Regular Meeting of the

## Santa Clara County Health Authority
## Quality Improvement Committee

Wednesday, December 9, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

**Via Teleconference**
(669) 900-6833
Meeting ID: 945 6646 6475
https://zoom.us/j/94566466475
Passcode: QIC120920

# AGENDA

| | | | | |
|---|---|---|---|---|
| **1.** | **Roll Call** | Dr. Paul | 6:00 | 5 min |
| **2.** | **Public Comment**<br>Members of the public may speak to any item not on the agenda; two minutes per speaker. The Quality Improvement Committee reserves the right to limit the duration of the public comment period to 30 minutes. | Dr. Paul | 6:05 | 5 min |
| **3.** | **Meeting Minutes**<br>Review minutes of the October 21, 2020 Quality Improvement Committee meeting.<br>**Possible Action:** Approve minutes of the October 21, 2020 Quality Improvement Committee meeting | Dr. Paul | 6:10 | 5 min |
| **4.** | **CEO Update**<br>Discuss status of current topics and initiatives. | Ms. Tomcala | 6:15 | 10 min |
| **5.** | **Provider Accessibility Assessment**<br>Review the Provider Accessibility Assessment.<br>**Possible Action:** Approve the Provider Accessibility Assessment | Ms. Switzer | 6:25 | 10 min |
| **6.** | **QI.30 Private Duty Nursing Policy**<br>Review the QI.30 Private Duty Nursing Policy.<br>**Possible Action:** Approve the QI.30 Private Duty Nursing Policy | Ms. Singh | 6:35 | 5 min |
| **7.** | **Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis**<br>Review the Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis.<br>**Possible Action:** Approve the Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis | Ms. Franke-Brauer | 6:40 | 10 min |

| | | | |
|---|---|---|---|
| **8. Annual Cal Medi-Connect (CMC) Continuity and Coordination of Medical Care Analysis (2020)**<br>Review the Annual CMC Continuity and Coordination of Medical Care Analysis (2020).<br>**Possible Action:** Approve the Annual CMC Continuity and Coordination of Medical Care Analysis (2020) | Ms. Patel | 6:50 | 10 min |
| **9. Personalized Information on Health Plan Services**<br>Review the Quality and Accuracy of Information on Web and Telephone Functionality.<br>**Possible Action:** Approve the Personalized Information on Health Plan Services | Ms. Nguyen | 7:00 | 10 min |
| **10. Pharmacy Benefit Information**<br>Review the Quality and Accuracy of Pharmacy Benefit Information.<br>**Possible Action:** Approve the Pharmacy Benefit Information | Ms. Nguyen | 7:10 | 10 min |
| **11. Grievance and Appeals Member Experience Analysis 2019**<br>Review the Grievance and Appeals Member Experience Analysis 2019. | Mr. Hernandez | 7:20 | 10 min |
| **12. Grievance and Appeals Report Q3 2020**<br>Review the Grievance and Appeals Report Q3 2020. | Ms. Luong | 7:30 | 10 min |
| **13. Quality Dashboard**<br>Review of the Quality Dashboard. | Dr. Liu | 7:40 | 5 min |
| **14. Compliance Report**<br>Review of the Compliance Report. | Mr. Haskell | 7:45 | 10 min |
| **15. Credentialing Committee Report**<br>Review 10/07/2020 Credentialing Committee Meeting Report.<br>**Possible Action:** Approve the 10/07/2020 Credentialing Committee Meeting Report | Dr. Nakahira | 7:55 | 5 min |
| **16. Adjournment**<br>The next QIC meeting will be held on February 9, 2021. | Dr. Paul | 8:00 | |

**Notice to the Public—Meeting Procedures**

- Persons wishing to address the Quality Improvement Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Nancy Aguirre 48 hours prior to the meeting at (408) 874-1835.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at (408) 874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan™

# Quality Improvement Committee

# Meeting Minutes

# October 21, 2020

Regular Meeting of the

## Santa Clara County Health Authority
## Quality Improvement Committee

Wednesday, October 21, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

# Minutes



| Members Present | Specialty |
|---|---|
| Ria Paul, MD, Chair | Geriatric Medicine |
| Ali Alkoraishi, MD | Adult & Child Psychiatry |
| Nayyara Dawood, MD | Pediatrics |
| Jennifer Foreman, MD | Pediatrics |
| Jimmy Lin, MD | Internist |
| Lily Boris, Medical Director | |
| Christine Tomcala, Chief Executive Officer | |

| Members Absent | |
|---|---|
| Jeffery Arnold, MD | Emergency Medicine |
| Laurie Nakahira, D.O., Chief Medical Officer | |

**Staff Present**
Chris Turner, Chief Operating Officer
Tyler Haskell, Interim Compliance Officer
Chelsea Byom, Director, Marketing & Communications
Janet Gambatese, Director Provider Network Operations
Johanna Liu, PharmD, Director, Quality & Process Improvement
Raman Singh, Director, Case Management
Theresa Zhang, Manager, Communications
Natalie McKelvey, Manager, Behavioral Health
Carmen Switzer, Manager, Provider Network Access
Lucile Baxter, Manager, Quality & Health Education
Victor Hernandez, Grievance & Appeals Quality Assurance Program Manager
Bryon Lu, Process Improvement Manger
Carmen Switzer, Provider network Access Manager
Jayne Giangreco, Manager, Administrative Services
Rita Zambrano, Executive Assistant

### 1. Roll Call

Ria Paul, MD, Chair, called the meeting to order at 6:03 pm. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

Minutes of the August 12, 2020 Quality Improvement Committee (QIC) meeting were reviewed.

**It was moved, seconded and** the minutes of the August 12, 2020 meeting were **unanimously approved.**

**Motion:** Dr. Dawood
**Second:** Dr. Alkoraishi
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold, Dr. Foreman, Dr. Lin

## 4. CEO Update

Christine Tomcala, Chief Executive Officer, reported the current Plan membership is 266,000 members. Of which, approximately 9,600 are Cal MediConnect (CMC) members and 256,500 are Medi-Cal members. Santa Clara Family Health Plan's (SCFHP) membership continues to increase. However, this increase isn't caused by new members, but rather by their redeterminations that are on hold due to the public health emergency.

Ms. Tomcala spoke to the Pharmacy benefit being transitioned on January 1, 2021. A state-wide Pharmacy Benefit Manager (PBM), Magellan, will be responsible for all Medi-Cal pharmacy benefits. This will include enteral nutrition amongst others. Dang Huynh, Director, Pharmacy and Therapeutics, and the Pharmacy team are currently working on a transition plan. With a major transition such as this, SCFHP anticipates some hiccups, but is hopeful for a smooth transition for our members.

Ms. Tomcala announced a second outbreak of COVID-19 within the skilled nursing facilities (SNF) over the past couple of weeks. There was an issue with one SNF in particular, Gilroy Healthcare and Rehab, a Covenant Care Facility. An outbreak occurred within this center and was reported on the news just this last week. The outbreak started in the summer, however, Gilroy Healthcare and Rehab was not forthcoming in reporting members with COVID-19 to SCFHP when asked. SCFHP learned a number of our members within Gilroy Healthcare and Rehab had COVID-19, and some of which, have passed on.

Dr. Alkoraishi inquired if it's possible to obtain a copy of the Magellan pharmacy benefit formulary, specific to psychotropic medication. Dr. Boris spoke to this and shared she does not expect changes for psychotropic medications, as they are a Medi-Cal carve out for fee-for-service. SCFHP does not oversee this formulary. No further questions were asked.

*Dr. Foreman joined the meeting at 6:13pm*

## 5. Annual Assessment of Physician Directory Accuracy Report 2020

Janet Gambatese, Director, Provider Network Operations, reviewed the Annual Assessment of Physician Directory Accuracy Report 2020. Ms. Gambatese presented a high level overview of goals SCFHP did not meet, their barriers, and how SCFHP can overcome them.

Dr. Paul asked why the provider participation was so, with only 60 providers. Ms. Gambatese explained the survey is administered to a select 60 providers. No further questions were asked.

**It was moved, seconded and** the Annual Assessment of Physician Directory Accuracy Report 2020 was **unanimously approved.**

**Motion:** Dr. Foreman
**Second:** Dr. Alkoraishi
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold, Dr. Lin

## 6. Provider Satisfaction Survey MY2020 Analysis

*Dr. Lin joined the meeting at 6:31pm.*

Carmen Switzer, Provider Network Access Manager, presented the Provider Satisfaction Survey (PSS) MY2020 Analysis. Ms. Switzer reviewed SCFHP's goals and objectives, the methodology, results of the PSS, and any areas for improvement.

Dr. Paul asked why there wasn't participation from Palo Alto Medical Foundation (PAMF) this year. Ms. Switzer explained the most SCFHP can do is hope the providers will complete the survey.

Dr. Lin asked if there is an incentive for the providers to complete the PSS. Ms. Switzer confirmed incentives are not provided, as the hope is that providers would want to provide input so that SCFHP can make improvements. Ms. Switzer added she will follow up with PAMF to increase their participation.

**It was moved, seconded and** the Provider Satisfaction Survey MY2020 Analysis was **unanimously approved.**

**Motion:** Dr. Lin
**Second:** Dr. Dr. Dawood
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**7. Call Code Analysis for Assessing Member Understanding of Policies and Procedures**

Theresa Zhang, Manager, Communications, presented the Call Code Analysis for Assessing Member Understanding of Policies and Procedures. Ms. Zhang reviewed how SCFHP completed the analysis, its findings, and the opportunities for improvement.

Dr. Dawood asked if the member's preference in communication is determined by an SCFHP administered survey. Ms. Zhang explained that a postcard or form is being developed, rather than a survey, to mail to members. On this postcard or form, members can check the appropriate boxes to indicate their preferred method of communication and fill in their contact information. Ms. Zhang mentioned that the postcard and form are still in a preliminary stage, and ongoing discussions and planning are taking place.

No further questions were asked.

**8. PHM 2C Activities and Resources**

Natalie McKelvey, Manager, Behavioral Health, reviewed the PHM 2C Activities and Resources. Ms. McKelvey highlighted some of the populations identified in the assessment and how SCFHP is addressing their needs.

The QIC discussed the following needs and changes to programming, resources, and the community resources available to address these identified needs from the population assessment.

Members over 75 or adults with disabilities and have a dependency for 3 or more activities of daily living who currently reside in the community or a LTC facility have needs around transitions of care, personal care and social determinants of health such as food security. To address these complex needs, CM programs conduct a comprehensive assessment of ADLs, social determinants of health, financial management and more. Aunt Bertha, a large inventory of resources in the community, is now available organizationally to assist with the identification and coordination of community resources and social services for these members during this transition. Updates are made to this inventory as new resources become available. The intensive support needed for successful transition indicated additional staffing was warranted. Added a dedicated RN CM for members transitioning from LTC back to the community.

Members who are experiencing homelessness or housing instability had frequent hospitalization and multiple barriers to care related to social determinants of health. Added the Homeless Management Information System (HMIS) to the community resources list.

Members with SMI had frequent ED visits and a lack of sufficient connections with primary care physicians. BH Program identified a need for more intensive follow up after hospitalization to connect members with appropriate BH and Medical follow-up. BH CM team members were dedicated to conducting more frequent outreach. The team works closely with community based organizations to address the member's needs.

Dr. Paul asked for clarification as to what HMIS is. Ms. McKelvey explained HMIS is a county-run health management system, which can assess a member's food and housing needs, as well as offer available resources.

**It was moved, seconded, and** the PHM 2C Activities and Resources were **unanimously approved.**

**Motion:** Ms. Tomcala
**Second:** Dr. Lin
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**9. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 2020**

Johanna Liu, Pharm D, Director, Quality & Process Improvement, presented the CAHPS Survey 2020. Dr. Liu presented the CAHPS Survey objectives, timeline, response rate, 2020 updates, overall performance, and ratings. Dr. Liu reviewed the opportunities for improvement and the next steps in improving the work plan.

This concludes Dr. Liu's presentation. No questions were asked.

**10. CY 19 HEDIS Measures Below MPL Analysis**

Lucile Baxter, Manger, Quality Improvement, presented the four (4) HEDIS measures that performed below the MPL levels in 2019. These measures included: Asthma Medication Ration (AMR), Adolescent Well Care Visit (AWC), Cervical Cancer Screening (CCS), and Comprehensive Diabetes Care – HbA1c Testing (CDC-HT).

Ms. Baxter reviewed the current interventions for members and providers to help increase the rates on these HEDIS measures. Dr. Lin suggested SCFHP offer incentives to members for greater participation. Ms. Baxter explained the current incentives available for members. Dr. Foreman, VHP, would like to collaborate with SCFHP to help increase the completion rate of these measures. Ms. Baxter will connect with Dr. Foreman offline.

**11. Policies**

Ms. McKelvey reviewed minor changes to the policies. No questions were asked.

**a.** QI.17 Behavioral Health Care Coordination. Minor sentence restructure in section II.B.
**b.** QI.20 Information Sharing with San Andreas Regional Center (SARC). The APL was updated in section II.A.3.
**c.** QI.21 Information Exchange Between SCFHP & County of Santa Clara Behavioral Health Services Department. No changes required.
**d.** QI.22 Early Start Program. No changes required.
**e.** QI.23 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care (SBIRT). The Gateway Access phone number was updated in section II.D.

**It was moved, seconded, and** the Policies QI.17, QI.20, QI.21, QI.22, QI.23 were **unanimously approved.**

**Motion:** Dr. Lin
**Second:** Dr. Dawood
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**12. 2021 Board and Committee Meeting Calendar**

Dr. Liu presented the 2021 Board and Committee Meeting Calendar. Dr. Liu reviewed the dates for the QIC meetings, and pointed out one of the QIC meeting dates that was moved outside of the regular meeting pattern.

There were no issues with the shared QIC meeting dates for 2021. This concludes Dr. Liu's presentation.

**13. Grievance and Appeals Report Q2 2020**

Victor Hernandez, Grievance & Appeals Quality Assurance Program Manager, presented the Grievance and Appeals Report for Q2 2020. Mr. Hernandez noted a decrease in cases received this year. This was likely due to COVID-19.

Mr. Hernandez reviewed the top three (3) Medi-Cal and CMC Grievance categories. Also reviewed were the grievances and appeals by network, vendor, reason, and the rational for overturns.

Ms. Tomcala suggested presenting the grievance rates moving forward. Mr. Hernandez agreed to include this in future QIC presentations. No further questions were asked.

**14. Quality Dashboard**

Dr. Liu presented the Quality Dashboard. Dr. Liu reviewed the completion rates for the Initial Health Assessment (IHA) and Potential Quality of Care Issues (PQI). Also reviewed were SCFHP's Member Incentives, Outreach Call Campaign, Health Homes Program (HHP), and Facility Site Review (FSR).

No questions were asked.

**15. Compliance Report**

Tyler Haskell, Interim Compliance Officer, presented the Compliance Report. Mr. Haskell reviewed the recent and ongoing audit activity. Mr. Haskell announced the CMS Program Audit has been officially closed out and expressed his felicitations to the various departments and staff involved.

Dr. Lin inquired when the next CMS Program Audit would be conducted. Mr. Haskell confirmed the next CMS Program Audit would be in 2022.

Mr. Haskell announced the Compliance Program Effectiveness (CPE) Audit will be launched soon. Any findings will not be reported to CMS, but rather used internally to correct and improve performance.

**16. Utilization Management Committee**

Minutes of the July 15, 2020 Utilization Management Committee (UMC) meeting were reviewed by Dr. Lin.

**It was moved, seconded and** the minutes of the July 15, 2020 meeting were **unanimously approved.**

**Motion:** Ms. Tomcala
**Second:** Dr. Alkoraishi
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**17. Pharmacy and Therapeutics Committee**

Minutes of the June 18, 2020 Pharmacy and Therapeutics Committee (P&T) meeting were reviewed by Dr. Lin.

**It was moved, seconded and** the June 18, 2020 P&T Committee meeting minutes were **unanimously approved.**

**Motion:** Dr. Dawood
**Second:** Dr. Alkoraishi
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**18. Credentialing Committee Report**

Dr. Boris reviewed the Credentialing Committee Report for August 5, 2020. There were no questions asked.

**It was moved, seconded, and** the Credentialing Committee Meeting Report was **unanimously approved.**

**Motion:** Dr. Lin
**Second:** Ms. Tomcala
**Ayes:** Dr. Alkoraishi, Dr. Boris, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala
**Absent:** Dr. Arnold

**19. Adjournment**

The next QIC meeting will be held on December 9, 2020. The meeting was adjourned at 8:03 pm.

Ria Paul, MD, Chair

Date

Santa Clara Family Health Plan™

# Accessibility of Provider Network – MY2020
# Cal MediConnect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

December 9, 2020

# Introduction

This report provides an overview of SCFHP's timely access survey results. SCFHP survey goals, objectives, methodologies and results are included in each reporting section.

- The following survey assessments are included in this report:
  - ❑ Provider Appointment Availability Survey
  - ❑ After Hours Survey
  - ❑ CAHPS
  - ❑ Member Grievance

# Introduction

SCFHP provider networks:

- ❑ Direct (individually contracted providers)
- ❑ Palo Alto Medical Foundation (PAMF)
- ❑ Physicians Medical Group (PMG)
- ❑ Premier Care (PC)
- ❑ Valley Health Plan (VHP)
- ❑ Kaiser

All networks with the exception of Kaiser are included in this report. The Plan to Plan agreement with Kaiser is exclusive to the Medi-Cal line of business.

# Provider Appointment and Availability Survey

Goal:

- ❑ Ninety percent (90%) of providers will meet appointment access standards

Objectives:

- ❑ Measure rate of compliance with timely access standards, at least annually.
- ❑ Evaluate SCFHP's timely access performance in comparison to goals.
- ❑ Develop interventions as appropriate/applicable to address deficiencies and/or gaps in timely access to care.

# Provider Appointment and Availability Survey

Santa Clara Family Health Plan

Methodology

- SCFHP follows the DMHC's methodology to administer the provider appointment and availability survey (PAAS).
- The following provider types were included in the survey:

  - ❑ Primary Care Providers
  - ❑ High Volume Specialists
  - ❑ High Impact Specialists
  - ❑ Behavioral Health Providers

- Survey dates:

  - ❑ Wave I – August 3, 2020 - August 16, 2020
  - ❑ Wave II - September 17, 2020 – October 12, 2020.

- The survey was initiated by fax and email with a telephone follow-up.

# Measures

Santa Clara Family Health Plan

## Table I: Appointment Access

| Provider Type | Urgent Appointment | Non-Urgent/ Routine Appointment | Non-Life Threatening Appointment | Follow-up Care |
|---|---|---|---|---|
| Primary Care Providers (All) | 48 hours | 10-days | NA | NA |
| Family Medicine | 48 hours | 10-days | NA | NA |
| Internal Medicine | 48 hours | 10-days | NA | NA |
| Specialists (All) | 96 hours | 15-days | NA | NA |
| Oncology (HIS) | 96 hours | 15-days | NA | NA |
| Gynecology (HVS) | 96 hours | 15-days | NA | NA |
| Cardiology (HVS) | 96 hours | 15-days | NA | NA |
| Ophthalmology (HVS) | 96 hours | 15-days | NA | NA |
| BH/MH - Prescribers | 48 hours | 10-days | 6-hours | 30-days |
| BH/MH – Non-Prescribers | 48 hours | 10-days | 6-hours | 30-days |

# Results – PCP

**Table I:** PCP Urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 62 | 23 | 83% | N | 74 | 15 | 80% | N | +3 |
| PAMF | 273 | 70 | 67% | N | 255 | 122 | 46% | N | +21 |
| PMG | 60 | 39 | 72% | N | 85 | 57 | 84% | N | -12 |
| PC | 32 | 13 | 69% | N | 29 | 18 | 94% | Y | -25 |
| VHP | 209 | 42 | 43% | N | NA | | | | NA |

Aggregate results:

- 2020: 67%

--VHP omitted: 73%

- 2019: 76%
- Response rate dropped by 32%

# Results - PCP

**Table II:** PCP Non-urgent Appointment

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 62 | 24 | 100% | Y | 74 | 16 | 100% | Y | None |
| PAMF | 273 | 71 | 96% | Y | 255 | 140 | 78% | N | +18 |
| PMG | 60 | 40 | 95% | Y | 85 | 60 | 95% | Y | None |
| PC | 32 | 13 | 92% | Y | 29 | 18 | 100% | Y | -8 |
| VHP | 209 | 46 | 80% | N | NA | | | | |

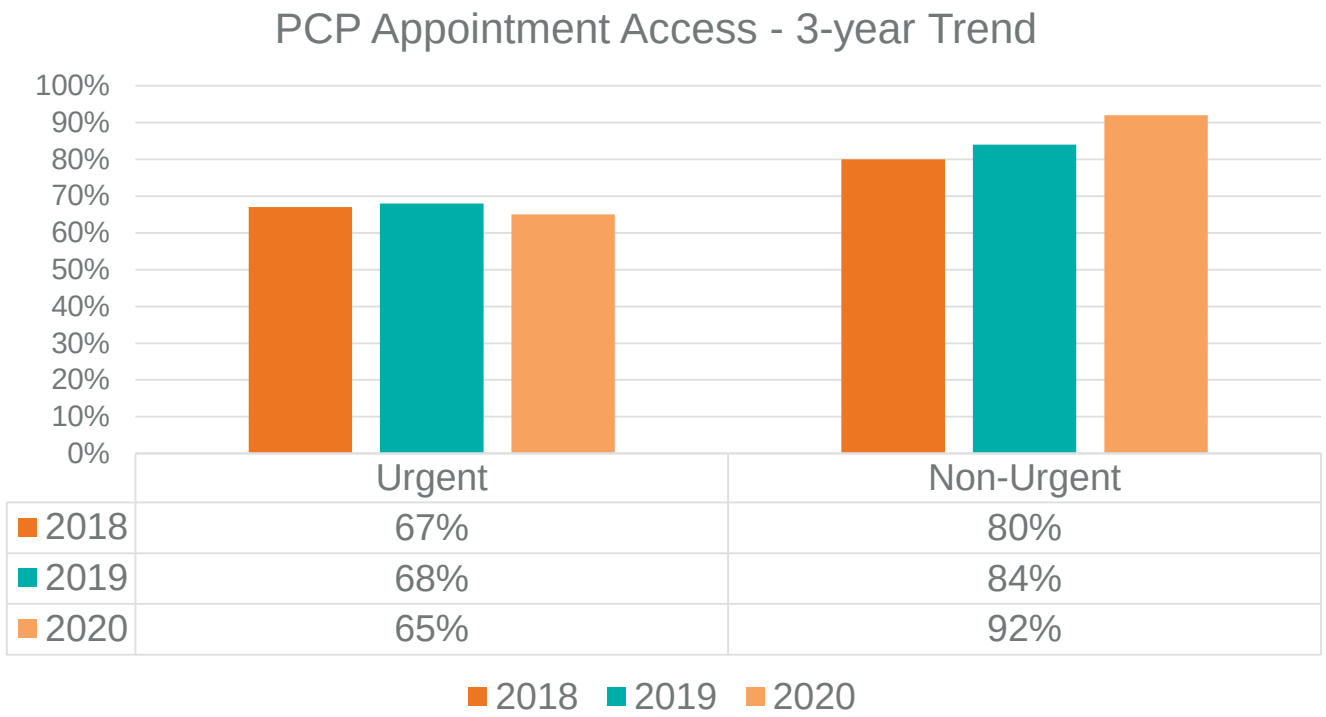
Aggregate results:

- 2020: 92%

--VHP omitted: 96%

- 2019: 93%
- Response rate dropped by 37%

# Results - PCP




| | Urgent | Non-Urgent |
|---|---|---|
| 2018 | 67% | 80% |
| 2019 | 68% | 84% |
| 2020 | 65% | 92% |

Average ratings (2018-2020):

- Urgent Care: 67% - VHP omitted: 69%
- Non-urgent Care: 85% - VHP omitted: 87%

# Conclusion

**PCP Appointment Access**

- The 3-year (2018-2020) analysis on PCP urgent appointment access revealed that results remain steady at 69% (VHP omitted), 21 percentage points below goal.

- The 3-year (2018-2020) analysis on PCP non-urgent appointment access revealed that results are trending upward and goal was met for the first time in 2020 at 92% (VHP omitted); 2 percentage points above goal.

- The Direct network had a slight increase in respondents in 2020 for urgent and non-urgent questions and showed an increase of 3 percentage points with urgent appointment access from 2019 and had no change at 100% for non-urgent access.

# Conclusion

**PCP Appointment Access**

- The PAMF network had a significant decrease in respondents for urgent (43%) and non-urgent (49%) questions and showed an increase in urgent care access by 21 percentage points and non-urgent access at 18 percentage points.

  --The Plan contacted PAMF regarding the significant drop in participation and they reported that their scheduling call center had staff shortages for the better part of 2020 due to the pandemic (COVID-19), and while PAMF agreed that access survey participation is important, they did not have the manpower to fully participate in the surveys. PAMF also reported that the compliance officer working with SCFHP to ensure survey participation and preparedness has left the organization, which may have contributed to the lack of participation and preparation for this measurement year.

# Conclusion

**PCP Appointment Access**

- The PMG network had a decrease in respondents in 2020 for urgent (32%) and non-urgent (33%) questions, and showed a decrease in urgent care access by 12 percentage points and no change at 95% for non-urgent access.

  --The Plan contacted PMG and they reported a significant turnover in staffing which may have contributed to the lack of responsiveness in 2020. They also expressed concerns that new staff members are unfamiliar with access standards and they agreed to a training session with SCFHP, scheduled for Dec 11, 2020.

- The PC network had a decrease in respondents in 2020 for urgent and non-urgent (28%) questions and showed a decrease in urgent care access by 25 percentage points and non-urgent access at 8 percentage points.

# Conclusion

**PCP Appointment Access**

- The VHP network rated the lowest with urgent care access at 43% and non-urgent care at 80%. Further review revealed that 28 of 42 respondents were from 4 clinic locations, all of which are in the city of San Jose.

  --The Plan contacted VHP's provider relations department and was advised that each clinic is aware of appointment access standards, and when specific providers are not available, there are other providers available in each clinic to ensure SCFHP members are seen within timely access standards.

  VHP also reported that when necessary patients are referred to one of their 4 urgent care facilities in San Jose, all of which have extended office hours.

  -- PCP network: 36% are open to new patients.

# Results - Specialists

**Table I:** Cardiology - Urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 61 | 13 | 38% | N | 68 | 11 | 35% | N | +3 |
| PAMF | 25 | 8 | 63% | N | 28 | 8 | 50% | N | +13 |
| PMG | 11 | 4 | 100% | Y | 26 | 8 | 88% | N | +12 |
| PC | NA | | | | NA | | | | NA |
| VHP | 12 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 67%
- 2019: 58%
- Response rate dropped by 7%

# Results - Specialists

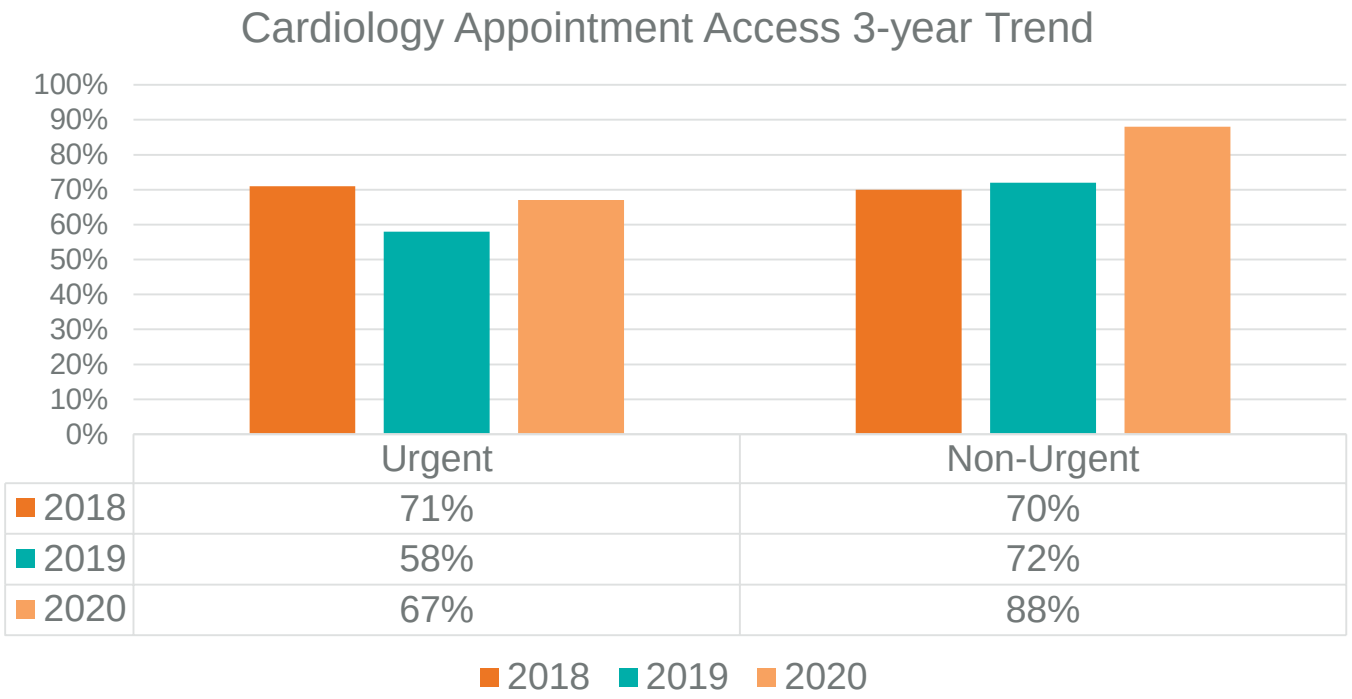
**Table II:** Cardiology - Non-urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 61 | 13 | 85% | N | 108 | 19 | 53% | N | +32 |
| PAMF | 25 | 9 | 78% | N | 28 | 8 | 75% | N | +3 |
| PMG | 11 | 5 | 100% | Y | 26 | 9 | 89% | N | +11 |
| PC | NA | | | | NA | | | | NA |
| VHP | 12 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 88%
- 2019: 72%
- Response rate dropped by 25%

# Results - Specialists




Average ratings (2018-2020):

- Urgent Care: 65%
- Non-urgent Care: 77%

# Results - Specialists

Santa Clara Family Health Plan

**Table I:** Gynecology - Urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 60 | 7 | 57% | N | 62 | 16 | 44% | N | +13 |
| PAMF | 49 | 13 | 46% | N | 52 | 15 | 27% | N | +19 |
| PMG | 12 | 6 | 50% | N | 22 | 13 | 69% | N | -19 |
| PC | NA | | | | NA | | | | NA |
| VHP | 49 | 2 | 50% | N | NA | | | | NA |

Aggregate results:

- 2020: 51%

  -- VHP omitted: No change

- 2019: 47%

- Response rate in 2020 dropped by 41%

# Results - Specialists

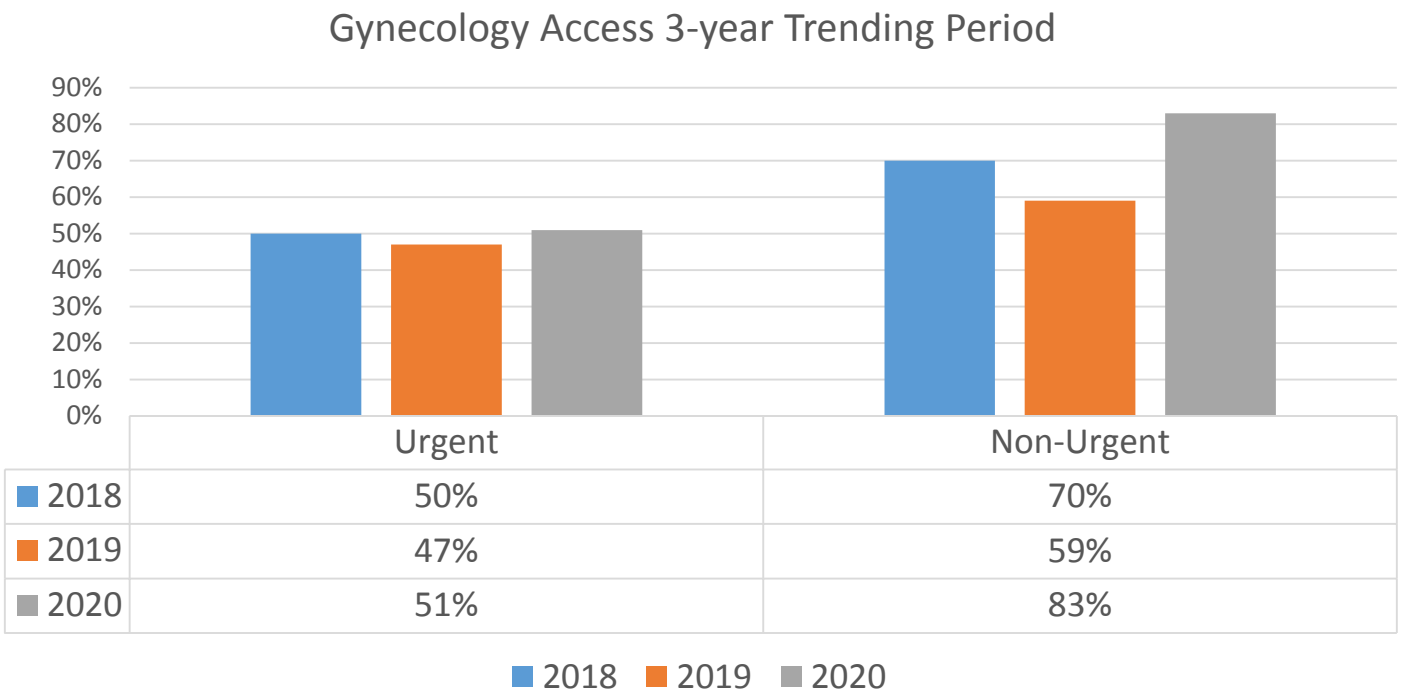
**Table II:** Gynecology - Non-urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 34 | 7 | 71% | N | 34 | 16 | 81% | N | -10 |
| PAMF | 49 | 17 | 76% | N | 52 | 17 | 18% | N | +58 |
| PMG | 12 | 7 | 86% | N | 22 | 13 | 77% | N | +9 |
| PC | NA | | | | NA | | | | NA |
| VHP | 11 | 2 | 100% | Y | NA | | | | NA |

Aggregate results:

- 2020: 83%
  --VHP omitted: 78%
- 2019: 59%
- Response rate dropped by 33%

# Results - Specialists




| | Urgent | Non-Urgent |
|---|---|---|
| 2018 | 50% | 70% |
| 2019 | 47% | 59% |
| 2020 | 51% | 83% |

Average ratings (2018-2020):

- Urgent Care: 49%
- Non-urgent Care: 71%

# Results - Specialists

**Table I:** Ophthalmology - Urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 115 | 5 | 100% | Y | 104 | 9 | 67% | N | +33 |
| PAMF | 24 | 9 | 67% | N | 23 | 5 | 40% | N | +27 |
| PMG | 15 | 9 | 89% | N | 18 | 6 | 100% | Y | -11 |
| PC | NA | | | | NA | | | | NA |
| VHP | 13 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 85%
- 2019: 69%
- Response rate increased by 15%

# Results - Specialists

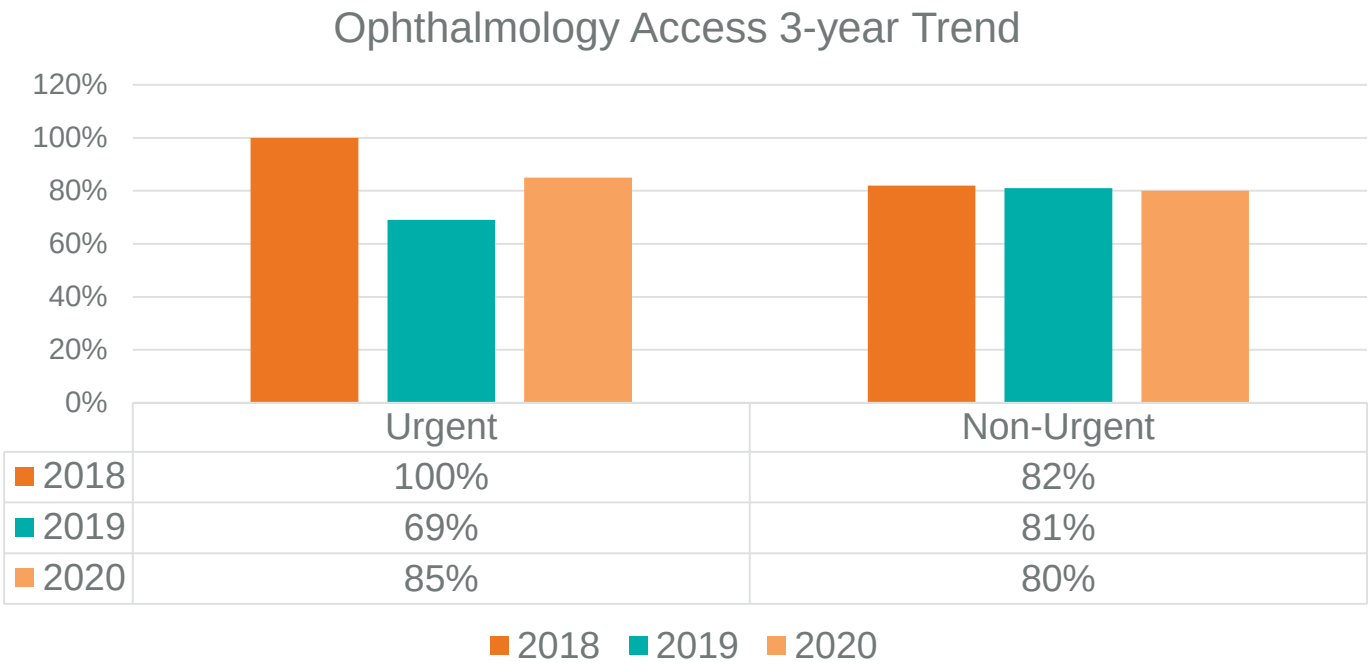
**Table II:** Ophthalmology - Non-urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 115 | 6 | 83% | N | 104 | 10 | 80% | N | +3 |
| PAMF | 24 | 9 | 67% | N | 23 | 8 | 63% | N | +4 |
| PMG | 15 | 9 | 89% | Y | 18 | 6 | 100% | Y | -11 |
| PC | NA | | | | NA | | | | NA |
| VHP | 13 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 80%
- 2019: 81%
- Response rate no change

# Results - Specialists




Average ratings (2018-2020):

- Urgent Care: 85%
- Non-urgent Care: 81%

# Results - Specialists

**Table I:** Oncology - Urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 50 | 4 | 75% | N | 52 | 6 | 17% | N | +58 |
| PAMF | 15 | 6 | 50% | N | 16 | 7 | 43% | N | +7 |
| PMG | 6 | 5 | 20% | N | 10 | 7 | 71% | Y | -51 |
| PC | NA | | | | NA | | | | NA |
| VHP | 10 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 48%
- 2019: 44%
- Response rate decreased by 25%

# Results - Specialists

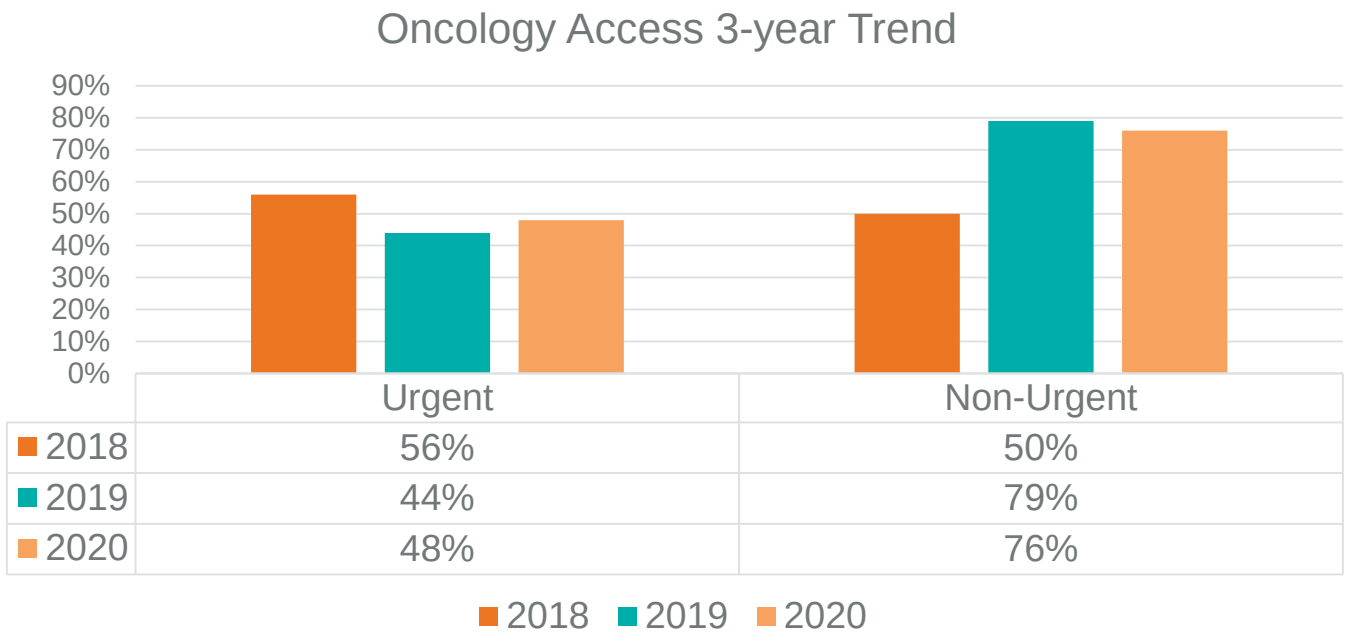
**Table II:** Oncology- Non-urgent Care Access

| Network | # Surveyed 2020 | # Responses 2020 | % Compliant 2020 | Met | # Surveyed 2019 | # Responses 2019 | % Compliant 2019 | Met | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| Direct | 50 | 5 | 80% | N | 52 | 8 | 50% | N | +30 |
| PAMF | 15 | 6 | 67% | N | 16 | 7 | 100% | Y | -33 |
| PMG | 6 | 5 | 80% | N | 10 | 7 | 86% | N | -6 |
| PC | NA | | | | NA | | | | None |
| VHP | 10 | 0 | NA | NA | NA | | | | NA |

Aggregate results:

- 2020: 76%
- 2019: 79%
- Response rate dropped by 27%

# Results - Specialists




| | Urgent | Non-Urgent |
|---|---|---|
| 2018 | 56% | 50% |
| 2019 | 44% | 79% |
| 2020 | 48% | 76% |

Average ratings (2018-2020):

- Urgent Care: 49%
- Non-urgent Care: 68%

# Conclusion

Santa Clara Family Health Plan

**Specialist Appointment Access**

- The 3-year (2018-2020) analysis on Cardiology revealed that urgent appointment access is averaging 65% due to minor variations, 25 percentage points below goal; and non-urgent appointment access is trending upward and currently at 88%; 2 percentage points below goal.

  -- Cardiology network: 98% are open to new patients.

- The 3-year (2018-2020) analysis on Gynecology urgent appointment access revealed that results remain steady at 49%, 41 percentage points below goal; and non-urgent appointment access is averaging 71% due to variations, 19 percentage points below goal.

  -- Gynecology network: 97% are open to new patients.

# Conclusion

Santa Clara Family Health Plan

**Specialist Appointment Access**

- The 3-year (2018-2020) analysis on Ophthalmology revealed that urgent appointment access is averaging 85% due to variations, 5 percentage points below goal; and non-urgent appointment access is trending steady at 81%; 9 percentage points below goal.

  -- Ophthalmology network: 86% are open to new patients.

- The 3-year (2018-2020) analysis on Oncology urgent appointment access revealed that results remain steady at 49%, 41 percentage points below goal; and non-urgent appointment access is trending upward and is currently 76%, 14 percentage points below goal.

  -- Oncology network: 100% are open to new patients.

# After Hours Survey

Santa Clara Family Health Plan (SCFHP) conducts an annual After-Hours survey to ensure that telephone triage or screening services are provided in a timely manner.

The survey also identifies if emergency 911 instructions are provided.

The provider types included in the survey are:

- ❑ Primary Care Providers
- ❑ Behavioral/Mental Health Providers

**Goal:**

Ninety percent (90%) of providers to meet after-hours standards

# After Hours Survey

**Methodology:**

- SCFHP follows the CMS and NCQA requirements to administer the after hours survey.
- The following provider types were included in the survey:
  - ❑ Primary Care Providers
  - ❑ Behavioral Health Providers
- Survey dates:
  - ❑ August 11, 2020 - August 20, 2020
- The survey was administered by phone during non-business hours PST 6pm to 8pm and on weekends.

# Measures

Table I: After-Hours Standards

| Service | Standard access requirement |
|---|---|
| Automated systems, office, or exchange/answering services | Must inform the patient that the provider will call back within 30 minutes. |
| Life-threatening situation | Automated systems must provide emergency 911 instructions, such as:<br>• "Hang up and dial **911** or go to the nearest emergency room."<br>Behavioral health providers should include the number to the Santa Clara County Behavioral Health:<br>• "Hang up and dial **911** or go to the nearest emergency room or call Santa Clara County Behavioral Health at **1-800-704-0900**." |
| Urgent need to speak with a provider | Automated systems, office, or exchange/answering services must connect the patient with an on-call provider or should direct the patient on how to contact a provider after hours. |

# Results - PCP

Santa Clara Family Health Plan

**Table I:** PCP

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 914 | 865 | 212 | 34 | 93% | 80% | +13 | Y |
| Timeliness | | | | 79 | 53% | 55% | -2 | N |

*Access = 911 message
*Timeliness = 30min call back message

Aggregate access results:

- 2020: 93%
  --VHP omitted: 95% (+15)
- 2019: 80%

Aggregate timeliness results:

- 2020: 53%
  --VHP omitted: 60% (+5)
- 2019: 55%

# Results - PCP

Santa Clara Family Health Plan

**Table III:** Direct Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 75 | 64 | 25 | 3 | 95% | 52% | +43 | Y |
| Timeliness | | | | 6 | 43% | 42% | +1 | N |

*Access = 911 message
*Timeliness = 30min call back message

**Table IV:** PAMF Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 365 | 353 | 34 | 8 | 94% | 80% | +14 | Y |
| Timeliness | | | | 20 | 52% | 48% | +4 | N |

*Access = 911 message
*Timeliness = 30min call back message

# Results - PCP

**Table V:** PMG Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 133 | 121 | 81 | 7 | 93% | 96% | -3 | Y |
| Timeliness | | | | 22 | 69% | 65% | +4 | N |

*Access = 911 message
*Timeliness = 30min call back message

**Table VI:** Premier Care Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 34 | 31 | 28 | 1 | 97% | 91% | +6 | Y |
| Timeliness | | | | 7 | 77% | 65% | +12 | N |

*Access = 911 message
*Timeliness = 30min call back message

# Results - PCP

**Table VII:** VHP Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 307 | 296 | 44 | 15 | 88% | NA | NA | N |
| Timeliness | | | | 24 | 25% | NA | NA | N |

*Access = 911 message
*Timeliness = 30min call back message

# Results – BH

**Table I:** BH

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 349 | 315 | 89 | 26 | 91% | 78% | +13 | Y |
| Timeliness | | | | 29 | 79% | 80% | -1 | N |

*Access = 911 message
*Timeliness = 30min call back message

Aggregate access results:

- 2020: 91%
  --VHP omitted: No change
- 2019: 78%

Aggregate timeliness results:

- 2020: 79%
  --VHP omitted: 90% (+11)
- 2019: 80%

# Results – BH

**Table II:** Direct Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 248 | 225 | 56 | 16 | 82% | 81% | +1 | N |
| Timeliness | | | | 18 | 80% | 85% | -5 | N |

*Access = 911 message
*Timeliness = 30min call back message

**Table III:** PAMF Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 40 | 34 | 15 | 6 | 82% | 80% | +2 | N |
| Timeliness | | | | 5 | 80% | 83% | -3 | N |

*Access = 911 message
*Timeliness = 30min call back message

# Results – BH

**Table IV:** PMG Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 2 | 2 | 2 | 0 | 100% | 50% | None | Y |
| Timeliness | | | | 0 | 100% | 50% | None | Y |

*Access = 911 message
*Timeliness = 30min call back message

**Table V:** Premier Care Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 1 | 1 | 1 | 0 | 100% | 100% | None | Y |
| Timeliness | | | | 0 | 100% | 100% | None | Y |

*Access = 911 message
*Timeliness = 30min call back message

# Results – BH

**Table VI:** VHP Network

| Standard | # Providers | # Responded | # Phones | Non-Compliant Phone #'s | 2020 | 2019 | PY Change | Met |
|---|---|---|---|---|---|---|---|---|
| Access | 58 | 53 | 15 | 4 | 92% | NA | NA | Y |
| Timeliness | | | | 6 | 34% | NA | NA | N |

*Access = 911 message
*Timeliness = 30min call back message

# Conclusion

**After Hours Survey**

- After-hours PCP and BH access (911 messaging) compliance has trended upward from 2019.

  --Exception: PMG - while PMG showed a decrease of 3 percentage points in 2020, goal was met at 93%

- After-hours PCP timeliness (30min call back messaging) compliance has trended upward from 2019 across all networks.

  The BH (NPMH) network continues to be challenged with meeting this standard. After-hours automated messaging from most NPMH provider types refer members to the ER, Crisis Center and/or Santa Clara County Mental Health.

# Conclusion

**After Hours Survey**

- The networks combined have 34 phone numbers that show non-compliance with access (911 messaging) and 79 phone numbers that show non-compliance with timeliness (30min call back messaging).
- Network providers deemed non-compliant with after-hours access/timeliness standards receive a corrective action letter from the Plan, and are expected to submit a corrective action plan within 30-days.
- Overall the networks have made a significant amount of progress in trending upward in meeting after-hours access and timeliness in the past 2-years.

# Member Experience Survey (CAHPS)

Santa Clara Family Health Plan

**Methodology**

- SCFHP uses a vendor to annually administer the CAHPS survey.
- Respondents were given the option of completing the survey in a language other than English.
- Due to the pandemic, changes were made to the methodology on follow up phone calls to non-respondents.
- Sample size – 1600 (800 standard and 800 over sample)

**Response Rate**

- 2020 response rate: 29.1%
  - +3 percentage points from 2018 response rate
  - +.3 percentage points from 2019 response rate

# Results - CAHPS

Santa Clara Family Health Plan

## Table I: Access

| Composite Rating & Questions | # Surveyed | Goal | Goal Met | Always and Usually (2019) | Always and Usually (2018) | PY Change |
|---|---|---|---|---|---|---|
| Rating of Health Plan (Q38) | 438 | 90% | Yes | 93% | 86% | +6 |
| Getting tests results when needed (Q21) | 318 | 90% | No | 82% | 83% | -1 |
| Getting appointments with specialists (Q29) | 246 | 90% | No | 75% | 75% | None |
| Getting needed care, tests or treatment (Q10) | 445 | 90% | No | 83% | 80% | +3 |
| Getting care needed right away (Q4) | 134 | 90% | No | 81% | 82% | -1 |
| Getting appointments (Q6) | 338 | 90% | No | 73 % | 76% | -3 |
| Getting seen within 15min of your appointment (Q8) | 335 | 90% | No | 58% | 54% | +4 |

- Most improved from 2019:
  - -- Rating on Health Plan +6
  - -- Getting seen within 15min of your appt
- Most decreased from 2019:
  - -- Getting appointments -3 from 2019

# Conclusion:

**CAHPS:**

- A total of 3 out of 7 measures showed improvement from 2019.
- “Getting seen within 15min of your appointment” has a relatively high impact on members and the Plan is pleased that satisfaction ratings showed an improvement of 4 percentage points from 2019.
- Overall “access” results showed the Plan’s performance improved by 8 percentage points.

# Member Grievances

Santa Clara Family Health Plan

**Table I: Access Jan-Dec 2019**

| Provider Type | Timely Appt | % | In Office Wait Time | % | Phone Access | % | Service Delay | % | Quality | % | Other | % | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCP | 7 | 47% | 2 | 100% | 4 | 88% | | | | | 5 | 71% | 18 |
| Specialist | 6 | 40% | | | | | 10 | 59% | | | 2 | 29% | 18 |
| Behavioral Health | | | | | 2 | 6% | | | | | | | 2 |
| Imaging | 2 | 13% | | | | | | | | | | | 2 |
| Interpreter Services | | | | | | | | | 3 | 100% | | | 3 |
| Pharmacy | | | | | | | 1 | 5% | | | | | 1 |
| DME | | | | | 2 | 6% | 3 | 18% | | | | | 5 |
| Transportation | | | | | | | 3 | 18% | | | | | 3 |
| Totals | 15 | 29% | 2 | 4% | 8 | 15% | 17 | 33% | 3 | 6% | 7 | 13% | 52 |

- Top 2 complaints:
  - ❑ Service delays (33%)
  - ❑ Timely appointments (29%)

# Conclusion

**Member Complaints**

- Service delays (33%):
    - Most were related to specialist referrals and prior authorization delays due to miscommunication issues between the PCP and specialist offices.
- Timely access (29%):
    - PCP complaints were mostly related to desired appointment dates were not available, some of which appeared to be within timely access standards. In most cases desired appointment dates were not available due to provider vacations or leave of absents.
    - SPC appointments not being scheduled timely as office staff are unaware of par status with the Plan and/or member is unaware of the timelines in which authorizations should be processed.
- No trending found on specific networks or providers.
- Complaints are within normal limits.

# Opportunities:

| Barrier | Opportunity | Intervention | Selected for 2020/2021 | Date Initiated |
|---|---|---|---|---|
| Timely access to urgent appointments. | Educate networks on urgent care access standards. | 1. Provider network outreach:<br>--PAMF: GYN<br>--PAMF & PMG: Oncology | Yes | Dec 2020 |
| | | 2. Issue CAP, resurvey and providers that show continued non- compliance will be required to take access training and submit an attestation. | Yes | Dec 2020 |
| | | 3. Distribute SCFHP's Timely Access Matrix to network providers via fax blast. | Yes | 01/2021 |
| After Hours messaging that advises patients –<br>1. On-call provide will call back within 30-minutes | Educate PCP and BH providers on after-hours timeliness messaging. | 1. Distribute SCFHP's Timely Access Matrix to network providers via fax blast. | Yes | 01/2021 |
| | | 2. Issue CAP | Yes | Dec 2020 |
| | | 3. Provider Outreach | Yes | TBD |

# POLICY

| | | | |
|---|---|---|---|
| **Policy Title:** | **Private Duty Nursing** | **Policy No.:** | QI.30 |
| **Replaces Policy Title (if applicable):** | | **Replaces Policy No. (if applicable):** | |
| **Issuing Department:** | Health Services – Care Management | **Policy Review Frequency:** | Annual |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☐ CMC | |

## I. Purpose

To define the case management services, authorization, and referral process for members under the age of 21 years who are EPSDT eligible and approved for Private Duty Nursing

## II. Policy

A. SCFHP is required to provide Case Management Services as set forth in the Medi-Cal contract to all enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when SCFHP is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved by the California Children's Services Program (CCS).

B. SCFHP is required to use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when SCFHP is not financially responsible for paying for the approved Private Duty Nursing services.

C. SCFHP's obligations to enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services who request Case Management Services for their approved Private Duty Nursing services include, but are not limited to:

   a. Providing the member with information about the number of Private Duty Nursing hours the member is approved to receive
   b. Contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf

c. Identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider
d. Working with enrolled Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

D. Approved enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, SCFHP has primary responsibility to provide Case Management for approved Private Duty Nursing Services.

a. When a Medi-Cal Managed Care Plan has approved a plan enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, the Managed Care Plan has primary responsibility to provide Case Management for approved Private Duty Nursing services. SA Pg. 11, para. 24.a.

b. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary responsibility to provide Case Management for approved Private Duty Nursing services.

c. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing Services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be SCFHP, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case Management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primary responsible for Case Management.

E. Members may choose not to use all approved PDN service hours and SCFHP is permitted to respect the member's choice. SCFHP will document instances when a member chooses not to use approved PDN services. When arranging for the member to receive authorized PDN services, SCFHP will document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

F. Request for Private Duty Nursing for members under the age of 21 years will be reviewed by a nurse for medical necessity.
a. Whether the request is approved or denied, the nurse will send a referral to notify the Case Management department of the member's needs and for assistance as appropriate.

## III. Responsibilities

A. Case Management
i. Review referrals from UM and assist member based on needs

ii. Case management services, except for when CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, would include the following:

1. Providing the member with information about the number of Private Duty Nursing hours the member is approved to receive
2. Contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf
3. Identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider
4. Working with enrolled Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

B. Utilization Management
   i. Review for medical necessity and approve or deny
   ii. Send all referrals to Case Management Department

## IV. Definitions

A. "Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. 3, para. 1.

B. "EPSDT services" means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)

C. "Home Health Agency" as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.

D. "Individual Nurse Provider" or "INP" means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

E. "Private Duty Nursing" means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

## V. References

Department of Health Care Services All Plan Letter 20-012

## VI. Approval/Revision History

| First Level Approval | Second Level Approval |
|---|---|
| Raman Singh<br>Director, Case Management<br><br>Date | Laurie Nakahira, DO<br>Chief Medical Officer<br><br>Date |

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| | | | | |

Santa Clara Family Health Plan™

# NCQA – Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Calendar Year 2019 Review

# Overview

Overview of SCFHP's analysis of the continuity and coordination between medical and behavioral healthcare - National Committee for Quality Assurance (NCQA)

- Review of Factors:
  1. Exchange of information between behavioral and medical care
  2. Diagnosis, treatment and referral of behavioral disorders commonly seen in primary care
  3. Appropriate use of psychotropic medications
  4. Management of co-existing medical and behavioral disorders (Intervention completed)
  5. Prevention programs for behavioral health
  6. Special needs of members with severe and persistent mental illness (Intervention completed)

The analysis reviewed data for CY 2019 as compared to our baseline year CY 2018 data.

# Factor 1 – Exchange of Information

SCFHP collects data on the exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

Methodology changed this year from Medical Record Review to Primary Care Physician (PCP) Questionnaire.

Population: CMC Members connected to both outpatient Behavioral Health (BH) services as well as PCP as evidenced by claims CY 2019 [denominator] whose PCPs received medication lists/updates at least annually and after BH updates [numerator].

- Goal: 80% of the total number of samples meet the timeliness standard.
- CY2018 (baseline) & CY 2019 (comparison year 1) we did not meet our goal.

**In CY 2018 (Med Rec Review),** we missed our goal by 45 percentage points. We were unable to obtain requested external information at this time and relied on Electronic Medical Record access information.

**In CY 2019 (PCP Questionnaire),** we missed our goal by 65 percentage points (20 percentage points lower). Our response rate was low at 22% (13/60 responses) and we will work to increase response rate by selecting a larger sample size from which to request information next year.

This factor was not chosen for implementation of interventions for this report cycle.

# Factor 2 – Appropriate diagnosis, treatment, & referral of behavioral disorders commonly seen in primary care

The SCFHP looks at the results of the HEDIS measure Antidepressant Medication Management (AMM) to monitor that members with a behavioral health diagnosis of depression are being appropriately treated.

Population: For each measure, the total number of Members taking medication for the specified period of time (numerator) is compared to the total number of Members prescribed antidepressant medication (denominator).

The two measures include the Acute Effective Treatment Phase (consistent compliance for12 weeks) as well as the Continuation Treatment Phase (consistent compliance for 6 months)

- Goal: 75th Percentile HEDIS for both AMM measures.
- CY2018 (baseline): 75th percentile Continuation Phase & 50th percentile Acute Phase.
- CY 2019 (comparison year): 50th percentile Continuation Phase & 25th percentile Acute Phase.
- We did not meet our goal

While no interventions were selected for this measure, Newsletter for Members mailed by Marketing with article 5/6/2019 indicating Mental Health as the key to wellbeing and promoting discussion of depression symptoms with PCPs and appropriate providers.

| Measure | 2018 | Goal Y/N | 2019 | Goal | Met/Not Met |
|---|---|---|---|---|---|
| Effective/ Acute Phase Treatment | 73.73% (87/118) | 75.39%- N | 71.78% (145/202) | 77.52% - N | Not Met |
| Continuation of Treatment | 61.86% (73/118) | 60.32%-Y | 57.92% (117/202) | 61.58% - N | Not Met |

# Factor 3 – Appropriate Use of Psychotropic Medications

The SCFHP collects data on Behavioral Health and Primary Care Practitioner adherence to prescribing guidelines concerning antidepressant medication prescriptions.

We chose to focus on PCP education and prescribing of antidepressant medication to be able to determine where any additional education or gaps in knowledge may be with providers.

Population: CMC M2M Members prescribed antidepressant medications for mental health (denominator) and determining if the prescription was written for the Member by their PCP (numerator) or Psychiatrist (numerator).

- Goal: 50% of antidepressant medications for this population to be prescribed by PCPs and 50% of antidepressant medications to be prescribed by Psychiatrists.

- Data discrepancy noted: CY 2018 data and CY 2019 were gathered for trending comparison in 2019; We met our goal.

| | Total # Scripts (denominator) | Psychiatrist Scripts | PCP Scripts | Not-Included * (unidentifiable providers) |
|---|---|---|---|---|
| CY 2018 | N = 944 | 278/944 = **29%** | 633/944 = **67%** | 33/944 = 4% |
| CY 2019 | N = 924 | 250/924 = **27%** | 628/924 = **68%** | 46/924 = 5% |

# Factor 3 – Appropriate Use of Psychotropic Medications

We plan to continue to monitor this measure to maintain a 50-50 split in prescriptions and chose to modify this goal to continue PCP education.

As there are research studies as well as American Psychological Association support to include talk therapy along with prescribing of antidepressants, current rates of talk therapy were reviewed showing that:

178 of total Members receive antidepressant prescriptions from PCPs (178/628) are connected to talk therapy (28%)

99 of total Members receive antidepressant prescriptions from Psychiatrists (99/250) are connected to talk therapy (40%)

**Goal**:

1) to *continue* to have at least 50% of antidepressant medication prescriptions to be provided by Primary Care Practitioners;

2) 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year. This will be measured by comparing the total number of Members receiving antidepressant medications for M2M conditions through PCPs (denominator) over those currently engaged in talk therapy as identified by CPT & HCPC talk therapy codes (numerator).

# Factor 5 – Secondary preventative behavioral healthcare program implementation

The SCFHP collects data on Members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions. These Members are identified through use of the Health Risk Assessment (HRA).

Population: All CMC Members who indicate depressive symptoms within their HRA [denominator] are offered Patient Health Questionnaire – 9 (PHQ-9) for review of need and support. The Member desire to complete or decline the PHQ-9 is noted for additional information to review for this population.

Goal = 80-100 % CMC Members with HRA indicators of depression have been offered to complete the PHQ-9, as captured within a PHQ-9 Assessment within the Health Plans case management software program.

- Our overall goal is supplemented with data to determine participation of Members who have been offered a PHQ-9 assessment (denominator) and the level of participation as declined or completed (numerator).

# Factor 5 – Secondary preventative behavioral healthcare program implementation

In CY 2019,
2831 Unique Members had identified symptoms and/or a diagnosis of Depression on their Health Risk Assessment.

Of the 2831 Members, 77 Members had agreed to complete a PHQ-9 assessment & 45 Members declined to complete.

**- PHQ-9 offer rate for the overall population = 4.3% (122/2831) – rate of outreach down**

**- Of Members offered, the PHQ-9 completion rate = 63% (77/122) – response rate up**

Outreach to Members by staff has decreased from CY 2018 (7.5%), with a PHQ-9 agreement rate of 57%. This shows that despite a decrease in outreach by 3.2 percentage points, Members agreed to complete the PHQ-9 63% of the time, an increase in completion by 6 percentage points. **Members are likely to engage if we can increase outreach**.

We did not meet our 80-100% goal. While we do not plan to implement an intervention for this measure, SCFHP plans to increase frequency of PHQ-9 staff trainings to address barriers noted such as employee turnover, new staff/increase in growth by the Case Management Department.

# Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders (Interventions Completed & Effectiveness)

The Santa Clara Family Health Plan collects data on CMC Members identified as having dual diagnoses of Schizophrenia (diagnosis code F29) as well as Diabetes Mellitus II (DMII).

% of Members with both Diabetes Mellitus Type II and Schizophrenia who had a Primary Care/Internal Medicine visit within CY 2019 (numerator) / total number of members diagnosed with both Diabetes Mellitus Type II and Schizophrenia (denominator).

**Goal** = 75% of CMC members identified with diagnoses of Schizophrenia & Diabetes Mellitus Type II to have attended at least one annual Primary Care Visit for ongoing physical health monitoring.

CY 2018 = did not meet our goal by 13.3 percentage points
CY 2019 = did not meet our goal by 12 percentage points.

| | CY 2018 Data | CY 2019 Data |
|---|---|---|
| Total Members with diagnoses Schizophrenia & Diabetes Mellitus II (Total N) | 94 | 97 |
| Those who met with PCP for follow up: | 58 | 61 |
| Those who did not meet with PCP for follow up: | 36 | 36 |
| Percentage who completed PCP follow up: | (58 / 94) = 61.7% | (61 / 97) = 63%<br>(increase 1.3%) |

# Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders (Interventions Completed & Effectiveness)

| Barrier | Opportunity | Intervention | Selected | Date Initiated |
|---|---|---|---|---|
| **Members of this subpopulation may not prioritize health care/annual PCP visits. (Deficit of Knowledge)** | Provide outreach and education to remind all Members of the importance of Health Care provider follow up appointments | 3 outgoing calls to connect with Member and remind to: Schedule PCP Annual Wellness exam + Have A1c blood testing completed | y | 11/5/2020-11/16/2020 |
| **Many Members diagnosed with SPMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care** | Information to Member and Providers to educate on need for DM2 follow up and potential medication influence on blood sugar (medical discussion) | Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have follow up A1c testing completed | Y | 12/2019 |

Workgroup to review Barriers and Discuss Interventions was conducted 10/2019 & 10/2020.

This factor was chosen for intervention implementation at baseline year CY 2018 and in CY 2019.

While our data in review of CY 2019 shows an increase in PCP appointment attendance by 1.3%, this is a small percentage and cannot be attributed toward effectiveness of our intervention.

The interventions for both analysis years were completed late in the year, indicating a likely reduced impact during our measurement cycle. SCFHP plans to improve timing of data collection and implementation of interventions in 2020 to improve upon intervention effectiveness and goal achievement.

# Factor 6 – Special needs of members with severe and persistent mental illness (Interventions Completed & Effectiveness)

The Santa Clara Family Health Plan (SCFHP) collects data based originally on the parameters of the HEDIS measure Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC); to increase number of Members addressed, increased the Severe Mental Illness diagnoses in our data pull.

SCFHP has expanded the HEDIS measure to include other Severe and Persistent Mental Illness (SMI) diagnoses, including:

- Schizophrenia
- Schizoaffective Disorders
- Bipolar Disorders
- Unspecified Psychosis

*Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia:* Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

After modifying the parameter, our population for this measure increased from single digit to double digit numbers.

Population: For measurement, all CMC Members diagnosed with both SPMI diagnoses & Cardiovascular Disease (denominator) & are reviewed through claims data to verify that they have been seen by their PCP for LDL-C blood work follow up (numerator).

# Factor 6 – Special needs of members with severe and persistent mental illness (Interventions Completed & Effectiveness)

*Goal:* 75% of Total Members with SPMI & CHF diagnoses will have completed LDL-C blood work testing for follow up treatment care with their providers.

SCFHP did not meet the set goal by 56 percentage points. There was no noted difference in CY2018 versus CY 2019 data results.

**TABLE.** Comparison CY 2018 & CY 2019: Dually Diagnosed Members (SMI + CHF) follow up testing

| | Total SMI + CHF Members | Members who COMPLETED LCL-C testing | Members who DID NOT COMPLETE LCL-C testing |
|---|---|---|---|
| **CY 2018** | 31 | 6 / 31 = **19%** | 25 / 31 = **81%** |
| **CY 2019** | 42 | 8 / 42 = **19%** | 34 / 42 = **81%** |

# Factor 6 – Special needs of members with severe and persistent mental illness

| Barrier | Opportunity | Intervention | Selected | Date Initiated |
|---|---|---|---|---|
| **Many Members diagnosed with SMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care** | Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have medical follow up completed | Fax letter to providers (BH & PCP) for medical follow up need (LDL-C lab order) | Y | 11/2020 |
| **Lack of support – Member may have forgotten to follow up and complete necessary follow up for medical condition of CHF by completing LDL-C testing** | Notify Members of identified need for LDL-C testing (3 outbound calls to Members) | Notify Members of identified need for LDL-C testing (3 outbound calls to Members) & offer assistance in obtaining PCP apt if desired. | Y | 10/2019 |

Workgroup to review Barriers and Discuss Interventions was conducted 10/2019 & 10/2020.

This factor was chosen for intervention implementation at baseline year CY 2018 and in CY 2019.

Review of CY 2019 shows no change in response to our first intervention completed in 2019 for this factor. No effectiveness of our intervention could be determined.

The interventions for both analysis years were completed late in the year, indicating a likely reduced impact during our measurement cycle. SCFHP plans to improve timing of data collection and implementation of interventions in 2020 to improve upon intervention effectiveness and goal achievement.

Santa Clara Family Health Plan™

# Questions?

Contact Tiffany Franke, Behavioral Health Lead at tfranke@scfhp.com or Mansur Zahir, Process Improvement Project Manager at MZahir@scfhp.com

# FAX

**TO:** **«Provider_Name»**

**FROM:** **Behavioral Health Department**
FAX: **1-408-874-1427**
PHONE: **1-877-723-4795**

DATE: August 24, 2020
PAGES: 2
**RE:** **Provider survey: Coordinating medical and behavioral health information**

---

Member: «Member_Name»
DOB: «Member_DOB»

Dear «Provider_Name»,

Santa Clara Family Health Plan (SCFHP) is dedicated to improving care coordination across multiple disciplines of medicine, including behavioral health. We acknowledge your key role as a primary care physician in providing and facilitating treatment for our members and want to ensure you have the information needed to provide them with the best care. To help us ensure this, we're asking that you please complete this 5-minute questionnaire about the communication of behavioral health information from «BH_Agency_Clinic» to your clinic during 2019. Once completed, you can return the survey via fax to the SCFHP Behavioral Health Department at **1-408-874-1427**. Please complete and submit by September 30, 2020.

You are receiving this because your patient **«Member_Name»** is connected to the County of Santa Clara Behavioral Health Services through «BH_Agency_Clinic».

We encourage all SCFHP patients to see their doctors in a timely manner for required screenings and recommended follow-up treatment. The information we receive from you in this survey will help us identify communication needs between medical and behavioral health practitioners to ensure quality of care. For SCFHP patients who are struggling with coordinating their treatment, SCFHP offers case management with case managers or care coordinators who work with the patient to personalize their care plan.

If you have any questions regarding this memo, please contact SCFHP Customer Service at **1-408-874-1788,** Monday through Friday 8:30 a.m. to 5 p.m., and ask to speak to a Case Manager in the Behavioral Health Department. Thank you for your partnership in providing quality care to our members.

Sincerely,
Behavioral Health Department
Santa Clara Family Health Plan

Santa Clara Family Health Plan™

# Coordinating medical and behavioral health information

Behavioral Health
**Phone: 1-408-874-1788**
**Fax: 1-408-874-1427**

Please provide answers pertaining to the patient's 2019 file to the best of your ability and return the survey to the SCFHP Behavioral Health Department via fax at **1-408-874-1427**. Should you not know an answer or decline to respond, please leave it blank. This information helps SCFHP review for quality and gaps in communications between different medical disciplines to improve patient care. Thank you for participating.

**In 2019 for the patient referenced in the cover letter:**

**1.** Did you at least receive one communication from any behavioral health providers?

☐ Yes;

**a)** What information was communicated?

☐ Behavioral health medications currently being prescribed to the patient
☐ Changes to behavioral health medications being prescribed to the patient
☐ Admission date/discharge notification of hospitalization – psychiatric or medical
☐ Updates to behavioral health medications after an event, such as hospitalization
☐ Other:_____

**b)** Did you feel that the information provided was sufficient?

☐ Yes
☐ No

**c)** Was the information received timely?

☐ Yes
☐ No

☐ No

**2.** Did the patient discuss with you or provide you with a list of their own current behavioral health medications?

☐ Yes
☐ No

**3.** Have you ever specifically requested a list of medications that were prescribed to the patient by their behavioral health provider?

☐ Yes

**a)** Did you receive the list?

☐ Yes
☐ No

☐ No

**4.** What barriers exist in obtaining information about the patient's behavioral health care or medications?

_____
_____
_____
_____

Santa Clara Family Health Plan™

# *Annual Cal Medi-Connect Continuity and Coordination of Medical Care Analysis (2020)*

Presenter: Neha Patel, Quality Improvement Nurse

# SCFHP monitors following measures

| | Name of Measure | Movement Across Settings | Movement Across Practitioners |
|---|---|---|---|
| Measure 1 | Transition of care – Medication Reconciliation (TRC-MR) | **[X]** | |
| Measure 2 | Comprehensive Diabetes Care (CDC) Eye Exam Rate | | **[X]** |
| Measure 3 | PCP Follow up After 30 days of Discharge | **[X]** | |
| Measure 4 | Plan All-Cause Readmissions (PCR) | **[X]** | |

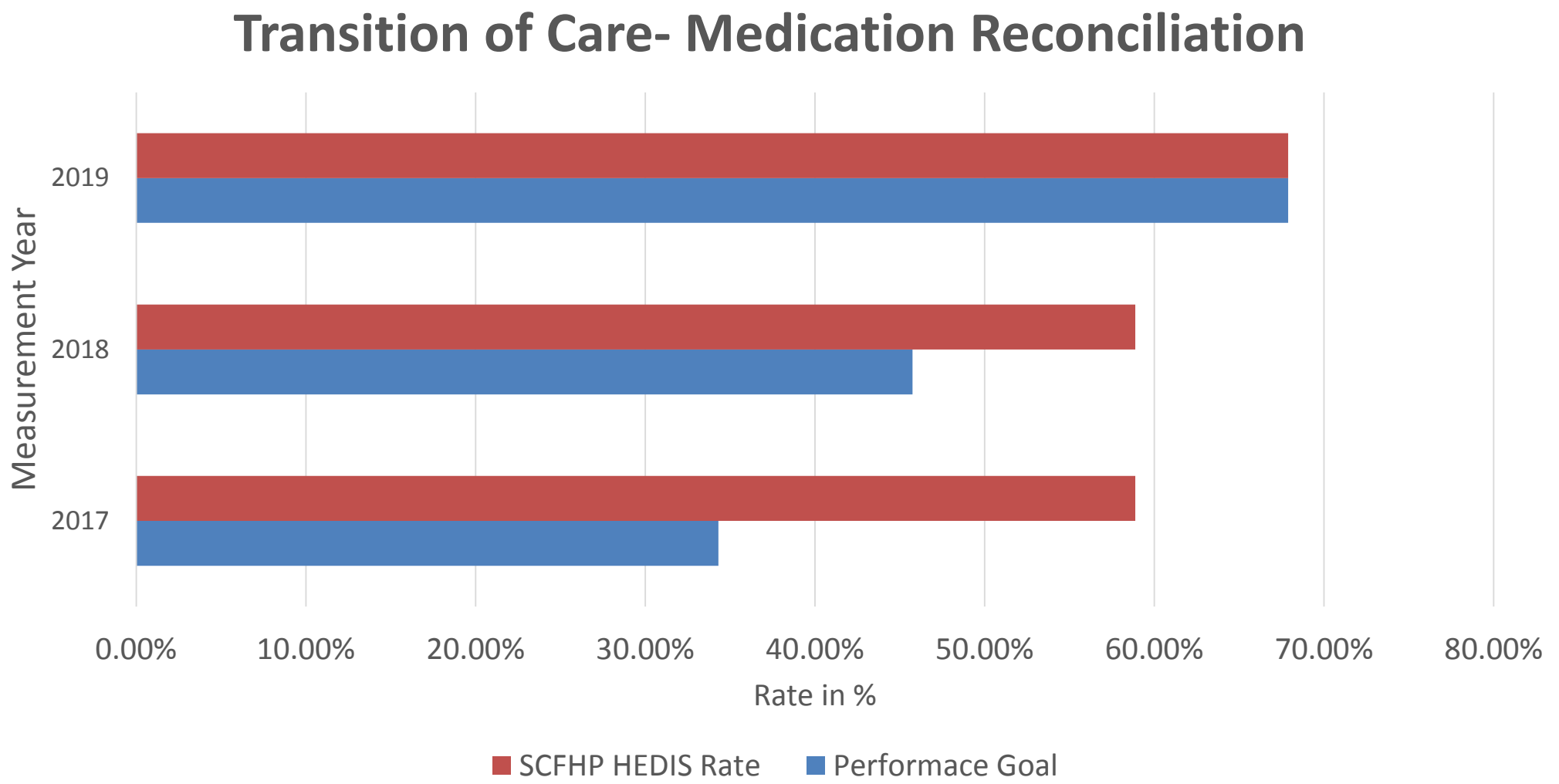
# Transition of Care- Medication reconciliation Post Discharge (TRC- MR)

## HEDIS Measure

Description: For members, 18 years of age and older, this measure identifies the percentage of discharges within the measurement/calendar year for whom medications were reconciled from the date of discharge through 30 days post-discharge (31 total days).

Proposed goal for MY 2020: 75$^{th}$ percentile

# Results


Transition of Care- Medication Reconciliation
Measurement Year
2019
2018
2017
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
Rate in %
SCFHP HEDIS Rate
Performace Goal

# Barrier and Analysis

Barrier: Identified that not all practitioners have the time to complete and document a through medication reconciliation at the initial visit post- discharge.

Interventions:

- PNO to work with practice transformation group to build a template of practitioner information along with a check-box for medication reconciliation for providers/clinic to decrease the administrative burden of medication reconciliation. Practice transformation group to educate the provider on utilizing the office staff to complete activities.
- Develop provider communication with the assistance of provider network management on the importance of complete and document medication reconciliation within 30 days
- Targeting to implement by Q2 2020

# Comprehensive Diabetes Care (CDC) Eye Exam Rate

## HEDIS Measure

- Description: This measure measures the members 18-75 years of age with diabetes (type 1 & type 2) who received a diabetic retinal eye examination within measurement year.
- Proposed goal for MY 2020: 75$^{th}$ percentile

# Results

| Measure: CDC- E | Numerator | Denominator | Rate | Performance Goal | Goal Met? |
|---|---|---|---|---|---|
| Measurement Y1 2017 | 297 | 411 | 72.26% | 62.53% | Y |
| Measurement Y2 2018 | 320 | 411 | 77.86% | 65.56% | Y |
| Measurement Y3 2019 | 328 | 411 | 79.81% | 82.05% | N |

# Barrier and Analysis

## Barrier: Lack of education among members about the importance of retinal eye exam.

Interventions:

- Develop gaps in care alert system in QNXT to notify internal staff to remind members about their due visit for retinal eye exam.
- Develop health education materials to promote importance of retinal eye exam for diabetic members.
- since Aug- 2018
- **Revision**: Published diabetes health education material for members in Oct 2020.

# Barrier and Analysis

Barrier: Medical record review suggest that optometrist/ophthalmologist do conduct eye exam for visual acuity screening but they do not always offer retinal eye exam to diabetic members.

Intervention:

- Develop provider communication with assistance of provider network management on educating optometrist/ophthalmologist on  identify and offer diabetic members who care due for their retinal eye exam.
- Targeting to implement by Q2 2021.
- **Revision**: Published diabetes health education material for provider in Oct 2020.

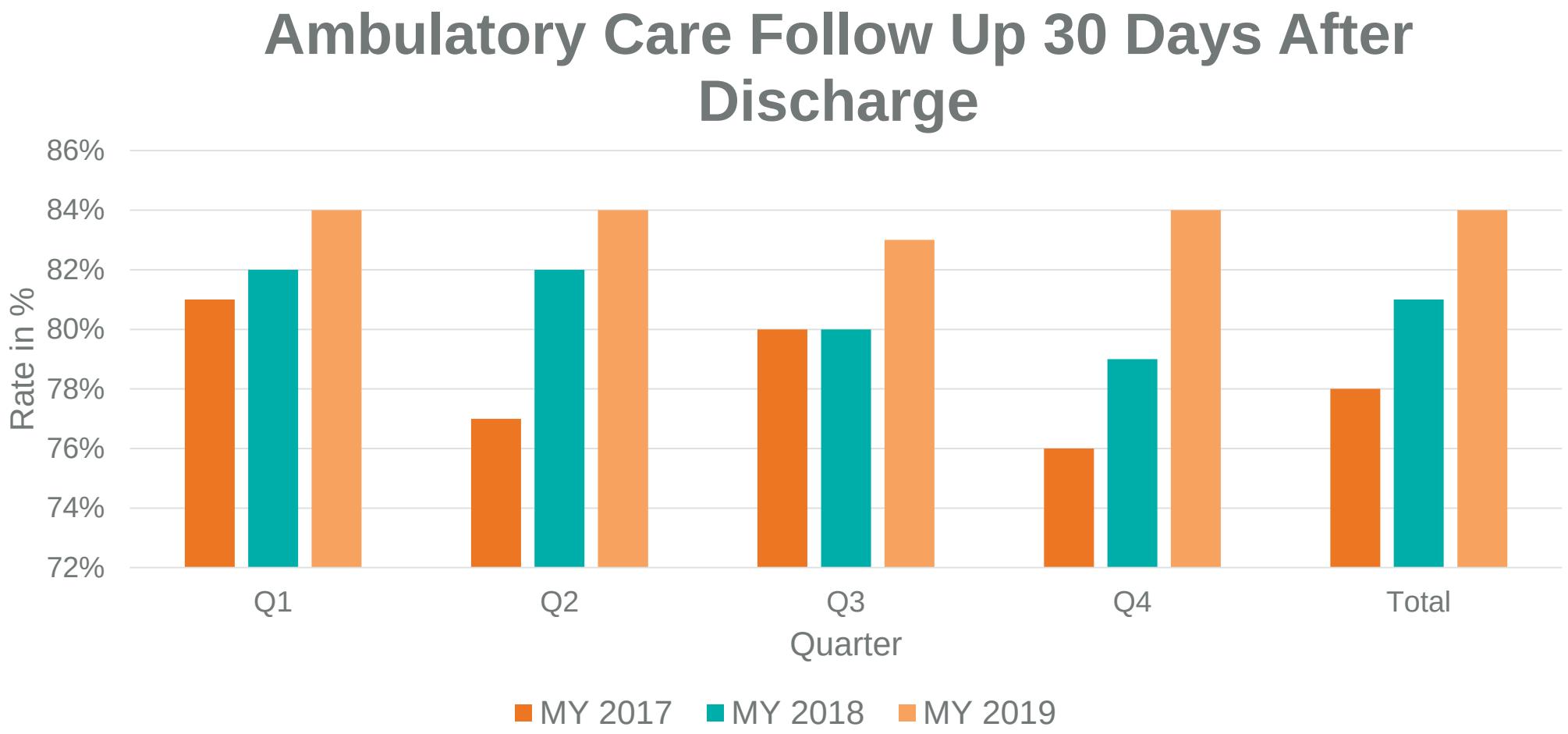
# PCP follow up after 30 days of Discharge Rate

## Regulatory requirement

- **Numerator definition**: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.
- **Denominator definition:** Total number of acute inpatient hospital discharges during the reporting period.
- **Goal for comparison**: 85% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge

- Proposed goal for MY 2020: 85%

# Results


Ambulatory Care Follow Up 30 Days After Discharge
86%
84%
82%
80%
78%
76%
74%
72%
Rate in %
Q1
Q2
Q3
Q4
Total
Quarter
MY 2017
MY 2018
MY 2019

# Barrier and Analysis

Barrier: PCPs are not always aware their patients have been admitted or subsequently discharged to home.

Interventions:

- Work with IT to build an IT report that automates the PCP admission notification reporting process.
- Physician contact information is consistently updated automatically in QNXT and across all systems.
- Cross function workgroup to work with hospitalist to develop the system to notify PCP about their member's hospitalization.
- Targeting to implement by Q-2 2021.

# Barrier and Analysis

Barrier: SCFHP currently lacks a centralized notification system from all contracted hospitals that allows PCP follow up post-hospital discharges.

Interventions:

- Work with IT to define a workflow to incorporate census data from all contracted hospitals to a centralized database allowing CM to send d/c notification to member's assigned PCP.
- Targeting to implement by Q-2 2021.

# Plan All-Cause Readmissions (PCR)

## HEDIS Rate

**Denominator:** County of Index Hospital Stays (HIS)

- An HIS is defined as an acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year.

**Numerator:** Count of 30-day Readmissions

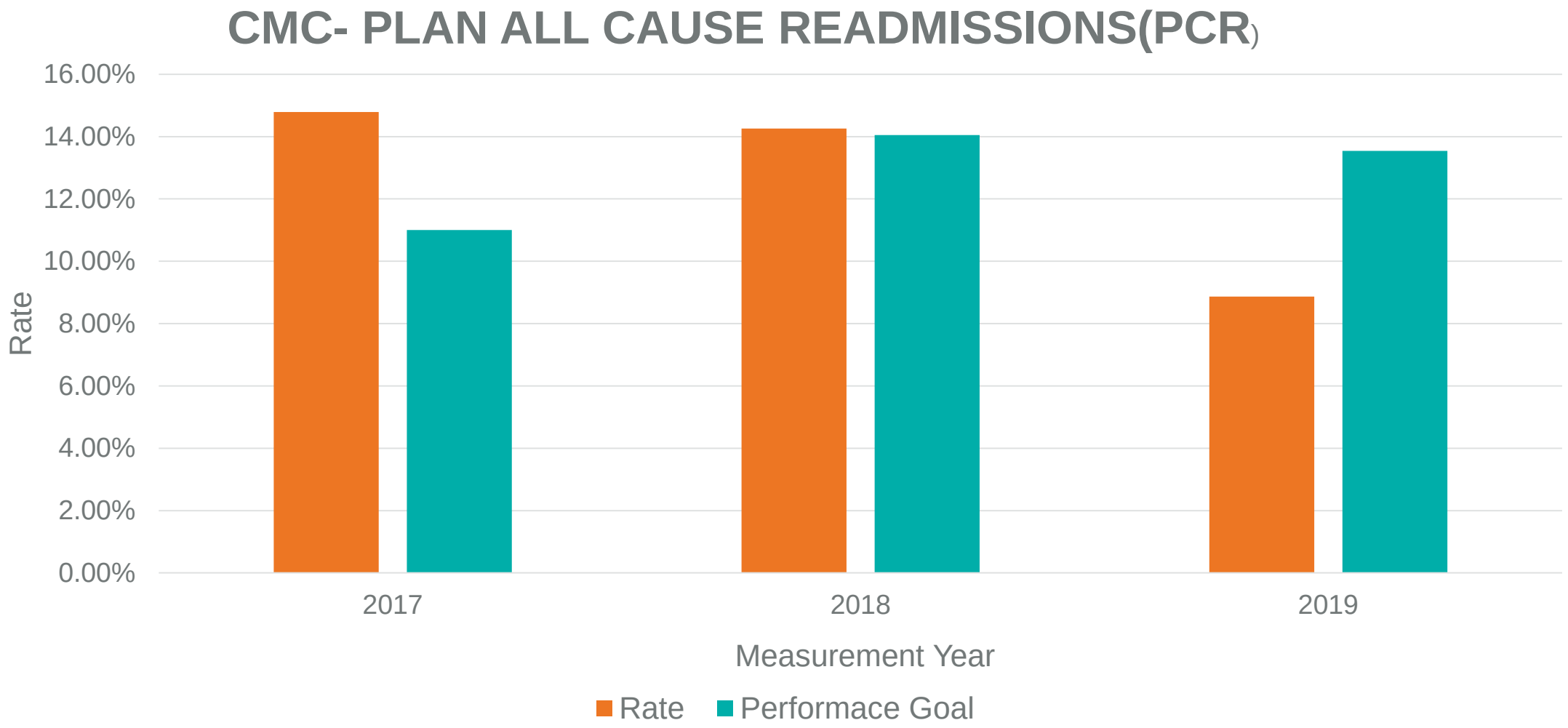
- Defined as an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date

**Expected Readmission Rate for MY 2019**

- Performance Goal: 13.54%

Proposed goal for MY 2020: A 2% decline from MY 2019 (13.54%)

# Results


CMC- PLAN ALL CAUSE READMISSIONS(PCR)
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Rate
2017
2018
2019
Measurement Year
Rate
Performace Goal

# Barrier and Analysis

## Barrier: Limited staff resources to conduct TOC calls.

Intervention:

- Assign member cases to UM care team with responsibility for TOC calls.
- Realign TOC workflow and staffing resources in the utilization management department for timely completion of all TOC calls with prioritization for identifying the patient population with the highest needs.
- Since April 2020.

# Barrier and Analysis

## Barrier: PCPs are not always aware their patients have been admitted or subsequently discharged to home

Intervention:

- As part of the transition of care (TOC) call follow-up, the case manager will send a notification letter to PCP with discharge information in an SBAR format for PCP to offer to follow up care post-discharge
- since 2018.

Santa Clara Family Health Plan™

# Thank you!

Neha Patel, Quality Improvement Nurse

# Santa Clara Family Health Plan
# Personalized Information on Health Plan Services:
# Website and Telephone Functionality - 2020
# Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 9, 2020

## I. Overview

In order to best serve our members, it is important for members to have the ability to easily obtain personalized health plan information.

Santa Clara Family Health Plan (SCFHP) has the responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. This includes the ability to change primary care practitioners (PCPs), and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services.

SCFHP ensures the availability of this information by:

1) SCFHP Website – Members may submit PCP change requests via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

2) Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, and determine if services require a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization and to offer assistance including the ability to initiate an Organization Determination on behalf of a member.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs.

## II. Methodology: Via Website

Annually, SCFHP measured the functionality of PCP change via the Health Plan website. Another area of focus was to review the information available on the website on how and when to obtain referrals and authorization for specific services. This analysis was completed in July 2020.

The auditor used a dummy account to test the functionality to change a PCP through the website. This same account was also used to test the accuracy and quality of how and when to obtain referrals and authorization for specific services. To validate the functionality of the PCP change option, the auditor signed onto the dummy account and submit a PCP change request to the SCFHP. The auditor then signed onto SCFHP's portal to verify that the request was received and the confirmation of the PCP change was in the dummy account.

To test the accuracy and quality of how and when to obtain referrals and authorization for specific services, the auditor navigated throughout the dummy account to ensure that she can find the information that are laid out in table 2 below.

**Goals:**

Accuracy: 100%

Quality: 100%

## III. Analysis

### a. Results

**Table 1: Accuracy of Personal Information on Health Plan Services on the Website**

| Measure | Goal | 2019 | Goal Met Y/N | 2020 | Goal Met Y/N |
|---|---|---|---|---|---|
| *Members can access the following in one session:* | | | | | |
| Functional Ability to Change Primary Care Practitioner | 100% | Yes | Y | Yes | Y |
| Determine how and when to obtain a referral or authorization for a specific service | 100% | Yes | Y | Yes | Y |

**Table 2: Quality of the Website: Quality of the information is assessed for the following during the accuracy review:**

| Measure | Goal | 2019 | Goal Met Y/N | 2020 | Goal Met Y/N |
|---|---|---|---|---|---|
| *Information is legible, complete and allows the member to understand:* | | | | | |
| How and when to obtain a referral or authorization for a specific service | 100% | Yes | Y | Yes | Y |
| Information accurately reflect what services SCFHP would pay for and if there is any limits on the services | 100% | Yes | Y | Yes | Y |
| *Other items that may also reflect the quality of the web site:* | | | | | |
| The link for the member handbook moves to the correct page | 100% | Yes | Y | Yes | Y |
| Detailed instructions are provided on what chapter/section of the member handbook to refer to on how and when to obtain referrals and authorizations for specific services | 100% | Yes | Y | Yes | Y |

**b. Quantitative Analysis**

SCFHP evaluated the functional ability to change PCPs. The goal is to have this function 100% of the time. This function was evaluated in July 2020 and found to be functioning as it should be, and therefore met the 100% goal established.

For the accuracy of information SCFHP set a goal of 100% of the time that the website accurately reflected the UM requirements for obtaining authorizations and referrals. In July 2020, the auditor reviewed to ensure members can find the information on how and when to obtain referrals or authorization for services. The link for the member handbook was validated to ensure it moved to the correct page so that member can access information on what SCFHP would pay for and if there are limitations.

**c. Qualitative Analysis**

No barriers or opportunities were identified for the functionality of the websites since all established goals were met at 100%.

## IV. Methodology: Telephone

Annually, SCFHP audits Customer Service telephone calls from members. To review the accuracy of the telephone calls of member requested information on determining how and when to obtain referrals and authorizations for specific services, the auditor (Customer Service Quality Manager) randomly selects ten(10) member contacts based on the selected call categories and call recording. Another ten (10) calls were specifically selected to review the quality assessment on the prior authorization submission process. The auditor assesses the call to determine whether the members were able to obtain answers to their inquiries. To determine the quality and accuracy of member inquiries, the auditor reviews the CSR's call documentation for completeness, listen to call recording to see if the CSR was accurate on informing the member whether or not a service requires a referral or a prior authorization. If a service does require a referral or an authorization, whether or not the CSR explain to the member on how to obtain one. If the service does require a prior authorization, was an organization determination offered and if the member requested to have one submitted, did CSR submit the request correctly, whether the turn-around time and the next steps were provided to the member. Data included in this analysis was captured from July 1, 2019 through June 30, 2020.

SCFHP members do not have any financial responsibility for covered services as long as they follow the plan's rules such as receiving services within the SCFHP network or contracted providers.

**Accuracy of Personal Information on Health Plan Services on the telephone:**

**Measure 1**: Did the CSR explain whether or not a service requires a referral and/or a prior authorization?
**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that CSRs explain whether or not a service requires a referral and/or a prior authorization
**Denominator**: Number of cases received from Q3-2019-Q2-2020
**Goal**: 100% of inquiries were responded accurately

**Measure 2**: The CSR accurately explains how the member can obtain an authorization or referral
**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that CSR accurately explains how the member can obtain an authorization or referral.
**Denominator**: Number of cases received from Q3-2019-Q2-2020
**Goal**: 100% of inquiries were responded accurately

**Measure 3**: The CSR provide a list of network provider to the member if the service does not require a prior authorization
**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that the CSR provide a list of network provider to the member if the service does not require a prior authorization
**Denominator**: Number of cases received from Q3-2019-Q2-2020
**Goal**: 100% of inquiries were responded with accuracy

**Quality of Personal Information on Health Plan Services on the telephone:**

**Measure 1:** Was the inquiry initiated by the member or member's representative
**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that the inquiry was initiated by the member or member's representative
**Denominator:** Number of cases received from Q3-2019-Q2-2020
**Goal: 100%** of callers were verified to ensure these are member and member's representative who initiated the request

**Measure 2**: CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service
**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that the CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service
**Denominator**: Number of cases received from Q3-2019-Q2-2020
Goal: 100% of inquiries were explained fully verifies the status of the authorization if there is one on the member's file before obtaining the requested service

**Measure 3**: Did the CSR clearly explain the options for members to submit a prior authorization request? If member agreed to initiate with CSR, did the CSR follow the standard operating procedures to initiate the process?

**Numerator**: Number of cases that were audited from Q3-2019-Q2-2020 that the CSR clearly explain the options for members to submit a prior authorization request and if member agreed to initiate with CSR, the CSR follow the standard operating procedures to initiate the process
**Denominator**: Number of cases received from Q3-2019-Q2-2020
Goal: 100% of inquiries were explained fully and carried out the prior authorization process.

**Measure 4**: If a prior authorization was submitted, did the CSR fully explain the next step and turn-round time to the member?
**Numerator**: Number of cases that were audited from Q3-2019-Q2- which the CSR fully explain the next step and turn-round time to the member after submitting the prior authorization request
**Denominator**: Number of cases received from Q3-2019-Q2-2020
**Goal**: 100% of inquiries were explained fully that CSR fully explain the next step and turn-round time to the member

## V. Analysis

### a. Results

**Table 3: Accuracy of Personal Information on Health Plan Services on the telephone:**

| Factor 1: Determine how and when to obtain referrals and authorizations for specific services, as applicable (Accuracy) | Total Sample | Accuracy Goal Met | | | % Accuracy Goal Met |
|---|---|---|---|---|---|
| | | Yes | No | N/A | |
| 1. Did the CSR explain whether or not a service requires a referral and/or a prior authorization? | 10 | 10 | 0 | 0 | 100% |
| 2. The CSR accurately explains how the member can obtain an authorization or referral. | 10 | 8 | 0 | 2 | 100% |
| 3. If a service does not require a prior authorization, did the CSR provide a list of network provider to the member? | 10 | 0 | 0 | 10 | NA |
| Factor 2: Benefit and financial responsibility-this factor is NA since members have no financial liability | | | | | |

**Table 4: Quality of Personal Information on Health Plan Services on the telephone:**

| Factor 1: Determine how and when to obtain referrals and authorizations for specific services, as applicable (Quality) | Total Sample | Quality Goal Met | | | % Quality Goal Met |
|---|---|---|---|---|---|
| | | Yes | No | N/A | |
| 1. Was the inquiry initiated by the member or member's representative? | 10 | 10 | 0 | 0 | 100% |
| 2. The CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service. | 10 | 10 | 0 | 0 | 100% |
| 3. Did the CSR clearly explain the options for members to submit a prior authorization request? If member agreed to | 10 | 10 | 0 | 0 | 100% |

| | | | | | |
|---|---|---|---|---|---|
| initiate with CSR, did the CSR follow the standard operating procedures to initiate the process? | | | | | |
| 4. If a prior authorization was submitted, did the CSR fully explain the next step and turn-round time to the member? | 10 | 10 | 0 | 0 | 100% |
| Factor 2: Benefit and financial responsibility-this factor is NA since members have no financial liability | | | | | |

**b. Quantitative Analysis**

Accuracy: All Accuracy and quality measures met the target goal of 100%. On Table 3, factor 1, measure 2, there were two cases that were "NA". This is a result of a member calling in to check the status of a prior authorization. Since the authorization was already approved, it was not necessary for the CSR to explain how the members can obtain an authorization. Also on Table 3, measure 3, all of the cases selected were "NA". On the cases that were audited, the members were calling to verify if a prior authorization was required for a service, and they already have the provider in mind therefore, the CSRS did not have the need to offer the list of network specialists. For factor 2, our members have no financial responsibility so this factor is NA.

**c. Qualitative Analysis**

All of the telephone measures met the goal at 100% for the accuracy and quality analysis, and no deficiencies were identified for this audit period.

# SANTA CLARA FAMILY HEALTH PLAN

## Pharmacy Benefit Information 2020: Telephone Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee December 9, 2020

## I. Overview

Pharmaceutical benefits and drugs change periodically throughout the year. In an effort to best serve members, Santa Clara Family Health Plan (SCFHP) has a responsibility to ensure that members can contact the organization over the telephone and receive accurate, quality information on drugs, coverage, and cost.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members related to pharmacy benefits. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the pharmacy benefit information provided by Customer Service Representatives (CSRs) to members.

## II. Methodology: Telephone

Annually, Santa Clara Family Health Plan audits the information provided to members over the telephone by its CSRs. If the total calls received are 30 cases or more, than the auditor selects 25% of the calls. If the total calls received are less than 30, then 100% of the cases are reviewed. The calls are checked for the ability for CSRs to provide accurate reflection of:

a. Financial responsibility per LIS level (copays)
b. Initiate the exceptions process
c. Order a refill for an existing mail-order prescription
d. Assistance to locate an in-network pharmacy
e. Assistance to conduct a pharmacy proximity search based on zip codes in Santa Clara County
f. Determine the availability of a generic substitutes

The audit will be performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefit information provided over the telephone. The audit period is from 07/01/19 through 06/30/20.

**Goal**:
Accuracy: 100%
Quality: 100%

## III. Data

**Table 1: Accuracy of Pharmacy Benefit Information for financial responsibility, exceptions process, order a refill for mail order prescription, location of in-network pharmacy, conducting a proximity search, determining the availability of generic substitutes.**

| Element B: Pharmacy Benefit Information—Telephone (Accuracy Analysis) | Total Sample | Accuracy Goal Met | | | % Accuracy Goal Met |
|---|---|---|---|---|---|
| | | Yes | No | N/A | |
| **Factor 1: Financial responsibility** | | | | | |
| Did CSR provide the correct copay amount for a drug according to member's financial responsibility level? | 27 | 27 | 0 | 0 | 100% |
| **Factor 2: Exceptions process** | | | | | |
| 1. Was the request submitted for the medication(s) member requested? | 25 | 25 | 0 | 0 | 100% |
| 2. Was the request marked correctly (standard vs expedited) per member's request? | 25 | 25 | 0 | 0 | 100% |
| 3. Was the correct turn-around time provided to the member (exception vs PA)? | 25 | 23 | 2 | 0 | 92% |
| **Factor 3: Order a Refill for an existing prescription** | | | | | |
| Did the CSR thoroughly respond to the member's inquiry about utilizing the pharmacy mail order? | 17 | 17 | 0 | 0 | 100% |
| **Factor 4 and 5: Location of in-network pharmacy, conducting a proximity search** | | | | | |
| Did the CSR conduct the proximity search utilizing the pharmacy locator tool or the Plan's provider search engine? | 1 | 1 | 0 | 0 | 100% |
| **Factor 6: Determine the availability of generic substitutes** | | | | | |
| 1. Did the CSR record and look up the correct medication that member provided? | 3 | 3 | 0 | 0 | 100% |
| 2. Did the CSR provide the correct generic substitution of a drug using the formulary tool? | 3 | 3 | 0 | 0 | 100% |

**Table 2: Quality of Pharmacy Benefit Information for financial responsibility, exceptions process, order a refill for mail order prescription, location of in-network pharmacy, conducting a proximity search, determining the availability of generic substitutes.**

| Element B: Pharmacy Benefit Information—Telephone (Quality Analysis) | Total Sample | Quality Goal Met | | | % Quality Goal Met |
|---|---|---|---|---|---|
| | | Yes | No | N/A | |
| **Factor 1: Financial responsibility** | | | | | |
| 1. Did CSR review the member's financial responsibility level and provide the maximum amount of copays the member would pay according to the pharmacy benefit? | 27 | 27 | 0 | 0 | 100% |
| 2. Did CSR educate member about the financial benefit of filling a 90 day supply when applicable? | 27 | 0 | 0 | 27 | N/A |
| **Factor 2: Exceptions process** | | | | | |
| 1. Did CSR fully explain/provide the restriction (s) pertaining to the medication (s) member requested? | 25 | 21 | 4 | 0 | 84% |
| 2. Did CSR inform the member of the next step for the exception submission process? | 25 | 20 | 5 | 0 | 80% |
| **Factor 3: Order a Refill for an existing prescription** | | | | | |
| Did the CSR provide instructions to place an order for refills or offer/ warm transfer the member set up the pharmacy mail order service? | 17 | 17 | 0 | 0 | 100% |
| **Factor 4 and 5: Location of in-network pharmacy, conducting a proximity search** | | | | | |
| Did the CSR locate and provide the correct name, address, phone number, hours of operation of an in-network pharmacy to the member? | 1 | 1 | 0 | 0 | 100% |
| **Factor 6: Determining the availability of generic substitutions** | | | | | |
| Did the CSR provide the response to member's request fully such as dosage and restrictions, if any? | 3 | 1 | 2 | 0 | 33% |

## IV. Quantitative Analysis

For the accuracy and quality of information, SCFHP sets a goal of 100%. Goals were met at 100% for factors 1, 3, 4, 5, and 6. For factor 2, 100% of the goal was met for all measures with the exception of one which only 92% out of 100% was met for measure 3 since the turn-around time for the exception process was not provided to the members.

The plan also had a goal of 100% for the quality of information provided for obtaining pharmacy benefit information. As with the accuracy rates, the goal is the same for quality. Goals were met at 100% for factors 1, 3, 4, and 5. Factor 1, measure 2 was "NA". This was mainly due to the benefit change that occurred in January of 2020 which SCFHP had waived the copayment for all generic medications. As a result, the opportunity to educate members about the benefit of filling a 90 day supply has diminished. Performance goal was missed for factor 2 which measure 1 received 84% of the goal and for measure 2, 80% which CSRs did not fully explain the restrictions for a medication and the member was not informed of the next step when an exception was submitted. For factor 6, only three samples were identified for the reporting period. Despite the low number of samples, only 33% of the goal was met.

## V. Qualitative Analysis:

Upon the completion of the quality and accuracy analysis, we recognize the outcome on this year's analysis can be improved. One of the areas was related to the exception process. CSR was skillful at looking up the drug name using the formulary tool to identify whether or not there are restrictions such as PA; however, there was no evidence of information being shared with the members. In addition, the CSRs was diligent in submitting the exception requests upon the member's request but the next step and turn-around time were not provided to the members. Lastly, when the CSR looked up the generic substitute of a drug, information about the drug dosage and drug restrictions were not provided to the members. Refresher trainings will be provided to remind CSRs to take the appropriate actions in these areas of deficiency.

| Deficiency | Accuracy or Quality | Plan for Correction | Target Date of Completion |
|---|---|---|---|
| 1.CSR did not fully explain/provide the restriction (s) pertaining to the medication (s) member requested | Quality | Provide refresher training to remind CSRs to review and provide all applicable drug restrictions to members. | 12/18/20 |
| 2. CSR did not inform the members of the next step for the exception submission process | Quality | Provide refresher training to remind CSRs to provide the turn-around time and to expect a phone call regarding the exception decision. | 12/18/20 |
| 3. When looking up a generic substitute for a drug, CSR should provide the dosage and restrictions of that drug if applicable. | Quality | Provide refresher training to remind CSRs to review and provide the drug dosage and restrictions to members. | 12/18/20 |
| 4. CSR need to provide and document the turn-around time (TAT) to members when an exception request is submitted. | Accuracy | Provide refresher training to remind CSRs to provide and document the TAT when an exception request is submitted. | 12/18/20 |

# Santa Clara Family Health Plan
# Member Experience, Including Behavioral Health: 2019 Analysis

**Prepared by:**

Victor Hernandez, Grievance & Appeals Quality Assurance Program Manager
Charlene Luong, Grievance and Appeals Manager
Tiffany Franke, Behavioral Health Case Manager, Behavioral Health - Health Services

For review by the Quality Improvement Committee, December 09, 2020

# I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaints and appeals may impact overall member satisfaction, SCFHP tracks and trends compliant and appeal activity to identify barriers to care and identify potential interventions.

The behavioral health member satisfaction survey is another means to monitor the member experience. The member experience assessment is used to identify areas of improvement and help meet the specific needs of SCFHP members. SCFHP reviews data associated with complaints and appeals and the Behavioral Health Member Satisfaction Survey on an annual basis. The quantitative analysis process includes a review of results and compares those results against any established performance goals. In future measurement years, the quantitative analysis will also track trends year over year. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to improving performance and quality. The process incorporates opportunities and/or interventions to address the root cause. In CY2019, the following measures were monitored for aspects shaping the Member Experience by conducting at a minimum, a quantitative analysis of all of the results and a qualitative analysis of non-behavioral health results:

1. Member complaint and appeals categories:
    a. Non-Behavioral Health
    b. Behavioral Health
2. Member Satisfaction Survey
    a. Behavioral Health

# 1. Member Complaints and Appeals

SCFHP collects data on five major categories of member grievances and appeals.

**Methodology**: SCFHP's Grievance and Appeals (G&A) Department uses the QNXT information system and the Grievance and Appeals database to document, collect, store and calculate grievance and appeals data which includes behavioral health-related issues. The data included in this analysis was captured in calendar year 2019 (January 1-December 31). The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to five categories required by NCQA. The data is then collected for the entire SCFHP Cal MediConnect population and is aggregated into the following categories:

- Quality of Care
- Access
- Attitude/Service

- Billing/Financial
- Quality of Practitioner office site

**Standards and Thresholds:**

SCFHP's goals are to:

- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and
- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category

  If a grievance and/or appeal exceeds this threshold, a root cause analysis will be conducted to identify the root cause and develop initiatives to address underlying issues. Internal and external stakeholders will be included as needed to assist in the root-cause analysis as well as remediation of the issues.

## Member Complaints/Grievances and Appeal Categories

**Table 1. CMC Member Complaints/Grievances Categories**

| Complaint / Grievance Category | 1Q-2019 | 2Q-2019 | 3Q-2019 | 4Q-2019 | (Jan. 1-Dec. 31, 2019) | Grievances / per 1,000 members<br><br>Average membership in 2019 = 8,051 |
|---|---|---|---|---|---|---|
| **Quality of Care** | **26**<br>*3.23* | **8**<br>*0.99* | **20**<br>*2.48* | **13**<br>*1.61* | **67** | **8.322** |
| **Access** | **10**<br>*1.24* | **11**<br>*1.37* | **17**<br>*2.11* | **28**<br>*3.48* | **66** | **8.198** |
| **Attitude/Service** | **121**<br>*15.0* | **101**<br>*12.5* | **136**<br>*16.9* | **123**<br>*15.3* | **481** | **59.744** |
| **Billing/Financial** | **151**<br>*18.8* | **168**<br>*20.9* | **167**<br>*20.7* | **115**<br>*14.3* | **601** | **74.649** |
| **Quality of Practitioner Office Site** | **0** | **1**<br>*0.12* | **0** | **0** | **1** | **0.124** |
| **Total** | **308** | **289** | **340** | **279** | **1216** | **151.037** |

**Quantitative Analysis: Member Complaints/Grievances**

SCFHP tracks and trends all member complaints/grievances for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all complaints from the Cal MediConnect membership. The data as shown in Table 1 represents all member complaints/grievances and is not a sample.

In 2019, the complaints/grievances analysis showed that two categories consistently did not meet the threshold throughout the year: Attitude/Service and Billing/Financial. Attitude and Service temporarily decreased by 16% with a result of 121 in the first quarter and a result of 101 in the second quarter. The third and fourth quarter remained closer to the first quarter's numbers, with a result of 136 and 123 respectively. Billing/Financial was consistently high throughout the year. However, Billing/Financial decreased by 31% from a result of 167 in the third quarter to a result of 115 in the fourth quarter.

In addition, Attitude/Service had a result of 59 grievances per 1,000 members and Billing/Financial had a result of 74 grievances per 1000 members for all of 2019. Out of the remaining three categories, Quality of Care and Access were also above the threshold when looking at all of 2019. Quality of Care had a result of 8 grievances per 1,000 members and Access had a result of 8 grievances per 1000 members; however, on a quarterly basis, these categories were below threshold. Quality of Care and Access both had one quarter where they were at 3 grievances per 1,000 members. Quality of Care's first quarter had 26 grievances and Access's fourth quarter had 28 grievances. The last category, Quality of Practitioner Office Site, met the goal and remained flat throughout the year.

**Table 2. CMC Member Appeal Categories**

| Appeals Category | 1Q-2019 | 2Q-2019 | 3Q-2019 | 4Q-2019 | (Jan. 1-Dec. 31, 2019) Total Appeals | Appeals / per 1,000 members Total membership in 2019 = 8,051 |
|---|---|---|---|---|---|---|
| **Quality of Care** | **0** | **0** | **0** | **0** | **0** | **0.000** |
| **Access** | **75**<br>*9.31* | **95**<br>*11.8* | **74**<br>*9.19* | **67**<br>*8.32* | **314** | **39.001** |
| **Attitude/Service** | **0** | **0** | **0** | **0** | **0** | **0.000** |
| **Billing/Financial** | **63**<br>*7.83* | **77**<br>*9.56* | **89**<br>*11.1* | **153**<br>*19.0* | **382** | **47.448** |
| **Quality of Practitioner Office Site** | **0** | **0** | **0** | **0** | **0** | **0.000** |
| **Total** | **138** | **172** | **163** | **220** | **693** | **86.076** |

## Quantitative Analysis: Member Appeals

SCFHP tracks and trends all member appeals for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all appeals inclusive of pre-service authorization and post-service claims appeals filed by a member or member representative. The data as shown in Table 2 is representative of all member appeals and is not a sample.

In 2019, the appeals analysis showed a significant increase in the fourth quarter of the year in the following category: Billing/Financial. This category increased by 72% from the third quarter to the fourth quarter, with results of 89 and 153 respectively. Both Access and Billing/Financial consistently did not meet their threshold goal throughout the year. The remaining three categories – Access, Attitude/Service and Quality of Practitioner Site – had results of zero appeals and, therefore, met the goal.

**Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 & 2)**

These cases are reported and analyzed by the Grievance and Appeals Review Workgroup, which meets on a quarterly basis. The Workgroup has representatives from the following departments at SCFHP: Executive team, Compliance, Provider Network Operations, Utilization Management, Quality Improvement, Customer Service, Case Management, and IT.

In analyzing the Attitude/Service grievances, the following root cause was determined for the high amount of grievances:

- Out of the 481 Attitude/Service grievances, 134 of them were a result of transportation services. This accounted for 28% of all Attitude/Service grievances in 2019. One vendor is responsible for 50% of all transportation grievances in 2019.
- In 2020, SCFHP involved their Customer Service and Provider Network Operations Departments to monitor the contracted transportation vendors and track their performance. Based on these results, SCFHP will meet with the individual vendors to determine what specific solutions can be made to decrease overall grievances.

In analyzing the Billing/Financial complaints/grievances the following root cause was determined for the high amount of grievances:

- Out of the 601 Billing/Financial grievances, 271 of them are a result of two specific hospitals. This equals to 45% of all Billing/Financial grievances in 2019.
- In 2020, SCFHP's Provider Network Operations Department is meeting with the staff and management of these hospitals to investigate the billing issue in an in-depth manner.

In analyzing the Billing/Financial appeals the following root causes were determined to be responsible for the increase:

- Post-service (claims payment) appeals were a significant portion of the Billing/Financial appeals category. This is a result of non-contracted providers failing to recognize the prior authorization rules for services rendered to SCFHP members. Specifically, all services requested intended to be rendered by a non-contracted provider require review and authorization by SCFHP's Utilization Management (UM) Department. Rather than the services being requested on a pre-service basis, providers rendered the services and then requested payment through the claims process. The claims were denied which led to appeals being filed.

| *Time Frame: January 1, 2019 - December 31, 2019* | | | | | | |
|---|---|---|---|---|---|---|
| **Behavioral Health Complaint / Grievance/Appeal Category** | **1Q-2019** | **2Q-2019** | **3Q-2019** | **4Q-2019** | **Total Grievances** | **BH Grievances/per 1,000 members Total CMC Membership in 2019 = 8,051** |
| **Quality of Care** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Access** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Attitude/Service** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Billing/Financial** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Quality of Practitioner Office Site** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | 0 |

**Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals**

There were no members who received behavioral services that filed appeals or grievances within CY 2019.

## 2. Member Satisfaction Survey – Behavioral Health

**Methodology:**

SCFHP conducts an annual telephonic member satisfaction survey for Cal MediConnect (CMC) members who receive behavioral health services. Members are identified through claims based on outpatient mental health services received in the previous calendar year. The total population for 2019 identified 2135 members. The health plan used a sample size calculator with a 95% confidence interval and a margin of error of 5 which resulted in a target sample size of 326.

Up to three calls were attempted for each member, with attention paid to the time of day (e.g. calling in the afternoon if not reached during the morning), alternate numbers (if available) and member language needs. Interpreter services were used for calls requiring a language other than that of the caller. All calls were made between the dates of April 3 and May 5, 2020 and were completed by health plan staff. A standard script was used as well as training to minimize discrepancies amongst staff in delivering the questionnaire to the members.

The results were recorded in the care management software in the form of an assessment. Results were provided in the form of a report. Questions 1-6 are demographic questions which got populated after successful completion of a survey in order to be easily extracted into a report.

The majority of the survey questions are adapted from the CAPHS survey.

**Questions 7-9 are related to access and are as follows:**

7) How often did you get an appointment as soon as you wanted?
8) How often did you see someone as soon as you wanted when you needed help right away?
9) How often did you get the help or advice you needed over the phone?

**Questions 10-14 are related to the quality of care and are as follows:**

10) How often did your counselor show respect for what you had to say?
11) How often did your counselor explain things in a way that you could understand? -
12) How often did your counselor listen carefully?
13) How often did your counselor spend any time with you?
14) How often did you feel comfortable raising issues or concerns?

**The remainder of the question are asked to determine overall progress of members using behavioral health services and are as follows:**

15) Compared to 12 months ago, how would you rate your ability to deal with daily problems?
16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations?
17) Compared to 12 months ago, how would you rate your ability to Accomplish the things you wanted to do?
18) Compared to 12 months ago, how would you rate your ability to deal with social situations?
19) What effect has your counseling had on your symptoms and problems?
20) What effect has your counseling had on the quality of your life?

Similar terms for counselor used included case manager, care coordinator, and behavioral health provider.

**Goals:**

1. Scores will be greater or equal to 85% combined average in “Always” and “Usually” categories for Questions 7-14

2. Obtain a valid sample size in order to begin to maintain a baseline for reference

## Behavioral Health: Member Satisfaction Survey Results

**Behavioral Health: Member Satisfaction Survey Results (Data Tables)**

| **Sample Size:** | **Total Outreach N = 385 members** |
|---|---|
| Completed Survey: | 104 (27%) |
| Survey Not Completed: | 281 (73%) |

| **Survey Not Completed (sub results):** | **281** |
|---|---|
| Unable to reach | 218 (76%) |
| Member/Caregiver was busy: | 16 (6%) |
| Member not available or in nursing home: | 15 (5%) |
| Didn't want to take survey: | 9 (3%) |
| Did not remember provider: | 8 (3%) |
| Member was sick or tired | 5 (2%) |
| Declined/no reason | 3 (<1%) |
| Didn't feel comfortable | 3 (<1%) |
| Member couldn't hear, declined | 2 (<1%) |
| Said already completed | 2 (<1%) |

| **Gender:** | **N = 104** | **%** |
|---|---|---|
| Female | 69 | 66% |
| Male | 25 | 24% |
| Unavailable | 10 | 10% |

| **Race/Ethnicity:** | **N = 100** | **%** |
|---|---|---|
| Hispanic/Latino | 31 | 31% |
| White/Caucasian | 31 | 31% |
| Asian | 24 | 24% |
| Unavailable | 8 | 8% |
| Black/African American | 6 | 6% |
| **Age:** | **N = 99** | **%** |
| +55 | 79 | 80% |
| 35-54 | 19 | 19% |
| 18-34 | 1 | 1% |

*Q7 – "How often did you get an appointment as soon as you wanted?"*

| **Q7 Responses –** | **N = 104** | **%** |
|---|---|---|
| Always | 68 | 65% |
| Usually | 12 | 12% |
| Sometimes | 21 | 20% |
| Never | 3 | 3% |

*Q8 – "How often did you see someone as soon as you wanted when you needed help right away?"*

| **Q8 Responses -** | **N = 102** | **%** |
|---|---|---|
| Always | 64 | 62% |
| Usually | 20 | 20% |
| Sometimes | 14 | 14% |
| Never | 4 | 4% |

*Q9 – "How often did you get the help or advice you needed over the phone?"*

| **Q9 Responses -** | **N = 104** | **%** |
|---|---|---|
| Always | 29 | 28% |
| Usually | 14 | 13% |
| Sometimes | 22 | 21% |
| Never | 39 | 38% |

*Q10 – "How often did your counselor show respect for what you had to say?"*

| **Q10 Responses -** | **N = 104** | **%** |
|---|---|---|
| Always | 82 | 79% |
| Usually | 14 | 13% |
| Sometimes | 6 | 6% |
| Never | 2 | 2% |

*Q11 – "How often did your counselor explain things in a way that you could understand?"*

| **Q11 Responses -** | **N = 104** | **%** |
|---|---|---|
| Always | 91 | 87% |
| Usually | 8 | 8% |
| Sometimes | 3 | 3% |
| Never | 2 | 2% |

*Q12 – "How often did your counselor listen carefully?"*

| Q12 Responses - | N = 104 | % |
|---|---|---|
| Always | 88 | 84% |
| Usually | 10 | 10% |
| Sometimes | 4 | 4% |
| Never | 2 | 2% |

*Q13 – "How often did your counselor spend any time with you?"*

| Q13 Responses - | N = 104 | % |
|---|---|---|
| Always | 71 | 68% |
| Usually | 19 | 18% |
| Sometimes | 13 | 13% |
| Never | 1 | 1% |

*Q14 – "How often did you feel comfortable raising issues or concerns?"*

| Q14 Responses - | N = 104 | % |
|---|---|---|
| Always | 93 | 89% |
| Usually | 4 | 4% |
| Sometimes | 5 | 5% |
| Never | 2 | 2% |

*Q15 – "Compared to 12 months ago, how would you rate your ability to deal with daily problems?"*

| Q15 Responses - | N = 18 | % |
|---|---|---|
| Much Better | 4 | 22% |
| A Little Better | 6 | 33% |
| About the Same | 6 | 33% |
| A Little Worse | 1 | 6% |
| Much Worse | 1 | 6% |

*Q16 – "Compared to 12 months ago, how would you rate your ability to deal with crisis situations?"*

| Q16 Responses - | N = 17 | % |
|---|---|---|
| Much Better | 3 | 18% |
| A Little Better | 6 | 35% |
| About the Same | 7 | 41% |
| A Little Worse | 1 | 6% |
| Much Worse | 0 | 0% |

*Q17 – "Compared to 12 months ago, how would you rate your ability to accomplish the things you wanted to do?"*

| Q17 Responses - | N = 17 | % |
|---|---|---|
| Much Better | 4 | 24% |
| A Little Better | 6 | 35% |
| About the Same | 4 | 24% |
| A Little Worse | 2 | 12% |
| Much Worse | 1 | 6% |

*Q18 – "Compared to 12 months ago, how would you rate your ability to deal with social situations?"*

| Q18 Responses - | N = 17 | % |
|---|---|---|
| Much Better | 4 | 24% |
| A Little Better | 3 | 18% |
| About the Same | 9 | 53% |
| A Little Worse | 1 | 6% |
| Much Worse | 0 | 0% |

*Q19 – "What effect has your counseling had on your symptoms and problems?"*

| Q19 Responses - | N = 18 | % |
|---|---|---|
| Very Helpful | 11 | 61% |
| A Little Helpful | 6 | 33% |
| Not Helpful or Harmful | 1 | 6% |

*Q20 – "What effect has your counseling had on the quality of your life?"*

| Q20 Responses - | N = 17 | % |
|---|---|---|
| Very Helpful | 13 | 76% |
| A Little Helpful | 3 | 18% |
| Not Helpful or Harmful | 1 | 6% |

**Quantitative Analysis: Behavioral Health Member Satisfaction Survey Results**

After over 900 call attempts, a total of 385 members answered the call. As a result, 104 members agreed to complete the survey, resulting in a response rate of 27%, which is an improvement in response rate from last year of 48% (13% to 27%).

Of the 281 surveys not completed, 73% were members we were unable to reach. This was not surprising given the known difficulty with reaching this population. Many members with behavioral health diagnoses in the county are difficult to contact due to changing addresses,

changes in where they access behavioral health services, changes in telephone numbers or not having a telephone to call. SCFHP acknowledges such limitations and will consider alternate methods for survey completion in the future, such as a combination of telephone and mail surveys. We are also looking into having a question added to the annual CAHPS survey to ask if the member received any behavioral health services so that the CAHPS survey results can be used.

While the goal to obtain a valid sample for analysis was met, the statistical sample size of 326 was not reached. Given the response rate we got, even if we attempted to contact all 2135 members, we still would not have achieved the 326 target sample.

As shown in table below, in every question except Q7 (got appointment as soon as wanted), there was an increase in the combined Always and Usually responses from the previous year.

Note: Question 9 was omitted from analysis due to poor wording.

**Table: % of combined "Always" and "Usually" Responses for Questions 7-14**

| Survey Question | Always and Usually Response % 2019 | Always and Usually Response % 2020 |
|---|---|---|
| Q7 - appointment soon as wanted | 86% | 77% |
| Q8 - helped when needed right away | 71% | 82% |
| Q10 - counselor was respectful | 87% | 92% |
| Q11 - counselor explained in a way you understood | 81% | 95% |
| Q12 - counselor listened carefully | 92% | 94% |
| Q13 – counselor spends time with you | 81% | 86% |
| Q14 – feel comfortable raising issues/concerns | 73% | 93% |

The average (mode) responses for each question were reviewed and compared to the responses from CY2018. The table below illustrates that for both years, most frequently, members reported positively regarding access to their behavioral health treatment providers, quality of counseling/behavioral health interventions received, and overall effect of counseling/services received. In terms of the overall effect of the services received, members responded positively or neutrally ("About the same") to changes in their own ability.

**Table: Average (mode) Member Responses**

| Survey Question | Most frequent Response | Response % 2019 | Response % 2020 |
|---|---|---|---|
| Q7 - appointment soon as wanted | Always | 62% | 65% |
| Q8 - helped when needed right away | Always | 55% | 62% |
| Q10 - counselor was respectful | Always | 73% | 79% |
| Q12 - counselor listened carefully | Always | 81% | 84% |
| Q17 - accomplish what want to do | A Little Better | 35% | 35% |

The following questions showed the same frequency of response categories, and similar to the questions above, there was an even higher positive response, but for the following questions, in 2020, the percentage of responses increased significantly, suggesting that the quality of care has improved.

| | | | |
|---|---|---|---|
| Q11 - understanding of counselor advice | Always | 65% | 87% |
| Q13 - counselor spent time w/ Member | Always | 62% | 89% |
| Q14 - comfortable raising concerns | Always | 54% | 89% |
| Q18 - ability deal with social situations | About the Same | 38% | 53% |
| Q19 - counseling effect on symptoms | Very Helpful | 46% | 61% |
| Q20 - counseling effect on quality of life | Very Helpful | 55% | 76% |

Below is the only question where we saw the same category frequency, but the responses were lower:

| | | | |
|---|---|---|---|
| Q16 - own ability deal with crisis | About the Same | 51% | 41% |

Below are the two questions where the category of the most frequent response changed.

1. Responses to the question “Ability to deal with daily problems” went from “a little worse” to “about the same or a little better”.

| Q15-Compared to 12 months ago, how would you rate your ability to deal with daily problems? | 2019 Response % | 2020 Response % |
|---|---|---|
| Much better | 14% | 22% |
| About the same | 27% | 33% |
| A little better | 16% | 33% |
| A little worse | 35% | 6% |
| Much worse | 5% | 6% |
| Declined to answer | 3% | 0% |

2. Responses to the question "How often did you get an appointment as soon as you wanted", although overall still low at 66%, showed increased responses to "Always", but for those who did not answer "always", there was a sharp decrease in the number who responded "Usually", and a large increase in the number who responded "Sometimes", indicating it may be getting harder to get the appointment as soon as they wanted. Responses from the 2018 CY survey were added to this analysis to check the trend over time.

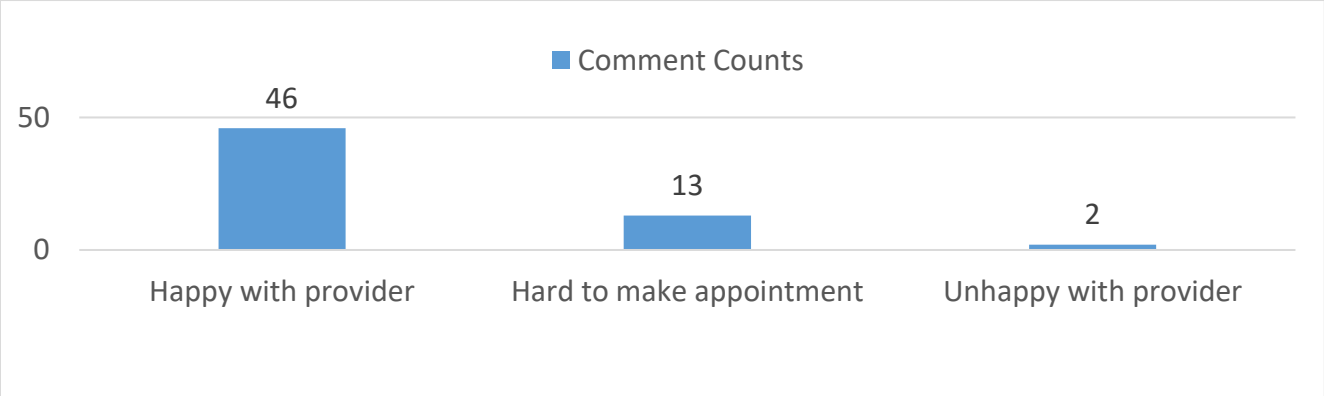
| Q7-How often did you get an appointment as soon as you wanted? | 2018 Response % | 2019 Response % | 2020 Response % |
|---|---|---|---|
| Always | 58% | 60% | 66% |
| Usually | 29% | 26% | 11% |
| Sometimes | 10% | 9% | 20% |
| Never | 3% | 6% | 3% |

The response for this question decreased, but the question was removed from analysis due to being poorly worded. The surveyors remarked that it was likely the members thought the question related to receiving care over the phone vs. in person. For the future, the question should be worded more like this: When getting services over the phone, how often did you get the help or advice you needed?

| | | | |
|---|---|---|---|
| Q9 – How often did you get the help or advice you needed over the phone | Always | 43% | 38% |

At the end of the survey, the member is asked if there is anything else they would like to share. Summary table of Analysis of comments is provided below:

**Table Comment Summary**




Overall, the majority of members reported positive or neutral experiences through their use of behavioral health care providers and services, and showed even more positive responses than in last years' survey. It may be helpful to determine the root cause of members who are not getting appointments as soon as they want.

**Qualitative Analysis: Behavioral Health Member Satisfaction Survey Results**

The goal of obtaining greater or equal to 85% of Always and Usually categories was met for all applicable questions with the exception of Q7 – getting an appointment as soon as you wanted (77%).
Data from the survey was brought to the Timely Access and Availability (TAA) Committee, which is made up of a cross-functional team with representatives from Provider Network Operations, Customer Service, Marketing, G&A, Quality, Compliance, Health Services and Claims. The Committee asked for additional

data and analysis to determine if there was any trend in provider networks or provider names from which the Provider Relations team could follow up.

Further assessment of the survey data relevant to members who replied “sometimes or never” to questions related to access did not show trending against any specific providers or networks. SCFHP will continue to monitor member satisfaction with access to behavioral health providers through annual surveys, member complaints and/or other applicable sources.

## Reporting

**Table: Committee Approval**

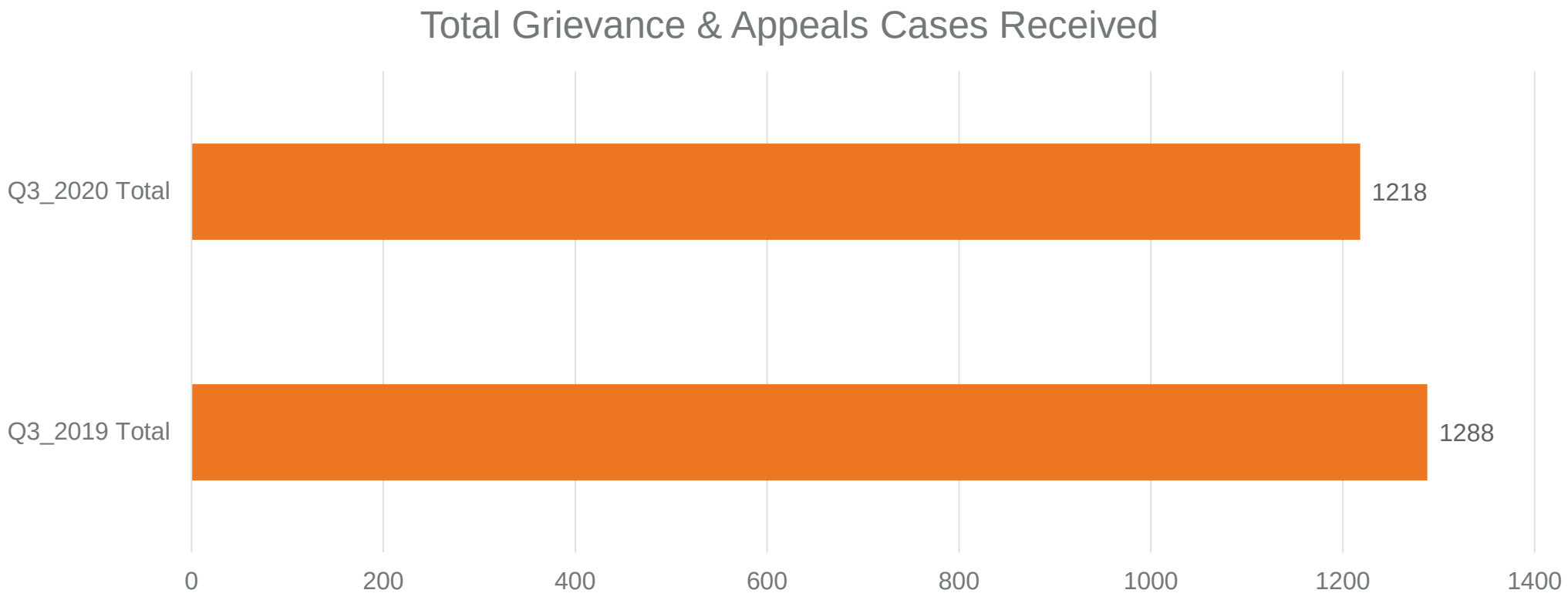
| Approving Committee | Date of Approval | Recommendations |
|---|---|---|
| Quality Improvement Committee | | |

Santa Clara Family Health Plan™

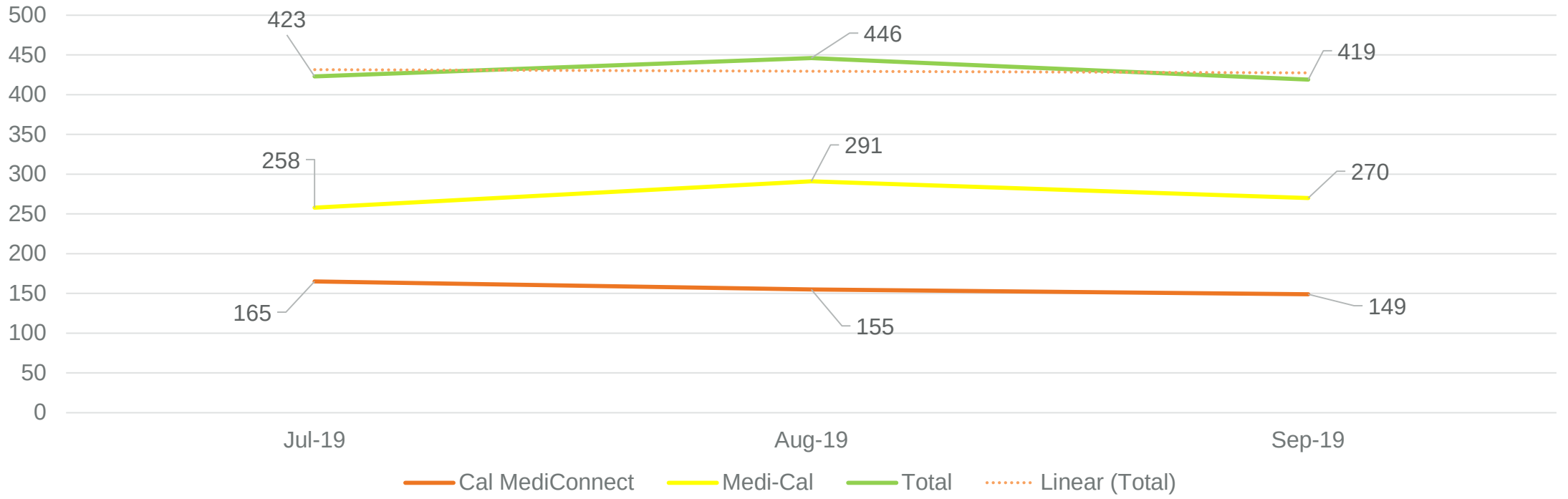
# Quality Improvement Committee

## Q3 2020 Grievance & Appeals Data

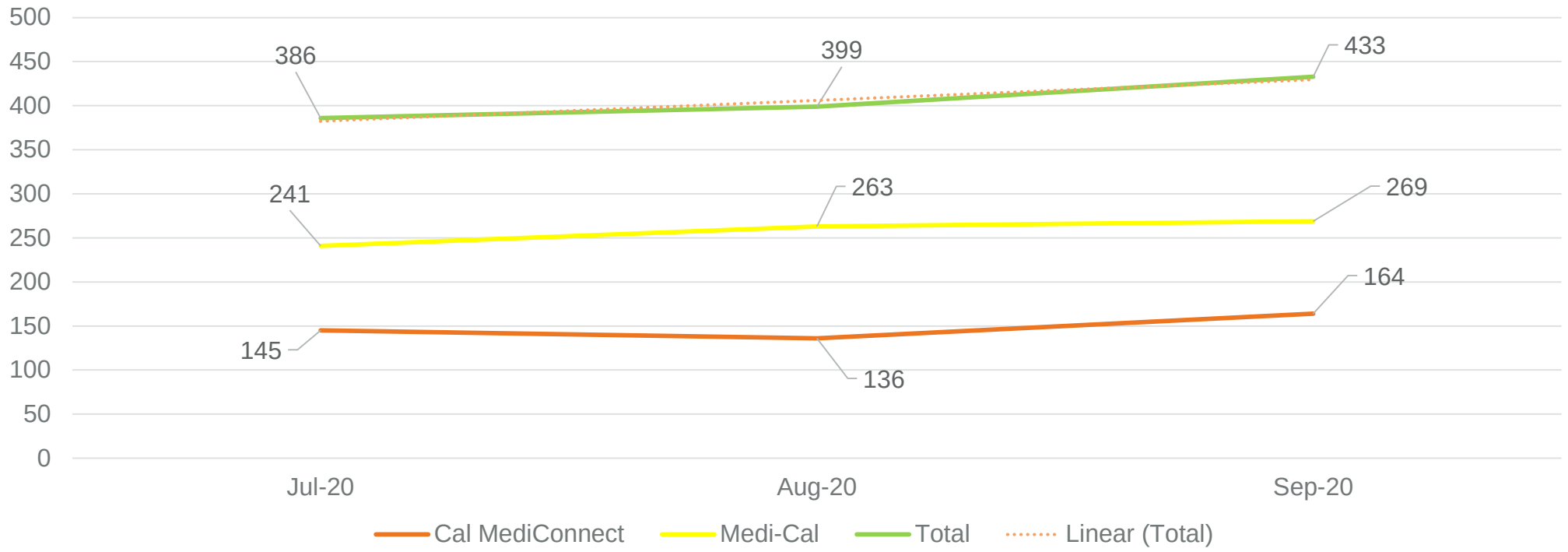
# Total Grievance & Appeal Cases Received (All LOB)



# Q3 2019 Total Grievance & Appeal Cases Received



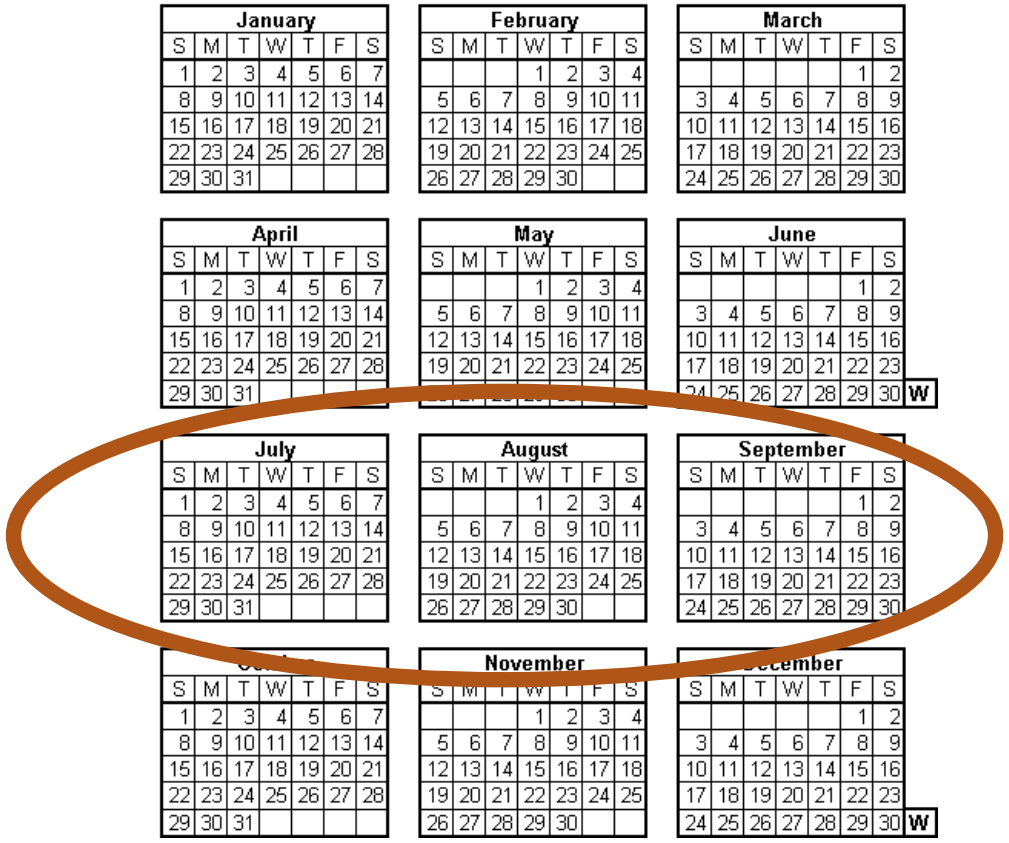
# Q3 2020 Total Grievance & Appeal Cases Received



# Q3 2020 Total Grievances
## *Rate per 1000 Members*

| | | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|---|
| **Total CMC Grievances** | | **95** | **101** | **109** |
| **CMC Total Membership** | | **9,029** | **9,266** | **9,428** |
| ***Rate per 1,000*** | | 11 | 11 | 12 |
| | | | | |
| **Total MC Grievances** | | 148 | 161 | 172 |
| **MC Total Membership** | | **248,007** | **251,004** | **253,252** |
| ***Rate per 1,000*** | | 0.60 | 0.64 | 0.68 |

# Medi-Cal



January

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

February

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

March

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

April

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

May

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |

June

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

W

July

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

August

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

September

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

[illegible]

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

November

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

[illegible]

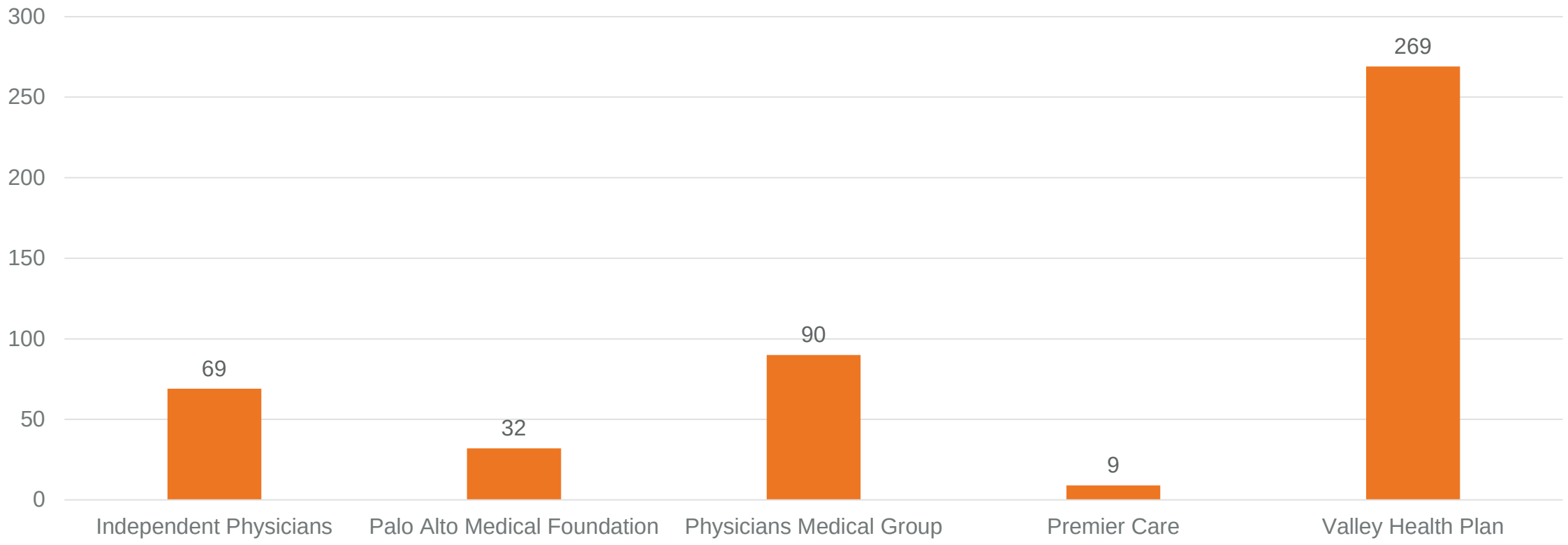
| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

W


## Q3 2020

# Q3 2020 MC Grievances by Network

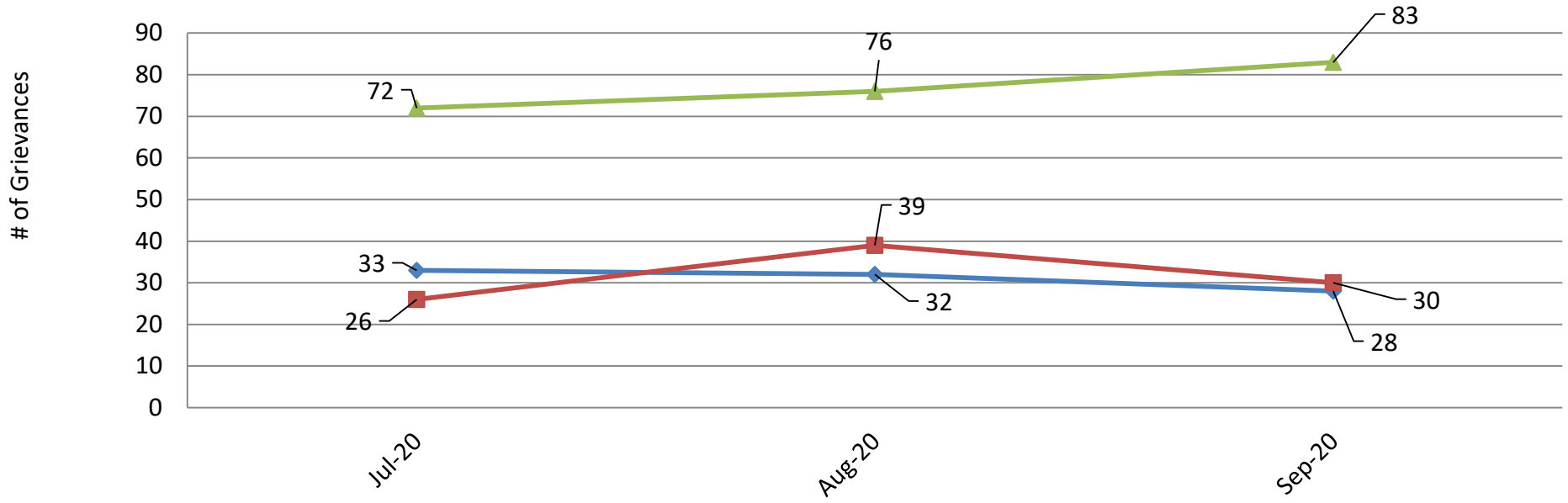
(Medicare Primary Grievances are distributed out to their corresponding network)



# Q3 2020 MC Grievances by Network
## *Rate per 1000 Members*

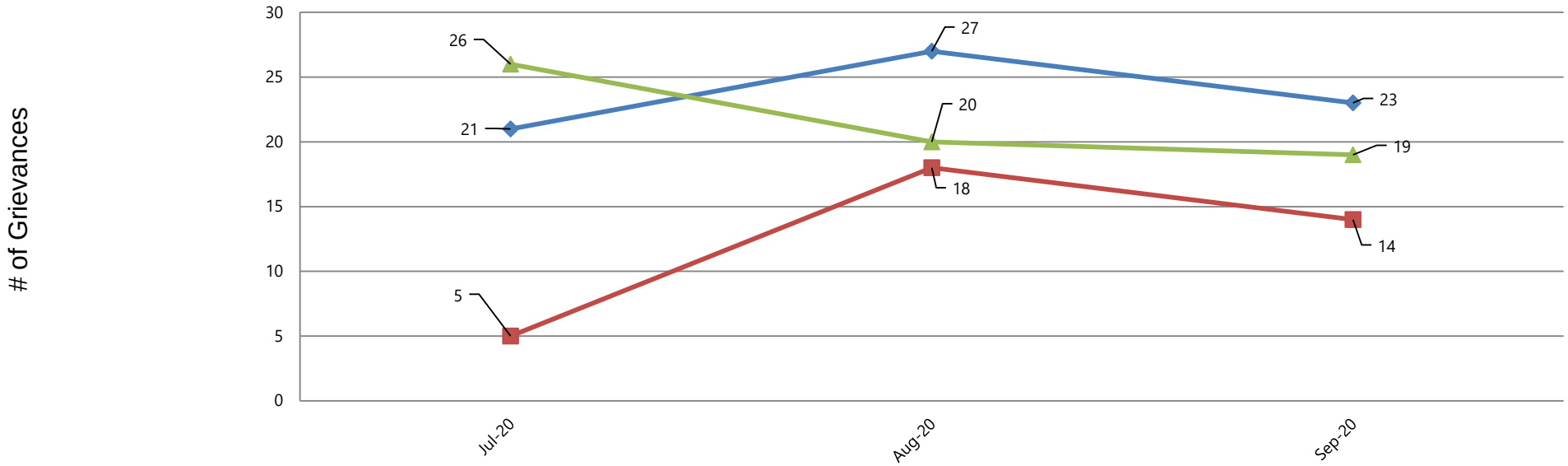
| Network | Jul-20 | Aug-20 | Sep-20 | Total Grievance Q3 by Network | Rate per 1,000 |
|---|---|---|---|---|---|
| INDEPENDENT PHYSICIANS | 15,844 | 16,113 | 16,358 | 50 | 3.06 |
| MEDICARE PRIMARY | 15,696 | 15,684 | 15,698 | 21 | 1.34 |
| PALO ALTO MEDICAL FOUNDATION | 6,696 | 6,759 | 6,823 | 32 | 4.69 |
| PHYSICIANS MEDICAL GROUP | 43,036 | 43,436 | 43,695 | 90 | 2.06 |
| PREMIER CARE | 15,144 | 15,274 | 15,344 | 9 | 0.59 |
| VHP NETWORK | 124,379 | 125,894 | 127,102 | 267 | 2.10 |

# Q3 2020:Top 3 Medi-Cal Grievance Categories



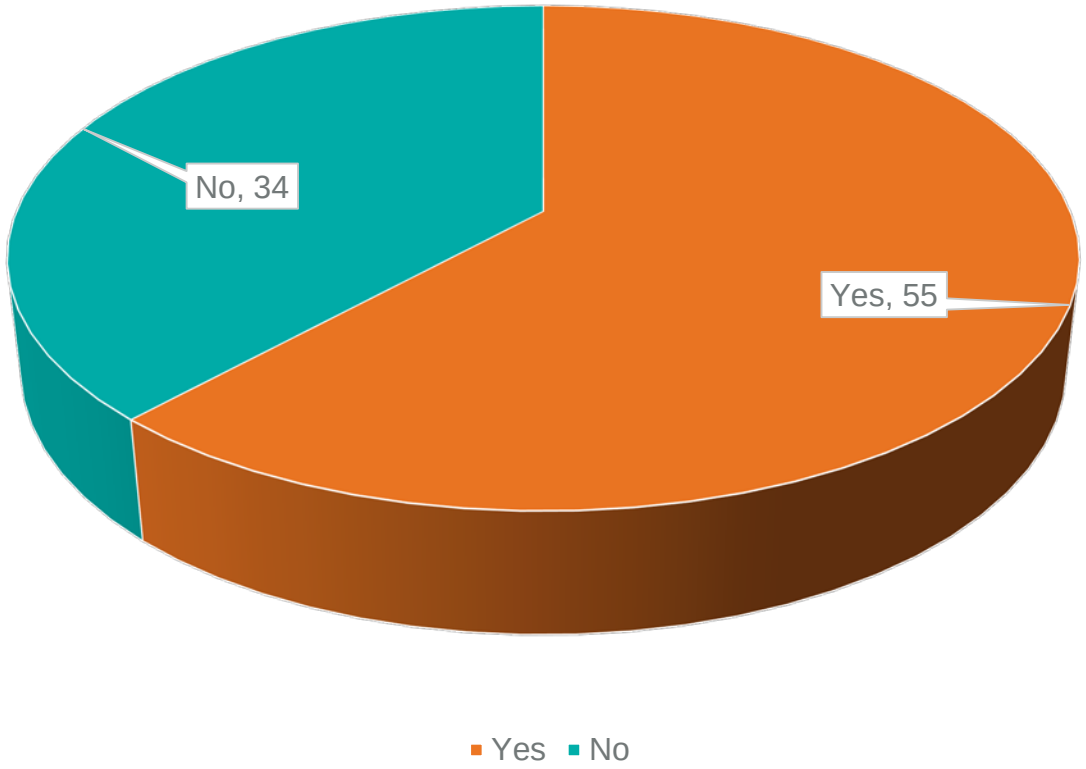

| | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|
| Access | 33 | 32 | 28 |
| Quality of Care | 26 | 39 | 30 |
| Quality of Service | 72 | 76 | 83 |

# Q3 2020:Top 3 Medi-Cal Grievance Subcategories

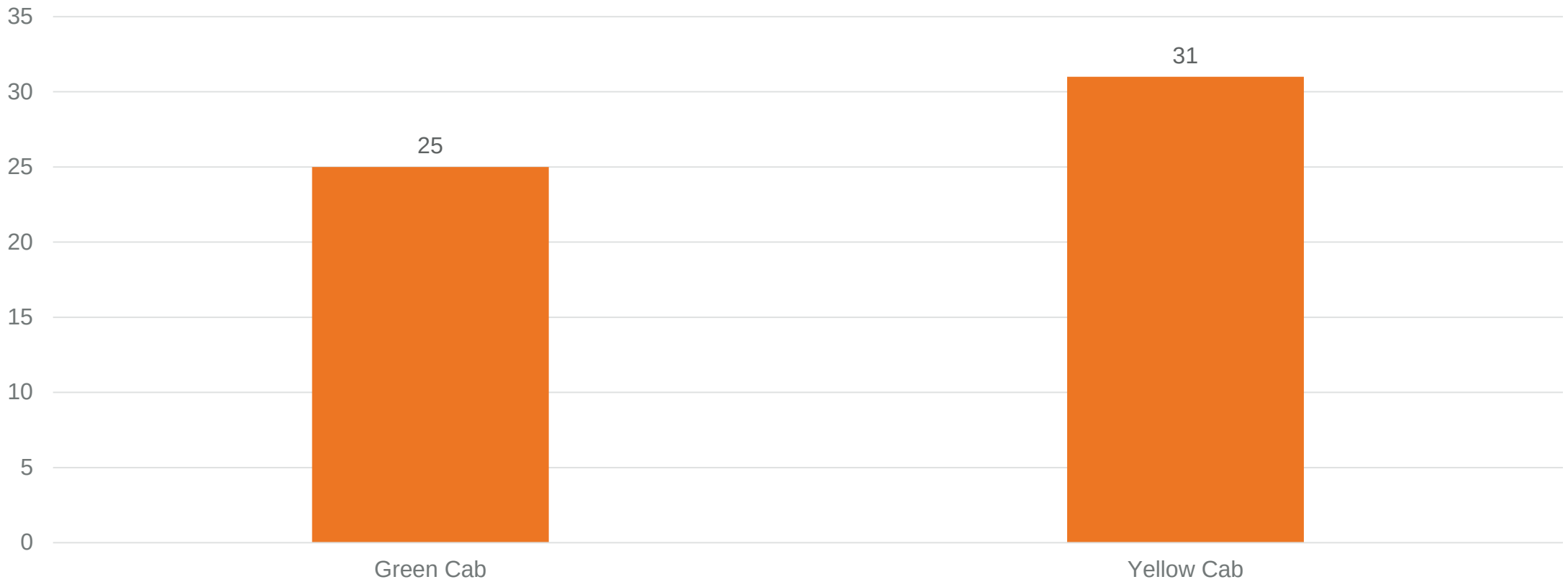



| | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|
| QOC- Inappropriate Provider Care | 21 | 27 | 23 |
| QOS-Poor Provider/Staff Attitude | 5 | 18 | 14 |
| QOS-Transportation Services (NMT) | 26 | 20 | 19 |

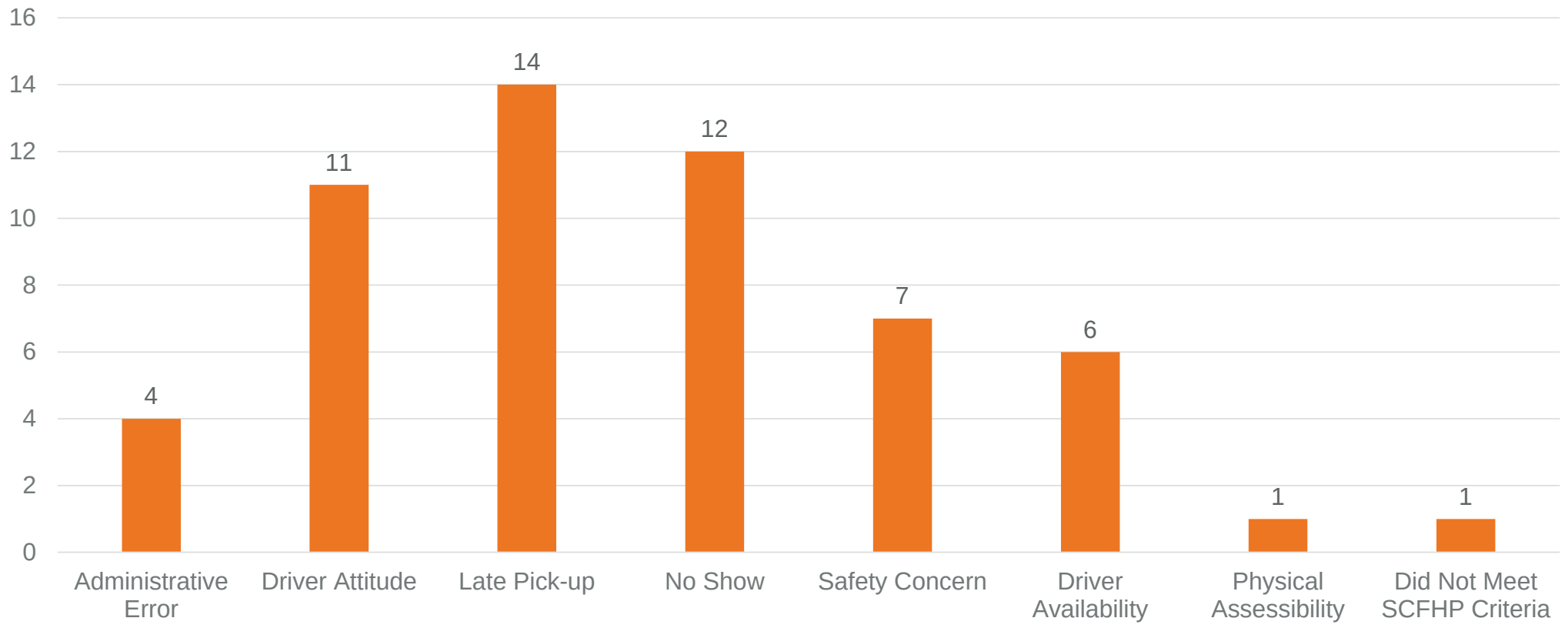
# Q3 2020 MC Inappropriate Provider Care PQI Issues Flag



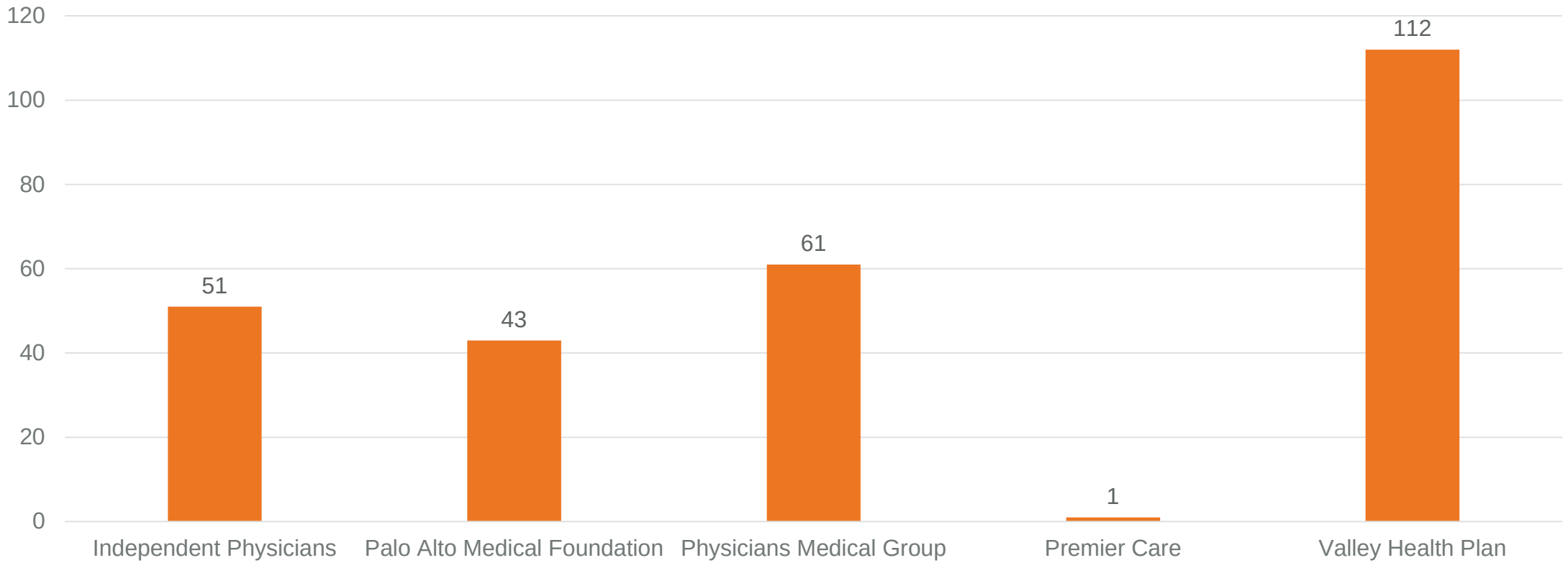
# Q3 2020 MC NMT Grievances by Vendor



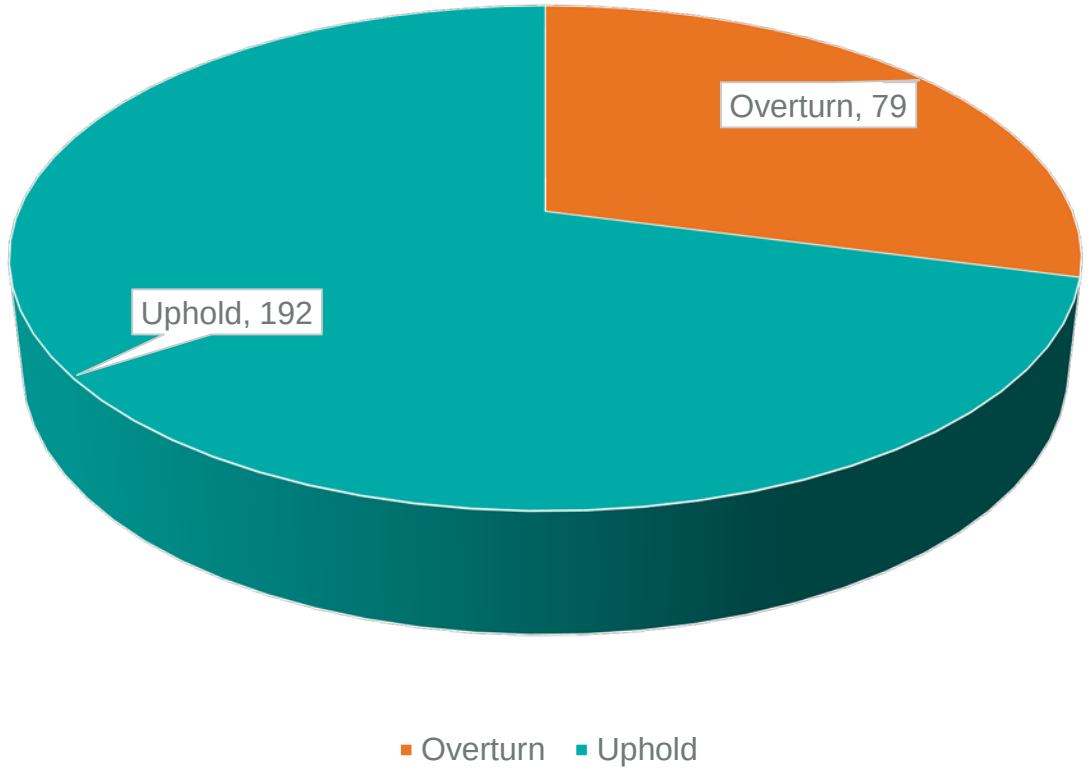
# Q3 2020 MC NMT Grievances by Reason



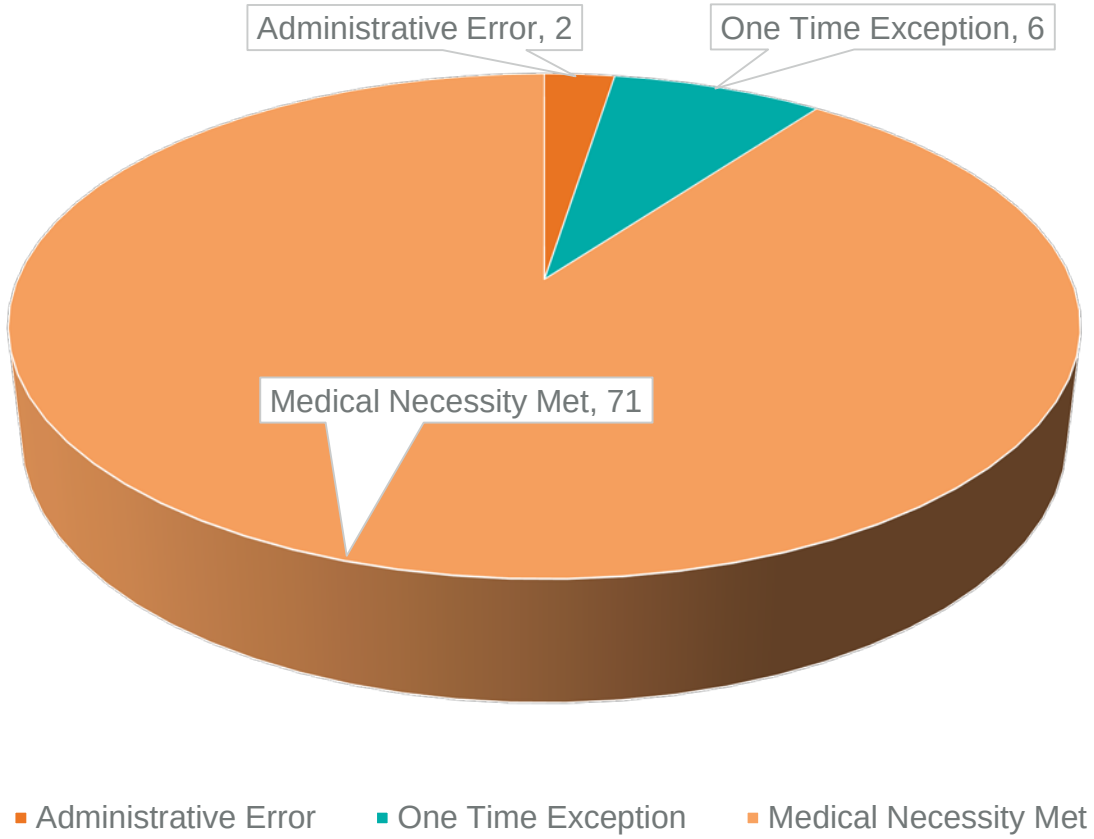
# Q3 2020 MC Appeals by Network



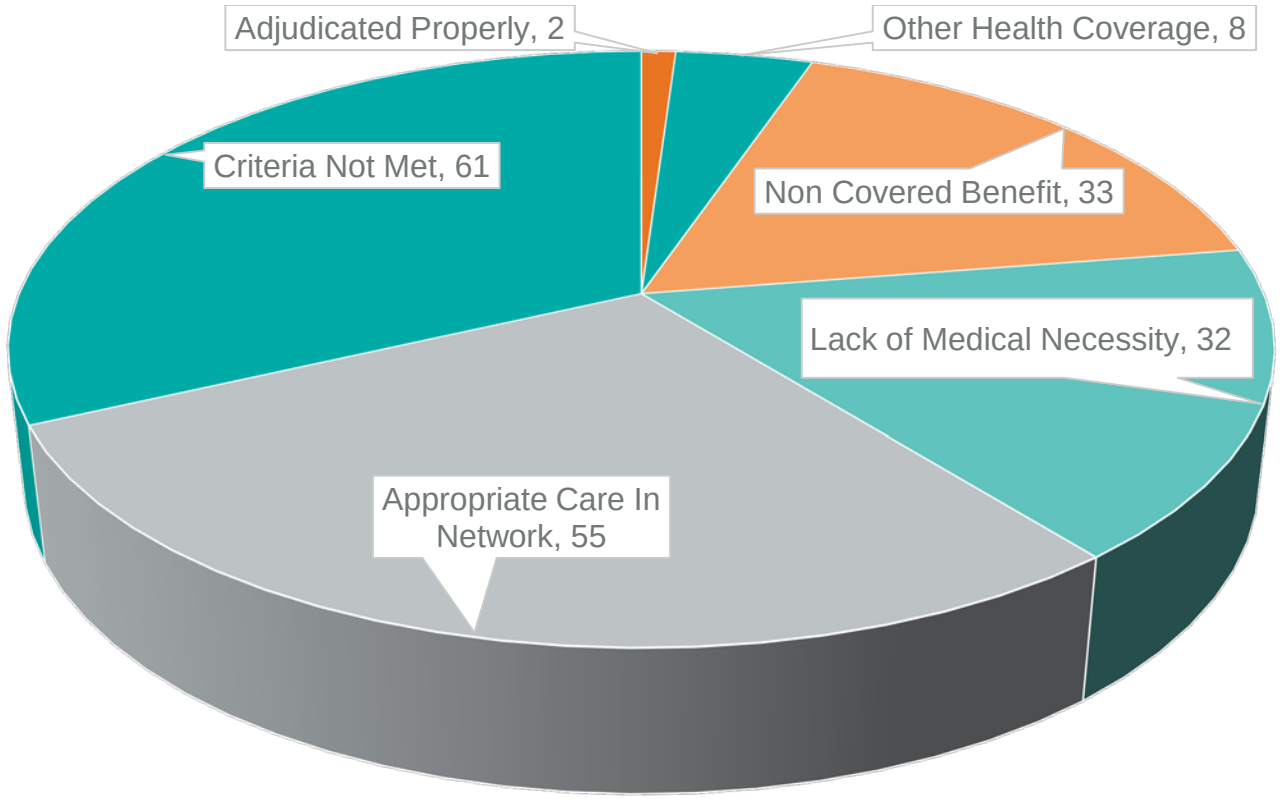
# Q3 2020 MC Appeals by Disposition



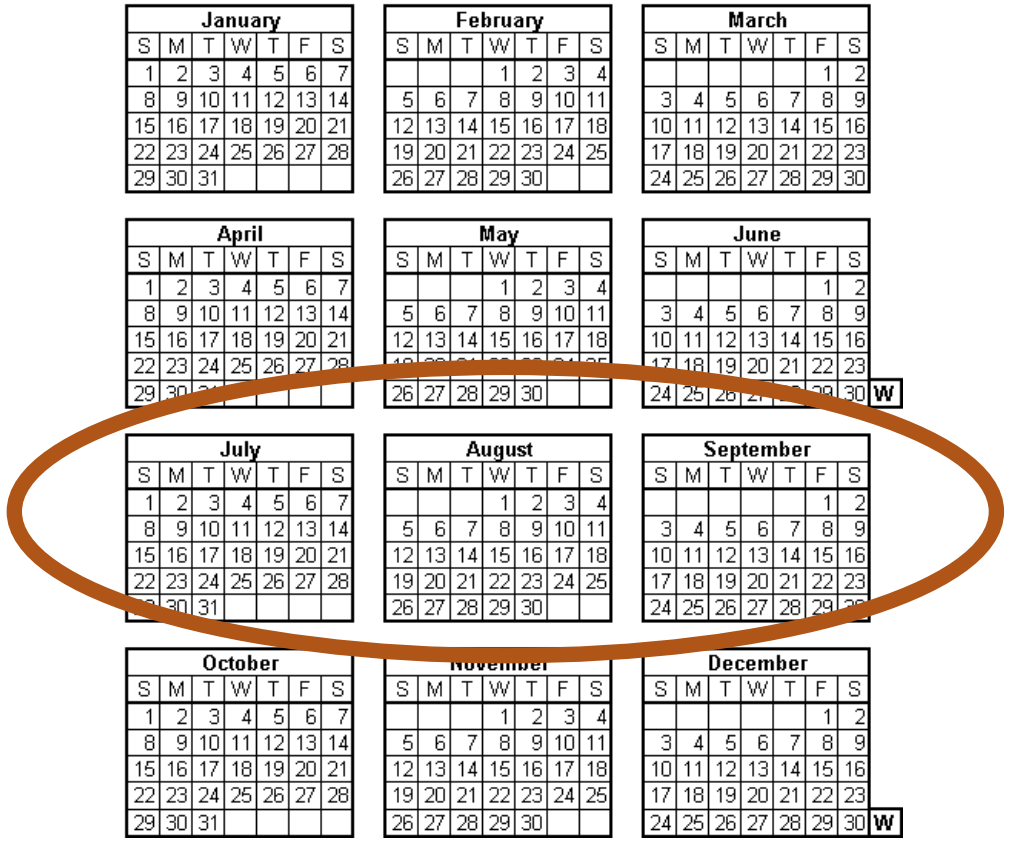
# Q3 2020 MC Appeals: Overturn Rationale



# Q3 2020 MC Appeals: Upheld Rationale



# Cal MediConnect



| January | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

| February | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

| March | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

| April | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

| May | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

| June | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

| July | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| | 30 | 31 | | | | |

| August | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

| September | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | |

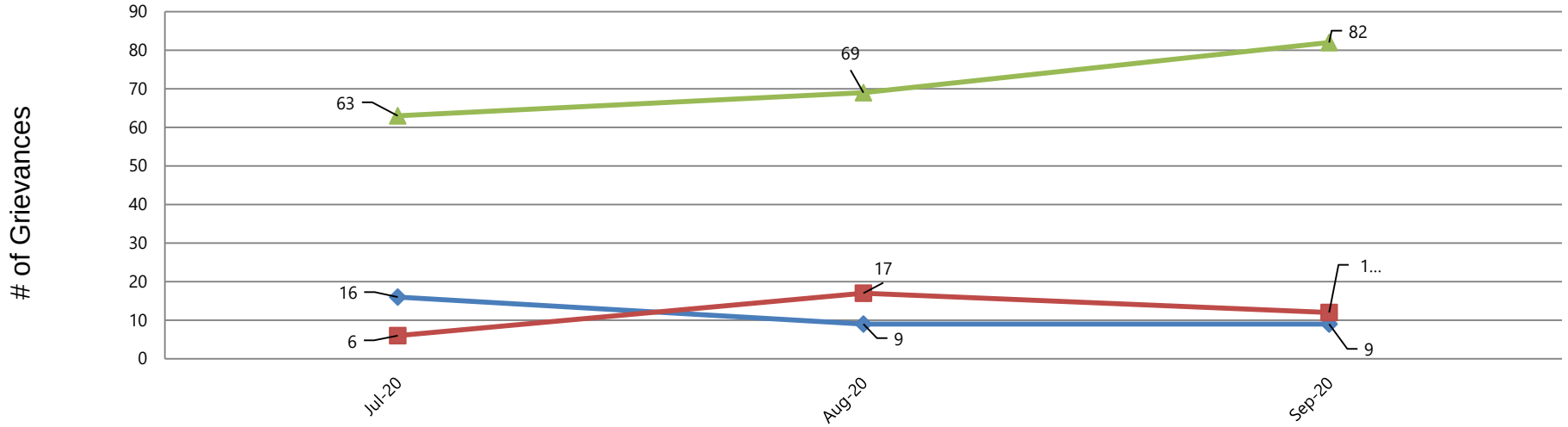
| October | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

| November | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

| December | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

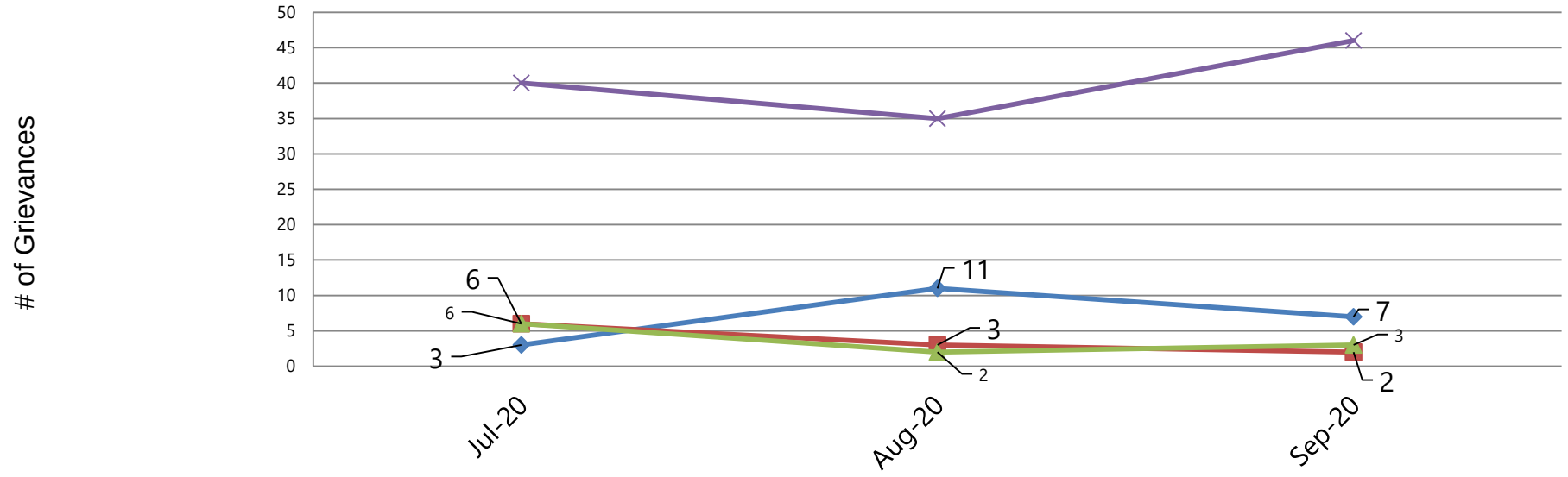

## Q3 2020

# Q3 2020:Top 3 Cal MediConnect Grievance Categories



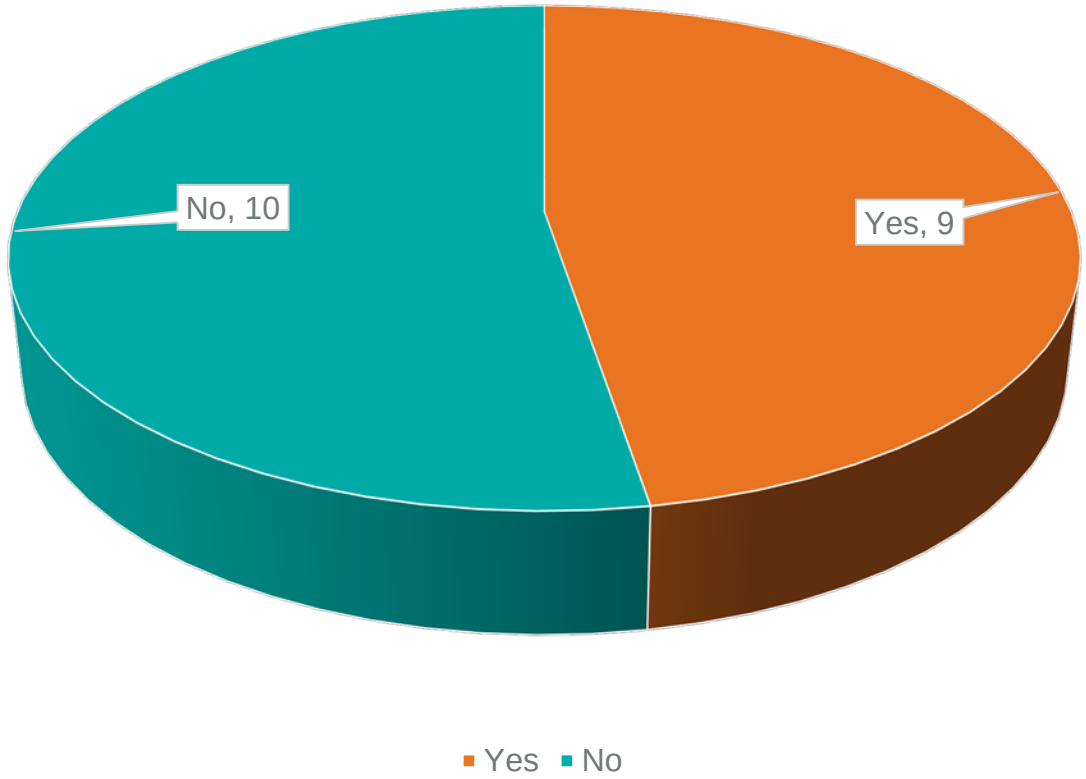

| | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|
| Access | 16 | 9 | 9 |
| Quality of Care | 6 | 17 | 12 |
| Quality of Service | 63 | 69 | 82 |

# Q3 2020:Top 3 Cal MediConnect Grievance Subcategories




| | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|
| QOC- Inappropriate Provider Care | 3 | 11 | 7 |
| Access-Provider Telephone Access | 6 | 3 | 2 |
| Access-Timely Access to PCP | 6 | 2 | 3 |
| QOS-Billing/Balance Billing | 40 | 35 | 46 |

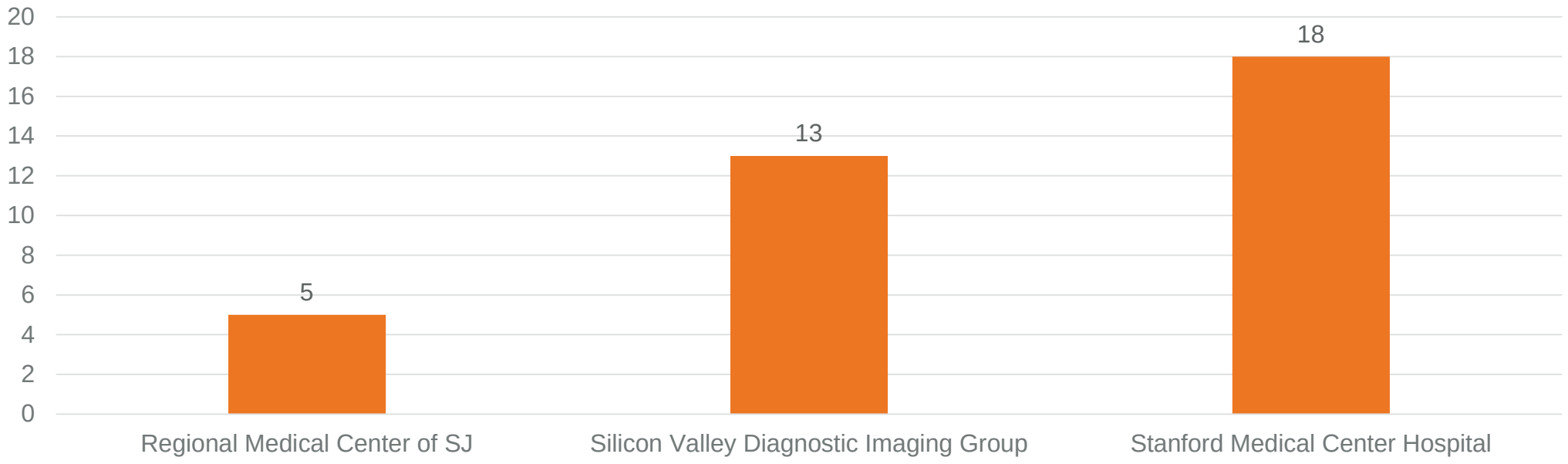
# Q3 2020 CMC Inappropriate Provider Care PQI Issues Flag



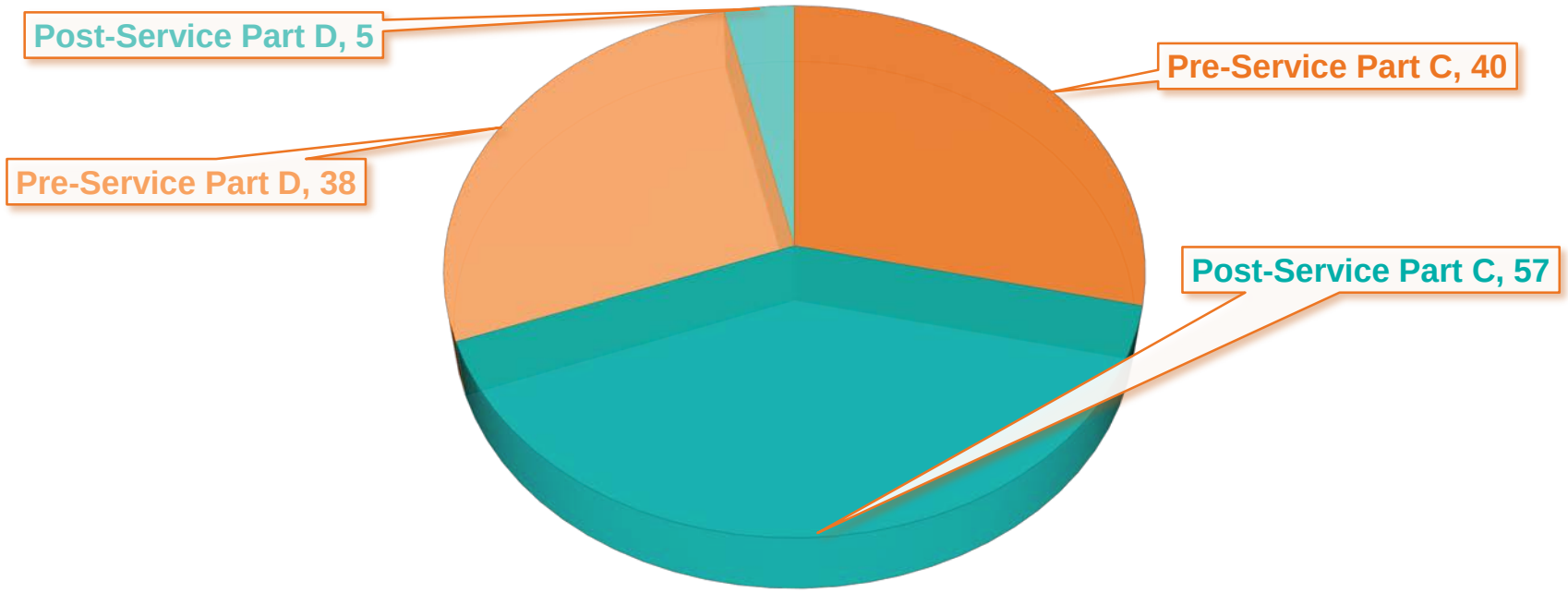
# Q3 2020 CMC Balance Billing by Providers

| | |
|---|---|
| BREG INC | 3 |
| BYRAM HEALTHCARE CENTERS INC-HUNTINGTON | 1 |
| CENTRAL VALLEY IMAGING ASSOC INC | 3 |
| CEP AMERICA - ANESTHESIA PC | 1 |
| EDMUND W TAI | 1 |
| EL CAMINO HOSPITAL-MOUNTAIN VIEW CAMPUS | 2 |
| EL CAMINO MEDICAL ASSOCIATES PC | 1 |
| EMERGENCY PHYSICIANS ASSOCIATES GILROY PC | 4 |
| EMERGENCY PHYSICIANS ASSOCIATES SAN JOSE PC | 4 |
| FIDERE ANESTHESIA CONSULTANTS | 3 |
| GOOD SAMARITAN HOSPITAL | 2 |
| HOSPITALIST MEDICINE PHYS | 1 |
| IHC - MERIDIAN AVE | 1 |
| KAISER HOSPITAL - SAN JOSE | 1 |
| KAISER HOSPITAL - SANTA CLARA | 1 |
| KCI USA INC | 1 |
| LAB CORP OF AMERICA-ECD SAN DIEGO | 1 |
| LABORATORY CORP OF AMERICA-YC BURLINGTON | 1 |
| MARIN GENERAL HOSPITAL | 1 |
| MINIMED DISTRIBUTION CORP | 1 |
| MORTEZA FARR DO INC | 1 |
| NORTHWEST TEXAS HEALTHCARE SYS | 1 |
| O'CONNOR HOSPITAL | 2 |
| PACIFIC MEDICAL INC | 2 |
| PAMF GROUP | 1 |
| PHYSICIANS SRVCS AT EL CAMINO HOSP | 3 |
| QUANTUM BAY AREA HOSPITALIST MEDICAL GRP INC | 2 |
| QUANTUM HEALTHCARE MEDICAL ASSOC | 1 |
| QUEST DIAGNOSTICS-SAN JOSE | 2 |
| RADIOLOGICAL ASSOC MED GRP | 2 |
| RAFIA PARVEEN | 1 |
| REGIONAL MEDICAL CENTER OF SJ | 5 |
| RURAL-METRO OF CALIFORNIA INC | 3 |
| SAINT LOUISE REGIONAL HOSPITAL | 3 |
| SILICON VALLEY DIAGNOSTIC IMAGING GROUP | 13 |
| SOLANO GATEWAY MEDICAL GROUP | 2 |
| ST JOSEPH HOSPITAL OF ORANGE | 1 |
| STANFORD MEDICAL CENTER | 18 |
| STANFORD MEDICAL CENTER HOSPITAL | 3 |
| SWEDISH HEALTH SERVICES | 1 |
| UNIVERSITY HEALTHCARE ALLIANCE | 2 |
| VALLEY RADIOLOGY MEDICAL ASSOC | 2 |

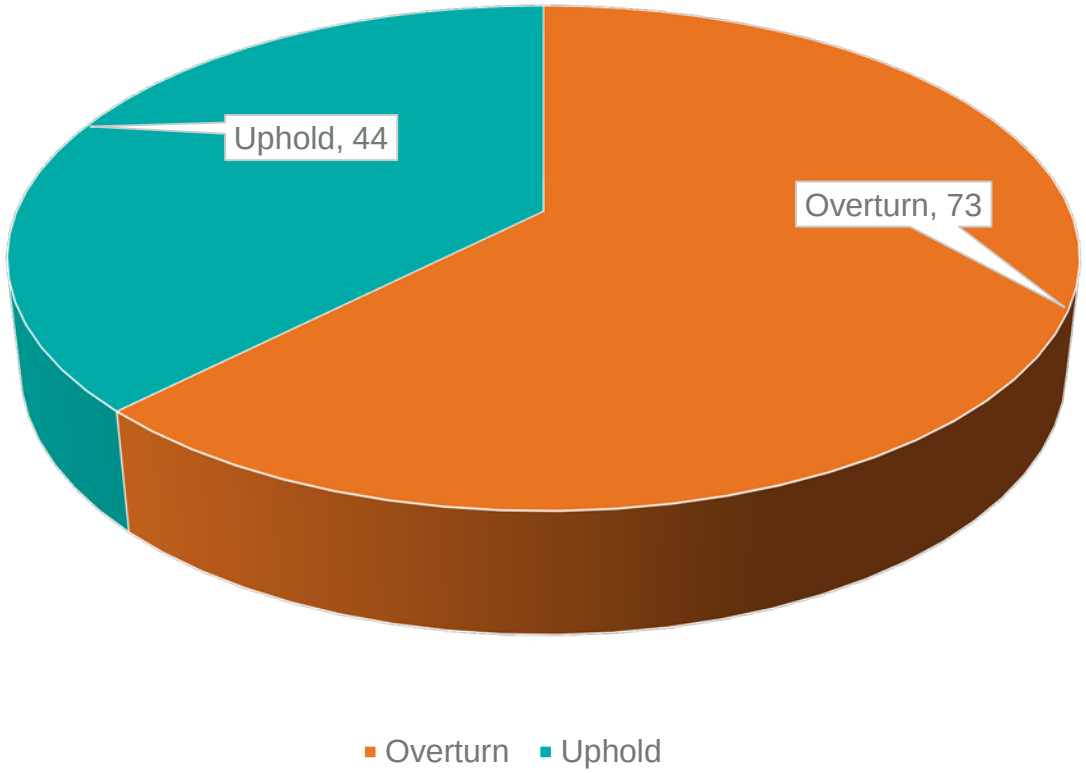
# Q3 2020 CMC Balance Billing
# Top 3 Providers



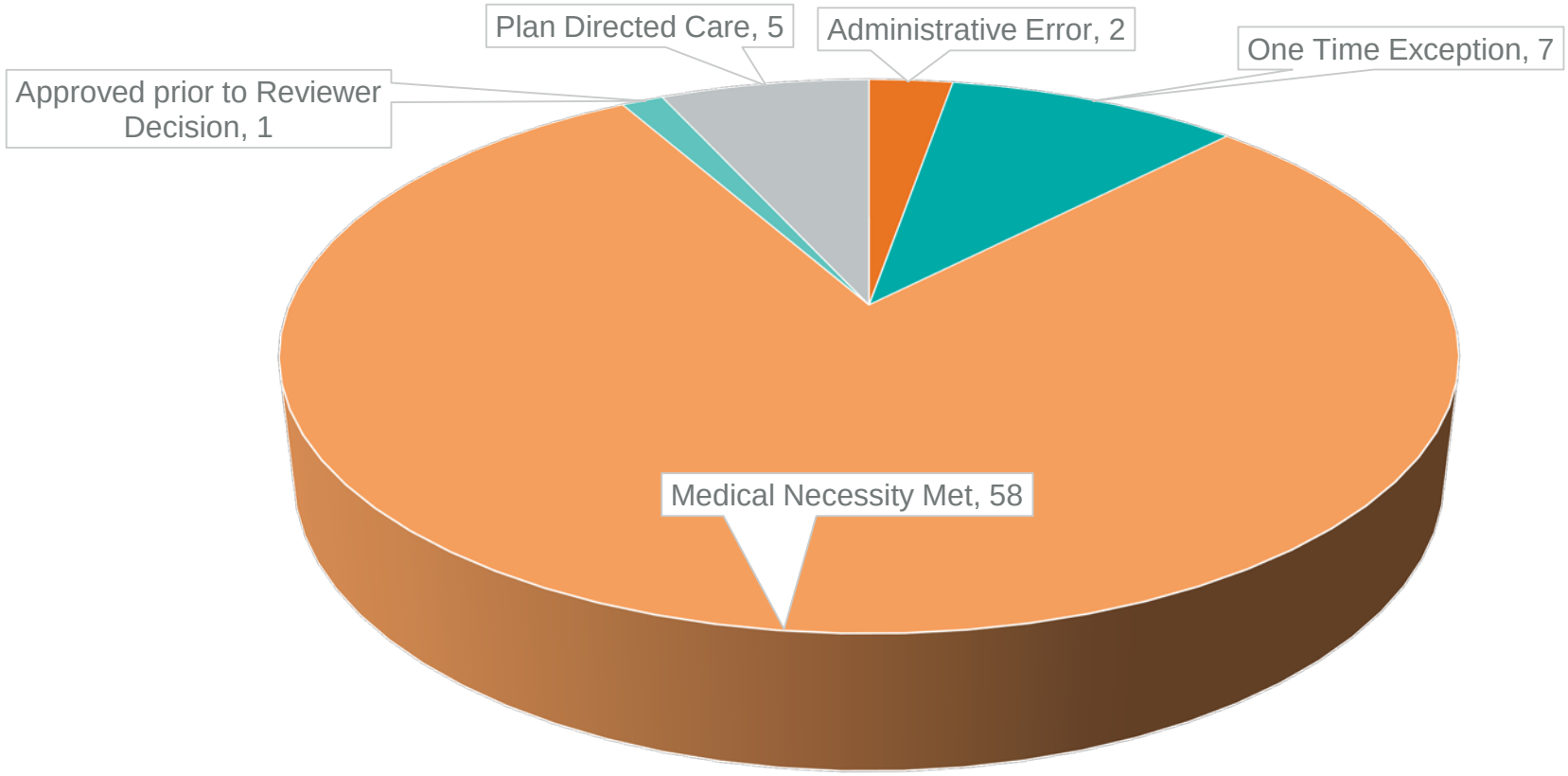
# Q3 2020 CMC Appeals by Case Type



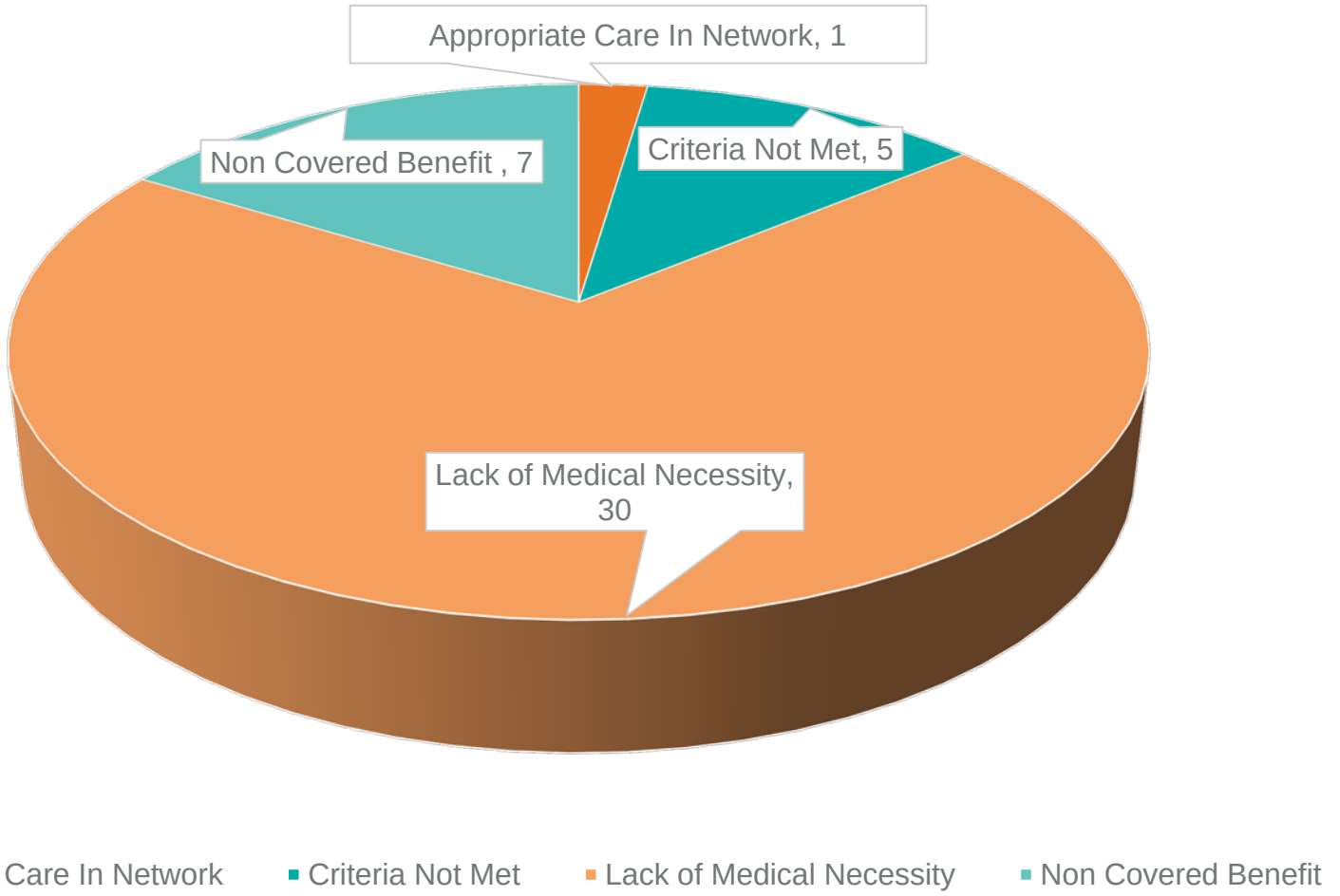
# Q3 2020 CMC Appeals by Disposition



# Q3 2020 CMC Appeal: Overturn Rationale



# Q3 2020 CMC Appeal: Upheld Rationale



Santa Clara Family Health Plan™

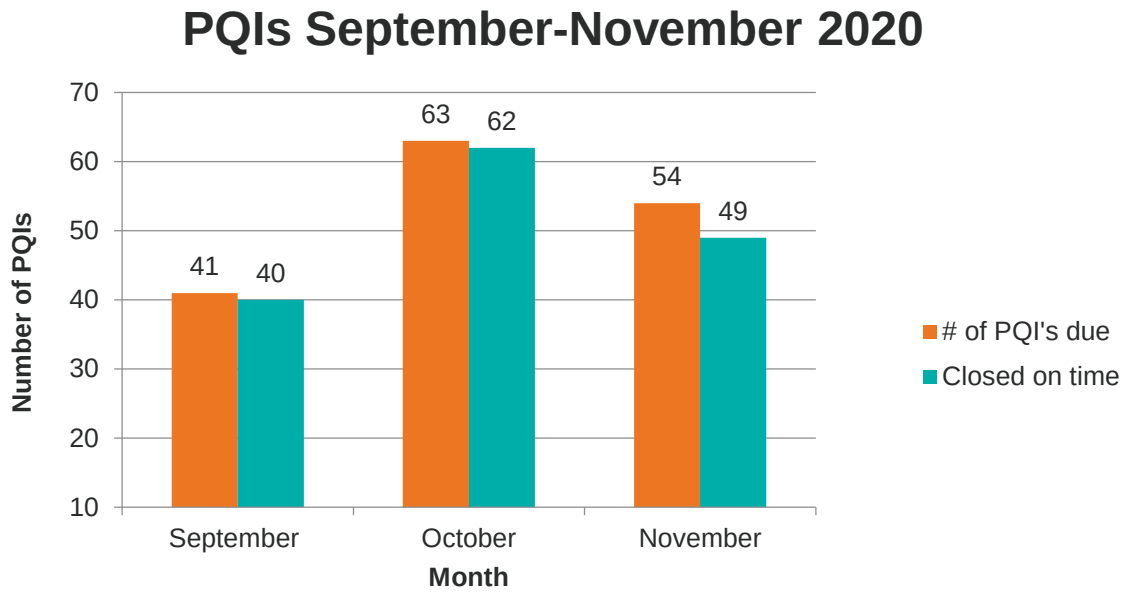
# Quality Improvement Dashboard

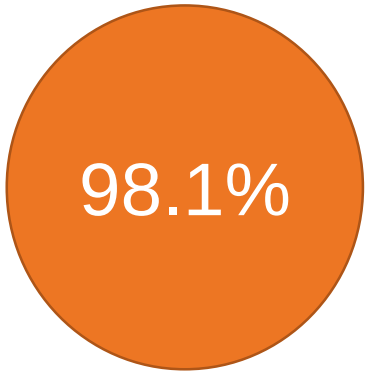
September- November 2020

# Potential Quality of Care Issues

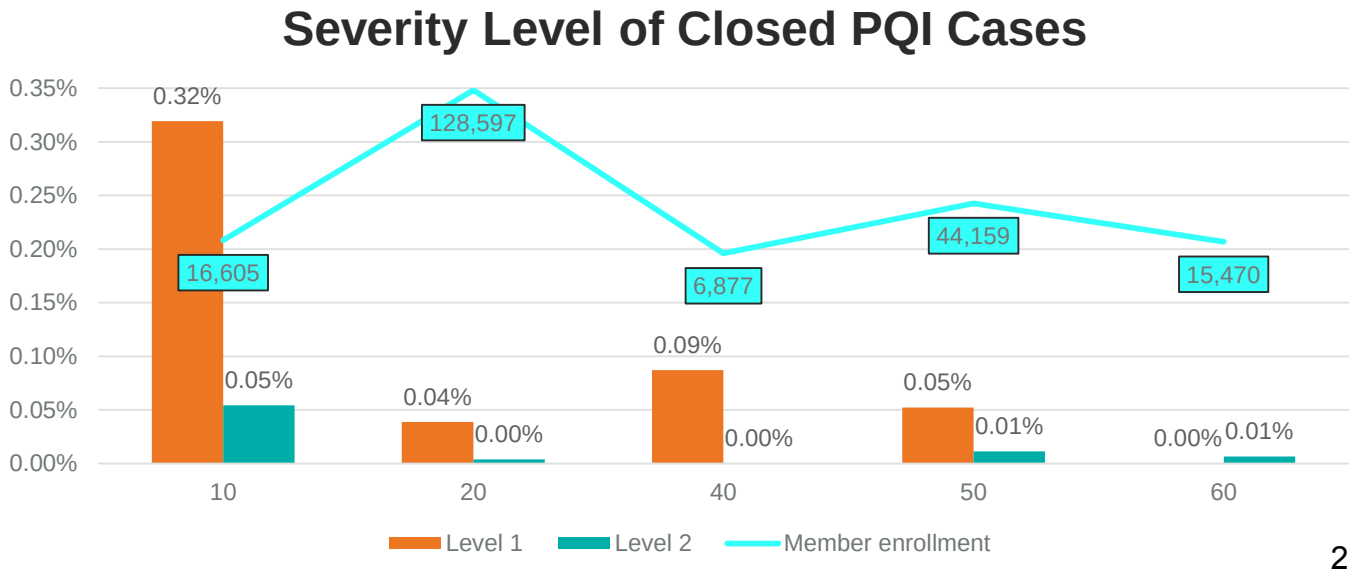
Santa Clara Family Health Plan

**Quality helps ensure member safety by investigating all potential quality of care (PQI) issues**




Percentage of PQIs due from September-November, 2020 closed on time within 60 days

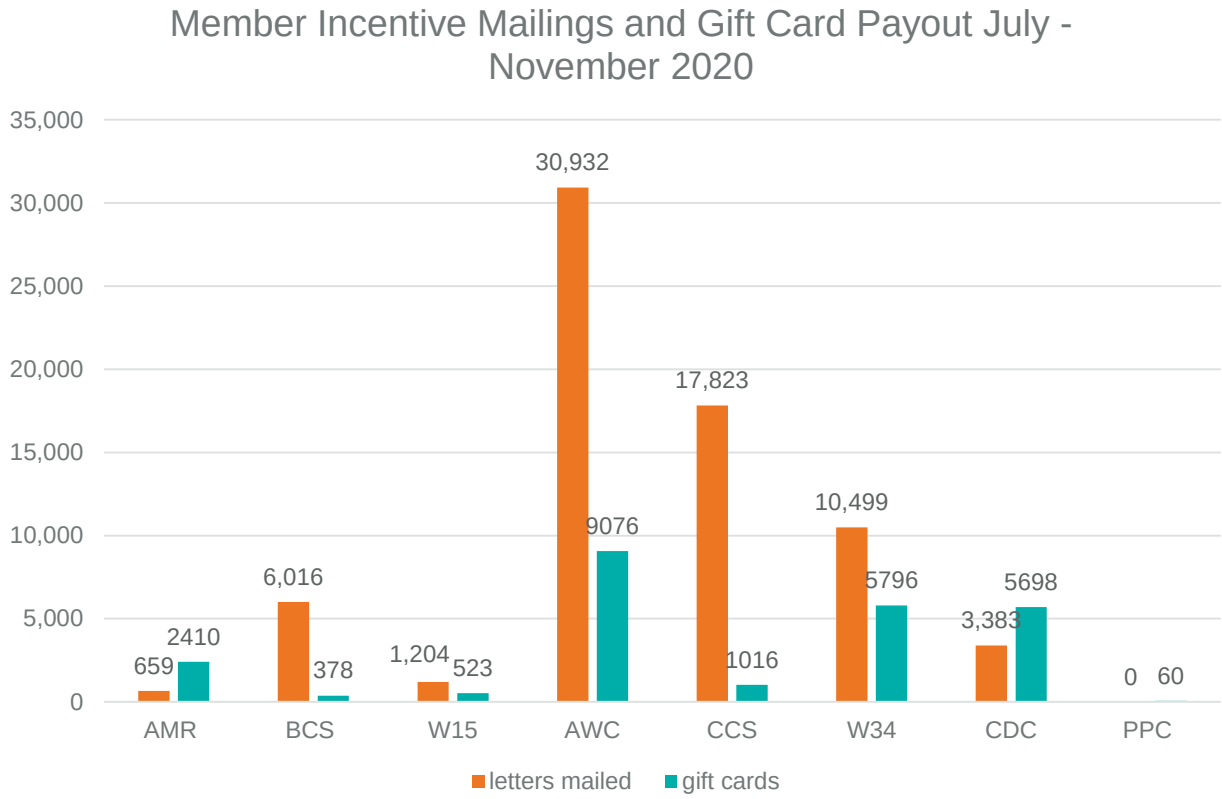


# Member Incentives:
## Wellness Rewards Mailing

**Letters to non-compliant members started in July for: W15, W34, AWC, BCS, CCS, CDC, AMR**

*PPC is referral based, no mailers

| | |
|---|---|
| Total # of mailers sent since July 2020 | 70,516 |
| Total # of gift cards mailed since July 2020 | 24,957 |

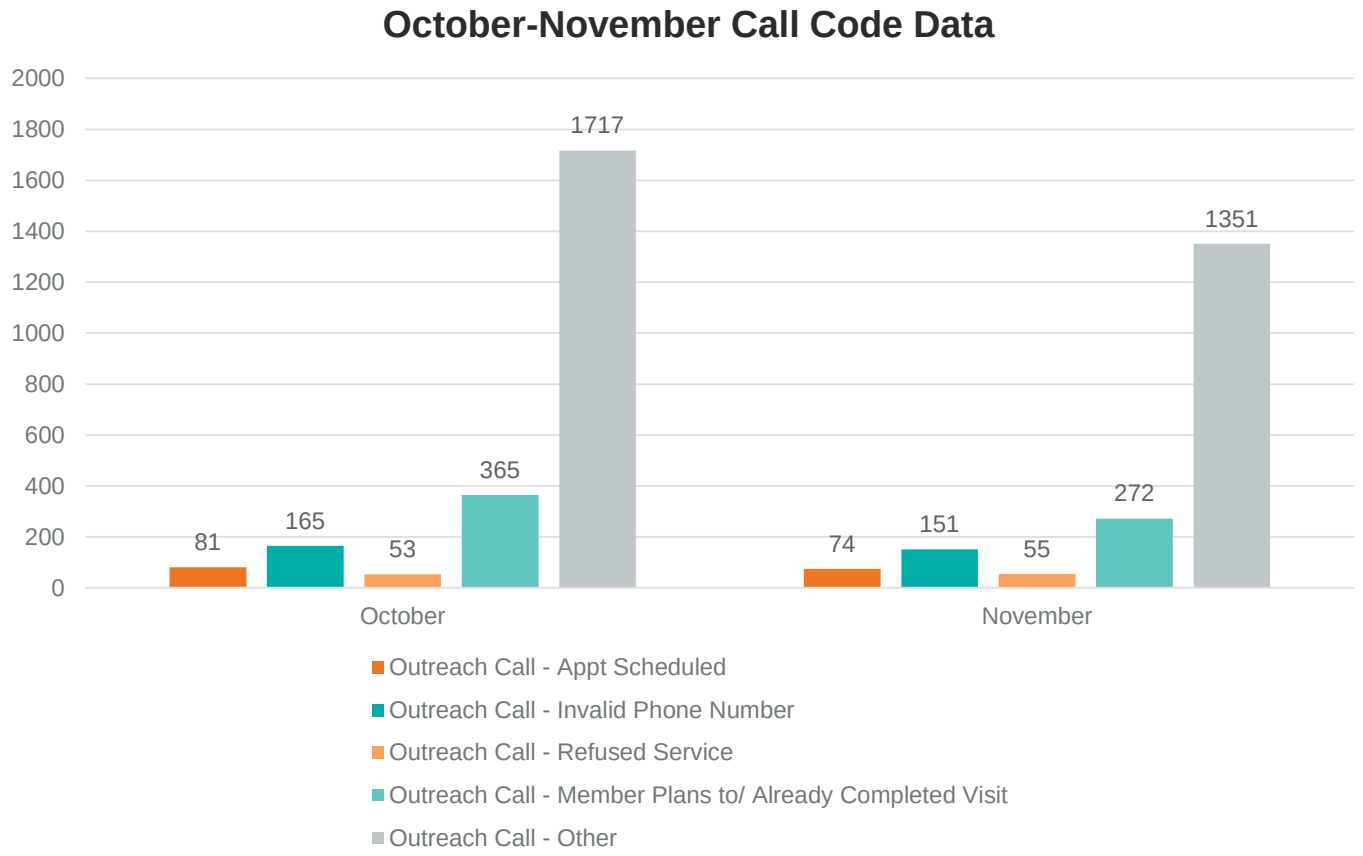


# Outreach Call Campaign

Santa Clara Family Health Plan

**Dedicated outreach call staff conduct calls to members for health education promotion, to help schedule screenings and visits while offering Wellness Rewards**

| Campaigns completed (October–November 2020) |
|---|
| Well-care visits in the first 15 months (W15) |
| Asthma Medication Ratio (AMR) |
| Controlling High Blood Pressure (CBP) |
| Comprehensive Diabetes Care (CDC) |
| Adolescent Well-Care Visit (AWC) |




**4, 284**

**Total number of attempted outreach in October-November 2020**

*As of October new call codes have been implemented to better categorize/identify the outcomes.

*Outreach call- Other include member demographic change requests, dis-enrollment requests, specific questions from members, calls that go to voicemails and other miscellaneous requests

# Health Homes Program (HHP)

Santa Clara Family Health Plan

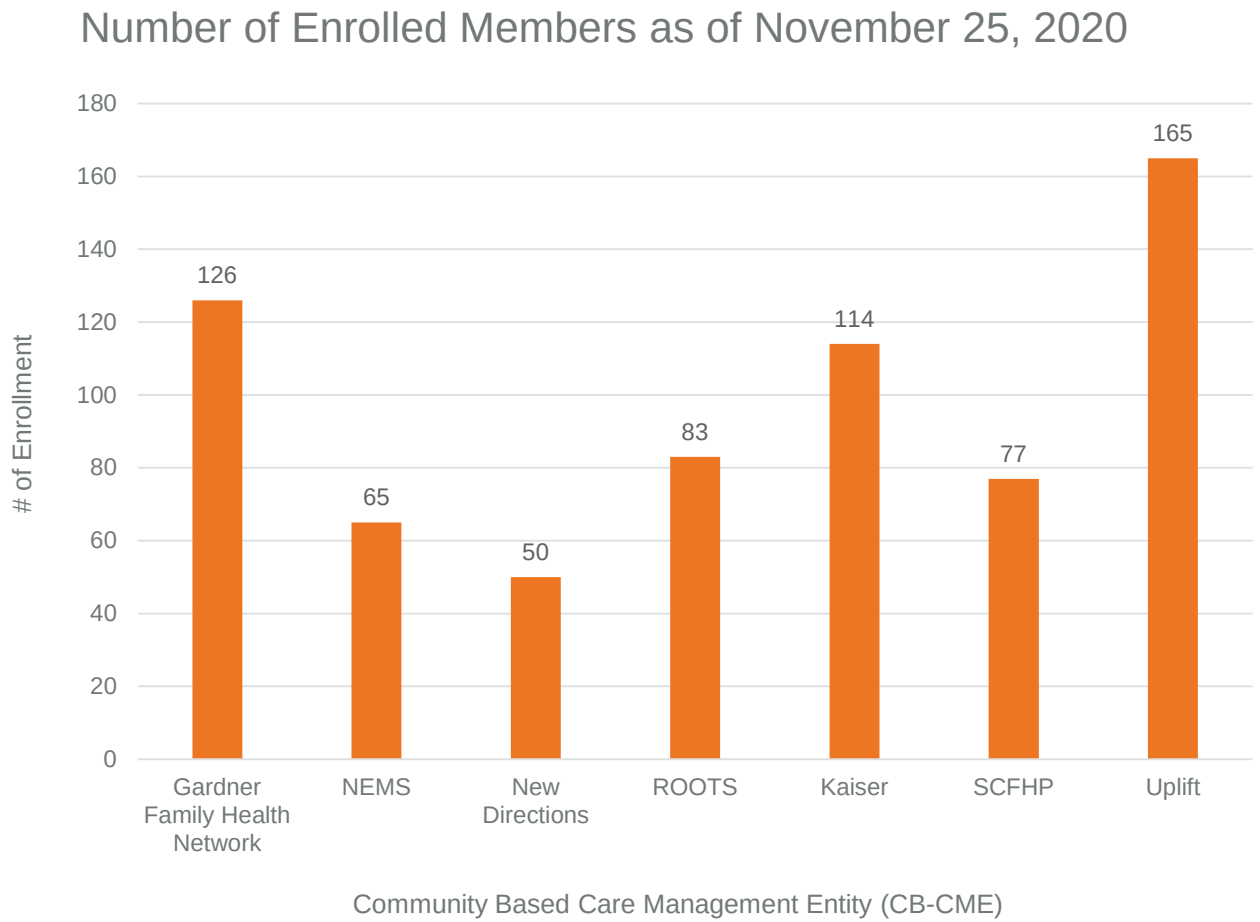
**HHP launched with Community Based Care Management Entities (CB-CMEs) on July 1, 2019 for Chronic Conditions and on January 1, 2020 for Serious Mental Illness**

## What is the Health Homes Program?

**HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders**

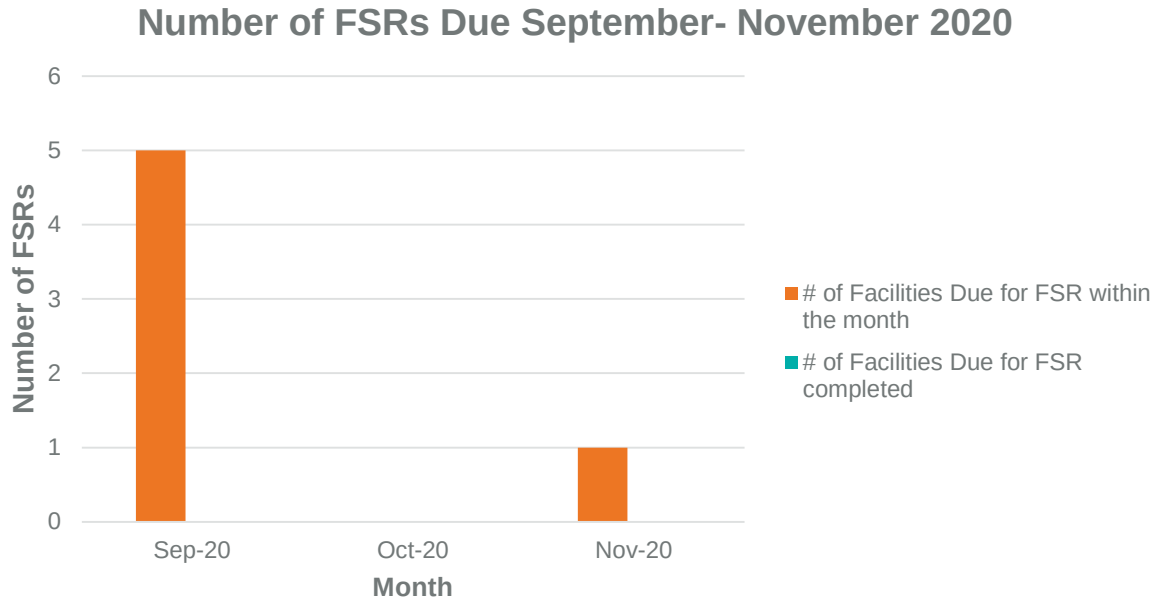
**680**

Members have verbally consented into Health Homes as of November 25, 2020



# Facility Site Review (FSR)

**What is a FSR?**
**A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety**




FSRs were not conducted due to the **COVID-19 situation-** Extensions have been approved by DHCS

*DHCS has temporarily suspended the requirement to conduct FSRs until the COVID-19 emergency declaration is rescinded. The FSRs will have to be completed once this emergency is over
*There were no FSRs due in October 2020
*Virtual FSRs will be soon introduced for new sites

# Compliance Report

**December 9, 2020**

## AUDIT UPDATE

- **Centers for Medicare & Medicaid Services (CMS) Program Audit**

  The Plan has closed out our CMS Program Audit Revalidation (Revalidation Audit). After working throughout the year to achieve full compliance with all previously identified findings, SCFHP received the final Revalidation Audit report from ATTAC, the firm conducting audit activities on behalf of CMS, in September, which included no findings. SCFHP submitted the report to CMS, and subsequently received from CMS a letter which recognized that we had sufficiently corrected all 31 of the Program Audit findings and officially closed the audit.

- **Compliance Program Effectiveness (CPE) Audit**

  In accordance with CMS requirements, the Plan recently began its annual Compliance Program Effectiveness Audit (CPE).

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**

  The DHCS has reached out to schedule our 2021 annual audit, beginning with an entrance conference on March 8.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**

  The Plan has been working to compile pre-audit documents requested by DMHC in advance of our March 2021 follow-up audit. The scope of this audit is limited to the outstanding deficiencies in our 2019 audit final report. We will submit pre-audit documents covering the review period of February 2020 through October 2020 by December 17.

Santa Clara Family Health Plan™

# Credentialing Committee Report

# October 7, 2020

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 10/07/2020

**Areas of Review or Committee Activity**

Credentialing of new applicants and recredentialing of existing network practitioners

**Findings and Analysis**

| **Initial Credentialing (excludes delegated practitioners)** | | |
|---|---|---|
| Number initial practitioners credentialed | 30 | |
| Initial practitioners credentialed within 180 days of attestation signature | 100% | 100% |
| **Recredentialing** | | |
| Number practitioners due to be recredentialed | 12 | |
| Number practitioners recredentialed within 36-month timeline | 12 | |
| % recredentialed timely | 100% | 100% |
| Number of Quality of Care issues requiring mid-cycle consideration | 0 | |
| Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues | 100% | 100% |
| **Terminated/Rejected/Suspended/Denied** | | |
| Existing practitioners terminated with cause | 0 | |
| New practitioners denied for cause | 0 | |
| Number of Fair Hearings | 0 | |
| Number of B&P Code 805 filings | 0 | |
| Total number of practitioners in network (excludes delegated providers) as of 09/30/2020 | 285 | |

| **(For Quality of Care ONLY)** | **Stanford** | **LPCH** | **VHP** | **PAMF** | **PMG** | **PCNC** |
|---|---|---|---|---|---|---|
| **Total # of Suspension** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total # of Terminations** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total # of Resignations** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total # of practitioners** | 1662 | 1515 | 791 | 825 | 328 | 67 |

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.