THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

- ☐ Imperial
- ☐ Riverside/San Bernardino
- ☒ Los Angeles
- ☐ Orange
- ☐ Sacramento
- ☐ San Diego

LINES OF BUSINESS:

- ☐ Molina Medi-Cal Managed Care
- ☐ Molina Medicare Options Plus
- ☒ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
- ☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

- ☐ **Medical Group/ IPA/MSO**

Primary Care

- ☐ IPA/MSO
- ☐ Directs

Specialists

- ☐ Directs
- ☐ IPA
- ☐ **Hospitals**

Ancillary

- ☐ CBAS
- ☒ SNF/LTC
- ☐ DME
- ☐ Home Health
- ☐ Other

FOR QUESTIONS CALL PROVIDER SERVICES:
(855) 322-4075, Extension:

Los Angeles/Orange Counties

X111113 X123071
X127657

Riverside/San Bernardino Counties

X127684 X120618

Sacramento County

X121360

San Diego County

X121805 X121401
X127709 X121413
X123006 X121599

Imperial County

X125682 X125666

Skilled Nursing Facility Flu Vaccination

This is an advisory notification to Molina Healthcare of California (MHC) network providers. As a Molina Healthcare contracted skilled nursing facility, you play a critical role in our members' health and their decision to get vaccinated against influenza.

The Advisory Committee Immunization Practices (ACIP) recommends annual influenza vaccination for everyone 6 months and older to prevent influenza. **This is particularly important for people who are at high risk of serious complications from influenza, which includes residents of long term care facilities.** As the influenza vaccines are typically available beginning in September, the Center for Disease Control and Prevention (CDC) recommends that the vaccination should be offered by the end of October.

We are requesting your support in coordinating the efforts of administering the vaccine at your facility to our members, which includes:

- **Member education**
- **Ordering of vaccines and supplies**
- **Facilitating communication between member and Primary Care Physician (PCP)**

We also ask that the attached Flu Vaccination Attestation be filled out and signed by the patient or patient's legal representative.

Please fax the completed Attestation to **Molina PDSA** at **(562) 499-6105**.

Below are additional materials for your reference and to distribute to your staff.

Reference Materials

"Key Facts about Seasonal Flu Vaccine." Centers for Disease Control and Prevention. https://www.cdc.gov/flu/protect/keyfacts.htm

"Frequently Asked Flu Questions: 2019-2020 Influenza Season." Centers for Disease Control and Prevention. https://www.cdc.gov/flu/season/flu-season-2019-2020.htm

CMS and DHCS Project Notice

As a Cal MediConnect Medicare-Medicaid Plan, Molina Healthcare participates in a Plan-Do-Study-Act (PDSA) as part of a Centers for Medicare & Medicaid Services and Department of Health Care Services quality improvement strategy to reduce avoidable hospitalizations for nursing facility residents. The ultimate goal of the PDSA continues to be to reduce avoidable hospitalizations or re-hospitalization by treating the member-in-place when medically appropriate in lieu of an immediate referral to an emergency room or hospital.

Molina Healthcare has collaborated with Care Connect Medical Group to address Molina's PDSA for Molina Duals patients assigned to Care Connect.

If your Molina Duals patient is with Care Connect, contact Care Connect:

- Prior to a patient transferring to acute hospital.
- For any patient needs or change of condition.
- For admit to hospice care.
- When patient is discharging from SNF.

Contacting Care Connect:

- Call at (888) 789-9585.
- MD/NP available 24 hours/7 days a week.
- Always mention patient is "Molina Duals."

QUESTIONS

If you have any questions regarding the notification, please contact your Molina Provider Services Representative at (855) 322-4075. Please refer to the extensions on page one.

Patient Name

Date of Birth

Date

Molina Dual Options Cal MediConnect Plan Medicare-Medicaid Plan

Flu Vaccination Attestation

This signed form shows that _____
Patient Name or Legal Representative

has gotten the Vaccine Information Statement. The forms for flu vaccine were also given. There was a chance to have all questions answered.

☐ I ***accept*** this vaccination with informed consent.

☐ I ***decline*** this vaccination with informed consent.

If declined, why?

_____
Patient or Legal Representative Signature

_____
Printed Patient or Legal Representative Name

_____
Facility Name

_____
Facility Representative Printed Name

_____
Facility Representative Signature