style="list-style-type: none"> o Homelessness – State looking at issues that impact health care costs and trying to partner with health plans in matching up services o Tobacco Cessation Program for adolescent – important to screen for tobacco use ▪ Governing Board – Board of Supervisors <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Continue to work on prenatal care and trying to improve postpartum and timeliness of prenatal care - <u>Important:</u> Pediatricians to ensure at first child visit that mother is getting postpartum check up between 3 and 8 weeks postpartum | | J. Tysell, MD |

| | | | |
|-----|--|--|--|
| | <ul style="list-style-type: none"> ▪ Pediatric Obesity <ul style="list-style-type: none"> - Continuing to work on pediatric obesity - Receiving a considerable amount of requests for Healthy Hearts authorizations - Developed an algorithm with more clear steps necessary to obtain a referral to Healthy Hearts – involves a physical and dietary counseling - Primary care system needs to be engaged - For resources contact Elisa Hernandez, Health Educator (Bilingual). ▪ HEDIS <ul style="list-style-type: none"> - Measure being looked at by the State is patients with persistent asthma using controllers - Ensure patients with persistent asthma are on controllers and patients who do not have persistent asthma are not on controllers - Education and compliance is important - Look forward for improved numbers this coming year | | |
| IV. | <p>New Business:</p> <ul style="list-style-type: none"> • Smoking Cessation <ul style="list-style-type: none"> ▪ Discussed the Tobacco Cessation Policy dated September 3, 2014 requirements: <ul style="list-style-type: none"> - Initial/annual assessment of tobacco use for patients 18 years and older - Smoking status can be assessed through the use of SHA (Staying Healthy Assessment) - No prior authorization needed for: nicotine gum, nicotine lozenge, nicotine patch and bupropion (90 days x 2 times) - Needs authorization: nicotine inhaler and nicotine spray - Important to keep a list of members who smoke - CCHP will cover four 10 minutes counseling sessions per year - Refer to California Smokers' Helpline: 1-800-NO-BUTTS Medi-Cal members could call and receive free nicotine patches, \$20.00 gift card and counseling through the phone ▪ Training <ul style="list-style-type: none"> - USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence" : http://bphc.hrsa.gov/buckets/treatingtobacco.pdf • Flu Updates <ul style="list-style-type: none"> ▪ Available in the packet • Adolescent SHA <ul style="list-style-type: none"> ▪ Informed providers there is an adolescent SHA | | J. Galindo, RN, PHN M. Berkery, RN |
| V. | <p>Other:</p> <ul style="list-style-type: none"> • Provider Bulletin was reviewed. | | J. Tysell, MD |
| VI. | <p>Adjournment: Meeting adjourned @ 8:55 a.m.</p> | | |

Next meeting – January 20, 2015

Pediatrics and Atherosclerosis

To Screen or Not to Screen?

Diane Dooley MD
Rose Cohen MD





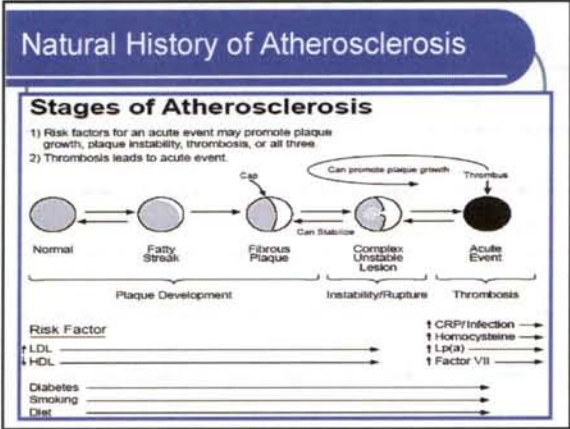
Expert Panel on Integrated
Guidelines for Cardiovascular
Health and Risk Reduction in
Children and Adolescents
FULL REPORT



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?





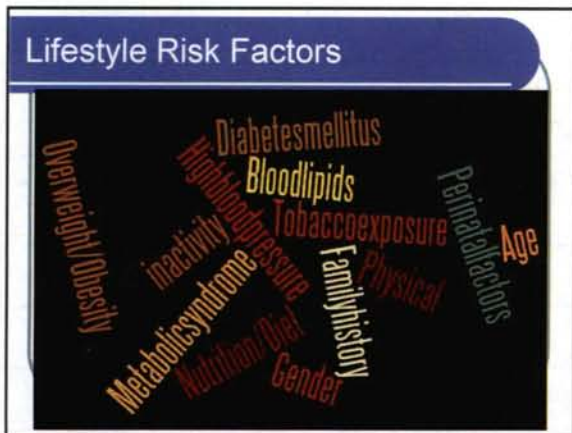
Lipids and atherosclerosis

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 >90th% X2 - 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



Secondary dyslipidemia

Table 9-3. CAUSES OF SECONDARY DYSLIPIDEMIA

| | |
|---|---|
| Exogenous Alcohol Drug therapy: Corticosteroids Isretinoin Beta-blockers Some oral contraceptives Select chemotherapeutic agents Select antiretroviral agents | Hepatic Obstructive liver disease/cholestatic conditions Biliary cirrhosis Alagille syndrome |
| Endocrine/Metabolic Hypothyroidism/hypoparathyroidism Diabetes mellitus type 1 and type 2 Pregnancy Polycystic ovary syndrome Lipodystrophy Acute intermittent porphyria | Inflammatory Systemic lupus erythematosus Juvenile rheumatoid arthritis |
| Renal Chronic renal disease Hemolytic uremic syndrome Nephrotic syndrome | Storage Glycogen storage disease Gaucher's disease Cystine storage disease Juvenile Tay-Sachs disease Niemann-Pick disease |
| Infection Acute viral/bacterial infection* Human immunodeficiency virus (HIV) infection Hepatitis | Other Kawasaki disease Anorexia nervosa Post solid organ transplantation Childhood cancer survivor Progeria Idiopathic hypercalcemia Kinifelter syndrome Werner's syndrome |

Screening Recommendations

| | |
|---|--|
| At risk screening <ul style="list-style-type: none"> Ages 2-8 years Family history +, parent with dyslipidemia, any other risk factors or high-risk condition Fasting lipid profile | Routine screening <ul style="list-style-type: none"> 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 \geq 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.

Grades reflect the findings of the evidence review.

Recommendation levels reflect the consensus opinion of the Expert Panel.

Supportive actions represent expert consensus suggestions from the Expert Panel provided to support implementation of the recommendations; they are not graded.

Birth–6 m Infants should be exclusively breastfed (no supplemental formula or other foods) until age 6 months.* Grade B
Strongly recommend

* 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.

6–12 m Continue breastfeeding* until at least age 12 months while gradually adding solids; transition to iron-fortified formula until 12 months if reducing breastfeeding Grade B
Strongly recommend

Fat intake in infants younger than 12 months of age should not be restricted without medical indication Grade D
Recommend

Limit other drinks to 100% fruit juice ≤ 4 oz/d; No sweetened beverages; encourage water Grade D
Recommend

* 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.

12–24 m Transition to reduced-fat* (2% to fat-free) unflavored cow's milk** (see Supportive Actions bullet 1) Grade B
Recommend

Limit/avoid sugar-sweetened beverage intake; encourage water Grade B
Strongly recommend

Transition to table food with:
• Total fat 30% of daily kcal/EER*** Grade B
Recommend

• Saturated fat 8–10% of daily kcal/EER Grade B
Recommend

• Avoid trans fat as much as possible Grade D
Strongly recommend

• Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EER Grade D
Recommend

• Cholesterol < 300 mg/d Grade B
Strongly recommend

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.

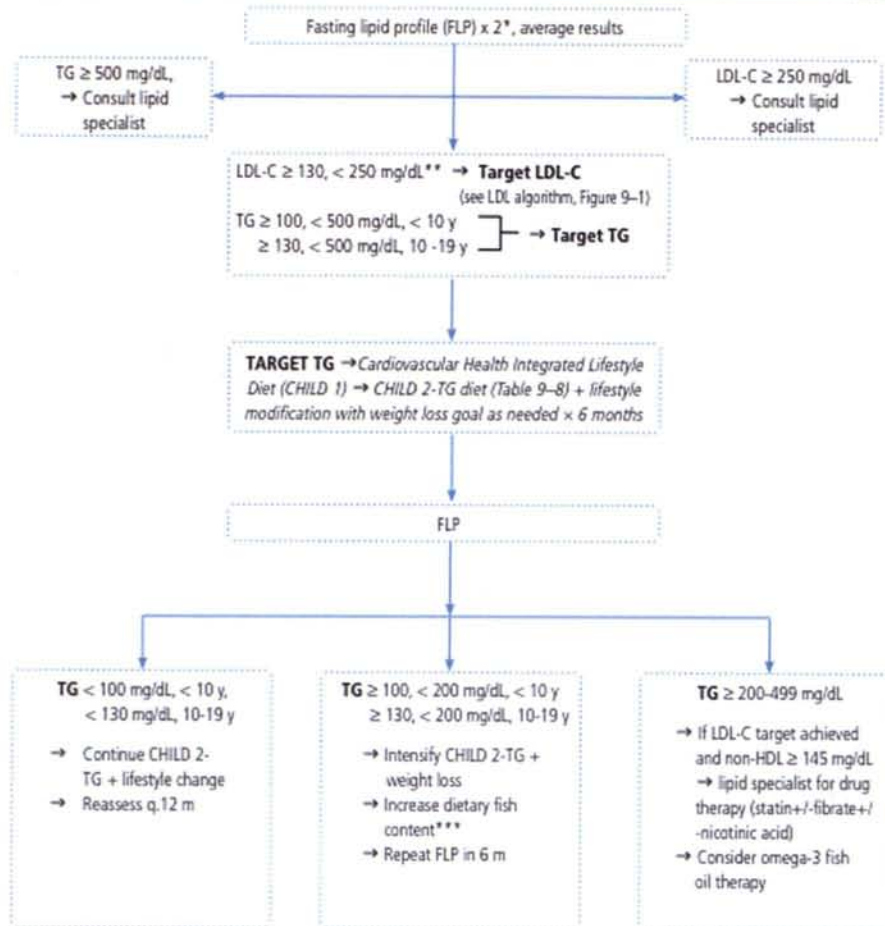
*** EER = Estimated Energy Requirements/d for age/gender (Table 5-1).

| | | |
|--|---|--------------------------------------|
| 2–10 y | Primary beverage: Fat-free unflavored milk | Grade A <i>Strongly recommend</i> |
| | Limit/avoid sugar-sweetened beverages; encourage water | Grade B <i>Recommend</i> |
| | Fat content: | |
| | • Total fat 25–30% of daily kcal/EER | Grade A <i>Strongly recommend</i> |
| | • Saturated fat 8–10% of daily kcal/EER | Grade A <i>Strongly recommend</i> |
| | • Avoid trans fat as much as possible | Grade D <i>Recommend</i> |
| | • Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EER | Grade D <i>Recommend</i> |
| | • Cholesterol < 300 mg/d | Grade A <i>Strongly recommend</i> |
| | Encourage high dietary fiber intake from foods* | Grade B <i>Recommend</i> |
| | Supportive actions: | |
| <ul style="list-style-type: none"> • 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. • Encourage dietary fiber from foods: Age plus 5 g/d.* • Limit naturally sweetened juice (no added sugar) to 4 oz/d. • Limit sodium intake. • 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). | | |

| | | |
|--|---|--------------------------------------|
| 11–21 y | Primary beverage: Fat-free unflavored milk | Grade A <i>Strongly recommend</i> |
| | Limit/avoid sugar-sweetened beverages; encourage water | Grade B <i>Recommend</i> |
| | Fat content: | |
| | • Total fat 25–30% of daily kcal/EER | Grade A <i>Strongly recommend</i> |
| | • Saturated fat 8–10% of daily kcal/EER | Grade A <i>Strongly recommend</i> |
| | • Avoid trans fat as much as possible | Grade D <i>Recommend</i> |
| | • Monounsaturated and polyunsaturated fat up to 20% of daily kcal/EER | Grade D <i>Recommend</i> |
| | • Cholesterol < 300 mg/d | Grade A <i>Strongly recommend</i> |
| | Encourage high dietary fiber intake from foods* | Grade B <i>Recommend</i> |
| | Supportive actions: | |
| <ul style="list-style-type: none"> • 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.



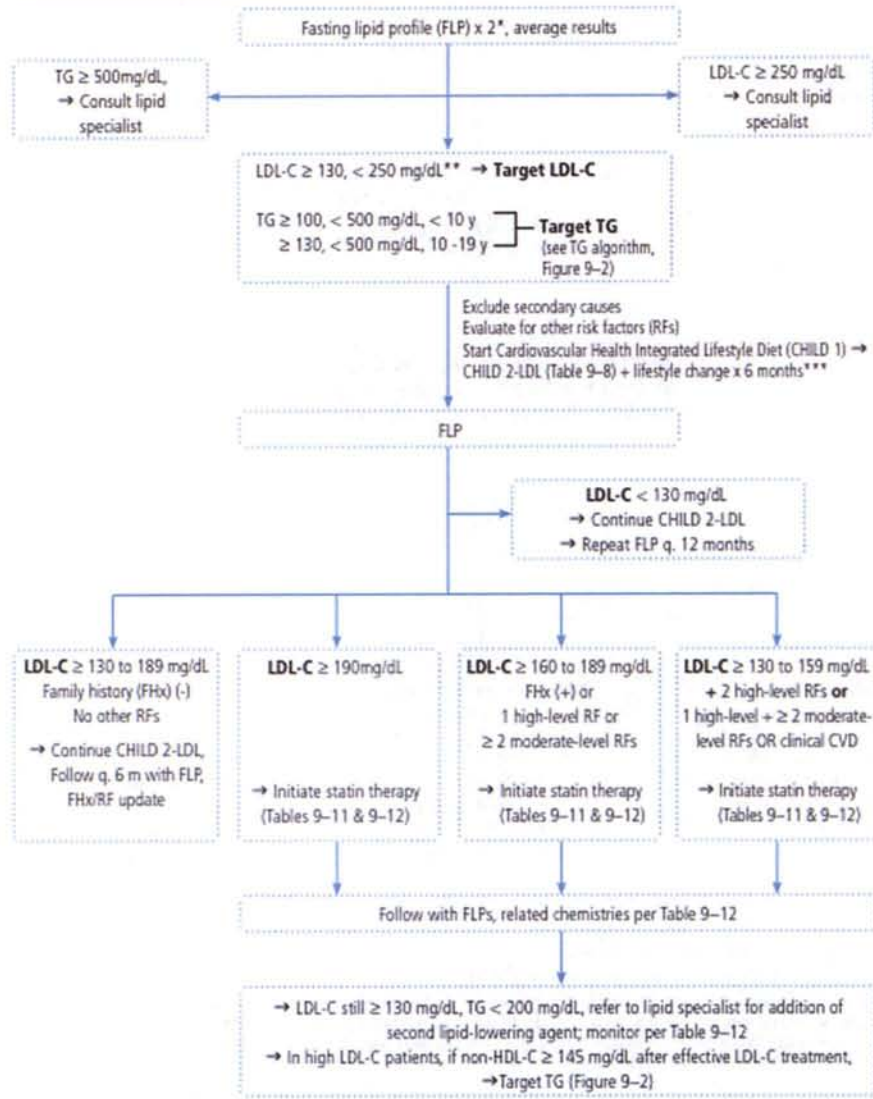
* Obtain FLPs at least 2 weeks but no more than 3 months apart.

** Per Table 9-5, use of drug therapy is limited to children ≥ 10 y with defined risk profiles.

*** 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, call the FDA's food information line toll free at 1-888-SAFEFOOD or visit www.fda.gov/Food/FoodSafety/Product-specificInformation/Seafood/FoodbornePathogensContaminants/Methylmercury/ucm115644.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.



* 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.



Home • CCHP • For Providers

Information for Providers

The CCHP 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. CCHP cares for over 100,000 members in Contra Costa County.



[\(https://hsvpn.cccounty.us/cclink/\)](https://hsvpn.cccounty.us/cclink/)

[Login to ccLink Provider Portal \(https://hsvpn.cccounty.us/cclink/\)](https://hsvpn.cccounty.us/cclink/)

Download [ccLink Provider Portal Access Agreement](#)

</healthplan/pdf/cclink-provider-agreement.pdf> | [Attachment A](#)

</healthplan/pdf/cclink-provider-agreement-Attachment-A.pdf>

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](#)

- [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](#).

[[help with PDF files](#)]

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

PATRICIA TANQUARY, MPH, PhD
Chief Executive Officer
JAMES TYSELL, MD
Medical Director



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

This publication was supported by Grant Number H23/CCH922507 from the Centers for Disease Control and Prevention (CDC).

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

3. _____ 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 _____
Signature Date

Referral Form Completed By _____
Signature Date

Title Phone

Person giving info _____ Relation to child _____ Phone _____

Internal Use Only

Referred to

| | |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | RCEB |
| <input type="checkbox"/> | SELPA: |
| <input type="checkbox"/> | 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 _____

| |
|------------------------------------|
| Attempts to contact Phone message: |
| |
| |
| |
| Final attempt letter sent: |

Birth Status:
 Vaginal _____
 C-Section _____
 Any Complications:

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** _____

WILLIAM B. WALKER, M.D.
HEALTH SERVICES DIRECTOR

WENDEL BRUNNER, M.D.
DIRECTOR OF PUBLIC HEALTH



CONTRA COSTA
PUBLIC HEALTH
COMMUNICABLE DISEASE
PROGRAMS
597 CENTER AVENUE, SUITE 200-A
MARTINEZ, CALIFORNIA 94553
PH (925) 313-6740
FAX (925) 313-6465

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:

<http://www.cdph.ca.gov/programs/immunize/Documents/CDPHHCFacilityICRecsforSuspectMeaslesPatients.pdf>

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>

