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: January 26, 2016

Where: **1350 Arnold Dr., Martinez Conference Room 103**

The agenda for the meeting is as follows:

I.	**CALL TO ORDER and INTRODUCTIONS**	James Tysell, MD
II.	**REVIEW and APPROVAL of MINUTES from previous meeting**	James Tysell, MD
III.	**REGULAR REPORTS**	
	1. 2015 Adult preventative Care guidelines - highlight changes 2. Behavioral Health referral data 3. Complex Patient Case management program 4. Heart Failure guidelines 5. FIT testing for colorectal cancer	James Tysell, MD
IV.	**NEW BUSINESS**	
	• Care coordination for young children with special health care needs • Disease Management Program	Vi Ibarra Elisa Hernandez, MPH
VI.	**OTHER**	
	• Claims Concerns • Provider Concerns	Alycia Rubio, Business Service Manager James Tysell, MD/CCHP Staff
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 April 21, 2015 and attached herein.

Our next scheduled meeting is:

April 26th, 2016

DRAFT

CONTRA COSTA HEALTH PLAN

East County

Quarterly Community Provider Network (CPN)

Meeting Minutes – October 27, 2015

Attending:

CCHP Staff: M. Berkery, RN, J. Tysell, MD; J. Galindo, RN, Diane Dooley, MD.

CPN Providers:

Guests: Mary Jane Kiefer MS, RD (WIC);

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 July 21, 2015:** Minutes were approved as presented.		M. Berkery, RN
III.	**Regular Reports:** ▪ **<u>Dr. Dooley Presentation</u>—Breastfeeding Guidelines** – Continued growth in HP. Large difference in intent to BF and actual. – Reasons: Supply of milk Pain Baby's ability Family support Ineffective assistance (bilingual) Return to work, exclusive return to work success – First month especially crucial: Frequent feeding, sucking. Pacifiers?? Controversial. – Goal: first two weeks exclusive, to establish milk supply. – IBCLC availability—CCHP is hiring for "gap". – Breast pumps: Month hospital grade level if urgent and if no suck, etc. (CCHP or WIC). Return to work (personal). WIC has "locker pumps" at hospital they loan thru ITC. Fill out prior authorization request **with reason**. • Provider training is available by WIC (2 days training)		Diane
IV.	**New Business** ▪ **Contra Costa CARES discussion:** This new program provides primary care services for undocumented adults. Only FQHCs will see these patients. It starts in December, 2015. Hospital, Emergency and care from specialists are not covered under this program.		J. Tysell, MD

V.	**Palliative Care:** ▪ Quality of life. Hospice with curative intent. ▪ Dr. Gretchen will bring more information about Pediatric Hospice for the next meeting.		
VI.	**PCP Providers and MH Access line:** There have been issues with the referrals. Dr. Tysell recommends having more information from the provider when the referral is done. Providers request a mechanism to check if the MH provider is accepting members.		
VII.	**Medical Managed Care Performance Dashboard Discussion** For full report: http://www.dhcs.ca.gov/services/Documents/MMCD/September172015Realease.pdf		
	ADHD Meds HEDIS discussion on return/follow up visits.		
	Dr. Saffier Class X number (special DEA for buprenorphine).		
	Immunization Updates		
	Adjournment: Meeting adjourned @ 8:50 A.M.		M. Berkery, RN

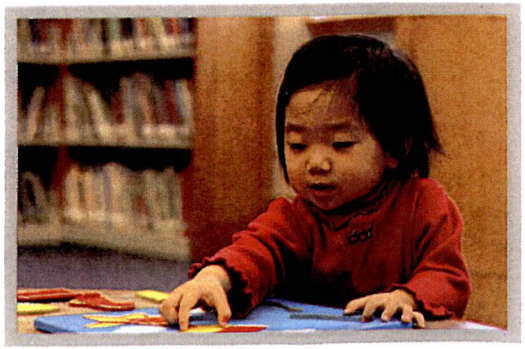
Next meeting January 26, 2016

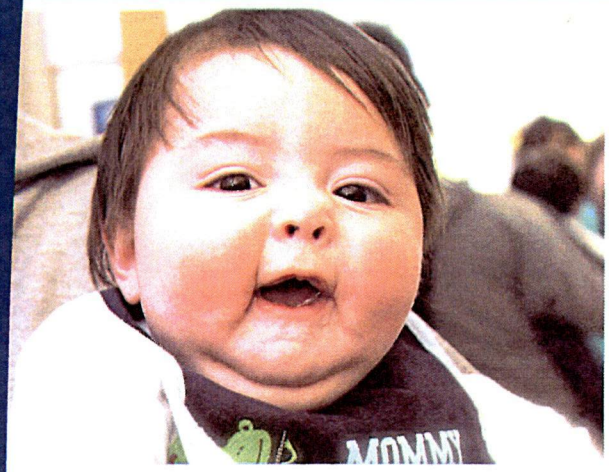
In California...

- Over 14% of families with special health care needs speak a language other than English at home.
- More than 4 in 5 children with special medical needs do not receive one or more basic aspects of quality health care.
- More than 1 million children have a special health care need.

In Contra Costa County...

- Approximately 10,500 children have a major disability. Many of these children and families face severe challenges. Health-care and other support services may be poorly coordinated, and families are left to navigate the fragmented and confusing system on their own. These challenges are magnified for children of color, low-income families, and those living in rural areas.





For more information about how to connect with Roundtable meetings to support the children you serve, contact:

Vi Ibarra
vibarra@careparentnetwork.org
(925) 437-1216

or

Care Parent Network
(925) 313-0999

2015

This project is funded through a grant from The Lucile Packard Foundation for Children's Health.

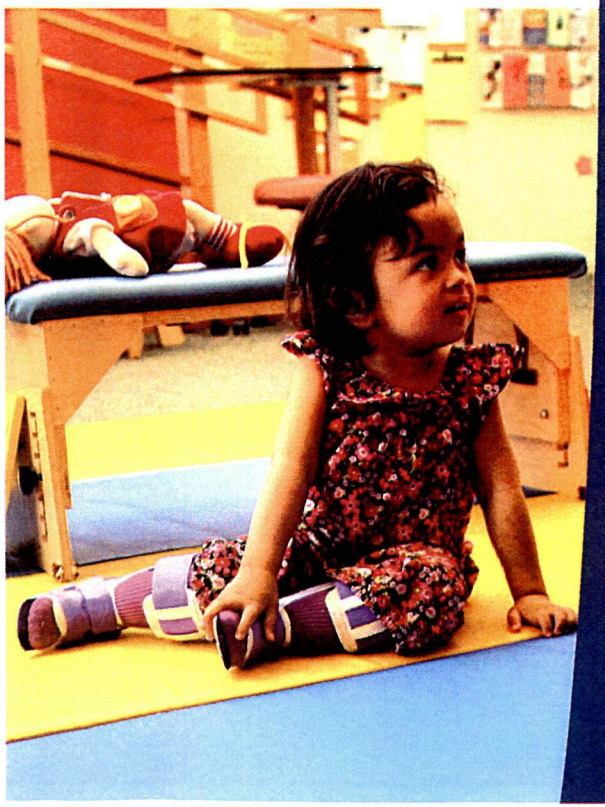
Lucile Packard Foundation *for* Children's Health

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA COUNTY

INTERAGENCY COUNCIL OF CHILDREN'S SERVICES

Roundtable Meetings



Roundtable participants include:

- California Children's Services
- Care Parent Network
- Contra Costa Health Plan
- Contra Costa Regional Medical Center/Health Centers
- Early Intervention Providers
- Mental Health Providers
- Public Health Nursing
- Regional Center of the East Bay
- SELPAs

Are you a Contra Costa provider working with a child age zero to five with...

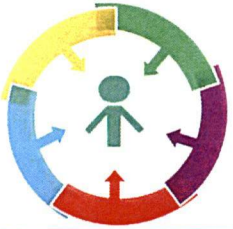
- Multiple or complicated diagnoses?
- Multiple referrals or coordination?
- Multiple agency involvement?
- Questions about eligibility for various programs?
- Delay in screening, assessment, or eligibility determination?
- A family with complex challenges?

Children are the focus at monthly Roundtable meetings. At these meetings, you will have the opportunity to share information about the child, with the parent's consent, in order to coordinate services with many of the other providers in Contra Costa County. Rather than relying on multiple emails and phone calls, speak directly with representatives from agencies to coordinate care for the children you work with.

Children with special needs in Contra Costa often interact with multiple providers, agencies, and case managers. While each agency may excel in its area of expertise (Health Care, Mental Health, Developmental, etc.), the best and most effective way to meet each family's unique needs is through interagency coordination.

Roundtable meetings provide a solution to the gaps in our system by ensuring that the needs of the whole child and family are addressed, that different components of care are coordinated, and that families get what they need in a timely manner from all of our programs.

- Connect
- Discuss
- Coordinate Care
- Make a Difference



CONTRA COSTA
INTERAGENCY COUNCIL OF CHILDREN'S SERVICES MEETING
AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Child's Name: _____
Date of Birth: _____
Home Address: _____
_____
Phone: _____

California Children's Services
Care Parent Network
Center for Early Intervention on Deafness
Contra Costa ARC's Early Intervention Programs: The George Miller Centers and Lynn Center
Contra Costa Employment and Human Services
Contra Costa County Office of Education
Contra Costa Health Plan
Contra Costa Mental Health
Contra Costa Public Health Nursing/Clinic Services
Contra Costa Regional Medical Center/Health Centers
Early Childhood Mental Health Program
Early Head Start/Head Start
First 5 Contra Costa
John Muir Health
Kaiser Permanente
Regional Center of the East Bay
Special Education Local Plan & Center Areas (SELPA)
We Care Services for Children
Other: _____

The purpose of this authorization is to allow the individuals/agencies listed below and any regular or contract employees of those agencies who are involved in my child's case, to use, disclose, and exchange information concerning my child with each other to develop a plan of comprehensive services. I hereby give my permission for release and exchange of confidential information limited to and as necessary to accomplish this purpose by the sources listed.

I hereby authorize the agencies listed above to use and disclose the following information during Contra Costa Interagency Council of Children's Services Meetings:

- Name and other personal identifying information
- Information related to the development of a treatment and/or service plan
- Educational records
- Summary of developmental history and progress
- Summary of medical history, diagnosis, treatment and progress
- Mental Health Information
- Prenatal History
- Court Records

I understand that I may inspect or copy the records that will be used or disclosed. I understand that my records are protected under state and federal confidentiality regulations (including Federal Regulation 42 CFR Part 2; and 45 CFS Parts 160 and 164; Civil Code 56.10 et seq., Welfare and Institutions Code sections 4514, 10850, and 5328 et seq., Education Code Section 49069) and cannot be disclosed without my written consent. Redisclosure without my specific written consent is strictly prohibited. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I may revoke this authorization in full or in part at any time by notifying a member of the treatment team in writing.

I understand that medical providers may not condition treatment, payment or enrollment in a health plan or eligibility for benefits based upon this authorization form.

This authorization expires automatically on your child's sixth birthday, or earlier if you prefer. A photocopy of this form is valid as the original. This authorization will be kept for six years.

I understand I have a right to receive a photocopy of this authorization form.

Print _____
Signature _____
Date _____
Expiration Date _____

(Check one) ☐ Parent ☐ Legal Guardian ☐ Authorized Representative

Staff Person Signature _____ Agency Affiliation _____ Date _____

CONTRA COSTA
REUNIÓN DEL CONSEJO INTERINSTITUCIONAL DE CONTRA COSTA DE LOS SERVICIOS PARA NIÑOS
AUTORIZACIÓN PARA EL INTERCAMBIO DE INFORMACIÓN CONFIDENCIAL

Nombre del niño: _____
Fecha de nacimiento: _____
Dirección: _____
_____
Número de teléfono: _____

Servicios para Niños de California (California Children's Services)
Care Parent Network
Centro de Intervención Temprana para la Sordera (Center for Early Intervention on Deafness)
Condado de Contra Costa ARC's Programa de Intervención Temprana: The George Miller Centers and Lynn Center
Departamento de Servicios Sociales del Condado de Contra Costa
Oficina de Educación de Contra Costa
Plan de Salud de Contra Costa
Contra Costa para la Salud Mental (Contra Costa Mental Health)
Servicios de Enfermería/Clínicos de Salud Pública de Contra Costa
Centro Médico Regional y Centros de Salud de Contra Costa
Programa de Salud Mental para la Primera Infancia (Early Childhood Mental Health Program)
Early Head Start/Head Start
First 5 Contra Costa
John Muir Health
Kaiser Permanente
Regional Center of the East Bay
Areas del Plan Local de Educación Especial (Special Education Local Plan Areas, SELPA)
We Care Services for Children
Otros:_____

El propósito de esta autorización consiste en permitir que las personas/organizaciones mencionadas a continuación, así como los empleados permanentes o contratados de dichas organizaciones que intervienen en el caso de mi hijo/hija, utilicen, divulguen e intercambien entre sí información acerca de mi hijo/hija para elaborar un plan de servicios integrales. Por medio de la presente presto mi consentimiento a la divulgación e intercambio de información confidencial con carácter limitado y con el alcance necesario para que las fuentes mencionadas cumplan cumplir con este propósito.

Por medio de la presente autorizo a las organizaciones mencionadas anteriormente a usar y divulgar la siguiente información durante las Reuniones del Consejo Interinstitucional de Contra Costa de los Servicios para Niños:

- Nombre y otra información de identificación personal
- Información relacionada con la elaboración de un plan de tratamiento y/o servicios
- Registros educativos
- Resumen del historial y progreso del desarrollo
- Resumen de historia clínica, diagnóstico, tratamiento y progreso
- Información sobre salud mental
- Historial prenatal
- Archivos judiciales

Comprendo que puedo examinar o copiar los registros que se utilizarán o divulgarán. Comprendo que mis registros están protegidos en virtud de reglamentaciones estatales y federales en materia de confidencialidad (entre ellas, el Reglamento Federal 42 CFR Parte 2; y 45 CFS, Partes 160 y 164; Código Civil 56.10 y siguientes, Código de Instituciones y Asistencia Social, artículos 4514, 10850, y 5328 y siguientes; Código de Educación, artículo 49069) y no puede ser divulgada sin mi consentimiento por escrito. Queda estrictamente prohibida la nueva divulgación sin mi consentimiento expreso por escrito. Comprendo que puedo revocar este consentimiento en cualquier momento, salvo que se hayan adoptado medidas sobre la base del mismo. Podré revocar esta autorización, en forma total o parcial, en cualquier momento notificando a un miembro del equipo de tratamiento por escrito.

Comprendo que los proveedores de atención médica no pueden condicionar el tratamiento, el pago o la inscripción en un plan de salud o la elegibilidad para recibir beneficios con fundamento en este formulario de autorización.

Esta autorización vencerá en forma automática en la fecha en que mi hijo/hija cumpla seis años de edad o con anterioridad a la misma, a mi opción. Una fotocopia de este formulario tiene la misma validez que el original. Esta autorización se conservará durante seis años.

Comprendo que tengo el derecho de recibir una fotocopia de este formulario de autorización.

Aclaración _____
Firma _____
Fecha _____
Fecha de vencimiento _____

(Marcar una opción) ☐ Padre ☐ Tutor Legal ☐ Representante Autorizado

Firma del miembro del personal _____ Organización a la que pertenece _____ Fecha _____

Contra Costa California Community Care Coordination Collaborative (7Cs)
Referral to Interagency Council of Children's Services Roundtable Meeting

Please bring this form and the signed parent consent to the next Roundtable meeting. For meeting details call (925) 313-0999.

Lucile Packard Foundation for Children's Health

Demographic Information

Today's Date	Name of Referrer	Agency/Organization	Phone#	Email Address

Child Last Name	Child First Name	MI	Parent Last Name	Parent First Name

☐ Male ☐ Female	Child's DOB	Child's Ethnicity	Primary Language	☐ Requires use of translator ☐ Has difficulty reading or writing in primary language

Child's Current Diagnoses, If Any	Home Phone	Cell Phone

Insurance Information

Private Insurance	**Medi-Cal (check one)**	
Network:	☐ Contra Costa Health Plan (CCHP)	☐ Anthem Blue Cross
	☐ Contra Costa Health Plan/Medi-Cal (CCHP/MC)	☐ Kaiser
	☐ Straight Medi-Cal	

Reason for Referral - check all that apply

- ☐ Client or family have social issues
- ☐ Client has multiple/complicated diagnosis
- ☐ Client has/needs multiple referrals/coordination
- ☐ Client has not been found eligible for services, but there is a concern
- ☐ Client has received conflicting diagnosis and/or disagreement in services and supports that are recommended.
- ☐ Client has experienced difficulty in accessing care or services
- ☐ Client has been unable to connect with a provider. Provider/agency name: _____
- ☐ Client has experienced a delay in screening, assessment or eligibility determination(s)

Services/Intervention/Agency Involvement

Check all that apply.

✓	Agency	Circle One		What assessments have been done? Provide date, if known.	Notes
☐	California Children's Service (CCS)	pending	receiving		
☐	Care Parent Network	pending	receiving		
☐	Children and Family Services (CFS)	pending	receiving		
☐	Clinic for Autism and ADHD Diagnostics (CAAD)	pending	receiving		
☐	Early Head Start/Head Start	pending	receiving		
☐	Early Intervention	pending	receiving		
☐	First 5	pending	receiving		
☐	Foster Care	pending	receiving		
☐	Mental Health	pending	receiving		
☐	Primary Care Provider	pending	receiving		
☐	Public Health Nurse	pending	receiving		
☐	Regional Center of the East Bay (RCEB)	pending	receiving		
☐	School District/SELPA	pending	receiving		
☐	other:	pending	receiving		
☐	other:	pending	receiving		
☐	other:	pending	receiving		

Check any boxes that apply. Note: there may be no boxes checked in the categories that do not apply.

1. Caregiver's Use of English	☐ Minimal English-speaking and reading skills ☐ Does not understand, read or speak English ☐ Resistant to the use of a translator
2. Caregiver's Use of Health Care System and Access to Care	☐ Has family issues that may affect the child receiving proper and timely care ☐ Fails to seek care for symptoms requiring evaluation / treatment ☐ Fails to return as requested to health care provider ☐ Inability to coordinate multiple appointment/treatment plans
3. Developmental Delay /Disability	☐ Child screened for developmental milestones with suspected delay but no diagnosis ☐ Child diagnosed with developmental delay and is not receiving services or treatment is not effective ☐ Severe developmental disability
4. Medical /Health Risk	☐ Medical or physical problems which moderately affect child's physical and intellectual development ☐ 2-3 medical specialty services needed ☐ Physical or medical problem which currently significantly impacts child's physical and intellectual development (e.g. pre-term infant, cardiac defect, genetic defect, seizure disorder, born addicted to drugs, etc.) ☐ Greater than 3 medical specialty services needed
5. Emotional or Behavioral Concerns	☐ Child exhibits inappropriate emotional behavior such as outbursts or inappropriate anger ☐ Child exhibits self-injurious behavior that does not leave physical marks ☐ Child exhibits abnormal emotional behavior or intense outbursts which interfere with activities of daily living ☐ Child exhibits self-injurious behavior that leaves marks on the child ☐ Child has needed hospitalization for the management of mental illness ☐ Child has had multiple visits to the emergency room for out of control behavior
6. Trauma to Child	☐ Some trauma to child (e.g. recent divorce or death of child's parent(s) or caregivers) ☐ Significant trauma to child (e.g. multiple surgeries/hospital visits; multiple foster home placements; child has witnessed violence)
7. Abuse, Neglect, or Domestic Violence	☐ History of abuse or prior Children and Families Services (AKA Child Protective Services) with episode resolved and case closed ☐ Ongoing child abuse/neglect or domestic violence investigation ☐ Previous abuse, neglect or domestic violence of serious nature ☐ Abuse, neglect or domestic violence suspected or discussed but no system intervention to date
8. Substance Abuse	☐ Suspected substance abuse, or caregiver or household member has a history of substance abuse ☐ High risk behavior indicating recent or current substance abuse; or there is proven substance abuse
9. Living Situation	☐ Crowded living situation or multiple families living in same dwelling ☐ Residing with foster family ☐ Shared custody of child ☐ Unstable- explain:
10. Financial Resources/ Transportation	☐ Limited resources to meet basic needs (clothing, food, shelter) or unable to manage finances ☐ Caregiver sometimes needs transportation assistance (unable to drive at night, out of their own neighborhood, etc.) ☐ Family unable to meet basic needs (clothing, food, shelter) ☐ Community resources are inaccessible due to transportation issues

Please describe all challenges in accessing care, including social, developmental, medical and financial issues:

Contra Costa California Community Care Coordination Collaborative (7Cs)
Referral to Interagency Council of Children's Services Roundtable Meeting

Frequently Asked Questions

What is 7Cs?
The Contra Costa California Community Care Coordination Collaborative (7Cs) was created by a grant from Lucile Packard Foundation for Children's Health in 2013. Partner agencies are working together to improve care coordination for children with special health care needs in Contra Costa County.

What are ICCS Roundtable meetings?
Roundtable meetings offer a forum for agency representatives to conduct care coordination on behalf of Contra Costa children with special health care needs, birth through five years, and their families. Roundtable meetings are a community interagency care coordination activity, based on voluntary agency representation participation. No single agency "owns" or operates the meeting.

Where and when to do the Roundtable meetings take place?
Meetings are held monthly in both West County and Central/East. For more details, contact Vi Ibarra at (925) 437-1216 or vibarra@careparentnetwork.org, or call Care Parent Network at (925) 313-0999.

What is the purpose of the referral form?
This form helps to compile information about the child in one place which is then used to start the discussion at the Roundtable meeting. Skip any questions you do not have the information for. It is not necessary that each question be answered prior to bringing the case for discussion. The questions on the back of the form (second page) refer to common risk factors. Any boxes checked in the shaded areas signify more serious issues than those in the unshaded areas.

Bring a copy of the referral form to give to the Children's Service System Coordinator or meeting facilitator. The referral form is intended to help identify common barriers to care for children with special health care needs. While a child/family may be helped on an individual level through the process of referral to the Roundtable meeting, the ultimate goal is to make improvements to the larger systems of care to help multiple children and families over time. The form will be used to track these larger systems issues over time.

Who can I refer to a Roundtable meeting?
You may refer a client who meets all of the following eligibility criteria:

- Child is a resident of Contra Costa County
- Child is 0 to 5 years old
- Child has increased risk for a chronic physical, developmental, behavioral or emotional condition
- Parent (or legal guardian) has signed an authorization to exchange confidential information

How is my referral shared at the Roundtable meeting?
You (or a representative from your agency who is familiar with the child/family) will bring the signed parent authorization and the referral form to a Roundtable meeting for discussion. If you are unable to attend the meeting, contact Vi Ibarra (contact information is above) to discuss alternative options.

SB 277: California's New School Vaccine Law

What physicians need to know

This document was jointly produced by the California Medical Association, the American Academy of Pediatrics, California and the California Academy of Family Physicians.

On June 30, 2015, California Governor Jerry Brown signed Senate Bill 277 into law. SB 277 removes the personal belief exemption (PBE) from school vaccination requirements and allows exemptions only for medical reasons. The SB 277 immunization requirements apply to students first admitted to school, child care or entering seventh grade starting in 2016.

Answers to the commonly asked questions related to the recent passage of Senate Bill 277 are found in the document below. This information does not constitute, and is no substitute for, legal or other professional advice. Physician offices should consult their personal attorneys or professional advisors for specific guidance on their compliance with SB 277.

Note: In this document you will find references to CMA On-Call documents. These documents are available free to members in the California Medical Association (CMA) online health law library at http://www.cmanet.org/cma-on-call. Nonmembers can purchase documents for $2/page.

Frequently Asked Questions about SB 277

1. When do children need to be vaccinated?

Starting in 2016, children will need the appropriate vaccinations or have a medical exemption prior to enrolling in public or private elementary or secondary schools, child care centers, day nurseries, nursery schools, family day care homes or development centers.

SB 277 does not, however, require immunizations for children who participate in home-based private schools and independent study programs that do not require classroom-based instruction, nor does it prevent those in individualized education programs from accessing necessary special education or related services. Physicians can find immunization schedules for the appropriate age ranges on the California Department of Public Health (CDPH) website Shots for Schools.

2. Can physicians sign personal belief exemptions (PBEs) after January 1, 2016?

As of January 1, 2016, the law pertaining to PBEs and the AB 2109 form is repealed and schools will no longer accept PBE forms on or after that date.

3. If the sibling of my patient has reported adverse reactions to vaccines, am I required to provide that patient with a medical exemption?

Medical exemption determinations are at the discretion of the licensed physician. SB 277 clarified that "family medical history" may be considered in making the determination, but there is no specific provision in the law that mandates a medical exemption based on family medical history.

4. What must be a part of the written statement for a medical exemption?

A written statement providing a medical exemption for a patient should state that, due to the physical condition or medical circumstances related to the child, immunizations are not considered safe for that child. The statement should also indicate the general nature (e.g. immunodeficiency, prior adverse reactions including allergy, medication that requires delay in vaccination) and probable duration of the medical condition for which the physician does not recommend immunization. It should also include the vaccines from which the child is exempted.

Physicians should keep in mind that a physician must make reasonable efforts to limit use or disclosure of protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. (45 C.F.R. §164.502(b)(1).) For more information on minimum necessary disclosure, see CMA On-Call document # 4101, "HIPAA Privacy Rule."

5. Does SB 277 affect existing personal belief exemptions?

If a personal belief exemption has been submitted prior to January 1, 2016, a child will be allowed to remain enrolled until entry in the next grade span.

These grade spans are defined as:

- Birth to Preschool.
- Kindergarten and grades 1 to 6, including transitional kindergarten.
- Grades 7 to 12, inclusive.

6. Can students take PBEs with them when they switch schools?

Students who have a PBE on file before January 1, 2016, may take it with them if they switch schools until they enter a new grade span (see question #5).

7. Will a personal belief exemption from another state or country be valid if the student enrolls in a California school?

No.

8. If a student has a conditional admission, where the student is allowed to attend school while they catch up on one or more immunization, can the physician decide what the catch-up schedule will be or is there a specifically required catch-up schedule?

California Department of Public Health (CDPH) does have a conditional admission immunization schedule for schools that lays out a catch-up schedule when children are conditionally admitted, but are not fully immunized prior to admission. Physicians can find information on conditional admission and related immunization schedules at http://www.shotsforschool.org/laws/conditional-admission. However, physicians always have the discretion to adjust the schedule based on the particular patient's needs and the physician's professional judgment.

9. Can a physician be held liable for providing—or not providing—a child with a medical exemption from vaccination requirements?

SB 277 does not alter current law regarding physician liability for medical exemptions from vaccine requirements—no applicable provisions protect a physician from liability for providing or not providing a medical exemption. Physicians must continue to exercise their professional judgment in providing or not providing any medical exemption from the vaccination requirements to ensure that it falls within the standard of care.

10. What do I do if a parent or guardian terminates the physician-patient relationship as a result of my decision not to provide a medical exemption?

When a patient expressly discharges you, you should follow up with a letter:

1. Confirming that the patient has terminated the relationship;
2. Emphasizing the need for follow-up care; and
3. Where possible, referring the patient to other sources of care.

For more information on the termination of the physician-patient relationship, see CMA On-Call document #3503, "Termination of the Physician-Patient Relationship."

11. For which diseases is vaccination required?

When medical exemption is not provided, SB 277 requires vaccinations for:

- Diphtheria
- Haemophilus influenzae type b
- Measles*
- Mumps*
- Pertussis (whooping cough)
- Poliomyelitis
- Rubella*
- Tetanus
- Hepatitis B
- Varicella (chickenpox)*

(Indicates vaccines are not needed if the patient has proof of immunity (e.g., serology or in some cases physician diagnosis).)*

The law also allows CDPH to include additional vaccinations it deems appropriate; however, the law allows for personal belief exemptions if the vaccinations are added to the list above by CDPH.

12. Is the adult immunization schedule also mandated?

No. There is no mandate for all adults to be immunized. However, effective September 1, 2016, Senate Bill 792 will prohibit individuals from being employed or volunteering at a day care center or a family day care home if they have not been immunized against influenza, pertussis and measles.

13. What are some resources related to school-mandated vaccinations?

- The Center for Disease Control and Prevention (CDC)'s Vaccine website (http://www.cdc.gov/vaccines) contains valuable information on vaccine schedules, recommendations and patient education materials.
- The CDC's Chart of Contraindications and Precautions to Commonly Used Vaccines can be found at http://www.cdc.gov/vaccines/recs/vac-admin/contraindications-vacc.htm.
- The American Academy of Pediatrics Immunization website contains policy guidelines, communication tools and parent resources at http://www2.aap.org/immunization/pediatricians/pediatricians.html.
- The California Department of Public Health's Immunization Branch website (https://www.cdph.ca.gov/programs/immunize/Pages/default_old.aspx) contains information on state immunization rates, updates, training, brochures and flyers related to immunizations.
- The California Department of Public Health's Shots for School website (http://www.shotsforschool.org) contains the latest updates on California's school immunization requirements, information on school immunization rates, and links to the laws and regulations related to school immunization.
- The California Department of Public Health's Senate Bill 277 Frequently Asked Questions at http://www.cdph.ca.gov/programs/immunize/Pages/Default.aspx.
- American Academy of Pediatrics, California can be reached by contacting Kris Calvin at kcalvin@aap.net or (626) 796-1632.
- California Academy of Family Physicians can be reached at cafp@familydocs.org or (415) 345-8667.

Stipulations			
APPLIES to:			
CPN members that are referred to contracted **CPN** providers **(excludes tertiary care centers such as UCSF and UC Davis**			
****RMC** except with asterisk			
EXCLUDES:			
RMC members accessing services in the CPN except with asterisk			
Services that are CCS eligible for **Medi-Cal** and **Healthy Families** members under 21 y/o			
Specialty	**CPT code**	**Brief Description**	**Applicable global period[1]**
Specialty physician follow up visit	99211-99215,Z7500		
Audiology		Audiologic function tests **NOT COVERED for MEDI-CAL members age 21 or over**	
Cardiology**		Echo	
		Stress Echo	
		EKG	
Dermatology **	11100-11101, 69100, 40490,54100, 67810, 56605	Biopsies	
	17000, 17003-17004, 67850, 17110-17111, 54050	Destructions	
	11900, 11901	Injections	
	11755	Nail Biopsy	
	29580	Unna Boot Applications	
	10060, 10061	I & D	
ENT	31231-31235, 31505, 31515-31571, 31575-31579, 43200	Endoscopy	
	42820, 42825, 42830, 42835	Tonsillectomy, Adenoidectomy or T & A **(CCHP auth required for age 12 or over)**	**90 days**
	69420-69436	Bilateral myringotomy tube placement (BMT)	**10 days**
Gastroenterology	43250-43251, 43255-43256, 43258	Upper GI endoscopy	
	43260-43267, 43269	ERCP	
	45378-45392, G0105, G0121	Colonoscopy	
	45330-45345, G0104	Flexible sigmoidoscopy	
	47000, 47100	Liver biospy **(CCHP auth is required for under 21 y/o)**	**CPT 47100= 90 days**
	49080-49081	Paracentesis	
	82926, 82928	Gastic acid analysis	
	89105	Secretin studies	
	47510-47511, 47530	Biliary drainage	**90 days**
	91010-91012	Esophageal manometry	
	10021, 10022	Fine needle aspiration, CT guided	
	47500, 47505, 74320	Percutaneous choloangiogram	
General Surgery	19100-19103	Breast biopsy	**CPT 19101= 10 days**
	49491-49492, 49495-49501, 49505, 49507, 49520-49521, 49525, 49650-49651	Inguinal hernia repair	**90 days**
	10021, 10022	Fine needle aspirations	
OB/GYN	59000-59001**	Amniocentesis if ≥ age 35 years at delivery	
	59840 **	D & C for missed abortion	**10 days**
	59830-59857**	Elective abortion	**90 days**
	58100**	endometrial biopsy	
	56605**	vulvar biopsy	

[1]Follow up office visits during the noted global period is not separately payable.

	57460**	colposcopy with LEEP	
	57454**	colposcopy	
	59025, 99500**	Initial non-stress test	
Ophthalmology	65855**	Trabeculoplasty (laser surgery of the eye)	**10 days**
	66761**	Laser PI (revision of iris)	**90 days**
	66821**	Lasar capsulotomy (lasering secondary to cataract)	**90 days**
	66820-66821**, 66830, 66982-66984	Lens surgery (incisions, cataract-related procedures)	**90 days**
	67145**	Laser prophylaxis (treatment of retina)	**90 days**
	67210**	Focal laser (treatment of retinal lesion)	**90 days**
	67228**	PRP laser (treatment of retinal lesion)	**90 days**
	67800, 67801**-67805	Chalazion removal, single or multi (remove eyelid lesion)	**10 days**
	67840**	Excision of eyelid lesion	**10 days**
	68760-68761**	Closure of tear duct/lacrimal punctal opening	**10 days**
	68801**	Dilation & irrigation of NLD (dilation of lacrimal punctal)	**10 days**
	76519**	A-Scan (Echo of eye)	
	92020	Gonioscopy	
	92083**	Visual Field Exam	
	92250**	Fundus Photo	
	92230, 92235, 92286-92287**	Internal eye photo with or w/o fluroscein angiogram	
Orthopedic Surgery	29800-29902	Arthroscopy	**90 days**
Perinatology **	99241-99245	Initial Consultation	
	99211-99215	Office Follow Up Visits	
	99244, 59000, 76946, 76811**	Genetic Amnicentesis Counseling, Amniocentesis,Ultrasound Guidance, Ultrasound	
	99244, 59015, 76946, 76801**	CVS Counseling, CVS, US Gudiance for CVS, Ultrasound	
	76801 .76813-76814	Nuchal Translucency	
	59000, 76946, 76805, 76811	Lung Maturity Amniocentesis, US Guidance, Ultrasound (pt <35 y/o), Ultrasound (pt >35 y/o)	
Pulmonary	**94010**	**Spirometry**	
	95806, G0398-G0400	**Ambulatory (unattended) sleep study (to dx OSA only)**	
	31625-31629	**Bronchoscopy with or w/o bx (once per pt per encounter)**	
	32000-32002	**Thoracentesis**	
	32400, 32405	**Percutaneous pleural, lung or mediastinum biopsy**	
	78580-78596	**Ventilation/perfusion scan**	
	10021-10022	**Fine needle aspiration guided CT or flouro**	
	94060, 94664****	**Pulmonary Function Test**	
Vacular Surgery**	36145, 36800, 36821, 36825, 36830-36831	Creation of AV fistula for hemodialysis	**90 days** (no global period for CPT 36145 or 36800)
	35266, 36832-36833, 36870	AV fistula revision	**90 days**
	35475-35476, 36860-36861, 37201, 75896, 75962*, 75978*	AV fistula declotting	*imaging included in payment
	93970 , 93990 , 93976 , 93971	u/s measure veins(extremity study),duplex scan HD access	

[1]Follow up office visits during the noted global period is not separately payable.

CCHP Season Flu Vaccine Matrix 2015-2016

CCHP Medi-Cal Members	Commercial & Medicare Members
CHDP Code 90655 (6-35 months) 90685 (Quadrivalent) 90656 (over age 3) 90686 (Quadrivalent) 90660 Flu Mist Vaccine (2 to 50 years) Plan Payment $9.45	Preservative Free Vaccine Ages: 6 months to 35 months 90685 $24.60 G0008 $43.64 Total payment $68.24
CHDP-Privately Purchased 90657 (6-35 months) $18,71 90658 (3 years and older) $13.76 90685 (6-35 months) $28.23 90686(over age 3) $22.44 Plan payment varies	Preservative Free Vaccine Ages: over age 3 90656 $13.88 90686: $18.16 G0008 $43.64 Total payment varies
For more information on the VFC program, please call (877) 243 - 8832	Regular Flu Vaccine Ages: 6 months to 35 months 90657 $6.02 G0008 $43.64 Total payment $49.66
Privately Purchased Vaccine Must bill on CMS 1500 ↓	Regular Flu Vaccine Ages: over age 3 Q2038: $12.04 G0008 $43.64 Total payment $55.68
Preservative Free Vaccine Ages: 19 years and over 90656 $19.49 90471 $4.68 Total payment $24.17	Nasal Vaccine Ages: 2 to 50 years 90672 (Quadrivalent)$ 26.87 G0008 $43.64 Total Payment 70.51
Regular Flu Vaccine Ages: 19 and over 90658 $17.59 90471 $ 4.68 Total payment $22.27	Regular Flu Vaccine Q2035* (Afluria) $13.03 Q2036* (Flulaval) $8.58 Q2037* (Fluvirin) $15.83 Q2038* (Fluzone) $12.04 G0008 $ 43.64 Total payment varies
Nasal Vaccine Ages: to age 50 90660 (Trivalent)$23.46 90672 (Quadrivalent)$27.03 90471 $4.68 Total Payment varies	90662 (High Dose- Ages 65 and over) $36.32 90673 (Egg allergy – Ages 18 and over) $ 37.19 G0008 $43.64 Total Payment varies
90662 (High Dose- Ages 65 and over) $39.72 90673 (Egg allergy – Ages 18 and over) $43.73 90471 $4.68	
Pneumococcal Polysaccharide Vaccine Reimbursement	
Ages: 2 and above 90732 $91.33 90471 $ 4.68 Plan Payment $96.01	Ages: 2 and above 90732 $77.85 G0008 $43.64 Plan Payment $121.49

**Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use.*

Immunization Updates

Senate Bill 277 went into effect on January 1, 2016. SB277 eliminates the personal belief exemption (PBE) from school-required immunizations in California. Therefore, providers may recycle any blank PBE forms they may have as schools may no longer accept the form.

Children entering child care, kindergarten/transitional kindergarten, and 7th grade will need to have school-required immunizations before the first day of school. Students with a PBE filed before 2016 will continue to be exempted until they enter kindergarten/transitional kindergarten and 7th grade.

Medical exemptions are not affected in any way by SB277.

I pasted some resources below that providers may find helpful.

The other update is that the Advisory Committee on Immunization Practices (ACIP) issued a permissive recommendation for meningococcal serogroup B vaccine.

SB277 FAQ for physicians:
http://www.immunizeca.org/wp-content/uploads/2015/11/2015-10-23-SB-277-FAQ2.pdf

Archived webinar for physicians (audio and slides):
http://www.immunizeca.org/wp-content/uploads/2015/10/CIC-Ed-Hour-Recording.mp3
http://www.immunizeca.org/wp-content/uploads/2015/10/Medical-Exemptions-SB277-final.pdf

General SB277 FAQ: http://www.shotsforschool.org/laws/exemptions/

ACIP Permissive Recommendation to Give Meningococcal Serogroup B Vaccine to Persons 16-23 Years of Age (Preferred Age is 16-18 Years):
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6441a3.htm

Smoking Cessation Webinars

Jennifer Matekuare, Operations Manager, of the Smoking Cessation Leadership Center has sent some information that may be of interest to our Providers. Please note that these are just the ones that have been posted to date.

So far they have three webinars scheduled for 2016:

- January 12th at 11am PST - **Digital and Social Media Interventions for Smoking Cessation in Young Adults, co-hosted by Truth Initiative,** with Dr. Amanda Graham, Megan Jacobs and Dr. Danielle Ramo
- March 9th at 11am PST – **Innovations in Smoking Cessation Medications** with Drs. Robin Corelli and Karen Hudmon
- April 26th at 11am PST – **Smoking and the Homeless** with Dr. Maya Vijayaraghavan

They will most likely have six additional webinars next year and are working to set these up. Please note that if the providers can't make the live date for the webinar, they can always watch the recording at their convenience.

All of the recordings on our website at: http://smokingcessationleadership.ucsf.edu/webinars/archive and if they are interested in receiving CME/CEUs, we have select recordings offering credit. You can see a list of these webinars at: http://smokingcessationleadership.ucsf.edu/webinars/cme

CONTRA COSTA HEALTH PLAN

Title: Case Management Program Description

Case Management
Policy #: CM 16.001

Origin Date: 8/2013
Author: Laurie Crider, RN Director

Applies to:
- ☒ Medi-Cal
- ☐ BAC
- ☐ Medicare
- ☐ State Sponsored
- ☐ Commercial
- ☐ All
- ☐ N/A

Regulatory / Accreditation:
- ☐ Department of Managed Care
- ☐ Other Reg. References:
- ☐ HCFA:
- ☒ NCQA
- ☐ DHS:
- ☐ N/A

Units:
- ☐ Administration
- ☐ Business Services
- ☐ Marketing
- ☐ Provider Affairs
- ☐ Advice Nurses
- ☒ Case Management
- ☐ Member Services
- ☐ Quality Management
- ☐ All Staff
- ☐ Health Ed/Cultural Living
- ☐ Planning, Survey, Reg. Affairs
- ☐ Auth/Utilization Management

OPS Council Approval Date & Sign Off___

POLICY

The Case Management (CM) program is an integral part of the service delivery system for Contra Costa Health Plan.

PURPOSE

Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Since complex case management is considered an opt-out program, all eligible members have the right to participate or decline participation.

GOALS

The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The primary goals of the program are to:

- Enhance the quality of life of the client
- Provide support and advocacy to member and provider
- Decrease fragmentation of care
- Promote cost-effectiveness
- Improve client and provider satisfaction
- Meet regulatory and accreditation requirements

SCOPE:

Case Managers coordinate individual services for members whose needs include ongoing assistance with coordinating health care services. The Case Managers work collaboratively with all members of the healthcare team, including the Primary Care Provider, Specialist Providers, Discharge Planners at the affiliated hospitals and Utilization Management staff at the Health Plan. The Case Management Director is responsible for oversight of program activities and reports to the CEO and Medical Director who reports to the Quality Council.

CM staff provide all clients, community providers, Health Plan employees and other health service providers with high quality professional service, which includes:

- Adherence to the confidentiality rules and regulations set forth by the Contra Costa Health Services Department. Department policy shall be distributed to each employee upon hire and annually by performance evaluation.
- The privacy and confidentiality of all clients and staff shall be respected in all medical and personal matters.
- Equal treatment to all clients equally, without regard to socioeconomic status, race, religion or cultural background.
- Acknowledgement of receipt of new referrals shall be made promptly and courteously to the referring party.

OBJECTIVES:

The CM program intends to accomplish the following:

- Upon enrollment of a beneficiary, CM will ensure the provision of Person-Centered Planning and treatment approaches that are collaborative and responsive to the beneficiary's continuing healthcare needs.
- Coordinate cost-effective services
- Monitor care which is easily accessible with no access barriers as related to the member's available benefits
- Apply benefits appropriately and coordinate with health plan staff to flex benefits
- Promote early and intensive treatment intervention in the least restrictive setting
- Provide accurate and up-to-date information to providers regarding member evaluations
- Create individualized treatment plans which are revised as the member's healthcare needs change
- Utilize multidisciplinary clinical, rehabilitative and support services.
- Arrange broad spectrum appropriate resources for members
- Deliver highly personalized case management services
- Grant adequate attention to member satisfaction
- Uphold strict rules of confidentiality and protect member rights and encourage member responsibility
- Provide ongoing case management program analysis and development
- Encourage collaborative collegial approaches to the case management process
- Promote the CM program's viability and accountability
- Ensure continuity of care for members who have applied for but do not meet the criteria for the home and community-based services waiver.
- Participate in the disenrollment process for CCHP Medi-Cal members to ensure an orderly transfer to FFS Medi-Cal or, for transplant candidates, to the transplant Physician/Facility.

IDENTIFIYING MEMBERS FOR COMPLEX CASE MANAGEMENT

DATA SOURCES

- Claim or encounter data
  - ED Data:
    - A monthly report will be generated from the Analysis and Reporting Unit which will include the cumulative number of "preventable" ED visits (as classified by the NYU Emergency Department Classification Algorithm) per member/recipient in the last rolling 12 months. Members/recipients with 5 or more avoidable visits in the last rolling 12 months will be referred directly to Complex Case Management for more intensive and on-going follow-up.
- Hospital discharge data
  - CCRMC weekly readmission report
- Pharmacy data
  - CCHP pharmacy director conducts quarterly review of members' utilization of scheduled medications (DEA schedules II, III, IV, V) to identify overutilization. If it appears that the member is abusing narcotics (i.e. using multiple physicians and/or pharmacies to purchase narcotics) the member is assigned a case manager.
  - From time to time, CCHP pharmacy director may respond to prescriber initiated requests for ad hoc reporting. Such ad hoc reports can involve medication history requests for a specific patient up to an entire practice of patients. Other reports can encompass system-wide medication utilization.
- Data collected through the UM management process
- Data supplied by members or caregivers
  - Health appraisals/screens completed by newly enrolled members and/or caregivers. If after the health screen is completed and if the member is determined to be high-risk (see criteria under Screening and Assessment Process) the appraiser electronically assigns the case to the CM Director for assignment to a Complex Case Manager for follow up.
- Data supplied by practitioners
- Shared Electronic Medical Record (EMR)
  - Case Managers are notified electronically via in-basket message in EMR of any abnormal lab values or inpatient admissions to Contra Costa Regional Medical Center.
- Analysis of member-specific information including historical fee-for-service utilization data, when available, provided by DHCS electronically at the time of enrollment.

REFERRAL SOURCES

1. The CM Unit staff can receive referrals from the following sources:
   - Primary Care Providers
   - CCHP Quality Management/Disease Management Unit
   - CCHP Utilization Management Unit: Continued hospitalization beyond 5 days or anticipated to be high cost are reviewed in a joint Utilization Management/Case Management case conference meeting with the Medical Director.
   - CCHP Authorization/Utilization Management Unit
   - CCHP Advice Nurse Unit
   - CCHP Member Services Unit
   - Hospital Discharge Planners

- Home Health Agency Staff
- CCHP, CCRMC/Health Center Health Educators
- Contra Costa County Public Health Division
- Contra Costa County Employment and Human Services
- Community Hospitals ED or discharge planning case managers
- Health Risk Assessments completed within the Case Management Department
- Member self-referral or referral from caregiver
- Weekly "difficult to Place" rounds at Regional Medical Center
- Care Transitions (CTI) Nurse
    1. CTI nurse will attend CCRMC morning interdisciplinary rounds no less than twice a week to review clients from the list with the attending MD, social services/discharge planners, UR nurses, and other team members.
    2. CTI coach will review all available client information and make the final determination regarding client inclusion in the program or direct referral to case management, mental health services or physician home visit program.
    3. Weekly concurrent review team report-CM Director meets with Medical Director and UM RN staff to review currently admitted members. Members are identified for CM based on re-hospitalization data and high-risk diagnoses including but not limited to CHF, COPD, ketoacidosis and sickle cell disease
-
- Other, if deemed appropriate by Director of Case Management

2. Referrals are made to the CM Unit by:
    - Completing the CM Unit Intake/Referral Form and faxing or sending it to the CM Unit
    - Referring party may call the CM Unit and provide the necessary information via telephone
    - CCLink (EMR) -All Health Services and Health Plan departments that use CCLink are trained to send electronic referrals to case management
    - Contracted Providers are notified of case management programs and referral processes via the *Provider Orientation Handbook and Manual*. In addition, provider brochures are available with instructions.

    Provider Manual Excerpt:

    Comprehensive Case Management Program

    The Comprehensive Case Management Program is intended to be a proactive service with participation from the client as well as the requesting provider and/or PCP. The purpose of the CM Program is to ensure that medically necessary care is delivered in the most efficient and effective setting for members who require extensive or ongoing services. The program is focused on the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs. As an ongoing effort to keep you informed of the client's care coordination needs, you will receive an initial report of identified case management needs and interventions as well as periodic updates. In order to make a referral to the program, simply complete the referral form provided and fax it to the CM Program. Telephone referrals can also be made. Leave a message including times you may be reached and someone will return your call promptly.

Case Management
Telephone: 925-957-7453
Fax: 925-313-6462

- Member/caregiver self-referrals are accepted telephonically. Members are made aware of case management services via EOC section 4 which states:
  - "The Case Management program is available to assist with the coordination of care and services provided to members who need help navigating the healthcare system. There is no cost to you for this program. If you feel you would benefit from the services of a case manager, please contact the Member Services Department. You may also be referred to Case Management by your healthcare provider. Since case management is considered an opt-out program, you have the right to participate or decline participation."
  - If member declines case management services, they will be mailed a Case Management Brochure for future reference and self-referral.

3. Referral shall be assigned by the CM Director. Assignment shall be based on where the client resides, complexity of needs, intensity of services, and individual CM caseloads.

4. Referral shall be acted on by the Case Manager assigned within 30 calendar days of receiving the referral.

5. Initial feedback (i.e., notification that referral has been received) in writing or by telephone shall be provided to the referral source within 30 days of the referral being entered into the database. Additional feedback to referral source and PCP shall be provided at 90-120 day intervals, while case is open.

6. If a client declines Case Management services or to cooperate with Case Management interventions, the referral source and PCP shall be notified, and communication documented in the notes. A Case Management Program brochure will be mailed to the client for future reference and self-referral to case management.

7. Case Management services are available to all CCHP members (and BHC/HCCI/MCE recipients) regardless of the member's age. CM referrals for members under the age of 21 who are eligible for CCS services will be redirected to CCS for case management in accordance with the Memorandum of Understanding between CCS and CCHP.

8. Guidelines for admission to CM Unit may include, but not limited to:
   - Referral for clinical assessment of benefit exception and substitution appropriateness.
   - Medical non-adherence (e.g., two or more missed appointments, misuse of medications, poor dietary adherence)
   - High utilization of ED visits (e.g., two visits in three months)
   - Clients who over/under utilize medical services that are available to them
   - Frequent hospital admissions (same or different diagnosis) and readmissions (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year)
   - Psychosocial high risk factors resulting in significant negative health outcomes
   - Cognitive changes as evidenced by significant fluctuations in memory, mood, personality or behavior by the geriatric client
   - Need for coordination of care for members receiving medically necessary services outside of the provider network.
   - Unstable medical conditions warranting closer monitoring (e.g., uncontrolled diabetes, exacerbating asthma, COPD, CHF)

- Complex or chronic medical condition, including those which affect multiple organ systems and/or which require ongoing complicated therapy (e.g. transplants, cancer, ESRD)
- Clients requiring assistance following a particular medical regime (e.g., pre-surgical)
- Self-care deficits requiring one-to-one or group health education to promote well-being
- Seniors and Persons with Disabilities (SPD) who are deemed "high-risk" based on Health Risk Screening completed at the plan level.
- Members who are disabled, those with multiple chronic illnesses and those in need of end-of-life care.
- Over/under utilize of medically necessary services

SCREENING & ASSESSMENT PROCESS

CCHP will screen and assess Medi-Cal members as follows:

Screening:

I. CCHP Case Management screens all newly enrolled Medi-Cal members to quickly triage at-risk and high-risk clients to Case Management and other appropriate services. The screening identifies the need for urgent provider appointments, and barriers to obtaining healthcare services.

II. If any of the following criteria are met, the member will be considered high-risk and will be assigned to Complex Case Management:
- Have been on oxygen within the past 90 days
- Are residing in an acute hospital setting
- Have been hospitalized within the last 90 days, or have had 3 or more hospitalizations within the past year
- Have had 3 or more ER visits in the past year in combination with other evidence of high utilization of services
- Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern, i.e. homelessness
- Have ESRD, AIDs and/or a recent organ transplant
- Have cancer, currently being treated
- Are pregnant
- Have been prescribed anti-psychotic medication within the past 90 days
- Prescribed 15 or more prescriptions in the past 90 days
- Have a self-report of a deteriorating condition
- Have other conditions as determined by the plan, based on local resources

III. The Plan outreaches to the member by mailing them the screening HRA within one week of enrollment. Telephone outreach will be attempted at least twice within 7 days if the HRA is not returned within 30 days of mailing. Member will be considered lost to follow-up if not response received after these three attempts.

Assessment:

I. All clients assigned to complex case management regardless of referral source receive a comprehensive assessment completed within 30 calendar days of referral and includes the following elements:
   a. Initial assessment of member's health status, including condition-specific issues
   b. Documentation of clinical history, including medication history
   c. Initial assessment of the activities of daily living
   d. Initial assessment of mental health status, including cognitive functions
   e. Initial assessment of life-planning activities
   f. Evaluation of cultural and linguistic needs, preferences or limitations
   g. Evaluation of visual and hearing needs, preferences or limitations
   h. Evaluation of caregiver resources and involvement
   i. Evaluation of available benefits within the organization and from community resources

II. Ongoing management of these clients includes:
   j. Development of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals
   k. Identification of barriers to meeting goals or complying with the plan
   l. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
   m. Development and communication of member self-management plans
   n. A process to assess progress against case management plan for the member
   o. Development of a schedule for follow-up and communication with members. Schedule is based on assigned acuity level (see acuity process on page 9) and monthly review of progress toward case management goals.

CASE MANAGEMENT SYSTEMS

All case management activities are charted in CCLink, Contra Costa Health Services Patient-Centric Electronic Medical Record (EMR). CCLink integrates documentation of healthcare services between the County Hospital, County Clinics and CCHP, with additional limited access to Public Health and Mental Health divisions. The shared EMR gives full access to case managers to view progress notes, problem/diagnosis lists, lab results, medication lists, health maintenance activities, care team members, and diagnostic imaging. All case management activities including health-risk assessments and care plans are viewable to all care team members.

Clinical Guidelines

The case management clinical staff uses the following evidence-based clinical guidelines to conduct assessment and management:

- *Micromedex,* a product of Truven Health Analytics, for medication guidelines and management including drug interactions, drug identification and allergy risk. Micromedex is located on the CM's desktop and Health Services Intranet site.
- *UpToDate,* an evidence-based, physician-authored clinical decision support resource. *UpToDate* is embedded in CCLink.
- CClink includes the North-South Institute Nutrition screening tool which has been validated by the NIH. The tool automatically computes the total nutritional score as good nutrition, moderate nutritional risk or high nutritional risk and suggests case management interventions.

- CCLink includes a case management screening tool based on recommendations from the California Department of Healthcare Services for the Seniors and Persons with Disabilities population.
- CCLink includes a case management assessment tool based on recommendations from CMS's (with NCQA advisement) Special Needs Population (SNP) program.

Automatic documentation

CCLink includes automated features that provider accurate documentation for each entry; recording actions or interaction with members, practitioners or providers; and automatic date, time and user ID/name stamps. To facilitate care planning and management, CCLink includes features to set prompts and reminders for next steps or follow-up contact.

Charting Standards

- Initial contact note must include a comprehensive description of the client's medical and psychosocial history with statement "see care plan for goals and barriers."
- Progress toward goals must be documented every 30 days using the CCLink Smart Text "CMPROGRESSTOWARDGOALS."
- Acuity will be charted every 30 days for high risk (acuity 1 & 2), and every 90 days for low risk (acuity 3 & 4).using the standardized flow sheet.
- "Priority "and/or "review due date" will be set on case summary screen to generate automated prompts for follow-up.
- Care Plan will include Problem statement, goals, interventions and barriers to meeting goals.
- Care Plan goals must include at least one client self-management goal.

If the member does not respond after three telephone attempts by the case manager in a two week period, the member may be considered lost to follow up and the case closed. The case manager will send a letter to the PCP and referring provider explaining why the case has been closed and that the member may be reopened to case management at such time as he/she chooses to participate. The case manager will also send a letter to the member explaining that the case has been closed and include the case management brochure which includes contact information should he/she wish case management services in the future.

PERSON CENTERED PLANNING

Person-Centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of basic and complex case management and discharge planning.

Case Management includes an opportunity for "person-centered planning" which assures that treatment approaches are collaborative. It includes identifying each member's preferences, choices, and abilities, allowing the member and any family, friends, and professionals of their choosing to participate fully in any discussion or decisions regarding treatments and services, and assuring that members receive all necessary information regarding treatment and services so that they may make an informed choice.

1. Based on the information identified through the assessment process, CCHP Case Management develops an individualized care plan which contains the following components:
    a. Identifies the need for appropriate involvement of caregivers
    b. Referral to community based organizations for members with intellectual/developmental disabilities as applicable.

c. Facilitates timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including referrals for any physical or cognitive barriers to access, and assignment to a Medical Home as follows:
    i. Conference call with member or caregiver and Appointment Unit to schedule new or follow-up Primary Care Appointment as needed.
    ii. Coordinate authorizations for DME and other specialty care with CCHP Utilization Management department
    iii. Review medication list provided by member/caregiver during the HRA process and coordinate with CCHP Pharmacy Unit. Self-reported medication list will be sent to the PCP for reconciliation as needed.
    iv. Quarterly and as needed CM team conferences with Health Services Mental Health Division to coordinate mental health and substance abuse services
d. Identifies the need for services necessary to assist members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status. Examples include but are not limited to:
    i. Referral to Community Based Adult Services
    ii. Referral to Independent Living Resources program
e. Identifies the need for coordinated care across all settings including those outside the provider network and to ensure that discharge planning is provided to members who are admitted to a hospital or institution. (UM policy 15.011)
f. Identifies the need for referrals to appropriate community resources and other agencies for services outside the scope of responsibility of the managed care health plan, including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities as identified in questions.
g. Determines timeframes for re-contact or reassessment at least annually and, if necessary, the circumstances or conditions that require redetermination of risk level.
h. Completed HRA's and care plans are forwarded to the Primary Care Provider (PCP) within 30 days of enrollment into complex case management.
i. With member and PCP input, care plans specific to individual needs are developed and updated at least annually

2. The Case Managers shall be in contact with the client's Primary Care Physician (PCP) on admission to the program and on a regular basis thereafter. The Contra Costa Health Plan (CCHP) Case Management (CM) Program shall methodically assign a specific level of service based on the severity of illness and the intensity of care required to each client enrolled in the CM Program. Assigning acuity levels to Case Management services will:
    - Improve consistency in services provided to individual members based on their projected level of service.
    - Achieve equity in caseload.
    - Accurately define intensity of care.
    - Enhance the ability of the Case Manager to anticipate the length of service required.
    - Provide guidelines for individual Case Managers in planning, coordinating and discontinuing services for clients receiving Case Management services.

Once a client has been accepted to receive Case Management services, an initial level of service is assigned. Levels of service may fluctuate based on ongoing needs assessments and should be reassessed every 30 days for acuity levels 1 and 2. Acuity should be

reassessed every 90 days for levels 3 and 4. In general, the level of service should decrease since the main objectives for Case Management services are:

- Promote self-empowerment.
- As reasonably expected, increase or maintain independence.
- Increase knowledge, understanding and utilization of available and appropriate resources.
- Encourage the proactive attainment of health care services in order to prevent episodic care and/or recurrent Case Management services.
- Enhance the client's ability to anticipate and/or self-plan for future health care needs.

There are four acuity levels of Case Management services:

- Level 1-High Intensity
- Level 2-Moderate Intensity
- Level 3-Low Intensity
- Level 4-Maintenance Care

HIGH INTENSITY (level 1)

Description: This level of Case Management requires the maximum amount of services or support to the client and their family. The case is considered complex and will require telephonic and on-site services due to instability of medical and/or psychosocial needs. The client has inadequate social support and requires continuous monitoring for change in conditions in order to be maintained in the home setting.

Intensity of Service: The anticipated length of service is twelve months. Goals are reassessed within 120 days to determine if allotted timeframe for services is adequate. A minimum of one in-person/home visit per month is required. A minimum of four contacts per month is anticipated.

Qualifying Factors: An initial score or adjusted score of 70-100 on the Intake Acuity Worksheet

AND has two or more of the qualifying conditions:

a. Two or more problems/concerns/issues to address within the next 90 days, which are detrimental to the physical and/or mental wellbeing of the client.
b. Two or more hospitalizations within the past 12 months.
c. Two or more specialty follow-up appointments/services, which may include ancillary services (e.g. home health, therapy, SNF).
d. Accessed the Emergency Room more than once per month for services, which did not require hospitalization.
e. Limited financial resources and/or social situation, which may attribute to non-compliancy with medical or psychological regimen or follow-up services.
f. A high risk for readmission within thirty days, repeat inappropriate usage of the Emergency Room within thirty days or non-compliance with medical or psychological regimen.

MODERATE INTENSITY (level 2)

Description: This level of Case Management services is also complex but requires less aggressive interventions than listed in Level I. The client needs assistances with obtaining, scheduling and getting to specialty appointments and follow-up appointments.

Intensity of Service: One initial and one follow-up on-site visit maybe necessary but telephone contacts are essential for the coordination and management of the client's

needs. The anticipated length of service is nine months. Goals are reassessed within 120 days to determine if allotted timeframe for services is adequate. Two to three contacts per month is required.

Qualifying Factors: An initial score or adjusted score between 40-69 on the Intake Acuity Worksheet AND have two or more of the qualifying conditions listed in Level 1 and/or in combination with the conditions listed below:

a. Due to cognitive deficits, require repetitive education on what resources are available and how to access the health care systems in the appropriate manner.
b. In the last 12 months, has health care charges exceeding $75,000.00 or pharmacy charges exceeding $500 per month.
c. Need coordination of care/services for one or more follow-up services (home care services, skilled nursing facility, specialist care, outpatient services, etc.) upon discharge from a recent hospitalization.
d. Need assistances with future health care planning such as applying for Medicare and/or Medi-Cal in addition to long-term care needs, end-of-life planning or financial resources.

LOW INTENSITY (level 3)

Description: This level of Case Management services requires minimal interventions and interactions. The client is goal driven, self-directed, and understands the essential components to medical management but lacks the fundamental understanding and navigational tools to coordinate and establish appropriate health care services in a timely manner. The client is able to self-manage their care, which includes maximizing their wellness and basic understanding about their diagnosis and symptom management.

Intensity of Service: The anticipated length of service is six months. On-site visit is usually not required but may be necessary. A minimum of one contact per month is anticipated.

Qualifying Factors: An initial intake score or adjusted score between 20-39 on the Intake Acuity Worksheet AND have one or more of the qualifying conditions listed in Level 1 or 2 and/or in combination with the conditions listed below:

a. Needs assistance navigating through the Health Care System in such ways as, but not limited to:
    - Establishing a primary care provider
    - Obtaining referrals for medically necessary specialty services
    - Understanding the components of their provider network
    - Contacting the Health Plan as well as the 24 hours Advice Nurse service in various circumstances (e.g. changing plan providers, urgent care needs, appointment, etc)
b. Needs assistance with applying for Medicare, Medi-Cal, SSI and/or SSDI

MAINTENANCE CARE (level 4)

Description: The Maintenance Care level

Qualifying Factors

The frail client who requires minimum but continued contact with their established Case Manager. The client may lack the self-care ability and/or social support to transition and disconnect him/herself from their only constant/sole source of support.

Intensity of Services: Ongoing. A minimum of 1 contact every 3 months

3. Access and barriers to appropriate individualized, specialized programs and community-based resources are reviewed as part of person-centered care planning.

4. Care Plan goals, barriers to meeting goals and progress toward goals will be assessed as follows:
    a. High-Risk(acuity level 1 or 2): every 30 days
    b. Low-Risk(acuity level 3 or4): every 90 day

   Case Manager will use automated SmartText template to document goals, barriers and progress at the same time acuity is reassessed. Documentation will be charted as an "acuity" contact type.
5. CCHP coordinates with Local Health Department (Public Health Department) for treatment of Tuberculosis (TB) according to the Memorandum of Understanding between CCHP and Contra Costa Health Services Public Health Department. Briefly, CCHP Provider Relations orients providers of their reporting obligation to Public Health. Once notified by a provider, Public Health is responsible for contacting the provider, the member and provides notification to CCHP. If necessary, Case Management and DOT are initiated.

CASE MANAGER QUALIFICATIONS

1. Current license to practice in the State of California from the California Board of Registered Nurses (RNs), the California Board of Behavioral Science Examiners (LCSWs, MFCCs), or the California Board of Psychology (PhDs).
2. Case Management Certification (CCM) highly preferred.
3. Minimum of three years clinical experience in one of the required licensed professions.
4. Experience as a Utilization Review Nurse, Discharge Planner, or Case Manager in a managed care setting (e.g. Preferred Provider Organization, Managed Care Organization, or Health Maintenance Organization) or in an acute or outpatient care setting highly preferred.
5. Ability to manage and prioritize multiple responsibilities simultaneously.
6. Self-motivated with the ability to function independently.
7. Sound clinical judgment and professional integrity.
8. Excellent verbal communication, written documentation and organizational skills.
9. Familiar with current healthcare systems and treatment modalities.
10. Strong computer knowledge with the ability to design, analyze and present relevant managed care reports.
11. Knowledge of Case Management Society of America (CMSA) Standards of Practice.
12. Ability to perform care needs assessments that cover the continuum of care early in the treatment course to facilitate coordination of activities for a smooth and safe transition from one level of care to another and care coordination activities to assist the patient in navigating through the Health Care Delivery System.

ORIENTATION

1. Orientation for new Case Managers shall consist of the following:
    - General orientation with the CM Director, which includes Health Plan overview, mission statement and introduction to other Health Plan Units' functions.
    - Review and understand all current CM policies and procedures
    - Observation of case management procedures with CM staff
    - As warranted, home visits with CM staff within Contra Costa County
    - Independently make home visits and open cases
2. Each new Case Manager shall receive his/her own orientation packet containing the following:
    - CCHP orientation materials

- Case Management training materials including job description and overview of Case Manager Responsibilities and Performance Appraisal.

3. Based on previous knowledge and experience, a new Case Manager will be assigned to work with an existing Case Manager for a minimum of the first week of employment.
4. New Case Managers shall not be counted in staffing levels until orientation is complete

PROGRAM ANALYSIS

1. Annual Population Assessment
   a. Plan will assess the characteristics and needs of its member population and relevant subpopulations
   b. Plan will review and update its complex case management processes to address member needs, if necessary
   c. Plan will review and update its complex case management resources to address member needs, if necessary
2. Annual evaluation of the processes for identifying members eligible for complex case management
   Clarity report which captures number of case management referrals received over a specified time period from each of the sources listed below. Annual analysis of data will include deficiencies and goals for improvement.
   a. Claim/Encounter data
      i. ED utilization reports
   b. Hospital discharge data
      i. Health Plan CTI RN attends daily rounds at CCRMC
      ii. Difficult to Place Meetings
   c. Pharmacy Data
   d. Data collected through UM processes
      i. CM Director attends weekly UM rounds to discuss members in community hospitals in order to identify member needs.
   e. Data supplied by members or caregivers
      i. Health Risk Assessments
   f. Data supplied by practitioners
      i. CCLink referrals generated from Electronic Medical Record (EMR)
3. Evaluation of member satisfaction with complex case management
   On an annual basis, the following data will be evaluated to identify opportunities to improve satisfaction with the complex case management program. Analysis will consider quantitative and qualitative data to identify patterns of member comments.
   a. Grievances: When a member is unhappy with the service he/she is receiving from the case manager, they may contact the Member Services department to file a grievance. The Case Management Director will receive quarterly the member grievance report from the Member Services department.
   b. Member Satisfaction Survey: Once the member has been receiving complex case management services for 90 days, a Health Plan representative (not the case manager) will attempt to make telephonic contact in order to complete the following member satisfaction survey:
      - My case manager treated me with respect. ☐Yes ☐No
      - Preferred type of communication ☐ Phone ☐ Written
      - There was good communication between my case manager and myself. ☐Yes ☐No
      - Case Management has been helpful to me. ☐Yes ☐No
      - Services provided which have been most helpful:

1-very helpful 2-helpful 3-somewhat helpful 4-not helpful 5-no opinion					
Help with my medicines	1	2	3	4	5
Family support	1	2	3	4	5
Community resource information	1	2	3	4	5
Regular communication	1	2	3	4	5
Health education	1	2	3	4	5
Help making appointments	1	2	3	4	5
Other: _____					

4. Annual assessment of the effectiveness of complex case management program. Three measures will be chosen. Potential measurements may include:

- Readmission rate for members in CCM
- PCP visit rate for members in CCM
- ER rate for members in CCM
- HEDIS-like measures but specific to members in CCM-
    - HbA1c rate
    - B/P screening for members with cardiac conditions
    - Cholesterol screening for members with cardiac conditions

All measures will focus on members in CCM to determine if CM services are effective. Measures will be determined annually based on demographics of members in the program. Measurement will be repeated every year to determine effectiveness of interventions.

For each measure, CCHP will:

- Identify a relevant process or outcome
- Use valid methods that provide quantitative results
- Set a performance goal
- Cleary identify measure specifications
- Collect data and analyze results
- Identify opportunities for improvement, if applicable

5. The goals of CCHP are to be responsive to the healthcare needs of the people of Contra Costa County and to encourage the promotion and awareness of CCHP to the general public, particularly those most medically vulnerable. The role of the Managed Care Commission (MCC), the principal advisory board to CCHP, is to help assure the attainment of these goals. The Commission is made up of No less than one Medi-Cal Subscriber

    - One Medicare Subscriber
    - One Commercial Subscriber
    - One person sensitive to medically indigent health care needs
    - One physician, non-contracting
    - One other provider, non-contracting
    - No less than nine at-large members, non-contracting
    - The Director of Health Services is an ex-officio, non-voting member.
    - The Chief Executive Officer of CCHP is an ex-officio, non-voting member.
    - The Board of Supervisors function as ex-officio, non-voting members

The Director of Case Management presents the Health Risk screening and assessment tools and process to the MCC for review and input. The HRA process will be presented to the MCC periodically to assure it is meeting the ongoing needs of this population.

CCHP DATA FROM MARCH 2014 TO SEPTEMBER 2015

YEAR	MONTH	PHP CCHP
2014	MARCH	218
	APRIL	337
	MAY	290
	JUNE	332
	JULY	468
	AUGUST	473
	SEPTEMBER	393
	OCTOBER	333
	NOVEMBER	307
	DECEMBER	293
TOTAL		*3,444*
2015	JANUARY	340
	FEBRUARY	405
	MARCH	447
	APRIL	406
	MAY	362
	JUNE	359
	JULY	453
	AUGUST	421
	SEPTEMBER	327
TOTAL		*3,520*
GRAND TOTAL		6,964

NUMBER OF CCHP ACCESS LINE REFERRALS FROM MARCH 2014 TO SEPTEMBER 2015	6,964
**This total includes CMU screening forms (re-authorization)*	
NUMBER OF CLIENTS WITH SUBMITTED CCHP CLAIMS	2,175
PERCENTAGE	31.23%

*From March 2014 to September 2015, Patient Accounting received 6,964 Behavioral Health Screening Forms from MH Access Line.
Out of the 6,964 clients, 2,175 had CCHP claims in PSP which is 31.23% of the total referrals.

NOTES:

- A lot of clients who were screened were not in our system (PSP).
- Some clients were both open to network and system of care which means that their acuity level is Moderate to Severe. In that case we don't enter the CCHP policy.
- Not all services were billable to CCHP. Some claims went straight to Medi-Cal while others were denied by CCHP mainly because of duplicate codes and patient not eligible.
- Some screened clients were never opened to network.
- Some clients never had services entered in PSP even if they were open to network.

ATTACHMENT B

Mild/Moderate -- CCHP clients (Access Line only) 7/1/15 thru 9/30/15	1110 Consumers
Yes - Client saw NetPro	214
No - Client did not see, and no longer wishes auths	40
No - Forwarded to Access Line Supervisor or Lead	9
Unknown - Spoke to Client - Not called NetPro yet or connected to NetPro	119
Unknown - Spoke to Client - Not seen yet - gave 3 new auths	82
Unknown - Left VM Msgs (2x) Client did not return our calls	361
Unknown - Could not reach Client (no vm, vm full, disconnected, wrong #)	137
UnKnown - We did NOT call them (staff shortage)	103
Clients called to report that provider was full or not calling them back. Other auths offered.	45

Period reported: 7/1/15 thru 9/30/15

CONTRA COSTA HEALTH SERVICES
MENTAL HEALTH DIVISION

REFERRAL FOR MENTAL HEALTH SERVICE SCREENING

For Psychiatric consult, use MR314-7 (Inpatient), or MR191-8 (Outpatient).

CARE MANAGEMENT UNIT ACCESS LINE

Phone: (888) 678-7277 Fax: (925) 372-4422

Date _____ [redacted]

Referring provider (print)_____ Pager _____

Phone_____ Voice mail _____

Best time/day and method to reach provider: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ AM ☐ PM
☐ Voice mail ☐ Pager ☐ Care Coordinator

Care Coordinator (print)_____ Phone _____

Notify the following ☐ MD/DO ☐ FNP ☐ Care Coordinator Notification Fax# _____

Your clinic is:_____

Patient name_____ Patient phone _____

Patient home city _____

Type of service requested ☐ Medication ☐ Case Management ☐ Psychotherapy
☐ Other:_____

Type of management requested ☐ Assess and co-manage ☐ Assess and assume care

Describe area of concern (Include brief significant medical information, current psychotropic medications, and previous/current treatment attempted.) PLEASE PRINT LEGIBLY

_____

_____

_____

_____

_____

_____

_____

_____

_____

Disposition (To be completed by Access Line Staff)

☐ Referral to county MH clinic ☐ Referral to provider network ☐ Other

_____

_____

_____

_____ _____
Disposition made by (print name) CMU Staff Phone number

☐ Information communicated to referring provider on (date) _____

Mental Health Referrals

Use this form (on reverse) for Referrals, not Consultations

Referrals for Mental Health Service Screening:

Mental Health Services include counseling/psychotherapy, case management, day treatment, and on-going psychiatric services by county psychiatrists. **Use this form (on reverse) or call the Access Unit** for all of these requests in all regions.

County-based psychotherapy is primarily short-term crisis intervention. Patients in need of counseling either brief or long-term are referred to the ***Provider Network***, a component of our system comprised of private therapists and organizations that contract with Contra Costa to provide Mental Health Services for patients with Medi-Cal, or to low-fee clinics for those with Basic Health Care. **Use this form or call the Access Unit**. CC HP also maintains its own provider referrals and should be contacted directly.

You may call and/or fax the form on the reverse side. **If you would like feedback regarding the patient's disposition,** please complete the form even if you call in the referral.

Access Unit Phone Number: 888-678-7277
Fax: 925-372-4422

Referral Process-in order of priority/preference:

1. Call to Access Unit by treating physician will be given highest priority. Calls from nurses or care coordinators are acceptable if they have actual clinical knowledge of the patient. If the patient is present, they will be scheduled for an assessment during the call. Please use for all urgent situations. (Crisis situations should be referred to 24th Street in Richmond or PES).
2. Form (on reverse) faxed to Access Unit from treating physician. Patient will be called within 72 hours or three working days. After patient is seen the form will be returned to you with final disposition.
3. Call by patient. Appropriate for those who can manage self-referral. Please ask patient to mention that they have discussed this referral with their primary care provider.

CONTRA COSTA HEALTH SERVICES
CHILDREN'S MENTAL HEALTH DIVISION

REFERRAL FOR MENTAL HEALTH SERVICE CHILDREN AND YOUTH

MENTAL HEALTH ACCESS LINE
Phone: (888) 678-7277
Fax: (925) 372-4422

For emergency services, refer to PES 925-646-2800

For all financial codes except:
CFS/Foster youth MediCal: Refer to CFS Social Worker
HO/Commercial CCHP and H9 Healthy Families: Refer to CCHP (925) 957-7239

Date_____

PROVIDER'S RETURN FAX:

REFERRING PROVIDER (print) _____

Practice location_____

Person completing form_____ Contact #_____Pager/VM/Phone

PATIENT NAME _____

PARENT/GUARDIAN NAME _____ Preferred Language _____

Phone #1 _____ Phone #2 _____ OK to leave a message? ☐ Yes ☐ No

Type of service requested ☐ Medication ☐ Psychotherapy/Counseling
☐ Other: _____

Reason for Consultation _____

_____

_____

Medical History _____

Current Medications _____

Past Medications _____

Areas of Clinical Concern	Mild	Severe		Mild	Severe
Attention/Impulsivity/Oppositionality	☐	☐	Developmental issue	☐	☐
Socialization/Communication	☐	☐	Aggression/Assault	☐	☐
Depression	☐	☐	Agitation/Mood swings	☐	☐
Cognition/Memory/Thought problems	☐	☐	Hearing voices/Psychosis	☐	☐
Anxiety/Fears/Panic attacks	☐	☐	Physical symptoms	☐	☐
Substance/Alcohol abuse	☐	☐	Peer relations	☐	☐
Family relations	☐	☐	Other:_____	☐	☐
School attendance/Suspension	☐	☐			

History of Significant Risk	Recent	Past		Recent	Past
Suicidal thoughts or acts	☐	☐	Threat of removal from home		
Behavior threatening/Dangerous to self/others	☐	☐	or residential placement	☐	☐
Psychiatric hospitalization	☐	☐			

DISPOSITION (To be completed by Access Line Staff)

☐ Referral to county MH clinic/clinician:_____Appt. Date/Time _____

☐ Authorized/Referred to network providers. Parent/Guardian to call for appointment.

☐ Consumer has commercial CCHP. Request faxed to CCHP. For questions, call 925-957-7239.

☐ Unable to contact parent/guardian. Please refer to MH Access Line at 888-678-7277.

☐ Other: _____

_____ _____

Disposition made by (print name) Staff Phone number

☐ Information faxed to referring provider on (date): _____

Children's Mental Health Referrals

Date:

Dear Parent,

Your child has been referred to our Children' s Mental health program for counseling or support. Sometimes a child' s behavior can be improved by talking to a mental health counselor. This program can also assist your child if medications are needed for a mental health problem such as depression.

Please contact the Children' s Mental Health program as soon as posible to discuss your concerns about your child. They are available Monday – Friday between 8 am and 4:30 pm at:

Children's Mental Health Access Line: 1-888-678-7277

All calls to this phone number are confidential. You will need:

- A quiet, private place to discuss your concerns
- Your child' s MediCal or Social Security number
- Your child' s date of birth

The counselors have interpreters if necessary. They will ask you a series of questions in order to decide who is the best doctor or therapist to help you with your child. If they are busy when you call, please wait and they will pick up the call as soon as possible.

[ ] Your doctor or nurse has made a written referral to the Access Line. A clinician at the Access line will attempt to contact you by phone when they receive this referral. Please give your doctor the best contact information so that the Access line can reach you during the day.

Thank you.

Referral Form
Contra Costa Health Plan Disease Management Program
Phone:925-313-6968 Fax: 925-313-6870

Program Description/Referral Guidelines

Program Description: Contra Costa Health Plan's (CCHP) Disease Management Program is aimed at improving the health outcomes for people with diabetes and for children with obesity. The program uses a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of program participant needs, evaluation, ongoing care monitoring, and tailored program participant/practitioner interventions.

Referral Guidelines:

- Pediatric Obesity-children must be ages 2-11, with a BMI%ile greater than or equal to 95
- Diabetes- All members with type I or II diabetes ages 18-75 are eligible

Patient Information-Diabetes Referral

Patient Name: _____ DOB _____ MR# _____

HgbA1c _____ BP: _____ Phone Number: _____

Address: _____

Email Address: _____ Language spoken: _____

Patient Information-Child Obesity Referral

Patient Name: _____ DOB _____ MR# _____

Recorded Weight: _____ Recorded Height: _____ BMI %ile _____

Address _____

Email Address: _____ Phone number: _____

Parent's Name: _____ Language spoken by parent: _____

Provider Information

Provider Name: _____ Phone number: _____

Fax number _____ Email Address: _____

Comments/Concerns:

CCHP Disease Management Program

1. There are TWO ways patients are enrolled in the program
   - Referrals
   - Identified by claims and encounter data

2. What makes a member eligible?

   The following patients are eligible for the programs:
   - Pediatric Obesity-children must be ages 2-11, with a BMI percentile for age and gender ≥ 95th
     - RMC- gathered through EHR data for ages 2-5
     - CPN- Encouraged to refer and use appropriate coding
       - ICD-10 code Z68.54 replaces ICD-9 code V85.54 to indicate pediatric BMI percentile ≥ 95th
   - Diabetes- All members with type I or II diabetes ages 18 and greater are eligible

3. The referral process:

   CCRMC PCPs: Refer patients to the Disease Management programs via ccLink under Pediatric Obesity or Diabetes in Meds & Orders.

   Community Providers Network: Use the Disease Management Program Referral Form which can be found on the CCHS website (cchealth.org/healthplan) in the **For Provider** section under **Forms and Resources**.

4. What happens after a referral is received?

   The program mails patients a welcome packet introducing them to the program and then sends quarterly information packets about their disease or condition. The information is geared to help patients better understand how to use both lifestyle and medical tools to improve their health. Patients are also offered information regarding special programs, classes, and self-help and community resources. Incentives are offered to our Medi-Cal and Medicare populations who complete provider visits, classes, labs and/or exams. They are also given the opportunity to call to speak with the Disease Management nurse for further teaching /coaching and assist with goal setting.

   Providers are given feedback regarding return visits, labs, and referrals relevant to their patient. We welcome your feedback about the programs. To find out more, email Disease.Management@hsd.cccounty.us or call Lourdes Jensen, RN, CDE at 925-313-6968.

5. Tips for Providers

   If you would like the DM nurse to reach out to a member for a specific issue, please make a clear notation on the referral, otherwise they will be added to the program but NOT contacted by the nurse.

How to refer

Community providers can fill out our single page referral form and fax it to our program nurse, Lourdes Jensen, at the number below.

Fax: (925) 313-6870.

Call: (925) 313-6968

Text: (925) 864-3189

Email: GoClub@hsd.cccounty.us

CONTRA COSTA
HEALTH PLAN
A Culture of Caring for over 40 years

A WEIGHT SUPPORT
PROGRAM FOR CHILDREN

What is the Go! Club?

The Go! Club is Contra Costa Health Plan's weight management program for children. It is a free service that promotes healthy weight and teaches parents about child nutrition and physical activity.

Who are we?

We are a team of professionals in the Quality Management Department at CCHP including a RN, Health Educator, Pediatrician, Project Manager and a few others who provide support to our program.

What do we do?

Our program is designed to complement any advice given by the child's doctor. We mail quarterly educational packets on a variety of topics related to child nutrition and activity. Our program can help children and their families with:

- Nutrition support
- Ideas on how to encourage children to play and exercise more
- Free weight management tools such as exercise toys, DVD's, recipe books, water bottle, and other gifts
- A nurse who parents can call, text or email about their child's weight and health
- Information on nutrition and exercise classes

Who can participate?

The Go! Club is for any Contra Costa Health Plan child between the ages of 2-11 with a BMI percentile greater than or equal to 95.

Once a child is in the Go! Club the parent can decide how much they want to participate. If they don't do anything the family will continue to get quarterly mailings. Families who want more support can contact the Go! Club nurse.