

**NOTICE OF A
SPECIAL MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS**

**THURSDAY, APRIL 16, 2020
2:00 P.M.**

**505 CITY PARKWAY WEST, SUITES 108-109
ORANGE, CALIFORNIA 92868**

BOARD OF DIRECTORS

Paul Yost, M.D., Chair	Dr. Nikan Khatibi, Vice Chair
Ria Berger	Ron DiLuigi
Supervisor Andrew Do	Alexander Nguyen, M.D.
Lee Penrose	J. Scott Schoeffel
Supervisor Michelle Steel	Bob Wilson
Supervisor Doug Chaffee, Alternate	

**INTERIM
CHIEF EXECUTIVE OFFICER**
Richard Sanchez

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
Sharon Dwiars

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to the Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, prior to the meeting.

The Board Meeting Agenda and supporting materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima website at www.caloptima.org.

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

- 1) Listen to the live audio at +1 (213) 929-4232 Access Code: 407-352-791 or**
- 2) Participate via Webinar at <https://attendee.gotowebinar.com/register/7221006737644326158> rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

None.

PUBLIC COMMENTS

At this time, members of the public may address the Board of Directors on matters not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors. Speakers will be limited to three (3) minutes.

INFORMATION ITEM

1. [COVID-19 Update](#)

REPORT ITEMS

2. [Consider Modifications to the CalOptima Homeless Clinic Access Program \(HCAP\) Homeless Health Initiative in Response to COVID-19](#)
3. [Consider Authorizing Modifications to the Post-Acute Infection Prevention Quality Initiative During the Coronavirus Disease \(COVID-19\) Crisis](#)
4. [Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic](#)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

Webinar Instructions for Joining the Special Meeting of the CalOptima Board of Directors
April 16, 2020 at 2:00 p.m.

- 1. Please register for the Special Meeting of the CalOptima Board of Directors on April 16, 2020 2:00 PM PDT at:**

<https://attendee.gotowebinar.com/register/7221006737644326158>

- 2. After registering, you will receive a confirmation email containing a link to join the webinar at the specified time and date.**

Note: This link should not be shared with others; it is unique to you.

Before joining, be sure to [check system requirements](#) to avoid any connection issues.

- 3. Choose one of the following audio options:**

TO USE YOUR COMPUTER'S AUDIO:

When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

--OR--

TO USE YOUR TELEPHONE:

If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

United States: +1 (213) 929-4232

Access Code: 407-352-791

Audio PIN: Shown after joining the webinar



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Coronavirus Disease 2019 (COVID-19) Update

**Special Board of Directors Meeting
April 16, 2020**

**Richard Sanchez
Interim Chief Executive Officer**

Introduction

- Unprecedented global pandemic radically changing daily life and health care system
- Significant short- and long-term impact on Orange County's health care system
 - Hospitals may be experiencing the lull before the storm
 - Community-based providers are experiencing decreased revenue
 - Increased unemployment may drive significant growth in CalOptima membership

COVID-19 Status as of April 9

	United States	California	Orange County	CalOptima
Cases	455,243	19,111	1,079	44
Deaths	16,191	503	17	3

Agenda

- Clinical Overview
 - Health Care System Changes
 - Telehealth
 - Homeless Population
 - Testing
- Communications
 - Providers
 - Members
- CalOptima Workforce Status
- Federal and State Updates
- Financial Update

CalOptima COVID-19 Response

- Goals

- Educate members and ensure they have access to needed care while reducing the risk of COVID-19 spread
- Educate and support providers and the local health care system as they respond to COVID-19
- Support and protect CalOptima staff
- Coordinate with county, state and federal public health efforts



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Clinical Overview

David Ramirez, M.D.
Chief Medical Officer


Health Care System Changes

- Centers for Medicare & Medicaid Services (CMS) recommendations
 - Delay all elective surgeries, and non-essential medical, surgical and dental procedures
- Centers for Disease Control and Prevention (CDC) recommendations
 - Call ahead before visiting provider offices
- In response, CalOptima modified several programs, including telehealth, homeless services, pharmacy and Program of All-Inclusive Care for the Elderly (PACE)

Telehealth: Provider Perspective


- Urging providers to use virtual services when appropriate
 - Physician services (COVID-19 cases and non-COVID-19)
 - Physical therapy
 - Behavioral health
 - Community-Based Adult Services (CBAS)
 - PACE
- Expanded permissible technologies
 - CMS and the Department of Health Care Services (DHCS) are allowing provider visits using telephones and other non-public communications during national emergency
- Maintaining reimbursement at the same rates as in-person services

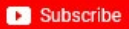
Telehealth: Provider Perspective (Cont.)






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Medicare Coverage and Payment of Virtual Services

 CSMHHSgov

 46.6K

50,275 views

 Add to  Share  More

 238  6

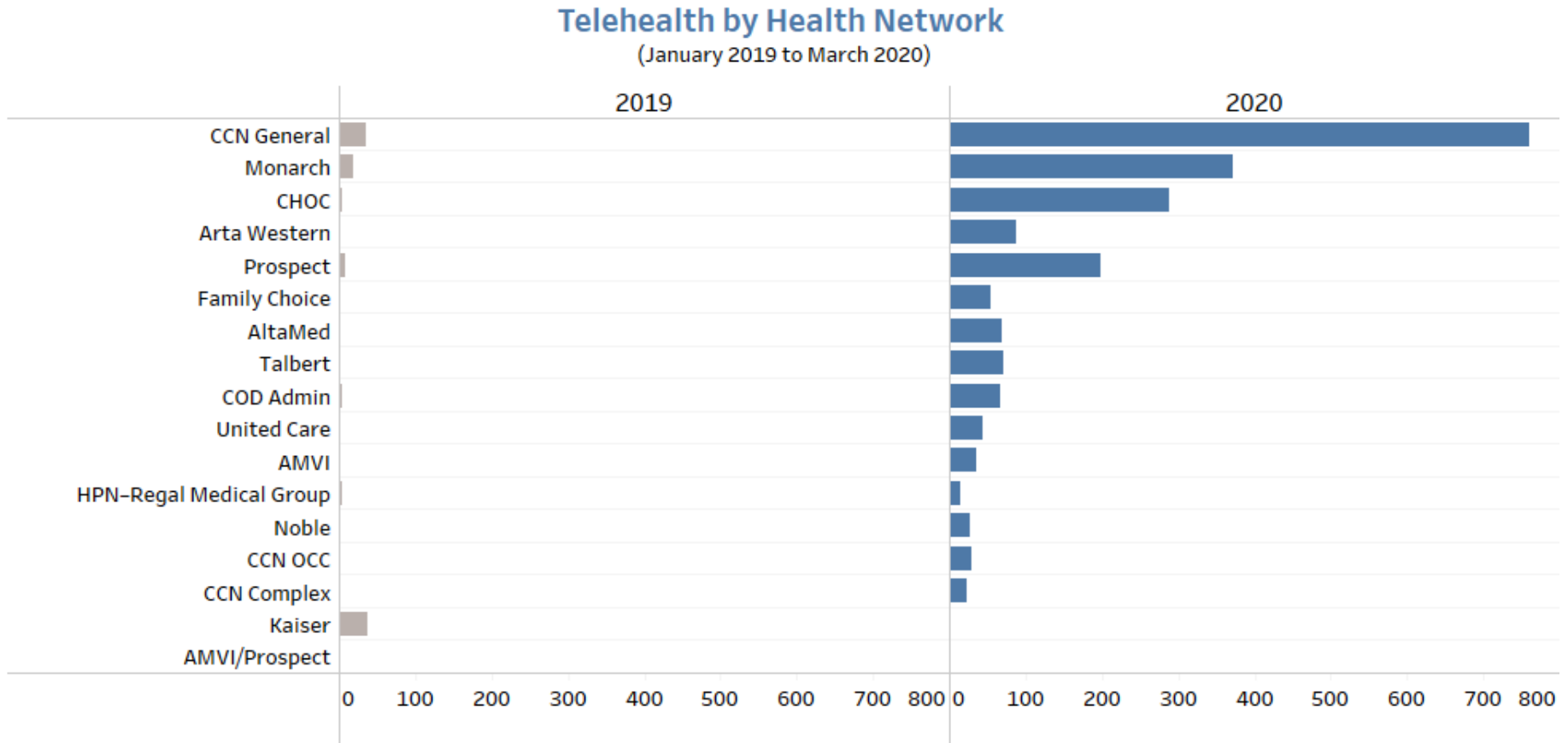
Published on Apr 3, 2020

This video will provide you with answers to common questions about the Medicare telehealth services benefit.

Telehealth: Members

- Following universal recommendation to have members call their provider to inquire about phone or telehealth visits, rather than going to the provider office
- Developing a comprehensive virtual care strategy for presentation to and approval by the Board
 - Select and contract with a mobile health interactive text messaging services vendor to effectively communicate with at-risk populations
 - Select and contract with a multipurpose provider group focused on using virtual visits to expand after-hours coverage and a specialized provider group to expand behavioral health support
- Seeing increasing acceptance of telehealth

Telehealth Services by Network



Notes: Based on claims and encounters received to date; CCN usage includes behavioral health

Homeless Population

- Updated Clinical Field Team (CFT) program to respond to COVID-19
 - CFTs now offer telehealth visits
 - Face-to-face visits still occurring when clinically necessary
 - Proposing to include CFT services via telehealth as part of the Homeless Clinic Access Program (HCAP)
- Collaborating with Orange County Health Care Agency (HCA) and CFT organizations to expand medical services
 - CFTs available to cover new shelter locations
 - County received authority to increase Whole-Person Care (WPC) recuperative care capacity by 90 beds
 - California has requested flexibility to serve homeless population through 1115 Waiver
 - State proposes to allow federal financial participation for emergency temporary housing related to COVID-19 and WPC pilot

Pharmacy

- Promoting home delivery options for members
- Authorizing early refills if requested
- Allowing 90-day medication fills
- Added disinfectants and gloves to the formulary
- Added dextromethorphan (generic for Robitussin DM) and acetaminophen (generic for Tylenol) to formulary
- Added hydroxychloroquine (generic for Plaquenil) prior authorization based on California Department of Public Health guidance

COVID-19 Testing

- Providers: CalOptima will reimburse Medi-Cal/Medicare rate, with no prior authorization required
- Members: Cannot be charged a co-pay; can self-assess using online tool; or contact provider or public health lab
- Test types: Molecular (presence of virus) and serologic (presence of antibodies to the virus)
- Lab types: Specialized lab (public health, hospital and commercial) and point-of-care lab (clinics and provider offices)
- Test results: Standard and rapid
- FDA-authorized tests

COVID-19 Testing (Cont.)

- Testing requirements
 - Collecting samples requires staff wearing personal protective equipment (PPE) and sample supplies
 - Running the test requires a lab with staff and reagents
- Nationally, there have been limitations on test kits, sample supplies and PPE
- Response has been criteria to limit the people tested
 - Criteria varies by region based on local factors
 - Currently, Orange County Public Health Department is prioritizing testing for hospitalized or high-risk populations with symptoms, using FDA-authorized tests
- Collaborating with Orange County Public Health Officer and providers to increase testing availability for members

Personal Protective Equipment (PPE)

- Lack of PPE has impacted CalOptima providers
 - More PPE has become available through efforts of the county and local suppliers
 - Constraint is primarily due to the supply chain
- CalOptima was able to order adequate PPE for our staff
 - PACE clinic staff: 1,000 N95 and 10,000 surgical masks
 - Staff not teleworking: 500 cloth face coverings
- CalOptima continues to support local efforts to obtain and distribute PPE through collaboration with the Orange County Emergency Operations Center (EOC)
 - Forwarding vendor information to the EOC
 - Encouraging CalOptima providers and community organizations with extra PPE to donate to the EOC

Long-Term Care Infection Control

- CalOptima-contracted skilled nursing facilities (SNFs) have a current census of 4,802 members
 - One COVID-19 case, possibly acquired in the ER
- Post-Acute Infection Prevention Quality Initiative (PIPQI)
 - Since October 2019, 24 participating SNFs, serving 1,600 members, substitute Chlorhexidine (CHG) soap for liquid soap along with use of Iodophor nasal swabs to decrease skin colonization with Multi-Drug Resistant Organisms, which leads to decreased infection rates
 - CHG has anti-viral, anti-bacterial and anti-fungal properties
 - CHG has been proven to significantly decrease inpatient hospitalizations for infection
 - CDC has funded a nurse trainer and strongly endorses PIPQI, the only such program in the country
 - CalOptima has approved an expansion of the program up to all 67 contracted SNFs
 - CalOptima proposes to prepay two quarterly incentives for program adherence (January–June 2020) and will skin test for CHG as safety permits

Surge Capacity

- Collaborating with EOC and HCA
- Monitoring daily inpatient and intensive care unit census
 - Orange County has ability to increase inpatient beds by approximately 41% over baseline
 - CalOptima will hold concurrent review requirements during surges
 - Preparing for possibility of additional inpatient sites
 - Mercy hospital ship, Fairview, ambulatory surgery centers and tents
- Health care workforce
 - Any Medi-Cal enrolled provider will be reimbursed at Medi-Cal rates for services provided to CalOptima members if not already credentialed and contracted with CalOptima
 - Prior authorization required for select services
 - Contracted with a nurse advice line

CalOptima PACE

- Suspended PACE day center attendance, but PACE clinic remains open
- Implemented an infection screening protocol of all individuals entering the PACE center
- Moved 76% of PACE staff to telework
- Transitioned all participants to home-based care
- Developed a Telehealth Triage Workflow providing the PACE clinic with an algorithm for determining whether the participant's issue can be handled by nursing or by the medical provider via telehealth

CalOptima PACE (Cont.)

- Implemented an interim telehealth solution for ongoing participant care
- Obtained and delivered pulse oximeters for high-risk participants to help monitor participants remotely
- Initiated daily follow-up with participants through “Wellness Calls”
- Developed a strategy to monitor and use PPE supplies
- Held weekly clinic staff meetings to keep staff abreast of the rapidly evolving situation
- Ongoing coordination with state and national PACE trade associations for best practices



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Communications

Ladan Khamseh
Chief Operating Officer

Provider Communications

- Frequently updated COVID-19 provider web page
 - Links to regulatory agencies' websites for specific COVID-19 updates
 - CalOptima announcements in response to COVID-19, including Telehealth FAQ
- Provider Alerts via fax blast
 - Regular and timely distribution of information to assist with member interactions

Provider Web Page

The screenshot shows the CalOptima website's provider communication page for COVID-19. The header includes the CalOptima logo and navigation links: Find a Provider, Members, Providers, About Us, and utility icons for accessibility and search. The main heading is "Providers" with a breadcrumb trail: Home > Features > Coronavirus Disease 2019 (COVID-19) > Provider Communication COVID-19. The central title is "Provider Communication COVID-19". A light blue text box contains a message about the rapidly evolving COVID-19 pandemic and encourages providers to monitor updates from key regulatory agencies. Below this are four blue buttons linking to: Centers for Medicare and Medicaid (CMS), California Department of Public Health (CDPH), Department of Health Care Services (DHCS), and Orange County Health Care Agency (OC HCA). The section "Additional Resources from CalOptima" features two white boxes: "Telehealth" (with a doctor icon) and "Provider Alerts (Fax Blasts)" (with a printer icon). The footer contains a "Back to Agenda" link and the CalOptima logo with the tagline "Better. Together."

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Find a Provider ▾ Members ▾ Providers ▾ About Us ▾ A ▾ [Accessibility] ▾ [Search]

Providers


You are here: [Home](#) > [Features](#) > [Coronavirus Disease 2019 \(COVID-19\)](#) > [Provider Communication COVID-19](#)


Provider Communication COVID-19

The COVID-19 pandemic is rapidly evolving. CalOptima providers are encouraged to monitor updates and guidance from key regulatory agencies central to the COVID-19 response. Links to these agencies are highlighted in the blue boxes below. Underneath the blue boxes are additional alerts and information from CalOptima. Thank you for your partnership in caring for CalOptima members.


[Centers for Medicare and Medicaid \(CMS\)](#) [California Department of Public Health \(CDPH\)](#) [Department of Health Care Services \(DHCS\)](#) [Orange County Health Care Agency \(OC HCA\)](#)

Additional Resources from CalOptima


Telehealth
How to use telemedicine to curb the spread of COVID-19


Provider Alerts (Fax Blasts)
Information to assist providers with member interactions during COVID-19 pandemic

[Back to Agenda](#)

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Provider Alerts Via Fax Blast

PROVIDER ALERT

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COVID-19 Telehealth Services Frequently Asked Questions (FAQs)

CalOptima is furnishing these FAQs to address providers' and affiliated health networks' (HNs') questions about providing telehealth services to our members to reduce potential exposure to COVID-19.

General Information:
Telehealth is a modality for the delivery of services. Providers who are qualified (qualified providers) to furnish services to members via telehealth include physicians and non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish services within their scope of practice and consistent with State telehealth laws and regulations as well as Medi-Cal and Medicare benefit, and coding and billing rules.

Please note that while some of the FAQs address currently existing guidelines and requirements for telehealth services, these FAQs also include emergency provisions such that these FAQs are only effective during the COVID-19 national health emergency. CalOptima will update providers and health networks, as and when, appropriate.

Qualified providers must inform the member about the use of telehealth and obtain verbal or written consent from the member for the use of telehealth as an acceptable mode of delivering health care services. That consent must be documented. If a qualified provider maintains a general consent agreement that specifically mentions the use of telehealth as a modality for delivery of services, such consent will be sufficient documentation and should be kept in the member's file. Authorization processes remain the same when requesting services, regardless of whether services are being provided in-person or via telehealth.

Members have a right to access their own medical records involving their telehealth sessions with their qualified provider. Members may not be precluded from receiving in-person services after agreeing to receive telehealth services.

Frequently Asked Questions Regarding Telehealth

1. As a qualified provider, can I provide telehealth services to CalOptima members to limit exposure and spread of COVID-19?
Answer: Yes. Qualified providers may do so if they deem that services are clinically appropriate to provide via telehealth and the member has consented to receive services via telehealth, you may provide services in accordance with Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) guidelines. These guidelines generally allow qualified providers to use telehealth in place of face-to-face encounters and receive Medi-Cal or Medicare reimbursement for such services, subject to compliance with other requirements and exceptions as noted. Please see links below for additional guidance.
 - DHCS guidelines: https://www.dhcs.ca.gov/services/medi-cal/Documents/mednetele_27966_m01e03.pdf
 - CMS guidelines: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
 - <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faq-31720.pdf>

Updated 3/24/2020



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PROVIDER ALERT

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CMS Partial Approval of California's 1135 Waiver Requests

On March 23, 2020, the Department of Health Care Services (DHCS) notified managed care plans (MCPs), like CalOptima, that the Centers for Medicare and Medicaid Services (CMS) has partially approved Section 1135 flexibilities as requested by DHCS on March 16th and March 19th. The approval letter is located on the DHCS website <https://www.dhcs.ca.gov/Documents/COVID-19/CA-1135-Flexibilities-Approval-Letter-Rev.032320.pdf>.

DHCS had requested CMS' review and approval of various Section 1135 waiver requests due to potential issues or challenges with meeting Medicaid and Medicare requirements in the healthcare delivery system in all California counties due to COVID-19.

The approved Medicaid provisions include the following:

- **Temporarily suspend Medicaid fee-for-service (FFS) prior authorization requirements**
 - CMS approved California's request to waive or modify the state plan prior authorization requirements and processes for benefits administered through the FFS delivery system.
- **Extend pre-existing authorizations which a member has previously received prior authorization through the end of the public health emergency**
 - CMS interprets prior authorization requirements to be a type of pre-approval requirement for which waiver and modification authority under Section 1135(b)(1)(C) of the Act is available.
- **State Fair Hearing Requests and Appeal Timelines**
 - CMS approved a waiver under Section 1135 that allows members to have more than 90 days, up to an additional 120 days for an eligibility of FFS appeal to request a State Fair Hearing (SFH).
 - CMS was able to modify the federal timeframes associated with appeals and SFHs; therefore, CMS approves the following through the end of the public health emergency:
 - Modification of the timeframe for managed care entities to resolve appeals before a member may request a SFH to no less than one day in accordance with the requirements outlined in the approval letter. This allows MCP members to proceed almost immediately to SFH without having an MCP resolve the appeal first by permitting the state to modify the timelines for MCPs to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements.
 - Section 1135 of the Act allows CMS to authorize a modification to the timeframes for required activities under Section 1135(b)(5)(D) of the Act. CMS authorizes the state to modify the timeline for MCPs to resolve appeals to no less than one day. If the state uses this authority, it means that all appeals filed between March 1, 2020 and the end of the public health emergency are deemed to satisfy the exhaustion requirement after one day (or more if that is the timeline elected by the state) and allow members to file an appeal to the SFH level.

Updated 3/26/2020



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PROVIDER ALERT

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Fairview Developmental Center Selected as Alternative Care Site to Fight COVID-19, Creating Medical Surge Capacity in Orange County

On April 1, 2020, California Governor Gavin Newsom and several Orange County elected officials announced the selection of Fairview Developmental Center in Costa Mesa as a "Regional Alternative Care Site", serving as a surge hospital location.

The action, which is supported by Costa Mesa Mayor Katrina Foley, Orange County Board of Supervisors Chair Michelle Steel (2nd District), State Assemblywoman Cottie Petre-Norris (AD 74) and US Representative Harley Rouda (CA 48), was announced during a virtual town hall meeting, which outlined the following components of the new Regional Alternative Care Site:

- An approximately 900 bed hospital
- At least 200 beds reserved for individuals with developmental disabilities
- Staffing support provided by the State of California
- Local staff support currently being discussed by the Orange County Health Care Agency (OC HCA) and Orange County Board of Supervisors

To view the full media announcement regarding this selection, visit: <http://www.oesnews.com/fairview-developmental-center-selected-as-alternative-care-site-to-fight-covid-19-and-create-medical-surge-capacity-in-orange-county/>.

Updated 4/3/20



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Health Network Communications

- Daily and weekly email communications
 - Includes health network question and response log to address operational and regulatory concerns related to COVID-19
- Virtual monthly and ad hoc meetings with health networks

Frequency	Type of Information
Daily	<ul style="list-style-type: none"> - Regulatory guidance (e.g., All Plan Letters, CMS updates, 1135 Waiver information, LTC/SNF/CBAS guidance, reporting requirements) - COVID-19 resources (e.g., coding/billing, testing sites and lab information, provider/member resources, regulatory flexibilities)
Weekly	<ul style="list-style-type: none"> - Consolidation of daily updates (e.g., regulatory guidance, COVID-19 resources). - Health network Q&A log with new or updated responses - Notification of provider and facility closures - Link to CalOptima COVID-19 webpages for providers and members
Monthly	<ul style="list-style-type: none"> - Summary of CalOptima COVID-19 initiatives provided by CalOptima's Chief Medical Officer or Deputy Chief Medical Officer, includes impact to health networks - Responses to health network COVID-19-related questions and concerns

Member Communications

- CalOptima website updated with COVID-19 member information
 - Frequently Asked Questions
 - Links to HCA and CDC websites
- Member Portal updated with a link to COVID-19 member information on website
- CalOptima Community Network member notification about telehealth approved by DHCS
 - Notification informs the member that their assigned PCP has notified CalOptima they will temporary stop seeing members in the office and will be providing services through telehealth
- CalOptima phone system updated to include COVID-19 messages

Outreach to Emerging-Risk Populations

- Bright Steps Maternity Management Program
 - Including “You are Not Alone” First 5 OC Coronavirus pamphlet in CalOptima Bright Steps weekly mailings
 - Informing Bright Steps participants about changes to hospital Labor and Delivery protocols
 - Screen everyone who comes and goes, allow one additional person plus delivering mom in delivery room, and require wearing a mask, etc.
- Chronic Conditions
 - Modified scripts for members with asthma, diabetes and COPD to include sharing COVID-19 prevention strategies and offering CalOptima assistance with medication refills, medical equipment or community resources

Communications in Development

- New banner for CalOptima website with option for members to connect with Customer Service via an online form
- OneCare and OneCare Connect wellness outreach
- COVID-19 outreach and prevention awareness campaign

Member Web Page

The screenshot shows the CalOptima website header with navigation links: Find a Provider, Members, Providers, and About Us. The main heading is "Health and Wellness" with a breadcrumb trail: Home > Features > Coronavirus Disease 2019 (COVID-19). Below the heading are four blue buttons: Self Care Guides, Wellness Programs, Member Health Rewards, and Interactive Self-Management Tools. The main content area features the title "Coronavirus Disease 2019 Frequently Asked Questions" and a sub-heading "What is Coronavirus Disease 2019 (COVID-19)?". The text below explains that a coronavirus is a type of virus causing diseases of varying severity, and that COVID-19 is a new strain first found in Wuhan, China, which is now spreading in the United States.

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Find a Provider ▾ Members ▾ Providers ▾ About Us ▾

Health and Wellness

You are here: [Home](#) > [Features](#) > [Coronavirus Disease 2019 \(COVID-19\)](#)

[Self Care Guides](#) [Wellness Programs](#) [Member Health Rewards](#) [+ Interactive Self-Management Tools](#)

Coronavirus Disease 2019

Frequently Asked Questions

What is Coronavirus Disease 2019 (COVID-19)?

A coronavirus is a type of virus that causes diseases with a wide range of severity, from the common cold to a more serious respiratory disease. COVID-19 is a new strain of respiratory coronavirus that has not been found in humans before. COVID-19 was first found in Wuhan, Hubei Province, China. There is now evidence that COVID-19 is spreading in the community in the United States.



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CalOptima Workforce Update

Temporary Telework Staff

- Based on HCA and CDC guidelines, CalOptima started reducing the number of staff working in each of its facilities, starting March 13
- Current status as of April 8

Active Employees*	Telework Employees	Non-Telework Employees
1,310	1,196 (91%)	114 (9%)

**Does not include approximately 60 temporary staff*

Non-Telework Staff

- Staff remaining in the building perform job functions that cannot be done remotely
 - Printing and mailing member and provider letters
 - Information Services support
 - Facilities support
 - Staff choosing not to work remotely
- Workplace modifications for non-teleworkers (as of April 10)
 - Conducting all meetings virtually
 - Encouraging staff to wear face covering
 - Allowing only one person in the elevators at a time
 - Cleaning common surfaces multiple times daily
 - Reminding staff to wash hands frequently
 - Removed seating from break rooms

Performance Monitoring

- Monitoring internal key performance metrics, including but not limited to:
 - Member call volumes and service levels
 - Authorization volumes and timeliness
 - Claims payment timeliness
 - Attendance

Human Resources Support

- Offering telework support to managers and employees
 - Managers
 - Hosting a webinar on Engaging a Remote Workforce, customized to CalOptima
 - Modifying metrics reporting for temporary telework program
 - Employees
 - Provided protected leave and/or ADA accommodations
 - Sharing ergonomics reminders
 - Sending frequent employee communications
- Continuing to hire
 - Holding phone interviews
 - Conducting virtual on-boarding and New Employee Orientation



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Federal and State Updates

TC Roady

Director, Regulatory Affairs and Compliance

Regulatory Landscape

- CMS is still considering some emergency waiver requests from California that will impact flexibilities and other elements of the state's COVID-19 response
- Governor's budget is expected to be transformed into a "workload budget" in the May Revise
 - Funds existing obligations and services and otherwise focuses primarily on emergency needs tied to the COVID-19 response
 - CalAIM will be delayed and is not expected to be in the budget

Presumptive Eligibility

- DHCS is creating a new aid code in the Fee-For-Service Medi-Cal system for COVID-19
 - Medi-Cal members with this aid code will not be assigned to CalOptima
- Aid code will allow uninsured and under-insured individuals free testing, diagnosis and treatment for COVID-19
- Aid code will be provided to California residents who need it, without regard to immigration status, income or resources



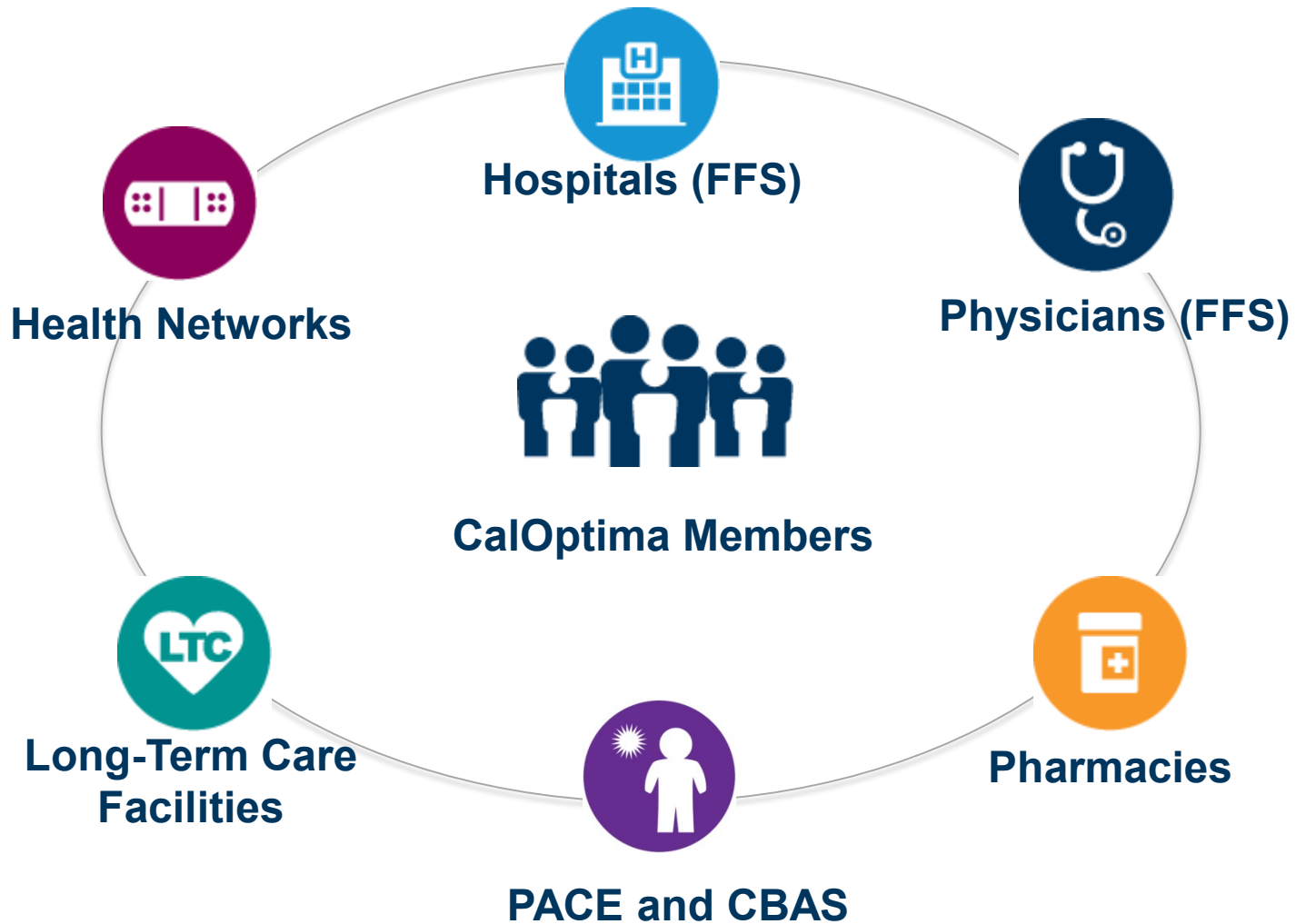
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Financial Update

Nancy Huang
Chief Financial Officer

Health Care Delivery System



Support During COVID-19

Provider Type	Method	Period	Action
Hospitals	FFS	N/A	\$245 million, including expedited HQAF, PHDP and EPP payments
Physicians	FFS	Ongoing	New Directed Payment process (Prop 56, GEMT, etc.)
Pharmacies	FFS/PBM	During Pandemic	Allow early refill, 90-day supply
CBAS	FFS	During Pandemic	Expand covered services to include telehealth and other out-of-center services
Health Networks	Capitation	April–June 2020	Up to \$14 million, via 5% Medi-Cal capitation increase
LTC Facilities	FFS	Ongoing	Expand PIPQI program and modify requirements

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020 Special Meeting of the CalOptima Board of Directors

Report Item

2. Consider Authorizing Modifications to the CalOptima Homeless Clinic Access Program (HCAP) Homeless Health Initiative in Response to COVID-19.

Contact

David Ramirez, MD, Chief Medical Officer (714) 246-8400

Recommended Actions

- 1) Authorize modification of the existing Homeless Clinic Access Program (HCAP) for Homeless Health Initiative to include:
 - a) Telehealth visits;
 - b) On-call services provided through the Clinical Field Team Pilot Program (CFTPP); and
- 2) Authorize the expenditure of up to \$1 million in provider incentives consistent with this proposed modification to the HCAP.

Background

CalOptima staff has launched various initiatives to provide clinical care for CalOptima Medi-Cal Members (Members) experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	<ul style="list-style-type: none">• Authorized establishment of a CFTPP• Authorized reallocation of up to \$1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the CFTPP• Authorized eight unbudgeted FTEs and related costs in an amount not to exceed \$1.2 million to service as part of CalOptima's Homeless Response Team• Directed staff to return to the Board with ratification requests and further implementation details
April 4, 2019	<p>Actions related to Delivery of Care for Homeless CalOptima Members:</p> <ul style="list-style-type: none">• Approved the creation of a restricted Homeless Health Reserve in the amount of \$100 million: \$24 million in previously approved initiatives using IGT 1-7 funds, and \$76 million in IGT 8 funds (approximately \$43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds• Stipulated that funds can only be used for homeless health <p>Actions and contracts with Federally Qualified Health Centers (FQHCs):</p>

	<ul style="list-style-type: none"> • Ratified the implementation plan for the Board authorized CFTPP • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Serve the People Community Health Center • Authorized expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
<p>August 1, 2019</p>	<p>Actions and contracts with FQHCs:</p> <ul style="list-style-type: none"> • Authorized allocation of expenditures of \$135,000 from the FY2019-20 Medi-Cal Health Homes Initiative (HHI) budget from medical expenses to administrative expenses • Authorized the HHI FQHC Expansion pilot • Authorized contract amendments with FQHCs and FQHC Look-alikes to participate in the HHI FQHC Expansion Pilot • Ratified contract amendment with Families Together of Orange County to participate in the CFTPP <p>Actions for development of CalOptima Homeless Clinical Access Program (HCAP)</p> <p>Authorized modification of the CalOptima Days quality improvement and incentive strategy to include HCAP for health care services in mobile units at, or in fixed clinical sites within, shelters or hotspots, including those FQHCs and FQHC Look-alikes participating in the CFTPP or HHI FQHC Expansion Pilot</p>
<p>March 5, 2020</p>	<ul style="list-style-type: none"> • Authorized extension of the CFTPP through December 31, 2020 • Authorized amendments of the CFTPP contracts with operational changes • Authorized extension of the HHI FQHC Expansion Pilot through December 31, 2020 and amendment to contracts to implement the extension

On January 31, 2020, the Secretary of the U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside of a list of “essential activities.” Subsequently, the Centers for Medicare & Medicaid Services (CMS) announced that all elective surgeries, non-essential medical, surgical, and dental procedures are to be delayed during the pandemic. Additionally, in order to continue to ensure access to necessary medical care for Medi-Cal enrollees, the Department of Health Care Services (DHCS) released emergency guidance regarding telehealth.

Discussion

Under the current HCAP, CalOptima offers eligible community health centers a monetary incentive according to two (2) tiers:

- Tier 1: An eligible community health center receives a provider incentive for event participation for a half day (4 hours) or a full day (8 hours).
- Tier 2: An eligible community health center receives a provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
 - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visits; or
 - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visits.

Due to the rapid spread of COVID-19, CalOptima staff has worked in partnership with the Orange County Health Care Agency (OC HCA) and the community health centers participating in the CFTPP to provide needed care to CalOptima members experiencing homelessness. OC HCA is establishing additional temporary shelters and partnering with motels to house individuals who are experiencing homelessness and are also at high risk, exhibiting flu-like symptoms, or have tested positive for COVID-19. The CFTPP will be relied upon to provide needed health care services for individuals at these locations. Under the current program design, on-call visits provided by the CFTPP are not eligible for HCAP incentives.

To support the community effort to provide care for individuals experiencing homelessness including those with COVID-19, Staff recommends expanding the current HCAP to include CFTPP scheduled on-call days. While start-up funds were initially provided to the community health centers participating in

the CFTPP, these funds were exhausted after the first year and the program is not sustainable for the community health centers to continue based on a per service reimbursement alone. The current HCAP criteria provides incentives to community health centers for providing health care services for a defined time period at a fixed location on a prescheduled basis. Expanding the HCAP will provide incentives to participating CFTPP community health centers for on-call services for a defined time period provided throughout the county, while encouraging the use of telehealth when possible and appropriate.

Staff recognizes the need for members experiencing homelessness to have reliable access to health care services where they are located and recommends including telehealth visits as part of HCAP, including the Tier 2 criteria to reduce the spread of COVID-19, exposure of healthcare staff to COVID-19. The use of telehealth visits will be in accordance with the CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services as well as the DHCS All Plan Letter (APL) 19-009 Supplement: Emergency Telehealth Guidance – COVID-19 Pandemic. During the national health emergency, telehealth visits will be the preferred visit type when clinically appropriate and feasible in an effort to avoid face-to-face contact to reduce the spread of COVID-19. Any non-public communication modalities including the telephone may be used for telehealth visits as authorized by DHCS and CMS. In order for those experiencing homelessness to have a telehealth visit, they would need to have access to a telephone. While providers will seek member consent to a telehealth visit, the Governor has issued an order relaxing the State statutory consent requirements for the COVID-19 crisis. Any individuals who decline telehealth visits will continue to be offered in person visits. In accordance with federal guidance, public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) are also not permissible for Telehealth.

CalOptima staff will continue to leverage the coordination and incentive mechanisms already established by the current HCAP. The effectiveness of program is measured by lead measures such as the number of members accessing services, the number of days with expanded hours being offered, and lag measures such as HEDIS, although CalOptima staff anticipates that some of the HEDIS measures or criteria may be modified due to the pandemic.

Fiscal Impact

The recommended action to expand Tier 2 provider incentives to include telehealth visits completed by an eligible provider under the HCAP will not have an additional fiscal impact. Staff anticipates that Homeless Health Initiative budgeted funds approved by the Board on August 1, 2019, for provider incentives will be sufficient to cover expenses related to the telehealth visit expansion.

The recommended action to expand Tier 1 provider incentives to include scheduled on-call days provided through the CFTPP is a Homeless Health Initiative budgeted item. Staff estimates costs of up to \$1 million for the period of April 1, 2020, through December 31, 2020. Current year expenses are budgeted under homeless health-related initiatives in the FY 2019–20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the “clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019. Management will include expenses related to the CFTPP for the period beginning July 1, 2020, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the healthcare services they need. By partnering with shelters, other hot spots, and Community Health Centers to implement the HCAP, CalOptima staff plans to help ensure that members experiencing homeless have access to preventive and primary health services—services that this population segment may not otherwise seek or be able to obtain. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
3. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
4. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal
5. Board Action dated August 1, 2019, Consider Actions Related to Homeless Health Care Delivery
6. Board Action dated August 1, 2019 Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative
7. Board Action dated December 5, 2019, Consider Approval of Homeless Health Initiatives Guiding Principles
8. Board Action dated March 5, 2020, Consider Actions Related to Homeless Health Care Pilot Initiatives
9. March 19, 2020 CMS Announcement: COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations
10. GG.1665: Telehealth and Other Technology-Enabled Services
11. DHCS All Plan Letter 19-009: Emergency Telehealth Guidance – COVID-19 Pandemic
12. Executive Order N-43-20

/s/ Richard Sanchez

Authorized Signature

04/10/2020

Date



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Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee for service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



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OneCare Connect

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

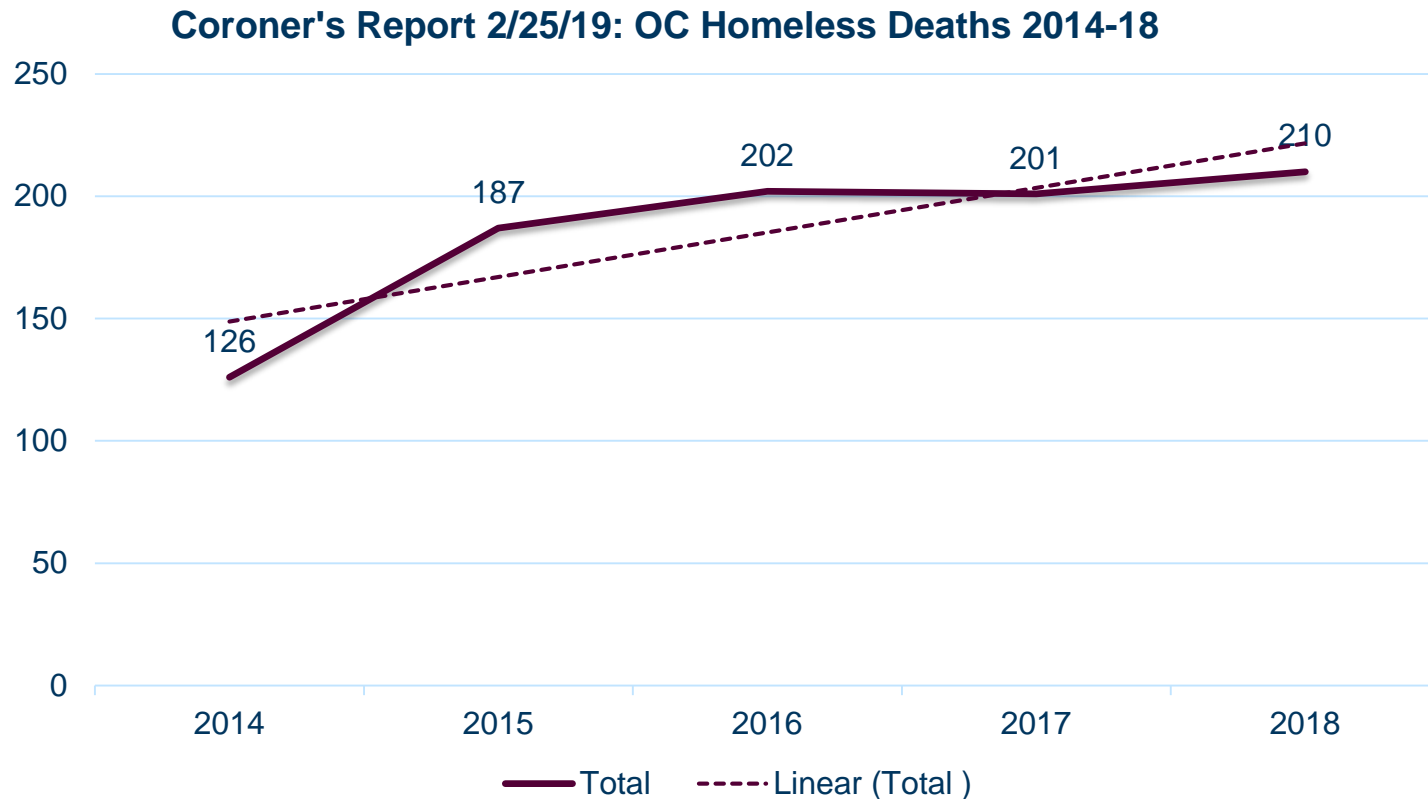
Michael Schrader
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner's Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
 - Clinical field teams (CalOptima)
 - CalOptima Homeless Response Team (CalOptima)
 - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
 - Opioid prescribing interventions (CalOptima)
 - Medication-assisted treatment (County and CalOptima)
 - Substance use disorder centers (County)
 - Medical detox (CalOptima)
 - Social model detox (County)
 - Naloxone (County and CalOptima)
 - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
 - Moderate-severe behavioral health (County)
 - Crisis intervention
 - Post-acute transitions
 - Intensive outpatient treatment programs
 - Mild-moderate behavioral health (CalOptima)
 - Screening
 - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee

Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit \$100 million for homeless health
 - Create a restricted homeless health reserve
 - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	\$11.4 million		IGT 1–7 (\$24 million total)
Recuperative Care	\$11 million		
Clinical Field Team Startup	\$1.6 million		
CalOptima Homeless Response Team (\$1.2 million/year x 5 years)	\$1.2 million	\$4.8 million	IGT 8 and FY 2018–19 operating funds (\$76 million total)
Homeless Coordination at Hospitals (\$2 million/year x 5 years)		\$10 million	
New Initiatives		\$60 million	
Total Reserve: \$100 million	\$25.2 million	\$74.8 million	

Clinical Field Team Structure

- Team Components

- Includes clinical and support staff
- Vehicle for transportation of staff and equipment
- Internet connectivity and use of Whole-Person Care (WPC) Connect

- Clinical Services

- Urgent care, wound care, vaccinations, health screening and point-of-care labs
- Prescriptions and immediate dispensing of commonly used medications
- Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
 - Coordination with CalOptima Homeless Response Team
 - Coordination with providers
 - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
 - Regular hours at shelters/hot spots
 - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
 - AltaMed
 - Central City Community Health Center*
 - Hurtt Family Health Clinic*
 - Korean Community Services*
 - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
 - Deploy on a phased basis, based on FQHC readiness

* *Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
 - Available to Blue Shirts and CHAT-H nurses
 - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
 - Establish working in-person relationships with collaborating partners
 - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
 - Maximum flexibility with access to any provider (no PCP assignment)
 - Fast-tracked authorization processing
 - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
 - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
 - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
 - \$2 million financial impact per year
 - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
 - Reallocate \$250,000 of the \$10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
 - Leverage existing process
 - County to coordinate and pay recuperative care vendor
 - CalOptima to reimburse County for 100 percent of cost
 - COBAR in April
 - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
 - Specifically used for homeless individuals
 - Includes social supports and referrals to services
 - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
 - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
 - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
 - Case management staff is trained and actively uses the system
 - Identify members enrolled in WPC
 - Coordinate with other partners caring for members
 - Access information from other partners
- Status of WPC Connect
 - Five hospitals are currently connected
 - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
 - Regulatory and legislative
 - Available permanent supportive housing and shelters
 - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
 - Enrollment assistance
 - Enhanced data connectivity technology
 - Housing supportive services
 - Other physical health services
 - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
 - Clinical field team implementation
 - Medical respite program
 - Homeless coordination at hospitals
- Additional action recommended by Board Ad Hoc
 - Create a restricted homeless health reserve in the amount of \$100 million
 - \$24 million – previously approved initiatives using IGT 1–7 funds
 - \$76 million – all IGT 8 funds (approximately \$43 million) with balance from FY 2018–19 operating funds
 - Stipulate that funds can only be used for homeless health

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OneCare (HMO SNP)

CalOptima

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OneCare Connect

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019 **Regular Meeting of the CalOptima Board of Directors**

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as “homeless” based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima’s ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to \$1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to \$1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in \$320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- \$500,000 from IGT 1 – Depression Screenings;
- \$100,000 from IGT 6 – IS and Infrastructure Projects;
- \$500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- \$500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to \$500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to \$500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader
Authorized Signature

3/27/2019
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip Code</u>
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17 th St., Ste 101	Santa Ana	CA	92701



CalOptima
Better. Together.

Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

*For Medi-Cal Members

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee for service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item

S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions

Authorize the \$60 million identified for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Background

Supervisor Do is requesting consideration to allocate the \$60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Attachments

1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, \$60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the \$60 million allocated:

- Clinic health care services in all homeless shelters - \$10 million
- Authorize mobile health team to respond to all homeless providers - \$10 million
- Residential support services and housing navigation - \$20 million
- Extend recuperative care for homeless individuals with chronic physical health issue-\$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,



ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of \$100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately \$100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved \$60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - \$10 million*
As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - \$10 million*
Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - \$20 million*
The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million*
CalOptima has twice allocated funds for recuperative care, bringing the total to \$11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

Supervisor Andrew Do
June 5, 2019
Page 4

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the “urgent” elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,



Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the \$60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the \$60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of \$10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services “eventually” will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

A handwritten signature in blue ink that reads "Andrew Do". The signature is fluid and cursive, with the first name "Andrew" being more prominent than the last name "Do".

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Actions Related to Homeless Health Care Delivery

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
 - a. Reallocate \$135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
 - b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
 - c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background

CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	<ul style="list-style-type: none">• Authorized establishment of a Clinical Field Team pilot program• Authorized reallocation of up to \$1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs• Authorized eight unbudgeted FTEs and related costs in an amount not to exceed \$1.2 million to service as part of CalOptima's Homeless Response Team• Directed staff to return to the Board with ratification request for further implementation details• Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

	<ul style="list-style-type: none"> • Approved the creation of a restricted Homeless Health Reserve in the amount of \$100 million: \$24 million in previously approved initiatives using IGT 1-7 funds, and \$76 million in IGT 8 funds (approximately \$43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health <p>Actions and contracts with FQHCs</p> <ul style="list-style-type: none"> • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
<p>June 27, 2019</p>	<p>Authorized \$60 million identified for new homeless health initiatives as follows:</p> <ol style="list-style-type: none"> 1. Clinic health care services in all homeless shelters - \$10 million 2. Authorize mobile health team to respond to all homeless providers - \$10 million 3. Residential support services and housing navigation - \$20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc’s intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately \$324,000, or \$270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately \$320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to \$300,000 from the \$10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile unit for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to \$300,000 for claims payments and up to \$270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019.

The recommended action to reallocate \$135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do’s Homeless Healthcare Proposal

/s/ Michael Schrader
Authorized Signature

7/24/19
Date

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corporation dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

CalOptima Board Action Agenda Referral
Consider Actions Related to Homeless Health Care Delivery
Page 6

Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084



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Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



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Medi-Cal

CalOptima

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OneCare (HMO SNP)

CalOptima

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OneCare Connect

CalOptima

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PACE

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Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

Clinical Field Team Pilot

- Board approved up to \$1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
 - Partner with up to five interested FQHCs that will:
 - Establish regular hours at high-volume shelters
 - Deploy to community locations on short notice
 - Coordinate to arrange for coverage with extended hours
 - Deliver urgent-care-type services to homeless individuals in need
 - Bill CalOptima for current CalOptima members
 - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
 - Eight new positions in Case Management department
 - Primary point of contact at CalOptima for homeless health services for CalOptima members
 - Dedicated phone line
 - Extended hours
 - Coordinate scheduling and dispatch of CFTs
 - Work closely with County, shelters and providers
 - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Expanded Service Options Under Consideration

- Embedded clinics at shelters
 - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
 - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
 - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
 - Set up a post-WPC recuperative care program
 - Reallocate part of \$10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
 - From WPC recuperative care funds
 - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
 - Coordinate with County to explore possibilities of:
 - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
 - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
 - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
 - WPC
 - Link clients to other programs that provide housing supportive services
 - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
 - Health Homes Program
 - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
 - Members must elect to participate
 - Care management includes housing navigation

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
 - Obtaining legal opinion
 - Seeking guidance from the Department of Health Care Services

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
 - WPC hospital navigators
 - Increased access to skilled nursing services
 - Recuperative care beyond 90 days
 - Recuperative care with behavioral health focus
 - Housing supportive services
 - Housing development and rental assistance

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

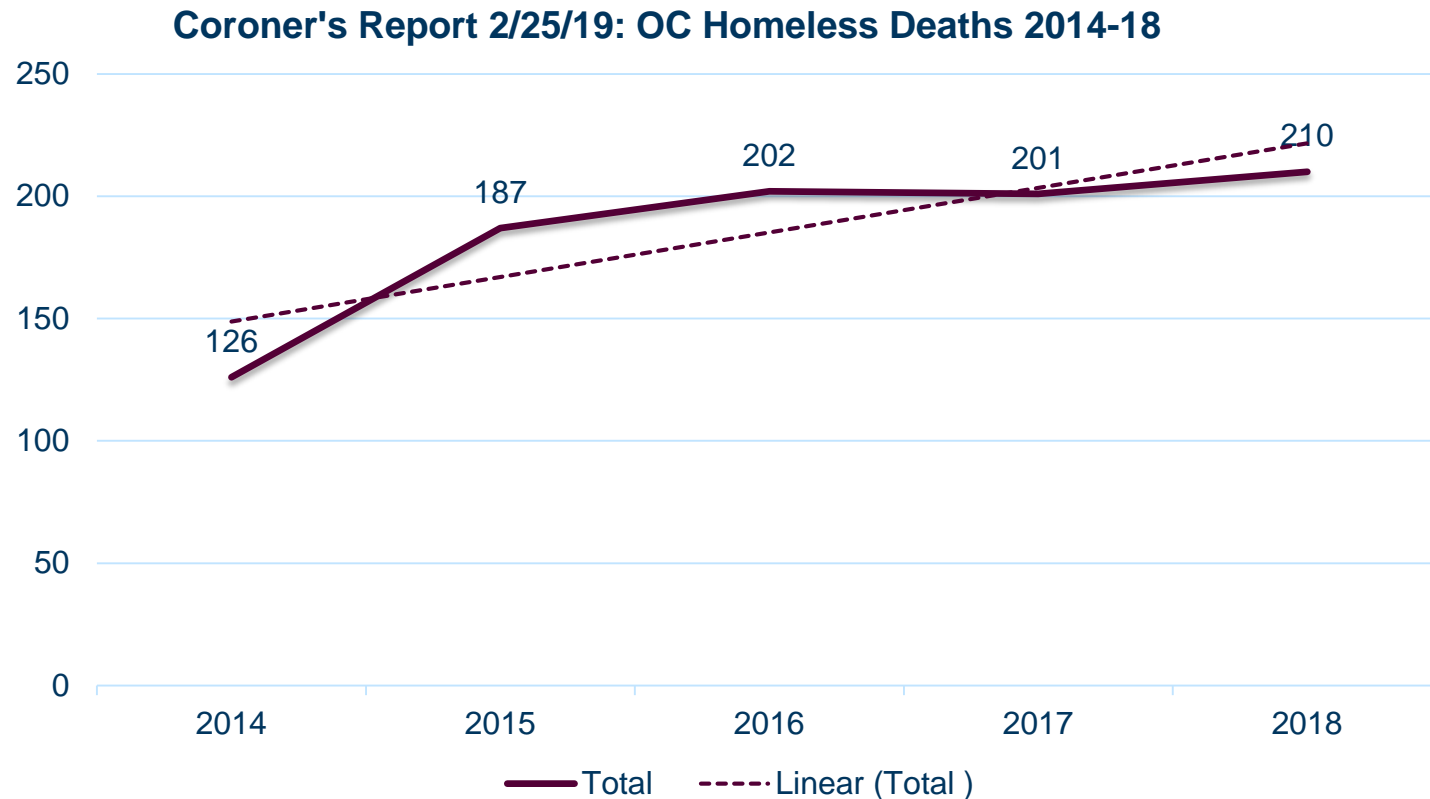
Michael Schrader
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner's Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
 - Clinical field teams (CalOptima)
 - CalOptima Homeless Response Team (CalOptima)
 - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
 - Opioid prescribing interventions (CalOptima)
 - Medication-assisted treatment (County and CalOptima)
 - Substance use disorder centers (County)
 - Medical detox (CalOptima)
 - Social model detox (County)
 - Naloxone (County and CalOptima)
 - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
 - Moderate-severe behavioral health (County)
 - Crisis intervention
 - Post-acute transitions
 - Intensive outpatient treatment programs
 - Mild-moderate behavioral health (CalOptima)
 - Screening
 - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee

Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit \$100 million for homeless health
 - Create a restricted homeless health reserve
 - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	\$11.4 million		IGT 1–7 (\$24 million total)
Recuperative Care	\$11 million		
Clinical Field Team Startup	\$1.6 million		
CalOptima Homeless Response Team (\$1.2 million/year x 5 years)	\$1.2 million	\$4.8 million	IGT 8 and FY 2018–19 operating funds (\$76 million total)
Homeless Coordination at Hospitals (\$2 million/year x 5 years)		\$10 million	
New Initiatives		\$60 million	
Total Reserve: \$100 million	\$25.2 million	\$74.8 million	

Clinical Field Team Structure

- Team Components

- Includes clinical and support staff
- Vehicle for transportation of staff and equipment
- Internet connectivity and use of Whole-Person Care (WPC) Connect

- Clinical Services

- Urgent care, wound care, vaccinations, health screening and point-of-care labs
- Prescriptions and immediate dispensing of commonly used medications
- Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
 - Coordination with CalOptima Homeless Response Team
 - Coordination with providers
 - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
 - Regular hours at shelters/hot spots
 - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
 - AltaMed
 - Central City Community Health Center*
 - Hurtt Family Health Clinic*
 - Korean Community Services*
 - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
 - Deploy on a phased basis, based on FQHC readiness

* *Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
 - Available to Blue Shirts and CHAT-H nurses
 - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
 - Establish working in-person relationships with collaborating partners
 - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
 - Maximum flexibility with access to any provider (no PCP assignment)
 - Fast-tracked authorization processing
 - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
 - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
 - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
 - \$2 million financial impact per year
 - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
 - Reallocate \$250,000 of the \$10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
 - Leverage existing process
 - County to coordinate and pay recuperative care vendor
 - CalOptima to reimburse County for 100 percent of cost
 - COBAR in April
 - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
 - Specifically used for homeless individuals
 - Includes social supports and referrals to services
 - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
 - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
 - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
 - Case management staff is trained and actively uses the system
 - Identify members enrolled in WPC
 - Coordinate with other partners caring for members
 - Access information from other partners
- Status of WPC Connect
 - Five hospitals are currently connected
 - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
 - Regulatory and legislative
 - Available permanent supportive housing and shelters
 - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
 - Enrollment assistance
 - Enhanced data connectivity technology
 - Housing supportive services
 - Other physical health services
 - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
 - Clinical field team implementation
 - Medical respite program
 - Homeless coordination at hospitals
- Additional action recommended by Board Ad Hoc
 - Create a restricted homeless health reserve in the amount of \$100 million
 - \$24 million – previously approved initiatives using IGT 1–7 funds
 - \$76 million – all IGT 8 funds (approximately \$43 million) with balance from FY 2018–19 operating funds
 - Stipulate that funds can only be used for homeless health

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OneCare (HMO SNP)

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OneCare Connect

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019 **Regular Meeting of the CalOptima Board of Directors**

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as “homeless” based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima’s ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to \$1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to \$1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in \$320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- \$500,000 from IGT 1 – Depression Screenings;
- \$100,000 from IGT 6 – IS and Infrastructure Projects;
- \$500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- \$500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to \$500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to \$500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader
Authorized Signature

3/27/2019
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip Code</u>
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17 th St., Ste 101	Santa Ana	CA	92701



CalOptima
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Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee for service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.

MEMORANDUM

DATE: May 2, 2019
TO: CalOptima Board of Directors
FROM: Michael Schrader, CEO
SUBJECT: CEO Report
COPY: Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April

CalOptima moved our \$100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- **Clinical Field Teams:** Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurr Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- **Anaheim Encampment:** Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- **Use of Funds:** Approximately \$60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- **Stakeholder Input:** The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- **State Programs and Legislation:** Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total \$36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force \$16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DMHC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigitte Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OCFA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item

S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions

Authorize the \$60 million identified for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Background

Supervisor Do is requesting consideration to allocate the \$60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Attachments

1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, \$60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the \$60 million allocated:

- Clinic health care services in all homeless shelters - \$10 million
- Authorize mobile health team to respond to all homeless providers - \$10 million
- Residential support services and housing navigation - \$20 million
- Extend recuperative care for homeless individuals with chronic physical health issue-\$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,



ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of \$100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately \$100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved \$60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - \$10 million*
As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - \$10 million*
Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - \$20 million*
The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million*
CalOptima has twice allocated funds for recuperative care, bringing the total to \$11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

Supervisor Andrew Do
June 5, 2019
Page 4

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the “urgent” elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,



Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the \$60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the \$60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of \$10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services “eventually” will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

A handwritten signature in blue ink that reads "Andrew Do". The signature is fluid and cursive, with the first name "Andrew" being more prominent than the last name "Do".

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Actions Related to Homeless Health Care Delivery

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
 - a. Reallocate \$135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
 - b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
 - c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background

CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	<ul style="list-style-type: none">• Authorized establishment of a Clinical Field Team pilot program• Authorized reallocation of up to \$1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs• Authorized eight unbudgeted FTEs and related costs in an amount not to exceed \$1.2 million to service as part of CalOptima's Homeless Response Team• Directed staff to return to the Board with ratification request for further implementation details• Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

	<ul style="list-style-type: none"> • Approved the creation of a restricted Homeless Health Reserve in the amount of \$100 million: \$24 million in previously approved initiatives using IGT 1-7 funds, and \$76 million in IGT 8 funds (approximately \$43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health <p>Actions and contracts with FQHCs</p> <ul style="list-style-type: none"> • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
<p>June 27, 2019</p>	<p>Authorized \$60 million identified for new homeless health initiatives as follows:</p> <ol style="list-style-type: none"> 1. Clinic health care services in all homeless shelters - \$10 million 2. Authorize mobile health team to respond to all homeless providers - \$10 million 3. Residential support services and housing navigation - \$20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc’s intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately \$324,000, or \$270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately \$320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to \$300,000 from the \$10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile unit for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to \$300,000 for claims payments and up to \$270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019.

The recommended action to reallocate \$135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do’s Homeless Healthcare Proposal

/s/ Michael Schrader
Authorized Signature

7/24/19
Date

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corporation dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

CalOptima Board Action Agenda Referral
Consider Actions Related to Homeless Health Care Delivery
Page 6

Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084



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Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

*For Medi-Cal Members

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee for service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

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Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.



A Public Agency

CalOptima
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Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

Clinical Field Team Pilot

- Board approved up to \$1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
 - Partner with up to five interested FQHCs that will:
 - Establish regular hours at high-volume shelters
 - Deploy to community locations on short notice
 - Coordinate to arrange for coverage with extended hours
 - Deliver urgent-care-type services to homeless individuals in need
 - Bill CalOptima for current CalOptima members
 - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
 - Eight new positions in Case Management department
 - Primary point of contact at CalOptima for homeless health services for CalOptima members
 - Dedicated phone line
 - Extended hours
 - Coordinate scheduling and dispatch of CFTs
 - Work closely with County, shelters and providers
 - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Expanded Service Options Under Consideration

- Embedded clinics at shelters
 - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
 - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
 - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
 - Set up a post-WPC recuperative care program
 - Reallocate part of \$10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
 - From WPC recuperative care funds
 - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
 - Coordinate with County to explore possibilities of:
 - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
 - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
 - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
 - WPC
 - Link clients to other programs that provide housing supportive services
 - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
 - Health Homes Program
 - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
 - Members must elect to participate
 - Care management includes housing navigation

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
 - Obtaining legal opinion
 - Seeking guidance from the Department of Health Care Services

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
 - WPC hospital navigators
 - Increased access to skilled nursing services
 - Recuperative care beyond 90 days
 - Recuperative care with behavioral health focus
 - Housing supportive services
 - Housing development and rental assistance

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner





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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

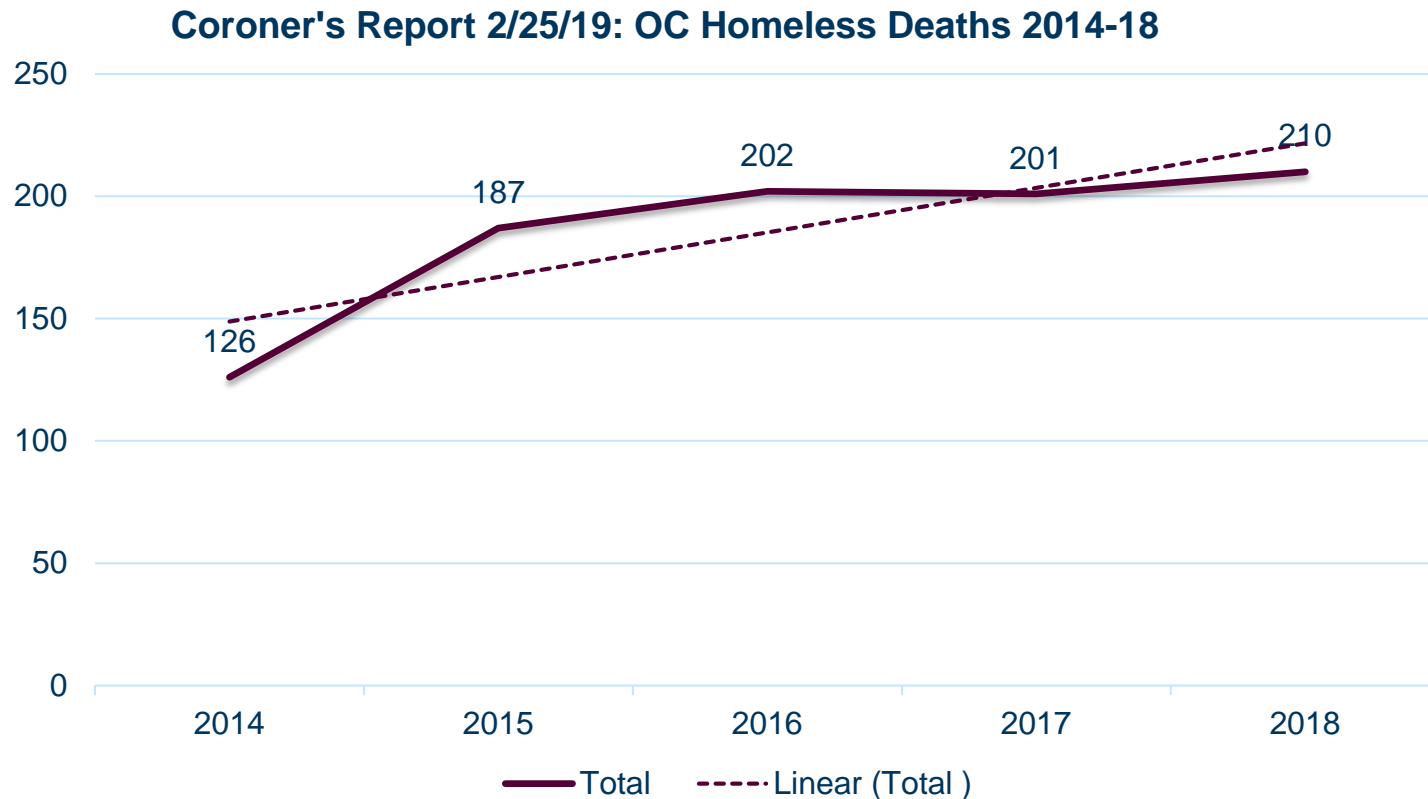
Michael Schrader
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner's Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
 - Clinical field teams (CalOptima)
 - CalOptima Homeless Response Team (CalOptima)
 - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
 - Opioid prescribing interventions (CalOptima)
 - Medication-assisted treatment (County and CalOptima)
 - Substance use disorder centers (County)
 - Medical detox (CalOptima)
 - Social model detox (County)
 - Naloxone (County and CalOptima)
 - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
 - Moderate-severe behavioral health (County)
 - Crisis intervention
 - Post-acute transitions
 - Intensive outpatient treatment programs
 - Mild-moderate behavioral health (CalOptima)
 - Screening
 - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee

Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit \$100 million for homeless health
 - Create a restricted homeless health reserve
 - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	\$11.4 million		IGT 1–7 (\$24 million total)
Recuperative Care	\$11 million		
Clinical Field Team Startup	\$1.6 million		
CalOptima Homeless Response Team (\$1.2 million/year x 5 years)	\$1.2 million	\$4.8 million	IGT 8 and FY 2018–19 operating funds (\$76 million total)
Homeless Coordination at Hospitals (\$2 million/year x 5 years)		\$10 million	
New Initiatives		\$60 million	
Total Reserve: \$100 million	\$25.2 million	\$74.8 million	

Clinical Field Team Structure

- Team Components

- Includes clinical and support staff
- Vehicle for transportation of staff and equipment
- Internet connectivity and use of Whole-Person Care (WPC) Connect

- Clinical Services

- Urgent care, wound care, vaccinations, health screening and point-of-care labs
- Prescriptions and immediate dispensing of commonly used medications
- Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
 - Coordination with CalOptima Homeless Response Team
 - Coordination with providers
 - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
 - Regular hours at shelters/hot spots
 - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
 - AltaMed
 - Central City Community Health Center*
 - Hurtt Family Health Clinic*
 - Korean Community Services*
 - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
 - Deploy on a phased basis, based on FQHC readiness

* *Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
 - Available to Blue Shirts and CHAT-H nurses
 - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
 - Establish working in-person relationships with collaborating partners
 - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
 - Maximum flexibility with access to any provider (no PCP assignment)
 - Fast-tracked authorization processing
 - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
 - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
 - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
 - \$2 million financial impact per year
 - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
 - Reallocate \$250,000 of the \$10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
 - Leverage existing process
 - County to coordinate and pay recuperative care vendor
 - CalOptima to reimburse County for 100 percent of cost
 - COBAR in April
 - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
 - Specifically used for homeless individuals
 - Includes social supports and referrals to services
 - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
 - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
 - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
 - Case management staff is trained and actively uses the system
 - Identify members enrolled in WPC
 - Coordinate with other partners caring for members
 - Access information from other partners
- Status of WPC Connect
 - Five hospitals are currently connected
 - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
 - Regulatory and legislative
 - Available permanent supportive housing and shelters
 - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
 - Enrollment assistance
 - Enhanced data connectivity technology
 - Housing supportive services
 - Other physical health services
 - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
 - Clinical field team implementation
 - Medical respite program
 - Homeless coordination at hospitals
- Additional action recommended by Board Ad Hoc
 - Create a restricted homeless health reserve in the amount of \$100 million
 - \$24 million – previously approved initiatives using IGT 1–7 funds
 - \$76 million – all IGT 8 funds (approximately \$43 million) with balance from FY 2018–19 operating funds
 - Stipulate that funds can only be used for homeless health

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

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Medi-Cal

CalOptima

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OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

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PACE

CalOptima

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019 **Regular Meeting of the CalOptima Board of Directors**

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to \$500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as “homeless” based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima’s ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to \$1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to \$1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in \$320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- \$500,000 from IGT 1 – Depression Screenings;
- \$100,000 from IGT 6 – IS and Infrastructure Projects;
- \$500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- \$500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to \$500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to \$500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader
Authorized Signature

3/27/2019
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip Code</u>
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17 th St., Ste 101	Santa Ana	CA	92701



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Homeless Health Care Delivery

**Special Meeting of the CalOptima Board of Directors
February 22, 2019**

**Michael Schrader
Chief Executive Officer**

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population <ul style="list-style-type: none"> • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks 	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
 - Physician services – primary and specialty care
 - Hospital services and tertiary care
 - Palliative care and hospice
 - Pharmacy
 - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
 - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
 - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
 - Difficulty with scheduled appointments
 - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
 - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
 - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
 - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
 - Percentage that were CalOptima members
 - Demographics
 - Causes of death
 - Prior access to medical care
 - Identify opportunities for improvement

Strengthened System of Care

- Vision
 - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
 - Reasons for partnering with FQHCs
 - Receive CalOptima reimbursement for Medi-Cal members
 - Receive federal funding for uninsured
 - Enrollment assistance into Medi-Cal
 - Offer members education on choosing FQHC as their PCP
 - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
 - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
 - Available with extended hours
 - Go to parks, riverbeds and shelters
 - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
 - Intensive case management services
 - Section 1915(c) Home and Community Based Services waiver
 - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
 - Housing navigation and supports
 - Section 1115 waiver
 - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
 - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
 - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
 - LA County administers a flexible housing subsidy pool
 - L.A. Care provided a \$4 million grant (total commitment of \$20 million over 5 years) for rent subsidies to house 300 individuals
 - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
 - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
 - Housing pool not in existence today under WPC Pilot
 - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
 - Dedicated CalOptima resources
 - Coordinate with clinical field teams
 - Interact with Blue Shirts, health networks, providers, etc.
 - Work in the community
 - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
 - On-site in shelters
 - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
 - Contribute to a housing pool
 - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
 - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
 - Contract with any willing FQHC that meets qualifications
 - ~~CalOptima financially responsible for services regardless of health network eligibility~~
 - ~~One year pilot program~~
 - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to \$1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
 - ~~Vehicle, equipment and supplies~~
 - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
 - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed \$1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



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OneCare (HMO SNP)

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OneCare Connect

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MEMORANDUM

DATE: May 2, 2019
TO: CalOptima Board of Directors
FROM: Michael Schrader, CEO
SUBJECT: CEO Report
COPY: Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April

CalOptima moved our \$100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- **Clinical Field Teams:** Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurr Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- **Anaheim Encampment:** Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- **Use of Funds:** Approximately \$60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- **Stakeholder Input:** The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- **State Programs and Legislation:** Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total \$36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force \$16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DMHC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigitte Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OCFA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item

S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions

Authorize the \$60 million identified for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Background

Supervisor Do is requesting consideration to allocate the \$60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Attachments

1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, \$60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the \$60 million allocated:

- Clinic health care services in all homeless shelters - \$10 million
- Authorize mobile health team to respond to all homeless providers - \$10 million
- Residential support services and housing navigation - \$20 million
- Extend recuperative care for homeless individuals with chronic physical health issue-\$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,



ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of \$100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately \$100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved \$60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - \$10 million*
As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - \$10 million*
Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - \$20 million*
The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million*
CalOptima has twice allocated funds for recuperative care, bringing the total to \$11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

Supervisor Andrew Do
June 5, 2019
Page 4

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the “urgent” elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,



Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the \$60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the \$60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of \$10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services “eventually” will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

A handwritten signature in blue ink that reads "Andrew Do". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019

Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to \$1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed \$231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

“CalOptima Day” is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to \$1.1Million. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for \$60 million in new Homeless Health Initiatives. As part of this action, the Board allocated \$10 million to “Clinic health care services in all homeless shelters.”

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member’s assigned health network or is not the member’s assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to \$1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).
- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
 - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
 - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	\$800	\$1,600
Tier 2	\$400	\$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately \$231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to \$1 million annually for provider incentives and \$231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the “clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to \$1.1Million. on December 1, 2016
3. CalOptima Day Fact Sheet

/s/ Michael Schrader
Authorized Signature

7/24/19
Date



CalOptima
Better. Together.

CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
 - Homeless Response Team to coordinate care
 - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
 - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
 - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams (CFTs)
- Mobile Clinics
- Telehealth

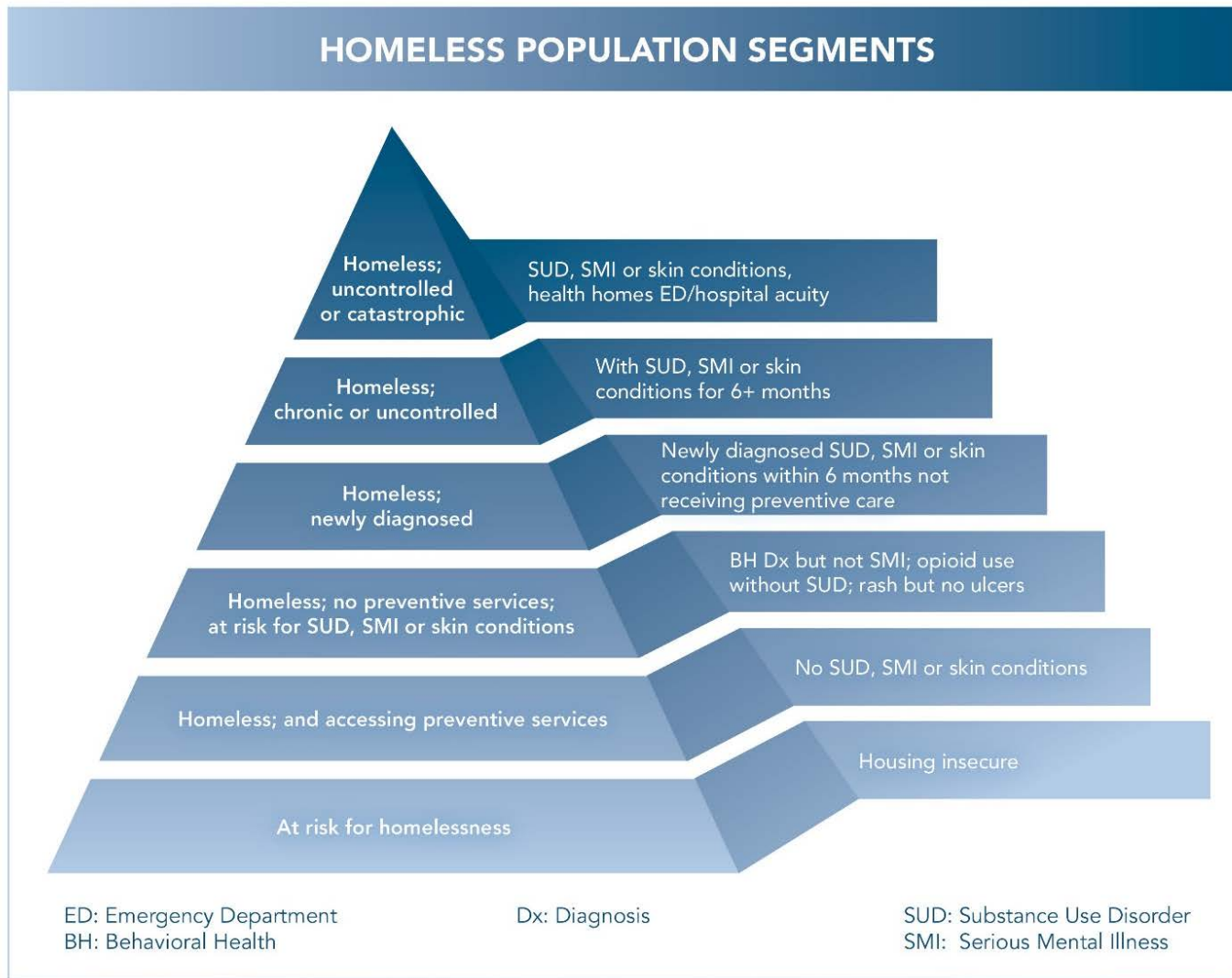
Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

A Population Health Approach



Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of \$60 million for new homeless health initiatives.
- As part of this action, the Board allocated \$10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative



Develop a CalOptima Homeless Clinic Access Program (HCAP)



Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
 - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
 - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
 - Providers are incentivized to host the event and can receive up to \$2,400 per CalOptima Day.
 - Members are incentivized with a \$25 gift card for completing a visit.

2018 CalOptima Day Focused Measures

- Well-Care Measures

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)

- Immunization Measures

- Childhood Immunization Status (CIS)
 - Combo 10
- Immunizations for Adolescents (AWC)
 - Combo 2

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
 - Access to Ambulatory and Preventive Care Services (AAP)
 - Adult BMI Assessment (ABA)
 - Chlamydia Screening (CHL)
 - Cervical Cancer Screening (CCS)
 - Adult Immunization Status (AIS)
 - Comprehensive Diabetes Care (CDC)
 - HbA1C
 - Retinal Eye Exam
 - Blood Pressure

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
 - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
 - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
 - Eligible provider completes 10 appointments during half day (4 hours)
 - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	\$800	\$1,600
Tier 2 Incentive	\$400	\$800

Fiscal Impact

- Expenses of up to \$1 million annually for provider incentives and \$231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to \$1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed \$231,087 in support of this expansion of the CalOptima Day quality incentive program.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to \$1.1 Million

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed \$1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

- | | |
|--|-------------------|
| • Budget augmentation for current quality initiatives: | \$ 457,740 |
| • New requests for quality initiatives: | <u>\$ 605,839</u> |
| Total Request | \$1,063,579 |

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to \$1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to \$1.1 million in medical expenses to fund the cost of the quality improvement activities.

CalOptima Board Action Agenda Referral
Consider Approval of Medi-Cal Quality Improvement and Accreditation
Activities During CalOptima FY 2016-17, Including Contracts and
Contract Amendments with Consultant(s), Member and Provider
Incentives, and Expenditures of Unbudgeted Funds of up to \$1.1 Million
Page 2

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

/s/ Michael Schrader
Authorized Signature

11/22/2016
Date

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	<ul style="list-style-type: none"> • Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey 	\$252,937
NCQA Consultant	<ul style="list-style-type: none"> • RFP results did not produce viable option; completed bid exception for known entity due to timeframe 	\$17,375
Quality Initiatives in Flight	<ul style="list-style-type: none"> • Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) • 	\$138,793
	<ul style="list-style-type: none"> • Member and provider incentives 	\$12,380
Required Training	<ul style="list-style-type: none"> • Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment 	\$28,480
Miscellaneous		\$7,775
Total		\$457,740

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	<ul style="list-style-type: none"> • Prenatal/postpartum incentive (Increase volume of outreach; \$10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; \$99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; \$149,900 	\$260,687
Provider Programs	<ul style="list-style-type: none"> • Physician office extended hours pilot project - MPL measures (\$10,000) • Prenatal/postpartum provider office incentive (\$5,000) • PCP office staff incentives for well women visits/screenings (\$75,000) • Physician office extended hours initiative mailing (\$2,500) 	\$92,500
Member Experience Initiatives	<ul style="list-style-type: none"> • Member focus groups, supplemental survey, provider CME (\$72,525) • Practice coaches for member experience (\$18,840) 	\$91,365
Provider Toolkits	<ul style="list-style-type: none"> • AWARE toolkit on antibiotic use (\$5,000) • Provider Outreach/Education on AAB Measure (Below MPL; \$1,500) 	\$6,500
Outreach Projects	<ul style="list-style-type: none"> • PSA for well women visits (Feb & May) - Culturally-specific radio stations (\$99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; \$44,887) • Educational posters/print ads for physician offices for Women’s Wellness Campaign (\$10,000) 	\$154,787
Total		\$605,839



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Quality Analytics Budget

**Board of Directors' Quality Assurance Committee Meeting
November 16, 2016**

**Board of Directors' Finance and Audit Committee Meeting
November 17, 2016**

**Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality**

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: \$457,740
 - Surveys & NCQA Fees
 - NCQA Consultant
 - Quality Initiatives in Flight
 - Required Training
 - Miscellaneous

- New requests for quality initiatives: \$605,839
 - Member Programs
 - Provider Programs
 - Member Experience Initiatives
 - Provider Toolkits
 - Outreach Projects

Budget Augmentation for Current Quality Initiatives: \$457,740

- Surveys & NCQA Fees: \$252,937
 - Addition of CG CAHPS – Adult & Child
 - Fee increases for regular CAHPS
 - Implement SPD CAHPS
 - Additional record retrieval for Medical Record Review
 - Increase in NCQA required fees
 - Timely Access Survey

- NCQA Consultant: \$17,375
 - RFP results did not produce viable option; completed bid exception for known entity due to timeframe

- Quality Initiatives in Flight: \$151,173
 - Flu/pneumococcal shot reminders
 - Preventive care visits
 - Pharyngitis kits
 - Readmissions project (CMS QIP)
 - Member communications (more non-adherent members; more measures to move)
 - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

➤ Required Training	\$28,480
▪ Annual Inovalon & HEDIS Best Practices training	
▪ CME expenses for physician training	
▪ Provider education activities	
▪ New hire equipment	
➤ Miscellaneous	\$7,775

Funding for Additional Program: \$605,839

➤ Member Programs	\$260,687
▪ Prenatal/postpartum incentive (Increase volume of outreach)	
▪ Breast Cancer Screening (Downward trend)	
▪ Cervical Cancer Screening (Below MPL)	
➤ Provider Programs	\$92,500
▪ Physician office extended hours pilot project – MPL measures	
▪ Prenatal/postpartum provider office incentive	
▪ PCP office staff incentives for well women visits/screenings	
▪ Physician office extended hours initiative mailing	
➤ Member Experience Initiatives	\$91,365
▪ Member focus groups, supplemental survey, provider CME	
▪ Practice coaches for member experience	
➤ Provider Toolkits	\$6,500
▪ AWARE toolkit on antibiotic use	
▪ Provider outreach/education on AAB Measure (Below MPL)	
➤ Outreach Projects:	\$154,787
▪ PSA for well women visits (Feb & May) – Culturally-specific radio stations	
▪ Child & adolescent outreach and events for childhood immunizations (13% decrease)	
▪ Educational posters/print ads for physician offices for Women’s Wellness Campaign	

Description of Additional Programs	Amount
Member Programs	\$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	\$10,887
Breast cancer screening (Downward trend)	\$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	\$149,900
Provider Programs	\$92,500
Physician office extended hours pilot project – MPL measures	\$10,000
Prenatal/postpartum provider office incentive	\$5,000
PCP office staff incentives for well women visits/screenings	\$75,000
Physician office extended hours initiative mailing	\$2,500
Member Experience	\$91,365
Member focus groups (\$50K), supplemental survey (\$20,475), provider CME (\$7K)	\$72,525
Practice coaches for member experience	\$18,840
Provider Tool Kits	\$6,500
AWARE Toolkit on antibiotic use	\$5,000
Provider outreach/education on AAB Measure (Below MPL)	\$1,500
Outreach Projects	\$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	\$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	\$44,887
Educational posters/print ads for physician offices for Women’s Wellness Campaign	\$10,000
Total	\$605,839

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

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Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

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QUALITY INITIATIVES

“CalOptima Day” Child and Adolescent Health and Wellness Event

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for health networks to host CalOptima Day, a one-day health and wellness event at one high-volume provider office or clinic of their choice, offering immunizations and well-care visits to children and adolescent Medi-Cal members.

Criteria for Participation:

- Health networks and the selected provider office or clinic will help market the event as “CalOptima Day.”
- Voluntary participation of one provider office or clinic per health network that serves a high volume of targeted CalOptima Medi-Cal members in Orange County
- Provider office or clinic must be in good standing with CalOptima and have no sanctions or corrective action plans in place at the time of participation.
- Health networks and provider office/ clinic are expected to host a wellness event targeting any or all the measures listed: W15, W34, AWC, CIS and IMA.
- Provider offices and clinics are expected to conduct member outreach efforts including outbound calling, scheduling appointments and record keeping.
- Provider offices/ clinics and the health network are expected to properly code the office visit in accordance to the HEDIS specifications and provide validation to CalOptima this occurred.
- The participating provider or clinic shall provide feedback and a summary report of all vaccinations and well-child visits completed at the event.
- CalOptima will provide gift cards to members as incentives for receiving a recommended immunization(s) during the CalOptima Day event.
- CalOptima will offer participating provider offices or clinics a monetary incentive for hosting the health and wellness event of \$300/hr. for each health event, up to \$2,400/event. Depending on budget, a primary care provider (PCP)/clinic site may conduct more than one event at the discretion of CalOptima.

For more information, email questions to QI_Initiatives@CalOptima.org.

Please note: A limited number of provider offices and/or clinics will be eligible to participate in the Child and Adolescent Health and Wellness Event. Be on the lookout for more opportunities to participate in a CalOptima incentive program.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019 **Regular Meeting of the CalOptima Board of Directors**

Report Item

13. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact

Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action

Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background

On April 4, 2019, the CalOptima Board of Directors committed expenditures of \$100 million for Homeless Health Initiatives within a three-year period. At that time, \$40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional \$60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the \$60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the \$60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the October 3, 2019, Board meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration. On October 28, 2019, the California Department of Health Care Services released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future Medi-Cal delivery system framework, starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. On November 7, 2019, the Board requested that staff consider the impact of CalAIM on the Guiding Principles, update the document if needed and present the information to the full Board.

Discussion

The Board recognizes that the approved \$60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute the new initiatives that are most impactful and relevant to our

members experiencing homelessness. The staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Fiscal Impact

The recommended action is budget neutral. The \$60 million allocation has already been approved by the Board. The recommended action has the effect of distributing funds to various as yet undetermined initiatives, but the amount will not exceed \$60 million.

Rationale for Recommendation

The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Homeless Health Initiatives: Guiding Principles presentation
2. Homeless Health Initiatives Guiding Principles
3. Crosswalk: Guiding Principles and Homeless Health Funding Categories
4. CalAIM Appendix D

/s/ Michael Schrader
Authorized Signature

11/26/2019
Date



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Homeless Health Initiatives: Guiding Principles

Board of Directors Meeting
December 5, 2019

Michael Schrader, Chief Executive Officer
TC Roady, Director, Regulatory Affairs and Compliance
Candice Gomez, Executive Director, Program Implementation

Agenda

- Current initiatives and Board direction
- California Advancing and Innovating Medi-Cal (CalAIM)
- Homeless Health allocation in light of CalAIM

Current Initiatives

Board-Approved Programs With \$100 Million Homeless Health Reserve	Funding
Be Well OC Regional Mental Health and Wellness Hub	\$11.4 million
Recuperative Care	\$10.75 million
Respite Care	\$250,000
Clinical Field Team Startup	\$1.6 million
CalOptima Homeless Response Team	\$6 million
Homeless Coordination at Hospitals	\$10 million
CalOptima Day and Quality Improvement Program	\$1.2 million
Federally Qualified Health Centers Expansion	\$.6 million
Total Allocated	\$41.8 million
Remaining Funding Available	\$58.2 million

- Other Board-Approved Programs Supporting Homeless Health
 - Medication-Assisted Treatment: \$6 million (IGT funds)
- Other Programs Pending Board Approval
 - Housing Supportive Services: \$2.5 million (reallocated from reserve)

Board Actions and Directives on Homeless Health

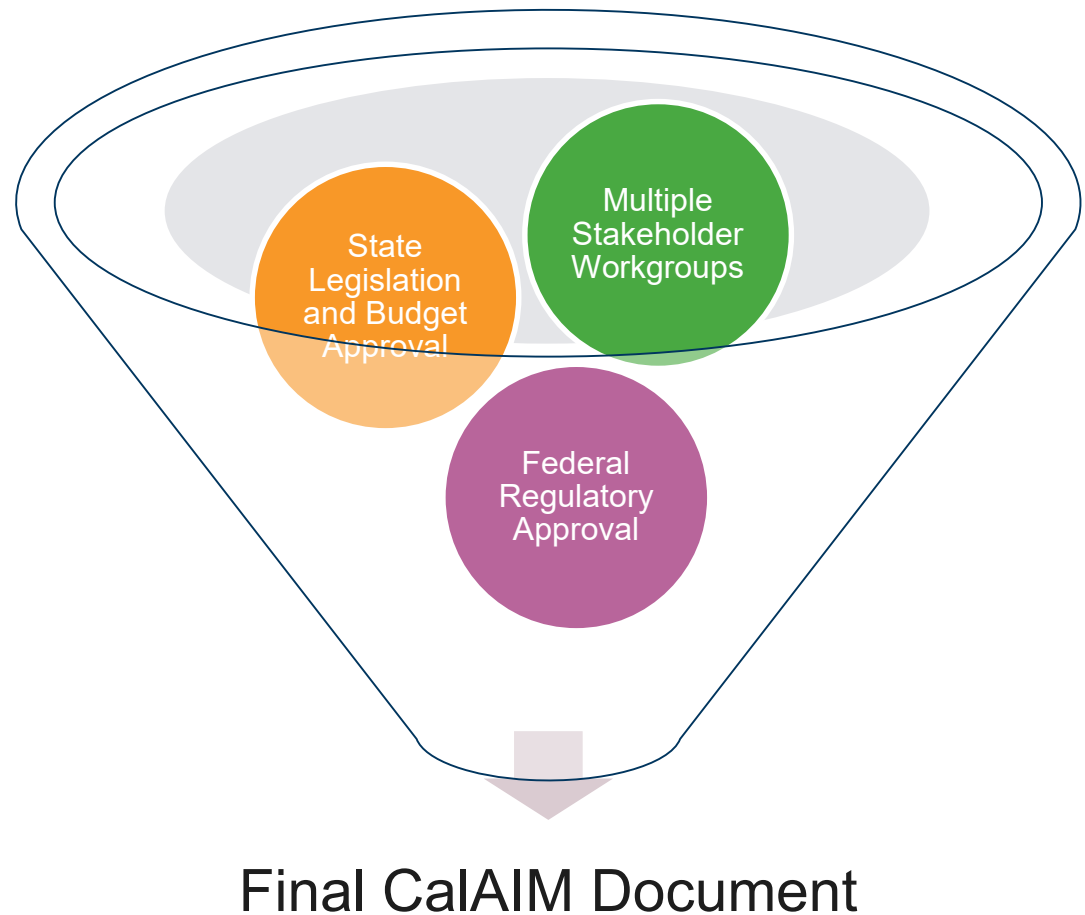
- In June, the Board adopted a \$60 million allocation for homeless health spending in four categories
 - Clinic health care services in all homeless shelters
 - Mobile health team response to all homeless providers
 - Residential support services and housing navigation
 - Recuperative care for those with chronic physical health issues
- Working with the Board's ad hoc committee, staff developed Guiding Principles and crosswalk to provide the Board with a tool to guide funding decisions
- CalAIM has the potential to affect homeless health spending in the future
 - Consider CalAIM's impact on Guiding Principles

CalAIM Background

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a proposal with the potential to significantly impact the future Medi-Cal delivery system framework
 - Spans a five-year period from 2021 to 2025
 - Contains more than 20 core initiatives
 - Expands Medi-Cal managed care plans' responsibilities
- The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals

CalAIM Process

- CalAIM is in the early stages of development
- CalAIM will evolve before reaching a final form for implementation starting January 1, 2021
 - Many layers of input will undoubtedly change the proposal



Five CalAIM Workgroups

Population Health/ Annual Enrollment

- Requires managed care plans to develop and maintain population health management strategies

Enhanced Care Management

- Explores implementation of an enhanced care management benefit and in lieu of services

Behavioral Health

- Considers integration of county-level mental health and substance use disorder programs

NCQA Accreditation

- Provides input on a proposal to require Medi-Cal managed care plans to obtain accreditation

Full Integration Plans

- Discusses full integration of physical health, behavioral health and oral health under one entity

Future CalAIM Implementation

- The various proposals have different effective dates, ranging from January 2021 to January 2025
 - Understanding the rules and regulations before and after implementation will be challenging
- With regard to CalOptima's Homeless Health Initiatives, three proposals (in their current form) have the most potential impact in the near term
 - Population Health Management
 - Enhanced Care Management
 - In Lieu of Services

Current State, Before CalAIM

- Programs that “bridge” to CalAIM
 - Health Homes Program (HHP)
 - Enhanced care management
 - Housing supportive services
 - Whole-Person Care (WPC)
 - Recuperative care
- Intergovernmental Transfer (IGT) 1–7 dollars
 - Enhanced services for Medi-Cal members
 - Reallocating funds toward housing supportive services
- IGT 8 dollars
 - Medi-Cal-covered services for Medi-Cal members
 - Enhanced hospital discharge planning
 - Transitions of care (under development with stakeholder group)

Future Possibilities, After CalAIM*

- Population Health Management (PHM)
 - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
 - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
 - Conduct initial member assessments and then reassessments on an annual basis
 - Offer basic, complex and enhanced care management

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
 - Statewide health plan benefit replacing HHP and WPC by January 1, 2021
 - Holistic, interdisciplinary approach to clinical and non-clinical needs of target populations
 - Individuals experiencing homelessness are specifically included as a target population
 - By July 2020, plans must submit transition plan moving from HHP and WPC to the ECM/ILOS model of care

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- ILOS can only be covered if:
 - State determines that the service is a medically appropriate and cost-effective substitute for a typical service
 - The service is optional (beneficiaries are not required to use ILOS)
 - The service is authorized and identified in the state's Medi-Cal managed care plan contract

*Subject to stakeholder input and CMS and DHCS approval

Menu of In Lieu of Services Options**

Housing transition navigation services
Housing deposits
Housing tenancy
Short-term post-hospitalization housing
Nursing facility transition/diversion
Recuperative care
Personal care and homemaker services
Respite care
Day habilitation programs
Home modifications
Meals/medically tailored meals
Sobering centers

**See CalAIM Appendix D for a detailed description of what is allowed under each of the above ILOS

CalAIM Advocacy

- California Association of Health Plans and Local Health Plans of California are actively participating in the CalAIM process
 - Managed care plans, including CalOptima, will be integral in shaping the eventual final CalAIM document
 - Managed care plans are generally very supportive of the direction CalAIM is headed
- Responding to the needs of Orange County's homeless population would be enhanced through adoption of certain current CalAIM proposals
 - CalOptima will advocate to this effect and pursue opportunities as available

Recommended Action

- Approve homeless health initiatives Guiding Principles and crosswalk as a framework for future funding allocations

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES

December 5, 2019

Organizations across Orange County are actively responding to the local homeless crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit \$100 million in a restricted homeless health reserve. At that time, \$40 million was directed to a range of specific initiatives, and \$60 million was for unidentified new initiatives:

Projects (as of April 4, 2019)	Allocated	Unallocated	Funding Category
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	\$11.4 million		IGT 1–7 (\$24 million total)
Recuperative Care	\$11 million		
Clinical Field Team Startup Costs	\$1.6 million		
CalOptima Homeless Response Team (\$1.2 million/year x 5 years)	\$6 million		IGT 8 and FY 2018–19 operating funds (\$76 million total)
Homeless Coordination at Hospitals (\$2 million/year x 5 years)	\$10 million		
New Initiatives		\$60 million	
Total Reserve: \$100 million	\$40 million	\$60 million	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining \$60 million in funding allocations for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers –\$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a recent state proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), suggests significant changes to the Medi-Cal managed care landscape starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. To move forward with effective funding allocations in this dynamic environment, staff have developed Guiding

Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these Guiding Principles starts from this place of inclusiveness.

- *CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.*

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. Intergovernmental Transfer (IGT) 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 dollars must be used according to different guidelines that restrict the spending to Medi-Cal-covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal-covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. However, the CalAIM proposal has the potential to expand Medi-Cal-covered benefits, which could broaden what CalOptima is permitted to fund for homeless health. This opportunity is under development, so until CalAIM is finalized, CalOptima must adhere to current rules. In any event, financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the \$60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal-covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's effort to better serve members who are homeless is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

- *CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.*

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

- *CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.*

**CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
AND FUNDING CATEGORIES**

December 5, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	Authorize mobile health team to respond to all homeless providers	Residential support services and housing navigation	Extend recuperative care for homeless individuals with chronic physical health issue
Guiding Principles	<p>Transparent and Inclusive*</p> <p><i>Transparent planning that includes providers and other key stakeholders</i></p>	<p><u>Consistent:</u> Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.</p>	<p><u>Consistent:</u> Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.</p>	<p><u>Consistent:</u> CalOptima and our health networks transparently and inclusively provide Medi-Cal members with case management and care coordination as appropriate. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.</p>	<p><u>Consistent:</u> Today, recuperative care is not currently a Medi-Cal benefit, apart from the WPC pilot to which CalOptima previously allocated funds for recuperative care. However, CalOptima is planning to advocate with providers and stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.</p>
	*Assumes continued coordination of input from biweekly health network/hospital meetings with CalOptima Board Homeless Health Ad Hoc.				
	<p>Compliant and Sustainable</p> <p><i>Sustained Medi-Cal funding for CalOptima from DHCS</i></p>	<p><u>Consistent:</u> Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms</p>	<p><u>Consistent:</u> Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in</p>	<p><u>Consistent:</u> Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a</p>	<p><u>Inconsistent:</u> Inconsistent today because recuperative care is not a Medi-Cal-covered service, except through the WPC pilot. Consequently, there</p>

		of ongoing state funding.	terms of ongoing state funding.	covered benefit under HHP. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Consequently, there is sustainable funding within these parameters.	is no source of sustainable funding currently. However, the CalAIM process has the potential to broaden Medi-Cal-covered services to include recuperative care.
	Strategic and Integrated <i>Integration with CalOptima's contracted health care delivery system</i>	<u>Consistent:</u> Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	<u>Consistent:</u> Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	<u>Consistent:</u> Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks. The CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be integrated into the CalOptima system.	<u>Consistent:</u> If recuperative care becomes a Medi-Cal benefit following completion of the WPC pilot and/or implementation of CalAIM, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable <i>Specific deliverables and measures of success</i>	<u>Consistent:</u> Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	<u>Consistent:</u> Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	<u>Consistent:</u> There is definition and accountability for health networks related to case management, care coordination and HHP CB-CME housing services. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be defined and accountable.	<u>Consistent:</u> If recuperative care becomes a Medi-Cal benefit, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

Acronyms:

CalAIM = California Advancing and Innovating Medi-Cal

CB-CME = Community-Based Care Management Entity

HHP = Health Homes Program

IHSS = In-Home Supportive Services

MSSP = Multipurpose Senior Services Program

PACE = Program of All-Inclusive Care for the Elderly

PCP = Primary Care Physician

PSH = Permanent Supportive Housing

WPC = Whole-Person Care

CMS Adult Elective Surgery and Procedures Recommendations:

Limit all non-essential planned surgeries and procedures, including dental, until further notice

To aggressively address COVID-19, CMS recognizes that conservation of critical resources such as ventilators and Personal Protective Equipment (PPE) is essential, as well as limiting exposure of patients and staff to the SARS-CoV-2 virus. Attached is guidance to limit non-essential adult elective surgery and medical and surgical procedures, including all dental procedures. These considerations will assist in the management of vital healthcare resources during this public health emergency.

Dental procedures use PPE and have one of the highest risks of transmission due to the close proximity of the healthcare provider to the patient. To reduce the risk of spread and to preserve PPE, we are recommending that all non-essential dental exams and procedures be postponed until further notice.

A tiered framework is provided to inform health systems as they consider resources and how best to provide surgical services and procedures to those whose condition requires emergent or urgent attention to save a life, preserve organ function, and avoid further harms from underlying condition or disease. Decisions remain the responsibility of local healthcare delivery systems, including state and local health officials, and those surgeons who have direct responsibility to their patients. However, in analyzing the risk and benefit of any planned procedure, not only must the clinical situation be evaluated, but resource conservation must also be considered. These recommendations are meant to be refined over the duration of the crisis based on feedback from subject matter experts. At all times, the supply of personal protective equipment (PPE), hospital and intensive care unit beds, and ventilators should be considered, even in areas that are not currently dealing with COVID-19 infections. Therefore, while case-by-case evaluations are made, we suggest that the following factors to be considered as to whether planned surgery should proceed:

- Current and projected COVID-19 cases in the facility and region.
 - consider the following tiered approach in the table below to curtail elective surgeries. The decisions should be made in consultation with the hospital, surgeon, patient, and other public health professionals.
- Supply of PPE to the facilities in the system
- Staffing availability
- Bed availability, especially intensive care unit (ICU) beds
- Ventilator availability
- Health and age of the patient, especially given the risks of concurrent COVID-19 infection during recovery
- Urgency of the procedure.

Tiers	Action	Definition	Locations	Examples
Tier 1a	Postpone surgery/procedure	Low acuity surgery/healthy patient- outpatient surgery Not life threatening illness	HOPD* ASC** Hospital with low/no COVID-19 census	-Carpal tunnel release -EGD -Colonoscopy -Cataracts
Tier 1b	Postpone surgery/procedure	Low acuity surgery/unhealthy patient	HOPD ASC Hospital with low/no COVID-19 census	-Endoscopies
Tier 2a	Consider postponing surgery/procedure	Intermediate acuity surgery/healthy patient- Not life threatening but potential for future morbidity and mortality. Requires in-hospital stay	HOPD ASC Hospital with low/no COVID-19 census	-Low risk cancer -Non urgent spine & Ortho: Including hip, knee replacement and elective spine surgery -Stable ureteral colic -Elective angioplasty
Tier 2b	Postpone surgery/procedure if possible	Intermediate acuity surgery/unhealthy patient-	HOPD ASC Hospital with low/no COVID-19 census	
Tier 3a	Do not postpone	High acuity surgery/healthy patient	Hospital	-Most cancers -Neurosurgery -Highly symptomatic patients
Tier 3b	Do not postpone	High acuity surgery/unhealthy patient	Hospital	-Transplants -Trauma -Cardiac w/ symptoms -limb threatening vascular surgery

*Hospital Outpatient Department

** Ambulatory Surgery Center

Created by: Sameer Siddiqui MD (used with permission)

Version 3/15/20



Policy: GG.1665
Title: **Telehealth and Other Technology-Enabled Services**
Department: Medical Management
Section: Population Health Management

CEO Approval: /s/ Michael Schrader 03/25/2020

Effective Date: 03/01/2020
Revised Date: Not applicable

Applicable to: Medi-Cal
 OneCare
 OneCare Connect
 PACE
 Administrative - Internal
 Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

- A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.
- B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.
- C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:
 - 1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;
 - 2. Comply with all state and federal laws regarding the confidentiality of health care information;
 - 3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;
 - 4. Document treatment outcomes appropriately; and
 - 5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member’s treatment.

- D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.
- E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.
- F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.
- G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.
- H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.
- I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.
- J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.
- K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

- 1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.
- 2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.
- 3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

- 1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:
 - a. The Qualified Provider meets the following licensure requirements:

- i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or
 - ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.
2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).
3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:
 - a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;
 - b. The Member has provided verbal or written consent in accordance with this Policy;
 - c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;
 - d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and
 - e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.
 - f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:
 - i. In an operating room;
 - ii. While the Member is under anesthesia;
 - iii. Where direct visualization or instrumentation of bodily structures is required; or
 - iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.
2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
3. CalOptima and its Health Networks shall not require providers to:
 - a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or
 - b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.
4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member
 - a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,
 - b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,
 - c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.
2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

- F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:
1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.
 2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.
- G. Other Technology-Enabled Services
1. E-Consults
 - a. E-consults are permissible only between Qualified Providers.
 - b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.
 - c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.
 2. Virtual/Telephonic Communication
 - a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).
 - b. Virtual/Telephonic Communications are classified as follows:
 - i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.
 - ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.
- H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.
 - a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.
 - b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.
 - I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.
 - J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

- A. Addendum: COVID-19 Emergency Provisions

V. REFERENCE(S)

- A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
- C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
- D. CalOptima Policy GG.1510: Appeals Process
- E. CalOptima Policy GG.1603: Medical Records Maintenance
- F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
- G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

- I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
- J. CalOptima Policy HH.1102: Member Grievance
- K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
- L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
- M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
- N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
- O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
- P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children’s Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima’s Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member’s treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member’s health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	<p>A Medi-Cal eligible recipient who meets one or more of the following conditions:</p> <ul style="list-style-type: none"> • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient’s residence or home with a clinic provider and a billable provider at the clinic. The patient’s health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC’s or RHC’s service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	<p>A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.</p>
Health Network	<p>A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.</p>
HIS-MOA Clinics	<p>Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details</p>
Medically Necessary or Medical Necessity	<p>Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.</p>
Medical Record	<p>A medical record, health record, or medical chart in general is a systematic documentation of a single individual’s medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.</p>

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.



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



BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:

In response to the COVID-19 pandemic, it is imperative that members practice “social distancing.” However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:

Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:¹

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim. For example, if an MCP reimburses a provider \$100 for an in-person visit, the MCP must reimburse the provider \$100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services’ guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

¹ Government Code section 8550, et seq.

SUPPLEMENT TO ALL PLAN LETTER 19-009
Page 2

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-43-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS on March 30, 2020, I issued Executive Order N-39-20 to pave the way for a temporary expansion of the health care workforce ahead of an anticipated surge in the need for medical treatment, and related strain on the health care delivery system, caused by COVID-19; and

WHEREAS clinics, hospitals, and other health care facilities and health care providers must maximize the number of capable health care workers through the use of telehealth services to ensure that Californians impacted by COVID-19 are able to access medical treatment as necessary; and

WHEREAS it is imperative to reduce the spread of COVID-19 and protect health care workers, including through the use of telehealth services, where possible, for any reason (not limited to the diagnosis and treatment of COVID-19 or related conditions); and

WHEREAS health care facilities housing vulnerable populations, such as nursing homes and psychiatric facilities, require special measures to protect those populations from COVID-19 and ensure continuity of care; and

WHEREAS on March 17, 2020, the Office for Civil Rights in the U.S. Department of Health and Human Services issued guidance ("Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency," available at <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>) announcing that the Office, in the exercise of its enforcement discretion, will not impose penalties for noncompliance with regulatory requirements imposed under the HIPAA Rules, as to covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency; and

WHEREAS even in an emergency situation, covered entities must continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures. Further, covered entities and their business associates must apply the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes, regulations, and certain local ordinances specified or referenced herein would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and the statutes of the State of California, and in particular, Government Code sections 8567 and 8571, do hereby issue the following Order to become effective immediately:

IT IS HEREBY ORDERED THAT:

- 1) The requirements specified in Business and Professions Code section 2290.5(b), related to the responsibility of a health care provider to obtain verbal or written consent before the use of telehealth services and to document that consent, as well as any implementing regulations, are suspended.
- 2) The penalties specified in Civil Code section 56.35, as well as any cause of action arising out of section 56.35 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 56.35) are suspended as applied to inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services.
- 3) The administrative fines, civil penalties, and private right of action specified in Civil Code section 56.36, as well as any other cause of action arising out of section 56.36 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 56.36, as well as the authority to bring a civil action set forth in subdivision (f) of section 56.36) are suspended as applied to inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services.
- 4) The civil penalties for health care facilities and providers specified in Civil Code sections 1798.29 and 1798.82, related to the timely notification to patients of a breach of the security system, are suspended as applied to any breach resulting from inadvertent, unauthorized access or disclosure during the good faith provision of telehealth services. Any cause of action arising out of section 1798.29 or section 1798.82 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 1798.29 or section 1798.82) is likewise suspended as applied to inadvertent, unauthorized access or disclosure that occurs during the good faith provision of telehealth services.
- 5) The deadlines specified in Health and Safety Code section 1280.15, related to notification to the Department of Public Health and to patients of the unauthorized access or disclosure of health information, are extended from a period of 15 days to a period of 60 days when the unauthorized access or disclosure is related to the good faith provision of telehealth services. The administrative penalties specified in Health and Safety Code section 1280.15, related to unauthorized access or disclosure of health information, are suspended when the unauthorized access or disclosure occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law. Any cause of action arising out of section 1280.15 (including, but not limited to, any cause of action

arising out of the Unfair Competition Law that is predicated on section 1280.15) is likewise suspended as applied to unauthorized access or disclosure that occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law.

- 6) The administrative penalties for health care providers specified in Health and Safety Code section 1280.17, related to safeguards of health information, are suspended for health care providers as applied to any inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law. Any cause of action arising out of section 1280.17 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 1280.17) is likewise suspended as applied to inadvertent, unauthorized access or disclosure that occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law.
- 7) The criminal penalties specified in Welfare and Institutions Code section 14100.2(h), related to persons who knowingly release or possess information about Medi-Cal beneficiaries, are suspended as applied to health care providers, health care facilities, and health care administrators for any inadvertent, unauthorized release of confidential information during the good faith provision of telehealth services. Any cause of action arising out of section 14100.2 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 14100.2) is likewise suspended as applied to health care providers, health care facilities, and health care administrators for any inadvertent, unauthorized release of confidential information during the good faith provision of telehealth services.
- 8) To the extent any provision of this Order suspends any penalty or other enforcement mechanism associated with the violation of any statute where such violation arises out of the good faith provision of telehealth services, such violation shall not constitute unprofessional conduct within the meaning of Article 10.5 of the Business and Professions Code or any other applicable law, or otherwise be cause for professional discipline.
- 9) Where the provision of telehealth services is conducted by a “covered health care provider” subject to the HIPAA Rules and described in the “Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency” (“Notification”) issued by the Office for Civil Rights in the U.S. Department of Health and Human Services on March 17, 2020, that covered health care provider shall ensure that its delivery of telehealth services is consistent with that Notification. This paragraph does not impose any mandatory requirements beyond any mandatory requirements imposed by the Notification itself, except that where the Notification encourages particular measures to safeguard patient privacy, but does not require such measures, covered health care

providers shall give due consideration to such measures and shall endeavor to adopt them to the extent possible.

10) For purposes of this Order, "telehealth services" includes the use of telehealth services to engage in the provision of behavioral or mental health services, in addition to the use of telehealth services to engage in the provision of medical, surgical, or other health care services. This paragraph should be construed to ensure that the provisions of this Order apply to the provision of behavioral or mental health services the same extent that those paragraphs apply to other forms of health care.

IT IS FURTHER ORDERED that as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 3rd day of April 2020.



GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020 **Special Meeting of the CalOptima Board of Directors**

Report Item

3. Consider Authorizing Modifications to the Post-Acute Infection Prevention Quality Initiative During the Coronavirus Disease (COVID-19) Crisis.

Contact

David Ramirez, MD, Chief Medical Officer, 714-246-8400

Emily Fonda, M.D., MMM, CHCQM, Deputy Chief Medical Officer, 714-246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to temporarily modify the Post-Acute Infection Prevention Quality Initiative (PIPQI) by:

1. Suspending skin testing requirements during the Coronavirus Disease (COVID-19) pandemic, and
2. Allowing early disbursement of the first quarterly incentive payment (January – March 2020) and prepayment of the second quarterly payment (April – June 2020) due to added Personal Protective Equipment (PPE) and personnel costs in participating skilled nursing facilities.

Background/Discussion

The PIPQI program for contracted skilled nursing facilities (SNFs) was approved by the Board in June of 2019 as a means of infection prevention by replacing liquid soap with Chlorhexidine (CHG) soap for bathing and using Iodophor nasal swabs every other week. This protocol had been successful in demonstrating a significant reduction in Multi Drug Resistant Organisms (MDROs) on the skin of patients in 16 CalOptima contracted SNFs in a two-year study conducted by UCI Infectious Disease Professor, Dr. Susan Huang, from 2017–2019. Over the same time period, CalOptima data showed a 61% reduction in inpatient hospital costs for infection in patients from the same 16 SNFs. The combination of achievements has gained strong endorsement from the Centers for Disease Control and Prevention (CDC).

Over the past six months, the CDC has been funding CalOptima's PIPQI trainer from University of California, Irvine, since the CDC has been fully engaged and supportive of the PIPQI program at CalOptima. Dr. John Jernigan, the Director of the Office of Healthcare-Associated Infections Prevention Research and Evaluation of the CDC's Division of Healthcare Quality Promotion, and his team have been following CalOptima's progress since the PIPQI program recently put the Plan on the national radar as the only county in the U.S. attempting such infection prevention.

Compliance from the current 24 participating contracted SNFs has been managed by tracking product invoices for Chlorhexidine (CHG) and Iodophor along with Hospital Acquired Infection (HAI) rates, which is ongoing. Added funding was recently requested in order to expand the program to include more SNFs and to retain two of CalOptima's Long Term Services and Supports (LTSS) nurses as full-time compliance officers, promoters, and trainers. Furthermore, the funding is currently available to provide quarterly financial incentives to the participating facilities with proven program adherence. The initial plan was to add random CHG skin testing in order to qualify for a \$7,500 quarterly incentive for each facility. At its April 2, 2020, meeting, the Board approved allocation of Intergovernmental Transfer

(IGT) 9 funds for certain initiatives. Included in this approval was \$3.4 million in additional funding over a three (3) year period for the expansion of the PIPQI.

However, due to the current COVID-19 precautions and social distancing requirements, CalOptima's LTSS nurses are currently performing their functions remotely since entrance to SNFs has been curtailed in the interest of patient safety. CalOptima's LTSS nurses are also not currently allowed access to the facilities to collect CHG skin testing samples; nevertheless, our belief is that participating contracted SNF partners are continuing to perform infection control and have been successful in preventing a large outbreak of COVID-19, with the extra burden of PPE costs and personnel overtime. Under these extraordinary circumstances it is important to note that CHG's anti-viral, anti-bacterial, and anti-fungal properties have been emphasized to all the facility medical directors.

In view of the temporary constraints that preclude skin testing in order to qualify for financial incentives, a suspension of the skin testing requirement is proposed for the duration of the national emergency, along with release of the quarterly incentive funds to our participating SNF partners, who are safeguarding the health and safety of a vulnerable population. The CHG skin testing protocol will be re-implemented when safety permits and the national emergency has come to an end.

Fiscal Impact

The recommended action to temporarily modify the PIPQI by suspending skin testing requirements during the Coronavirus Disease pandemic and early disbursement of quarterly payments to qualifying SNFs has no additional fiscal impact to CalOptima's operating budget. Staff anticipates that IGT 9 revenue from the State will be sufficient to cover the expenditures for the PIPQI.

Rationale for Recommendation

The recommended actions will support CalOptima's efforts to continue providing quality healthcare to our members residing at SNFs during the COVID-19 public health crisis and allow CalOptima to continue its robust partnership with participating SNFs after the current pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 6, 2019, Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments
2. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
3. PIPQI Presentation

/s/ Richard Sanchez
Authorized Signature

04/10/2020
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "...decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "...the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed \$2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader
Authorized Signature

5/29/2019
Date



CalOptima
Better. Together.

Post-Acute Infection Prevention Quality Initiative

**Regular Meeting of the Board of Directors
June 6, 2019**

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

**Care Management, Long-Term Services and Supports and
Senior Programs**

Background

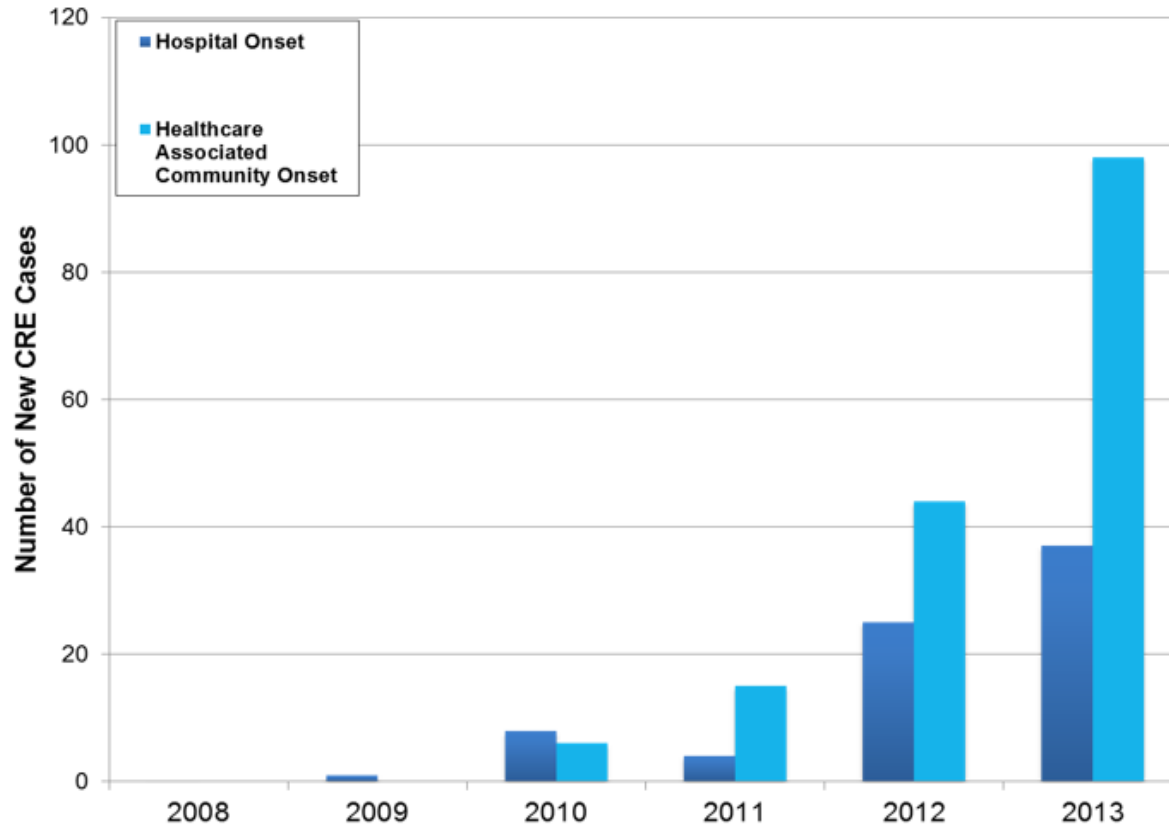
- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
 - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
 - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
 - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 → overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
 - Methicillin Resistant *Staphylococcus aureus* (MRSA)
 - Vancomycin Resistant Enterococcus (VRE)
 - Multi-Drug Resistant Pseudomonas
 - Multi-Drug Resistant Acinetobacter
 - Extended Spectrum Beta Lactamase Producers (ESBLs)
 - Carbapenem Resistant Enterobacteriaceae (CRE)
 - Hypervirulent KPC (NDM)
 - *Candida auris*
- **10–15% of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA

Hospital and Healthcare-Associated Community Onset CRE Incidence
(N = 21 Hospitals)



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency



Early Release / Vol. 64

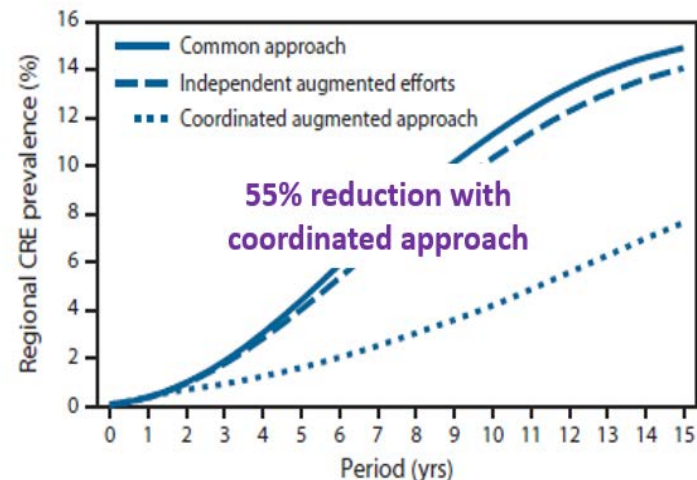
Morbidity and Mortality Weekly Report

August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD¹; Damon Toth, PhD²; Bruce Y. Lee, MD³; Windy Tanner, PhD²; Sarah M. Bartsch, MPH³; Karim Khader, PhD²; Kim Wong, PhD⁴; Kevin Brown, PhD²; James A. McKinnell, MD⁵; William Ray²; Loren G. Miller, MD⁶; Michael Rubin, MD, PhD²; Diane S. Kim⁷; Fred Adler, PhD⁸; Chenghua Cao, MPH⁷; Lacey Avery, MA¹; Nathan T.B. Stone, PhD⁹; Alexander Kallen, MD³; Matthew Samore, MD²; Susan S. Huang, MD²; Scott Fridkin, MD¹; John A. Jernigan, MD¹

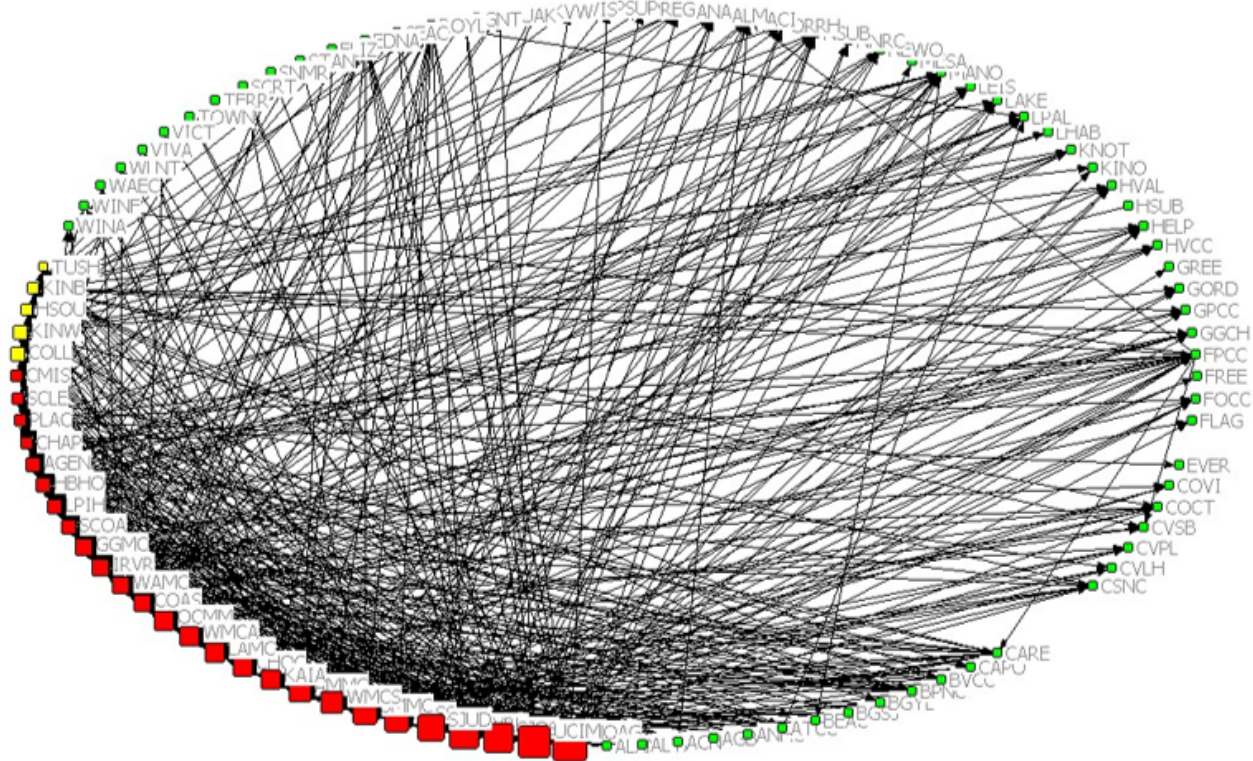
FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*



* Additional information available at <http://www.cdc.gov/drugresistance/resources/publications.html>.

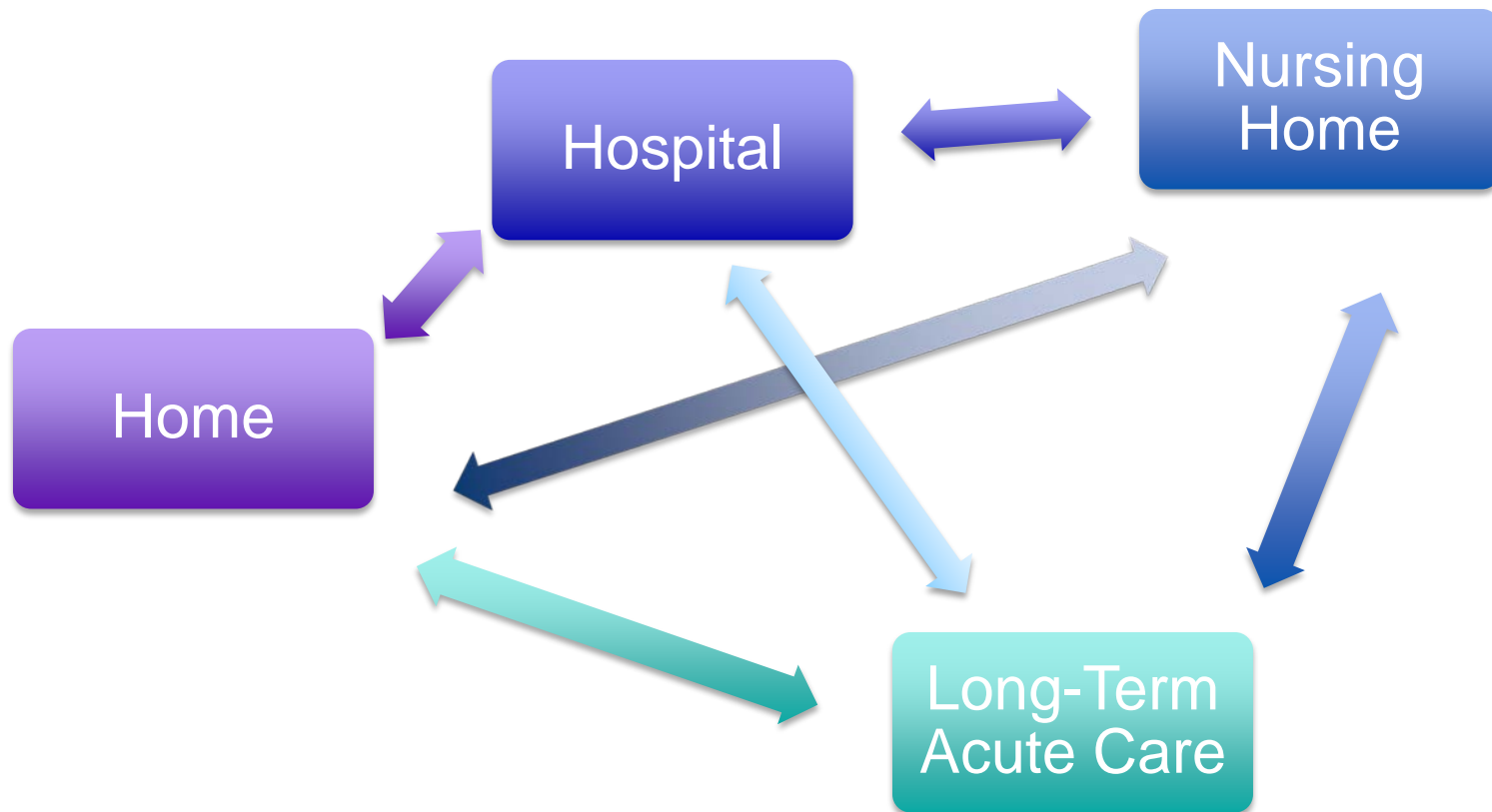
Extent of the Problem

OC Hospitals and Nursing Homes 10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	900	64%	42%	16%	34%	2%

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥ 1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

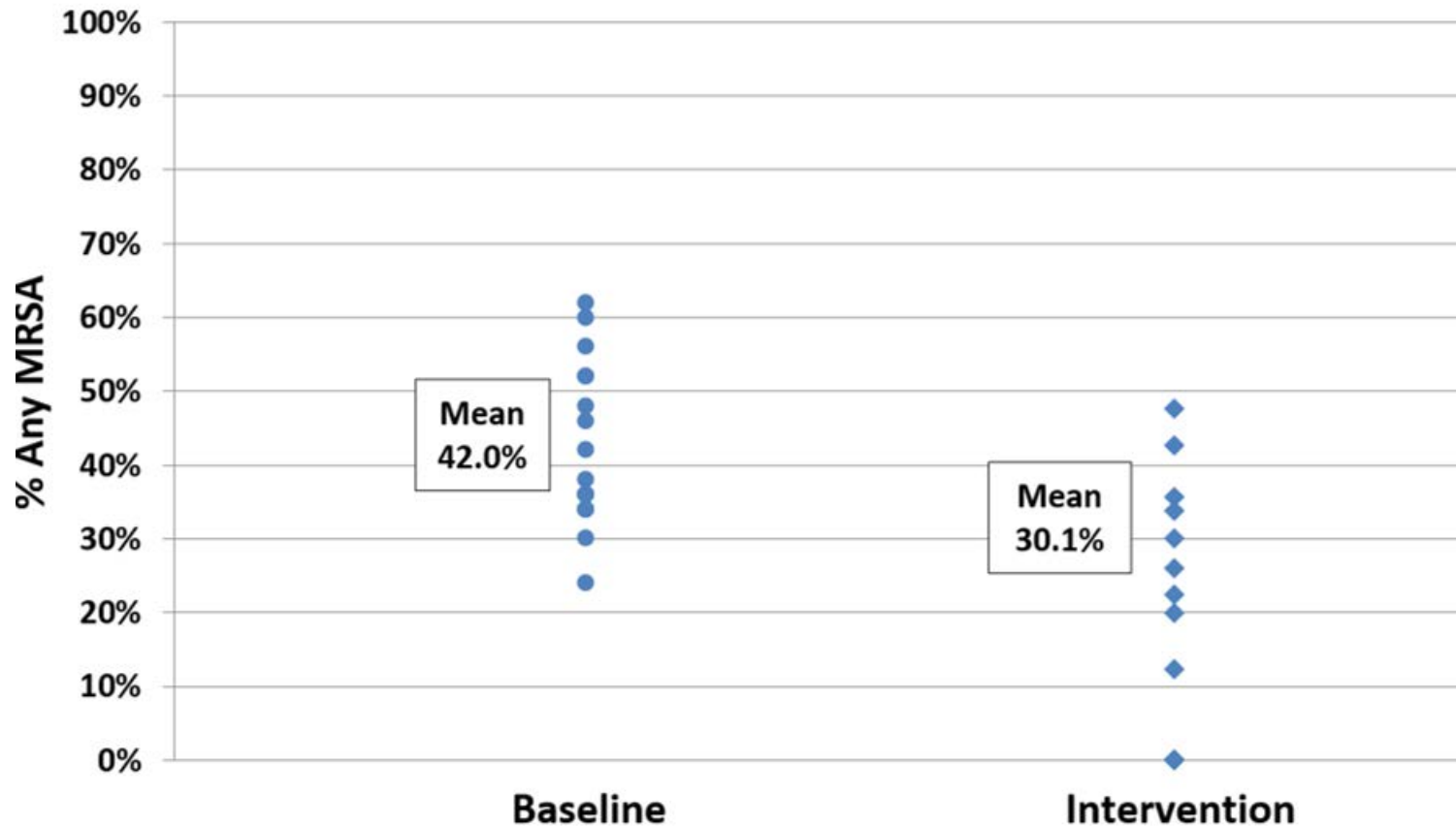
- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
 - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
 - CHG on admit and for all routine bathing/showering
 - Nasal iodophor on admit and every other week
 - <https://www.cdc.gov/hai/research/cdc-mdro-project.html>
- Following initial testing and training
 - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
 - MRSA, VRE, ESBL, CRE and any MDRO
 - By body site
 - Nasal product reduces MRSA
 - CHG bathing reduces skin carriage

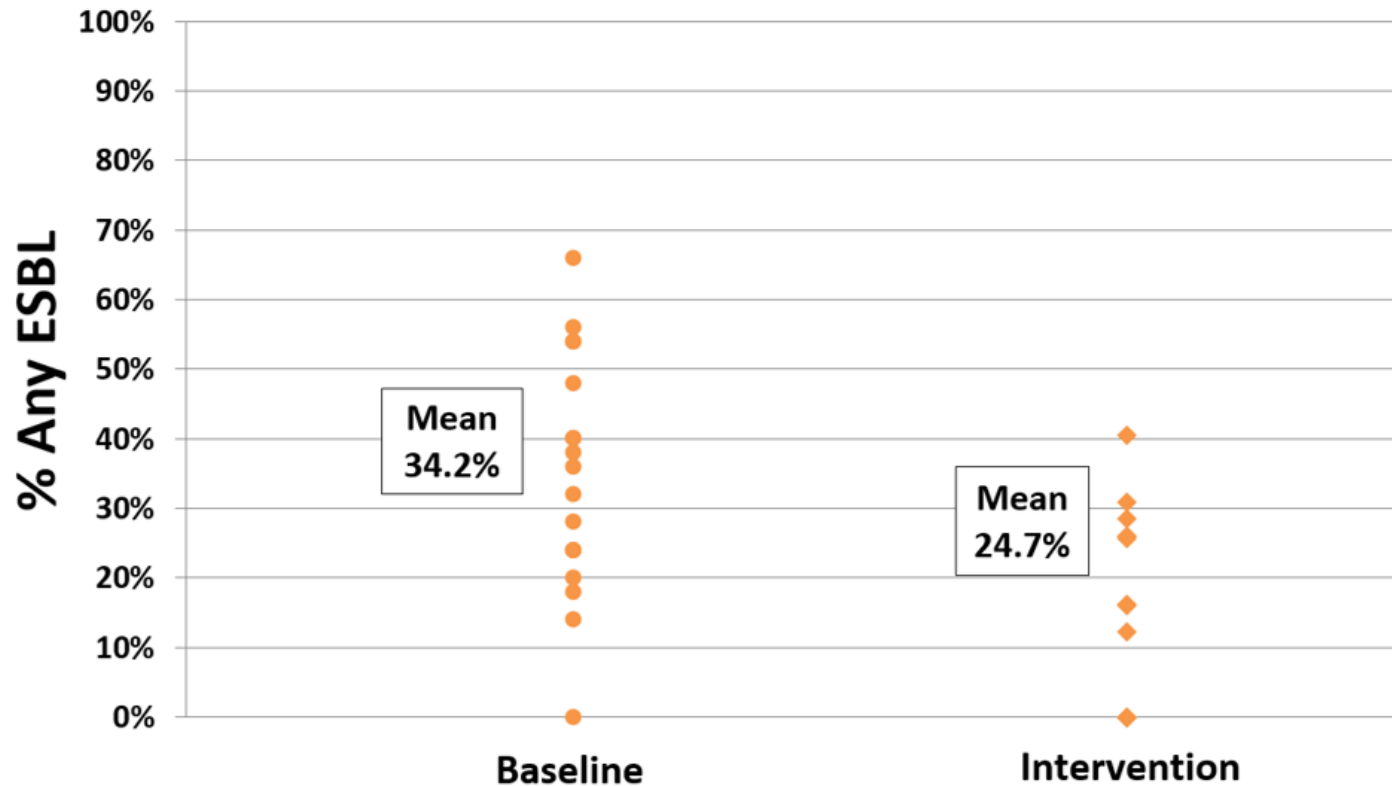
SHIELD Outcomes

SHIELD Impact: Nursing Homes 28% reduction in MRSA



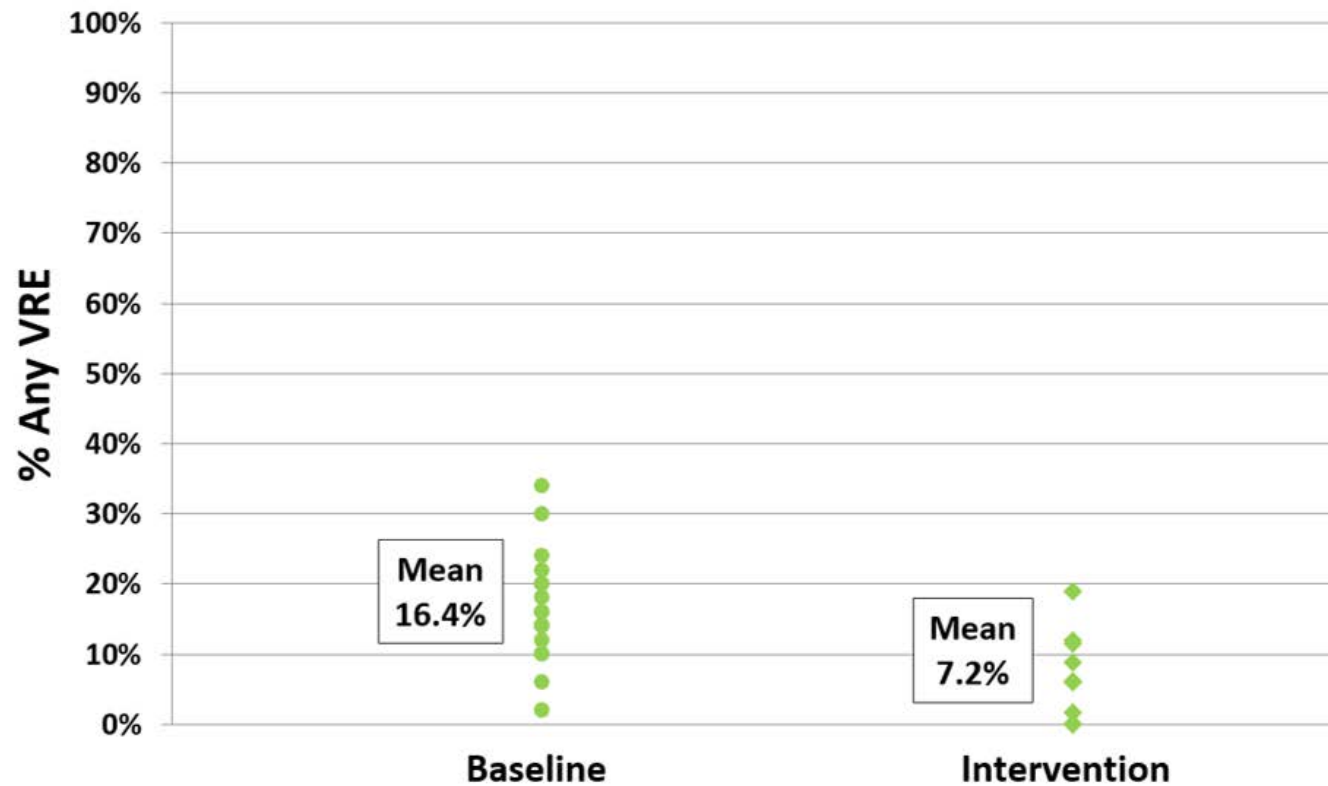
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 28% reduction in ESBLs



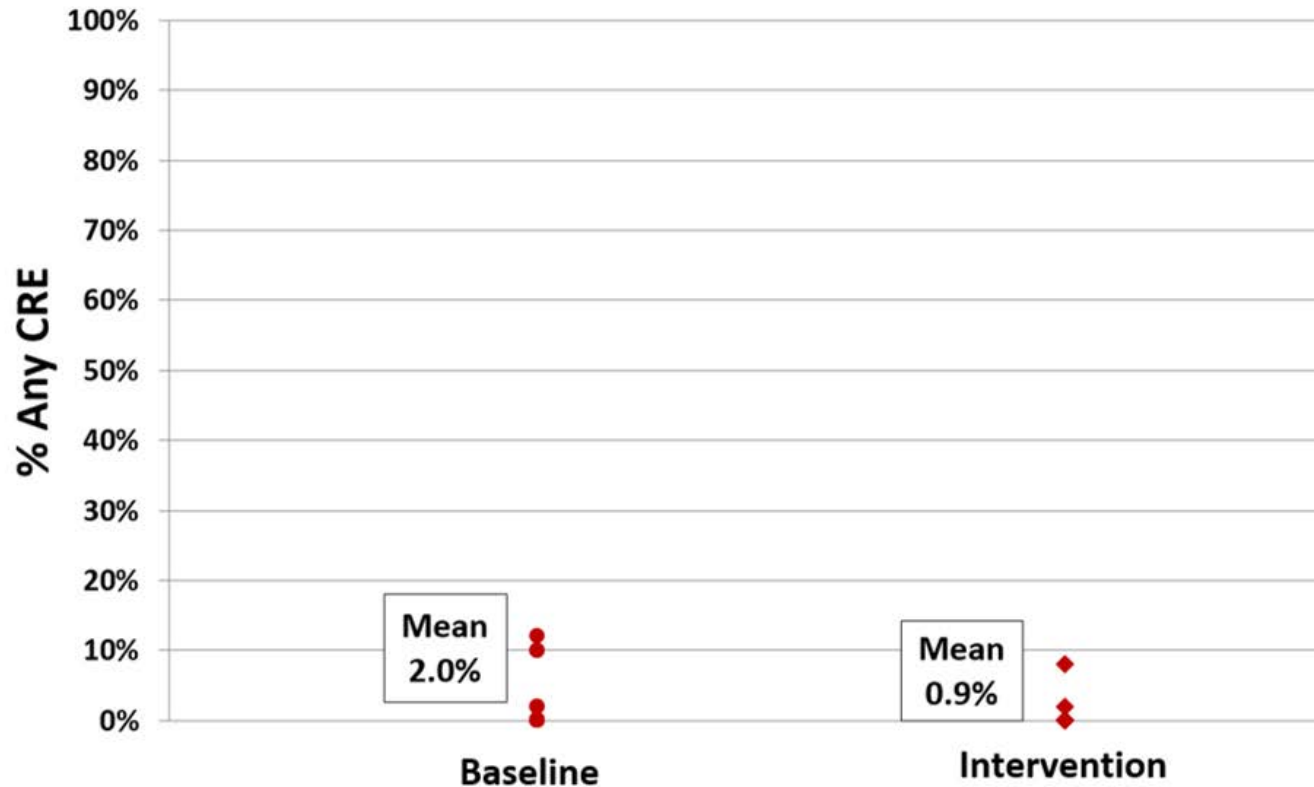
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 56% reduction in VRE



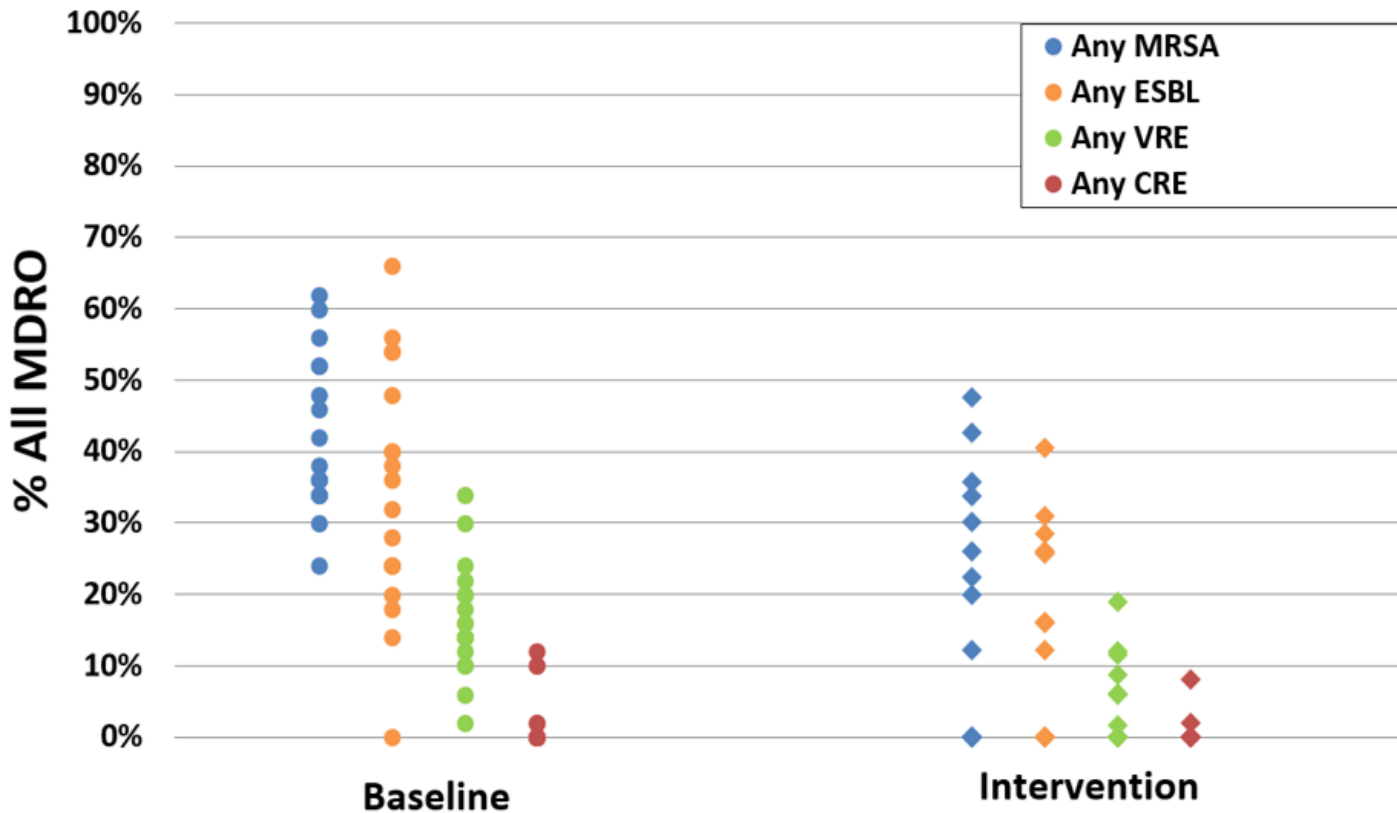
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 25% reduction in all MDROs



Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: **ORANGE**

From: **2015-10** To: **2018-12**

Category P - Primary Diagnosis

		Select Year-Month Begin 2015-10	Select Year-Month End 2018-12	Select Category P Diagnosis Level Category P - Primary Diagnosis	Select Risk Group * Multiple values	Select LTC Facility County ORANGE								
		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid gray; padding: 2px;">Select Year-Month Begin 2015-10</div> <div style="border: 1px solid gray; padding: 2px;">Select Year-Month End 2018-12</div> <div style="border: 1px solid gray; padding: 2px;">Select Category P Diagnosis Level Category P - Primary Diagnosis</div> <div style="border: 1px solid gray; padding: 2px;">Select Risk Group * Multiple values</div> <div style="border: 1px solid gray; padding: 2px;">Select LTC Facility County ORANGE</div> </div>												
		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid gray; padding: 2px;">2015 Q4</div> <div style="border: 1px solid gray; padding: 2px;">2016 Q1</div> <div style="border: 1px solid gray; padding: 2px;">2016 Q2</div> <div style="border: 1px solid gray; padding: 2px;">2016 Q3</div> <div style="border: 1px solid gray; padding: 2px;">2016 Q4</div> <div style="border: 1px solid gray; padding: 2px;">2017 Q1</div> <div style="border: 1px solid gray; padding: 2px;">2017 Q2</div> <div style="border: 1px solid gray; padding: 2px;">2017 Q3</div> <div style="border: 1px solid gray; padding: 2px;">2017 Q4</div> <div style="border: 1px solid gray; padding: 2px;">2018 Q1</div> <div style="border: 1px solid gray; padding: 2px;">2018 Q2</div> <div style="border: 1px solid gray; padding: 2px;">2018 Q3</div> <div style="border: 1px solid gray; padding: 2px;">2018 Q4</div> </div>												
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	\$682,769	\$854,676	\$1,159,922	\$920,317	\$1,691,337	\$1,231,903	\$997,810	\$1,236,197	\$634,628	\$979,762	\$1,113,238	\$1,176,910	\$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	\$133,362	\$311,661	\$124,676	\$189,669	\$227,224	\$209,419	\$175,738	\$164,181	\$40,354	\$84,565	\$127,609	\$41,123	\$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
 - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = \$1,196,011
 - Inpatient costs for the last 6 quarters following training and use of CHG protocol = \$468,009
 - \$728,002 lowered inpatient expenditure (61%) for infection in the participating facilities
- 51 contracted facilities not utilizing the CHG program:
 - Inpatient costs for the last 6 quarters = \$6,165,589
 - Potential 61% lowered inpatient expenditure for infection = \$3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
 - Plan for extended use of an existing trainer in OC for one year
 - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
 - Decreased infection-related hospitalizations
 - An opportunity for a significant advancement in population health management
 - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
 - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
 - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
 - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
 - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
 - Include a trainer provided by the CDC for one year
 - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
 - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner





**Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County**

SHIELD Orange County – Together We Can Make a Difference!

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

Visit our CDC webpage here!

<https://www.cdc.gov/hai/research/dc-mdro-project.html>

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
 - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
 - Nasal decolonization with 10% povidone-iodine
 - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
 - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
 - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team

(949) 824-7806 or SHIELDOrangeCounty@gmail.com



CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____ / _____

Today's Date: _____ / _____ / _____

Completed by: _____

- Proof of product purchase
- Evidence the decolonization program handout is in admission packet
- Monitor and document compliance with bathing one day each week
- Monitor and document compliance with iodophor one day each week iodophor is used
- Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	<input type="checkbox"/>	_____ gallons	_____ gallons
10% Iodine Swabsticks	<input type="checkbox"/>	_____ boxes	_____ boxes

_____ swabs per box

INTERNAL USE ONLY –APPROVAL:

Facility Name: _____ Unit: _____ Date: _____

STAFF Skills Assessment: CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

Nursing Assistant (CNA) Nurse LVN Other: _____

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

- Y N Resident received CHG bathing handout
- Y N Resident told that no rinse bath provides protection from germs
- Y N Provided rationale to the resident for not using soap at any time while in unit
- Y N Massaged skin *firmly* with CHG cloth to ensure adequate cleansing
- Y N Cleaned face and neck well
- Y N Cleaned between fingers and toes
- Y N Cleaned between all folds
- Y N N/A Cleaned occlusive and semi-permeable dressings with CHG cloth
- Y N N/A Cleaned 6 inches of all tubes, central lines, and drains closest to body
- Y N N/A Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers
- Y N N/A Used CHG on surgical wounds (unless primary dressing or packed)
- Y N Allowed CHG to air-dry / does not wipe off CHG
- Y N Disposed of used cloths in trash /does not flush

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

2. If more than 6 cloths was used, provide reason.

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

5. Do you ever wipe off the CHG after bathing?

ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

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ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; $P=0.03$; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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METHICILLIN-RESISTANT *STAPHYLOCOCCUS aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.¹ It is the most common cause of skin, soft-tissue, and procedure-related infections.² Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.^{1,3,4}

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.^{5,6} Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).⁷⁻¹⁰ Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

METHODS

TRIAL DESIGN AND INTERVENTION

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge

(Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

RECRUITMENT AND ELIGIBILITY CRITERIA

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

FOLLOW-UP

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits (\$25, \$30, \$35, and \$50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.¹¹ A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)¹² or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine ($\geq 8 \mu\text{g}$ per milliliter) on microbroth dilution.^{13,14} All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the par-

ticipant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and non-adherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.¹⁵ Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approxi-

mately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

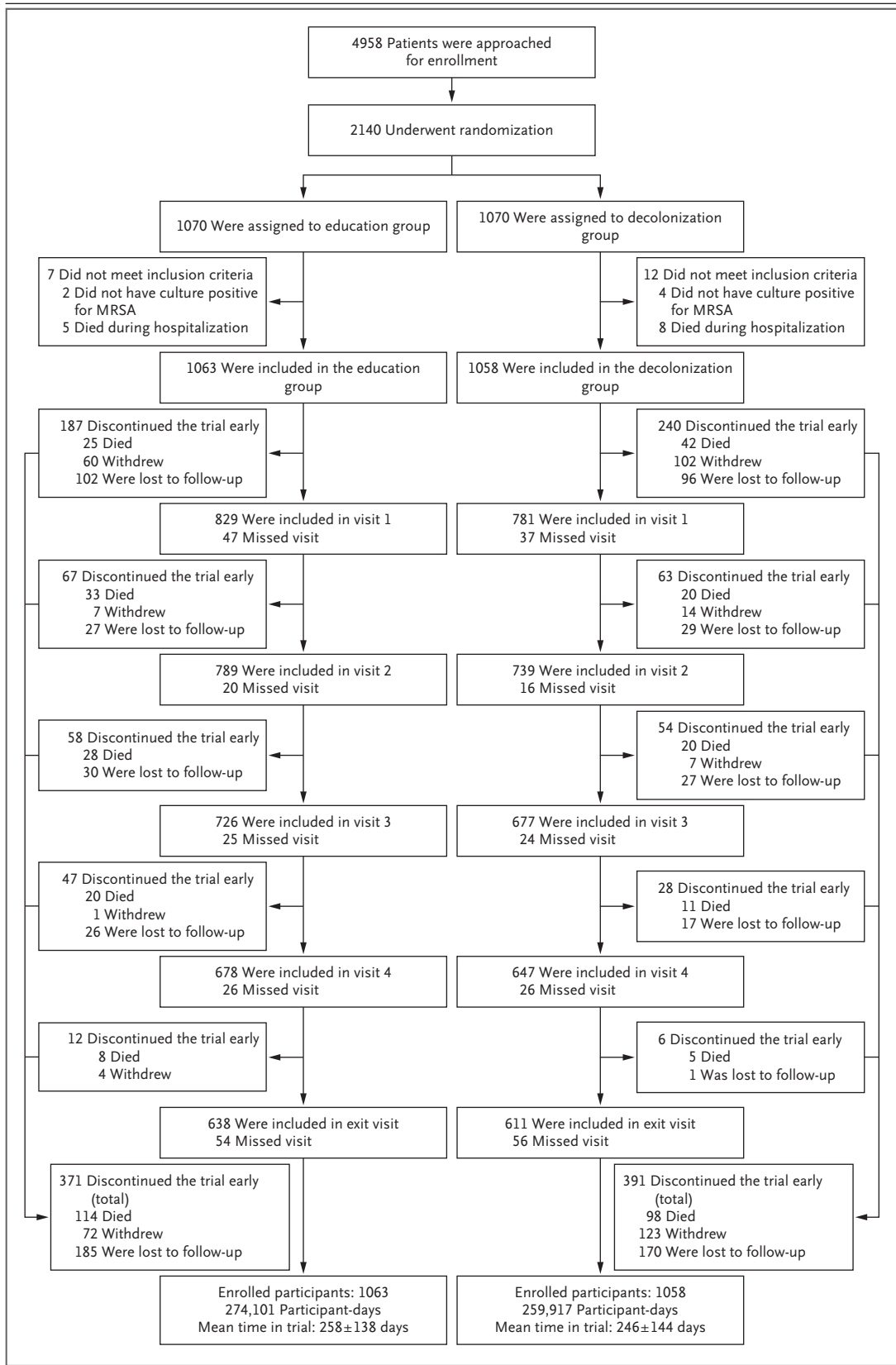


Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (\pm SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI],

0.52 to 0.96; $P=0.03$). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus-minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.

† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.

‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.

§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.

¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.

|| By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).

** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.

†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.

‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading to hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.

† This was the primary outcome.

‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96) †	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI) ‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI) ¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infec-

tion was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, $P=0.97$). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, $P=0.82$) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care-associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.¹⁶ MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.^{1,17-19} In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.¹⁶

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),^{6-10,19-22} a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.²³⁻²⁶ In contrast, twice-monthly decolonization

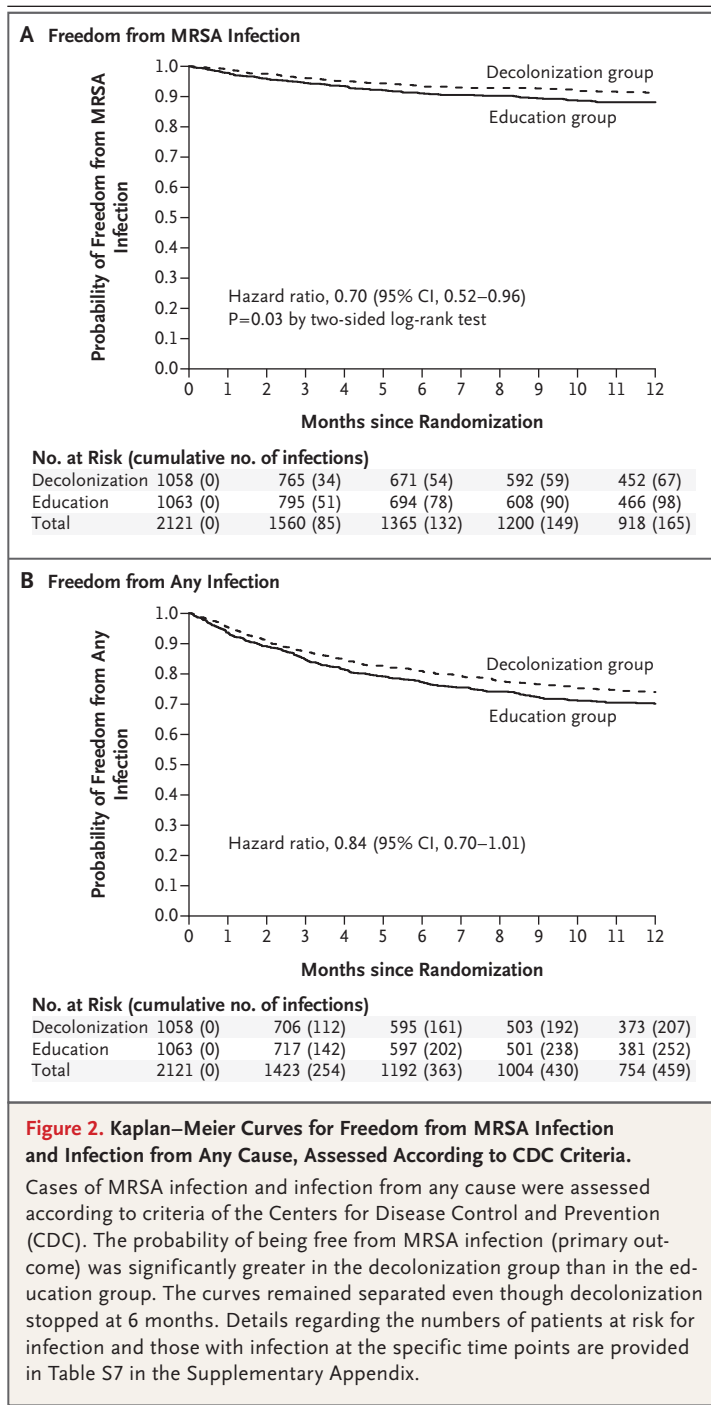


Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

ing and mupirocin application.^{8,9,22} This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.^{8,9,22}

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.²⁷⁻³⁰

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and

reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.³¹⁻³³ It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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[PUBLIC HEALTH](#)

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

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ANNA GORMAN



A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics.

Heidi de Marco/KHN

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said [Dr. John Jernigan](#), who directs the CDC's office on health care-acquired infection research.



"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to [15 percent of hospital patients and 65 percent of nursing home residents](#) harbor drug-resistant organisms, though not all of them will develop an infection, says [Dr. Susan Huang](#), who specializes in infectious diseases at the University of California, Irvine.

"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or [CRE](#), often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as [carbapenems](#). CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says [Dr. Michael Lin](#), an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which [has been shown](#) to reduce infections when patients bathe with it.





The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.

Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused [rare but severe allergic reactions](#).

In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a [Kaiser Health News analysis](#), and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says [Dr. Matthew Zahn](#), medical director of epidemiology at the Orange County Health Care Agency

"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.



Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.

Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, [published in February](#) in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.



"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator [Shaun Dahl](#) says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says. Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

Kaiser Health News is a nonprofit news service and editorially independent program of the Kaiser Family Foundation. KHN is not affiliated with Kaiser Permanente.

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | Updated 1:47 p.m. ET April 12, 201

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.



Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. (Photo: Heidi de Marco, Kaiser Health News)

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” *E. coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote handwashing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control work was new to many nursing homes, which don't have the same resources as hospitals, Lin said.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, said Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency. "We don't have an infinite amount of time," he said. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

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Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County, and discovered they do so far more than imagined. That prompted a key question: "What can we do to not just protect our patients but to protect them when they start to move all over the place?" she recalled.

Her previous research showed that patients with the MRSA bacteria who used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic, could reduce their risk of developing a MRSA infection by 30%. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

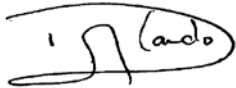
There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,

A handwritten signature in black ink, appearing to read "Denise Cardo". The signature is enclosed within a hand-drawn oval shape.

Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020 **Regular Meeting of the CalOptima Board of Directors**

Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400

Nancy Huang, Chief Financial Officer (714) 246-8400

Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of \$45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Office, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
 - a. Additional initiative(s) related to member access and engagement; and
 - b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima’s estimated share is expected to be approximately \$45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees’ recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program’s financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima’s Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately \$45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting \$40.5 million of the anticipated \$45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	\$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	\$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	\$2.0 million

4. IGT Program Administration	Other priority areas	Five-years	\$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One-year	Up to \$31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	\$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated \$4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima’s operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

Gary Crockett, Chief Counsel
 Board of Directors’ Finance and Audit Committee
 Board of Directors’ Quality Assurance Committee

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader
Authorized Signature

03/26/2020
Date



A Public Agency

CalOptima
Better. Together.

Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting

April 2, 2020

David Ramirez, M.D., Chief Medical Officer

Nancy Huang, Chief Financial Officer

Candice Gomez, Executive Director, Program Implementation

IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
 - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
 - Funds are outside of operating income and expenses
 - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
 - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview

1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	\$12.43 million	September 2012
IGT 2	\$8.70 million	June 2013
IGT 3	\$4.88 million	September 2014
IGT 4	\$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	\$14.42 million	December 2016
IGT 6	\$15.24 million	September 2017
IGT 7	\$15.91 million	May 2018
IGT 8	\$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	\$121.31 million	

* Pending DHCS guidance

IGT 9 Status

- CalOptima's estimated share is approximately \$45 million
 - Expect receipt of funding in calendar year 2020
 - Funds used for Medi-Cal programs, services and operations
 - Funds are part of operating income and expenses
 - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
 - Managed through the fiscal year budget
- Stakeholder vetting on the following focus areas
 - Member access and engagement
 - Quality performance
 - Data exchange and support
 - Other priority areas

Proposed Allocation and Initiatives

- Staff has identified initiatives targeted \$40.5 million of the anticipated \$45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	\$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	\$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	\$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	\$2.0 million
5. Whole Child Model Program	Other priority areas	One–year	Up to \$31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	\$4.5 million

1. Member Access and Engagement: Expanded Office Hours

- Description
 - Offer additional incentives to providers and/or clinics
 - Expand office hours in the evening and weekends
 - Expand primary care services to ensure timely access
- Guidelines
 - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
 - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
 - Two-year initiative
 - Budget request of \$2.0 million (\$500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
 - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
 - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
 - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
 - Two FTE to support adoption, training and monitoring
- Key Components
 - Three-year initiative
 - Budget request of \$3.4 million (\$1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
 - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
 - Other organizations within the delivery system may also be added
 - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
 - Participating organizations will:
 - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
 - Be eligible for an incentive once each file exchange is in place
- Key Components
 - One-year initiative
 - Budget request of \$2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition

- Administrative support for prior, current and future IGTs
 - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
 - Fund Grant Management System license, public activities and other administrative costs

- Guidelines

- Will be consistent with CalOptima policies and procedures
- Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs

- Key Components

- Five years of support
- Budget request of \$2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
 - CalOptima launched WCM on July 1, 2019
 - Based on the initial analysis, CalOptima is projecting an overall loss of up to \$31.1 million in FY 2019–20
- Challenges
 - Insufficient revenue from DHCS to cover WCM services
 - Complex operations and financial reconciliation
- Key Components
 - One year
 - Budget request of up to \$31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Return to the Board as needed regarding
 - New or modified policy and procedures
 - Contracts
 - Additional initiatives

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018 **Regular Meeting of the CalOptima Board of Directors**

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact

The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation

Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence

Gary Crockett, Chief Counsel

Attachment

Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413
Phone (916) 345-8268
www.dhcs.ca.gov

[Back to Agenda](#)

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:
 1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
 3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
 4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.
- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:
 1. The governmental funding entity's name and Federal Tax Identification Number,
 2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
 3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).
 - The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.
 - The proposals and letters of interest are due to DHCS **by 5pm on Friday, August 31, 2018**. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. **Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.**

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

Greg Hamblin
Page 4

uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,



Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Insert Participating Funding Entity Name is willing to contribute up to \$ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

Attachment B
SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:
 County:
 Health Plan:

Instructions

Complete all yellow-highlighted fields. Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				\$	\$
Outpatient				\$	\$
All Other				\$	\$
Total	\$	\$	\$	\$	\$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)?
 If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (state, county, city, other):

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

(iv) Does the transferring entity have general taxing authority?

(v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction?

5. Comments / Notes

ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
 IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	\$ 138,114,451	\$ 68,412,249	\$ 7,133,302	\$ 62,568,900
Federal Match	\$ 98,985,353	\$ 34,206,125	\$ 6,277,306	\$ 58,501,922
Governmental Funding Entity's Portion	\$ 39,129,098	\$ 34,206,124	\$ 855,996	\$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories ¹	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage ²	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 12,571,887
Child - MCHIP	1,273,587	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 6,469,822
Adult - non MCHIP	1,082,406	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 18,898,809
Adult - MCHIP	38,000	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 663,480
SPD	466,754	\$ 755.18	\$ 798.48	\$ 43.30	-	\$ 43.30	\$ 20,210,448
SPD/Full-Dual	22,794	\$ 219.25	\$ 229.52	\$ 10.27	-	\$ 10.27	\$ 233,170
BCCTP	7,156	\$ 1,225.69	\$ 1,296.82	\$ 71.13	-	\$ 71.13	\$ 509,006
LTC	14,686	\$ 10,472.34	\$ 10,858.28	\$ 385.94	-	\$ 385.94	\$ 5,667,915
LTC/Full-Dual	0	\$ 6,036.73	\$ 6,235.58	\$ 198.85	-	\$ 198.85	\$ -
OBRA	0	\$ -	\$ -	\$ -	-	\$ -	\$ -
Whole Child Model	74,642	\$ 1,824.65	\$ 1,962.92	\$ 138.27	-	\$ 138.27	\$ 10,321,014
Optional Expansion	2,853,119	\$ 442.21	\$ 471.45	\$ 29.24	7.31	\$ 21.93	\$ 62,568,900
	8,307,835	\$ 309.49	\$ 328.62	\$ 19.14	2.51	\$ 16.62	\$ 138,114,451

¹The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.

²Other Departmental Usages decreases available rate funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "...decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "...the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed \$2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader
Authorized Signature

5/29/2019
Date



CalOptima
Better. Together.

Post-Acute Infection Prevention Quality Initiative

**Regular Meeting of the Board of Directors
June 6, 2019**

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

**Care Management, Long-Term Services and Supports and
Senior Programs**

Background

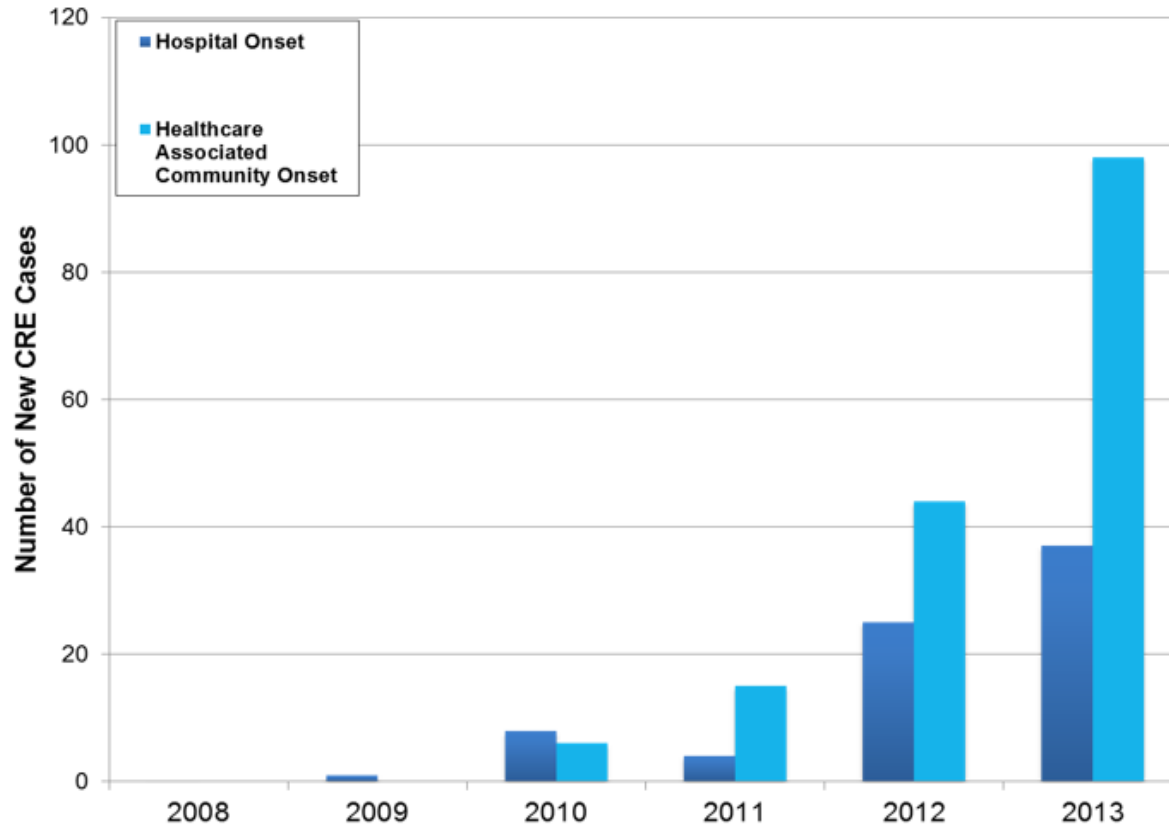
- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
 - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
 - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
 - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 → overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
 - Methicillin Resistant *Staphylococcus aureus* (MRSA)
 - Vancomycin Resistant Enterococcus (VRE)
 - Multi-Drug Resistant Pseudomonas
 - Multi-Drug Resistant Acinetobacter
 - Extended Spectrum Beta Lactamase Producers (ESBLs)
 - Carbapenem Resistant Enterobacteriaceae (CRE)
 - Hypervirulent KPC (NDM)
 - *Candida auris*
- **10–15% of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA

**Hospital and Healthcare-Associated Community
Onset CRE Incidence**
(N = 21 Hospitals)



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency



Early Release / Vol. 64

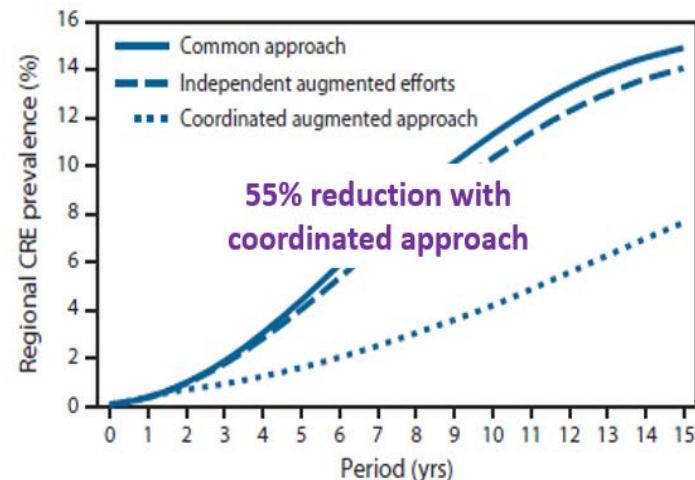
Morbidity and Mortality Weekly Report

August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD¹; Damon Toth, PhD²; Bruce Y. Lee, MD³; Windy Tanner, PhD²; Sarah M. Bartsch, MPH³; Karim Khader, PhD²; Kim Wong, PhD⁴; Kevin Brown, PhD²; James A. McKinnell, MD⁵; William Ray²; Loren G. Miller, MD⁶; Michael Rubin, MD, PhD²; Diane S. Kim⁷; Fred Adler, PhD⁸; Chenghua Cao, MPH⁷; Lacey Avery, MA¹; Nathan T.B. Stone, PhD⁹; Alexander Kallen, MD³; Matthew Samore, MD²; Susan S. Huang, MD²; Scott Fridkin, MD¹; John A. Jernigan, MD¹

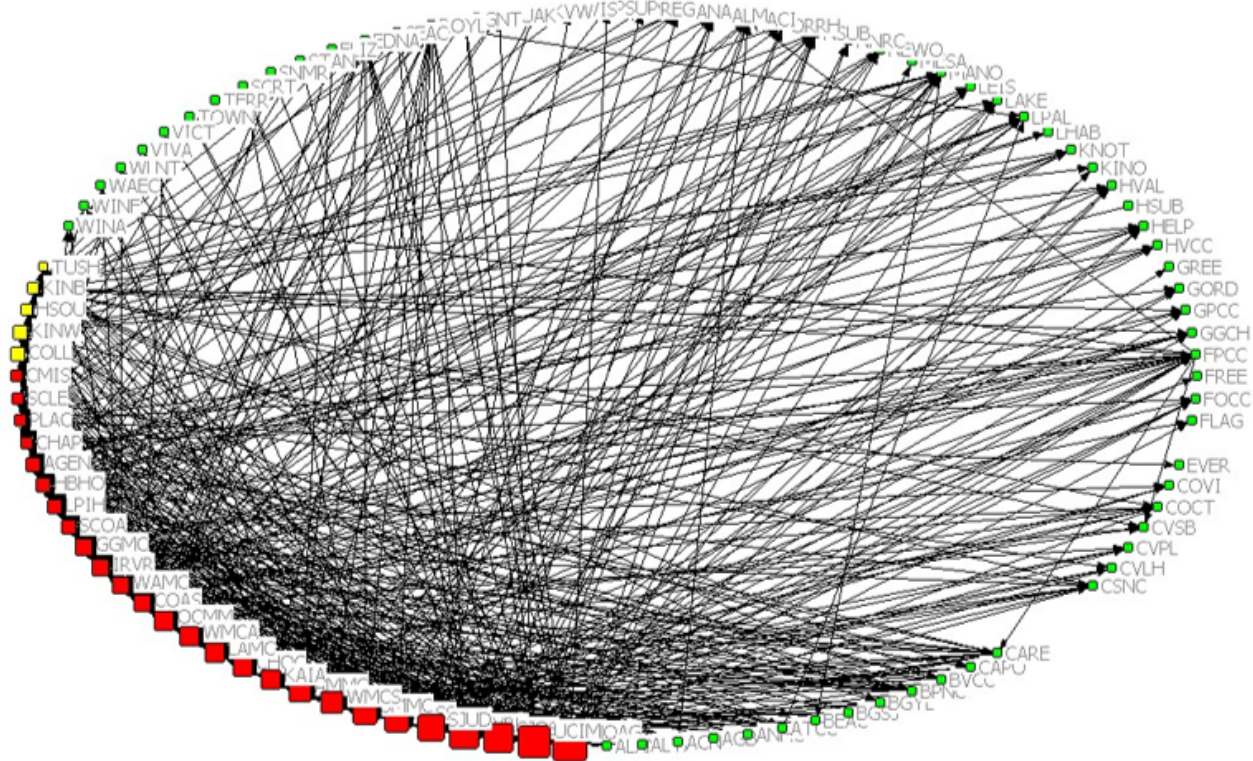
FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*



* Additional information available at <http://www.cdc.gov/drugresistance/resources/publications.html>.

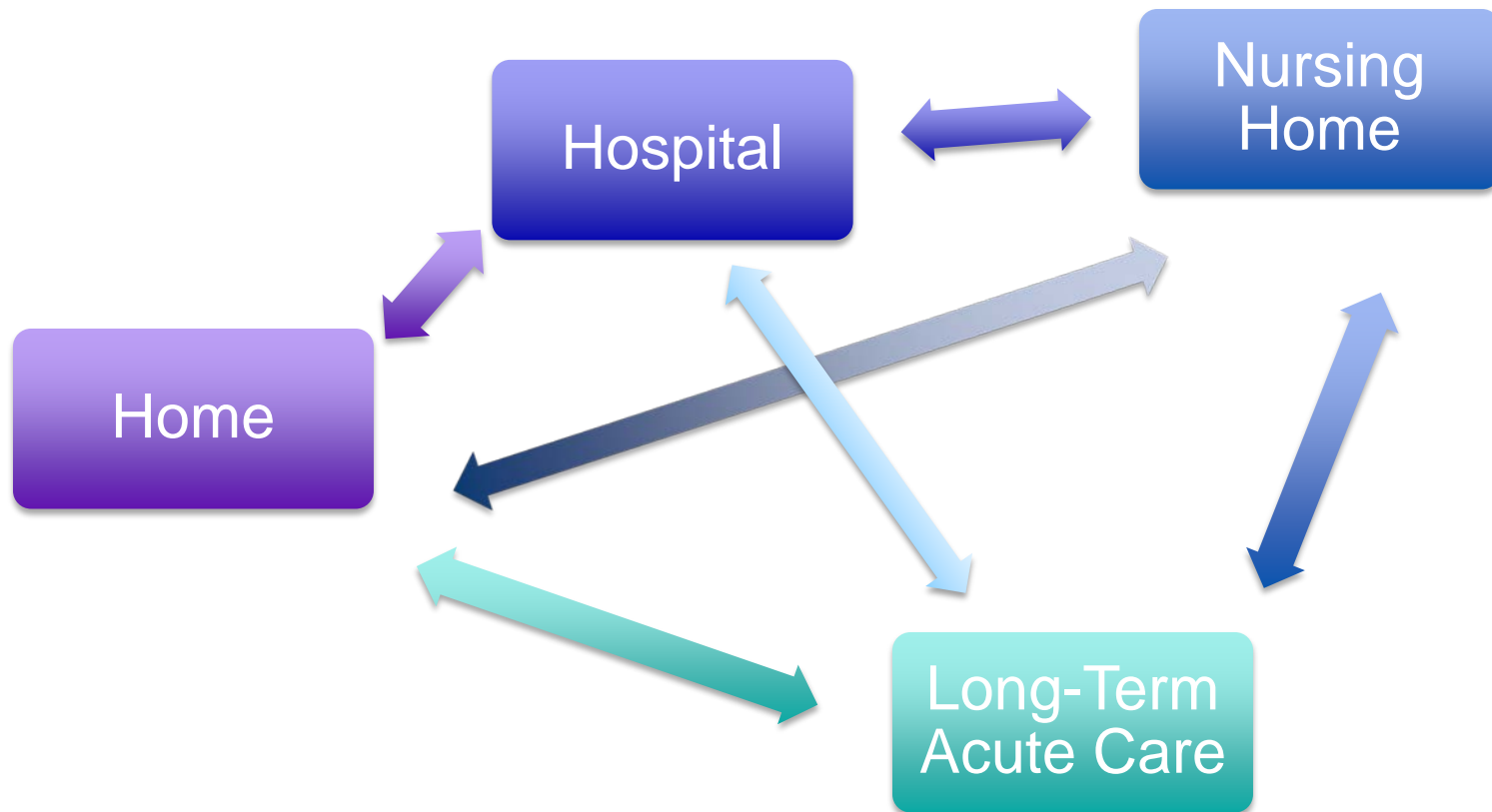
Extent of the Problem

OC Hospitals and Nursing Homes 10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	900	64%	42%	16%	34%	2%

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥ 1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

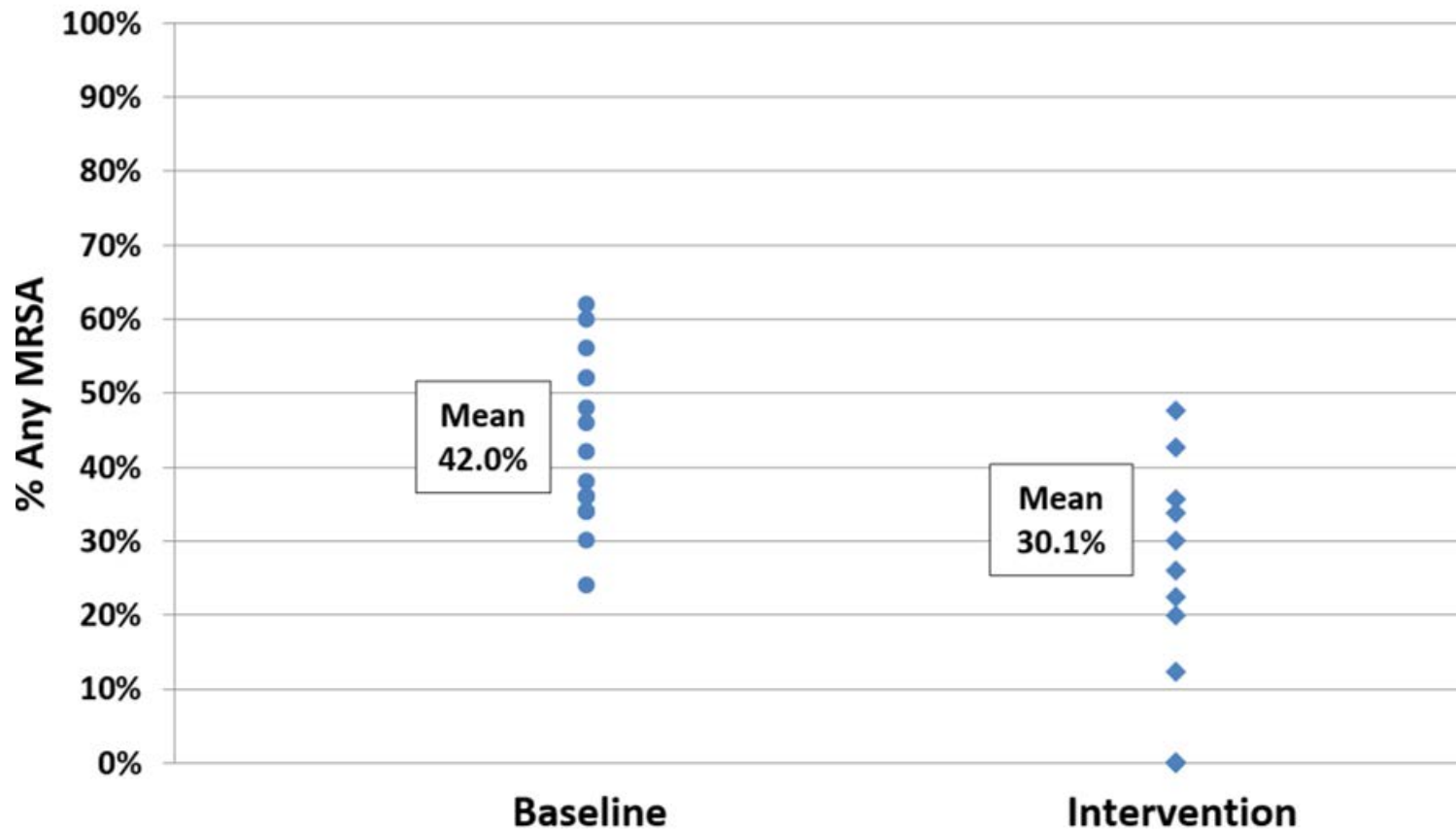
- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
 - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
 - CHG on admit and for all routine bathing/showering
 - Nasal iodophor on admit and every other week
 - <https://www.cdc.gov/hai/research/cdc-mdro-project.html>
- Following initial testing and training
 - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
 - MRSA, VRE, ESBL, CRE and any MDRO
 - By body site
 - Nasal product reduces MRSA
 - CHG bathing reduces skin carriage

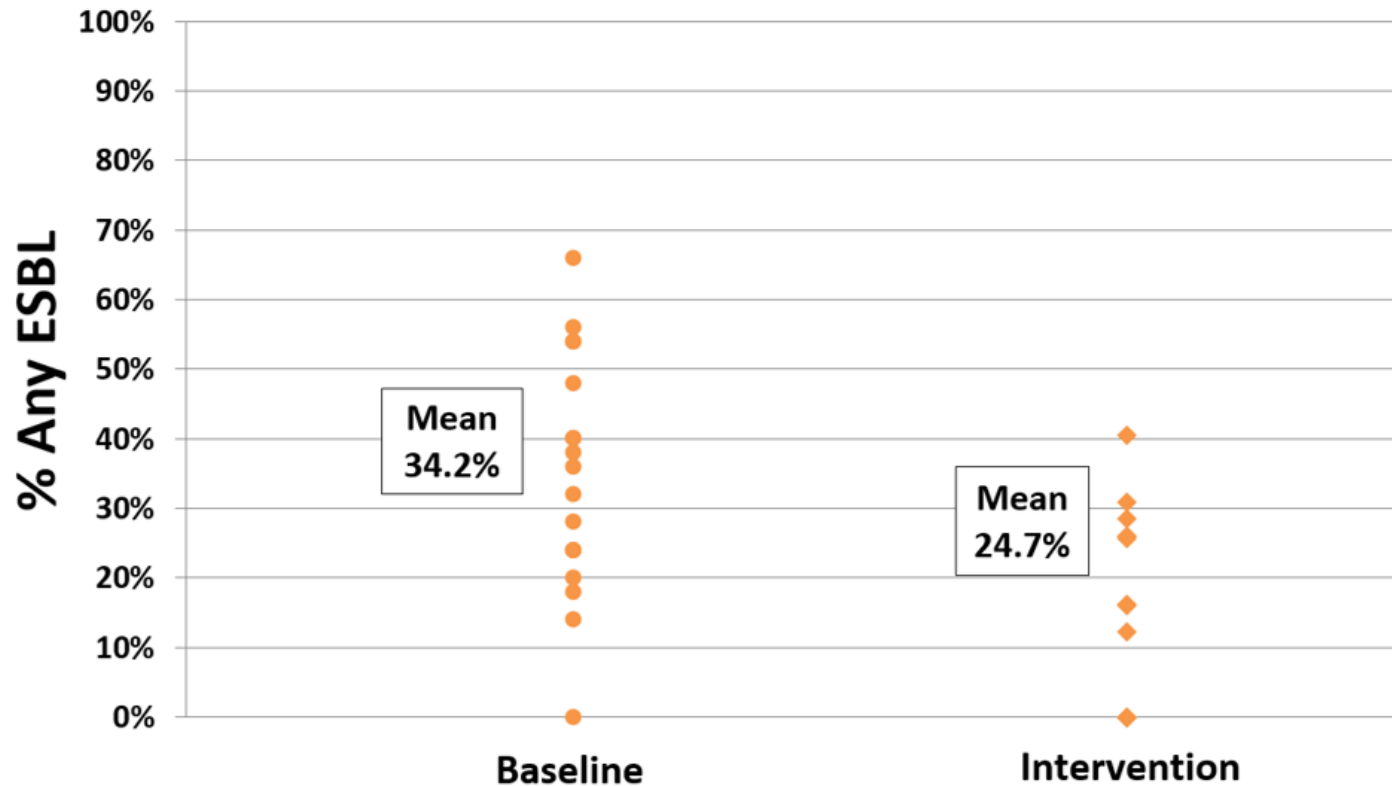
SHIELD Outcomes

SHIELD Impact: Nursing Homes 28% reduction in MRSA



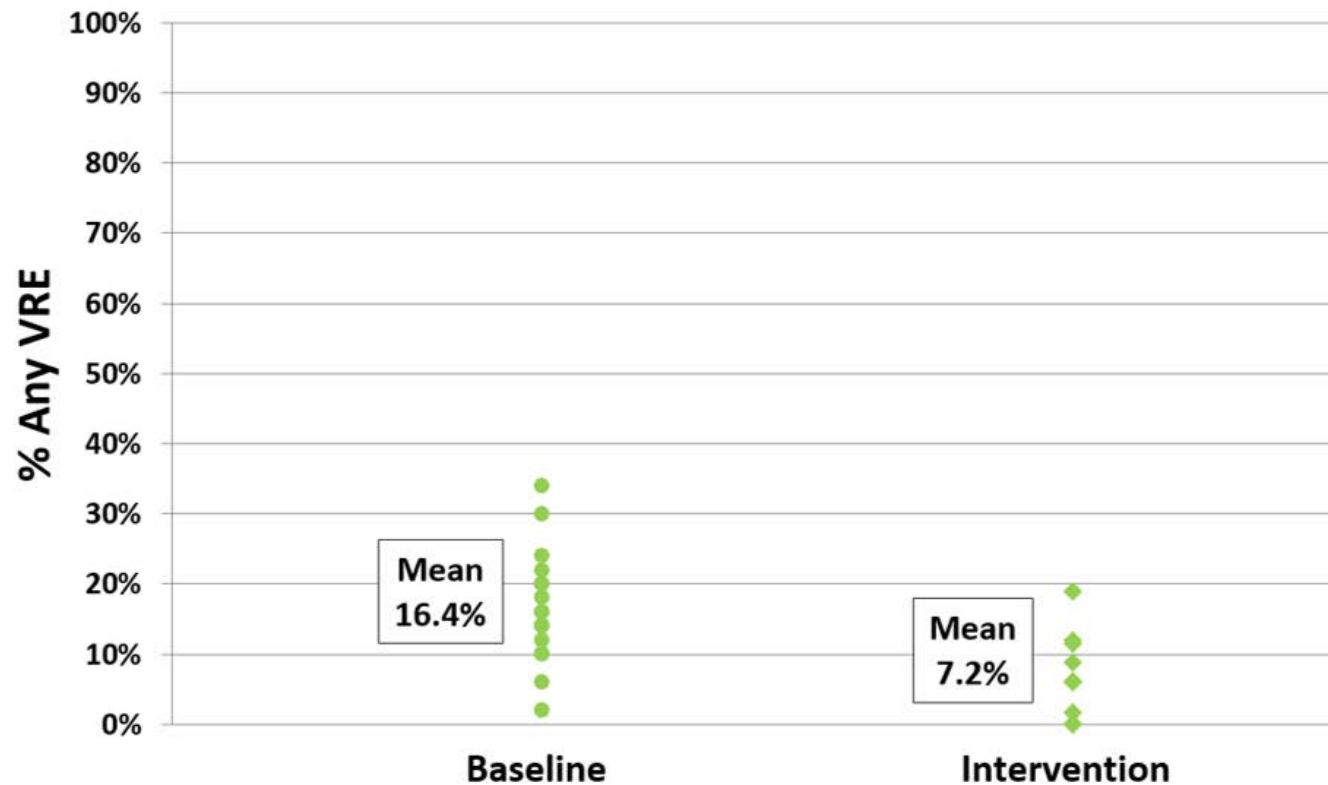
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 28% reduction in ESBLs



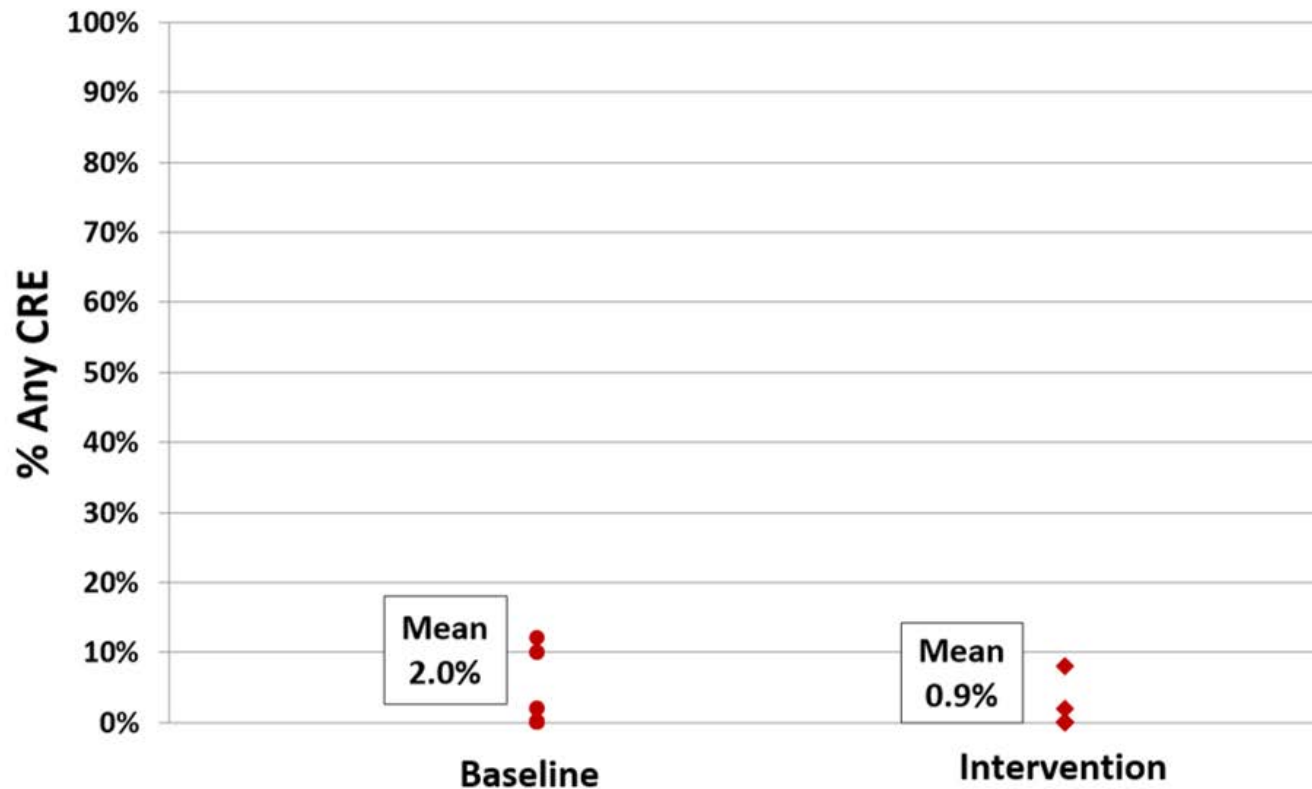
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 56% reduction in VRE



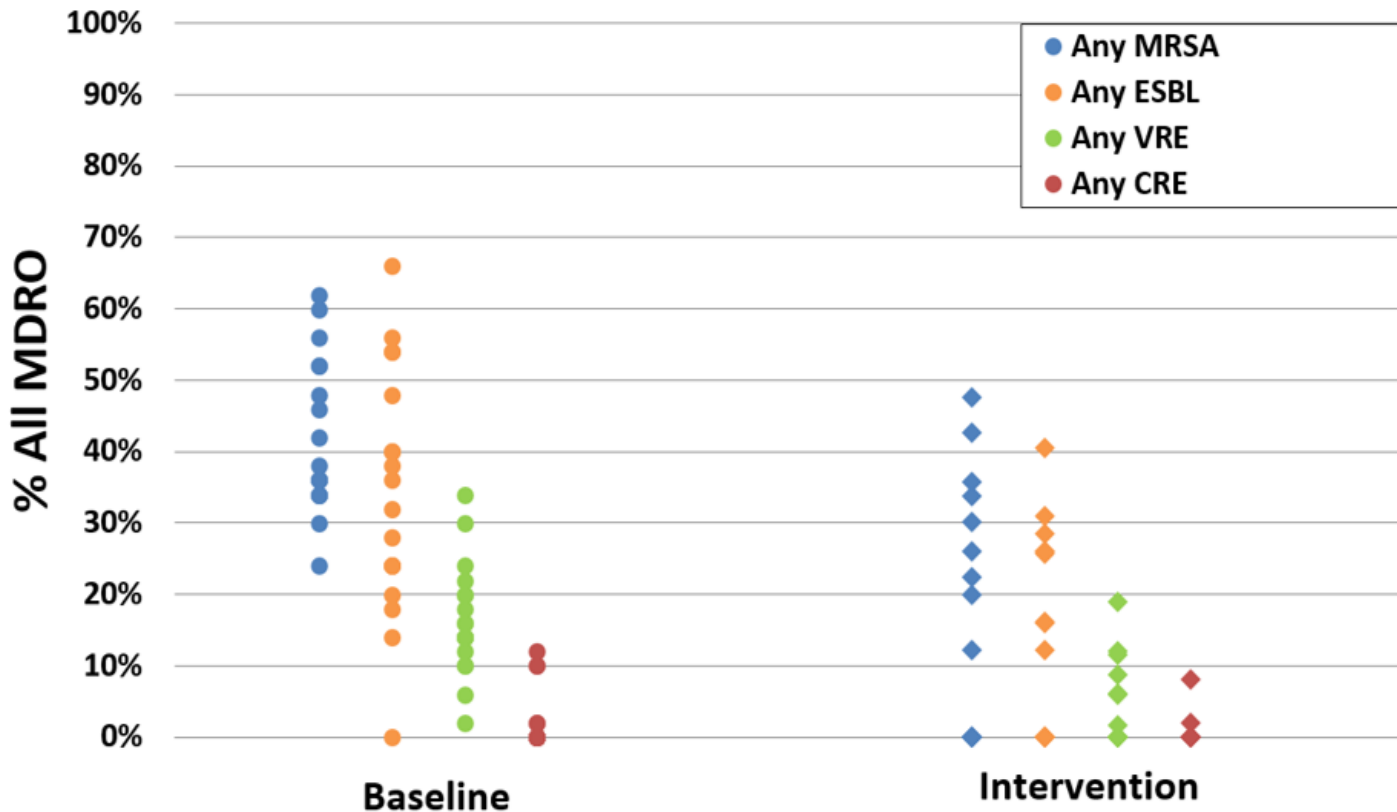
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes 25% reduction in all MDROs



Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: **ORANGE**

From: **2015-10** To: **2018-12**

Category P - Primary Diagnosis

		Select Year-Month Begin 2015-10	Select Year-Month End 2018-12	Select Category P Diagnosis Level Category P - Primary Diagnosis	Select Risk Group * Multiple values	Select LTC Facility County ORANGE								
		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid gray; padding: 2px;">Select Year-Month Begin 2015-10</div> <div style="border: 1px solid gray; padding: 2px;">Select Year-Month End 2018-12</div> <div style="border: 1px solid gray; padding: 2px;">Select Category P Diagnosis Level Category P - Primary Diagnosis</div> <div style="border: 1px solid gray; padding: 2px;">Select Risk Group * Multiple values</div> <div style="border: 1px solid gray; padding: 2px;">Select LTC Facility County ORANGE</div> </div>												
		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid gray; padding: 2px;">Before SHIELD OC</div> <div style="border: 1px solid gray; padding: 2px;">During SHIELD OC</div> </div>												
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	\$682,769	\$854,676	\$1,159,922	\$920,317	\$1,691,337	\$1,231,903	\$997,810	\$1,236,197	\$634,628	\$979,762	\$1,113,238	\$1,176,910	\$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	\$133,362	\$311,661	\$124,676	\$189,669	\$227,224	\$209,419	\$175,738	\$164,181	\$40,354	\$84,565	\$127,609	\$41,123	\$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
 - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = \$1,196,011
 - Inpatient costs for the last 6 quarters following training and use of CHG protocol = \$468,009
 - \$728,002 lowered inpatient expenditure (61%) for infection in the participating facilities
- 51 contracted facilities not utilizing the CHG program:
 - Inpatient costs for the last 6 quarters = \$6,165,589
 - Potential 61% lowered inpatient expenditure for infection = \$3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
 - Plan for extended use of an existing trainer in OC for one year
 - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
 - Decreased infection-related hospitalizations
 - An opportunity for a significant advancement in population health management
 - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
 - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
 - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
 - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
 - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
 - Include a trainer provided by the CDC for one year
 - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
 - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CalOptima

Better. Together.



Medi-Cal
CalOptima
Better. Together.



OneCare (HMO SNP)
CalOptima
Better. Together.



OneCare Connect
CalOptima
Better. Together.



PACE
CalOptima
Better. Together.



**Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County**

SHIELD Orange County – Together We Can Make a Difference!

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

Visit our CDC webpage here!

<https://www.cdc.gov/hai/research/dc-mdro-project.html>

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
 - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
 - Nasal decolonization with 10% povidone-iodine
 - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
 - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
 - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team

(949) 824-7806 or SHIELDOrangeCounty@gmail.com



CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____ / _____

Today's Date: _____ / _____ / _____

Completed by: _____

- Proof of product purchase
- Evidence the decolonization program handout is in admission packet
- Monitor and document compliance with bathing one day each week
- Monitor and document compliance with iodophor one day each week
iodophor is used
- Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	<input type="checkbox"/>	_____ gallons	_____ gallons
10% Iodine Swabsticks	<input type="checkbox"/>	_____ boxes	_____ boxes

_____ swabs per box

INTERNAL USE ONLY –APPROVAL:

Facility Name: _____ Unit: _____ Date: _____

STAFF Skills Assessment: CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

Nursing Assistant (CNA) Nurse LVN Other: _____

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

- Y N Resident received CHG bathing handout
- Y N Resident told that no rinse bath provides protection from germs
- Y N Provided rationale to the resident for not using soap at any time while in unit
- Y N Massaged skin *firmly* with CHG cloth to ensure adequate cleansing
- Y N Cleaned face and neck well
- Y N Cleaned between fingers and toes
- Y N Cleaned between all folds
- Y N N/A Cleaned occlusive and semi-permeable dressings with CHG cloth
- Y N N/A Cleaned 6 inches of all tubes, central lines, and drains closest to body
- Y N N/A Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers
- Y N N/A Used CHG on surgical wounds (unless primary dressing or packed)
- Y N Allowed CHG to air-dry / does not wipe off CHG
- Y N Disposed of used cloths in trash /does not flush

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

2. If more than 6 cloths was used, provide reason.

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

5. Do you ever wipe off the CHG after bathing?

ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

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ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; $P=0.03$; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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METHICILLIN-RESISTANT *STAPHYLOCOCCUS aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.¹ It is the most common cause of skin, soft-tissue, and procedure-related infections.² Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.^{1,3,4}

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.^{5,6} Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).⁷⁻¹⁰ Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

METHODS

TRIAL DESIGN AND INTERVENTION

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge

(Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

RECRUITMENT AND ELIGIBILITY CRITERIA

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

FOLLOW-UP

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits (\$25, \$30, \$35, and \$50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.¹¹ A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)¹² or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine ($\geq 8 \mu\text{g}$ per milliliter) on microbroth dilution.^{13,14} All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the par-

ticipant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and non-adherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.¹⁵ Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approxi-

mately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

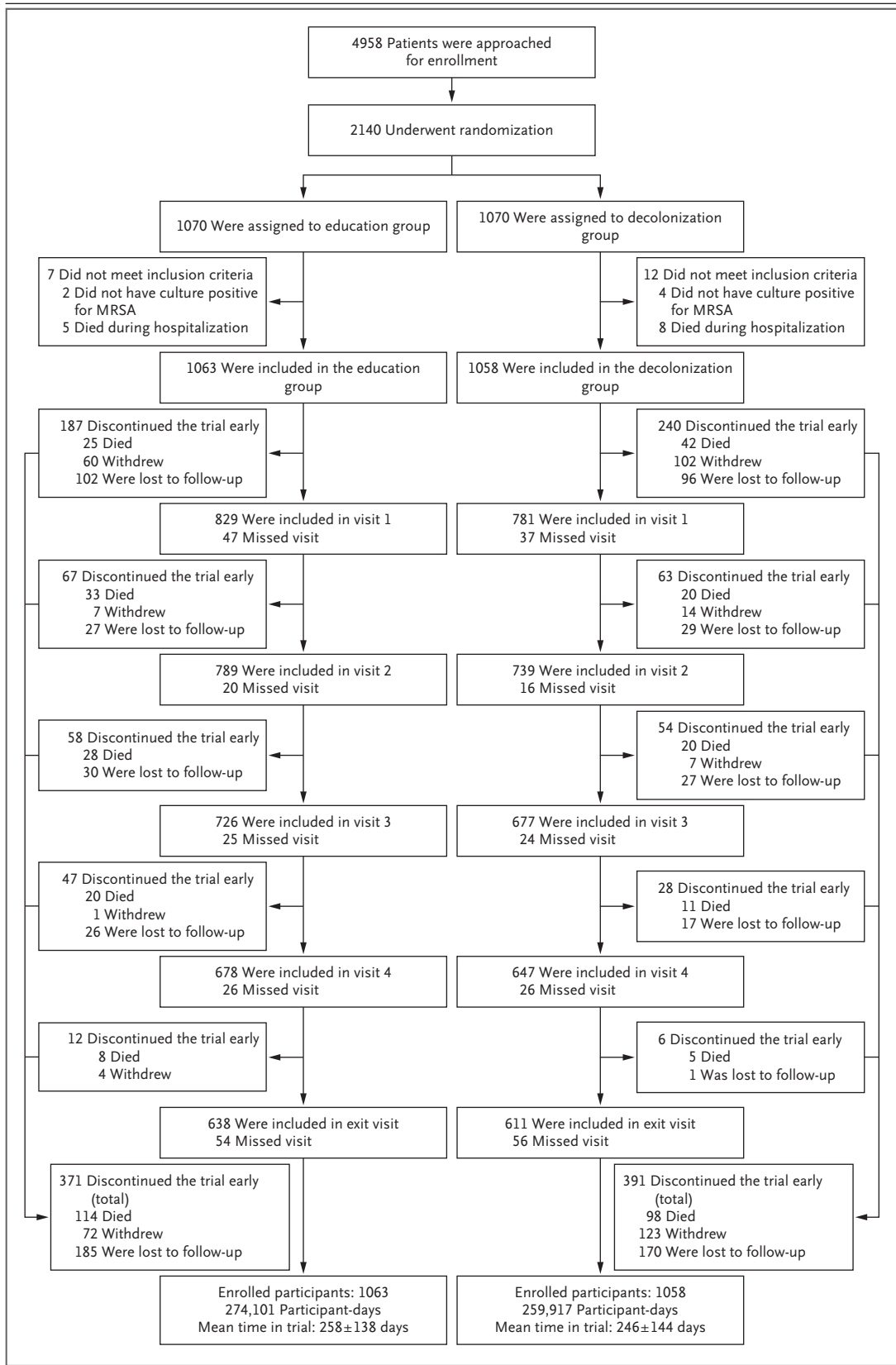


Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (\pm SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI],

0.52 to 0.96; $P=0.03$). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus-minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.

† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.

‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.

§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.

¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.

|| By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).

** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.

†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.

‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading to hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.

† This was the primary outcome.

‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96) †	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI) ‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI) ¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infec-

tion was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, $P=0.97$). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, $P=0.82$) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care-associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.¹⁶ MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.^{1,17-19} In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.¹⁶

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),^{6-10,19-22} a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.²³⁻²⁶ In contrast, twice-monthly decolonization

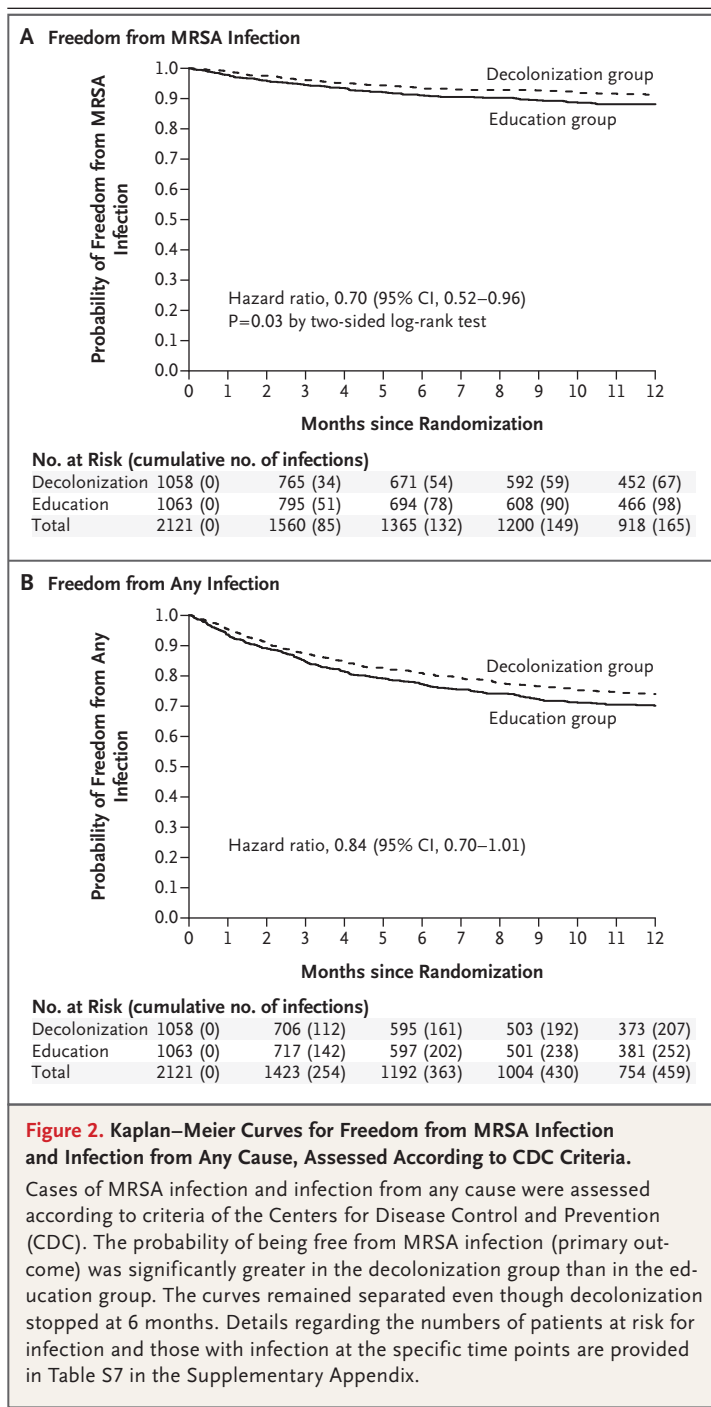


Figure 2. Kaplan-Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

ing and mupirocin application.^{8,9,22} This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.^{8,9,22}

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.²⁷⁻³⁰

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and

reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.³¹⁻³³ It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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[PUBLIC HEALTH](#)

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 2019 5:00 AM ET

ANNA GORMAN



A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics.

Heidi de Marco/KHN

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said [Dr. John Jernigan](#), who directs the CDC's office on health care-acquired infection research.

[Back to Agenda](#)



"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to [15 percent of hospital patients and 65 percent of nursing home residents](#) harbor drug-resistant organisms, though not all of them will develop an infection, says [Dr. Susan Huang](#), who specializes in infectious diseases at the University of California, Irvine.

"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or [CRE](#), often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as [carbapenems](#). CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says [Dr. Michael Lin](#), an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which [has been shown](#) to reduce infections when patients bathe with it.





The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.

Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused [rare but severe allergic reactions](#).

In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a [Kaiser Health News analysis](#), and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says [Dr. Matthew Zahn](#), medical director of epidemiology at the Orange County Health Care Agency

"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.



Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.

Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, [published in February](#) in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.



"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator [Shaun Dahl](#) says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says. Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

Kaiser Health News is a nonprofit news service and editorially independent program of the Kaiser Family Foundation. KHN is not affiliated with Kaiser Permanente.

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | Updated 1:47 p.m. ET April 12, 201

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.



Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. (Photo: Heidi de Marco, Kaiser Health News)

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” *E. coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

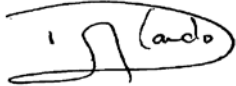
There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,

A handwritten signature in black ink, appearing to read "Denise Cardo". The signature is enclosed within a hand-drawn oval shape.

Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:

High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
 - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
 - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
 - CPT code descriptions:
 - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
 - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
 - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
 - \$125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
 - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
 - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation

- Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total \$2 million (up to \$500,000 for FY2019/20, remaining amounts from FY2019/20 and \$750,000 for FY2020/21, \$750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima’s Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima’s program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima’s contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima’s Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
 - Potential improved Star ratings
 - Strengthens community and national partnerships:
 - UCI (Professor Susan Huang -Department of Infectious Diseases)
 - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
 - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
 - contracted nursing facilities
 - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It’s a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

- B. Dedicate two Long Term Support Services Nurses to:
- 1) Provide training for newly participating facilities,
 - 2) Provide ongoing support and compliance monitoring* at all participating facilities,
 - 3) Develop additional informing, training and monitoring materials.
- C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount \$3.4 million over 3 fiscal years (\$1 million for FY2019/20, \$1.2 million for FY 2020/21 and \$1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima’s Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: \$2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: \$2,000,000

Project Timeframe: Five-years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total \$31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:

To Support care delivery for WCM population in FY 2019-20

- 1) Insufficient revenue from DHCS
- 2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A



CalOptima
Better. Together.

Post-Acute Infection Prevention Quality Initiative (PIPQI)

**Special Board of Directors Meeting
April 16, 2020**

**David Ramirez, M.D., Chief Medical Officer
Emily Fonda, M.D., MMM, CHCQM, Deputy Chief Medical Officer**

Post-Acute Infection Prevention Quality Initiative (PIPQI) Program

- Since October 2019, 24 participating skilled nursing facilities (SNFs) substitute Chlorhexidine (CHG) soap for liquid soap along with use of Iodophor nasal swabs to decrease skin colonization of Multi-Drug Resistant Organisms, which leads to decreased infection rates.
- CHG has anti-viral, anti-bacterial and anti-fungal properties.
- CHG has been proven to significantly decrease inpatient hospitalization for infection.
- The Centers for Disease Control and Prevention (CDC) has funded a nurse trainer in Orange County and strongly endorses CalOptima's PIPQI, the only such program in the country.
- CalOptima proposes to provide a quarterly incentive (\$7,500 per SNF) for program adherence. Following the COVID-19 crisis — as safety permits — will skin test for CHG.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020 Special Meeting of the CalOptima Board of Directors

Report Item

4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact

Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed \$80,327; and
2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed \$48,000 to fund contract extensions through June 30, 2020.

Background

On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed \$915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of \$20,000 from the Professional Fees budget to fund these contracts.

Discussion

Emergency Purchases Related to Coronavirus Pandemic

Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	\$30,110
	Member personal protective equipment	\$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	\$30,000
Facilities	Staff personal protective equipment	\$11,905
	Gloves, disinfectant products	\$578

Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 (\$1,000/month)	\$3,000
	Total	\$80,327

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima’s employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is \$48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to \$128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez
Authorized Signature

04/10/2020
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children’s Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400

Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of \$20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)

One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 crisis.

Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;
- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;
- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;
- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;
- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.
- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.
- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.
- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.
- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:
 - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).
 - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.
 - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.
 - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.
- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.
- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	Completion Date	Fee
Review Past Telehealth Attempts	March 30, 2020	\$3,500
Assessment of Virtual Care Strategy	April 17, 2020	\$10,500
Gap Analysis	May 1, 2020	\$21,000

Provide Recommendations	May 15, 2020	\$21,000
Vet Recommendations to Stakeholders	May 15, 2020	\$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	\$3,500
Develop Implementation Workplan	June 30,2020	\$14,350
TOTAL		\$94,850

Medical Consultants in Response to COVID-19 Situation

On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California’s governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima’s Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima’s PACE members who are considered the highest risk population. Therefore, the Plan’s executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership’s considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- \$10,000 for each medical consultant
- Total: \$20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of \$100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed \$20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to \$20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader
Authorized Signature

03/26/2020
Date

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children’s Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

Policy: GG.1665
 Title: Telehealth and Other Technology-Enabled Services
 Department: Medical Management
 Section: Population Health Management

CEO Approval:

Effective Date: 03/01/2020
 Revised Date: Not applicable

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
- PACE
- Administrative - Internal
- Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

- A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.
- B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.
- C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:
 - 1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;
 - 2. Comply with all state and federal laws regarding the confidentiality of health care information;
 - 3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;
 - 4. Document treatment outcomes appropriately; and
 - 5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member’s treatment.

- D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.
- E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.
- F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.
- G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.
- H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.
- I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.
- J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.
- K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.
2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.
3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:
 - a. The Qualified Provider meets the following licensure requirements:

- i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or
 - ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.
2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).
3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:
 - a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;
 - b. The Member has provided verbal or written consent in accordance with this Policy;
 - c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;
 - d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and
 - e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.
 - f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:
 - i. In an operating room;
 - ii. While the Member is under anesthesia;
 - iii. Where direct visualization or instrumentation of bodily structures is required; or
 - iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.
2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
3. CalOptima and its Health Networks shall not require providers to:
 - a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or
 - b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.
4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member
 - a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,
 - b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,
 - c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.
2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.
2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

- a. E-consults are permissible only between Qualified Providers.
- b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.
- c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

- a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).
- b. Virtual/Telephonic Communications are classified as follows:
 - i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.
 - ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.
 - a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.
 - b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.
 - I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.
 - J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

- A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

- A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
- C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
- D. CalOptima Policy GG.1510: Appeals Process
- E. CalOptima Policy GG.1603: Medical Records Maintenance
- F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
- G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

- I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
- J. CalOptima Policy HH.1102: Member Grievance
- K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
- L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
- M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
- N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
- O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
- P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children’s Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima’s Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member’s treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member’s health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 202001

Term	Definition
FQHC/RHC Established Member	<p>A Medi-Cal eligible recipient who meets one or more of the following conditions:</p> <ul style="list-style-type: none"> • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	<p>A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.</p>
Health Network	<p>A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.</p>
HIS-MOA Clinics	<p>Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details</p>
Medically Necessary or Medical Necessity	<p>Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.</p>
Medical Record	<p>A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.</p>

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 2020040

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding “new” and “established” patients, “face-to-face”/in-person, and “four walls” requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
 - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
 - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

<https://www.dhcs.ca.gov/>

Policy: MA.2100
Title: Telehealth and Other Technology-Enabled Services
Department: Medical Management
Section: Population Health Management

CEO Approval:

Effective Date: 03/01/2020
Revised Date: Not applicable

Applicable to: Medi-Cal
 OneCare
 OneCare Connect
 PACE
 Administrative - Internal
 Administrative – External

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I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

- A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).
- B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.
- C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.
- D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.
- E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.
- F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

- 1 G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed
2 for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS
3 guidance and this Policy.
4
- 5 H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver
6 Covered Services comply with applicable laws, regulations, guidance addressing coverage and
7 reimbursement of Covered Services provided via Telehealth.
8
- 9 I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and
10 Remote Monitoring Services that are commonly furnished remotely using telecommunications
11 technology without the same restrictions that apply to Medicare Telehealth Covered Services may
12 also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the
13 requirements set forth in this Policy.
14
- 15 J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise
16 modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum
17 attached to this Policy for information related to health-related national emergency waivers.
18

19 **III. PROCEDURE**

20 **A. Member Consent to Telehealth Modality**

- 21
- 22
- 23 1. Members must consent to the provision of virtual Covered Services that are provided via secure
24 electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-
25 Visits, which consent shall be documented in the Member's medical records.
26

27 **B. Provision of Covered Services through Telehealth**

- 28
- 29 1. A Qualified Provider may provide Covered Services to an established Member via Telehealth
30 when all of the following criteria are met:
31
- 32 a. The Member is seen in an Originating Site;
33
- 34 b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA)
35 or in a county outside of a Metropolitan Statistical Area (MSA);
36
- 37 c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified
38 Provider;
39
- 40 d. The Telehealth Covered Services encounter must be provided through Interactive Audio
41 and Video telecommunication that provides real-time communication between the Member
42 and the Qualified Provider (store and forward is limited to certain demonstration projects).
43 See Section III.C. of this Policy for other Technology-Enabled services that are not
44 considered to be Telehealth, and which may be provided using other modalities; and
45
- 46 e. The type of Telehealth Covered Services fall within those identified in the CMS List of
47 Services (available at [https://www.cms.gov/Medicare/Medicare-General-
48 Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes)).
49
- 50 f. The Qualified Provider must be licensed under the state law of the state in which the Distant
51 Site is located, and the Telehealth Covered Service must be within the Qualified Provider's
52 scope of practice under that state's law.
53
- 54 2. The Originating Site for Telehealth Covered Services may be any of the following:

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- a. The office of a physician or practitioner;
 - b. A hospital (inpatient or outpatient);
 - c. A critical access hospital (CAH);
 - d. A rural health clinic (RHC);
 - e. A Federally Qualified Health Center (FQHC);
 - f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);
 - g. A skilled nursing facility (SNF); or
 - h. A community mental health center (CMHC).
3. Telehealth Service Requirements and Electronic Security
- a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.
 - i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.
 - ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
 - iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.
4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:
- a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.
 - b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.
5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

1 C. Other Technology-Enabled Services

2
3 1. Virtual Check-In Services

- 4
5 a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In
6 Services to connect with Members outside of the Qualified Provider's office if all of the
7 following criteria are met:
8
9 i. The Virtual Check-In Services are initiated by the Member;
10
11 ii. The Member has an established relationship with the Qualified Provider where the
12 communication is not related to a medical visit within the previous seven (7) days and
13 does not lead to a medical visit within the next twenty-four (24) hours (or soonest
14 appointment available);
15
16 iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;
17
18 iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate
19 Members on the availability of the service prior to the Member's consent to such
20 services); and
21
22 v. The Member verbally consents to Virtual Check-In Services and the verbal consent is
23 documented in the medical record prior to the Member using such services.
24
25 b. Live interactive audio, video or data telecommunications, Asynchronous Store and
26 Forward, and telephone may be used for Virtual Check-In Services subject to compliance
27 with Section III.D below.
28
29 c. Qualified Providers may bill for Virtual Check-In Services furnished through secured
30 communication technology modalities, such as telephone (HCPCS code G2012) or captured
31 video or image (HCPCS code G2010).
32

33 2. E-Visits

- 34
35 a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a
36 secure online patient portal if all of the following criteria are met:
37
38 i. The Member has an established relationship with a Qualified Provider;
39
40 ii. The provider furnishing the E-Visit is a Qualified Provider; and
41
42 iii. The Members generates the initial inquiry (communications can occur over a seven (7)-
43 day period).
44
45 b. Live interactive audio, video, or data telecommunications, Asynchronous Store and
46 Forward, and telephone may be used for Virtual Check-In Services subject to compliance
47 with Section III.D. of this Policy.
48
49 c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as
50 applicable, for E-Visits.
51

52 3. E-Consults

1 a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone,
2 internet and Electronic Health Record modalities are permitted where such consult services
3 meet the requirements in applicable billing codes, including time requirements.
4

5 b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452
6 for E-Consults.
7

8 4. Remote Monitoring Services
9

10 a. Remote Monitoring Services are not considered Telehealth Covered Services and include
11 Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring
12 and Principle Care Management services.
13

14 b. Remote Monitoring Services must meet the requirements established in applicable billing
15 codes.
16

17 D. The Qualified Provider must comply with all applicable laws and regulations governing the security
18 and confidentiality of the electronic transmission. Qualified Providers may not use popular
19 applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat,
20 Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and
21 federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when
22 so permitted, they may only be used for the time period such applications are allowed. In such
23 public emergency circumstances, Qualified Providers are encouraged to notify Members that these
24 third-party applications potentially introduce privacy risks. Qualified Providers should also enable
25 all available encryption and privacy modes when using such applications. Under no circumstances,
26 are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video
27 communication applications) permissible for Telehealth.
28

29 E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima
30 Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004:
31 Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and
32 MA.9004: Expedited Service Appeal.
33

34 F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in
35 accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by
36 this Policy shall be made in accordance with all applicable CMS requirements and guidance.
37

38 **IV. ATTACHMENT(S)**
39

40 A. COVID-19 Emergency Provisions Addendum
41

42 **V. REFERENCE(S)**
43

44 A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the
45 Department of Health Care Services (DHCS) for Cal MediConnect

46 B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare
47 Advantage

48 C. CalOptima Contract for Health Care Services

49 D. CalOptima Policy CMC.9002: Member Grievance Process

50 E. CalOptima Policy CMC.9003: Standard Appeal

51 F. CalOptima Policy CMC.9004: Expedited Appeal

52 G. CalOptima Policy MA.9002: Member Grievance Process

53 H. CalOptima Policy MA.9003: Standard Service Appeal

- I. CalOptima Policy MA.9004: Expedited Service Appeal
- J. Title 42 United States Code § 1395m(m)
- K. Title 42 CFR §§ 410.78 and 414.65
- L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

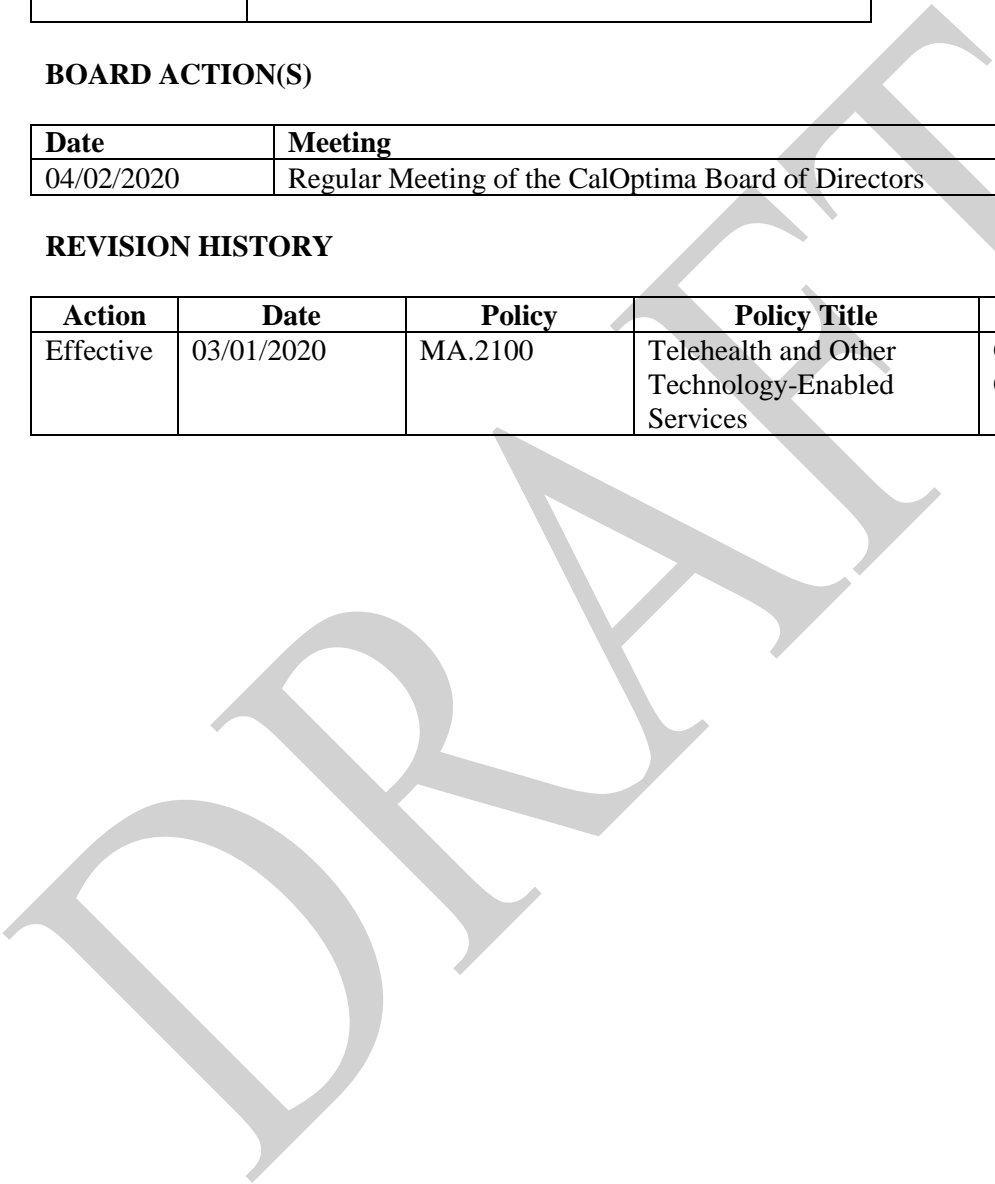
Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect



IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS’ list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member’s treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member’s health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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RICHARD FIGUEROA
ACTING DIRECTOR

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



GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.¹ This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.² *Revised text is found in italics.*

BACKGROUND:

The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),³ codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,⁴ Health and Safety Code (HSC) Section 1374.13,⁵ and Welfare and Institutions Code (WIC) Sections 14132.72⁶ and 14132.725.⁷ For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

¹ The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc

² More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: <https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx>

³ AB 415 is available at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415

⁴ BPC Section 2290.5 is available at:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC

⁵ HSC Section 1374.13 is available at:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC

⁶ WIC Section 14132.72 is available at:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC

⁷ WIC Section 14132.725 is available at:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:

Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.⁸

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>



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



BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:

In response to the COVID-19 pandemic, it is imperative that members practice “social distancing.” However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:

Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:¹

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim. For example, if an MCP reimburses a provider \$100 for an in-person visit, the MCP must reimburse the provider \$100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services’ guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

¹ Government Code section 8550, et seq.

SUPPLEMENT TO ALL PLAN LETTER 19-009
Page 2

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[e] sajcookie@gmail.com [c] +1.415.377.9514 [a] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a \$5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed \$150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the \$38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed \$15M.
- Successfully awarded (now) over \$18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract (\$128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California’s Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use \$38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over \$120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare

<https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896>.

HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare

ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;

HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO

Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital

Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!

Idea Exchange in Digital Healthcare Summit, University of California Irvine,
Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA

Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;

2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011

eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a \$9 Million budget.

WISE Healthcare Corporation, Redlands, CA **8/2017-Present**
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA **2/2013-7/2017**
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA **9/2008 – 3/2013**
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a \$ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over \$40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over \$120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA **4/2008 – 8/2008**
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA
Consultant, Sr. Data Architect

3/2007- 4/2008

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA
Chief Technology Officer

3/2005-3/2007

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA

7/1999 –2/2007

Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over \$32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech 2002-Present
 Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPERIENCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present

A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.

2017 – Present

A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board

2016 – Present

A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.

2012 – Present

Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA**2011 – Present**

On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013

Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over \$2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board**2008 – 2013**

A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA**2008 - 2012**

A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Management
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

E-MAIL PSCHIED12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

3/07-1/08 Primary Provider Management Company San Diego, CA
*Medical Director, Family Choice Medical Group, Vantage Medical Group-
San Diego*

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02-7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
*Clinical Instructor of Family Medicine, Department of Family and Preventive
Medicine*

E-MAIL PSCHIED12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present California A070698

2001-Present Diplomate, American Board of Family Practice

2014-Present Diplomate, American Board of Addiction Medicine

2020-Present Diplomate, American Board of Preventive Medicine,
Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations

Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting

Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
 - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
 - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California

April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA

November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA

May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team’s remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA

January 2006 – May 2014

Chief Executive Officer (10/11–5/14)

Medical Director (7/06–5/14)

Inpatient Medical Director (1/06–7/06)

- Responsible for year over year financial and performance success of \$50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience