



Provider bulletin

HEALTHY PEOPLE. HEALTHY COMMUNITIES



Equity as an indicator of a successful health plan

In 2021 the Alliance's Board adopted new strategic priorities to guide our quest to achieve the Alliance's vision of Healthy People, Healthy Communities. These priorities include **health equity** and **person-centered** delivery system transformation.

The prioritization of health equity reflects our board and staff's commitment to operate a managed care plan that not only delivers cost-effective health care services through committed local partners, but also measures its success based on whether our members' health is as good as it would be if they did not face poverty, discrimination and/or disability.

Over the next four years, we will focus on eliminating health disparities and optimizing outcomes for Alliance children and youth, partnering with you to ensure that our members receive culturally competent care.

The Alliance is first and foremost a managed care plan, with a mission of ensuring accessible, quality health care guided by local innovation. We remain committed to our core purpose and functions, and we embrace an expanded definition of success that includes our members achieving the health status they deserve. We look forward to your continued partnership on the journey ahead.

Stephanie Sonnenshine
Stephanie Sonnenshine, CEO

Page 2 *The results are in! See the HEDIS awards and updated measures*

Page 6 *Recommendations on how best to taper benzodiazepine dosages*

Page 10 *Proven ways to encourage immunizations and well-child visits*

Alliance Board Meetings

Wednesday, Jan. 25, 2023
3-5 p.m.

Wednesday, Feb. 22, 2023
3-5 p.m.

Meetings may be held via videoconference based on current CDC guidelines, and dates may change. Please check the Alliance website for meeting details:
www.thealliance.health/category/meetings-and-events.

Physicians Advisory Group Meeting

Thursday, March 2, 2023
Noon to 1:30 p.m.

Whole Child Model Clinical Advisory Committee (WCMCAC) Meeting

Thursday, March 16, 2023
Noon to 1 p.m.



2022 HEDIS results and awards

We're happy to share that we've closed out the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) reporting year 2022 with all audit deliverables met and no adverse findings.

Despite many shifting requirements due to the pandemic, HEDIS outcomes indicated that our providers maintained quality of care in the areas our members needed it the most.

Santa Cruz and Monterey saw great improvements in the measures for weight assessment and counseling pertaining to body mass index, nutrition and physical activity. Postpartum follow-up rates increased significantly, and chlamydia screening in women saw notable gains. Perhaps most impressive, child and adolescent well-care visits leapt past the NCQA 75th percentile benchmark, and well-child visits in the first 15 months showed shifts in improvement from a difficult 2021 reporting year.

Merced County data indicated improvements in postpartum follow-up and timeliness of prenatal care, achieving NCQA's highest standard of care – the 90th percentile. Controlling high blood pressure rates improved dramatically from the previous year, surpassing Monterey's and Santa Cruz's traditionally higher rates of performance. This is a great indication that our tri-county region flexes in ways where care is needed most.

HEDIS awards

Looking back to 2021 and the great efforts made by standout providers, we hereby announce the Measurement Year 2021 (MY2021) HEDIS Award winners.

HEDIS Measurement Year (MY) 2022 measure list update

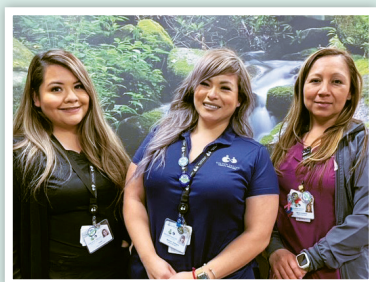
The Alliance has received an updated measure set called the Managed Care Accountability Set (MCAS) for HEDIS MY2022. Consisting of 30 reported measures, the MCAS continues to align with the Centers for Medicare & Medicaid Services Child & Adult Core Sets and the NCQA's HEDIS standards. The Alliance will be held to a minimum performance level (MPL) for 13 of these measures. See page 4 for a list of updated MCAS measures, including brief descriptions of their requirements. For more information and technical specifications, please email QI@ccah-alliance.org.

HEDIS MY2021 Award of Excellence winners



» Montage Medical Group – Carmel: Monterey County winner

We have exceeded the national 90th percentile average in the Breast Cancer Screening measure. The clinic has a dedicated team that performs targeted member outreach to close care gaps. The team reaches members by using data from our Provider Portal, and then they schedule appointments for members.



» Golden Valley Health Center – Los Banos: All County winner

In partnership with the Alliance's Quality Improvement team, we've increased well-care visit rates for Alliance members 3 to 17 years of age. Earning this HEDIS Engagement Award showcases the clinic staff's tireless efforts to identify patients in need of appointments and vaccines and work to make sure our services are highly accessible to members of our community.



» **St. Junipero Children's Clinic: All County winner**

We come close to the NCQA 90th percentile in childhood immunization rates by working as a team. We run reports periodically to make sure all patients who missed appointments are back on track. We call and text to remind members about appointments and make sure to update patients' phone numbers.

» **Newman Medical Clinic: Merced County winner**

We have been able to exceed the NCQA 90th percentile in the Counseling for Nutrition measure because of our medical assistants and providers. They work hard to provide counseling for nutrition and to enter visit information into patients' electronic medical records. We always work to employ and retain sufficient staff, and we use innovative ways to complete documentation.

Provider selections are based on the Merced, Monterey and Santa Cruz counties' reporting regions. Provider awardees had the highest aggregated rate across all HEDIS measures held to minimum performance level in their respective grouping.



» **Long Thao, MD – Merced: Merced County winner**

Our immunization rates approach 90th percentile levels. We encourage immunizations by having been in practice for 34 years and building families' trust. They understand that I want the best for their health and have confidence in what I recommend.

» **Plazita Medical Clinic: Santa Cruz County winner**

We have exceeded the NCQA 90th percentile by over 25% for Child and Adolescent Well-Care Visits for members 3 to 21 years of age by reaching out to patients' parents. We are open evenings and Saturdays to accommodate the working parent's schedule. We use lists from the Alliance portal and our own lists that show us the patients missing their physicals and immunizations.

» **Dignity Health Medical Foundation – Merced: All County winner**

Our clinic is honored to receive the HEDIS Engagement Award for our work on breast cancer screening intervention. Thank you to the Alliance for being a great partner in this journey.



» **Pediatric Medical Group of Watsonville: All County winner**

Our Well-Child Visits rates in members 0 to 15 months of age are almost 15% higher than NCQA's 90th percentile. To track when our patients are due for care, we generate lists from our EMR, and we compare this to the list of Alliance members in the report section of the Alliance Provider Portal. Our staff calls members to schedule appointments, and we send reminders by text, calls and letters. At appointments, providers make sure vaccinations are up-to-date and hand out educational materials, and the staff schedules the next appointment. Most important is to let families know that we truly care about their child's health.

» **Montage Medical Group – Upper Ragsdale: Monterey County winner**

Our prenatal care rates have been outstanding because the clinic reserves appointment slots for newly pregnant members. If needed, providers will double-book patients to ensure that pregnant members are seen.

MY2022 Managed Care Accountability Set measures

Measures held to MPL	Brief description				
Acute and Chronic Disease Management					
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9.0%)	Members 18-75 years of age with diabetes (type 1 and 2) whose HbA1c level was in poor control (>9.0%) during the measurement year.				
Controlling High Blood Pressure	Members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during 2022.				
Women's Health					
Breast Cancer Screening	Women 50-74 years of age who had a mammogram to screen for breast cancer anytime on or between Oct. 1, 2020, and Dec. 31, 2022.				
Cervical Cancer Screening	Women who were screened for cervical cancer using the following criteria: → 21-64 years of age who had cervical cytology performed within the last 3 years. → 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. → 30-64 years of age who had cervical cytology/hrHPV co-testing within the last 5 years.				
Chlamydia Screening in Women	Women 16-24 years of age who were identified as sexually active and who had a test for chlamydia.				
Prenatal and Postpartum Care	Timeliness of prenatal care: Women who had a prenatal visit within the first trimester or within 42 days of enrollment. Postpartum care: Women who had a postpartum visit between 7 and 84 days after delivery.				
Children's Health					
Child and Adolescent Well-Care Visits	Members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.				
Childhood Immunization Status – Combo 10	Children who received the following immunizations before their second birthday				
	→ 4 DTaP → 3 IPV	→ 1 HepA → 3 HepB	→ 3 Hib → 2 Flu	→ 1 VZV → 4 PCV	→ 1 MMR → 2 or 3 RV
Immunizations for Adolescents	Adolescents who received the following immunizations by their 13 th birthday: → 1 MCV (given 11-13 years) → 1 Tdap (given 10-13 years) → 2 HPV (given 9-13 years)				
Lead Screening in Children	Children 2 years of age who had one or more capillary or venous lead blood tests by their second birthday.				
Well-Child Visits in the First 30 Months of Life	Members who had the following number of well-child visits with a PCP during the last 15 months: 1. Six or more well-child visits for children who turned 15 months old during the measurement year. 2. Two or more well-child visits for children who turned 30 months old during the measurement year.				
Behavioral Health					
Follow-Up After Emergency Department Visit for Mental Illness – 30 days	The percentage of Emergency Department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit (31 total days).				
Follow-Up After Emergency Department Visit for Substance Use – 30 days	The percentage of Emergency Department (ED) visits among members ages 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit (31 total days).				

2023 Care-Based Incentive (CBI) program

Central California Alliance for Health's CBI program comprises a set of measures encouraging preventive health services and connecting Medi-Cal members with their primary care providers. The program offers financial incentives and technical assistance to support providers in helping members self-manage their care and reduce proximal health care costs. The CBI program pays qualifying contracted provider sites, including family practice, pediatrics and internal medicine. Provider incentives are broken into two categories:

- Programmatic measures are paid annually based on rate of performance in each measure.
- Fee-for-service (FFS) measures are paid quarterly when a specific service is performed or a measure is achieved.

CHANGES

Measure changes – redistribution of points

Points were reallocated for the new Health Equity measure.

- **Ambulatory Care Sensitive Conditions:** 1 point removed.
- **Preventable Emergency Visits:** 1 point removed.
- **Initial Health Assessments:** 1 point removed.
- **Quality of Care Measures:** 2 points removed.

RETIRED

Retired measures

- **Unhealthy Alcohol Use in Adolescents and Adults.**
- **Asthma Medication Ratio.**
- **90-Day Referral Completion.**
- **Tuberculosis (TB) Risk Assessment.**

NEW

Programmatic measures

Adverse Childhood Events (ACEs) Screening in

Children and Adolescents: This measure was moved from the exploratory to programmatic measure category. This measure is based on the percentage of members 1-20 years of age who are screened for ACEs annually.

Health Equity: This measure was moved from the exploratory to programmatic measure category. It will continue to assess racial/ethnic disparities in health plan performance via child and adolescent well-care visits.

The methodology has changed to close the gap to the 50th or 75th percentile by 50% based on baseline rates for the various races/ethnicities from Q4 2022.

FFS measures

Adverse Childhood Experiences (ACEs) Training and

Attestation: The plan shall pay providers, including mid-level providers and second- and third-year residents, for completing the ACEs Aware training and attestation. Providers will need to complete the ACEs Aware training and attestation to receive Prop 56 payment **and** to qualify for the new ACEs FFS measure.

Exploratory measures

Colorectal Cancer Screening: This measure looks at the percentage of members 45-75 years of age who had appropriate screening for colorectal cancer. For members 46-75 years old, you can use any of the following criteria for compliance:

- Fecal occult blood test within the last year.
- Flexible sigmoidoscopy within the last five years.
- Colonoscopy within the last 10 years.
- CT colonography within the last five years.
- Stool DNA with FIT test within the last three years.

See the 2023 CBI Incentive Summary for the full points breakdown:
www.morehealth.org/CBI-summary.

Tapering benzodiazepine dosages

If benzodiazepines are overprescribed or co-prescribed with opioids, patients may experience serious side effects, including death. It's important to limit benzodiazepine dosage and duration to the minimum needed for the necessary clinical effect.

Providers should regularly reassess patients' needs for benzodiazepines and discuss discontinuation strategies. Please review your patients' medical profiles and, if appropriate, consider tapering/discontinuing benzodiazepines to improve the safety of their drug regimen.

Please note:

- Tapering schedules should be individualized for each patient.
- Dosage should be adjusted based on the patient's response.

Based on the patient, a rapid or slow taper may be appropriate.

Rapid taper for patients who have taken benzodiazepines for <4 weeks. Benzodiazepine discontinuation takes place by a relatively larger drop in dose and

more frequent dose reduction than in a slow taper. A rapid taper might involve an initial 25%-30% dose reduction weekly until 50% of the dose is reached, followed by 5%-10% dose reductions weekly.

Slow taper for patients who have been on benzodiazepines for >4 weeks. A common approach is an initial dose reduction of 5%-25%, followed by further reductions of 10%-25% every 2 weeks.

If withdrawal symptoms occur, return to the dose prior to the most recent reduction and slow the rate of the taper.

For more information, refer to www.morehealth.org/tapering.

Naloxone for patients

California prescribers are required to offer naloxone or another drug approved by the U.S. Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression as a rescue medication when one or more of the following conditions are present:

- Prescription dosage for the patient is ≥ 90 mg morphine equivalent

daily dose.

- Opioid medication is prescribed concurrently with benzodiazepine or other central nervous system depressants.
- Patient presents with an increased risk for overdose, including a history of overdose, a history of substance use disorder or a risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.



Please review your patients' medical profiles and, if appropriate, consider prescribing or furnishing naloxone to improve the safety of your patients' drug regimens.

Note: These naloxone prescription requirements became effective per AB 2760 on Jan. 1, 2019.

Reference: Medical Board of California's FAQ document for AB2760: www.morehealth.org/AB2760FAQs.

Evusheld™ is underused in preventing COVID-19 infection

In June 2022, emergency use authorization of Evusheld™ was updated to recommend repeat dosing every six months. A Phase 3 study (TACKLE)¹ demonstrated a 50% decrease in the risk of progression to severe COVID-19 or death in the Evusheld™ treatment

group versus the placebo group.

Evusheld™ has only been administered to a fraction of eligible members since its initial approval in December 2021. We recommend that you consult your member panels, identify members who are moderately to severely

immunocompromised and recall them for Evusheld™ administration.

To locate COVID-19 therapeutics, including Evusheld™, visit www.morehealth.org/covid-19-therapeutics.

¹www.astrazeneca.com/content/aztraz/media-centre/press-releases/2021/azd7442-phiii-trial-positive-in-covid-outpatients.html

Enhanced Care Management and Community Supports: Services and referrals

At the beginning of 2022, Enhanced Care Management and Community Supports (ECM/CS) services became available to Alliance members. These services are part of the California Advancing and Innovating Medi-Cal initiative to address social determinants of health and improve health equity statewide.

The Alliance is committed to supporting providers in utilizing ECM/CS services to help members receive quality care and achieve their best possible health outcomes. Below, please find an overview of services and how to submit a referral.

Enhanced Care Management

ECM providers deliver:

- Member outreach and engagement.
- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional care.
- Individual and family support services.
- Referrals to community social supports.

Community Supports

The Alliance currently offers the following Community Supports:

- Housing Transition Navigation Services.
- Housing Deposits.
- Housing Tenancy and Sustaining Services.
- Medically Tailored Meals.
- Recuperative Care.
- Short-term Post Hospitalization Housing.
- Sobering Centers (Merced and Monterey counties).

To learn more about which ECM/CS services are currently available in Merced, Monterey and Santa Cruz counties, visit our ECM/CS provider page at www.morehealth.org/ECM.

How to submit referrals

Providers or requesting entities may submit ECM/CS referrals to the Alliance through the Provider Portal or by email, mail, fax or phone.



Provider Portal referral

Registered providers can log in to the secured Alliance Provider Portal to submit, inquire about, cancel or add information to existing referrals. Access the Provider Portal online at www.thealliance.health/for-providers/provider-portal.



Email, mail or fax

Alliance providers can submit referrals for ECM/CS by completing an Enhanced Care Management Provider Referral Form or a Community Supports Provider Referral Form. Both forms can be found on our website at www.morehealth.org/ECM.

Please return completed forms to the Alliance's ECM team by using one of the following methods:

- Email: listecmteam@ccah-alliance.org.
- Mail: Attention: ECM Team
1600 Green Hills Road, Scotts Valley, CA 95066.
- Fax: **831-430-5819**.



Phone

Refer a member to ECM/CS services by calling **831-430-5512**.

Here are some tips for a successful referral:

- Always include a population of focus when referring a member.
- Referrals are a "no wrong door" approach. We accept all incoming referrals.

If you have questions about the referral process, please call **831-430-5512**.

Physical therapy codes

The following CPT codes must be used when submitting claims for physical therapy:

Physical Therapy Codes for Medi-Cal Lines of Business (if CPT criteria met)

99243 An initial Physical Therapy Evaluation – requires a referral from the member's linked Primary Care Physician (PCP) or treating physician.

97110 Therapeutic procedure, 1 or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.

97014 Application of a modality to 1 or more areas: electrical stimulation therapy.

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.

97113 Aquatic therapy with therapeutic exercises.

97116 Gait training; includes stair climbing.

97124 Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).

97140 Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.

97530 Therapeutic activities direct (one-on-one) patient contact by provider, each 15 minutes.

97535 Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.

What you need to know

- An approved referral will allow up to 12 patient visits/service dates.
- Visits are limited to 60 minutes/4 units per service date.
- Separate anatomical sites require separate approved referrals.
- Frequency and unit limitations apply.
- Prior authorization is required for continued treatment beyond the initial 12-visit referral.
- Assigned referral numbers and authorization numbers must be submitted on claim forms.

» For more information regarding physical therapy, refer to the Alliance Provider Manual: www.morehealth.org/Alliance-Provider-Manual. You can also call the Claims Department Monday through Friday from 8:30 a.m. to 4:30 p.m. at **800-700-3874, ext. 5503**.



Important changes to prenatal screening program

Effective Sept. 19, 2022, providers should order both the circulating free DNA and maternal serum alpha fetoprotein screening tests using the CalGenetic Portal through the California Department of Public Health (CDPH). As of Sept. 19, 2022, the Alliance does not authorize these tests and will void them as a duplication of service that is available through CDPH.

For more information, visit www.morehealth.org/prenatal.

Social determinants of health (SDOH) screening

Screening members for SDOH factors helps providers understand the complexity of the members they serve. It also helps members improve their relationships and trust with their health care team. Clinicians can create a realistic care plan once they understand a member's current stressors and available resources.

Preparing to screen for SDOH

- Use a **checklist** to evaluate for clinic readiness to initiate SDOH screening, such as the American Academy of Family Physicians checklist: www.morehealth.org/SDOH-checklist.
- Use an **evidence-based screening tool**, like Accountable Health Communities Health-Related Social Needs Screening Tool¹ or the PRAPARE tool². Many electronic health record systems now offer these tools and others inside their systems.
- A **comparison of screening tools** is available at www.morehealth.org/screeningtools.

Set up your clinic for success

- Consult a **tool kit to support SDOH screening in clinical settings**, like one from the American Academy of Family Physicians, American Academy of Pediatrics or the National Association of Community Health Centers.
- **Partner with community-based organizations** to help make timely connections for members to resources.

Connect with patients

- **Sit down** to achieve eye-level communication.
- **Use plain language** and avoid medical jargon or technical terms.

SDOH diagnosis codes

In addition to completing the SDOH screening, list the issues as diagnosis codes on the medical claim. Diagnosis codes for SDOH can be found in coding resources and in DHCS APL 21-009: www.morehealth.org/SDOH-codes.

¹www.innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

²www.prapare.org

2022 Population Needs Assessment: Findings and action plan

The Population Needs Assessment (PNA) survey gives us feedback on what members think about the care and services they've received. Members shared that their PCP is good at scheduling appointments with a specialist when needed and that they have enough support to help their child lose weight.

Alliance members also shared that they'd be most interested in receiving information or help from us on how to access our transportation services, answer a health plan question, choose a doctor, and who to call at night when sick.

To ensure that we meet our members' needs, PNA feedback will be shared with Alliance staff, providers, our Member Services Advisory Group and our community partners. We will continue testing our materials in the community to build a greater awareness of how to contact us with questions, set up transportation, pick a doctor and call the Nurse Advice Line. We will also share our action plan to address member needs for health education, cultural and linguistic services, and quality improvement programs.

Access the 2022 PNA Report at www.morehealth.org/2022-PNA-report.

Proven strategies for improving immunizations and well-child visits

Well-child visits and immunizations are critical parts of pediatric care. These areas are measured by MCAS¹ and are part of our Care-Based Incentive program.² During the pandemic, rates of well-child visits and immunizations dropped significantly, posing a challenge for providers to bring rates back up as families begin to resume care.

The Alliance is committed to supporting provider offices with information to help children catch up on care. Here are some proven strategies for improving immunizations and well-child visits within your office.



Immunizations

- Keep spreadsheets from your medical record system to track when patients are due next for vaccines, and cross-reference the spreadsheet with Provider Portal reports every month.
- For any child behind on vaccines, call the parent or guardian and schedule a visit. If the patient does not show, call the parent or guardian again.
- After three attempts to call the patient's parent or guardian, if they are still resistant to vaccine follow-ups, then discuss vaccines at their next well-child visit.



Well-child visits

- Track when each child's next visit is due using your medical record system and following the Bright Futures Periodicity Schedule: www.morehealth.org/periodicityschedule.
- For older children, reach out the month of the child's birthday and schedule the visit as close as possible to the child's birthday.
- Following every well-child visit, schedule the next visit while the parent or guardian is there in person, even if the next visit is a year out. This can be communicated to the parent or guardian as a way to "save their place" on the schedule.



Appointment reminders

- Send text messages two days before the patient's appointment, with the prompt to reply "C" to confirm the appointment.
- If no text response is received from the patient's parent or guardian, then call them to confirm.
- On the day of appointment, if the patient's parent or guardian has not been reached to confirm, give them a 10-minute grace period.
- For patients with more than a couple of no-shows, flag the member as unconfirmed in your appointment system and use that appointment space for urgent visits or walk-ins.




Improving pediatric measures

- Leverage missed opportunities (episodic and sick visits) to increase preventive services (immunizations) by converting acute visits into well-visits when possible.
- Book out infant visits (for example, book two to three at a time).
- Shorten the time between visits, if needed, to catch up. For example, if a child missed their 2-month check, complete it at 3 months and keep the 4-month visit on schedule (you can bill infant well-visits every 14 days until the child is 12 months old).
- Use minimum spacing between vaccines when needed to stay on schedule. For more information, see the Centers for Disease Control and Prevention's Catch-up Immunization Schedule: www.morehealth.org/catch-up.

¹www.morehealth.org/hedis

²www.morehealth.org/care-based-incentive

 For more strategies on how to optimize well-child visits from 0 to 15 months, read best practices from MDwise at www.morehealth.org/best-practices. You can also contact your Alliance Provider Relations Representative at **800-700-3874, ext. 5504**.



COVID-19 vaccines for children 6 months through 5 years old

In June of this year, the U.S. Food and Drug Administration approved a COVID-19 vaccine for children 6 months through 5 years old, providing some of our youngest population with protection from serious illness, hospitalization and death. However, the vaccination rate for this age group remains low, and talking with parents about vaccines can be challenging. Here are four steps recommended by the Centers for Disease Control and Prevention¹ that can aid in these conversations:

How to talk to parents about COVID-19 vaccines

- 1 Be empathetic and sensitive to culture and circumstances.
Remember that debating does not work.
- 2 Ask permission to discuss vaccines.
- 3 Ask a scaled question. For example, "On a scale of 1 to 10, how likely are you to vaccinate your child against COVID-19?"
- 4 Respond to questions with competency and provide scientific information.

COVID-19 vaccines and dose spacing for children

Vaccine	Number of doses	Dose spacing
Pfizer (6m-4yrs)	3	First and second: at least three weeks apart, with the third dose two months after the second dose.
Moderna (6m-5yrs)	2	One month (or 28 days) apart.

The COVID-19 immunization schedule for people 6 months and older can be found at www.morehealth.org/COVID-immunization-schedule.

¹www.cdc.gov/vaccines/covid-19/hcp/engaging-patients.html

Healthier Living Program

The Alliance's Healthier Living Program (HLP) helps members with chronic conditions control their symptoms and understand how their health problems affect their lives. Topics include pain management, nutrition, exercise, stress reduction, emotions and communicating with doctors. The HLP also allows members to connect with other members who are experiencing similar life challenges.

The six-week workshop is offered online, over the phone and in person at community locations. Members who participate receive a Target gift card for up to \$50.

Providers can refer members to HLP workshops by submitting a **Health Education and Disease Management Referral Form** on our website: www.morehealth.org/disease-management-referral. We also have flyers in English, Spanish and Hmong available: www.morehealth.org/disease-management-flyers.

For more information, call the Alliance Health Education Line at **800-700 3874, ext. 5580**.

Important phone numbers

Provider Services	831-430-5504
Claims	831-430-5503
Authorizations	831-430-5506
Status (non-pharmacy) . .	831-430-5511
Member Services	831-430-5505
Web and EDI	831-430-5510
Cultural & Linguistic Services	831-430-5580
Health Education Line . .	831-430-5580



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New providers

Merced County

Primary Care

- Jaideep Misra, MD, *Internal Medicine*
- Augustine Provencio, MD, *Family Medicine*
- Roger Quach, DO, *Family Medicine*
- Marc Kevin Yee, MD, *Internal Medicine*

Referral Physician/Specialist

- Gregory Glover, MD, *Interventional Cardiology*
- Francisco Lazaga, MD, *Diagnostic Radiology*
- Nicole Nocera, MD, *Diagnostic Radiology*
- Bradford Piatt, MD, *Diagnostic Radiology*
- H. Sapna Reddy, MD, *Diagnostic Radiology*
- Nikki Tang, MD, *Dermatology*
- Craig Zippe, MD, *Urology*

Monterey County

Referral Physician/Specialist

- Margaret Cooper-Vaughn, MD, *Obstetrics and Gynecology*
- David Dansky, MD, *Emergency Medicine*

Santa Cruz County

Primary Care

- Margaux Lazarin, DO, *Family Medicine*

Referral Physician/Specialist

- Nilda Moreno-Ruiz, MD, *Obstetrics and Gynecology*
- Amila Silva, MD, *Ophthalmology*
- Jeffrey Tsao, MD, *Ophthalmology*



ALLIANCE HOLIDAY CLOSURES

- Friday, Dec. 23, 2022
(Christmas Eve observed)
- Monday, Dec. 26, 2022
(Christmas Day observed)
- Monday, Jan. 2, 2023 (New Year's Day observed)
- Monday, Jan. 16, 2023
(Martin Luther King Jr. Day)
- Monday, Feb. 20, 2023
(Presidents Day)