Health Plan of San Joaquin

Look and Learn
3rd Quarter
August 16, 2023

Community • Partnership • Wellness

Agenda

Operational Updates - *Presenter: J'neen Abramjian, Manager, and Claudia Potosme, Provider Relations Representative II*

- HPSJ Network
- HPSJ Mandatory Provider Training
- Provider Semi-Annual Validation
- Medi-Cal Renewal Process

ECM/CS/ UM - *Presenter: Niyati Reddy, Director of Special Projects Operations & Andrea Smith, RN, Manager of Transition of Care*

- Updates on Reporting
- Policy Updates
- Incentive Payment Program (IPP)
- Transitional Care Services (TCS)

HEDIS - Presenter: Vanessa Lagemann, Manager of HEDIS and Accreditation

- HEDIS Update

Health Education - *Presenter: Setar Testo, Manager of Health Education*

- Member Incentives

Next Look and Learn: November 8th, 2023

Health Plan of San Joaquin

Operational Updates

J'neen Abramjian, Manager
Claudia Potosme – PR Rep II

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Meet the Provider Services TEAM

Ana Aranda, Director of Provider Services

J'neen Abramjian, Manager of Provider Services

Provider Services Representative I

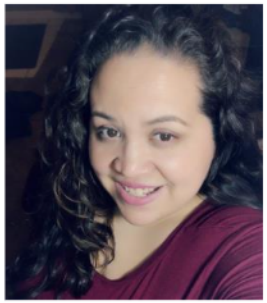
Elizabeth Bossen

Kavita Chand

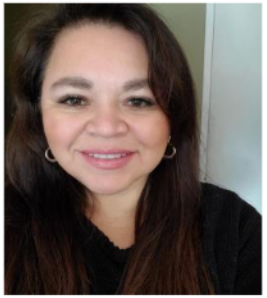
Tamese Livers

Provider Services Representative II

Claudia Potosme



Christina Villar



Evelyn Terra

Susana Medina

Health Plan of San Joaquin (HPSJ) Network

HPSJ Network	San Joaquin	Stanislaus	Both Counties
Primary Care Physician (PCP)	154	122	283
Specialist (SPC)	370	202	578
Hospitals			14
Federally Qualified Health Centers (FQHC's)			6
Rural Health			9
Enhanced Care Management (ECM)/ Community Services (CS)			29

HPSJ Mandatory Annual Provider Training

- ❑ Cultural Competency and Sensitivity Training
- ❑ Anti-Fraud, Waste, and Abuse Training
- ❑ HIPAA Provider Training

Link: https://www.hpsj.com/provider-trainings/

Attestations are required to receive credit for the completed training!

Provider Data Validation

Mailed out 2nd reminder – July 2023

Forms to be completed:

- Attestation Roster Template
- Roster Template

Link:

https://www.hpsj.com/forms-documents/

Attestation Roster Template	Jan 25th, 2023
Roster Template HPSJ 2022	Dec 13th, 2022

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Medi-Cal Renewal

Renewal Period

- April 1 to June 30, 2023 – First Phase Ended

- July 1, 2023 – First day a Medi-Cal recipient will not have coverage if they do not complete and turn in their Medi-Cal Renewal on time to their County Office.

Mountain Valley Network – Effective 1/1/2024

Mountain Valley Provider Network / Alpine and El Dorado

- 70 managed care enrollees in Alpine
- 19,100 managed care enrollees in El Dorado
- Hundreds of Medi-Cal providers at over 76 sites in Alpine and El Dorado

Mountain Valley Network – Effective 1/1/2024

Provider Network / Alpine and El Dorado

Provider	Type	County
Alpine County Public Health	Primary Care / Behavioral Health Services	Alpine County
Barton Healthcare Systems	Primary Care Physicians (PCP) / Mixed Specialties / Behavioral Health	El Dorado County
Barton Medical Foundation and Hospital	Hospital	El Dorado County
Better Life Counseling	Behavioral Health	El Dorado
El Dorado Community Health Clinics	FQHC - Primary Care Physicians (PCP) / Mixed Specialties / Behavioral Health	El Dorado County
El Dorado County Public Health	Public Health Provider (e.g., California Children Services (CCS), Clinical Testing, Communicable Prevention)	El Dorado County
Marshall Medical Center	Primary Care Physicians (PCP) / Mixed Specialties / Behavioral Health	El Dorado County
Marshall Medical Center	Hospital	El Dorado County
Shingle Springs Health and Wellness Center	Primary Care Physicians (PCP) / Mixed Specialties / Behavioral Health	El Dorado County
Vitreo-Retinal Medical Group	Specialist	El Dorado County
WellSpace Health	Specialist / Behavioral Health	Placer and Sacramento Counties

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CalAIM: Enhanced Care Management and Community Supports Update

Niyati Reddy

Director of Special Projects, Operations

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California Advancing & Innovating Medi-Cal (CalAIM)

- CalAIM is an initiative launched by DHCS to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, program, and payment reforms across the Medi-Cal program.

- As initial benefits and services of CalAIM, Enhanced Care Management offers intensive care coordination services for high need members. Community supports offer supportive services which address social determinants of health which often impact health outcomes.

- ECM and CS Key Goals:
  - Improved care coordination
  - Integrated services
  - Facilitating community resources
  - Addressing social determinants of health (SDOH)
  - Improving health outcomes
  - Decreasing inappropriate utilization and duplication of services

ECM Populations of Focus and Timeline

Go Live Timing	Populations of Focus
July 1, 2023	▪ Adults without Dependent Children/Youth Living with Them Experiencing Homelessness ▪ Children and Youth Populations of Focus o Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness o Children and Youth At Risk for Avoidable Hospital or ED Utilization o Children and Youth with Serious Mental Health and/or SUD Needs o Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition o Children and Youth Involved in Child Welfare o Children and Youth with I/DD o Pregnant or Postpartum Youth
January 1, 2024	• Birth Equity • Individuals Transitioning from Incarceration (Justice-Involved)

HPSJ Community Supports

Housing Transition Navigation Services	Nursing Facility Transition/Diversion to Assisted Living Facilities
Housing Deposits	Community Transition Services/Nursing Facility Transition to a Home
Housing Tenancy and Sustaining Services	Personal Care and Homemaker Services
Short-Term Post-Hospitalization Housing	Environmental Accessibility Adaptations(Home Modifications)
Recuperative Care (Medical Respite)	Medically-Supportive Food/Meals/Medically Tailored Meals
Respite Services	Sobering Centers
Day Habilitation Programs	Asthma Remediation

DHCS – Recent Release of ECM/CS Statewide Policy Guides

DHCS just released updated policy guidance for ECM and Community Supports in multiple areas: Contracting, Referrals, Authorizations and Claims

ECM Policy Updates Summary:

- Contracting
  - HPSJ will contract with ECM providers specializing in each of the specific PoF who have an existing footprint in the communities they serve.
  - HPSJ will list all ECM and CS providers in the Provider Directory under 'Other Service Providers'
- Eligibility
  - HPSJ follows eligibility criteria set forth by DHCS and will not impose additional eligibility criteria for authorization of ECM
  - HPSJ will not withhold authorization until a care plan has been completed
  - No annual reassessment is required for continued authorization.

DHCS – Recent Release of ECM/CS Statewide Policy Guides

ECM Policy Updates Summary (cont)

- Referrals
  - HPSJ will be responsible for regularly and proactively identifying members who meet ECM eligibility criteria via referrals from the community
- Assignment
  - Some continuity of care rights apply for members who move MCPs or counties
  - HPSJ will prioritize assignment of the Member to a provider that is already known and trusted by the Member

DHCS – Recent Release of ECM/CS Statewide Policy Guides

CS Policy Updates Summary:

- Contracting
  - HPSJ will contract with organizations that have experience delivering CS services and an existing footprint in the communities they serve. This includes "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system
- Referrals
  - DHCS expects MCPs to develop the relationship needed to source the majority of referrals for CS from the community (i.e., PCPs, clinical providers, ECM and CS Providers and other CBOs)
  - HPSJ is required to inform Members of Community Support services
  - HPSJ will consider referral requests from Members from their families, guardians and caregivers, ECM Providers, CS Providers and other Providers

DHCS – Recent Release of ECM/CS Statewide Policy Guides

CS Policy Updates Summary (cont):

- Authorization
  - HPSJ has Policies for expediting the authorization of certain CS for urgent needs
    - Recuperative Care, Short-Term Post-Hospitalization Housing, Sobering Centers, and Medically Tailored Meals being offered post-acute care as time-sensitive and must be subject to expedited authorization
  - HPSJ has a process for presumptive authorization for all CS where a delay could harm a Member
- Eligibility
  - HPSJ will not restrict CS service definitions

ECM/CS Reporting Update - Purpose

- In April 2023, DHCS shared an updated version of the CalAIM Data Reporting Guidance based on ECM and Community Support Provider feedback.
- Statewide standardization has been requested between MCPs and ECM Providers to:
  - Maximize the comprehensiveness of information flowing to ECM providers to support care management
  - Prioritize key information that should flow back to MCPs; a d
  - Mitigate MCP and Provider burden associated with ECM, especially in counties with more than one MCP
- DHCS is requesting that MCPs, ECM and CS Providers must adopt the common standards described in this guidance

ECM Updated Reporting Requirements

Per DHCS CalAIM Data Reporting Guidance, the ECM Monthly Member Information and Member Response Files have been updated with:

- Additional required and optional fields (e.g., member homeless indicator, member preferred language, Populations of Focus)
- Frequency update: quarterly with same schedule as Quarterly Reporting
- Four (4) separate templates with new report naming convention (uploaded to File Exchange through DRE, will be e-mailed to you and uploaded to website)
- **Effective 07/25/23, HPSJ will require ECM Providers to use the new templates going forward**

ECM Updated Reporting Requirements

- **HPSJ ECM Member Information File Workbook (inclusive of 4 tabs)** (Monthly File from HPSJ to ECM Provider)

- HPSJ Member Response File, which was 1 file with 3 reporting tabs, has been separated into three (3) separate templates for easy monitoring:
  - **ECM Provider Return Transmission File** (Quarterly File from ECM Provider to HPSJ)
    - Previous template name: 'ECM Member Response'
  - **ECM Provider Initial Outreach Tracker File** (Quarterly File from ECM Provider to HPSJ)
    - Previous file template name: 'ECM Outreach Attempt'
  - **Potential ECM Member Referral File**(Quarterly File from ECM Provider to HPSJ)
    - Previous file template name: 'Referral Report'

ECM Updated Reporting Requirements

New File Name	Previous File/Tab Name	Updated Frequency	Naming Convention	Transmission
HPSJ ECM Member Information File		No change/Monthly		Outbound from HPSJ to Provider
ECM Provider Return Transmission File	ECM Member Response	Quarterly by 25th of the month following quarter end		Inbound from ECM Provider to HPSJ
ECM Provider Initial Outreach Tracker File	ECM Outreach Attempt	Quarterly by 25th of the month following quarter end		Inbound from ECM Provider to HPSJ
Potential ECM Member Referral File	ECM Potential Referral	Quarterly by 25th of the month following quarter end		Inbound from ECM Provider to HPSJ
ECM Quarterly Capacity Report	No change at this time	Quarterly by 25th of the month following quarter end		Inbound from ECM Provider to HPSJ
CS Quarterly Capacity Report	No change at this time	Quarterly by 25th of the month following quarter end		Inbound from CS Provider to HPSJ

New ECM Reporting Deadlines 2023

ECM Provider Return Transmission File
ECM Provider Initial Outreach Tracker File
Potential ECM Member Referral File

- **Q2** – April – June
  - Providers' Deadline Due Date is July 25, 2023
- **Q3** – July – September
  - Providers' Deadline Due Date is October 25, 2023
- **Q4** – October – December
  - Providers' Deadline Due Date is January 25, 2024

Community Support Reporting Requirements

Effective September 1, 2023, DHCS developed guidance to define standards for two key exchanges of information between MCPs and Community Support Providers to increase statewide standardization and facilitate efficient outreach to members, improve MCP's ability to track the status and progress of service delivery:

  - MCP Community Supports Authorization File (from MCP to each CS bi-weekly)
  - Community Supports Provider Return Transmission File (from CS Provider to MCP on a quarterly basis)

- HPSJ will be creating new templates to share with CS Providers by August 2023 and will provide training on these requirements and new templates. Stay tune for Training date.

NOTE: this new data sharing requirement do not apply to Members receiving sobering center services as those services are provided to members under urgent circumstances and are only covered for a duration of less than 24 hours

ECM/CS Quarterly Capacity Reporting Update

Effective November 14, 2023, DHCS is requesting MCPs to update the Quarterly Reporting templates with additional required and optional data fields for the following reports:

- Quarterly ECM Implementation Monitoring Reporting
- Quarterly Community Supports Implementation Monitoring Reporting

- HPSJ will be creating updated templates to share with you by September 2023 to be ready to be used for Q3 submission (November)

ECM/CS Quarterly Capacity Reporting Deadlines 2023

- **Q2** – April – June
  - Providers' Deadline Due Date is July 25, 2023
- **Q3** – July – September
  - Providers' Deadline Due Date is October 25, 2023
- **Q4** – October – December
  - Providers' Deadline Due Date is January 25, 2024

CalAIM: Incentive Payment Program (IPP)

- As the first set of CalAIM initiatives, Enhanced Care Management (ECM) and Community Supports programs required new investments for infrastructure and capacity building.

- To support these investments, CalAIM IPP includes goals to:
  - Build appropriate and sustainable capacity;
  - Make necessary investments to enhance delivery system infrastructure;
  - Bridge current silos across physical and behavioral health care service delivery;
  - Reduce health disparities and promote health equity;
  - Incentivize take up of Community Supports.

- The program period runs across three distinct program years from 2022 – 2024. Currently in Program Year 2 until 12/31/2023.

- Offering this incentive funding for pending and fully contracted ECM and CS HPSJ providers

CalAIM: Incentive Payment Program (IPP)

- Funding domains for the following priorities:
  - Delivery System Infrastructure
  - ECM Provider Capacity Building
  - Community Supports Provider Capacity Building and Community Support Take-Up
  - Quality and Emerging CalAIM priorities

CalAIM: Incentive Payment Program (IPP)

- If you are currently a contracted ECM or CS Provider with HPSJ or intend to/in process of contracting, your organization may request IPP funding through an application and review process:
  - Application Window is open until 09/01/2023
  - Request an IPP Application for Program Year 2 by sending an email to: nreddy@hpsj.com
  - Complete and submit IPP Application to Niyati Reddy
    - You must include the following with the application as part of the review process:
      - Funding Narrative/Request
      - Total funding request with a cost description and detailed budget with key milestones by 12/31/2023
      - Attestation that there is non-duplication of funding by other funding streams

Health Plan of San Joaquin

Transitional Care Services (TCS)

Mike Shook, RN

Director Utilization Management

Andrea Smith, RN

Manager Transition of Care

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Key TCS Components

For Members who are experiencing or are likely to experience a care transition, the following must occur:

- **TCS start** – within 24 hours of being made aware of a transition occurring
- Developing and regularly updating a discharge planning document for the Member; this includes facilitating discharge instructions developed by a hospital discharge planner or discharge facility staff.
- Ensuring the completion of discharge risk assessment and coordinating any follow up provider appointments and support services to facilitate safe and appropriate transitions from one setting or level of care to another.
- Coordinating medication review/reconciliation.
- Providing adherence support and referral to appropriate services
- **TCS end -** once the member has been connected to all needed services, including those identified through the discharge risk assessment

HPSJ Collaboration Components:

- **1:1 discussions with those in the facility who may already be doing care coordination around member transitions**
  - Does discharge care coordination already exist in the facility?
  - What components of TCS is the facility already addressing or open to addressing?
    - DC follow-up visit scheduling
    - Coordination of benefits
    - Referrals to other needed services
- **Establishing contact methods to share information on the different TCS components facilities may be engaged in**
  - Contact preferences – ex: phone call vs. secure email
  - Creation of templates for information exchange
  - Establishing regular opportunities to meet and discuss TCS
- **Offer of support and access to HPSJ information and resources**
  - The HPSJ TCS team is available for discussion and support in implementing or communicating TCS components
  - The HPSJ TCS team has DHCS approved TCS material available for co-branding for other facility/provider use
  - The HPSJ TCS team can serve as subject matter experts on TCS components and assist in problem solving

Resources/References

- **CalAIM Population Health Management (PHM) Policy Guide:** https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-May-Update-0509023.pdf
    - **TCS considerations begin on pg. 26**

HPSJ Specific Contacts:

- TOC: Andrea Smith, Manager Transition of Care: asmith@hpsj.com
- General: Customer Service: 8am-5pm: (888) 936-Plan (7526)

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Converged Provider Data Enablement

Vanessa Lagemann, Manager, HEDIS and Accreditation

Community • Partnership • Wellness

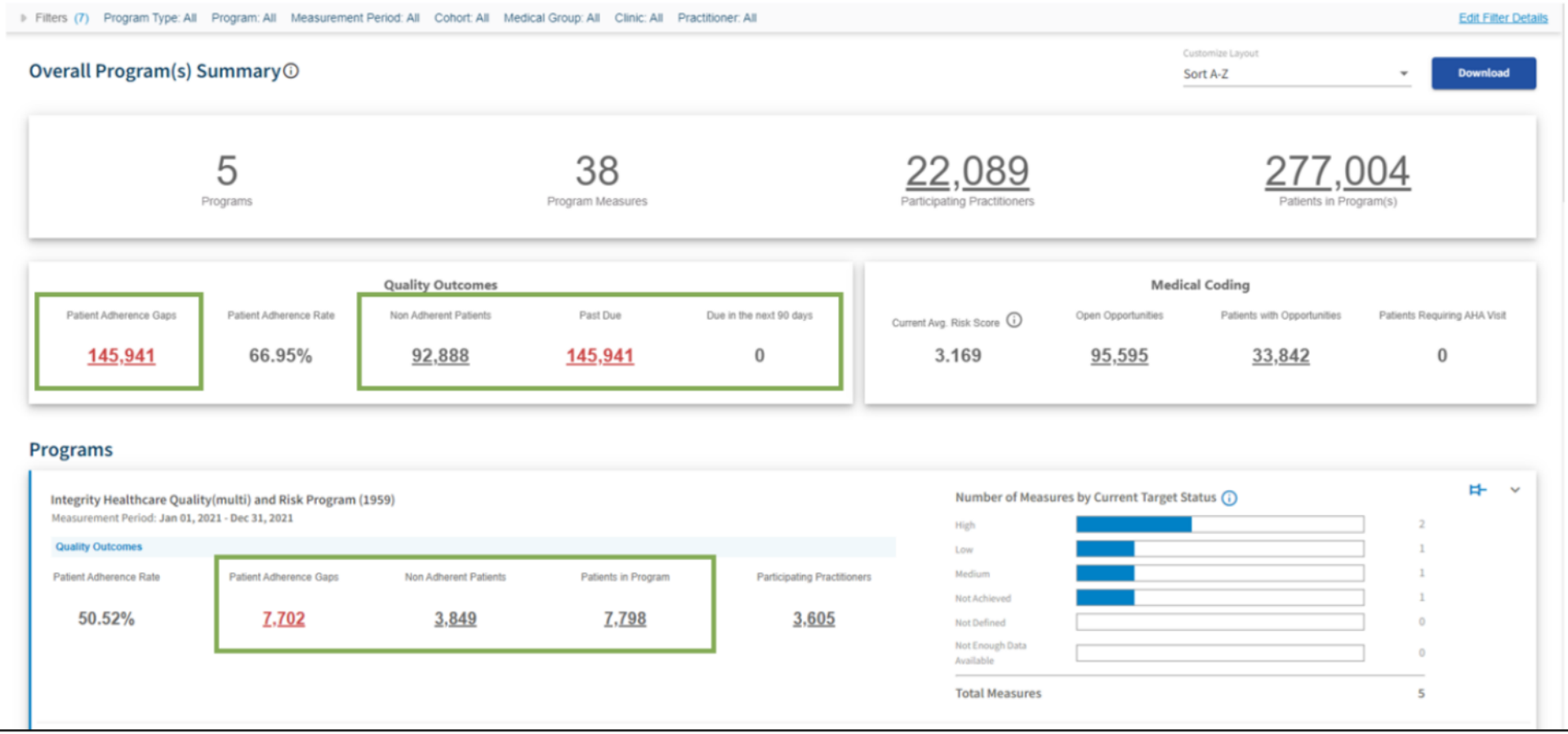
COMING SOON!

HPSJ is working with our new HEDIS vendor **Inovalon** to build out new Provider Portal:

Converged Provider Enablement

from

Sneak Peak – Drill into Patient Detail



Measure Name	Measure Weight	Current Measure Rate	Applicable Patients	Patient Adherence Gaps	Next Target Rate	Patients Needed to Reach Target	Target Status
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis MY 2021 - Age 18 to 64 years (AABMY21-AGE64)	1	38.46%	104	64	45.00%	7	Medium
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis MY 2021 - All Ages (AABMY21-TOTAL)	1	38.93%	131	80	60.00%	28	Low
Colorectal Cancer Screening MY 2021 - All Eligible Members (COLMY21-COL)	1	50.70%	7,665	3,779	-	0	High
Colorectal Cancer Screening MY 2021 - Non-Medicare Total (COLMY21-NONMCR)	1	50.70%	7,665	3,779	-	0	High

COMING SOON!!

Keep an eye out for upcoming Provider Alerts and Communications regarding:

- Official Launch Date
- Live Training Availability
- Training Videos and Guides
- AND MORE!

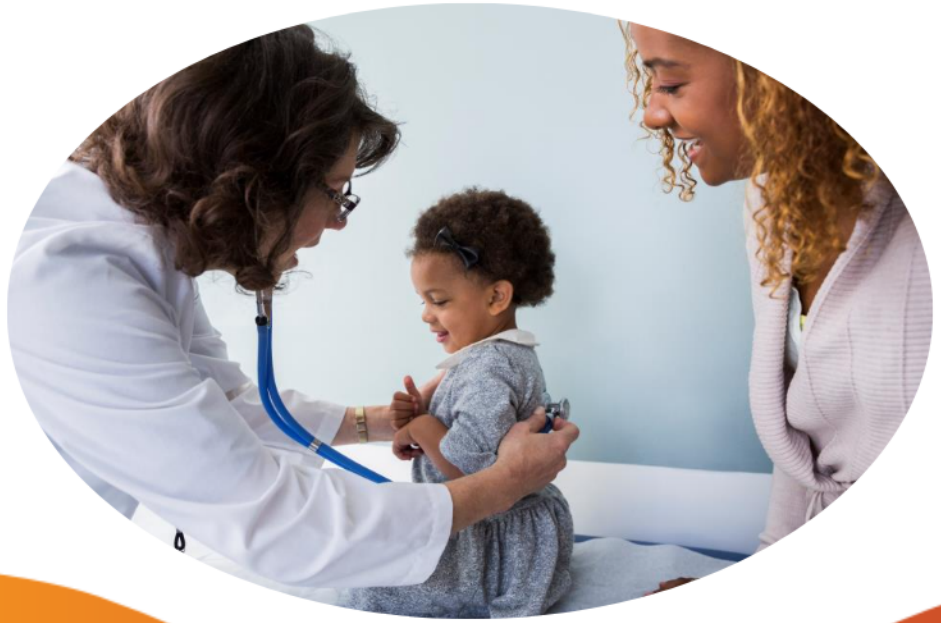
Lead Screening for Children 6 months to 6 years

Vanessa Lagemann, Manager, HEDIS and Accreditation

Health Plan of San Joaquin

LEAD SCREENING IN CHILDREN (LSC)

All California providers who perform Periodic Health Assessments (PHA) on patients between **the ages of six months to six years (72 months)** must comply with current federal and state laws and industry guidelines issued by the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB). The CLPPB updated guidelines align with the Centers for Disease Control and Prevention (CDC) guidelines published in 2021.



Lead Poisoning

- One of the most common and preventable environmental diseases
- NO KNOWN SAFE LEVEL
- Prevention is the best approach
- Screening – Blood lead test

Target Age Group

- Children 6 years and under
- Organs are still developing
- Young children prone to:
  - Increased hand to mouth activity
  - Pica
- Increased GI absorption
  - Lead absorption in children and adolescents – 50%
  - Lead absorption in adults 21 and older – 10%

Absorption of Lead

- Absorption and Storage
  - GI is the main absorption site
  - Respiratory
  - Absorption is similar to iron and calcium
  - Approximately 73% of total body lead is stored in bone
    - Half life of lead in blood is approximately 30-60 days
    - Half life of lead in bone is 10 – 30 years

Effects of Lead Poisoning

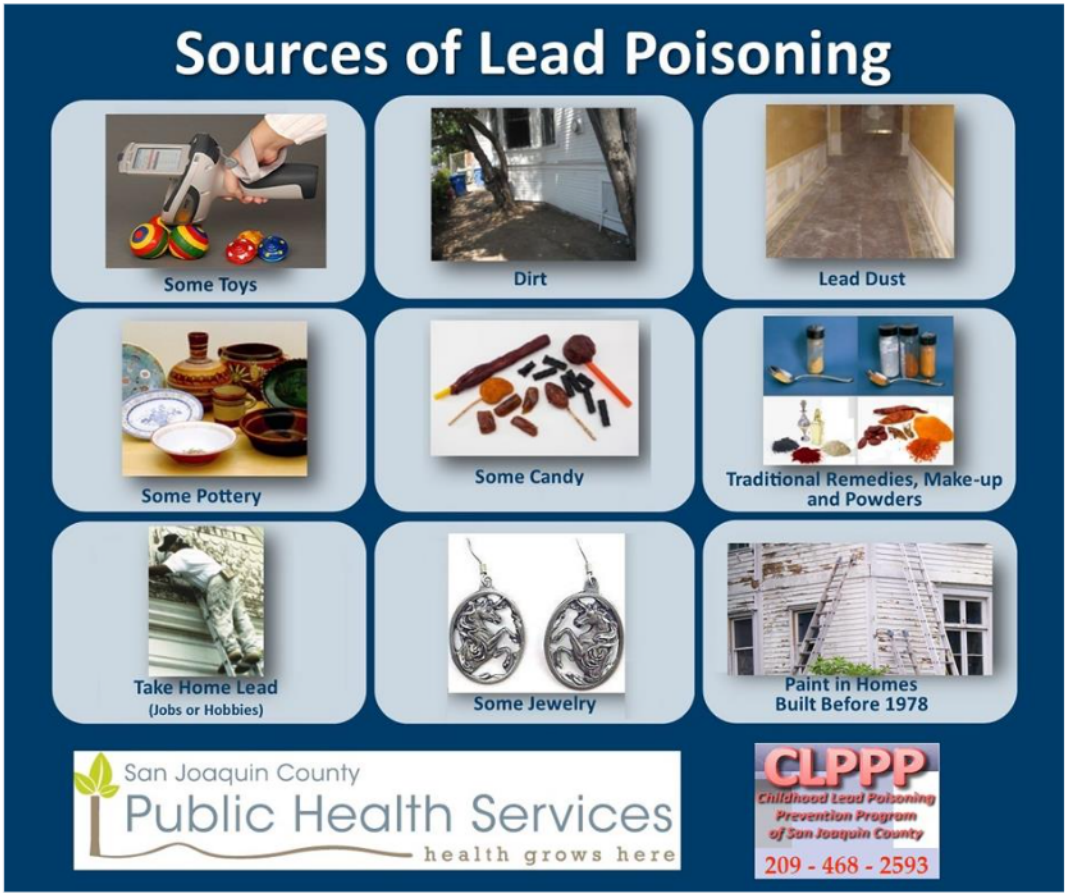
- Anemia
- Neurotoxin
  - Learning disorders
  - Lower IQ's
  - Attention Deficit Hyperactivity Disorder (ADHD)
- Other Disorders
  - Intrauterine Growth Restriction
  - Reproductive Disorders
  - Delayed Sexual Maturation
  - Behavioral Disorders

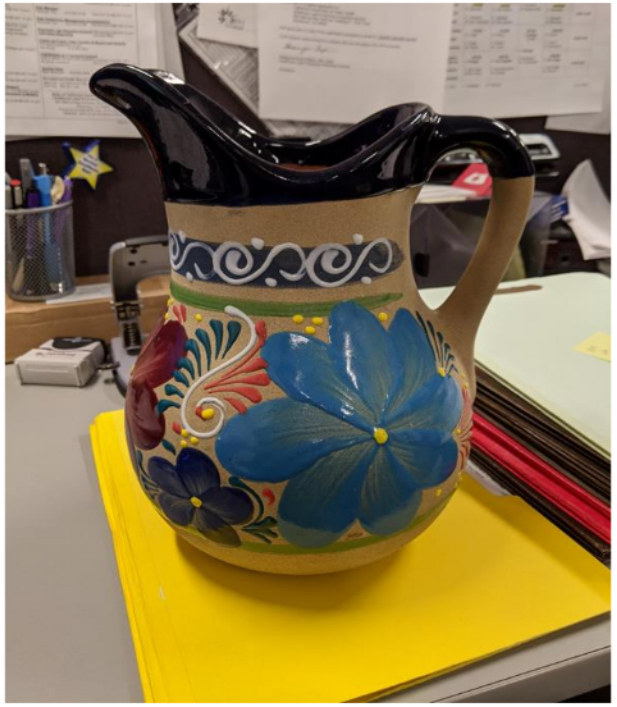
Earliest Clinical Symptoms

- Most children do not exhibit clinical symptoms
  - Do not look or act sick
  - May present with complaints of:
    - Stomachache, crankiness, headaches, loss of appetite
  - May also see
    - Anemia – Important to test Iron levels
    - Constipation

  - Symptoms seen by California Lead Poisoning Prevention Program (CLPPP) Coordinator
    - Earliest signs seen on home visits have been speech delays.

Sources of Lead





Sources of Lead Cosmetics

- Surma

Sources of Lead – Baby Food

- Parents should be advised to avoid baby food products that contain ingredients testing high in heavy metals, such as rice products
- We are now considering baby food products and baby juice as potential lead sources

Prevention is the Goal

- Family Education
  - Discuss risks with family
  - Document that education was provided
- Nutrition
  - Calcium and iron deficiencies can cause an increase in lead absorption
  - Encourage a variety of healthy foods from each food group
  - Frequent health snacks and meals

Prevention is the Goal

- Use cold water for drinking or mixing formula
- Housekeeping
  - Wet mop windowsills & floors. Dispose of dirty water in toilet, not sink.
  - Wash toys
- Wash child's hands often
- Use a door mat

Lead Screening Requirements

At a minimum, all Medicaid members 6 months to 6 years must receive documentation of:

- Oral or written anticipatory guidance/education about the dangers of lead poisoning in children provided to the patient's caregiver* **AND**
- Documentation of lead screening lab orders and results **OR**
- Documentation of signed refusal from the patient's caregiver including the reason for refusal.

*Anticipatory guidance for the dangers of lead poisoning **MUST BE** documented at every Patient Health Assessment

Oral and Written Guidelines

1. **Oral or written guidance on the harms of lead exposure.**
   - Especially from deteriorating or disturbed lead-based paint or dust
   - Children are particularly at risk around the time they begin to crawl until 72 months of age.
2. **Guidance must be provided to parent/guardian at EACH well child visit in this age range.**

Lead Testing

3. **Order or perform blood lead screening tests:**
   - Between the ages of 6 months – 12 months **AND**
   - Between the ages of 13 months – 24 months **OR**
   - Between 24 and 72 months where the patient has no record of a previous blood lead screening performed **OR**
   - Patients 6 months – 72 months new to your clinic with no prior evidence available of lead screening completed **OR**
   - If patient is refugee status, follows the CDC Recommended guidelines for Post Arrival Lead Screenings of Refugees.

Lead Testing for Immigration/Refugees

4. **Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.**

Recommended Screening Measures	Population
Initial lead exposure screening with blood test	○ All refugee infants and children ≤ 16 years of age ○ Refugee adolescents > 16 years of age if there is a high index of suspicion, or clinical signs/symptoms of lead exposure ○ All pregnant and lactating women and girls*
Follow-up testing with blood test, 3-6 months after initial testing	○ All refugee infants and children ≤ 6 years, regardless of initial screening result ○ Children and adolescents 7-16 years with EBLL at initial screening ○ Consider repeat testing in adolescents > 16 years of age with risk factors
*All newly arrived pregnant or breastfeeding women should be prescribed a prenatal or multivitamin with adequate iron and calcium. Referral to a healthcare provider with expertise in high-risk lead exposure treatment and management may be indicated for EBLLs.	

Testing Methods

What is the preferred testing method?

- Capillary (finger stick) **OR**
- Venous blood sampling methods (venous method is preferred because it is more accurate and less prone to contamination)
    - ***All confirmatory and follow-up*** blood lead level testing must be performed using blood samples taken through the venous blood sampling method.

How do results get reported?

- California law requires laboratories performing blood lead analysis on blood specimens drawn in California to electronically report all results to the California Lead Poisoning Prevention Branch (CLPPB).

Results Follow-Up

<3.5 mcg/dL Initial blood lead level (BLL) & routine retest may be capillary (CBLL) or venous (VBLL)

- If screened early (before 12 months), retest in 3-6 months as the lead exposure risk increases with increased infant mobility.
- Follow up with VBLL in 6-12 months if indicated
- Provide education about common sources of lead exposure and information on how to further prevent exposure appropriate milestones are being met.

≥3.5 mcg/dL Initial BLL may be capillary or venous. Every retest must be venous.

- Follow the recommendations for <3.5 mcg.dL results **AND**
- Report the test results to your state or local health department.
- Obtain an environmental exposure history from the caregiver to identify potential sources of lead.
- Follow the CDC guidelines for retesting: https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Case Management Performed by CLPPP

Includes follow up on all levels 3.5 mcg/dl and above

- Levels in 3.5 – 9.4 mcg/dl range
  - Letters/educational materials sent to patients/caregivers
- Persistent levels in 3.5 – 9.4 mcg/dl range
  - Home visit
    - Provide education on potential sources, prevention and nutrition
  - Evaluation of property
  - Possible environmental investigation
- Blood lead levels in the 9.5 and above – State case
  - State Case requires:
    - Visit by the Environmental Health Specialist and the CLPPP Public Health Nurse
    - ASQ and nutrition assessment
    - Case management of 1 year or more.

Leadcare II McKessen Placement Program

Free use of a LeadCare II Analyzer to new customers who:

- Purchase 4 LeadCare II Test Kits
- Commit to purchase 8 test kids annually (384 tests)*

Who should consider this program?

- Program is available for clinic locations that have not previously purchased LeadCare II Analyzer.
- The Program is suitable for customers who prescribe a minimum of seven lead tests per week.

For More information see attached PDF or contact LeadCare Sales at:

Adobe Acrobat Document

1-800-305-0197

LeadCareSales@meridianbioscience.com

www.meridianbioscience.com/leadcare

Promo Code: 6253702

*Initial four-kit purchase counts towards the first years eight-kit commitment

Need Assistance?

Where can I refer patients with high lead levels?

- San Joaquin and Stanislaus County have Lead Poisoning Prevention programs that provide case management and assistance for families.
    - San Joaquin County:
      http://clppp.sjcphs.org/
      (209) 468-2593
      PHS-CLPPP@sjcphs.org
    - Stanislaus County:
      http://www.schsa.org/PublicHealth/pages/clppp/
      (209) 558-8860
      CLPPP@schsa.org
      Adavod@schsa.org

Additional Resources and Information

- Standard of Care Guidelines for CA Health Care Providers: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-care%20guideline_sources%20of%20lead.pdf
- California Childhood Lead Poisoning Prevention Branch (CLPPB):https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx
- Centers for Disease Control and Prevention (CDC) Childhood Lead Poisoning Prevention Guidelines: https://www.cdc.gov/nceh/lead/data/blood-lead-reference-value.htm
- CDC Lead Screening Guidelines: Immigrant, Refugee and Migrant Health: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html

If you have any questions, please call our Provider Services Team at 209-942- 6340, or call our Customer Service Department at 1-888-936-PLAN (7526). You may also visit https://www.hpsj.com/alerts/ for online access to the documents shared.

Incentives

The plan incentivizes both members and providers to complete blood lead screenings. For more information:

- FQHC's/RHC's - https://www.hpsj.com/2023-provider-incentive-quality-measures-for-fqhc-rhc/
- PCP's/OB/GYNS - https://www.hpsj.com/2023-provider-incentive-quality-measures-for-pcp-ob-gyn/
- Member Incentives - https://www.hpsj.com/myrewards/

Health Plan of San Joaquin

Thank You

Health Plan of San Joaquin

myRewards Member Incentive Process

Setar Testo, Manager of Health Education

Community • Partnership • Wellness

myRewards

Sent to member via email, text, or regular mail.

2023 Member Incentives: Children's Health

Visit/Service	Children's Health
Childhood Immunizations (CIS-10)	By 2 years of age completion of the required vaccinations which include DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, flu.
Well Child (0- 15 months)	children need at least six well-child visits with a provider during their first 15 months of life
Well Child 15-30 months	Children between 15-30 months of age need at least two well child visits with their provider.
Exam for Children and Adolescents 3-21 years	children 3–21years of age who received one or more well-care visit with a provider (PCP or OBGyn)
Lead Screening	Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Catch up screening for those who have not been tested up to 7 years of age.
Flu Shot	Any Member receiving a flu vaccine between 1/1/23-12/31/23
Immunizations for Adolescents	Member who is 13 years of age who had each of the following: one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series

2023 Member Incentives: Maternal Health

Visit/Service	Maternal Health
Prenatal Immunization	Pregnant people should receive influenza and Tdap vaccinations during their pregnancy to protect Mom and Baby.
Prenatal Appointment	Prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment
Postpartum Visit	postpartum visit on or between 7 and 84 days after delivery
Postpartum Depression Screening	Postpartum Depression Screening

2023 Member Incentives: Cancer Prevention

Visit/Service	Cancer Screening
Colorectal Cancer Screening	Adults 50–75 who had screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years.
Mammogram (Breast Cancer Screening)	women 50–74 years of age need at least one mammogram to screen for breast cancer every two years.
Pap Smear (Cervical Cancer Screening)	Women 21–64 years of age need a cervical cancer screening (pap smear) every 3 years.

2023 Member Incentives: Adult Preventive Health/Other

Visit/Service	Preventive Health Adults/Other
Adult Access to Ambulatory Care	Adults 20 and over should see their PCP once a year for a preventive health visit. This visit ***may*** cover the ABC's of health: • A1c Check- Checking your blood sugar levels • Blood Pressure Check • Cholesterol or Cancer screenings
A1c (HBD)	adults 18–75 years of age with diabetes (type 1 and type 2) who had A1c Testing.
Flu Shot	Any Member receiving a flu vaccine between 1/1/23-12/31/23

Full List 2023 Member Incentives

Visit/Service	Description
Childhood Immunizations (CIS-10)	By 2 years of age completion of the required vaccinations which include DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, flu.
Colorectal Cancer Screening	Adults 50–75 who had screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years.
Postpartum Depression Screening	All postpartum people should receive a depression screening after delivery and follow up care if needed.
Prenatal Immunization Status	Pregnant people should receive influenza and Tdap vaccinations during their pregnancy to protect Mom and Baby.
Adult Access to Ambulatory Care	Adults 20 and over should see their PCP once a year for a preventive health visit. This visit may cover the ABC's of health: • A1c Check- Checking your blood sugar levels • Blood Pressure Check • Cholesterol or Cancer screenings
Prenatal Appointment	Prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment
Mammogram (Breast Cancer Screening)	women 50–74 years of age need at least one mammogram to screen for breast cancer every two years.
Pap Smear (Cervical Cancer Screening)	Women 21–64 years of age need a cervical cancer screening (pap smear) every 3 years.
A1c (HBD)	adults 18–75 years of age with diabetes (type 1 and type 2) who had A1c Testing.
Well Child (0- 15 months)	children need at least six well-child visits with a provider during their first 15 months of life
Well Child 15-30 months	Children between 15-30 months of age need at least two well child visits with their provider.
Exam for Children and Adolescents 3-21 years	Children 3–21years of age who received one or more well-care visit with a provider (PCP or OBGyn)
Lead Screening	Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Catch up screening for those who have not been tested up to 7 years of age.
Postpartum Visit	postpartum visit on or between 7 and 84 days after delivery
Flu Shot	Any Member receiving a flu vaccine between 1/1/23-12/31/23
Immunizations for Adolescents	Member who is 13 years of age who had each of the following: one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series

Health Plan of San Joaquin

HOW TO SIGN UP FOR AN HPSJ ACCOUNT
CÓMO REGÍSTRASE PARA UNA CUENTA DE HPSJ

1

Visit www.hpsj.com/portal

Visite la pagina: www.hpsj.com/portal

2

Click **"Create Account"** under the login box

Haga clic en **"Create Account"** (Crear una cuenta) debajo de la casilla para iniciar sesión.

3

Fill out your information and click **"Create"** at the bottom of the form

Complete su información y haga clic en **"Create"** (Crear) en la parte inferior del formulario

Make sure you have your HPSJ Member ID Card when signing up.

Cuando se registre, asegúrese de tener a mano su tarjeta de identicación de miembro de HPSJ.

PST09172019

Tip Sheet

Health Plan of San Joaquin

Sign up for an HPSJ online account today using your computer, tablet or phone!

On-the-go access to your Health Plan of San Joaquin member data. Get a new ID card, change your doctor or update your profile. Need a specialist? HPSJ members can access their health information from their device, at all times. **You can access your account using your computer or the mobile App.**

Ready to create an account?

Visit www.HPSJ.com/portal

Let's make an account!

Need help?

Go to **www.hpsj.com/create-an-account** to watch the help video, or call Customer Service at 1.888.936.7526 TTY/TDD 711.

Have this before you start:

1. **HPSJ Member ID** (9-digit starting 200)
2. **Birth Date**
3. **Zip Code**
4. **First Name / Last Name**
5. **Mobile Number**
6. **Email for an account**
7. **Username**
8. **Password***

***Your password must be at least 8 characters.**
You must have at least three of the following:

- A capital letter
- A lower case letter
- A symbol (example: #, $, @)
- A number

If the box turns red, you need to correct the information before an account can be created. Read the notes under the red box to find out what information must be corrected.

Welcome [redacted]

To update your profile, change your Primary Care Provider, order an ID card or perform other transactions, please use the navigation menu under **My Tools.**

Your Messages

Benefits-[redacted]

Authorizations-Approved Requests

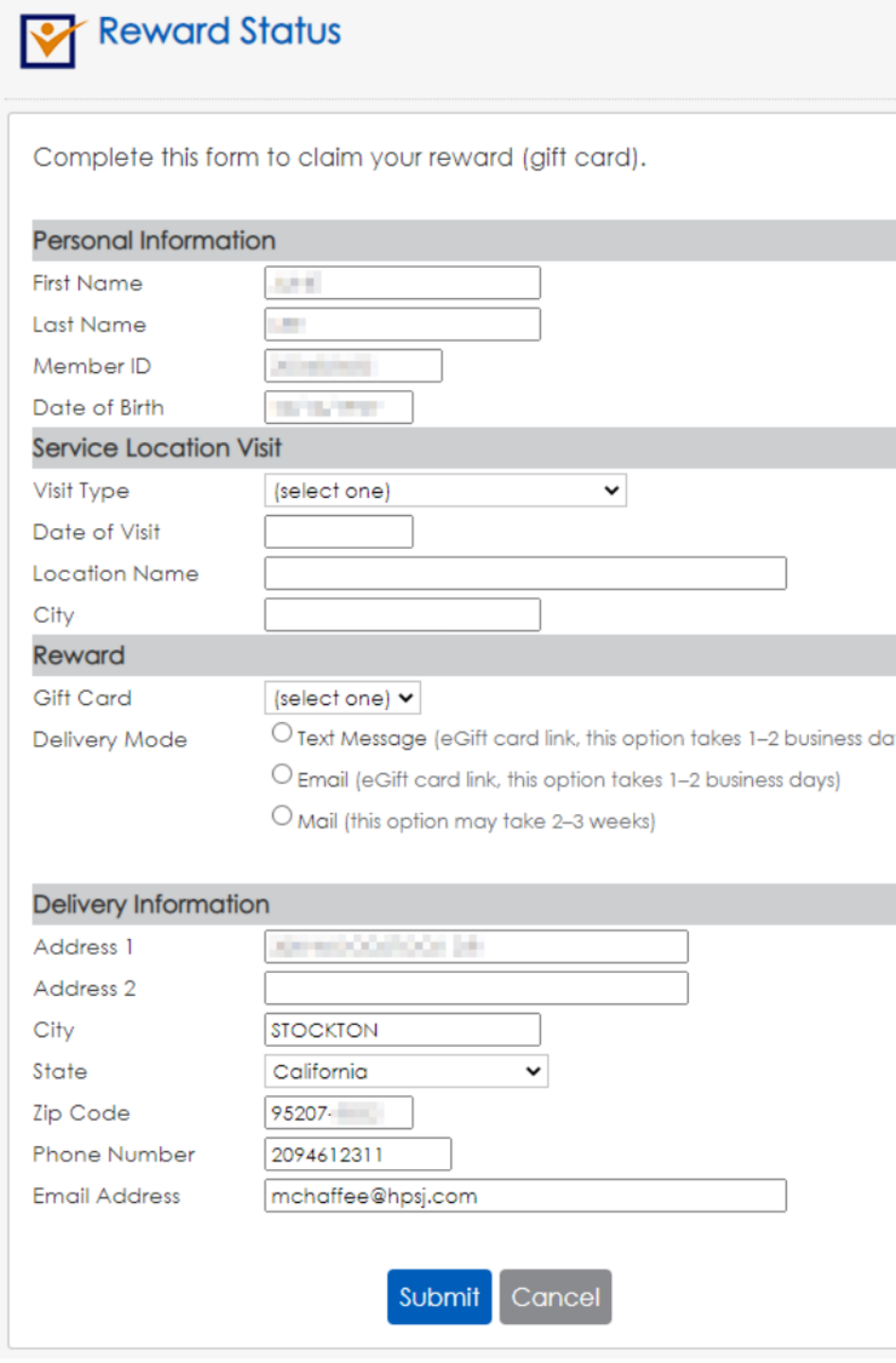
All Messages

Quick Links

- My Profile
- My Health Record
- Provider Search
- HealthCheck
- My ID Card
- Ask a Nurse
- Change My PCP
- myHPSJ Mobile App
- Contact HPSJ
- myRewards

myRewards Form

Same form as before



Chronic Disease Resources

Diabetes

- ✓ Diabetes Prevention Program
- ✓ Low Risk Diabetes Mailers
- ✓ High Risk Diabetes Case Management
- ✓ Health Education Diabetes Support
- ✓ Health Education Classes upon partner/provider request

Hypertension

- ✓ *Upcoming:* Hypertension Booklet
- ✓ Health Education Diabetes Support
- ✓ Health Education Classes upon partner/provider request

healtheducation@hpsj.com

Fluoride Varnish

HPSJ offers a turn-key solution to Fluoride Varnish training for your clinic! We bring to you:

- ✓ Certified Fluoride Varnish Trainer
- ✓ Materials for training including fluoride varnish applications, oral health hygiene kits, and varnish for after training to help with initial implementation
- ✓ Health Educator support and linkage to provider services team

All attendees receive a certificate acknowledging completion of CHDP Fluoride Varnish Training session.

To schedule your training email healtheducation@hpsj.com

New Provider Alert

Quality Measure: Topical Fluoride Varnish for Children (TFL-CH)

Children 1 – 21 years old should receive at least 2 topical fluoride applications each year.

Topical Fluoride Varnish does not require a Prior Authorization for children up to age 6. Fluoride Varnish Treatment Guidelines:

- Children up to 72 Months of age
- Physicians or other qualified health care professionals may apply topical fluoride varnish
- Up to 3 fluoride applications are covered up to three times a year. For more information, please see the Medi-Cal Provider Manual for Dental Benefits: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dental.pdf

Prescription coverage for fluoride drops and tablets are available for Medi-Cal members up to age 21. Some prescriptions may require authorization and have age requirements.

- Visit the Medi-Cal Rx website for information on covered prescriptions, days supplied and age limitations: https://medi-calrx.dhcs.ca.gov/home/

Fluoride Varnish Guidelines:

- The U.S. Prevention Service Task Force (USPSTF) recommends that PCPs prescribe oral fluoride supplementation starting at 6 months for children whose water supply is deficient in fluoride in addition to applying fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption.

San Joaquin and Stanislaus County do not have fluoridated water for residents.

- The American Academy of Pediatrics (AAP)/Bright Futures Periodic Schedule recommends fluoride varnish application at least once every 6 months for all children and every 3 months for children at high risk for caries.

REVISED Provider Alert - New Measure - Topical Fluoride Varnish for Children (TFL-CH) and HPSJ's Topical Fluoride Varnish & Supplementation Benefit Reminder

Health Plan of San Joaquin

Thank you