HealthPlan OF SAN MATEO
Healthy is for everyone

Provider Manual

Section 9

Quality Improvement

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Introduction

The purpose of the Health Plan of San Mateo's (HPSM's) Quality Improvement (QI) Program is to establish methods for systematically working to ensure that all HPSM members receive high quality health care and to help optimize their health status. Through the QI Program and in collaboration with HPSM providers, HPSM strives to continuously improve the structure, processes and outcomes of its health care delivery system.

HPSM's QIP has a commitment to quality that relies on HPSM senior management oversight and accountability, and integrates the activities of all departments in meeting program goals and objectives. The QIP involves members, participating providers, regulators, plan sponsors and evaluators in the development, evaluation, and planning of quality activities.

HPSM incorporates continuous quality improvement methodology that focuses on the specific needs of HPSM customers. It is organized to identify and analyze significant opportunities for improvement in care and services, to develop improvement strategies and to systematically track whether these strategies result in progress towards established benchmarks or goals. Focused QI Program activities are carried out on an ongoing basis to ensure that quality of care issues are identified and corrected. Quality studies and monitoring activities are reported through the quality committee structure to HPSM's governing body. The QI Program Description is reviewed and updated annually.

Provider Site and Medical Record Review

The purpose of the provider site and medical record review is to ensure that primary care providers, pediatricians, obstetricians/gynecologists and high volume SPD-seniors and persons with disabilities-network referral specialty providers, CBAS Centers and high volume SPD ancillary services, are in compliance with applicable local, state, federal and HPSM standards. **HPSM** conducts provider site reviews for all new Medi-Cal PCPs, pediatricians, and OB/GYNs, as a pre-contractual requirement prior to completion of initial credentialing. **HPSM** conducts provider site reviews triennially for PCPs, pediatricians, and OB/GYN providers as a requirement of participation in the California Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications. This is a requirement of HPSM's contract with the State.

A full scope review is conducted utilizing the criteria and guidelines of the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD). The criteria is outlined in a MMCD Policy Letter 02-02 dated May 16, 2002 or superseding Policy Letter, Full Scope Site Review & Medical Record Review Survey 2012 & Guidelines, and Policy

Letter 12-006, superseding MMCD PL 11-013[1] or updates, and summarized here. In addition to the criteria noted in the policy letter, supplemental criteria may be used by HPSM to address additional requirements applicable for quality studies.

A full scope site review is not required automatically as a part of the re-credentialing process. Re-credentialing includes information from other sources pertinent to the credentialing process such as quality improvement criteria and may include medical record reviews.

Full Scope Facility Site Review

Initial Reviews

All primary care sites serving HPSM managed care members undergo an initial site review prior to completion of credentialing and assignment of members to the prospective provider. The schedule for performing a facility site review is determined by Quality Program staff and the prospective provider. It is based on the prospective credentialing date as well as the provider's availability and preference. A copy of the 2012 Facility Site Review Survey Tool, 2012 Medical Record Review Survey Tool, 2012 FSR Guidelines, 2012 MRR Guidelines, and Physical Accessibility Review, is mailed to each provider with notification of the review date. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

Recertification Reviews

Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with HPSM and Medi-Cal criteria and guidelines.

Moving to or Adding a New Site

Providers who move to a new site or open an additional office site must have a facility site review at their new location. The site review must be completed as soon as possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), but no later than 30 calendar days after the date the new site was opened for business (or HPSM's notification date). The site review for relocated offices must be completed prior to the provider's re-credentialing date.

[1] (MMCD Policy Letter 03-02 Dated June 23, 2003, MMCD Policy Letter 02-03 Dated May 16, 2002, MMCD Policy Letter 02-02 Dated May 16, 2002 or superseding Policy Letter 96-6), 2012 Full Scope Site Review Survey, 2012 Medical Record Survey Tool, 2012 FSR & 2012 MRR Guidelines, MMCD Policy Letter 12-0006, Superseding MMCD PL 11-013.

Adding a New Provider

Providers who move into an office which has a current site review will only require a medical record review to be credentialed.

When More Frequent Site Reviews May Be Necessary

HPSM reviews sites more frequently when it determines this to be necessary, based on findings from monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Assessment and Improvement Committee, or the Commission. Additional reviews may also be done at the discretion of the Medical Director or the Quality Nurse, after discussion with the Medical Director, if patient safety or compliance with applicable standards is in question.

The Site Review Survey Tool is mailed to providers prior to an on-site audit. Relevant information is presented and shared with provider office staff at the time of the site review.

Medical Record Review

A minimum of ten (10) medical records are reviewed initially for each primary care provider as part of the initial site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review. If additional records are reviewed, scores must be calculated as outlined below.

Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review of 10 medical records. If there are still fewer than 10 records for assigned members at the end of six months, a medical record review is completed on the total number of records available and the scoring is adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Site Review Survey and Medical Record Scoring

A minimum passing score of 80% on **both** the Site Review Survey and Medical Record Review Survey is required. Scores are computed based on the following checklist of categories and assigned values:

Site Review Survey:	
Access/Safety	29 points
Personnel	22 points
Office Management	25 points
Clinical Services	34 points
Preventive Services	13 points
Infection Control	27 points
Total	**150 points**

Medical Record Review Survey:	
Format	80 points
Documentation	70 points
Continuity/Coordination	80 points
Pediatric Preventive (if applicable based on case mix)	(19) X # of records
Adult Preventive (if applicable based on case mix)	(15) X # of records
OB/CPSP Preventive (if applicable based on case mix)	(20) X # of records
Total	**Points possible will differ from site to site**

The Site Review survey is scored in the following manner:

1. Full Pass: 100%
2. Exempted Pass: 90% or above, *without* deficiencies in critical elements, Infection Control, Pharmacy, or any one section scoring below 90%.
3. Conditional Pass: 80-89%, or 90% or above *with* deficiencies in critical elements, scoring below 90% in a section, or a deficiency in pharmaceutical services, or infection control.

4. Not Pass: below 80%

The Medical Record Survey is scored in the following manner:

1. Full Pass: 100%
2. Exempted Pass: 90% or above: (Total score is greater than or equal to 90%, and all section scores are 80% or above).
3. Conditional Pass: Total MRR is 80-89% or any section(s) score is <80%
4. Not Pass: Below 80%

Critical Elements for Scoring

There are *nine critical elements* related to the potential for adverse effect on patient health or safety. These have a scored "weight" of two points. All other survey elements are weighted at one point. A full point is given if the scored element meets the applicable criterion. Zero points are given for any scored element that is considered only "partially" met by the reviewer. Zero points are given if an element does not meet criteria. The nurse reviewer determines the "not applicable" (N/A) status of each criterion based on the site-specific assessment. The reviewer must explain all criteria that are scored as zero or N/A.

The nine critical elements are:

1) Exit doors and aisles are unobstructed and egress (escape) accessible.
2) Airway management equipment, appropriate to practice and populations served, are present on site.
3) Only qualified/trained personnel retrieve, prepare or administer medications.
4) Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5) Only lawfully-authorized persons dispense drugs to patients.
6) Personal Protective Equipment (PPE) is readily available for staff use.
7) Needle stick safety precautions are practiced on-site.
8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazard non-sharps) are placed in appropriate. leak-proof, labeled containers for collection, processing, storage, transport or shipping.
9) Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.

An acceptable corrective action plan must be submitted within 10 business days of the survey date for any deficiencies found during any monitoring visits for any of these critical elements. This is regardless of the survey score attained. Corrections must be made within 30 calendar days of the survey date.

Corrective Action Plans (CAPs)

Sites that receive an Exempted Pass (90% or above, *without* deficiencies in critical elements, pharmaceutical services, or infection control, or less than 90% in a section) are not required to complete a corrective action plan (CAP) unless determined necessary by HPSM. However,

all sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements, less than 90% in a section, or a deficiency in pharmaceutical services, or infection control) must complete an acceptable CAP to address the cited deficiencies.

HPSM staff provides a written report of site survey findings that specifies any deficiencies for all critical and non-critical elements. For all critical and non-critical elements requiring immediate correction, providers must submit an acceptable CAP that attests that corrections were completed within 10 business days of the survey date. Within 30 days of the survey date, HPSM staff verifies corrections of critical elements and other survey deficiencies requiring immediate correction. For all other non-critical deficiencies, providers must submit an acceptable CAP by 30 calendar days from the date of the written CAP request.

Providers' CAP documentation must identify the specific deficiency, an acceptable plan of corrective action(s) needed, projected and actual date(s) of the correction, re-evaluation timelines/dates, and responsible persons(s). HPSM staff, with oversight by HPSM's Medical Director, will review the CAP to determine if it is acceptable. HPSM's Peer Review Committee may be consulted for advice on standards of practice issues as necessary.

If the CAP cannot be verified and approved within 60 days from the date of the written CAP request, an on-site visit may be scheduled. If the CAP cannot be closed, the provider will be referred to the Medical Director. The reasons for a late CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

Providers may request a time-specific extension period to complete corrections if extenuating circumstances that prevented completion of corrections can be demonstrated, and if agreed to by HPSM. (This period may not exceed 90 calendar days from the survey findings report and CAP notification date unless a longer extension is approved by the State of California Department of Health Care Services.). HPSM will perform a focused review at any site that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

Once a CAP is approved, it will be reviewed by the Medical Director as part of the Credentialing Review process.

Non-Passing Providers

A *pre-contractual provider* who scores below 80% on the full scope site review survey will not be recommended for credentialing completion or contract approval until a passing score is achieved and correction of any missed critical elements is verified. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey. After achieving a score of 80% or higher, a CAP must be completed as previously described.

Contracted providers who fail the site review upon recertification survey are notified of the survey score, all cited deficiencies and CAP requirements at the time of the failed survey.

Providers who do not complete a CAP that addresses the deficiencies completely will be referred to the Medical Director for review and possible referral to the Peer Review Committee. The reasons for an unacceptable CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

HPSM may suspend any contracted provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by HPSM staff within the CAP timelines previously noted. New members will not be assigned to the provider until a score of 80% is achieved on a subsequent full scope site review and required corrections are verified and the CAP is closed.

Non-Compliant Provider

Any network provider who does not comply with survey criteria within the established timelines will be subject to Peer Review action and may be recommended for removal from the network. In such an instance, HPSM members will be re-assigned to other network providers following plan policies and procedures.

Provider Appeal Process

Providers removed from the network may appeal the decision. HPSM has a formal process to resolve grievances submitted by providers. Please refer to Section 5 -Provider Disputes and Grievances for additional information. If verified evidence of corrections is accepted by HPSM and the removal decision is reversed, a Site Survey may be repeated. If the current survey and CAP are accepted, the site will be re-surveyed no later than 12 months following closure of the CAP. If HPSM does not reverse the decision, and the provider would like to again become an HPSM provider, he/she may re-apply through HPSM's application process. As previously noted, all applicants must undergo and pass an initial Full Scope Survey.

Facility Site Focused Review

Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The focused review is a "targeted" audit of one or more specific site or medical record review survey areas and is not substituted for the full scope survey. Reviewers may use appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review require the completion and verification of corrective actions according to CAP timelines previously described.

Facility Site Monitoring

HPSM staff monitors any contracted HPSM physician practice site between regularly

scheduled full scope site review surveys. This may include visits for quality activities or follow up on member complaints. Indications of site deficiencies discovered through monitoring activities will require on-site inspection according to site review requirements. As a result, HPSM may schedule a full scope site review audit, conduct an additional focused onsite review, or conduct a medical record review. When non-compliance with the nine (9) Critical Elements is identified through monitoring processes, HPSM will determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

Healthcare Effectiveness Data and Information Set (HEDIS)

HPSM is required by the State of California Department of Health Care Services (DHCS) to perform quality measure studies for our Medi-Cal line of business. The Centers for Medicare and Medicaid Services (CMS) require HPSM to perform quality studies for HPSM's CareAdvantage and Cal MediConnect programs as well. In addition, as the Third Party Administrator for the Access to Care for Everyone (ACE) program, San Mateo County's indigent care program, HPSM collects quality measures for this program also. The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that purchasers and consumers of health care services have the information they need to compare the performance of managed health care plans. DHCS and CMS use HEDIS measures to assess how well HPSM is providing quality services for our members. The funders of ACE have asked that we use select HEDIS measures to demonstrate level of quality of care for this population as well.

There are two phases to each HEDIS study. HPSM's data analysts perform the first phase by examining HPSM's administrative data (e.g. claims data and enrollment information). This type of information may not fully reflect the actual care provided to our members when the services are capitated and not separately billed to HPSM. In phase two, HPSM staff, or contracted vendor staff, undertakes an extensive examination of the relevant members' medical records in provider offices. In these ways, data is collected that provides information to DHCS, CMS and San Mateo County about the level of clinical care, preventive care, access to care and utilization of services that HPSM members receive.

Clinical Practice Guidelines and Best Practices

Clinical practice guidelines help to improve the quality of care for our members by providing HPSM physicians with systematically developed, evidence-based guidelines on best practices. These guidelines assist both physicians and patients in decision-making regarding appropriate health care for specific clinical circumstances.

HPSM promotes the use of practice guidelines that have been developed using nationally recognized scientific evidence published in peer reviewed journals, released by Specialty

Societies or Academies, or promulgated by national advisory committees.

The guideline topics and resources are evaluated and updated at least annually, with the input of HPSM's Quality Improvement Committee (QIC) and any other interested HPSM provider. Providers can access the clinical guidelines in the Provider Resources section of the HPSM website: www.hpsm.org/provider/resources/guidelines

Additional resources

National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov/guidelines/index.htm

United States Preventive Services Task Force: www.ahrq.gov/clinic/uspstfix.htm

Quality Committees

HPSM has multiple avenues for physicians to contribute to its quality program. The most important way is through providing high quality and preventive care to HPSM members. Without our providers, HPSM could not offer services to our members.

HPSM's Medical Directors and Provider Network Manager have an "open door" policy. Contact information is freely available to physicians. When any physician has a quality improvement suggestion or a quality concern, they are encouraged to contact these or any otherHPSM staff to share their thoughts, via phone, e-mail or letter.

There are also formalized ways for HPSM providers to participate in quality activities with the plan. These are through the San Mateo Health Commission quality advisory groups.

Physician Advisory Group (PAG)/Peer Review Committee (PRC)

Purpose/Responsibilities

- Serves in an advisory capacity to HPSM, providing community physician insight and feedback on the quality initiatives of the plan.
- Reviews areas in need of quality improvement identified via HEDIS or other comparable measurements and assists HPSM in developing potential interventions.
- After quality improvement initiatives are developed, provides feedback on the tools, materials, incentives, etc. that are developed to implement the initiative.
- As HPSM practicing physicians, provide real-world feedback on how they, their colleagues and their patients are accepting/participating in HPSM's quality initiatives, to help HPSM continuously improve its efforts and outcomes.
- The PRC meets regularly to review all HPSM credentialing recommendations and to address HPSM credentialing concerns (e.g. when a potential provider does not appear to meet or no longer appears to meet HPSM credentialing requirements). The PRC

meets confidentially to provide a peer-based resource for reviewing provider issues related to credentialing, quality of care issues or similar concerns.

- Where indicated, the PRC makes recommendations (e.g. regarding sanctions) to the San Mateo Health Commission for final decision-making. Any sanctions or actions affecting individual providers are protected by Evidence Code 1157.

Membership

Committee membership is reflective of the provider network. It includes a physician member of the San Mateo Health Commission, a physician of the San Mateo Medical Center, a maximum of nine HPSM contracting physicians, the majority of whom are primary care physicians from the adult and pediatric community (representing care of adults and children) and at least three specialists representing different disciplines.

Quality Improvement Committee (QIC)

Purpose/Responsibilities

The Quality Improvement Committee (QIC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QI activities, and ensures practitioner participation in the QI program through planning, design, implementation, or review. The QIC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIC meets and reports at least quarterly to the Commission.

Membership

The QIC is a multi-disciplinary committee, the membership includes:

- At least one Commission member, (Current chair)
- Medical Director, (Current co-chair)
- Quality Improvement Director
- Practicing network physicians
- Support staff and guests will be invited to attend the meetings as reporting requirements dictate.

San Mateo Health Commission

Purpose/Responsibilities

- Delegates management of the QIP to HPSM's Executive Director while retaining overall authority and responsibility for program implementation, continuity and effectiveness.
- Monitors QP strategies and activities outlined in HPSM's QP Annual Report/Evaluation and Work Plan, and at the time of any substantive revision.

- Monitors and reviews HEDIS results and establishes activities/opportunities for improvement
- Reviews the identification of Quality of Care issues and development of Quality Improvement Projects to establish interventions/activities
- Reviews quarterly reports about monitoring and evaluation activities performed as a result of the QP implementation, discusses these reports as necessary, raises any issues of concern and requests follow-up as indicated.
- Identifies opportunities to improve care and service, directs action to be taken, or resolves problems when indicated, independent of any other quality activities.

Membership

Members are appointed by the San Mateo County Board of Supervisors and include: two members of the San Mateo County Board of Supervisors; the San Mateo County Manager or his/her designee; an HPSM contracted physician; a public representative of senior and/or minority communities in San Mateo County; a representative beneficiary served by the commission; a San Mateo County hospital staff physician; an HPSM contracted pharmacist, and a member of the public at large.

Quality Improvement Projects

HPSM is required by the State of California to conduct and/or participate in at least two Performance Improvement Projects (PIPs) annually. These projects may be based on HEDIS measures or other measures that have been identified by HPSM as opportunities for improvement.

The Center for Medicare and Medicaid Services (CMS) requires HPSM to conduct a Quality Improvement Project yearly as well (QIP)s. CMS dictates that each QIP run for three consecutive years and consist of three phases: baseline assessment, intervention, and evaluation.

Even when QIPs focus on member activities, they cannot succeed without our provider network participation, so HPSM always appreciates provider input and feedback on the PIPs and QIPs. All projects are presented at the Quality Improvement Committee meetings, as well, to ensure that the tools and interventions planned appear feasible and useful from a provider perspective.

The QI Department works on a variety of topics including but not limited to the following:

- Asthma
- Cancer Screening
- Chlamydia Screening

- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Prenatal & Postpartum Care
- Reducing Health Disparities
- Reducing 30 Day Readmissions
- Well Visits for Children and Adolescents

Providers are encouraged to contact HPSM if they are currently working on any of these topics to discuss ways that HPSM can provide support for these efforts.

Individual Health Assessment (IHA)

An IHA is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her PCP. HPSM is required by the California Department of Health Care Services (DHCS)and the Centers for Medicare and Medicaid Services to ensure that all newly enrolled HPSM members receive an Initial Health Assessment (IHA) within 120 days of enrollment. . HPSM encourages providers to use the DHCS Staying Healthy Assessment (SHA) tool to receive an additional incentive, and help meet this requirement (see below).

Assessment Components

The IHA consists of a comprehensive history, physical, mental status assessment and where age appropriate, developmental exam, diagnosis and plan of care, preventive services and the Staying Health Assessment (SHA) is also required. The SHA is a standardized form used by all managed care plans to streamline the Individual Health Education Behavioral Assessment (IHEBA).

Staying Healthy Assessment (SHA) Tool

The Staying Healthy Assessment (SHA) Tool assists PCPs in:

- Identifying and tracking individual health risks and behaviors
- Targeting health education counseling interventions
- Providing referral and follow-up.

The SHA tool should become a permanent part of the member's medical record and be referred to annually. When potentially high risk health behaviors are identified, PCPs are expected to ask appropriate follow-up assessment questions to identify patient's health education needs and facilitate focused educational counseling that addresses health behavior changes. If providers identify concerns that need additional evaluation, referrals to

resources such as behavioral health, substance treatment, other specialty providers, etc. should be made.

Facilitating health education intervention

Information provided on the Staying Healthy Assessment tool combined with the patient's medical history, conditions, problems, testing results, and other related factors, can help a provider recommend appropriate health education interventions. If a member is in need of a health education service that is not outlined in the HPSM provider manual, , the provider is encouraged to contact the Health Education department at (650) 616-2165 for information about other community resources.

Medi-Cal and Care Advantage Pay for Performance (P4P) Program

HPSM has a Pay for Performance programs for contracted Medi-Cal and CareAdvantage primary care providers. Additional program information can be found in the program guidelines on the HPSM website, www.hpsm.org.

Potential Quality Issues (PQI)

What is a PQI?

A Potential Quality Issue (PQI) is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern exists.

Purpose: To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue to determine opportunities for improvement in the provision of care and services to Health Plan of San Mateo (HPSM) members, and to direct the appropriate actions for improvement based upon outcome, risk, frequency and severity.

How are PQI's Identified?

- Member grievances
- Concurrent, prospective and retrospective utilization review
- Claims and encounter data
- Care coordination
- Medical record audits

What happens when a quality issue is identified?

Medical records/initial provider responses are usually requested. Note that HPSM contracted

providers are mandated to response to requests.

A Quality Improvement Nurse conducts a multi-step quality review which is then evaluated and finalized by a HPSM Medical Director.

The provider of concern is notified if the HPSM Medical Director finds that a quality of care issue has occurred. A corrective action plan or other follow ups may be requested from the provider of concern.

Based on the nature or complexity of the case, it can be referred to the Peer Review Committee (PRC) for final determination. The PRC is comprised of HPSM network providers who represent multiple disciplines.

Who can refer a PQI?

- Health plan staff
- Health plan members
- Any contracted or non-contracted provider and staff
- Any member of the community

When should a PQI be referred?

- Any time there is a suspected quality of care concern; some examples may include:
- A delay in obtaining a referral
- Rudeness from clinical providers or clinical staff members
- Possible inadequate assessment of an adult or child
- Complication in the delivery of a child
- Unexpected death of an adult or child

How can a PQI be referred?

Please use the PQI Referral Form. The form can be downloaded from the Provider Forms page on hpsm.org. You can also request a copy of the form via email (pqireferralrequest@hpsm.org) or by calling 650-616-2579. Complete forms can be returned by fax to 650-616-2030.