A MESSAGE FROM
Dolly C. Goel, MD

There has been much discussion about the recent executive orders impacting the Affordable Care Act (ACA). While the future changes are unclear, I would like to stress that Valley Health Plan’s (VHP) commitment to high quality and affordable healthcare remains unchanged. We are committed to our community partnerships which extend high-quality healthcare care to the employees and residents of the County of Santa Clara. All of us at VHP are proud to be part of an organization where everyone counts and holds a commitment to accomplish results and sustain service excellence. Thank you for providing quality care to our members and continuing your partnership with us to improve patient experiences in the coming year.

Table of Contents

Member Satisfaction Survey ......................... 2
The Accreditation Association for Ambulatory Health Care (AAAHC) .... 3
Provider Satisfaction Survey .......................... 4
Provider Relations Department Updates .......... 5
Member Rights & Responsibilities .................... 6
Quality Management Team Updates ................ 8
The Provider Bulletin is Going Green ............ 9
Important Information Regarding Timely Access Regulations & Surveys .......... 9
Communication Matters Exchange of Information ..................... 10
HEDIS Quick Reference Guide ...................... 12
Adult Diabetes Prevention Program ................. 13
Formulary Change Notice ......................... 14
Clinical Practice Guidelines .................... 15
MEMBER SATISFACTION Survey

Each year Valley Health Plan (VHP) hires an outside vendor to conduct a Member Satisfaction Survey. The survey employs a standardized tool that is used across the country called the Consumer Assessment of Health Plan Services for the commercial line of business and the Quality Health Plan issuer for the Covered California line of business. The results of the survey are part of the overall score for the VHP’s accreditation through National Committee for Quality Assurance (NCQA) and the information is available to the public.

Here is how VHP scored this year for the Commercial Line of Business:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2017</th>
<th>Goal</th>
<th>VHP Goal Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Health Plan</td>
<td>73.70%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Rating of All Health Care</td>
<td>68.04%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>81.58%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>74.17%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>Customer Service</td>
<td>71.21%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>60.80%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>66.82%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>89.96%</td>
<td>National Average</td>
<td>N</td>
</tr>
</tbody>
</table>

Here is how VHP scored this year for the Marketplace Line of business:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2017</th>
<th>Goal</th>
<th>VHP Goal Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Health Plan</td>
<td>73.98%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Rating of All Health Care</td>
<td>80.00%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>89.51%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>89.61%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Customer Service</td>
<td>73.89%</td>
<td>National Average</td>
<td>Y</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>64.35%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>63.64%</td>
<td>National Average</td>
<td>N</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>88.64%</td>
<td>National Average</td>
<td>N</td>
</tr>
</tbody>
</table>

What do the scores mean?

Rating of Health Plan
The VHP score is significantly higher than the score from last year and the national average for both Lines of Business. VHP ranks in the highest category for satisfaction and achieved the highest score in likelihood for the member to recommend VHP to someone seeking healthcare.

Rating of All Health Care and Rating of Personal Doctor
The score for VHP meets or exceeds the national average for both Lines of Business. VHP continues to strive to provide excellent care to the membership and improve access to care. Information is obtained through a variety of sources throughout the year to inform the Plan on areas where members would like to see improvements. These sources include comments on the member surveys, calls into Member Services, requests for services, potential quality issues and provider suggestions. VHP engages community providers in committees such as the Utilization Management Committee, Quality Management Committee, and the
Valley Health Plan (VHP) is pursuing accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC). Accreditation distinguishes VHP by providing the highest quality of care to members with a rigorous onsite survey process determined by an independent, external process of evaluation. This is an important milestone in the continuing growth and success of VHP. Pursuing accreditation shows our commitment to providing the highest levels of quality care to our members, and the same high level of quality in our business practices.

The AAAHC mission and vision aligns with the Institute for Healthcare Improvement Initiative’s Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care and are in line with VHP’s vision for the future.

VHP is the only locally based commercial health plan in Santa Clara County and has served the community for over 30 years. VHP offers a quality network of primary and specialty care providers. VHP continues to offer the lowest cost Covered California plans across all metals in Santa Clara County. Simultaneously, VHP provides a vital source of payor diversification to provider network partners, many of which are primarily focused on safety-net populations.

The AAAHC was founded in 1979 and is the leader in ambulatory health care accreditation with more than 5,000 organizations accredited nationwide. AAAHC accredits a variety of organizations including ambulatory surgery centers, office-based surgery centers, endoscopy centers, student health centers, military health care clinics, and large medical and dental practices. AAAHC serves as an advocate for the provision of high-quality health care through the development of nationally recognized standards and through its survey and accreditation programs. AAAHC accreditation is recognized as a symbol of quality by third-party payers, medical organizations, liability insurance companies, state and federal agencies, and the public.

Why AAAHC?

The AAAHC has been surveying and accrediting health plans/managed care organizations since 1983. In 2012, the Standards for Health Plans were significantly revised to incorporate the mandates under the Affordable Care Act and provided the foundation for a strong focus on managed care principles and special programs. In 2013, AAAHC was approved as an accreditsor for Qualified Health Plan Issuers on the state and federal exchanges. In 2014, AAAHC added an accreditation program designed to meet the unique needs of Federal Employee Health Benefits plans. This makes the AAAHC a good fit as the goal of VHP is to align with providers to serve the population.

The Health Plan Rankings can be found at: http://healthinsuranceratings.ncqa.org/2017/HprPlandetails.aspx?id=1502
PROVIDER SATISFACTION Survey

Valley Health Plan (VHP) monitors practitioner experience and satisfaction annually. VHP collected practitioner experience by utilizing the Industry Collaborative Effort (ICE) survey tool. This report provides an overview and analysis of satisfaction with a variety of services and is intended to survey VHP’s Primary Care (PCP) and Behavior Health (BH) practitioners.

VHP appreciates and thanks the providers who participated by completing the survey and we value the feedback you shared. If you did not participate in this survey, we encourage you to participate in the future and make your voice count.

The survey is intended to gauge satisfaction with authorization/referral processes, access to non-urgent PCPs, urgent care services, access to non-urgent specialists, access to non-urgent ancillary providers/services and access to BH. The survey results are as follows:

**PCPs/ Practitioners (N =44)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Satisfied/ Satified</th>
<th>Dissatisfied/ Very Dissatisfied</th>
<th>Not Applicable/ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Prior Authorization Process</td>
<td>77.27%</td>
<td>4.55%</td>
<td>18.18%</td>
</tr>
<tr>
<td>Access to Urgent Care</td>
<td>59.09%</td>
<td>9.09%</td>
<td>31.08%</td>
</tr>
<tr>
<td>Access to Non-Urgent Primary Care Physicians’</td>
<td>72.73%</td>
<td>4.55%</td>
<td>22.73%</td>
</tr>
<tr>
<td>Access to Non-Urgent Specialists</td>
<td>79.55%</td>
<td>11.36%</td>
<td>9.09%</td>
</tr>
<tr>
<td>Access to Non-Urgent Ancillary</td>
<td>72.73%</td>
<td>6.82%</td>
<td>20.45%</td>
</tr>
<tr>
<td>Access to Behavioral Health</td>
<td>61.36%</td>
<td>11.36%</td>
<td>27.27%</td>
</tr>
</tbody>
</table>

**Behavioral Health Practitioners (N=21)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Satisfied/ Satified</th>
<th>Dissatisfied/ Very Dissatisfied</th>
<th>Not Applicable/ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Prior Authorization Process (Q1)</td>
<td>71.43%</td>
<td>0.00%</td>
<td>28.57%</td>
</tr>
<tr>
<td>Access to Urgent Care (Q2)</td>
<td>47.62%</td>
<td>9.57%</td>
<td>42.86%</td>
</tr>
<tr>
<td>Access to Non-Urgent Primary Care Physician’s</td>
<td>61.90%</td>
<td>4.76%</td>
<td>33.33%</td>
</tr>
<tr>
<td>Access to Non-Urgent Specialists</td>
<td>71.43%</td>
<td>14.29%</td>
<td>14.29%</td>
</tr>
<tr>
<td>Access to Non-Urgent Ancillary</td>
<td>61.90%</td>
<td>4.76%</td>
<td>33.33%</td>
</tr>
<tr>
<td>Access to Behavioral Health</td>
<td>71.43%</td>
<td>14.29%</td>
<td>14.29%</td>
</tr>
</tbody>
</table>

Through continued performance improvement during 2016-2017, VHP improved the authorization process and member access to health care services. Santa Clara Valley Medical Center (SCVMC), one of VHP’s largest providers created the Center for Leadership Training (CLT) which has been an ongoing initiative aimed toward meeting timely access regulatory standards. Through partnership with SCVMC, VHP has noted a dramatic improvement in the reduction of the number of complaints about access since the implementation of the CLT Phase initiative in August of 2016.

In July 2017, VHP rolled out the MDLIVE Telemedicine Program. MDLIVE provides real-time member access to urgent care and BH providers. VHP continues to expand the network by targeting ancillary and specialty providers in high demand identified through referral and utilization reports.

The 2017 Provider Survey will be distributed in the next few weeks. Please take an opportunity to provide us with the feedback we need to meet your needs as practitioners.
PROVIDER RELATIONS

Department Updates

If you have any questions or concerns, feel free to contact our Provider Relations Department at 408.885.2221.

New Staff

Valley Health Plan (VHP) is expanding its staff to continue to lead in the innovation process of continued provider relations. This will allow further expansion to the provider network, streamlining the process of onboarding, and claims payouts. Please help welcome our new staff!

Richard Schreck - Provider Relations Manager
Katherine Smith - Provider Relations Specialist
Idir Fenniche - Provider Relations Specialist

Provider Coverage

Provider coverage is also taking off with flying colors as new phases continue to grow with our covered members. With member enrollments reaching over 160,000, VHP is still on an exponential growth path. Third quarter provider visits were a huge success with our team. Having our Provider Relations specialists interacting with our providers will continually allow new bonds of work relationships to better serve our members in the years to come.

Accreditation

VHP geared up for its next Accreditation Association for Ambulatory Health Care (AAAHC) visit. The visit took place November 7-9, 2017. The goal was to pass all credentialing requirements to better serve our members. The health record performance goal will increase effective January 2018 from 80% to 90% as approved at the QMC meeting.

Clearinghouse Update

Utah Health Information Network (UHIN) is now the exclusive connection point for receiving all claims and reports. VHP chose UHIN because of their reputation for excellent customer service and ability to streamline the claims process.

VHP is excited to offer you 835 electronic claim payment/remittance information. You will receive your 835s electronically direct from your clearinghouse. This means you will save time by no longer having to log on to Change Healthcare to download and print a PDF version of the 835. Depending on your clearinghouse, you may need to enroll for 835s. Please contact your clearinghouse directly to determine your steps for 835 enrollment.

If you do not already use a clearinghouse for claims submission, VHP can still work with you to receive 835’s. To do so, visit UHIN.org to find out more about claims submission (837) and electronic remittance (835). If you are experiencing any issues with your current clearinghouse that prevent you from getting your claims processed, please contact UHIN Customer Service at customerservice@uhin.org or 1.877.693.3071 (toll-free).

Change of Address

It is very important that VHP has your correct address and phone number on file so that we may direct patients to your practice. We also want to make sure you receive important mailings about additions or changes to benefits, providers/networks, or tools to help you maintain an effective practice.

If you have recent practice changes, visit: www.valleyhealthplan.org/sites/p/Pages/provider-directory-change-form.aspx to use the Provider Directory Online Verification and Change Form.
A member has the right to:

1. Exercise these rights without regard to race, disability, sex, religion, age, color, sexual orientation, creed, family history, marital status, veteran status, national origin, handicap, or condition, without regard to your cultural, economic, or educational background, or source(s) of payment for your care;

2. Be treated with respect and recognition regarding your dignity and your right to privacy;

3. Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs;

4. Be provided with information about VHP, its services, Plan Providers, and member rights and responsibilities;

5. Know the name of the Primary Care Physician who has primary responsibility for coordinating your health care and the names and professional relationships of other Plan Providers you see;

6. Actively participate in your own health care, which, to the extent permitted by law, includes the right to receive information so that you can accept or refuse recommended treatment;

7. Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment or procedure. Except for Emergency Services, this information will include a description of the procedure or treatment, the medically significant risks involved, alternative courses of action and the risks involved in each the name of the Plan Provider who will carry out the treatment or procedure;

8. Full consideration of privacy concerning your course of treatment. Case discussions, consultations, examinations, and treatments are confidential and should be conducted discreetly. You have the right to know the reason should any person be present or involved during these procedures or treatments;

9. Confidential treatment of information in compliance with state and federal law including HIPAA (including all communications and medical records) pertaining to your care. Except as is necessary in connection with administering the Agreement and fulfilling State and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written permission from you or your authorized representative;

10. Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand;

11. Give informed consent unless medically inadvisable, before the start of any procedure or treatment;

12. Refuse health care services to the extent permitted by law and to be informed of the medical consequences of that refusal, unless medically inadvisable;

13. Readily accessible and ready referral to Medically Necessary Covered Services;

14. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage;

15. A second medical opinion, when medically appropriate, from a Plan Physician within the VHP Network;

16. Be able to schedule appointments in a timely manner;

17. Reasonable continuity of care and advance knowledge of the time and location of your appointment(s);

18. Reasonable responses to any reasonable requests for Covered Services;

19. Have all lab reports, X-rays, specialist’s reports, and other medical records completed and placed in your files as promptly as possible so that your Primary Care Physician can make informed decisions about your treatment;
20. Change your Primary Care Physician;
21. Request and expedited change of a provider due to medical necessity;
22. Review your medical records, unless medically inadvisable;
23. Be informed of any charges (Co-payments) associated with Covered Services;
24. Be advised if a Plan Provider proposes to engage in or perform care or treatment involving experimental medical procedures, and the right to refuse to participate in such procedures;
25. Leave a Plan Facility or Hospital, even against the advice of Plan Providers;
26. Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals;
27. Be informed of, and if necessary, given assistance in making a medical Advance Directive;
28. Have rights extended to any person who legally may make decisions regarding medical care on your behalf;
29. Know when Plan Providers are no longer under a contractual arrangement with VHP;
30. Examine and receive an explanation of any bill(s) for non-Covered Services, regardless of the source(s) of payment;
31. Voice complaints or appeals about VHP or the care it provides;
32. File a Grievance without discrimination through VHP or appropriate State or federal agencies;
33. Know the rules and policies that apply to your conduct as a Member;
34. Make recommendations regarding Valley Health Plan's member rights and responsibilities policy; and
35. Participate with practitioners in making decisions about your health.

A member has the responsibility to:

1. Provide complete & accurate information (to extent possible) that VHP and its practitioners/providers need in order to provide care. Inform practitioner/provider about any health issues, medications, and allergies. This information should also include living will, medical power of attorney, or other directive that could affect care;
2. Follow plans and instructions for care that you have agreed to with your practitioner;
3. Behave in a manner that doesn’t interfere with your Plan Provider or their ability to provide care;
4. Safeguard the confidentiality of your own personal health care as well as that of other Members;
5. Accept fiscal responsibility associated with non-Covered Services. Covered Services are available only through Plan Providers in your VHP Network (unless such care is rendered as Emergency Services or is authorized);
6. Cooperate with VHP or a Plan Provider’s third party recovery efforts or Coordination of Benefits;
7. Participate in your health care by scheduling and keeping appointments with Plan Providers. If you cannot keep your appointment, call in advance to cancel and reschedule;
8. Report any changes in your name, address, telephone number, or your family’s status to your employer, Covered California, and a VHP Member Services Representative; and
9. Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
QUALITY MANAGEMENT Team Updates

The Quality Management (QM) program is centered on Valley Health Plan’s (VHP) Vision, Mission, and Values.

The scope and content of the quality program represents the entire VHP delivery system. The team’s monitoring and evaluation activities involve a planned, systematic and ongoing process to improve the quality of care and service members receive.

QM Program Goals
VHP’s QM program goals are to ensure that our members receive high quality care and service wherever they access care. The team accomplishes this by ensuring standards and regulations are followed by care givers, addressing member satisfaction concerns, and ongoing monitoring for anti-fraud activities, member grievances, potential quality issues, and unusual risk occurrences. VHP’s monitoring includes medical and behavioral services provided to our members. The team is also focused on identifying opportunities for performance improvement throughout the care delivery system.

What has the QM team been up to during the last year?

During 2016, the QM efforts and activities focused on member safety, access and availability, health management programs, prevention health and member experience.

Some of the highlights for 2016 were:

1. Coordination of Care - The annual Consumer Assessment of Healthcare Provider Systems survey revealed 79.25% percent of members reported their personal doctor “always and usually” were informed about care from other practitioners.

2. QM Department completed a quality project to seek input from our members receiving behavioral healthcare. Overall members’ reported they were satisfied with their behavioral health experience at 77.78% (agree and strongly agree).

3. A quality project revealed 100% of members who participated in the Care Management program identified with depression and diabetes had a treatment plan and follow-up care in place to meet their needs.

4. VHP and Santa Clara Valley Medical Center (SCVMC) have worked hard over the last year to ensure member’s received an appointment with a specialist timely. As a result of this work, VHP has noted member concerns related to appointment access at SCVMC has dropped by 59.90% by the end of the year.

5. VHP and Navitus are working hard to ensure that medications are being delivered in a safe manner by reviewing drug usage throughout the year and taking the appropriate action to notify provider(s) of any concern with the medications being taken.

What are some of the planned QM team activities we have been working on for 2017?

During 2017 the QM team has been working on various quality projects like:

• Monitoring the MDLIVE activities and performance

• Unit Based Teams performance improvement projects

• Taking actions and re-measuring performance for continuity and coordination of care between primary care physicians and other practitioners

• Completing a follow-up survey to assess members’ satisfaction with behavioral health experience

• Monitoring the new condition management program

VHP is implementing a new software program that identifies members eligible for certain services. This will enable VHP to notify members of benefits and services. This is being done with the goal of improving the healthcare members receive.

When it comes to member satisfaction - have you heard of Survey Monkey? In the coming months, this is a user friendly survey tool VHP will use to get your feedback through the VHP website.

Overall, the QM team is excited with the quality activities for this year and we are continuously looking for opportunities for performance improvement which will result in an excellent customer experience.
THE PROVIDER BULLETIN is Going Green!

This will be our last Valley Health Plan (VHP) Provider Bulletin sent by mail. Visit: www.valleyhealthplan.org/sites/p/Bulletin-and-Updates/Pages/Provider-Bulletin-and-Updates.aspx

Has your office gone green yet?
VHP takes part in 837 electronic claims, 835 electronic remittance, and ACH/EFT electronic payment. To enroll in 837 and or 835, please contact your clearinghouse who will then connect with our clearinghouse Utah Health Information Network (UHIN). Visit UHIN.org to find out more about claims submission (837) and electronic remittance (835). If you are experiencing any issues with your current clearinghouse that prevent you from getting your claims processed, please contact UHIN Customer Service at customerservice@uhin.org or 1.877.693.3071 (toll-free).

If you are interested in electronic payment ACH/EFT, visit www.valleyhealthplan.org/sites/p/fr/Forms/Pages/Providers-Forms-Home.aspx to download the ACH enrollment form.

Contact Provider Relations at 408.885.2221 if you would like to know more about these services.

IMPORTANT INFORMATION
Regarding Timely Access Regulations & Surveys

Valley Health Plan (VHP) will be conducting three annual surveys as required by the Department of Managed Health Care (DMHC)’s Timely Access Regulations. DMHC requires VHP to report the results of the survey and address any deficiencies. Therefore, we remind you that your participation is required.

**Appointment Availability Survey:** Survey Period Late-October 2017 - December 31, 2017

**Providers will be contacted via phone to complete the survey. Required Time: 10 Min**

1. VHP is required to provide timely health care services that are appropriate for the patient’s condition and consistent with professional practices.

2. VHP has retained the Center for the Study of Services (CSS) as the survey vendor to administer the 2017 Appointment Availability Survey.

3. DMHC requires that if practices fail to complete the survey within 48 hours of the initial contact, the practices must be marked as “non-compliant.”

4. The 2017 survey methodology is at www.dmhc.ca.gov/ on the DMHC website.

**Provider Satisfaction Survey:** Survey Period Late-October 2017 - December 31, 2017

**Providers will receive a fax to complete the survey. Required Time: 5 Min**

5. VHP is required to assess provider satisfaction and identify areas of improvement.

6. The survey will be faxed to a sample of physicians and should take no more than 5 minutes to complete.

7. If your office receives a request to participate in the survey, please complete the survey promptly and return the survey as instructed on the form.

**Provider After-Hours Access Survey:** Survey Period Late-October 2017 - December 31, 2017

**CSS will contact providers and/or the answering service during after-hours to conduct the survey.**

VHP is required to assess office after-hour triage and screening services to ensure the accuracy of emergency and non-emergency instructions provided to members by the health practitioners.
COMMUNICATION MATTERS Exchange of Information

We know your offices are very busy seeing patients and understand that sharing information can take a significant amount of your time but, it is a critical step that can go a long way in improving outcomes for patients. Remember that at the end of the day, it is your patients who will benefit from good communication!

If you have questions about factors that limit your ability to share information, please call VHP Member Services at 1.888.421.8444 (toll-free) so they can assist.

Exchanging information between Emergency Room (ER) Providers & Primary Care Practitioners (PCPs)

To deliver a higher level of quality of care in managing a patient, it is important for all health care providers to be able to share information with the PCPs. ER providers can assist PCPs in better managing their patient’s care by sharing the following information with them:

- Reason(s) for the visit
- Significant findings/events that occurred during the visit
- Procedures performed, and care, treatment and services provided
- Information/education provided to the patient and their caregiver

Some of the potential barriers for not communicating can be:

- Having adequate time, staffing, or other resources to communicate to the patient’s PCP
- Increased workload and interruptions in workflow due to the fast paced nature of work in the ER
- Complex medical conditions which restrict the ability to share information
- Accuracy of contact information and incompatible information systems
- Misinterpretations of privacy concerns related to the Health Insurance Portability Accountability Act (HIPAA)

Some of these barriers can be overcome by getting the member to sign a “release of information” form which allows you to communicate with other practitioners involved in the patient’s care. Coordination of care is a key determinant of overall health outcomes, improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. Lack of coordination in the handoff from these settings to the PCPs can result in repeated ER visits.

Exchanging information between Hospitals & PCPs Post-discharge

Achieving the best outcome for your patients depends on you having the entire picture of their care. Having patient information at the time of follow-up visits reduces the risk of errors in your patient’s care. Studies show that coordination of care:

- Is a key determinant of overall health outcomes
- Improves patient safety
- Avoids duplicate assessments, procedures or testing
- Results in better treatment outcomes
- Can reduce risk of readmission and avoidable ER utilization

Joint Commission standards require that the following information be shared with the PCPs at the time of the discharge:

- Reason(s) for hospitalization
- Significant findings/events during the inpatient stay
- Procedures performed and care, treatment and services provided
- Patient’s condition at the time of discharge
- Information/education provided to the patient and their caregiver

What we ask from you:

- Ensure that hospital records indicate updated PCP contact information.
- Implement effective mechanisms to deliver documented discharge summaries to correct PCPs in a timely manner.
- Ensure that PCPs will have access to this patient discharge information prior to the patient’s follow up visit.
Exchanging information between Specialists & PCPs

It is important for all the health care practitioners that are involved in managing the care of a patient to be able to share information so they can deliver a higher level of quality of care to the patient. Sharing information helps practitioners coordinate care for the patient. Coordination of care is a key determinant of overall health outcomes, improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes.

The potential barriers to accurate communication between doctors include:

- Perceived lack of authority to share information
- Time constraints and increased workload
- Interruptions in workflow
- Complexity of the medical conditions restricting ability to share information.
- Limitations of the communication medium and accuracy of contact information
- Incompatible information systems
- Misinterpretations of privacy concerns related to HIPAA

Studies have shown that up to 63% of PCPs and 35% of Specialists were dissatisfied with the communication between them. Specialists are concerned with the timeliness and adequacy of the information in the referral notes sent to them by the PCPs. On the other hand, PCP’s are complaining that they don’t get any information back from the specialists within 30 days of the patient's visit. Both types of practitioners agree that this information would have been very helpful in appropriately managing the patient’s care.

The following problems have been reported as a result of poor coordination of care:

- Practitioners find it difficult to comprehensively reconcile medications for their patients
- They have to unnecessarily repeat tests or procedures because results were unavailable at time of visit.

Exchanging information between Skilled Nursing Facilities (SNFs) and PCPs Post-Discharge

It is important for all the health care providers that are involved in managing the care of a patient to be able to share information so they can deliver a higher level of quality of care to the patient. SNFs are a very important component in the continuum of care and sharing information about the patients care helps the PCPs better manage their patient. Coordination of care is a key determinant of overall health outcomes, improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes.

Best practices and standards of care that the following information be shared with the PCPs at the time of the discharge:

- Reason(s) for admission into facility
- Significant findings/events during the stay
- Procedures performed and care, treatment and services provided
- Patient’s condition at the time of discharge
- Information/education provided to the patient and their caregiver

Some of the barriers can simply be overcome by getting your patients to sign a “release of information” form at the time of the admission. This is important because lack of coordination in the handoff from SNFs to community care practitioners can result in high chance of readmission to inpatient facilities for a number of reasons. Studies have shown that the availability of a discharge summary at the post-discharge visit tends to be low and this has a negative impact on the quality of the follow up visit.
What is HEDIS (Healthcare Effectiveness Data and Information Set)?
HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. Through HEDIS, NCQA ensures that Valley Health Plan (VHP) is taking ownership and accountability for the timeliness and quality of care (acute, preventive, behavioral (mental) health, and other) delivered to its diverse membership.

Why is HEDIS Important?
As both State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. HEDIS reporting is mandated by NCQA for compliance and accreditation. It is important that health care providers and their staff members become familiar with HEDIS to understand what health plans are required to report. These measures are used to gauge the quality of care our members receive and to identify areas for improvement.

How rates are calculated?
HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures that are typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services. While hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires a review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, and prenatal care. To ensure the validity of HEDIS results, all data elements are rigorously audited by certified auditors using a process designed by NCQA. Health plan members benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's health care system. HEDIS data is also the centerpiece of most health plan "report cards" that appear in national magazines and local newspapers.

How are we doing?
HEDIS helps us zone in on problem areas and identify potential gaps in member care. Ultimately, high HEDIS scores mean that members are actively engaged in their care and receiving the care they need.

For the 2017 HEDIS season, VHP did very well on several measures. THANK YOU for the high quality of care you provide to our members and for thoroughly documenting the care you have provided. This documentation confirms the excellent care you provide.

This year we are very focusing on improving several measures. These measures include:

- Asthma Measures
- Depression Measures
- Cancer Screening Measures:
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Screening

VHP recognizes it is important for providers to receive information to assist in identifying members who may be in need of care and testing. VHP plans to roll out a program where information will be given to providers identifying members who are in need of care using Care Gap Finder. VHP is in the process of validating information in Care Gap Finder reports and testing. VHP welcomes your feedback on the rollout of these reports. If you would like to be involved by providing suggestions or participating in our testing, please call 408.885.5924 for more information.

If you would like training on HEDIS in general or best documentation practices to get credit for HEDIS measures, please let us know by calling Provider Relations at 408.885.2221 to request training.

Working together to improve HEDIS rates.
VHP would like to reinforce the strong partnership with its practitioners and providers to promote awareness on the importance of HEDIS measures. You know the value of screenings, regular office visits, and immunizations for our members. Please remind them of the importance of getting preventive care. Here are some suggestions for you:

1. Use your electronic health record to identify patients who haven’t been seen recently.

2. Offer resources. If patients are concerned about costs, make sure they understand that preventive check-ups are part of their covered benefit. If a patient tends to cancel often or is a habitual no-show, find out why, and recommend ways to help them make it to their appointment.

3. Submit accurate and timely claims/encounter data. This will ensure you get the credit you deserve and prevent unnecessary outreach to members.

4. Notify/remind members. Simply remind members while they are at your office to schedule their screening appointments or lab tests as appropriate.

5. Improve the member experience. We know that you are committed toward improving the member’s care experience and VHP believes that we cannot achieve our goal unless patients have access to timely care, and are satisfied with the care they receive. A positive member experience is optimal in achieving positive health outcomes.

6. Reinforce communication strategies. Communication is pivotal to our success and collaboration between you and your patients is beneficial to both.

7. Maintain clarity of the health records. Keep your record accurate, legible, and complete to facilitate good record review. Use of correct diagnosis and procedure codes.

VHP appreciates the pressures and effort of providing high quality health care to our members and value the hard work demonstrated by providers. We look forward to continued success and growing our partnership in 2018.

VHP offers an Adult Diabetes Prevention Program to Employer Group, Covered California, and Individual & Family Plan Members. As of 01/01/18, VHP will offer the program to Medi-Cal enrollees in the VHP Network.

VHP is partnering with the YMCA to offer a 16-week Adult Diabetes Prevention Program including YMCA membership at no-cost.

The program can help your patients make lifestyle changes to improve their overall health & well-being while lowering their disease risk.

Enroll today! Change is tough - we can help!
Have your patients contact the YMCA Diabetes Prevention Program at ymcadpp@ymcasv.org or 408.351.6440.

Visit www.ymca.net/diabetes-prevention to learn more about the program.
**FORMULARY CHANGE Notice**

Effective January 1, 2018, Valley Health Plan (VHP) will implement the following formulary changes for the Employer Group, Covered California Plan, and Individual & Family Plan Formularies.

The formularies are reviewed and selected by VHP Plan Providers on the VHP Pharmacy & Therapeutic Committee in accordance with professionally-recognized medical standards for their medical and cost effectiveness.

To make this change easier, the medication below will continue to be covered at the current tier through 12/31/2017.

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>THERAPEUTIC CLASS</th>
<th>NEW STATUS EFFECTIVE 1/1/2018 FOR CURRENT MEMBERS</th>
<th>POSSIBLE COVERED ALTERNATIVES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCU-CHEK AVIVA PLUS METER</td>
<td>Diabetic Supplies</td>
<td>Not Covered</td>
<td>FREESTYLE FREEDOM LITE METER</td>
</tr>
<tr>
<td>ACCU-CHEK GUIDE CARE METER</td>
<td>Diabetic Supplies</td>
<td>Not Covered</td>
<td>FREESTYLE LITE METER</td>
</tr>
<tr>
<td>ACCU-CHEK NANO METER</td>
<td>Diabetic Supplies</td>
<td>Not Covered</td>
<td>FREESTYLE PRECISION NEO METER</td>
</tr>
<tr>
<td>ACCU-CHEK NANO SMARTVIEW METER</td>
<td>Diabetic Supplies</td>
<td>Not Covered</td>
<td>(A new meter for the preferred test strips is available at no cost with a new prescription)</td>
</tr>
<tr>
<td>OXYCONTIN TAB (oxycodone HCL)</td>
<td>Opioid Agonists</td>
<td>Not Covered</td>
<td>XTAMPZA ER CAP QL</td>
</tr>
<tr>
<td>metanasone nasal spray</td>
<td>Nasal Steroids</td>
<td>Not Covered</td>
<td>fluticasone nasal spray QL</td>
</tr>
<tr>
<td>PREVACID SOLUTAB</td>
<td>Proton Pump Inhibitor</td>
<td>Not Covered</td>
<td>triamcinolone nasal spray QL</td>
</tr>
</tbody>
</table>

*Please note: All possible covered alternatives may not be listed
‡QL: Quantity Limits apply

If your patient is affected by these changes, a letter has been sent to the affected patients and their providers.

**What if my patient will be adversely affected by the formulary change?**

If for medical reasons your VHP patient cannot be converted to a formulary alternative, you can download a Prescription Drug Prior Authorization Form or Step Therapy Exception Request Form from www.valleyhealthplan.org and fax the complete form to 1.855.668.8551. If you have additional questions, please contact Navitus at 1.866.333.2757 (toll-free).

**What if I need further assistance?**

For any questions regarding this formulary update, please contact VHP Provider Relations at 408.885.2221 or Navitus at 1.866.333.2757 (toll-free).
Valley Health Plan (VHP) has adopted AxisPoint Health Care Management Evidence-Based guidelines. These guidelines meet the National Committee for Quality Assurance (NCQA) Health Plan Quality Improvement. VHP Medical Management Committees review and update guidelines annually and all AxisPoint Health updates. These guidelines, which are not intended to replace clinical judgment, are statements designed to assist practitioners in making decisions about appropriate health care for specific clinical intervention.

The following are links to clinical evidence-based guidelines:

**Attention Deficit Hyperactivity Disorder**

**Coronary Artery Disease**

**Diabetes**

**Depression**


NOTE: The above referenced guidelines constitute recommendations that are based on evolving clinical evidence. Practitioners are encouraged to contact the guideline developer periodically to check for updates. Valley Health Plan does not create the guidelines, nor are they prescriptive. Clinicians remain responsible in accordance with their own professional judgment regarding patient assessment and the care of the individual.