Spring 2022

PLANSCAN

Health Plan of San Joaquin

Reminder: Roster/Data Validation

As part of the state mandated regulations, health plans must validate information from our providers at a minimum of every 6 months. We will be sending reminder notices to provider offices prior to the data needing to be validated.

According to Senate Bill 137, failure to respond can result in the provider being temporarily removed from the provider directory until it is resolved.

In this issue:

Provider Satisfaction Survey – Results Are In!

The results of the 2021 provider satisfaction survey are in! The survey targets providers to measure their satisfaction with Health Plan of San Joaquin. Information obtained from these surveys allows HPSJ to measure how well we are meeting our valued providers' needs.

The composite areas that we focus on include the following:

- Overall Satisfaction
- Network/ Coordination of Care
- All other Plans (Comparative Rating)
- Finance
- Utilization and Quality Management
- Health Plan call center service staff
- Provider Relations

Would recommend HPSJ:
91.5%

Measure Name	2020 SPH Medicaid BoB %tile
Would Recommend (% Yes)	**84th**
All Other Plans (Comparative Rating) (% Well or Somewhat above average)	**95th**
Overall Satisfaction (% Completely or Somewhat Satisfied)	**77th**
Finance Issues (% Well or Somewhat above average)	**98th**
Network / Coordination of Care (% Well or Somewhat above average)	**96th**
Network / Coordination of Care (% Well or Somewhat abouve average)	**74th**
Health Plan Call Center Service Staff (% Well or Somewhat above average)	**100th**
Provider Relations (% Well or Somewhat above average)	**72nd**

Areas of Overall Strengths within HPSJ
1. Timeliness of obtaining pre-certification/referral/ authorization information
2. Health Plan's facilitation/support of appropriate clinical care for patients
3. Accuracy and timeliness of claims processing
4. Satisfaction with Health Plan's call center service
5. Degree to which plan covers and encourages preventative care and wellness
6. Quality of written communications, policy bulletins, and manuals

Your survey responses let us know how we are doing and what we can improve on.
Please make sure to complete this year's survey online or by mail once you receive it.

We value your partnership and will continue to work towards our mutual goal of providing quality care and services to our members and your patients.

Virtual Look & Learn: Quality Measures

Health Plan of San Joaquin will be holding a virtual Provider Look and Learn event on June 8, 2022 from 12:00 pm – 1:00 pm.

Topics include:

- PCP Provider Incentive 2022
- ACEs Presentation
- Annual regulatory trainings for providers
- Provider validation process
- Virtual navigation of HPSJ website (access standards, available training, communications, etc.)

We look forward to your participation! Add to your Calendar

Provider Manual Change – Updated HCD List

HPSJ updated the High-Cost Drug Claim Submission and Payment Rules. You can find updates to the comprehensive drug list in **Section 10** of the Provider Manual: www.hpsj.com/provider-manual

- **Effective Date: April 1st, 2022**
- **The claim must be billed with revenue code 0636, HCPCS code and NDC code**
- **Claims for high-cost drugs will be paid according to the provider's agreement**

Do you have a prenatal or postpartum patient who needs case management or social work support?

Your local Maternal Child Adolescent Health (MCAH) programs are here to support the community. The following are no-cost resources for prenatal, postpartum people and parents of children.

Refer your patients to:

San Joaquin County:

- Nurse Home Visiting
- Black Infant Health
- Healthy Families San Joaquin
- Safe Sleep San Joaquin

Phone: 209.468.3004

Fax: 209.468.2072

For a copy of the referral form, email
mcah-info@sjcphs.org

Stanislaus County:

- Nurse Family Partnership
- High Risk Maternal and Child Health
- Adolescent Family Life Program

Phone: 209.558.7400

Fax: 209.558.8315

For a copy of the referral form, email
PHN-CHS@schsa.org

These programs help parents develop skills to take better care of themselves and their babies. Parents will have access to their own specially trained Public Health Nurse, or Social Worker as well as a network of support. There is no cost to community residents and programs will connect participants to other vital resources* such as:

- Free car seats and safety training
- Free diapers
- Free cribs and safe sleep tips
- Breastfeeding and postpartum support

Support can include home visits, group sessions, or case management depending on the specific program and participant need. To learn more about each individual program email the or call using the information above and request details about their programs and services.

***Resources are dependent on each county and only available while supplies last.**

2022 Quality Measures and Incentives

HPSJ's Quality and Provider Services teams will guide you on how to access updated monthly lists of your patients that require the service/test. We will also share best practices for increasing compliance.

HPSJ teams outreach to patients through texts and calls and provide incentives for key services to encourage them to schedule and keep appointments.

You can check out our member incentive program at www.hpsj.com/hpsj-member-rewards

2022 Primary Care Physician Incentives

Quality Improvement Measures - HEDIS®	Description for Providers - HEDIS® Measure	Incentive Per Measure*
Breast Cancer Screening (BCS)	Women 50 - 74 years of age who had a mammogram to screen for breast cancer.	$50
Cervical Cancer Screening (CCS)	CCS women 21-64 years of age who were screened for cervical cancer.	$50
Childhood Immunization Status Combination 10 (CIS)	Children received Combination 10 vaccines by age 2.	$50
Chlamydia Screening (CHL)	Women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	$50
Controlling High Blood Pressure (CBP)	Adults 18-85 years of age who were diagnosed with hypertension and whose blood pressure was adequately controlled (<140/90 mmHg).	$50
HBD-HbA1c Poor Control	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9.0%)*	$50
IMA- Immunizations for Adolescents Combination 2	Adolescents received Combination 2 vaccines by age 13.	$50
Initial Health Assessment (IHA)	IHA is first 120 days after enrollment into the plan.	$50
Lead Screening in Children (LSC)	Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	$50
Well-Child Visits (W30) (Calculated as 2 separate measures)	Well child visits in the first 30 months of life. 1. 6+ Visits in 15 months 2. 2+ visits 15-30 months	 $50 $50
Well-Child Visits 3-21 (WCV)	Annual well child visit for 3-21 year olds.	$50

2022 FQHC/RHC Incentives

Measures	
Breast Cancer Screening (BCS)	Cervical Cancer Screening (CCS)
Childhood Immunization Status Combination 10 (CIS)	Chlamydia Screening in Women (CHL)
Controlling High Blood Pressure (CBP)	HBD-HbA1c Poor Control - Diabetic patients with A1c >9 (lower is better)
IMA- Immunizations for Adolescents Combination 2	Initial Health Assessment (IHA)- IHA is first 120 days after enrollment into the plan
Lead Screening in Children (LSC)	Prenatal Visit (PPC-Pre) First routine prenatal care visit (within the time frame)
Postpartum visit (PPC-Post) 1-84 days after delivery	Well-Child Visits (W30) (Calculated as 2 separate measures) 1. 6+ Visits by 15 months 2. 2+ Visits 15-30 months
Well Child Visits 3-21 years (WCV)	

Questions about incentives? Contact our Provider Services team: providerservicesdepartment@hpsj.com

Questions about quality measures? Contact our Quality team: HEDIS@hpsj.com

Enhanced Care Management and Community Supports

Starting in January of 2022, new benefits and services called Enhanced Care Management (ECM) and Community Supports (CS) became available for Medi-Cal members in San Joaquin County. They will be implemented in Stanislaus County effective July 1, 2022.

Enhanced Care Management (ECM)

The ECM benefit is designed to provide a whole-person approach to care that addresses both clinical and non-clinical needs for high need Medi-Cal beneficiaries. It is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. ECM offers no-cost services to qualifying members to:

- Improve care coordination and integrating services
  - Person-centered, goal oriented and culturally relevant to ensure members receive needed services in a supportive, effective, efficient, timely and cost-effective manner
  - Face-to-face member visits, when possible, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports
  - Keep doctors updated on member health needs and wishes
  - Understand medication needs and how to access refills
- Address social determinants of health
- Connect members to needed community and social services through assessment and referral to CS as appropriate

Current ECM populations of focus being treated (DHCS website: California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management)

Populations experiencing homelessness and

- Have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage

Adult high utilizers

- Five or more avoidable emergency room visits in a six-month period; AND / OR
- Three or more preventable unplanned hospital and / or short-term skilled nursing facility stays in a six-month period.
- Individuals with a pattern of very high utilization

Adult with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) and

- Are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to stable housing, history of Adverse Childhood Experiences (ACEs) AND
- Meet one or more of the following criteria: are at high risk for institutionalization, overdose and/or suicide. Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care

Community Supports (CS)

Community Supports (CS), previously known as In Lieu of Services or ILOS, are medically appropriate and cost-effective services. CS services are optional for members, and they are not required to use them.

HPSJ has the option to offer Community Supports from a list of services pre-approved by the Department of Health Care Services (DHCS) and may add or remove services as needed. HPSJ has elected to offer all 14 services over time.

HPSJ is rolling out CS in phases:

San Joaquin County effective January 1, 2022, and Stanislaus County effective July 1, 2022
▪ Housing Transition Navigation Services
▪ Housing Deposits
▪ Housing Tenancy and Sustaining Services
▪ Short-term Post-Hospitalization Housing
▪ Recuperative Care (Medical Respite)
▪ Meals / Medically Tailored Meals
▪ Sobering Centers

San Joaquin County and Stanislaus County effective July 1, 2022
▪ Asthma Remediation
▪ Environmental Accessibility Adaptations (Home Modifications)

ECM members may qualify for CS however CS is not restricted solely to members receiving ECM, and other members may be eligible. ECM and CS will continue to be made available to additional populations through July 2023.

Important Reminders

- For ECM, primary care providers should participate in coordination efforts as a member of the interdisciplinary care team.
- ECM and CS referrals should be made following HPSJ ECM and CS referral and authorization guidelines.
  - Faxes sent to 209.942.6302
  - Refer through provider portal

Information on ECM and CS is available in HPSJ's Provider Manual (Pages 12-21) at www.hpsj.com/provider-manual. If you have questions or need assistance, please call our Provider Services team at 209.942.6340.

Adverse Childhood Events (ACEs) Screening

What is ACEs?

Adverse Childhood Events, or ACEs, are a variety of traumatic and/or stressful events that are experienced during childhood. These events contribute to what is considered "toxic stress", which has lasting effects upon the body, increasing risk for various health issues and may reduce life expectancy.

What is required for ACEs Screening?

ACEs screening requires either the provider or the patient/parent to fill out a questionnaire that helps identify the number of ACEs experienced by an individual. For children/teens ages 12-19, the questionnaire can be filled out either by the parent, or by the patient themselves. These forms should be maintained in the patient health record. Providers may screen members utilizing a qualifying ACEs questionnaire or PEARLs tool as often as deemed appropriate and medically necessary.

Is Telehealth allowed for screening?

Yes, per DHCS, it is allowed if the provider believes that the screening can be given in a clinically appropriate manner during the visit and with documentation in the medical record.
Documentation must include:

- The tool that was used
- That the completed screen was reviewed
- The results of the screening
- The interpretation of the results
- What was discussed with the member/family
- Any actions taken (if appropriate)

What should you do if the patient has a high-risk score?

High risk scores for ACEs are considered an ACE score of 4 or greater. If you think the member can benefit from counselling, please call to refer, or have the member call, Beacon Health Options at (888) 581-7526 to assist with finding an in-network therapist.

Patients identified with other Social Determinants of Health (SDOH), like homelessness or food insecurities, can benefit from several programs in the community and potentially from some of the Community Support Services offered by HPSJ.

Please contact HPSJ's Case Management and Social Work teams if a member requires assistance connecting with these programs.

Case Management: 209.942.6352

HPSJ Social Work: 209.942.6395

Reimbursement for Screenings

Per DHCS APL 19-018, "Each Managed Care Plan (MCP) is required to make the $29.00 required minimum payment to a particular Network Provider:

- Once per year per Member screened by that Provider, for a child Member assessed using the PEARLS tool, and
- Once per lifetime per Member screened by that Provider, for an adult Member through age 64 assessed using a qualifying ACEs questionnaire."

ACES Training and Other Tools

All Providers are required to take the training and attest that they have completed the training to DHCS. Plans can provide payment only to providers that have attested to training.

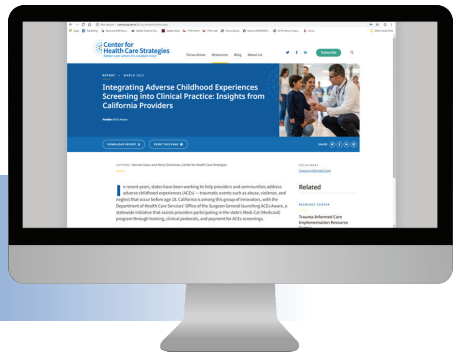
Website for core training, attestation & other resources for you and your staff: www.acesaware.org/learn-about-screening/training/. The required training is "Becoming ACEs Aware in California". This certification is required to receive Medi-Cal reimbursement for ACE screenings. Don't forget to fill out the Attestation Form once complete: Medi-Cal: ACEs Provider Training Attestation

Screening Tools (available in 17 languages): www.acesaware.org/learn-about-screening/screening-tools/

Billing/Payment information: www.acesaware.org/learn-about-screening/billing-payment

The Center for Health Care Strategies' March 2022 report shares perspectives from Medi-Cal providers on how to effectively integrate ACE screening into clinical practice for children and adults.

Read the Report: Integrating Adverse Childhood Experiences Screening into Clinical Practice: Insights from California Providers - Center for Health Care Strategies (chcs.org)



Update: Transition of Pharmacy Services

On January 1, 2022, the pharmacy benefits for Health Plan of San Joaquin were transitioned to Medi-Cal Rx, the new California State agency. There have been challenges since the benefit was launched. The state implemented changes to ensure that beneficiaries can continue to get their medications filled. Details regarding the transition can be found at: www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx.

Providers that continue to have challenges filling medications at the point of sale are encouraged to reach out directly to Medi-Cal Rx. Call the 24/7 Medi-Cal Rx Call Center Line, 1.800.977.2273, TTY 711, or visit www.Medi-CalRx.dhcs.ca.gov for help. If there are further questions and Medi-Cal Rx is unable to assist, contact the HPSJ Pharmacy Team at pharmacydepartment@hpsj.com or via HPSJ's secure voicemail at 209.461.2212. They will respond within one business day.

Caravan FOR Health

As part of HPSJ's Back to Care initiative, we have launched a new community outreach model – Caravan for Health. The goal of Caravan for Health is to engage providers and members at local community events to complete well care exams. Events include local baseball games through a partnership with Modesto Nuts and Stockton Ports, Tracy African American Chamber Juneteenth celebration, Family Resource & Referral Children & Youth Day, and many other opportunities throughout the summer.

"By convening our primary care doctors and local resources at public events and health fairs, we create a convenient way for members to complete exams that have been put off throughout the pandemic. Community wellness can be achieved by coming together to improve access to health care services." – Andrea Swan, Director of Quality

Any HPSJ contracted provider can participate. Services include:

- Well-child exams
- Immunizations/flu shots
- Blood pressure checks
- COVID-19 tests and vaccines
- Well-woman exams (mammogram, cervical cancer screenings, etc.)
- Sports physicals

HPSJ will notify members that they can make an appointment with their primary care doctor to complete their well care visit or attend a local health fair. **Please remind members to bring a photo ID, HPSJ member ID card, and Child Immunization Card.**

HPSJ will provide giveaways that include:

- Backpacks for school-age children that include school supplies
- Women's and men's self-care items
- Other health education material
- Tickets to Stockton Ports baseball games (100 tickets available per game that HPSJ attends – see dates below)

While supplies last! HPSJ will provide backpacks to our provider partners. If you cannot store the items in the office, you can receive vouchers to pass along to your HPSJ patients. HPSJ members can pick up their backpack at any of the community events planned after June 15th.

Modesto Nuts Health Fair Events at John Thurman Field

601 Neece Dr, Modesto, CA 95351

May 27th | 12 P.M. - 7 P.M. Dia de la Mujer – Women's Health

June 17th | 12 p.m. - 7 P.M. Carros Locos – Men's Health

July 29th | 12 p.m. - 7 P.M. Dia de Los Estudiantes – Children's Health Backpack Drive

Stockton Ports Health Fair Events at Banner Island Ballpark

404 W Fremont St, Stockton, CA 95203

May 21st | 12 P.M. - 7 P.M. Women's Health

June 12th | 8 a.m. - 3 P.M. Men's Health

July 17th | 11 a.m. - 6 P.M. Children's Health Backpack Drive

Visit www.hpsj.com/care for other upcoming health fairs and more backpack pick up locations.

Developmental Screening (DEV) in the First Three Years of Life

DEV is a Centers for Medicare and Medicaid Services (CMS) Core Set measure that is also part of the Department of Healthcare Services' (DHCS) Managed Care Accountability Set (MCAS) measures. DEV tracks the percentage of children screened for risk for developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on their first, second, or third birthdays. This measure includes children ages 1 year old to 3 years old.

What is Required for DEV?

Children should be screened, at a minimum, once by age 1, once more by age 2, and once more by age 3. Documentation in the medical record should include all of the following:

- A note indicating the date the test was performed
- A standardized tool recognized by Bright Futures and the American Academy of Pediatrics (https://publications.aap.org/toolkits/resources/15625/)
- Evidence of a screening result or screening score

The M-CHAT (Modified Checklist for Autism in Toddlers) does not count for this measure. This measure is specific to general developmental surveillance that should occur with all children, not just at-risk children. The M-CHAT can be done in tandem with this screening at the recommended ages for Autism testing.

How do I bill for DEV?

DEV is an administrative measure and data can only be collected through claims and encounter data. It is important that you ensure you have coded all of your claims and encounters for your patients' visits to the highest level of specificity.

Code Type	Code	Definition
CPT	96110	Developmental Screening

For frequency of billing and other coding recommendations, please see page 16 of the Medi-Cal Provider Manual for Preventative Services at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/prev.pdf

What do I do if a child screens positive for developmental delays?

Children who get screened as positive for developmental delays should be referred to Valley Mountain Regional Center (VMRC). Children who are identified as having Autism or as possibly Autistic can also be referred to Beacon for Autism services.

- **Beacon Referral Line: 888.581.7526**
- **VMRC Referral Line: 209.955.3281 (San Joaquin County); 209.557.5619 (Stanislaus County)**

HPSJ's Case Management and Social Work departments are here to assist with connecting members and their families to needed services.

Case Management
209.942.6352

HPSJ Social Work
209.942.6395

If you have questions about the DEV measure and its requirements, please contact our Quality team at HEDIS@hpsj.com.

Additional Resources

Here is more information on general developmental screening guidelines:

- https://publications.aap.org/pediatrics/article/145/1/e20193449/36971/Promoting-Optimal-Development-Identifying-Infants
- https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf
- https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_ECVisits_BF4.pdf

You can view HPSJ's Provider Alert from March 7, 2022

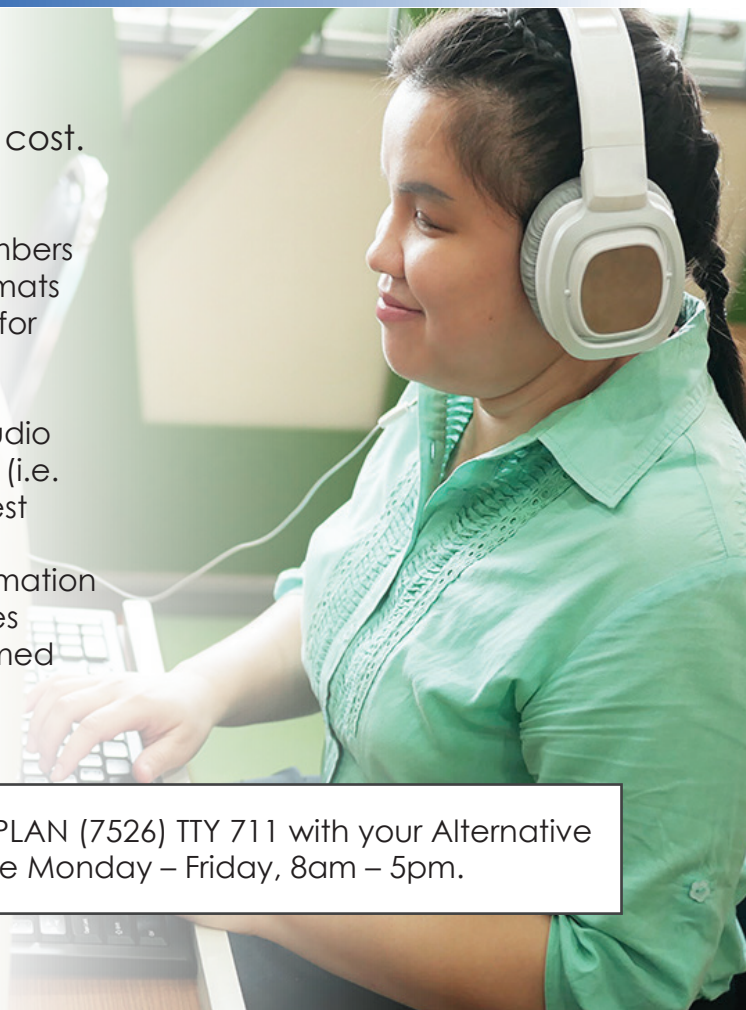
Read the Alert

New Director Leading HPSJ Contracting Team

Health Plan of San Joaquin is happy to announce the arrival of Helen Bayerian, Director of Provider Contracting. Helen has worked in the Medi-Cal managed care provider contracting arena for over 16 years, where she has been part of the evolution of the Medi-Cal program. Helen finds contracting to be very challenging and rewarding, believing in the mission to address the needs of the Medi-Cal population. Helen's experience includes strategic planning to address access, quality, and improved health outcomes. Helen oversees our dedicated contracting team and works collaboratively with the Provider Relations Department to serve our provider community. Helen looks forward to partnering with our valued providers.

"In the coming year, we will be working on California Advancing and Innovating Medi-Cal (CalAIM), a Medi-Cal initiative focused on a population health approach, utilizing prevention and attention to whole person care by extending care beyond the current health care settings directly into the communities we serve. We will also continue to develop our provider network and contract with essential specialties and services for our members and enhance the provider experience." – Helen Bayerian (Director, Provider Contracting)

Alternative Format Communication



HPSJ members have the right to request member informing materials in an alternative format at no cost.

What is alternative format?
Alternative format is a way of communicating with members who are visually impaired. HPSJ provides alternative formats like Braille, audio CD, large print, and electronic format for easy reading.

If a member selects an electronic format, such as an audio or data CD, the information will be provided encrypted (i.e. password protected). However, the member can request to receive the information unencrypted (not password protected). Unencrypted materials may make the information more vulnerable to loss or misuse. If the member chooses unencrypted materials, they will have to fill out an informed consent before HPSJ can mail the materials.

Call HPSJ Customer Service Department at (888) 936.PLAN (7526) TTY 711 with your Alternative Format Request. Customer Service is available Monday – Friday, 8am – 5pm.

Thriving Partnerships

HPSJ is proud to partner with Golden Valley Health Centers and we congratulate them on 50 years of service to the community! GVHC provider, Dr. Elaine Soriano, shares HPSJ's passion to serve the underserved population and provide quality care.

Q and A

Dr. Soriano recently received the Employee of the Year award with GVHC and states, "I am very humble to receive this award and deeply honored because I feel that it is my duty as a physician to advocate for people and patients, especially the marginalized. It's an honor to have been chosen for this award. My team and Golden Valley leadership have been instrumental. I am thankful for their support and for the opportunities given to me. It takes a great organization to achieve the things we have been able to achieve in the community."

"My personal mission is to provide quality care for our patients and reduce barriers to access for everyone in our community regardless of language, ethnicity, age, culture, financial capabilities. To advocate for the underserved patients and always provide quality care regardless of their financial capabilities. I always treat my patients as a family member."

HPSJ has launched a Back to Care initiative that includes a focus on children's health. As a pediatrician, we wanted to know more about Dr. Soriano's passion to serve her younger patients. "I am an advocate of preventative medicine and I work to emphasize how important that is for the children. I always emphasize to our providers and students that well child visits are a partnership between the parent (or legal guardian) and the pediatrician for the care of the child. I am passionate about well child visits because I believe that if you get children healthy at an early age, they become healthy adults. If you get them immunized, pay attention to the preventative medicine, and educate the parents when the child is young, we as providers are making a huge impact because these children will stay healthy, and it empowers them to become healthy and empowered individuals. One of my other passions is being an immunization advocate. Immunizations provide access to care that sometimes is overlooked. We can prevent so many diseases with immunizations. This is what motivated me to partner with HPSJ for the immunization drive-up clinics."

Because Dr. Soriano's mission aligns with that of HPSJ, we asked her if she is currently working on any special community projects.
"With the support of our former CMO/COO, Dr. Ellen Piernot, I was able to become the lead provider for the immunization drive-up clinic. In partnership with HPSJ, we were able to serve our community through the pandemic. I also worked with the nursing department and operational department to establish the antibody clinic."

As we encourage HPSJ members to get back to care, Dr. Soriano shares with us what she is looking forward to most.
"I look forward to more patients coming in for in-person well child visits and immunizations. I am looking forward to partnering with HPSJ and others to get patients back in our clinics and get the preventative care they need. I am looking forward to patients getting their COVID-19 vaccine and educating them on the benefits of the vaccine - helping them understand the importance of the vaccine and how it does not only provide protection to them but also their family members and the community."

"I would like to say to other providers in the community that we all need to advocate for our patients. We must partner with parents. We must remember why we became health care providers – do the right thing, make sure we are offering quality care to our patients, and break down barriers to allow patients access to quality care. Be well-child warrior and an advocate!"

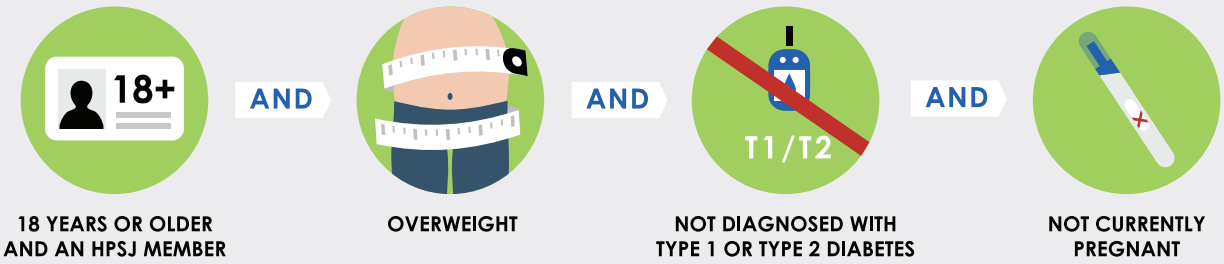
Have Your Patients Enrolled in HPSJ's Diabetes Prevention Program?

It's Not Too Late!

Refer your HPSJ patients today

HPSJ is contracted with Melon Health to provide a comprehensive Diabetes Prevention Program.

To be eligible for the program, members must meet ALL of the following criteria:



18 YEARS OR OLDER AND AN HPSJ MEMBER

OVERWEIGHT

NOT DIAGNOSED WITH TYPE 1 OR TYPE 2 DIABETES

NOT CURRENTLY PREGNANT

AND Meet ONE of these

DIAGNOSED WITH PREDIABETES

PREVIOUSLY DIAGNOSED WITH GESTATIONAL DIABETES

HIGH-RISK RESULT ON PREDIABETES RISK TEST

WWW.HPSJ.COM/DPP

Your HPSJ patients receive:

- A CDC - approved curriculum
- The skills to help members enjoy life and handle stress
- A trained lifestyle coach to help support members
- Support from other people with the same goals as members — and fun
- A year-long virtual program through an app
- Weekly modules for the first 6 months, then once or twice a month for the following 6 months

DPP is NOT for those who have Type 1 or Type 2 diabetes or are pregnant at this time.

You can refer members by visiting www.melonhealth.com/dpp and providing the patient information in the contact us section.

For more information visit www.hpsj.com/dpp or contact health education via voicemail 209.942.6356 or email healtheducation@hpsj.com.