AGENDA

For a Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, October 10, 2018, 6:30-8:30 PM
Santa Clara Family Health Plan, Sycamore
6201 San Ignacio Avenue, San Jose, CA 95119
and

VIA TELECONFERENCE AT:
3411 S. Conway Ct.
Kennewick, WA 99337

1.	**Introduction**	Dr. Paul	6:30	5 min.
2.	**Meeting Minutes** Review minutes of the August 08, 2018 Quality Improvement Committee meeting. Possible Action: Approve 08/08/2018 minutes	Dr. Paul	6:35	5 min.
3.	**Public Comment** Members of the public may speak to any item not on the Agenda; two minutes per speaker. The Committee reserves The right to limit the duration of public comment period to 30 minutes.	Dr. Paul	6:40	5 min.
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:45	10 min.
5.	**Action Items**		6:55	40 min.
	a. Email Response Evaluation **Possible Action:** Approve Email Response Evaluation	Ms. Enke		
	b. Accessibility of Services Analysis **Possible Action:** Approve Accessibility of Services Analysis	Ms. Switzer		
	c. Continuity and Coordination between Medical and Behavioral (BH) Healthcare **Possible Action:** Approve Continuity and Coordination Between Medical and BH Healthcare	Ms. Franke		
	d. Annual Assessment of Experience with UM Process **Possible Action:** Approve Annual Assessment of Experience with UM process	Ms. Enke		

e. Asessment of Physician Directory Adequacy — Ms. Enke
   Possible Action: Approve Assessment of Physician Directory Adequacy
f. Member Experience Analysis — Mr. Breakbill
   Possible Action: Approve Member Experience
g. Assessing Member Understanding of Marketing Information Analysis — Ms. Enke
   Possible Action: Approve Assessing Member Understanding of Marketing Information Analysis

6. **Discussion Items** — 7:35 — 30 min.
   a. Access and Availability — Ms. Switzer
   b. Appeals and Grievances — Mr. Breakbill
   c. Experience with Case Management — Ms. Cagle
   d. Continuity and Coordination of Medical Care — Ms. Cagle

7. Committee Reports
   a. Credentialing Committee — Dr. Robertson — 8:05 — 5 min.
      Review August 15, 2018 report of the Credentialing committee
      Possible Action: Approve Credentialing Committee report as presented.
   b. Pharmacy and Therapeutics Committee — Dr. Lin — 8:10 — 5 min.
      Review June 21, 2018 minutes of the committee meeting
      Possible Action: Approve Pharmacy and Therapeutics Committee minutes as presented.
   c. Utilization Management Committee — Dr. Lin — 8:15 — 5 min.
      Review minutes of the July 18, 2018 UM committee meeting
      Possible Action: Approve Utilization Management Committee minutes as presented.
   d. Compliance Report — Ms. Larmer — 8:20 — 5 min.
   e. Quality Dashboard — Dr. Liu — 8:25 — 5 min.

8. Adjournment — Dr. Paul — 8:30

Notice to the Public—Meeting Procedures

- Persons wishing to address the 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.

- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Caroline Alexander 48 hours prior to the meeting at 408-874-1835.

- To obtain a copy of any supporting document that is available, contact Caroline Alexander 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 Avenue, San Jose, CA 95119.

- This agenda and meeting documents are available at www.scfhp.com

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, August 08, 2018

Voting Committee Members	Specialty	Present Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	Y
Jimmy Lin, MD	Internist	Y
Ria Paul, MD, Chair	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Jeffrey Arnold, MD	Emergency Medicine	N
Christine Tomcala, CEO	N/A	N

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Lily Boris, MD	Medical Director	N
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	N
Sandra Carlson, RN	Director of Medical Management	Y
Jamie Enke	Manager, Process Improvement	Y
Divya Shah	Health Educator	Y
Caroline Alexander	Administrative Assistant	Y
Eric Tatum	Director of Provider Network Management	Y
Carmen Switzer	Provider Network Access Manager	Y (via telephone)
Mai Chang	Manager of Quality Improvement	Y
Zara Hernandez	Quality Improvement Coordinator	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:32 p.m. Quorum was established at this time.			
Review and Approval of May 9, 2018 and June 6, 2018 minutes	The minutes of the May 9, 2018 and June 6, 2018 Quality Improvement Committee meetings were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the May 9, 2018 and June 6, 2018 meeting were approved as presented.		
Public Comment	No public comment.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
CEO Update	Dr. Robertson presented the CEO Update on behalf of Ms. Tomcala, CEO. Health Plan has completed move into new location. Question by Dr. Paul if upcoming provider trainings can be held at Santa Clara Family Health Plan new location. Dr. Robertson stated trainings will be scheduled to be held at Santa Clara Family Health Plan. Health Plan notified by CMS audit starting last week. Data validation taking place. Onsite audit will take place first week of September.			
Action Items A. Cultural Needs and Preferences Assessment Evaluation	Ms. Switzer presented the Cultural Needs and Preferences Assessment Evaluation. Santa Clara Family Health Plan collects data on the cultural, ethnic, racial and linguistic needs and preferences of its membership and the availability of providers in the network with these same characteristics to determine the adequacy of the provider network to meet the needs of its members. To assess member needs, data is collected from multiple sources to include: • 2010 U.S. Census • Statistical Atlas • Fact Finder • Provider Reports on languages from QNXT: January 1, 2018 to June 30, 2018 • Language Line/Translation Usage: January 1, 2018 to June 30, 2018 • Member Complaints: January 1, 2018 to June 30, 2018	Approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	The report focused on Cal MediConnect line of business. The top three languages spoken at home other than English were Spanish, Vietnamese and Chinese. Results show provider count for each specialty and provider languages. Dr. Paul mentioned the count of Specialists seemed to be higher than the count of Primary Care Physicians. Behavioral Health Providers including High Volume indicated no Vietnamese speaking providers in area of Addiction Medicine. Dr. Alkoraishi mentioned there is one Vietnamese speaking provider available in Addiction Medicine. SCFHP provides interpreter services through a vendor. The plan also hires bilingual customer service representatives and routinely monitors their interpretation proficiency to further promote timely and quality access to interpretation. To further understand membership language diversity and potential barriers to care due to language barriers, SCFHP reviewed data from its interpreter service Language Line. The data showed the range of languages spoken by SCFHP members. There were forty three different languages where interpreter services were used; some of which are not frequently seen, such as Portuguese-Creole, Swahili, and Tigrinya. The language line and translation data was analyzed two different ways, one was through the duration of the calls, and second was frequency of language selected. The top three languages (Spanish, Vietnamese and Chinese) in both categories are largely the same and accounted for 70% of all interpreter services requests. Santa Clara Family Health Plan serves a very diverse membership. However, the languages spoken are heavily weighted on the top three languages, where 70% of interpreter service requests come from those three languages. At this time, all needs appear to be met with our current network and member diversity. Santa Clara Family Health Plan will continue to			

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	evaluate the needs of its members to ensure they receive the care and services they need in their preferred language.			
B. Availability of Practitioners Evaluation	Ms. Switzer presented the report on Availability of Practitioners for Cal MediConnect line of business. Santa Clara Family Health Plan uses established standards to measure the number of providers available to its members (provider to member ratio) and the geographic location of the providers to the members (driving distance to provider) to ensure members have providers available to meet their health care needs. Santa Clara Family Health Plan measures at least annually its primary care providers, high volume specialists, high impact specialists, and behavioral health providers to ensure members have an adequate number of providers located in their area to meet their health care needs. Analysis showed that the standards for geographic time or distance were not met for Geriatrics in the cities of Gilroy, Morgan Hill, Mountain View, San Martin and Palo Alto. Although the disparity of Geriatrics providers is significant over the other primary care provider types, the analysis concludes that all CMC members, including those in the cities of Gilroy, Morgan Hill, San Martin, and Palo Alto have adequate access to primary care providers. The analysis on Behavioral Health Providers showed that standards for geographic time or distance were not met for Clinical Social Workers (CSW) in the cities of Gilroy and San Martin. Data showed that the standards for geographic time or distance and provider to member ratios were not met for Addiction Medicine providers in the cities of Gilroy, Morgan Hill, and San Martin.	Approved as presented.		

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	Overall the analysis demonstrates that SCFHP standards for specialist availability are realistic for the communities and delivery system within Santa Clara County. Santa Clara Family Health Plan is able to demonstrate its ability to meet standards relevant to provider to member ratios and geographic distances across the high volume, high impact specialists, primary care providers and behavioral health providers that were identified within the data reports, with the exception of Geriatrics, Clinical Social Workers and Addiction Medicine providers in the North West and/or South East areas of Santa Clara County. SCFHP contracting efforts are across all provider types that members experience access issues. Dr. Lin mentioned Stanford has closed panel. Questioned why Stanford has a closed panel. Dr. Paul mentioned many panels close early at Stanford due to providers having to devote time to research and academics (limits clinic time).			
C. Member Services Telephone Access Evaluation	Ms. Enke presented the Member Services Telephone Access Evaluation. Santa Clara Family Health Plan monitors member access to telephone services on a regular basis to ensure that SCFHP is providing access to members and meeting member expectations for service. Average Speed of Answer (ASA), Average Hold Time (AHT), Abandoned Rate and Service Level Rate are all monitored. These are metrics and goals required by SCFHP's contract with CMS and DHCS for the Customer Service Call Center. Analysis for Q3 2017 through Q2 2018 indicates that the ASA goal of ≤ 30 Seconds was not met in any of the measured quarters but significantly improved in Q1 2018 and came within 2 seconds of being met in Q2 2018. The AHT goal of ≤ 120 Seconds was met in every measured quarter. The abandonment rate goal of < 5% was not met in Q3 2017 and Q4 2017 but was	Approved as presented.		

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	met in Q1 2018 and Q2 2018. The service level rate goal of 80% in < 30 Seconds was only met in Q2 2018. Root cause analysis was done and the following barriers were identified: • Staff Shortages and Absenteeism: • Training • Call Increases • Real Time Management An action plan has been developed to address the identified barriers mentioned above. Dr. Paul asked if monitoring/oversight is exclusively for SCFHP call center or does health plan have any oversight with Valley Health Plan customer service? Ms.Liu commented health plan does not have oversight with Valley Health Plan and suggested members submit a grievance. This will allow health plan to better support case regarding member experience with Valley Health Plan customer service.			
D. Cultural and Linguistics Program Work plan	Ms. Shah presented the 2017 Cultural and Linguistics (C&L) Program Evaluation and the 2018 C & L work plan. Amendment made to Objective 5 on evaluation: report created to identify alternate languages requested by members. Partnered with new interpreting vendor. Will monitor utilization monthly. Working on process on how to log alternate languages in QNXT.	Approved as presented.		

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Discussion Items A. Annual Assessment of Member and Provider Experiences with UM Process	Ms. Carlson presented the Annual Assessment of Member and Provider Experiences with UM Process report. Santa Clara Family Health Plan monitors experience with the utilization management (UM) process to ensure that adequate member and provider satisfaction is achieved. Annually, SCFHP completes an analysis which incorporates practitioner and member survey questions, member complaint categories related to processes for UM, and CAHPS data (if available). This analysis allows the organization to formulate an action plan addressing low member and provider satisfaction with UM functions within SCFHP. SCFHP monitors Practitioner Satisfaction with the UM Processes through the performance of a satisfaction survey. Twenty eight unique providers successfully completed the survey for a total of 34 authorizations. Performance goal for each area is 90%. Goal was met in only one of five areas: • Satisfaction with process for obtaining pre-certification/referrals/authorization information: 97% • Timeliness of obtaining pre-certification/referrals/authorization information: 88% • Familiarity with SCFHP's prior authorization guidelines/grid: 82% • Ease of understanding SCFHP's appeal process after a denial determination: 74% • Overall satisfaction: 85% Floor was opened for general discussion with Quality Improvement Committee Providers. Addressed if there were any barriers to consider for providers and any opportunities for improvements to UM processes. Dr. Paul mentioned primary care providers usually have office staff call to respond to surveys. Dr. Lin recommended doing surveys via Fax Blast.			

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	Dr. Paul recommended adding a link to the satisfaction survey in the provider e-newsletter. Another barrier identified is that the provider portal is active for checking authorizations but not for submitting authorization requests. SCFHP collects and tracks member complaints across the organization. To help measure member satisfaction with the UM process, member complaints were looked at from July 1, 2017 to June 30, 2018 regarding UM. Complaints were classified into two categories: • Grievance, Part C: Organization determination/reconsideration process • Grievance, Part D: Coverage determination/redetermination process Goal in each area is less than 3 complaints per 1,000. For both areas, goal was met. 2.26 Per 1,000 for Part C, and 0.80 per 1,000 for Part D. SCFHP conducts a member satisfaction survey regarding experience with the UM process. Of the 50 members contacted, 19 distinct members provided responses, providing a 38% response rate. Only 2 members refused to answer the survey, and 29 members were unable to be contacted after two outreach call attempts. Goal is 90% in each area of member satisfaction survey. Some goals were not met in the area of member satisfaction: • Ease of getting needed care, tests or treatment: 58% • How often did patient get appointment as soon as needed: 84% • Ease of understanding approval or denial letters from authorization decisions: 74% Low member response rate may have increased the odds of not meeting goals for these measures. The first two will require further interventions involving SCFHP's Access and Availability team. UM team is currently undergoing initiatives			

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	to train staff to complete authorization letters with more member-friendly verbiage. Floor was opened for general discussion with Quality Improvement Committee Providers. Dr. Paul mentioned access is an issue.			
B. HEDIS Results 2018	Ms. Chang presented the 2018 HEDIS Results. Reported it was a good HEDIS year. Challenges included missing claims files, challenges with vendor software syncing medical record chart data, shortened timelines for Medical Record Review, and new HEDIS data files having to be created. Achievements included submitting clean data to vendor; meeting CMC quality withhold threshold requirements, 92.2% medical record retrieval rate, and 100% Valley Health EMR abstraction. Opportunities: one Medi-Cal measure fell below MPL. One measure reached 90th percentile, up from last year. Cervical Cancer Screening rate dropped but did not fall below MPL. Increased timeliness of prenatal care rate. Controlling high blood pressure rate is relatively flat. Childhood immunization status also remained flat. Kicking off a performance improvement project in the area of childhood immunizations, specifically targeting Net 60. Drop in Well Child visits. Encouraging providers to use correct code for this measure. Dr. Foreman recommended doing a deeper dive into this type of visit not being documented. Plan All Cause Readmissions (PCR) increased. Factors contributing to this increase were members not following up with primary care physician after discharge or member not feeling well and readmitted. 30 day follow up after hospitalization for mental illness increased from 38.46% in 2017 to 44.8% in 2018. Quality Withhold Benchmark is 56%. Improvement plans are as follows:	Bring back findings on Well Child visits		

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	MCAL: • Comprehensive Diabetes Care-Medical attention for nephropathy; HbA1c test • Texting campaign for all Auto-Assignment Measures CMC: • Comprehensive Diabetes Care-HbA1c test • Call Campaign for targeted measures			
C. Initial Health Assessment (IHA) Quality Study 2nd Half '17	Ms. Chang presented the Initial Health Assessment Quality Study for the second half of 2017. The California Department of Health Care Services requires Medi-Cal providers to complete an Initial Health Assessment (IHA) within 120 days of joining Santa Clara Family Health Plan (SCFHP). SCFHP provider compliance rates show opportunities for improvement as assessed by sampling random provider medical records. Barriers to compliance identified include provider-related and system-related issues, such as lack of awareness and/or documentation of the required elements, lack of awareness of new members and coding issues. SCFHP is working to improve provider education and reduce barriers in order to increase rates of compliance in the coming year. Total number of compliant charts identified was twice as large in Q3 (28) as in Q4 (14). This most likely reflects the change in methodology between the two quarters, which also resulted in almost twice as many charts being reviewed in Q3 as Q4 (46 vs. 25). Overall IHA compliance is less than SCFHP expects providers to achieve. A number of barriers have been identified as contributing to the current rates. Some barriers are provider related, others are system related. Going forward, SCFHP expects to see a gradual increase in IHA compliance rates over the coming months as a result of SCFHP's strong efforts to educate providers and improve communication between providers and SCFHP in 2017.			

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	The Quality Improvement Department will evaluate medical record review as a method to assess provider compliance with IHA requirements and continue to research other ways to assess compliance. Ongoing efforts and results will be reported to the SCFHP Quality Improvement Committee.			
D. Timely Access Survey Results (VHP)	Ms. Switzer presented the Timely Access Survey Results for Valley Health Plan (VHP). This was presented as a follow up from the May 9th Quality Improvement committee meeting action items. Overall results showed that for securing appointments either on an urgent or non-urgent basis, VHP met the target goal of 90% compliance for two measures: • Non-urgent appointment within 10 days for PCPC • Both Urgent and non-urgent appointments with Child and Adolescent Psychiatry Specialists All other measures fell short of the goal of 90% compliance. VHP believes that the reason for falling short from meeting their goal of 90% was in part due to low provider participation rates. Ms. Switzer reported that Valley Health Plan's quality improvement plan was implemented across multiple fronts to improve provider response numbers and results for measurement year 2018: • Increase the survey sample size, • Ensure provider contact information is correct and current, and • Explore approaches they can use to connect with providers in advance and during the survey process. In addition, Valley Health Plan implemented a Telehealth service in July 2017, where members have access 24/7 and every day of the year.	Present Quality Improvement Plan in December	Eric Tatum/Carmen Switzer	

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	To monitor VHP's improvement efforts, SCFHP will request that VHP provide progress reports in future Joint Operating Committee meetings.			
E. Appeals and Grievances	Report deferred to next meeting in October due to audit preparation.	Present at October 10th Quality Improvement Committee meeting		
F. Conflict of Interest Forms	Ms. Liu reminded committee members to sign Conflict of Interest form required to be signed annually.			
Committee Reports				
A. Credentialing Committee	Dr. Robertson presented the June 6th Credentialing Committee meeting minutes. No providers were terminated, all passed credentialing. No state fair hearings.	Minutes of the June 6th, 2018 Credentialing Committee meeting were approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the March 18th Pharmaceutical and Therapeutics Committee meeting minutes. Annual review of policies was done. New drugs were presented during generic pipeline presentation.	Minutes of the March 18, 2018 Pharmaceutical and Therapeutics Committee meeting were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
C. Utilization Management Committee	Dr. Lin presented the April 18th, 2018 Utilization Management Committee minutes. Whole Child will take effect in 2021. Long term care cannot be in custodial care out of county. SPD admission rate at 14%.	Minutes of the April 18, 2018 Utilization Management Committee meeting were approved as presented.		
D. Compliance Report	Compliance Report was deferred until October Quality Improvement Committee meeting due to audit preparation.	Present Compliance Report at October 10th Quality Improvement Committee meeting		
E. Quality Dashboard	Dr. Liu presented the Quality Dashboard. Revamping the dashboard. Number of members eligible for an IHA was 3,298 in June. Only 1,422 were completed within 120 days of enrollment. Percentage of Facility Site Reviews (FSRs) completed timely is 100%.			
F. Non Agenda Item	Discussed meeting time. Will continue to meet at 6:30 p.m.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Ria Paul at 8:25 p.m.			
Next Meeting	Wednesday, October 10, 2018- 6:30 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD
Quality Improvement Committee Chairperson

SCFHP Personalized Information on Health Plan Services:

2018 E-mail Response Evaluation

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee (QIC) on October 10, 2018

I. Overview

Providing accurate and timely personalized information of member health plan services is central to the promotion of member engagement and self-management. SCFHP has a responsibility to provide accurate, quality information on health plan services to members through the website, over the telephone, and through e-mail.

In an effort to make this information readily available, SCFHP ensures that members can contact the organization through e-mail for any reason and receive responses within one-business day.

Personal information on health plan services may change periodically throughout the year; therefore, SCFHP has an obligation to be sure the information submitted via e-mail to members is accurate, current and timely. This is accomplished by measuring and evaluating the quality and accuracy of the information. SCFHP audits e-mail response annually to identify any opportunities to improve interactions with the members.

II. Methodology: E-mail

The Call Center collects all member e-mails through Microsoft Outlook and documents the contact in the QNXT Call Tracking system. Data included in this analysis was captured from July 1, 2017 through June 30, 2018.

A dedicated staff in Customer Service checks the e-mail inbox intermittently throughout each business day. The staff will respond to the member's inquiry with a thorough answer to the member's question within one-business day.

Once a complete reply is sent to the member, the request is documented in the QNXT call tracking system using appropriate contact codes. The call note includes the question and inquiry received from the member and the response provided.

SCFHP audits the information on e-mail turnaround time and the quality of the email response on a quarterly basis to be able to identify opportunities to improve based on data collected and analyzed. This data is then rolled up into an annual rate for comparison year over year.

Measure 1: Email Turnaround-Time

- **Numerator:** Number of emails received from Q3-2017 through Q2-2018 that were responded to within one business day
- **Denominator:** Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails are collected, reviewed and responded to within one-business day.

Measure 2: Response Comprehensiveness

- **Numerator:** Number of emails received from Q3-2017 through Q2-2018 where the response adequately addressed the member request
- **Denominator:** Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails comprehensively address the member's request

Measure 3: Spelling Errors

- **Numerator**: Number of emails received from Q3-2017 through Q2-2018 where zero spelling errors were identified
- **Denominator**: Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails were responded to with zero spelling errors

Measure 4: Member Services Contact Information Provided

- **Numerator**: Number of emails received from Q3-2017 through Q2-2018 where the Member Services contact information was provided
- **Denominator**: Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of email responses contained Member Services contact information

III. Analysis

a. Results

Table 1: Timeliness and Quality of E-mail Responses

Measure	Goal	Q3-2017.	Q4-2017	Q1-2018	Q2-2018	Goal Met Y/N
M1: Responses sent to Member within one-business day	100%	NA	NA	NA	100%	Y
Information is legible, complete and allows the member to understand:						
M2: The response comprehensively addresses the member request	100%	NA	NA	NA	100%	y
Other items that may also reflect the quality of the e-mail response:						
M3: No spelling errors identified	100%	NA	NA	NA	100%	y
M4: Member Services contact information provided	100%	NA	NA	NA	100%	y

b. Quantitative Analysis

No emails were received in Q3-Q4 2017 or Q1 of 2018. There was one e-mail contact for Q2 2018 and the response met turnaround time quality and accuracy standards. Overall, the volume of e-mail inquiries for the Cal MediConnect line of business is low. This is most likely due to several factors that affect the specific population we serve. These factors can prevent members from accessing electronic devices required to submit emails. Factors include: language barriers, multiple chronic medical conditions, education levels, and economic background.

c. Qualitative Analysis

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
NA	NA		NA	

IV. Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan
Accessibility of Services
MY2018

Medicare - Cal-MediConnect

Prepared by: Carmen Switzer, Provider Network Access Manager
For review and approval by the Quality Improvement Committee
October 10, 2018

INTRODUCTION

The purpose of the Santa Clara Family Health Plan's (SCFHP) annual timely access report is to demonstrate how the Plan has monitored compliance and non-compliance of timely access regulations during Measurement Year (MY) 2018. SCFHP's Timely Access & Availability Work Group and Quality Improvement Committee monitor timely access and reporting activities to ensure members receive timely access to services and care. SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser survey results.

When access is identified as not being met, per SCFHP, the Centers of Medicare and Medicaid Services (CMS) and/or other regulatory agencies, an analysis of findings and corrective action plan are required. The Provider Network Management Department regularly monitors and reports access activities to the Timely Access & Availability (TAA) Work Group and Quality Improvement Committee (QIC). The TAA work group and QIC review, evaluate, and make recommendations as needed.

Description of Line of Business: Cal MediConnect is a dual eligible plan for members who qualify for both Medicare and Medi-Cal. Cal MediConnect members have access to case managers to help with transition of care, coordination of health services, community resources and other support.

Annually the health plan conducts surveys to determine the ability of network providers to provide appointments to members according to SCFHP, federal, state and/or other agency standards. SCFHP monitors and reports on timely access to appointments on primary care, specialists, behavioral health and ancillary services on an annual basis.

Primary Care Providers are defined as physicians, nurse practitioners, certified nurse midwifes, and physician assistants licensed in the areas of General Practice, Family Medicine, Internal Medicine and Geriatrics.

High **Volume** Specialists (HVS) are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high volume analysis includes gynecology, cardiology and ophthalmology.

High **Impact** Specialists (HIS) are defined as specialists who treat conditions that have high mortality and morbidity rates and where treatment requires significant resources**.** High impact specialists are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high-impact analysis includes hematology/oncology.

High **Volume** Behavioral Health (BH) providers are defined as Behavioral Health providers located in a high-volume geographic area or in a high-volume specialty (or both), and are likely to provide services to a large segment of members. Behavioral health providers are defined as prescribing - Psychiatry and non-prescribing-Psychology, Licensed Clinical Social Workers and Marriage/Family Counselors. High volume behavioral health providers are identified by analyzing claims and encounter data for a 12-month period.

Data collection includes assessment of access to appointments through member and/or provider surveys and an analysis of member complaints and appeals. Member complaints and appeals are tracked and trended in our QNXT and Grievance and Appeals database. Appointment access complaints and appeals are categorized as access complaints or appeals. Member complaints from January to June of 2018 are assessed in this report relative to appointment access.

Santa Clara Family Health Plan contracted with an external survey vendor, Center for the Study of Services (CSS), to administer access surveys for MY2018. This report provides an overview and analysis of SCFHP's provider timely access results. The Plan's goals, objectives, methodologies and results are included in each report section within this report.

The following surveys and assessments are included in this report:

1. Provider Appointment Availability Survey and After-Hours Survey
2. CAHPS
3. Provider Satisfaction Survey
4. Member Grievances

1. PROVIDER APPOINTMENT AND AVAILABILITY SURVEY AND AFTER-HOURS SURVEY

GOALS

To ensure that SCFHP meets the provider appointment access standards established by DMHC and other regulatory agencies and to meet the needs of its members.

OBJECTIVES

- Measure primary care, specialist and behavioral health provider's timely appointment access, at least annually.
- Measure primary care after-hours access at least annually.
- Evaluate SCFHP's timely access performance in comparison to goals.
- Identify areas to improve timely appointment access.
- Develop interventions as appropriate to address deficiencies and/or gaps in care.

METHODOLOGY- PROVIDER APPOINTMENT AND AVAILABILITY SURVEY (All Providers)

SCFHP provided Cal-MediConnect provider rosters to CSS for the following provider types: primary care, high volume, high impact specialty and behavioral health providers. These files followed the DMHC MY2018 PAAS Provider Contact List Templates. CSS reviewed the contact lists for missing and duplicate provider records (according to DMHC MY 2018 PAAS de-duplication rules) before considering the contact lists final. CSS worked with SCFHP to modify the DMHC's survey tools to incorporate new measure questions pertaining to language assistance services and finalized the survey questionnaire tool.

CSS surveyed all providers in the final sample. Sixty percent (60%) of providers were surveyed in the first wave from June 14 - June 29, 2018, with the remaining providers surveyed three weeks later from July 19 – August 3, 2018. The survey was initiated by fax and email (email included a personalized URL to take the survey online;

the fax directed providers to www.cssresearch.org/Appointment and provided a unique login code) with a telephone follow-up. Three call attempts were made during business hours (9:00 am – 4:30 pm Pacific Time) and within a 48-hour time period from the first attempt. The timeframe to complete the survey online or by fax was limited to 48 hours from the time of the message.

All data received was checked for accuracy and completeness by at least two CSS staff working on the project. The data was then systematically cleaned and transformed for reporting. At least two CSS staff checked that data was de-duplicated, that it reflected calculating compliance, and that it was standardized and formatted correctly. CSS then used raw data and results templates to deliver survey results to SCFHP.

METHODOLOGY - AFTER-HOURS (PCP Only)

The after-hours survey was administrated by CSS survey vendor. The survey was conducted between June 25 – June 29, 2018 during non-business hours Pacific Standard Time (6:00 pm - 8:00 am on weekdays, and all day on weekends). The survey sample included all contracted primary care (N=469), and behavioral health (N=153) providers. SCFHP provided CSS a provider contact list, which they were responsible for de-duplicating to ensure each provider was surveyed once.

Providers who shared the same phone numbers were combined into groups of up to five (5) providers for a unique survey administration and the survey results were then attributed to all the providers. If twenty (20) providers share the same phone number, then these providers would be grouped into four (4) separate sample units for one dialing.

If a live person (provider or answering service) was reached, the respondent was asked the same questions from the survey questionnaire tool, and if the call went directly to an automated recording, the interviewer collected the response based on the message. If the automated recording provided an option to connect to a live person (by pressing a button or staying on the line), the interviewer selected that option and also recorded the answers the person gave. The interviewer did not leave a voice message during any of the telephone attempts.

The Plan requires providers to direct patients with a life-threatening emergency to hang up and dial 911 and compliance for this measure is determined through questions Q2 and Q5. The Plan determines if the provider meets the Timeliness measure (provider call back within 30-minutes) through questions Q3 and Q4 or Q6, Q7, Q9 and Q10 (are blank) or Q9 and Q10. The survey tool in Appendix A includes the survey questions related to after-hours.

The following measures table includes the provider types that were included in the survey and the standards for each provider type.

MEASURES TABLE

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care	After-Hours Care
Family Practice	48 hours	10-days	NA	NA	24-hours / 7-days a week
General Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Internal Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Geriatrics	48 hours	10-days	NA	NA	24-hours / 7-days a week
Oncology (High Impact)	96 hours	15-days	NA	NA	NA
Gynecology (High Volume)	96 hours	15-days	NA	NA	NA
Cardiology (High Volume)	96 hours	15-days	NA	NA	NA
Ophthalmology (High Volume)	96 hours	15-days	NA	NA	NA
Behavioral Health - Prescribers	48 hours	10-days	6-hours	30-days	NA
Behavioral Health – Non-Prescribers	48 hours	10-days	6-hours	30-days	NA

RESULTS

Table I: Primary Care Provider

A. Standard: Urgent Care Appointment within 48-hours (PCP providers combined)

# of Providers Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
175	161	108	90%	No	67%	72%	-5%

B. Standard: Urgent Care Appointment within 48-hours (PCP provider break down)

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Family Medicine	77	70	48	90%	No	69%	NA	NA
General Practice	11	10	9	90%	Yes	90%	NA	NA
Geriatrics	1	1	1	90%	Yes	100%	NA	NA
Internal Medicine	86	80	50	90%	No	63%	NA	NA

Quantitative Analysis (Tables I - A and B)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for the PCP urgent care appointment measure. As shown in Table 1A, which includes all PCP provider types, the urgent appointment measure fell short of the goal by 23 percentage points at 67%, and there was a decrease of 5 percentage points from 2017. Table 1B, shows the PCP breakdown by provider type, which concludes that General Practice and Geriatric providers met the goal at 90% and 100% respectively. There are very few General Practice and Geriatric providers within the SCFHP network, which explains why the total surveyed was only 14. Family practice and internal medicine providers did not meet goal with an outcome of 69% and 63% respectively. SCFHP did not break down PCP provider types in 2017, thus there is no comparison data available.

C. Standard: Non-Urgent/Routine Appointment within 10-days (PCP providers combined)

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
175	172	156	90%	Yes	91%	91%	No Change

D. Standard: Non-Urgent/Routine Appointment within 10-days (PCP provider break down)

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Family Medicine	77	77	70	90%	Yes	91%	NA	NA
General Practice	11	10	9	90%	Yes	90%	NA	NA
Geriatrics	1	1	0	90%	No	0%	NA	NA
Internal Medicine	86	84	77	90%	Yes	92%	NA	NA

Quantitative Analysis (Tables I - C and D)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for the PCP non-urgent/routine care appointment measure. As shown in Table 1C, PCP providers met goal at 91% and there was no change from 2017. Table 1D, shows the PCP breakdown by provider type, which concludes that all PCP types with the exception of Geriatrics met or exceeded the goal. As stated above, there are very few General Practice and Geriatric providers within the SCFHP network, which explains why the total surveyed was only 14. SCFHP did not break down PCP provider types in 2017, thus there is no comparison data available.

E. After-Hours – Access Compliance: 911 Information

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Primary Care Provider (PCP)	401	401	90%	Yes	100%	88%	+12%

F. After-Hours – Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Primary Care Provider (PCP)	401	176	90%	No	44%	74%	-30%

Quantitative Analysis (Tables I - E and F)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for after-hours measures. The after-hours survey measure on whether appropriate instructions relative to life-threatening emergency situations were provided to members calling after-hours was met at 100%, and improved by 12 percentage points from 2017. However, the timeliness standard to return the members call within 30-minutes or less, was not met with an outcome of 44% and there was a decrease from 2017 by 30 percentage points.

Qualitative Analysis (Tables I - A thru F)**:** For MY2018, the Plan used a new methodology for sampling and a vendor was used to conduct the survey. The number of PCP's who were surveyed provide a statistically valid sample size from which conclusions could be drawn. The raw data report showed that Palo Alto Medical Foundation failed to meet the urgent appointment standard by 21%, Physician Medical Group by 12% and directly contracted providers and Premier Care by less than 1% collectively. It appears that the stringent requirements regarding scheduling urgent appointments within a 48-hour timeframe and the after-hours standard to return a patient call within 30 minutes or less continue to be a challenge for providers.

The after-hours results for call backs within 30-minutes showed the following rate of compliance outcomes for each group of providers: Direct (N=21) at 19%, Palo Alto Medical Foundation (N=241) at 44%, Physicians Medical Group (N=112) at 45%, and Premier (N=27) at 52%. Provider education on timely appointment access and after-hours call backs within 30-minutes, should be a focus point for interventions this year.

Table II: High Impact and High Volume Specialist

A. Standard: Urgent Care Appointment within 96-hours

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	34	24	90%	No	71%	73%	-2%
Oncology (N=73)	16	9	90%	No	56%	New Measure	NA
Opthamology (N=95)	28	28	90%	Yes	100%	New Measure	NA
Gynecology (N=138)	21	17	90%	No	81%	New Measure	NA

B. Standard: Non-Urgent/Routine Appointment within 15-days

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	40	28	90%	No	70%	72%	-2%
Oncology (N=73)	16	8	90%	No	50%	New Measure	NA
Opthamology (N=95)	28	27	90%	Yes	96%	New Measure	NA
Gynecology (N=138)	21	19	90%	Yes	90%	New Measure	NA

Quantitative Analysis (Tables II - A and B)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for specialist urgent care and non-urgent/routine care appointment measures. The urgent appointment goal was met by ophthalmology and non-urgent/routine appointment goal was met by ophthalmology and gynecology. The other specialists fell short of the goal for urgent and non-urgent/routine care appointments. Compared to 2017, cardiology results decreased for urgent care and non-urgent/routine care by 2 percentage points. These metrics are new for gynecology, oncology and ophthalmology; thus, results will be used as a benchmark for 2019.

Qualitative Analysis (Tables II - A and B)**:** While attempts were made to increase the number of respondents within each of the specialty areas, the actual results were such that it is difficult to draw any conclusions as it relates to responsiveness on gaining appointments either on an urgent or non-urgent/routine basis. While the results showed that the targeted goal of 90% was not reached, you have to look at the actual number of respondents to judge the validity of the percentages. SCFHP experiences nearly no survey participation from Stanford Medical Group and 43% of network specialists are within this group. SCFHP has reached out to Stanford leadership to request participation, and the Plan reported low-participation by Stanford Medical Group to the Department of Health Care Services. The raw data showed that the majority of Cardiologists that did not meet the urgent or non-urgent/routine access standards were directly contracted providers (14), followed by Palo Alto Medical Foundation (4) and Physicians Medical Group (3). Oncologists that did not meet the urgent or non-urgent/routine access standards were directly contracted providers (1), followed by Palo Alto Medical Foundation (15). The gynecology providers that did not meet the urgent access standard were directly contracted providers (3).

SCFHP sends corrective action letters to providers who do not meet access standards and a resurvey is completed within 60 days from sending the corrective action letter. Resurveyed providers who show continued non-compliance are required to submit a corrective action plan and to complete timely appointment access training with SCFHP provider relations staff members. SCFHP's provider relations staff members will focus on provider outreach to train providers on timely appointment standards and document these efforts.

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Table III: Behavioral Health

A. Psychiatry (N=57)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	6	4	90%	No	67%	New Measure	NA
Urgent Care within 48-hours	4	1	90%	No	25%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	0	90%	No	0%	New Measure	NA
Follow-up Routine Care within 30-days	6	6	90%	Yes	100%	New Measure	NA

B. Psychology (N=1)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	1	1	90%	Yes	100%	New Measure	NA
Urgent Care within 48-hours	0	NA	90%	NA	NA	New Measure	NA
Non-Life Threatening Emergency within 6-hours	1	0	90%	No	0%	New Measure	NA
Follow-up Routine Care within 30-days	1	1	90%	Yes	100%	New Measure	NA

C. Non-Physician Mental Health (N=63)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	7	3	90%	No	43%	New Measure	NA
Urgent Care within 48-hours	5	4	90%	No	80%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	1	90%	No	17%	New Measure	NA
Follow-up Routine Care within 30-days	8	8	90%	Yes	100%	New Measure	NA

Quantitative Analysis (Tables III – A thru C)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for behavioral health measures. Only one measure across all provider types was met (follow-up routine care within 30-days). Psychology met all but one measure (non-life threatening emergency within 6-hours) and the raw data report showed that the psychologist did not answer the "urgent care within 48-hours survey question. The other measures across all behavioral health provider types fell short of the 90% goal. These are new measures; thus, there is no comparison data available, and MY2018 results will be used as a benchmark for 2019.

Qualitative Analysis (Tables III – A thru C)**:** SCFHP has identified that some of the barriers to meeting the goals were a lack of extended office hours, hours of operation not suiting the patient and providers not aware of appointment access standards. Appointment access is always an important metric in monitoring our providers for quality of care and service. SCFHP will continue to expand its behavioral health network in order to provide better access to its members, as well as identify additional health systems that can join the Plan in 2018/2019.

Conclusion - Timely Appointment Access:
Survey results showed that PCPs are able to meet non-urgent/routine appointment standards; however, as noted they continue to show non-compliance with urgent care appointments. The Plan believes that PCPs are challenged with urgent appointment standards due to the stringent requirement to schedule appointments within a 48-hour timeframe, coupled with providers not having an adequate understanding of regulatory requirements. The PCP after-hours access compliance resulted in 100% in 2018, up from 88% in 2017, which is a marked improvement. However, it is clear that PCP providers will require training/education on meeting timeliness compliance, as only 44% were compliant out of 401 surveyed.

For High Volume/High Impact Specialists, only 1 specialist type (Ophthalmology) out of 4 met the urgent appointment standard and 2 met the non-urgent/routine appointment standards, which concludes that provider training on access standards is necessary.

The least amount of survey participants were from behavioral health providers; thus, it may be difficult to identify trends; however, the results did indicate that all respondents were not able to meet the non-life threatening emergency within 6-hours. Training for behavioral health providers is needed across all standards with a focus on the non-life threatening emergency within 6-hours standard.

2. MEMBER EXPERIENCE SURVEY (CAHPS)

METHODOLOGY

Questionnaire: SCFHP uses a vendor to annually administer the CAHPS survey. The survey results are then officially published by CMS. At the time of this analysis, the final CMS CAHPS report was unavailable. Additionally, many of the questions of interest have historically been "NA" on the final CMS report. Therefore, for purposes of this report SCFHP has used DSS' unofficial CAHPS report for SCFHP, which provides the plan's rates in comparison to DSS' entire book of business.

The survey instrument is a booklet with a cover letter explaining the importance of completing the survey. This was mailed, along with a business reply envelope addressed to DSS, to the sample beneficiaries using first class postage. A copy of the survey is provided in Appendix F.

Data Collection: A Synopsis of the methodology is outlined below:

Survey protocol	Date
Pre-notification letter	3/6/2018
First questionnaire mailed	3/13/2018
Second questionnaire mailed	4/4/2018
Initiate follow-up calls to non-responders	4/20/2018
Last day to accept completed surveys	6/1/2018
Data submission to CMS	6/20/2018

Item	Volume
Total mailed	1,600
Ineligibles	133
Total completed surveys	431
Mail completes	351
Phone completes	80
Adjusted response rate	29.38%

Staffing of the toll-free help line. DSS staffed a toll-free phone line for beneficiaries to call if they had any questions.

Sample design.

•**Qualified respondents.** Beneficiaries eligible for the survey were those 18 years and older (at the time of the sample draw) who were enrolled in the Cal-MediConnect plan and had been continuously enrolled for six months or longer.

•**Sample type.** A simple random sample of eligible beneficiaries was drawn.

•**Sample size/sampling error.** A sample of 431 beneficiaries was obtained, for which the overall sampling error is +/-4.7% at the 95% confidence level, using the most pessimistic assumption regarding variance (p=0.5).

Data processing and analysis. DSS processed all completed surveys and analyzed the results. The results in this report have not been case-mix adjusted.

Comparison averages. Most measures are compared to the 2017 National Average from CMS (2017) Nat'l Avg.), and the DSS Book of Business is made up of 182 MA plans with a total of 93,685 beneficiaries.

Spanish surveys. Respondents were given the option of completing the survey in Spanish. English and Spanish materials were mailed to 210 members who were identified by the plan as Spanish-speaking. A telephone number was also provided on the survey cover letter for all members to call to complete the survey in Spanish. There were 67 surveys completed in Spanish.2018 final results were not received as of the date of this report. The tables below show 2017 results relevant to member satisfaction in Timely Access and Rating of Health Plan measures through the 2017 CAHPS survey.

RESULTS

Composite Rating & Questions	# Surveyed	Total N (those who responded)	Goal	Goal Met	Always and Usually (2018)	Always and Usually (2017)	Change
Rating of Health Plan	391	344	90%	No	87.98%	83.18%	+4.8%
Ease of getting tests or treatments (Q10)	394	311	90%	No	78.93%	81.74%	-2.81%
Received appointment to see a **specialist** as soon as needed (Q29)	224	161	90%	No	71.88%	63.93%	+7.95%
Got **urgent** care as soon as needed (Q4)	159	118	90%	No	74.21%	75.29%	-1.08%
Got check-up or **routine** appointment as soon as needed (Q6)	313	244	90%	No	77.96%	73.48%	+4.48%
Getting seen within 15min of your appointment (Q8)	320	194	90%	No	60.63%	48.26%	+12.37%

Quantitative analysis: The response rate in "Always" and "Usually" is combined to compare the member/enrollee satisfaction in timely appointment access and rating of health plan measures between 2017 and 2018. As shown in the table above, the goal was not met for any measures; however, member satisfaction improved in 4 out of 6 measures, which is a marked improvement from 2017. The measure most improved was "getting seen within 15min of your appointment" (Q8) with an increase of 12.37 percentage points. The measure for "got urgent care as soon as needed" (Q4), showed a decrease in satisfaction by 1.08 percentage points, and it appears that this result is trending across survey outcomes.

Qualitative analysis: SCFHP has identified that member/enrollee overall low satisfaction on the timely urgent care measures are due to the following factors:
- Providers do not have an adequate understanding of regulatory requirements for timely access to care.

- Longer wait times for urgent and non-urgent/routine care due to clinic scheduling staff not fully understanding provider scheduling protocols. ***For example,*** *providers have contacted SCFHP following the receipt of a corrective action letter, and will explain that his or her scheduling protocols are aligned with timely access/appointment standards and that the staff misinformed the survey interviewer.*

- Stringent requirements regarding scheduling urgent appointments within a 48-hour time-frame continue to be a challenge for providers.

Conclusion - CAHPS:
SCFHP is pleased to acknowledge 4 out of 6 measures show a marked improvement from 2017. The overall rating on satisfaction with the Health Plan improved by 4.8 percentage points, which may be attributed to the

Plans on-going efforts to improve operational procedures and member/provider communications. SCFHP's Provider Network Management, Quality Management, Provider Relations and Contracting departments will continue to develop and improve initiatives to address timely access issues with PCPs, specialists and behavioral health providers. SCFHP has developed a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. SCFHP has taken a more active role working with network providers in support of plan initiatives that are aimed toward meeting regulatory requirements and improving overall access and quality of care.

3. PROVIDER SATISFACTION SURVEY

GOALS:
To ensure that SCFHP providers have a positive experience with health plan services.

OBJECTIVES: Measure provider experience (satisfaction) at least annually.

- Evaluate provider's satisfaction with performance measures.
- Identify any areas for improving contracted provider's experience with the health plan.
- Develop interventions as appropriate to address gaps in service.

STANDARDS AND THRESHOLDS FOR PROVIDER SATISFACTION:

-Eighty percent (80%) of provider's will be satisfied
-Seventy percent (70%) of providers will be satisfied with authorization/referral process

METHODOLOGY

In MY2018, SCFHP utilized CSS as the survey vendor to administer the PSS. The survey was administered with a fax-only methodology to all of the PCPs (N= 401), Specialists (N=528), and Behavioral Health (N=123) providers. SCFHP provided CSS a provider contact list consisting of 1052 records and CSS identified a total of 495 unique fax numbers to administer the survey. Since the same fax numbers were shared among multiple providers in the same medical groups, one unique survey was faxed to each distinct fax number and the results were attributed to all providers sharing the same fax number. The surveys were distributed in four waves. The first wave began on June 27, 2018 and surveys were faxed to all available (495) fax numbers. Subsequent waves were limited to non-respondents from the previous wave and so on until the 4th wave was completed. Providers were instructed to complete the survey by rating how satisfied they are with various service areas of SCFHP. The returned surveys were captured using manual data entry. Each returned survey was identified by the original tracking identification number that was created by CSS.

Note: *In 2017, SCFHP did not break out provider types, such as PCPs, Specialists and BH. The 2018 survey was revised significantly; thus, there are very few 2017 comparisons available and the results will be used as a benchmark for 2019. Where noted, 2017 survey data reflects the combined responses of all providers not broken out by PCP, Specialist and BH. Please see Appendix B & C, which includes the provider satisfaction survey tools for 2018 and 2017. The analysis below will include notations that will reference the questions on the 2018 survey tool, i.e., Q4a, Q5a and etc.*

RESULTS

Table I: Overall Satisfaction

A. Overall Satisfaction with SCFHP Services

Provider Type	Goal	Goal Met	Very Satisfied/Satisfied (1 & 2)	Dissatisfied/Very Dissatisfied (3 & 4)	Not Applicable/No Experience (5)
PCPs (N=56)	80%	Yes	88%	11%	1%
Specialists (N=86)	80%	No	79%	15%	6%
Behavioral Health (N=15)	80%	Yes	92%	3%	5%
Total	**80%**	**Yes**	**86%**	**10%**	**4%**

Survey Question: 7a

Quantitative Analysis (Table I - A)**:** The combined satisfaction level across all three types of providers surveyed was 86%; thus, the goal was met. The satisfaction level across all surveyed providers came in at 6% above SCFHP's goal. The highest result was with behavioral health providers at 92% and the lowest with specialist providers at 79%. These are new measures; thus, there is no comparison data available, and MY2018 results will be used as a benchmark for 2019

B. Overall Satisfaction with Prior Authorization/Referral Process

Question	Goal	Goal Met	Very Satisfied/Satisfied (2018)	Very Satisfied/Satisfied (2017)	Change from 2017
Prior Authorization and Referral Process	70%	Yes	77%	86%	-9%

Survey Question: 1a-b

Quantitative Analysis (Table I – B)**:** The combined satisfaction level with the Prior Authorization/Referral Process across all providers surveyed was 77%; thus, the goal was met. However, provider satisfaction decreased by 9 percentage points from 2017. The 2018 raw data reports showed that PCP satisfaction with the prior authorization and referral process was at 82%, specialist providers at 78% and behavioral health providers at 70%.

C. Overall Satisfaction by Primary Care Providers (N=98)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1&2)	Very Dissatisfied/ Dissatisfied (3&4)	Not Applicable/ No Experience (5)	Very Satisfied/ Satisfied (1&2) 2017	Change from 2017
*Utilization Management	80%	Yes	82%	7%	11%	NA	NA
*Claims/Appeals	80%	No	75%	17%	8%	NA	NA
**Timely Access	80%	No	75%	9%	16%	78%	-3%
*Customer Service	80%	Yes	87%	13%	0%	NA	NA
*Provider Relations	80%	Yes	81%	18%	1%	NA	NA
*SCFHP Provider Network	80%	No	66%	30%	4%	NA	NA

*Denotes new measure
**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – C)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the goals were exceeded with an outcome of 88%, and 81%. In 2017, the very satisfied/satisfied result across the provider network on prior authorizations and referrals was at 86% respectively. PCP's very satisfied/satisfied results did not meet the goal with an outcome of 75% on timely appointment access questions (Q3a-f), and in 2017, the results across the provider network was at 78%. However, as stated in the methodology for this section, SCFHP did not breakdown provider types in previous years, and the Plan added a new measure in 2018 on timely access (Q3f). The PCPs very satisfied/satisfied rating of SCFHP's provider network (Q6a-c) was the lowest with an outcome of 66%. There is no other comparison data, as all other measures are new for MY2018.

Qualitative Analysis (Tables I – A, B, C): The raw data report showed that PCP satisfaction ratings on non-urgent behavioral health appointments (Q3e) and availability of behavioral health providers (Q6c) had the highest level of dissatisfaction at 33%; which is an average percentage based on questions Q3e and Q6c. As referenced in the availability of provider network analysis (presented in the QIC meeting on August 8, 2018), a study of mental health shortages in California by the Office of Statewide Health Planning and Development (OSHPD) indicated mental health shortages across many rural areas of the state. Additionally, according to data from the California Employment Development Department, demand for mental health and substance abuse social workers, and substance abuse and behavioral disorder counselors shortages has grown by 22.8 percent through 2017. As also noted in the availability of provider network analysis, there are known provider shortages and recruitment challenges with behavioral health providers in the North West and/or South East areas of Santa Clara County, which are within rural communities. SCFHP continues to monitor recruitment activities and contractual opportunities in this area, as well as other areas of the county as necessary to ensure CMC members have timely access to health care providers. The raw data reports also show that customer service staff relevant to knowledge about questions (Q4b) had the highest level of satisfaction at 91%, and no PCP's responded with an answer of not applicable/no experience. The same question (Q5b) was answered relevant to provider relations staff and the level of satisfaction was at 68%. One area that SCFHP can focus on is collecting additional data from providers concerning issues with behavioral health access; i.e., behavioral health provider types and services that are difficult to access. The Plan can also focus on providing additional training to customer service and provider relations staff members to ensure representatives have the knowledge and tools available to assist with provider questions.

D. Overall Satisfaction by Specialist Providers (N=105)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1&2)	Dissatisfied/Very Dissatisfied (3&4)	Not Applicable/ No Experience (5)	Very Satisfied/ Satisfied (1&2) 2017	Change from 2017
*Utilization Management	80%	No	75%	11%	14%	NA	NA
*Claims/Appeals	80%	No	60%	12%	28%	NA	NA
**Timely Access	80%	No	60%	3%	37%	78%	-3%
*Customer Service	80%	No	78%	14%	8%	NA	NA
*Provider Relations	80%	No	79%	12%	9%	NA	NA
*SCFHP Provider Network	80%	No	66%	14%	20%	NA	NA

*Denotes new measure
**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – D)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the first goal was not met by 1 percentage point with an outcome of 79%, and the second goal was exceeded by 8 percentage points with an outcome of 78%. In 2017, the very satisfied/satisfied result across the provider network on prior authorizations and referrals was at 86% respectively. Results on appointment access questions (Q3a-f) showed that the goal was not met with an outcome of 60% and in 2017, the results across the provider network was at 78%. However, as stated in the methodology for this section, SCFHP did not breakdown provider types in previous years, and the Plan added a new measure in 2018 on timely access (Q3f). Thirty seven percent (37%) of specialists answered not applicable/no experience with appointment access and only 3% were very dissatisfied/dissatisfied; thus, if more specialists had experience with timely access, results may have shown a higher rating on very satisfied/satisfied. Results on claims/appeals questions (Q2a-c) did not meet the goal with an outcome of 60%. However, 28% answered not applicable/no experience, therefore it appears that the persons completing the survey were unable to give an adequate rating on this measure. There is no other comparison data, as all other measures are new for MY2018.

Qualitative Analysis (Table I – D): All areas measured did not meet the goal of 80%. However, customer service and provider relations missed the goal by only 1 or 2 percentage points. The raw data report shows that 12% of specialists were very dissatisfied/dissatisfied with claims/appeals (Q2a-c), and although 28% answered not applicable/no experience, the Plan did have a claims system conversion in 2017 that may have contributed to a lower percentage of satisfaction. Following the Plan's system conversion, it has worked diligently to improve claims processing and is confident that claims survey results in measurement year 2019 will reflect those efforts.

The raw data reports show that the ratings relevant to SCFHP's provider network is with availability of behavioral health providers (Q6c), and appointment access is with availability of behavioral health providers (Q3e), with an average dissatisfaction rating of 11%. As indicated above in the PCP qualitative analysis, this result is likely due to behavioral health provider shortages. As stated above, SCFHP will continue to assist its members to receive timely behavioral health care as needed.

The raw data report also showed that provider relations relevant to friendliness and helpfulness had the highest level of satisfaction at 85%. Customer service and provider relations "ability to resolve concerns/issues" had the highest level of dissatisfaction at 21%. SCFHP has courteous and friendly customer service and provider relations team members and continuously strive to improve service to our providers. One area that SCFHP can focus on is working to improve training and documentation utilized by the provider relations staff to enhance our provider training programs.

E. Overall Satisfaction by Behavioral Health Providers (N=28)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1 & 2)	Very Dissatisfied/ Dissatisfied (3 & 4)	Not Applicable /No Experience (5)	Very Satisfied/ Satisfied (1 & 2) 2017	Change from 2017
*Utilization Management	80%	No	66%	2%	32%	NA	NA
*Claims/Appeals	80%	No	69%	4%	27%	NA	NA
**Timely Access	80%	No	30%	0%	70%	78%	-3%
*Customer Service	80%	No	73%	2%	25%	NA	NA
*Provider Relations	80%	Yes	94%	3%	4%	NA	NA
*SCFHP Provider Network	80%	Yes	81%	0%	19%	NA	NA

*Denotes new measure

**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – E)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the first goal was met with an outcome of 92%, and the second goal was met with an outcome of 70%. In 2017, the only question under the "UM" section was relevant to satisfaction with prior authorizations and referrals, and as noted above, the Plan did not breakdown provider types in previous surveys; thus the very satisfied/satisfied result across the provider network on prior authorizations and referrals in 2017 was at 86% respectively. The behavioral health providers answered not applicable/no experience more often than PCPs and specialists with an average outcome of 30%. The very satisfied/satisfied rating on timely access (Q3a-f) was the lowest with an outcome of 30%; however, very dissatisfied/dissatisfied was at 0% and the not applicable/no experience had an outcome of 70%; thus, if more BH providers had experience with timely access, results may have shown a higher rating on very satisfied/satisfied. The outcomes on utilization management (Q1a-d) and claims/appeals (Q2a-c) were also rated below the goal by behavioral health providers; however, the very dissatisfied/dissatisfied average rating was 3% and the not applicable/no experience average rating was 30%, which indicated that with additional responses, it could swing the percentage of satisfaction upward or downward.

Qualitative Analysis (Table I – E): Compared to PCP's and specialists, the behavioral health providers had a much lower number of participation in the survey, likely due to circumstances where several BH providers manage their own schedules between patients, coupled with non-standard office hours. Although the behavioral health providers rated the lowest in satisfaction with timely access to appointments (Q3a-f), 70% answered not applicable/no experience. It should also be noted that with a relatively small number of respondents (28), the responses of additional BH providers could swing the percentages by ~20% one way or the other.

Conclusion - Provider Satisfaction:
SCFHP met both stated standards and thresholds for provider satisfaction for 2018. The threshold standard for overall satisfaction is a new measure; therefore, 2018 results will be used as a benchmark for 2019. While the Plan is pleased that both threshold goals were met, the prior authorization and referral process results indicated a 9% decrease on satisfaction from 2017; thus there is room for improvement. As a result of the new questions added to the survey in MY 2018, the Plan will further assess the results that show a high level of dissatisfaction and determine steps to address and improve in those areas. SCFHP will work with staff members from

Utilization Management, Contracting, Provider Relations, Customer Service and Claims to find ways to improve service to our providers. In addition, SCFHP will look at ways to increase awareness of timely appointment access standards.

4. MEMBER ACCESS GREVIENCES

Table A: Member Complaints (January - June 2018)

Provider Type	Case Description	# of Complaints
Primary Care	Untimely Non-Urgent/Routine Appointment	3
Primary Care	In-office Wait Times/Other	5
Physical Therapist (PT)	Untimely Non-Urgent/Routine Appointment	2
Urologist	Untimely Non-Urgent/Routine Appointment	1

Quantitative Analysis (Table A): There were a total of eleven (11) member complaints regarding access in Q1 and Q2 of 2018. Review of member complaints showed that there were none reported relevant to Geriatrics, Addiction Medicine, Clinical Social Workers (HVP) or any other high volume/impact providers. A total of three (3) members reported timely appointment access issues with specialists; Urologist (1) and PT (2).

The member seeking an appointment with a Urologist resides in the city of Sunnyvale, where there are no Urology providers. The distance to the closest Urologist from Sunnyvale is 5.8 miles or 4.53 minutes in the city of Mountain View, where there are a total of eight (8) Urologists, and the farthest from the distance standard is 14.5 miles or 12.8 minutes in the city of San Jose, where there are a total of ten (10) Urologists. SCFHP has thirty five (35) contracted Urologists, of which thirty four (34) are open to new patients. The provider to member ratio is met a 1:214.

The members seeking an appointment with a Physical Therapist (PT) reside in San Jose, where there are six (6) PT providers, all of which are open to new patients. Follow up with the PT providers confirmed an approximate wait of sixty (60) days for a new patient appointment. The provider to member ratio is met a 1:682. The data show that standards for geographic time and distance was met for Physical Therapy.

The other PCP complaints were relevant to timely appointments, in-office wait times and the desire to be assigned to a primary care provider closed to new patients.

Qualitative Analysis: SCFHP has identified that some of the member PCP complaints were related to lack of extended office hours, hours of operation not suiting the patient and members desired PCP is not in network. As shown in the member complaints record, complaints are resolved expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. As referenced in the availability of provider network analysis, a study in California by the Office of Statewide Health Planning and Development (OSHPD) indicated that California had only 38.6 physical therapists per 100,000 persons compared to 56.8 physical therapists per 100,000 persons nationwide. Results from a California Hospital Association survey came to similar conclusions. According to that study, vacancies in Physical Therapy have a negative impact on hospital efficiency and access to care.

Conclusion - Member Access Grievances:
The raw data on member complaints demonstrate that SCFHP is able to resolve complaints made by members expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. SCFHP continues to re-direct members to network and/or out-of-network specialists to ensure timely access to care is met.

OPPORTUNITIES

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
Timely access—PCP urgent appointments within 48-hours	• Improve access to urgent care appointments	• Improve training materials • Conduct provider outreach(Training)	Yes	TBD
Timely Access—Behavioral Health non-life threatening emergency within 6-hours	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards	• Explore contracting opportunities to expand BH network • Improve training materials • Conduct provider outreach (Training)	Yes	TBD
After-Hours Access (return call within 30min or less)	• Improve after-hours access	• Improve training materials • Conduct provider outreach (Training)	Yes	TBD

PARTICIPANTS:

Provider Network Access Manager
Timely Access and Availability Work Group
Behavioral Health
Quality Improvement
Grievances and Appeals
Provider Relations
Customer Service

Attachments:
Appendix A: After-Hours Survey Tool
Appendix B: Provider Satisfaction Survey Tool (2018)
Appendix C: Provider Satisfaction Survey Tool (2017)

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		

Appendix A: After-hours Survey Tool

After-Hours Survey 2018

Q1. Hello, my name is _____. Is this the after-hours service for Provider1, Provider2, Provider3, Provider4, and Provider5?

{DO NOT READ ANSWER OPTIONS.}

1) Yes, for all → Go to **INTRO 2**
2) Yes, for some→ Select **Final Disposition then go to INTRO 2**
3) No, this survey cannot be completed for all (Interviewer select reason) → Select **Final Disposition**
4) No, this is not the after-hours service → Reschedule call +2 hours
5) Reached a recording or auto attendant → Go to **Question 5**
6) No Answer → Go to **END CALL**

(Programming Note: Include a dropdown field of disposition codes next to each provider so final dispositions can be chosen for providers who are ineligible. If at least one provider is eligible, the survey should be continued.

Selections should include:

- Phone number is disconnected or non-working (P31)
- Provider not known at this number (P30)
- Provider is retired or deceased (P20)
- Provider has moved or left the office for other reasons (P20)
- Provider does not participate in health plan (P24)
- Phone number not a healthcare provider office (P30)
- Provider refused to participate (P40)
- Respondent (or auto-attendant) does not speak English (P30)
- Respondent asked to be placed on DNC list (DNC)

>>INTRO 1<<
Hello, my name is _____. Is this the after-hours service for Provider1, Provider2, Provider3, Provider4, and Provider5?

1) Yes → Go to **INTRO 3**
2) Yes, for some → Select **Final Disposition then go to INTRO 3**
3) No for all or Refusal → Select **Final Disposition**

(Programming Note: Include a dropdown field of disposition codes next to each provider so final dispositions can be chosen for providers who are ineligible. If at least one provider is eligible, the survey should be continued.)

>>INTRO 2<<

This call may be monitored and recorded for quality assurance and training purposes. I'm calling from CSS Research on behalf of [SCFHP], of which Provider1, Provider2, Provider3, Provider4, and Provider5 are affiliated. We are conducting an after-hours access survey and would like to ask you a few questions regarding whether Provider1, Provider2, Provider3, Provider4, and Provider5 are available to his/her/their patients after hours. For record keeping purposes, may I have your name?

{RECORD INTERVIEWEE NAME}

Interviewee Name: _____ → Go to **Question 1b**

>>INTRO 3<<

This call may be monitored and recorded for quality assurance and training purposes. I'm calling from CSS Research on behalf of [SCFHP], of which Provider1, Provider2, Provider3, Provider4, and Provider5 are affiliated. We are conducting an after-hours access survey and would like to ask you a few questions regarding whether Provider1, Provider2, Provider3, Provider4, and Provider5 are available to {his/her/their} patients after hours. For record keeping purposes, may I have your name?

{RECORD INTERVIEWEE NAME}

Interviewee Name: _____ → Go to **Question 9**

Q1b. (INTERVIEWER RECORD: Are you speaking with one of the named providers?)

1) Yes
2) No or Not Sure

Q2. What would you tell a caller who states he/she is dealing with a life-threatening emergency situation?

{DO NOT READ ANSWER OPTIONS. CHOOSE ALL THAT APPLY.}

a) Go to the nearest emergency room.
b) Hang up and dial 911.
c) Leave your name and number, someone will call you back.
d) Go to an urgent care center.
e) The doctor or an on call physician can be paged or called at another number.
f) Transfer to a PCP, advice/triage nurse, or urgent care center.
g) Don't know or not specified
h) Other: {TYPE ANSWER}

{INTERVIEWER NOTES}

An example of an emergency situation is a sudden onset of chest pain. For the purposes of this survey, the caller is a patient, not a doctor or pharmacist.

(Programming Note: If Q1b = 1, skip Q3 and Q4 and go to **CLOSE**)

Q3. If a patient expresses an urgent need to speak with a clinician, is there a way you can put them into contact with the provider, an on-call provider or a health care professional such as an advice nurse tonight?

{DO NOT READ ANSWER OPTIONS.}

3) Yes
4) No or Not Ascertained → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Yes" if you are speaking to the health care provider directly. If you are unsure whether the patient can be put into contact with a provider tonight, ask follow up questions such as: (If the respondent can contact the provider) Will the patient speak to the provider if called? (If a message can be left) Will they call back?

Q4. In what timeframe can the patient expect to hear from the provider or on-call provider?

{DO NOT READ ANSWER OPTIONS.}

1) Immediately (can cross connect/transfer) → Go to **CLOSE**
2) 30 minutes or less → Go to **CLOSE**
3) More than 30 minutes → Go to **CLOSE**
4) Not specified → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Not specified" if the respondent says "As soon as possible". Choose "Immediately" if you are speaking to the health care provider directly, or if the call can be transferred immediately.

Q5. {INTERVIEWER RECORD} What does the recording or auto attendant tell a caller who states he/she is dealing with a life-threatening emergency situation? **(Select all that apply.)**

a) Go to the nearest emergency room.
b) Hang up and dial 911.
c) Leave your name and number, someone will call you back.
d) Go to an urgent care center.
e) The doctor or an on call physician can be paged or called at another number.
f) Transfer to a PCP, advice/triage nurse, or urgent care center.

g) No emergency instructions provided.
h) Other: {TYPE ANSWER}

Q6. {INTERVIEWER RECORD} Were any of the following options given by the recording or auto attendant? **(Select all that apply.)**

a) The caller is given the option to page the provider through the recording
b) A phone number or pager number is given to reach the provider, an on call provider, or an after-hours service
c) The caller is able to leave a message
d) None of the above

{INTERVIEWER NOTES}
Choose option A if the option (such as stay on the line/press extension number) is given to connect immediately to a health care provider - which includes a physician, nurse, therapist, etc.
For option B, a nurse advice line is an example of an after-hours service. A cell phone or home phone number is an example of a different phone number.
For Option C, the message must specify that the call will be returned.

(Programming Note: If options A or D are chosen, end the survey.)

Q7. {INTERVIEWER RECORD} In what timeframe can the patient expect to hear from the provider or on-call provider?

1) Immediately (can cross connect/transfer)
2) 30 minutes or less
3) More than 30 minutes
4) Recording does not specify

Interviewer Note: Choose "Recording does not specify" if the recording states they will call back "As soon as possible". Choose "immediately" if the option is given to connect to a provider (stay on the line/press extension) or after hours service (i.e. nurse advice line).

Q8. {INTERVIEWER RECORD} Does the recording/auto-attendant offer an option to speak with a live person?

1) Yes (INTERVIEWER: choose option to connect to live person) → Go to **Intro 1**
2) No → Go to **END CALL**

{INTERVIEWER NOTES}
Choose option 1 if you can speak to an operator or a named person. Only record option 1 after a live person is on the line, otherwise choose option 2.

(Programming Note: Display Question 8 only if option A on Question 6 is NOT marked.)

Q9. If a patient expresses an urgent need to speak with a clinician, is there a way you can put them into contact with the provider, an on-call provider or a health care professional such as an advice nurse tonight?

{DO NOT READ ANSWER OPTIONS.}

1) Yes
2) No or Not Ascertained → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Yes" if you are speaking to the health care provider directly.

Q10. In what timeframe can the patient expect to hear from the provider or on-call provider?

{DO NOT READ ANSWER OPTIONS.}

1) Immediately (can cross connect/transfer) → Go to **CLOSE**
2) 30 minutes or less → Go to **CLOSE**
3) More than 30 minutes → Go to **CLOSE**
4) Not specified → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Not specified" if the respondent says "As soon as possible". Choose "Immediately" if you are speaking to the health care provider directly, or if the call can be transferred immediately.

>>CLOSE<<
Thank you very much for your time. Have a nice day/evening.

>>END CALL<<

Santa Clara Family Health Plan™

Appendix B: Provider Satisfaction Survey Tool (2018)

Dear Provider:

Santa Clara Family Health Plan is committed to improving the services we offer to our contracted providers. As part of this commitment, we ask you to complete this short survey on your satisfaction with our services. Your responses will help us identify areas of improvement. Various members of your administrative and medical staff may be best qualified to provide input on questions based on their areas of expertise. Please take a few minutes to complete this survey and return by fax to 800-205-3745.

Santa Clara Family Health Plan is working with the Center for the Study of Services (CSS), an independent research organization, for this survey. If you have any questions, please contact CSS at providerfeedback@cssresearch.org.

How satisfied are you with each of the following?

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	No Experience
1. Utilization Management					
a. Timeliness of the prior authorization process	☐1	☐2	☐3	☐4	☐5
b. Timeliness of the ready referral process	☐1	☐2	☐3	☐4	☐5
c. Efficiency of the UM appeals process	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness of staff	☐1	☐2	☐3	☐4	☐5
2. Claims/Appeals					
a. Timeliness of clean claims processing	☐1	☐2	☐3	☐4	☐5
b. Promptness of answers to claims inquiries	☐1	☐2	☐3	☐4	☐5
c. Efficiency of the claims appeals process	☐1	☐2	☐3	☐4	☐5
3. Patients' Timely Access to…					
a. Urgent care	☐1	☐2	☐3	☐4	☐5
b. Non-urgent primary care	☐1	☐2	☐3	☐4	☐5
c. Non-urgent specialist care	☐1	☐2	☐3	☐4	☐5
d. Non-urgent ancillary diagnostic and treatment	☐1	☐2	☐3	☐4	☐5
e. Non-urgent behavioral health	☐1	☐2	☐3	☐4	☐5
f. Covered services	☐1	☐2	☐3	☐4	☐5
4. Customer Service Staff's…					
a. Ability to answer calls promptly	☐1	☐2	☐3	☐4	☐5
b. Knowledge about my questions	☐1	☐2	☐3	☐4	☐5
c. Ability to resolve my concerns/issues	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness	☐1	☐2	☐3	☐4	☐5
5. Provider Relations Staff's…					
a. Ability to respond to questions promptly	☐1	☐2	☐3	☐4	☐5
b. Knowledge about my questions	☐1	☐2	☐3	☐4	☐5
c. Ability to resolve my concerns/issues	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness	☐1	☐2	☐3	☐4	☐5
6. SCFHP's Provider Network					
a. Quality of SCFHP's provider network	☐1	☐2	☐3	☐4	☐5
b. Availability of medical health providers	☐1	☐2	☐3	☐4	☐5
c. Availability of behavioral health providers	☐1	☐2	☐3	☐4	☐5
7. Overall Satisfaction					
a. Overall experience with Santa Clara Family Health Plan	☐1	☐2	☐3	☐4	☐5

Thank you for your feedback!

Please fax the completed survey back to 800-205-3745.

Santa Clara Family Health Plan™

Appendix C: Provider Satisfaction Survey (2017)

PROVIDER SATISFACTION WITH ACCESS SURVEY
FACSIMILIE TRANSMITTAL – ACTION REQUESTED WITHIN 5 BUSINESS DAYS
FAX YOUR RESPONSES TO: (408) 376-3537

Dear Provider:

The **State of California Timely Access to Non-Emergency Health Care Services Regulation** (§1300.67.2.2, Title 28, California Code of Regulations) requires service plans to maintain an adequate provider network to ensure patients receive timely access to care as appropriate for their condition, and to solicit provider's perspective and satisfaction with the patient's ability to receive access to care within the timelines set forth under California law.

Please check your Provider Type: PCP ☐ Specialist ☐

IPA/Medical Group Affiliation: Direct/Independent Providers ☐ PAMF ☐ PMGSJ ☐ Premier Care ☐

Please check all of the above that apply to you.

Please tell us your satisfaction level with each of the below:

HOW SATISFIED ARE YOU WITH:	**1. Very Satisfied**	**2.Satisfied**	**3. Dissatisfied**	**4.Very Dissatisfied**	**Not Applicable/ Unknown**
The referral and/or prior authorization process necessary for your patients' to obtain covered services?	☐	☐	☐	☐	☐
Your patients access to:					
urgent care	☐	☐	☐	☐	☐
non-urgent primary care	☐	☐	☐	☐	☐
non-urgent specialty services	☐	☐	☐	☐	☐
non-urgent ancillary diagnostic and treatment services	☐	☐	☐	☐	☐
behavioral health non-urgent care	☐	☐	☐	☐	☐
Your satisfaction with the language assistance program:					
coordination of appointments with an interpreter	☐	☐	☐	☐	☐
availability of appropriate range of interpreters	☐	☐	☐	☐	☐
training and competency of interpreters	☐	☐	☐	☐	☐

Please fax your responses to (408) 376-3537 within 5 days of receipt.

THANK YOU!

Santa Clara Family Health Plan (SCFHP)

Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Quality Improvement Committee: October 10, 2018

Factor 1: Exchange of Information – Medical Record Review of Behavioral Health and Primary Care Practitioners (PCPs)

I. The Santa Clara Family Health Plan (SCFHP) collects data on exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

Commented [JE1]: One you abbreviate this once, you don't have to spell out Santa Clara Family Health Plan again in the rest of the document

II. Methodology

SCFHP pulled all claims for any Cal MediConnect (CMC) member that had at least one visit with a PCP or Internal Medicine Specialist AND a Behavioral Health (BH) Practitioner visit in an outpatient setting within the calendar year 2017. To qualify for this data pull, the member had to have an established PCP relationship identifiable from our claims system database.

From this data set, we identified 385 unique members. We calculated a statistically valid sample by using a 90% confidence interval and a margin of error of 10. The total sample size came out to 58. We randomly selected the 58 from the population of 385. For the 58 members, the BH Team coordinated a medical record review with Santa Clara County BH Services to measure the timeliness of BH Practitioner and Primary Care Practitioner (PCP) communications regarding medication updates as found within each BH file.

For timeliness, we checked for records documented within the BH Practitioner chart that BH medications were communicated to the PCP at minimum once per year; the factor of timeliness has been defined as such to state that if a BH Provider communicated member BH medications to the PCP within the Calendar Year of 2017 this is a pass. Many of our BH specialists serve our members through the County of Santa Clara Behavioral Health Department or through county contracted providers, which means that both the BH specialist and the PCP have access to the member medical records using an EMR (Electronic Medical Records) system. These scenarios automatically meet the timeliness criterion as both BH specialist and PCP are able to access the same records.

a. **Goal:** 80% of the total number of samples meet the timeliness standards.

III. Analysis

a. Results

Of the SCFHP unique sample of 58 Members, 15 Members were granted automatic credit for the timeliness standard of Medical Record Review as both PCP and BH Providers are 1) located through the same Valley Health Clinic for BH and PCP services, and 2) the PCP and BH Providers share the same Electronic Medical Record system, with the ability to view each provider's notes, medications, and diagnoses.

The current information shows that at this time, 15 out of 58 Members meet our timeliness standard, with a Pass rate of 26% and a Do Not Pass rate of 74%.

We did not meet our goal that 80% of the total number of samples meet the timeliness standards.

Commented [TF2]: Reworded this sentence per JE request to make more sense.

b. Quantitative analysis

The Health Plan found that 43 of our total 58 files Do Not Pass do not meet the established timeliness standard.

The current information shows that at this time, 15 out of 58 Members meet our timeliness standard, with a Pass rate of 26% and a Do Not Pass rate of 74%.

c. Qualitative analysis

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of medical records indicating Member Behavioral Health medications were communicated at least once within the previous year to the PCP. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

2017 Barrier and Opportunity Analysis Table (Factor 1 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
HIPPA/Privacy Information (Deficit of Knowledge) – difficult for PCPs and Psychiatrists to cross-communicate regarding medical and Behavioral Health diagnoses & medications as frontline staff are under the impression that they cannot provide any information to Provider without a consent from the Member.	Educate members on the importance of signing a release to allow sharing of medical record information between member providers.	Article within SCFHP Newsletter stating importance and benefits of signing a release to allow sharing of medical record information between member providers	N	n/a
Access to Medically Relevant information (PCP and Psychiatrist)	Increase communication paths between PCPs and	Include Member lab results and medications filled through the	N	n/a

Commented [JE3]: Are we going to update this for the final report? Not sure if we can keep this in and get it approved if we still have additional review we need to do.

Commented [JE4]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

Commented [JE5]: Since we are focusing on timeliness, want to make sure that the barrier addresses that. Does this make sense?

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
	Psychiatrist in order to support relevant exchange of member information (e.g. medications)	SCFHP Physician Portal.		

Commented [JE6]: I am not sure how much control over our disclosure forms? If not we don't have as much, maybe providing lab data through the portal would be more feasible/actionable.

Factor 2: Diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care (AMM HEDIS measure)

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

II. **Methodology**

SCFHP utilized the AMM HEDIS measurement to monitor the adherence of members to their antidepressant medications. SCFHP partners with a HEDIS vendor to run our HEDIS measures each year. The rates are pulled using the HEDIS technical specifications (footnote)[i]. For our baseline data we reviewed HEDIS rates for AMM in 2017. The rates measure the following:

Commented [JE7]: Add tech specs to exhibit.

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

a. **Goal**: To maintain a rate in the HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures.

III. **Analysis**

a. Results

i. Effective Acute Phase Treatment: % of members who remained on an antidepressant medication for at least 12 weeks

	False	True	Grand Total
Count of Effective Acute Phase	31	87	118
	26.27%	73.73%	100.00%

ii. Effective Continuation Phase Treatment: % of members who remained on an antidepressant medication for at least 180 days

	False	True	Grand Total
Count of Effective Continuation Phase	45	73	118
	38.14%	61.86%	100.00%

Rate Description	Mean	P10	P25	P50	P75	P90
AMM - Rate - Effect.Acute Phase Tx	69.41	58.82	63.5	69.51	75.39	79.61
AMM - Rate - Effect.Continuation Phase Tx	54.42	41.12	47.53	54.11	60.32	66.55
Eligible Population per 1000 MY	27.13	14.45	19.45	24.98	32.23	41.68

b. Quantitative analysis

SCFHP scored in the 50th HEDIS percentile for the AMM Effective Acute Phase Rate. For the AMM Effective Continuation Phase Rate, SCFHP scored in the 75th HEDIS percentile. The goal was to achieve 75th percentile for both rates. While achieving our goal for the continuation phase, we were 5.88 percentage points behind the 75th percentile for the acute phase. Thus, we must conclude that there is room for improvement when it comes to CMC members maintaining their antidepressant medication treatment over a twelve week period. Our goal for the year 2018 will be to increase the percentage points of the Acute Phase rate high enough to achieve 75th percentile for our 2017 data, while maintaining our rate in the continuation phase.

c. Qualitative analysis

The quantitative analysis shows that during the first 12 weeks, or 180 days, of taking an antidepressant medication, SCFHP CMC Members are less **likely** to continue taking the medications during this Acute Treatment Phase than Members associated with other CMC Health Plans.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of Members Antidepressant Medication compliance. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], an Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist [contractor]), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

Commented [JE8]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

The analysis identified these specific barriers:

2017 Barrier and Opportunity Analysis Table (Factor 2 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Member knowledge about need for antidepressant medication adherence when beginning a new medication – takes time to take effect & need to continue to take for ongoing effect to last	Member Education regarding antidepressant medication information	Provider letter requesting Provider review antidepressant medication with Member when Member attends appointment (Medication compliance	N	n/a

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
		conversation request)		
Lack of support – lack of a Care Coordinator/Case Manager to assist in health promotion and member tracking	Identify and promote social support in prioritizing and assisting with health care goals (member may be more likely to follow up with ongoing support)	Offer Member a Personal Services Coordinator/Case Manager or coordinate with existing supports to track medications (refills, med management) and appointments (help create a system for tracking with health as priority)	N	n/a

Factor 3: Appropriate Use of Psychotropic Medications - Primary Care Practitioners (PCPs) and Antidepressant Medication Prescriptions

I. SCFHP collects data on BH and PCP adherence to prescribing guidelines concerning antidepressant medication prescriptions. Santa Clara County behavioral health members are able to access appropriate antidepressant medications through two avenues – Behavioral Health/Psychiatrist prescription (as connected through the local county mental health system), or access through Primary Care/Internal Medicine Doctor prescription. Due to a high demand for antidepressant medications and an acknowledged limited number of psychiatrists available to members throughout the county, the Health Plan identified that not only are adherence to prescribing guidelines (for all prescribing providers) concerning antidepressant medications vital to providing members with direct access to care, but also that PCP comfort level in using their medical skills to prescribe antidepressants needs to be addressed.

II. **Methodology**

SCFHP uses HEDIS NCD (National Coverage Determination) antidepressant medication codes for identification of Members receiving these prescriptions through the Health Plan's Pharmacy Benefit Management system (MedImpact).

SCFHP analyzed Calendar Year (CY) 2017 along with available CY HEDIS NCD codes for antidepressant medications, along with the diagnostic codes for Mild-to-Moderate diagnoses (Mild-to-Moderate based on level of functioning/county clinic placement as well as DSM-V diagnostic code) are used to determine:

1. the number of Cal MediConnect Members with a Mild-to-Moderate ICD 10 diagnostic code[ii]
2. who also have filled an antidepressant medication prescription within the past year

    a. The antidepressant medication had to have been filled by the member's PCP/Internal Medicine Doctor or a Psychiatrist

a. Goal = to have 75% of antidepressant medication prescriptions to be provided by Primary Care Practitioners and 25% of antidepressant medication prescriptions to be provided by Psychiatrists.

3. This metric will be used to indicate an increase in access to care for members who require antidepressant medications as well as Provider preparedness to prescribe appropriately as set by FDA (Food & Drug Administration); while prescribing of such medications falls within the scope of PCP practice, SCFHP acknowledges that appropriate prescribing of medications falls within different PCP comfort levels – the Health Plan has begun to

Commented [TF9]: Correct place to state this? Helps to explain more thoroughly the why as to what we are measuring and will feed into the ideas for future monitoring and improvement measures.

Commented [JE10R9]: This is good here. I would also just mention that it is not just PCPs adhering to the guidelines, it is also having them feel comfortable enough prescribing the meds, right?

Commented [JE11]: Add in CY 2017 measurement year

Commented [TF12R11]: Sufficient that stated in Body Paragraph? CY 2017?

Commented [TF13]: Need define – but need to include here?

outline as well as implement means to improve PCP awareness of antidepressant guidelines as will be discussed further along within this Factor.

III. Analysis

CY 2017 data

Of the Total Number of individual prescriptions (N = 7739)

- 3791 were prescribed by psychiatrists
- 3182 were prescribed by PCPs (Internal Medicine, Family Practice, General Practice, Geriatric medicine)
- Of the total, 766 were prescribed by other types of medical professionals (e.g. Neurologists, Cardiologists, Urologists, etc).

For the purposes of analyses we will not include practitioners which do not fit into these categories.
N = 3791+3182= 6973.

PCPs prescribing antidepressants for M2M (Mild to Moderate) Members = 54.4%
(Total Number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant medications = 3791 / 6973 = 54.4%)

Psychiatrists prescribing antidepressants for M2M (Mild to Moderate) Members = 45.6%
(Total Number of Psychiatrist antidepressant prescriptions / total number of prescriptions for antidepressant medications = 3182 / 6973 = 45.6%)

Results (Prescriptions written):

-PCPs prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant) = (3791 / 6973 = 54.4%)

PCPs prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of Psych antidepressant prescriptions / total number of prescriptions for antidepressant) = (3182 / 6973 = 45.6%)

a. Results

SCFHP found that of the 6973 prescriptions written for antidepressant medications, 3791 were prescribed by PCPs (as defined, those Physicians providing services as Internal Medicine, Family Practice, General Practice, Geriatric medicine) & 3182 were prescribed by Behavioral Health Providers (as defined, those BH Providers noted as Psychiatrists).

4. 54.4% of Antidepressant medications were thus prescribed by PCPs
5. 45.6% of Antidepressant medications were thus prescribed by BH Providers.

b. Quantitative Analysis

The SCFHP obtained our baseline data; of the total number of prescriptions for antidepressant medications, 54.4% were written by PCPs and 45.6% were written by BH Practitioners. From our data collected, SCFHP did not meet our goal of 75% antidepressant prescriptions by PCPs and 25% antidepressant prescriptions by Psychiatrists.

Of the scripts written, there were *208 unique PCPs* identified and *83 unique BH Practitioners* identified.

With more PCPs available in a multitude of settings (Geriatric clinics, Internal Medicine clinics, Private Practice Practitioners, etc.) than Psychiatrists (predominantly through County/County Contracted Agencies), it is apparent that **despite** a near 50/50 split in Antidepressant medication prescriptions, PCPs are an ongoing, useful component to address antidepressant medication needs within the County.

There are more PCP providers available than Psychiatrists, and this indicates that it would be more likely for a member to obtain a PCP appointment (and thus a prescription) than a BH appointment. Many of the county Psychiatrists are also associated specifically with mental health clinics, many of which only serve those with more severe mental illness, such as Schizophrenia.

Our CY 2018 goal is suggested to be incremental in increase to continue to show improvement, with a goal increase of 5 percentage points for PCP antidepressant medication prescriptions (PCPs = 59.4% and Psychiatrists = 40.6%).

Commented [JE14]: Perfect

c. Qualitative Analysis

The quantitative analysis shows currently of our identified population, PCPs are prescribing 54.4% of the total antidepressants and Psychiatrists are prescribing 45.6%.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the number of PCPs

prescribing antidepressants for this population by 5 percentage points. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], , an Adult Psychiatrist [Consultant]), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

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The analysis identified these specific barriers:

2017 Barrier and Opportunity Analysis Table (Factor 3 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Provider perception between referral and consultation distinction.	Identify Members in maintenance stage of medication versus modifying medications for symptom management – PCPs more inclined to manage "ongoing" prescriptions than polypharmacy Members or Members undergoing BH medication changes	Upon implementation of consultation access line with Santa Clara County BH Services, send out letter to Providers informing of line availability and clarifying distinction between consultation and referral.	N	n/a
PCPs lack knowledge and/or comfort level required to manage/prescribe their members' antidepressant medications	Improve comfort levels of PCPs prescribing antidepressant medications by providing access to consultants	Implement an access telephone line with Santa Clara County Behavioral Health Services Department to provide access to psychiatrist for telephonic medication consultation; 2) Ongoing education to Contracted PCPs on	N	n/a

Commented [JE16]: I reworded this so that the different between barriers/opportunities/intervention is clear

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
		antidepressant medications, general prescribing guidelines and considerations (3/2018)		

Factor 4: Management of Treatment access and follow-up for Members with coexisting medical and behavioral disorders – Management of Treatment of Members with Schizophrenia and Diabetes Mellitus Type II

I. The Santa Clara Family Health Plan collects data on Members identified as having dual diagnoses of Schizophrenia as well as Diabetes Mellitus II.

II. **Methodology**

SCFHP collects data on Cal MediConnect Members (CMC) with diagnoses of Schizophrenia as well as Diabetes Mellitus Type II and rates of Primary Care Practitioner/Internal medicine provider appointments as evidenced by Claims data. For the purposes of this initial year, the Health Plan will determine the percentage of Members who had a Primary Care/Internal Medicine visit within CY 2017 (numerator) compared to the total baseline number of members diagnosed with both Diabetes Mellitus Type II and Schizophrenia (denominator). This percentage is used to determine a deficit in acceptable Primary Care Practitioner annual exams to support need for ongoing analysis and monitoring.

a. 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.

III. **Analysis**

a. Results

Total number of Members with diagnoses of Schizophrenia and Diabetes Mellitus Type II were identified through claims data in CY 2017 (**N = 130**). Of these Members, 77 were identified as having had a Primary Care Practitioner (PCP) annual visit (59.2%) and 53 were identified as not having has a Primary Care Practitioner (PCP) visit (40.8%).
We did not meet our CY 2017 goal by 15.8 percentage points.

b. **Quantitative Analysis**

SCFHP identifies that the number of CMC Members diagnosed with both Schizophrenia and Diabetes Mellitus Type II of whom saw Primary Care Practitioners within the CY 2017 (77 members of a total of 130, or 59.2%) number to be low. This is baseline data collected for ongoing analyses year over year.

c. **Qualitative Analysis**

The baseline data indicates an increased need for CMC Members diagnosed with both Schizophrenia and Diabetes Mellitus Type II (DM2) to be seen on an

ongoing basis for follow up regarding medical care. Members with Severe Mental Illnesses, such as Schizophrenia, often experience symptoms which promote an increase in disorganization and decrease in ability to process information, keep track of ongoing appointments and track ongoing progress of medical needs. SCFHP identifies this population as vulnerable to factors which may limit Member ability to follow up in an ongoing manner for medical care.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to increase the number of CMC Members dually diagnosed with Schizophrenia and Diabetes Mellitus 2 who have met with their Primary Care Provider at least once every year. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist consultant), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

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2017 Barrier and Opportunity Analysis Table (Factor 4 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	**Selected for 2018?**	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 remind Member: Schedule PCP Annual Wellness exam + Have A1c blood testing completed	Y	10/2018
Communication between PCP and Psychiatrists often limited due to consent forms and misunderstanding of HIPPA	Member education regarding benefits of permitting certain data to be shared across multiple providers	Article within SCFHP Newsletter stating importance and benefits of signing a release of information to allow sharing of medical record information between member providers	N	n/a

The barrier analysis completed in the baseline year CY 2017 identified that PCPs and Psychiatrists are in need of increase in communication methods – it was

suggested at the BH Workgroup that many members with severe mental Illnesses such as Schizophrenia may neglect their own medical care as it is not a top priority for them; the Member may be disorganized or overwhelmed with current obligations (family, case management if connected to a mental health clinic, group attendance/addressing mental health symptoms, etc.). An intervention to increase Member awareness of the importance of follow up care with PCP regarding Diabetes Mellitus 2 management within this subpopulation has been implemented as of October 2018. Outreach to the entire population involved 3 calls to each member to offer assistance in scheduling of Annual Wellness Exam for Diabetes Mellitus 2 follow up care and assistance with SCFHP transportation to and from this appointment. This intervention will remain in place for the measurement cycle to determine if the performance goal is attainable.

Factor 5: Secondary Preventative Behavioral Healthcare Program Implementation – PHQ-9

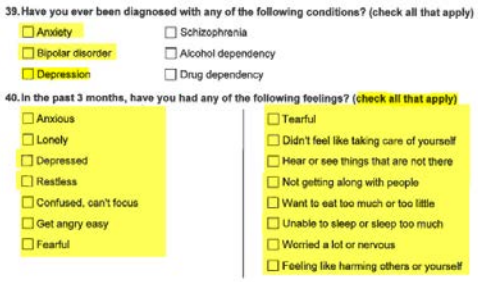
I. SCFHP collects data on members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions. Data pulled from the Health Plans annual Health Risk Assessment (HRA) identified Members who have self-reported a diagnosis of depression and/or depressive symptoms as present within the previous 3 months.

In an effort to acknowledge the high prevalence of depression amongst the overall population, and thus the subpopulation of Santa Clara Family Health Plan Members, coupled with treatment needs/considerations for health wellness, the Health Plan has collected data concerning levels of Member identified depression and the data address the need for a secondary behavioral health program to connect members, as based on their current level of depression and need, to appropriate interventions. It is based on this data collected that the Health Plan identified the need for PHQ-9 (Patient Health Questionnaire - 9) assessment completion and follow up care monitoring.

II. **Methodology**

The SCFHP collects data on CMC as identified within the HRA, completed annually by Members, to identify the population of members currently self-indicating diagnoses and/or symptoms of depression.

Health Risk Assessments completed between July 1, 2017 and June 30, 2018 were reviewed for responses on HRA mental health questions:


39. Have you ever been diagnosed with any of the following conditions? (check all that apply)
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Alcohol dependency
- ☐ Drug dependency

40. In the past 3 months, have you had any of the following feelings? (check all that apply)
- ☐ Anxious
- ☐ Lonely
- ☐ Depressed
- ☐ Restless
- ☐ Confused, can't focus
- ☐ Get angry easy
- ☐ Fearful
- ☐ Tearful
- ☐ Didn't feel like taking care of yourself
- ☐ Hear or see things that are not there
- ☐ Not getting along with people
- ☐ Want to eat too much or too little
- ☐ Unable to sleep or sleep too much
- ☐ Worried a lot or nervous
- ☐ Feeling like harming others or yourself

a. Goal = 80-100% of CMC Members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment.

Depression indicators included symptoms associated with depression, and/or a marked diagnosis of Depression or Bipolar

Disorder or Anxiety as self-identified and submitted on Health Risk Assessment (HRA) form.

III. Analysis

a. Results

Within our specified timeframe of 12 months (July 2017 – June 2018):

3127 Unique Members had identified symptoms and/or a diagnosis of Depression on their Health Risk Assessment.

Of the 3127 Members, 171 Members had completed a PHQ-9.

5.47% had a PHQ-9 assessment.

Total HRA Members with BH indicator on HRA	Total HRA Members with PHQ9	
3,127	171	5.47%

This assessment measure is useful in guiding interventions and thus *supports* the need for a PHQ-9 Program – assessment scores may be used to help guide treatment and resources to those most in need.

b. Quantitative Analysis

SCFHP acknowledges that there are many CMC members who had indicated depressive symptoms/diagnosis of depression.

Of these 3127 members (of whom account for 42 % of the SCFHP CMC total member population as calculated based on total CMC population June 2018 = 7503), 5.47% had a PHQ-9 assessment.

Our goal to meet for our specified timeframe was 80-100% of sample Member's to have completed a PHQ-9; the total number of completed surveys is low considering the prevalence of depressive symptoms and depression within our population. SCFHP did not meet our goal. As a baseline year these data support the need for a PHQ-9 and/or depression program for CMC Members.

c. Qualitative Analysis

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to increase the number of completes PHQ-9 assessments and communication of appropriate interventions/treatment for all CMC Members who have indicated a diagnosis of depression and/or depressive symptoms as identified on the Member's Health Risk Assessment (HRA); we would like to retain the objective of 80-100% PHQ-9 percentage completion rate for these Members. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist consultant), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

Commented [JE18]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

Barrier and Opportunity Analysis Table (Factor 5 – Baseline Year Data CY [July 2017 – June 2018]):

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
Case Managers not always completing a PHQ-9 for members that indicate they have depression	Implement a process to ensure the PHQ-9 assessment is offered every time a member indicates depression on the health risk assessment	1) Create an automated trigger within the Essette Case Management system after HRA is entered to indicate need for PHQ-9 and PHQ-9 follow up 2) Ongoing Annual training on PHQ-9 program	Y	10/2018
Lack of support – providers may not be aware of need to address Member's depression.	Notify Providers when their assigned members indicate that they have depression	Create a new provider letter that can be sent from the case management system with the member's PHQ-9 results included	N	n/a
Member access to PHQ-9 in preferred language	Provide Members with access to PHQ-9 in their	Submit PHQ-9 for translation and send	N	n/a

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
	preferred language	by mail to member when requested		

The barrier analysis completed in the baseline year (Baseline Year Data [July 2017 –June 2018]) identified that there are many members currently experiencing symptoms of depression and are in need of treatment interventions; this supports the need for a PHQ-9 Program to allow for addressing such symptoms through a specific, monitored program. It was suggested at the BH Workgroup that internal systems could be created to increase SCFHP Case Manager awareness of appropriate Members for this program, thus increasing PHQ-9 completion and member appropriate interventions to address presented needs. An intervention to create an automated trigger within the Essette Case Management system after HRA is entered to indicate need for PHQ-9 and PHQ-9 follow up was implemented in 10/2018; also ongoing initial as well as annual training on the PHQ-9 program will continue to take place (stated start date of 10/2018). The intervention will remain in place for the measurement cycle to determine if the performance goal is attainable.

Factor 6: Special Needs of Members with severe and persistent mental illness – HEDIS measure of Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

I. SCFHP looks at the results of the HEDIS measure Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) to monitor that members with Schizophrenia and Cardiovascular Disease are being appropriately treated.

II. **Methodology**

SCFHP utilized the SMC HEDIS measurement to monitor the adherence of members to their antidepressant medications. SCFHP partners with a HEDIS vendor to run our HEDIS measures each year. The rates are pulled using the HEDIS technical specifications. For our baseline data we reviewed HEDIS rates for AMM in 2017. The rates measure the following:

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.

https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

a. Goal = to fall within the 75th Percentile of Members following treatment care with their providers.

III. **Analysis**

a. Results

SCFHP's HEDIS vendor identified only 4 Members who met this very specific criteria. Of the 4 Members, 100% followed up for cardiovascular care with their Provider in 2017

b. **Quantitative Analysis**

The suggested goal was to achieve 75th percentile the total rate. The Santa Clara Family Health Plan met this goal – 100% of Members completed follow up care as indicated by their PCP.

SCFHP acknowledges that a total population size of 4 members for this HEDIS measure is quite small. We believe this may be due to the strict eligibility criteria for this specific measure (footnote[iii]). Despite meeting our goal (100%) this measure will not be an ongoing factor the Health Plan will continue to monitor due to its low

impact in the CMC member population. For 2018, SCFHP will identify a measure the Health Plan may follow up with and utilize for better assisting the Severe Mental Illness population in maintaining their physical and mental health.

c. **Qualitative Analysis**

There is no qualitative/barrier analysis at this time. SCFHP met the stated goal, and will be measuring a new goal for 2018.

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[i] HEDIS AMM technical specifications link:
http://icat/initiatives/ncqa_first_survey/Shared%20Documents/1.%20Project%20Management/Workgroups/QI6A/Data/Factor%202%20-%20AMM%20HEDIS%20Measure/Antidepressant%20Medication%20Management.docx

[ii] **Mild to Moderate** defined as ICD-10 codes of diagnoses Major Depressive Disorder, Bipolar Disorder and Other Mood Disorders with indication of being in partial or full remission, and indication of mild or moderate status were acceptable; any indication of above stated diagnoses with psychotic features were ruled out.

[iii] HEDIS SMC technical specifications link:
http://icat/initiatives/ncqa_first_survey/Shared%20Documents/1.%20Project%20Management/Workgroups/QI6A/Data/Factor%206%20-%20SMC%20HEDIS%20Measure/SMC%20HEDIS%202018%20Tech%20Specs.docx

Santa Clara Family Health Plan (SCFHP)

Member and Practitioner Satisfaction with the UM Process: 2018 Analysis

Quality Improvement Committee: October 10, 2018

I. Introduction

SCFHP monitors experience with the utilization management (UM) process to ensure adequate satisfaction is achieved. Annually, SCFHP completes an analysis which incorporates practitioner & member survey questions, member complaint categories related to processes for UM, and CAHPS data. This analysis allows the organization to formulate an action plan addressing low member and provider satisfaction with (UM) functions within SCFHP.

Practitioner Satisfaction with UM Processes

Practitioner Survey Results for Satisfaction with UM

II. SCFHP monitors Practitioner Satisfaction with the UM Processes by conducting a satisfaction survey.

III. Methodology

SCFHP collects and tracks provider satisfaction from survey responses. SCFHP Personal Care Coordinators (PCCs) administer a phone survey to both primary care and specialty practitioners. The survey is conducted during the month of July and all practitioners are called at least twice. The practitioners are chosen from a random sample of 50 members that had completed authorizations (outpatient and inpatient) with a received by the health plan UM department in the month of June 2018. The 50 members had a combined total of 65 authorizations received during this time frame. Each referring provider from those authorizations was surveyed on their UM experience with that authorization. In total, 28 unique providers responded regarding their experience with a total of 38 authorizations. By surveying practitioners on authorizations from the previous month, we are able to capture more accurate responses as the practitioner will be more familiar with the request.

The denominator for the survey is the number of responses received for each question for each authorization. The numerator for the survey is calculated for each question as follows:

1. **Question 1:** Rate your level of satisfaction with obtaining precertification and/or authorization for requested services for Health Plan members.
    a. Numerator: The number of providers who answered that they were “Completely satisfied” or “Partially satisfied” for each authorization they were surveyed on

2. **Question 2:** Did you receive a determination letter for this authorization within the appropriate timeframe? (14 days with routine requests, 72 hours for Expedited requests)
    a. Numerator: The number of providers who answered that answered “Yes” for each authorization they were surveyed on

3. **Question 3:** Are you familiar with where to find SCFHP’s prior authorization grid for Cal MediConnect members?
    a. Numerator: The number of providers who answered that answered “Yes” for each authorization they were surveyed on

4. **Question 4:** If applicable for a denial determination, were you able to understand the information included to explain SCFHP's Appeal process?
    a. Numerator: The number of providers who answered that answered "Yes" for each authorization they were surveyed on

IV. Results:

SCFHP collects and tracks provider satisfaction from our practitioner satisfaction survey responses regarding satisfaction with the UM process. The survey questions used to measure satisfaction are listed in the table below.

Provider Response Rates

	Reponses Received	Refused	Unable to Contact	Total	Response Rate
# of Authorizations	34	25	6	65	52%
Distinct Providers	28	6	27	61	46%

Measurement Year & Practitioner Type	Numerator	Denominator	Performance Rate	Performance Goal	Goal Met? (y/n)
Satisfaction with process for obtaining pre-certification/referrals/authorization information	33	34	97%	90%	Y
Timeliness of obtaining pre-certification/referrals/authorization information	30	34	88%	90%	N
Familiarity with SCFHP's prior authorization guidelines/grid	28	34	82%	90%	N
Ease of understanding SCFHP's appeal process after a denial determination	25	34	74%	90%	N
Overall Satisfaction	29	34	85%	90%	N

V. Analysis:

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve the member and provider satisfaction with the UM process. The quantitative analysis process includes a review of results and compares those results against an established performance goal. In future analyses, we will compare results year over year. The qualitative analysis process utilizes the data to identify potential root cause and barriers

applicable to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause. SCFHP will track and trend each measure over a three year period.

a. Quantitative analysis

The performance goal for all provider satisfaction questions was set at 90%. This was only met for one question: Satisfaction with the process for obtaining pre-certification/referrals/authorization information. Two questions had a satisfaction rate within 5 percentage points of the performance goal: "Timeliness of obtaining pre-certification/referrals/authorization information" at 88% and "Ease of understanding SCHP's prior authorization guidelines/grid". The lowest favorable response rate was regarding the ease of understanding SCFHP's appeal process after a denial determination. Only 75% of responses per authorization answered that the process was easily understandable. The overall satisfaction rate with SCFHP's UM process landed 5 percentage points below our performance goal of 90%.

b. Qualitative analysis

The results of the satisfaction survey were discussed at the August 8, 2018 Quality Improvement Committee. This committee includes internal staff representing Quality Improvement, Provider Network Management, Compliance and Health Services staff. Additionally, external committee physicians were present. Multiple barriers and root causes were discussed for those areas in which SCFHP did not meet the performance goal. The barriers discovered impact all of the missed performance goals.

a. Individuals responding to the survey did not understand the required regulatory turnaround time frames, as an internal systems review of the actual authorizations for which the individuals were speaking to has been properly processed within the required timeframes. CMS protocols include a turn-around time (TAT) of 14 days for routine authorization requests as compared to Medi-Cal regulations which specify a 5 day TAT. These survey findings reflect that Providers selecting the choice of "Unsure" resulted in lower performance rates for this measure. All four of these authorizations were actually completed within 72 hours of receipt of the request.
    i. Root causes:
        1. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand the regulatory time frame requirements.
            a. Providers do not have enough time to participate in phone surveys
b. Responders were not familiar with SCFHP's prior authorization grid because of the location of the grid and the types of office staff responding to the survey
    i. Root causes:
        1. Providers/staff cannot find the prior authorization grid because it is not easily accessible, and/or the SCFHP website location is not intuitive and/or confusing
        2. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand the prior authorization grid
            a. Providers do not have enough time to participate in phone surveys
c. Responders did not understand SCFHP's appeal process after a denial determination
    i. Root causes:

1. Existing SCFHP materials regarding the appeal process is not sufficient in educating providers about the appeal process
2. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand or be familiar with SCFHP's appeal process
    a. Providers do not have enough time to participate in phone surveys

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Providers and office staff are not familiar with SCFHP UM processes (turnaround times, appeal process, authorization grid)	Make information regarding SCFHP UM processes more available and accessible to providers and office staff	Add information regarding key UM processes to SCFHP's provider portal Engage providers through additional education efforts When providing verbal notification for authorization determinations, include the required time frame in the verbal message Evaluate location of information on scfhp.com to make it more easily located by providers	Yes	11/01/2018 *after a revised prior authorization grid has been approved by UMC on 10/17/18.
Office staff are completing the surveys over actual providers, who may be more familiar with SCFHP's UM processes	Develop alternative survey methods to reach more Providers vs. Office Staff	Use a larger provider sample size in future provider satisfaction surveys In addition to phone survey, publish future survey links to the provider portal and	No	By end of Q2 2019

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
		provider e-newsletters		

Member Satisfaction with UM Processes

SCFHP measures Member Satisfaction with the Utilization Management Process through annual monitoring of complaints from members related to Utilization Management Processes and through the performance of a member satisfaction survey. The CAHPS survey is also conducted, however, the plan did not receive adequate response rates for the questions related to the UM process.

I. Methodology

SCFHP collects and tracks member complaints across the organization. While all departments may receive member complaints, a formal process exists to document complaints in the Grievance and Appeals (G&A) department. All complaints received in other departments are routed to G&A for documentation and tracking. Members may submit complaints through several methods: verbal complaints received via phone and written complaints received via fax, standard and electronic mail. Complaints gathered in G&A are documented in a central database repository in which they are categorized. Complaints are broken into multiple categories. The specific categories which may contain complaints regarding the Utilization Management (UM) process are as follows:

NCQA Category	Type	Sub-Type
Billing and Financial Issues	Grievance, Part C	Organization Determination/Reconsideration Process
Billing and Financial Issues	Grievance, Part D	Coverage Determination/Redetermination Process

Once complaints are categorized, they are reviewed monthly by a cross-functional team for trends and opportunities.

In addition to complaints, SCFHP conducts a member satisfaction survey regarding experience with the UM process. 50 random members were chosen from all authorizations received in the month of June 2018. The survey was conducted in July 2018. Members were asked about their experience with the UM process within one month of the request since the experience is fresher and more memorable. The members were called at least twice and their survey responses recorded in our case management system. Of the 50 members contacted, 19 distinct members provided responses, providing a 38% response rate. Only 2 members refused to answer the survey, and 29 members were unable to be contacted with the contact information on file.

The denominator for the survey is the number of responses received for each question. The numerator for the survey is calculated for each question as follows:

5. **Question 1:** In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
    a. Numerator: The number of members who answered that it was “always easy” for them to get the care they needed

b. **Note**: A sub-question of Question 1 was asked of members that stated it was never or sometimes easy to get the care needed. This question gave three options to respond why it was not easy. There are no benchmarks for this question, as it is informational only.

6. **Question 3:** In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
   a. Numerator: The number of members who answered "Usually" or "Always"

7. **Question 4:** How easy is it for you to understand the approval or denial letter for the authorization decisions which you received from Santa Clara Family Health Plan?
   a. Numerator: The number of members who answered "Usually" or "Always"

II. Results:

Member Survey Results for Satisfaction with UM

SCFHP collects and tracks member satisfaction from relevant CAHPS survey responses regarding satisfaction with the UM process. The CAHPS survey questions used to measure satisfaction are listed in the table below.

a. Member Satisfaction Survey Results

Survey Question	MY 2018	Goal	Goal Met Y/N
Q1: Ease of getting needed care, tests or treatment	58%	90%	N
Q3: How often did patient get appointment as soon as needed	84%	90%	N
Q3: Ease of understanding approval or denial letters from authorization decisions	74%	90%	N

Member Complaints Related to UM Processes

The below grid describes the complaints captured with results for the July 2017 – June 2018.

b. Member UM Complaint Results

			2017						2018						
NCQA Category	**Type**	**Subtype**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Total**
Billing and Financial Issues	**Grievance Part C**	Org Determination /Reconsideration Process	2	1	0	0	2	1	0	2	3	3	1	2	17
	Grievance Part D	Coverage Determination /Reconsideration Process	0	0	0	0	0	0	0	0	2	1	1	2	6
Grand Total			**2**	**1**	**0**	**0**	**2**	**1**	**0**	**2**	**5**	**4**	**2**	**4**	**23**

Complaint Category	MY Jul 2017 – Jun 2018*	Goal	Goal Met Y/N
Org Determination /Reconsideration Process	2.26 per 1,000	< 3 per 1,000	Y
Coverage Determination /Reconsideration Process	0.80 per 1,000	< 3 per 1,000	Y

**Measure is calculated as complaints per 1,000. Calculation:*
7,532 (Total CMC Membership)/1,000 = 7.532
# of complaints/7.532 = Complaints per 1,000

III. Analysis:

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve member satisfaction with the UM process. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause.

a. Quantitative analysis

Since this was the first measurement year for the member satisfaction survey and the complaints analysis, SCFHP has only one measurement year of data. The survey and analysis will be re-run in the next measurement year to measure performance improvement. The UM complaints per 1,000 rate fell within SCFHP's performance goal of 3 complaints per 1,000. Because our goal was met, an action plan will not be developed. The member satisfaction survey results did not meet our performance expectation for any of the three questions asked. One limitation of this survey, which will be improved in the next measurement year, is to expand the sample size and complete more outreach attempts to increase the validity and quantity of responses. The performance goal for all questions was 90%. The question that had the lowest satisfaction rate was regarding the ease of getting needed care, tests or treatment. Only 58% of the members that responded that it was always easy to get the care needed. A sub-question was then asked to members that felt it was not easy to get the care needed. 4 members responded that it was because there were no

available appointment times. 2 members responded that they did not have transportation to the appointment. The second lowest satisfaction rate was regarding the ease of understanding approval or denial letters for authorization decisions. Only 74% of members found that it was usually or always easy to understand approval or denial reasons. The highest scoring question was regarding the rate at which patients were able to get an appointment as soon as needed. 85% of members answered that they were usually or always to get an appointment when needed.

b. Qualitative analysis

The results of the member satisfaction analysis were presented at the Quality Improvement Committee on August 8, 2018. This committee includes internal staff representing Quality Improvement, Provider Network Management, and Health Services staff. Additionally, external committee physicians were present. Multiple barriers and root causes were discussed for the areas in which SCFHP did not meet the performance goal.

1. Members did not feel it was easy to get the care, tests or treatment needed
    1. Root causes:
        a. Many PCPs and specialists have access issues and appointment scheduling is not flexible
        b. Members do not know how to get access to transportation needed to arrive at the appointment
2. Members felt that they did not get an appointment as soon as needed
    1. Root causes:
        a. Many PCPs and specialists have access issues and appointment scheduling is not flexible
        b. Members may not understand what constitutes an urgent appointment
3. Members do not easily understand the reason for an approval or a denial, which is distributed in the determination letter
    1. SCFHP's denial and approval language do not correspond to members' literacy levels

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Members do not understand SCFHP's transportation benefits	Educate members on how to obtain transportation assistance for appointments	Member transportation needs are assessed within the required Health Risk assessment. Identified needs will be addressed by Case management staff	Y	11/1/2018

		during the members individual care planning process		
PCP and Specialist access issues	SCFHP will evaluate and monitor all access and availability complaints	?? Members will be educated through periodic newsletters to call SCFHP to inform of any provider access issues	N	By end of Q2 2019
Members may not understand when an urgent appointment is needed	Educate members' on the difference between urgent and routine appointments and when both are needed	Train case management staff to educate members on SCFHP's Nurse Advice Line (NAL) when members report lack of access to transportation	Y	11/01/2018
SCFHP's approval and denial letter language is not sufficiently member friendly	Improve denial and approval language	Update denial language template grid to be more member-friendly Conduct staff trainings on the importance of and guidelines for using member friendly language in all member correspondence	Y	10/01/2018

Member and Practitioner Satisfaction with the UM Process Reporting

Approval History:

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan Assessment of Physician Directory Accuracy: 2018 Analysis

Quality Improvement Committee : October 10, 2018

Overview

Santa Clara Family Health Plan (SCFHP) aims to provide its members and prospective members with the most accurate and up-to-date information possible in our physician directories. Provider directories function as a vehicle for our members to connect with our providers and access the healthcare delivery system. By performing routine outreach to our providers to keep their information up to date, we maintain our dedication to our members and their health. SCFHP monitors activities directed at improving the accuracy of the physician directory, as necessary, to improve the outcomes of the monitored activities.

Annually, SCFHP, reviews data associated with physician directory accuracy. Through analysis, SCFHP Plan identifies opportunities for improvement. During 2018, the following measures were monitored for aspects of physician directory accuracy.

Measure 1: Accuracy of office locations

Measure 2: Accuracy of phone numbers

Measure 3: Accuracy of hospital affiliations

Measure 4: Accuracy of accepting new patients

Measure 5: Awareness of physician office staff of physician's participation in the organization's network

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve physician directory accuracy. The quantitative analysis process includes a review of results and compares those results against an established performance goal. In future measurement years, trends will be assessed. The qualitative analysis process utilizes the data to identify potential root cause and barriers applicable to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause. SCFHP will track and trend each measure over a 3-year period, beginning with Baseline/Measurement Year 1:

1. Baseline/Measurement Year1 2018
    a. Quantitative analysis
    b. Qualitative analysis to include barriers, opportunities and recommended interventions to meet performance goals in measurement year 1.
    c. Implementation of interventions for measurement year 1.

I. Methodology

SCFHP measures the rate of physician directory accuracy through a provider outreach campaign to confirm provider directory accuracy. The data informatics team pulls the latest data used to produce the provider directory. From the data extract, a statistically significant sample is randomly selected. The following parameters were used to calculate the sample size:

Parameter	Value
Margin of Error	10%
Confidence Level	90%
Population Size	590
Recommended Sample Size	61

Two provider relations staff made calls during the months of April through July using the attestation form attached in Exhibit A. An analyst performed a randomized selection of PCP and SCP office and provided the listing to the Manager, Provider Database and Reporting, grouping the list by location so the caller could make one call to each office. For practitioners with multiple offices, each location was called. When there were multi-specialty offices, each practitioner was counted as one. Staff were instructed to talk to the office manager, who would have the most accurate information on whether the practitioner was taking new patients and which products were accepted by the office for payment. Based on the response from the provider's office, the provider relations staff records whether the information in the directory is accurate. If the information is not accurate, the representative records the accurate information into a spreadsheet to be updated into the provider database and subsequently updated into the directory.

Measure 1: Accuracy of office locations

Numerator: Number of respondents with correct address listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of office locations listed in the directory

Measure 2: Accuracy of phone numbers

Numerator: Number of respondents with correct phone numbers listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of phone numbers listed in the directory

Measure 3: Accuracy of Hospital Affiliations

Numerator: Number of respondents with correct hospital affiliation listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of hospital affiliations listed in the directory

Measure 4: Accuracy of Accepting New Patients

Numerator: Number of respondents with correct 'Accepting New Patients' designation
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of 'Accepting New Patients' designation in the directory

Measure 5: Awareness of physician office staff of physician's participation in the organization's network

Numerator: Number of respondents with awareness of participation in organization's network
Denominator: Total number of physician offices which responded
Goal: 100% awareness of physician office staff participating in the organization's network

II. Analysis

a. Results

Table #1. Measures 1-5 – Provider Directory Accuracy

	Accuracy of Office Locations	Accuracy of Phone Numbers	Accuracy of Hospital Affiliations	Accuracy of Accepting New Patients	Awareness of Office Staff of Physicians Participation in the Organization's Network
Number of Respondents with Accurate Entries	58	56	58	59	47
Total Physician Responses	61	61	61	61	61
Accuracy Percentage (%)	97%	93%	97%	98%	79%
Goal	100%	100%	100%	100%	100%
Goal Met (Y/N)	N	N	N	N	N

b. Quantitative analysis

The performance goal set in Measurement Year 1 (MY1), 2018 of 100% was not met. The rate of accuracy of hospital affiliations and office locations was 97% which is three percentage points below the performance goal. The accuracy of accepting new patients was the highest, which was at 98%. The accuracy of the phone numbers was 93% and lowest accuracy level was for participation in the organization's network at 79%.

c. Qualitative analysis

In an effort to meet the performance goal for 2019, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of all accuracy measures. We focused on the two lowest performing measures, where there was the most opportunity for improvement. The analysis was completed by internal staff comprised of the PNM data analyst, Manager, Provider Database and Reporting, and the Manager, Process Improvement.

2018 Barrier and Opportunity Analysis Table 2.0

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Delays in receiving changes from providers through their delegates	Provide additional avenues for submitting provider changes	Ensure that timeliness of provider changes is discussed at quarterly joint operation committees Continue to build out electronic attestation solutions available via the provider portal	Y	9/26/18
Rapidly changing provider data due to frequent staff changes	Inform providers of importance of submitting timely information	Ensure that timeliness of provider changes is part of provider orientation onboarding Continue to build out electronic attestation solutions available via the provider portal	Y	9/26/18

III. Reporting

Committee Approval Table 3.0

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	10/10/2018	

Exhibit A

SAMPLE PROVIDER ATTESTATION FORM

Santa Clara Family Health Plan
The Spirit of Care

Provider Directory Attestation

Date: xx/xx/xxxx

Santa Clara Family Health Plan is required to validate provider demographics every quarter in accordance with all our regulatory requirements. **Please review and complete the attestation below before xx/xx/xxxx and fax back to 408-376-3537.** If there are any changes, please write the updates below in the "Changes Needed" column, then sign and date at the bottom. If there are no changes, check the "No Change" box for each item. If the field has nothing listed in it, SCFHP does not have any data for this field and is required to; therefore, please add that to the Changes Needed / Added column.

	No Change	Changes Needed / Added
Legal Name & Title (as listed on License)	☐	
Other Name(s) (recognized by patients)	☐	
Practitioner NPI #	☐	
CA State License #	☐	
CA State License Expiration Date	☐	
DEA #	☐	
DEA Expiration Date	☐	
Practitioner Gender	☐	
Practitioner Ethnicity	☐	
Languages Spoken by Provider	☐	
Practitioner Hospital Affiliations and effective date of affiliation	☐	
Practitioner Specialty (Include additional specialties as applicable)	☐	

Board Certified? (If yes, please list specialty and certifying board)	☐	
Board Certification Initial Certification and Expiration Date(s)	☐	
Academic Degree Description	☐	
Highest Level of Education attained	☐	
Name and NPI of Supervising Physician (if a Midlevel)	☐	
Has Practitioner Completed Cultural Competency Training? (List date and Name of training)	☐	

Additional Trainings/Certifications?

QASP Level	☐	**Homelessness**	☐
Substance Abuse	☐	**Deafness or hard of hearing**	☐
Trauma informed	☐	**Other**	☐
Physical Disabilities	☐	***Specify;***	
Chronic Illness	☐		
HIV/AIDS	☐		
Serious mental illness	☐		

Medical Group Name/ Practice Name	☐	
Practice Location Address	☐	
Practice City, State Zip	☐	
Practice Phone	☐	
After Hours Phone Number	☐	
Practice Fax	☐	
Practice Fax for Authorizations	☐	
Secure Email (for patient communication only)	☐	
Email (for Health Plan communication)	☐	

Website URL	☐	
Tax ID # (used for billing)	☐	
Organizational/Billing NPI	☐	
Languages Spoken by Office Staff	☐	
Does Practitioner participate in telehealth?	☐	

Proximity to Public Transport (Less than 1 Block, 1 block or more	☐	

Hours at this location:

Days		Hours
Monday	☐	
Tuesday	☐	
Wednesday	☐	
Thursday	☐	
Friday	☐	
Saturday	☐	
Sunday	☐	

Are you participating as a PCP at this location?	☐	
FTE Equivalent at this Location		
Age Limits (youngest/oldest)	☐	
Gender Limits	☐	
Does Practitioner see Children?	☐	
Accepting New Patients at this location	☐	

Is provider enrolled in Medi-Cal? ☐ Yes ☐ No

Please use the space below to provide additional information regarding this practitioner.

Attestation Completed By:

Print Name: _____

Print Title: _____

Signature: _____

Date Completed: _____

Santa Clara Family Health Plan Member Experience, Including Behavioral Health: 2017 Analysis

Quality Improvement Committee: October 10, 2018

Authors: Mariana Ulloa, QI Project Manager; Darryl Breakbill, G&A operations Manager; Tiffany Franke, Social Work Case Manager Lead

I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from their members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaint and appeal activity may impact overall member satisfaction, SCFHP tracks and trends this activity, in addition to identifying barriers and implementing interventions. The behavioral health member satisfaction survey is another means to monitor the member experience. Overall, the member experience approach is designed through the analysis to help meet the specific needs of SCFHP members. SCFHP reviews data associated with Complaint 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 CY2017, 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 information systems QNXT and the Grievance and Appeals database to 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 2017 (January 1-December 31). The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to the 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

Member Complaints/Grievances and Appeal Categories

Table 1. CMS Member Complaints/Grievances Categories

Complaint / Grievance Category	1Q-2017	2Q-2017	3Q-2017	4Q-2017	(Jan. 1-Dec. 31, 2017) Total Grievances	Grievances / per 1,000 members 7,482 = 2017 average
Quality of Care	4	3	11	7	25	3.341
Access	4	3	5	5	17	2.272
Attitude/Service	31	23	26	48	128	17.108
Billing/Financial	24	5	88	74	191	25.528
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	63	34	130	134	361	48.249

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 includes all member complaints/grievances and is not a sample. In 2017, the complaints/grievances analysis showed a significant increase in the second half of the year in two categories: Attitude/Service and Billing/Financial. Attitude and Service increased by 55% with a result of 31 in the first quarter and a result of 48 in the fourth quarter. The Billing and Financial category had the largest increase and more than tripled over the course of the year with a result of 24 in the first quarter and a result of 88 and 74 in the third and fourth quarters respectively. In addition, Attitude/Service had a result of 17 per 1000 members for the year and Billing and Financial had a result of 25.5 per 1000 members. The remaining three categories, Quality of Care, Access, and Quality of Practitioner Site had significantly lower numbers and remained flat throughout the year.

Table 2. CMS Member Appeal Categories

Appeals Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Appeals	Appeals / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	43	37	56	143	279	37.289
Quality of Practitioner Office Site	0	0	0	0	0	0.000

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 which include pre-service authorization appeals and post-service claims appeals filed by members or member representatives. The data as shown in Table 2 includes all member appeals and is not a sample. In 2017, the appeals analysis showed a significant increase in the second half of the year in the following category: Billing/Financial. The Billing and Financial category more than tripled over the course of the year with a result of 43 in the first quarter and a result of 143 in the fourth quarter. In addition, the results indicate 37 appeals per 1000 members. The remaining four categories, Quality of Care, Access, Attitude/Service and Quality of Practitioner Site had results of zero appeals.

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

SCFHP convened a Grievance and Appeals workgroup on October 3, 2018 that included interdepartmental representatives from the following departments Behavioral Health Case Management, Grievance and Appeals Operations, Compliance, Quality Improvement, Customer Service, and the Executive Team to conduct and review a root cause analysis of the increased number of Attitude/Service and Billing/Financial complaints/grievances and the Billing/Financial appeals.

In analyzing the Attitude/Service complaints/grievances the following root causes were determined for the increase:

- There was an increase in the amount of transportation grievances from Yellow Cab. These complaints were related to not being picked up on time. In addition, because

the Transportation Services Program expanded in 2017, there was a corresponding increase in opportunities for related complaints and grievances.

- There were no other identified trends in the grievances received during Q4 2017. The concerns varied from the delay in processing authorizations to the attitude of Customer Service Representatives with SCFHP.

In analyzing the Billing/Financial complaints/grievances the following root causes were determined for the Q3 2017 increase:

- Quest Diagnostics inappropriately balance billed SCFHP members for lab services. This was due to a misunderstanding of the Cal MediConnect line of business in that both the primary and secondary payment comes from SCFHP. This was since corrected by working with the Provider Network Management and Customer Service Departments to relay the appropriate billing practices to Quest Diagnostic. This resulted in a reduction of those cases in Q4 2017.

In analyzing the Billing and Financial appeals the following root causes were determined for the increase:

- The Grievance & Appeals Department received a new body of work related to post-service claims denials. Effective 9/1/2017, claims reconsiderations transitioned from the Provider Dispute Resolution team to G&A. Additionally, Cal MediConnect members started to receive Integrated Denial Notices related to claims denials. This gave members the right to file an appeal on denied payment.

Behavioral Health Member Complaints/Grievances and Appeals

Table 3. Behavioral Health CMS Member Complaint/Grievance Categories

Behavioral Health Complaint / Grievance Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Grievances	BH Grievances / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	1	0	0	1	0.134
Attitude/Service	1	0	2	4	7	0.936
Billing/Financial	2	0	5	0	7	0.936
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	3	1	7	4	15	2.005

Quantitative Analysis: Behavioral Health Member Complaints/Grievances

SCFHP tracks and trends all member behavioral health 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 member and member representative initiated complaints from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those members were reviewed to verify whether or not a complaint was filed. The data as shown in Table 3 includes all member behavioral health grievances/complaints and is not a sample. In 2017, the complaints/grievances analysis showed a result of zero complaints/grievances in the following categories: Quality of Care, and Quality of Practitioner Site. The remaining three categories: Access, Attitude/Service and Billing/Financial had significantly low numbers and remained flat throughout the year.

Table 4. Behavioral Health CMS Member Appeals Categories

Behavioral Health Appeals Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Appeals	B/H Appeals / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	0	0	0	3	3	0.401
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	0	0	0	3	3	0.401

Quantitative Analysis: Behavioral Health Member Appeals

SCFHP tracks and trends behavioral health 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 member and member representative initiated appeals from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those members were reviewed to verify whether or not an appeal was filed. The data as shown in Table 4 includes all member behavioral health appeals and is not a sample. In 2017, the behavioral health appeals analysis showed a result of zero for the following categories: Quality of

Care, Access, Attitude/Service and Quality of Practitioner Site. The Billing and Financial category had significantly low numbers throughout the year.

2. Behavioral Health CMS Member Satisfaction Survey

Methodology:
SCFHP conducts an annual telephone, member satisfaction survey for all CalMediconnect members who receive behavioral health services. SCFHP identified all members that received behavioral health services between 12/01/2017 and 12/31/2017. The surveyor asked the member a total of 20 questions and recorded the answers in an on-line survey tool. A total of 230 members were identified and SCFHP staff attempted to reach each member via telephone to conduct the member satisfaction survey.

Quantitative Analysis: Behavioral Health Member Satisfaction Survey Results

The first 6 questions of the survey capture demographic information such as line of business, gender, age, race/ethnicity, and level of education **(Please See Figure 1).** Highlights and summarization of the demographic questions include:

- 57 or 25% of the 230 members identified actually completed the survey.
- The majority of non-responders did not participate because they never answered the phone.
- 24, or 10% of the total members refused to participate.
- The majority of the respondents were female, over 55, White or Hispanic with an education above the high school level.

***Figure 1*. Behavioral Health: Member Satisfaction Survey Results (Questions 1-6)**

Sample Size	230
Completed Survey	57
Did not complete survey	173
% complete	25%

Gender:	
Male	22
Female	35

Age:	
18-34	0
35-54	11
55+	46

Race/Ethnicity:	
American Indian/Native Alaskan	0
Asian	6
Black/African American	7
Hispanic/Latino	14
Native Hawaiian/Pacific Islander	1
White/Caucasian	26
I prefer not to answer	3

Level of Education:	
Less than High School	6
High School/GED	19
Post-Secondary Education	14
College Graduate	18

Reason for not completing:	
Deceased	14
Would not answer phone	93
No working phone #	19
Member/PR Refused	24
Member/PR Incapable	11
Member Termed/Disenrolled	11
Other	1
Total	**173**

Questions 7-20 of the survey are related to the quality of care and are as follows:

Q7) How often did you get an appointment as soon as you wanted?
Q8) How often did you see someone as you wanted when you needed help right away?
Q9) How often did you get the help or advice you needed over the phone?
Q10) How often did your counselor show respect for what you had to say?
Q11) How often did your counselor explain things in a way that you could understand? -
Q12) How often did your counselor listen carefully?
Q13) How often did your counselor spend any time with you? -
Q14) How often did you feel comfortable raising issues or concerns? -
Q15) Compared to 12 months ago, how would you rate your ability to deal with daily problems? -
Q16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations? -
Q17) Compared to 12 months ago, how would you rate your ability to Accomplish the things you wanted to do?
Q18) Compared to 12 months ago, how would you rate your ability to deal with social situations? -

Q19) What effect has your counseling had on your symptoms and problems?
Q20) What effect has your counseling had on the quality of your life?

Highlights and summarization of the quality of care questions include:

For Questions 7-14 included in **Table 1** below:

- Question 9, "How often did you get the help or advice you needed over the phone?", had a significant number of negative responses with 19 members (33%) stating "never" as their answer.

Table 1	**Never**	**Sometimes**	**Usually**	**Always**	**Total**
7) How often did you get an appointment as soon as you wanted?	3	6	17	31	57
8) How often did you see someone as you wanted when you needed help right away?	3	12	13	29	57
9) How often did you get the help or advice you needed over the phone?	19	12	9	17	57
10) How often did your counselor show respect for what you had to say?	2	5	7	43	57
11) How often did your counselor explain things in a way that you could understand?	3	3	11	40	57
12) How often did your counselor listen carefully?	0	6	9	42	57
13) How often did your counselor spend any time with you?	2	8	11	36	57
14) How often did you feel comfortable raising issues or concerns?	0	7	6	44	57

For Questions 15-18 included in **Table 2** below:

- Question 15, "Compared to 12 months ago, how would you rate your ability to deal with daily problems?", had the lowest result with 12 members stating their answer as "much worse" or "a little worse".

Table 2						
	Much Worse	**A Little Worse**	**About the Same**	**A Little Better**	**Much Better**	**Total**
15) Compared to 12 months ago, how would you rate your ability to deal with daily problems?	4	8	8	15	22	57
16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations?	1	3	16	15	22	57
17) Compared to 12 month ago, how would you rate your ability to accomplish the things you wanted to do?	2	6	12	23	14	57
18) Compared to 12 months ago, how would you rate your ability to deal with social situations?	3	2	17	16	19	57

For Questions 19 and 20 included in **Table 3** below:

- Question 19, "What effect has your counseling had on your symptoms and problems?", and Question 20, "What effect has your counseling had on the quality of your life?", most members answered positively with either "a little" or "much better" as their response.

Table 3					
	A Little or Very Harmful	**Not Helpful or Harmful**	**A Little Helpful**	**Very Helpful**	**Total**
19) What effect has your counseling had on your symptoms and problems?	1	2	24	30	57
20) What effect has your counseling had on the quality of your life?	0	5	18	34	57

SCFHP will use 2017 data as a baseline result. 2018 data will be compared to 2017 to identify trends and areas that need improvement.

3. Reporting

Committee Approval

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Assessment of Member Understanding of Policies & Procedures: Call Code Analysis

Date Analysis Conducted: 4/17/2018

By: Devdhar Patel, Communications Systems & Analytics Manager and Chelsea Byom, Manager, Marketing & Communications

Process:

Call report was generated from an internal call reporting system for calls received between January 1, 2018 and April 5, 2018.

CMC Call Reports contained information by the following list of fields:

Call_Date1
Create_User_ID1
Caller_ID
Type_Issue1
LOB
Member_Full_Name
Member_HPID
dob
Population_Type
Enroll_Coverage_Rate_Code
Provider_Name
Network_Name
PCP_Network
Provider_ID
Status
ClosedDate
TAT
Resolution
Resolnotes
CallNotes
Assigned_To

The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to help focus the analysis.

The resulting list contained the following types of issues and their descriptions:

Type_Issue1	Description
Access to Care	GRV
Administrative	Materials Request
Inquiry Auth	INQ Auth Member Call Medical
Inquiry Auth	INQ Auth Member Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Medical
Inquiry Benefit	INQ Benefit Case Management Support

Type_Issue1	Description
Inquiry Benefit	INQ Benefit Dental Service
Inquiry Benefit	INQ Benefit DME, Enteral and Parenteral Service
Inquiry Benefit	INQ Benefit Mental Health Service
Inquiry Benefit	INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP
Inquiry Benefit	INQ Benefit Other (need to specify)
Inquiry Benefit	INQ Benefit Pharmacy
Inquiry Benefit	INQ Benefit Specialist
Inquiry Benefit	INQ Benefit Vision Service
Inquiry Billing	INQ Billing Statement
Inquiry Claim	INQ Claim Status
Inquiry General	INQ General Assistance with obtaining appointment
Inquiry General	INQ General HRA
Inquiry General	INQ General Medi
Inquiry General	INQ General Provider/Network Information Inquiry
Quality of Serv	GRV
Referral Grv	GRV
Transportation	Member Communications Notice

Next, the analysis focused on the members that called within 90 days of their enrollment date with the CMC plan.

Member's health plan ID (HPID) was reported in the call report. HPID was used to source member's enrollment date from the internal enrollment data tables. Member's enrollment date was measured against the call date to identify if the member called within 90 days of his or her enrollment. The following pivot table outlines the frequency of calls members made by the type of issue (call codes) within 90 days of member's enrollment.

Row Labels	Count of Member_HPID	Count of Member_HPID2
⊞ Access to Care	2	0.31%
⊞ Administrative	42	6.47%
⊞ Inquiry Auth	17	2.62%
⊟ Inquiry Benefit	360	55.47%
INQ Benefit Case Management Support	42	6.47%
INQ Benefit Dental Service	28	4.31%
INQ Benefit DME, Enteral and Parenteral Service	27	4.16%
INQ Benefit Mental Health Service	16	2.47%
INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP	7	1.08%
INQ Benefit Other (need to specify)	101	15.56%
INQ Benefit Pharmacy	79	12.17%
INQ Benefit Specialist	36	5.55%
INQ Benefit Vision Service	24	3.70%
⊞ Inquiry Billing	8	1.23%
⊞ Inquiry Claim	13	2.00%
⊞ Inquiry General	144	22.19%
⊞ Quality of Serv	32	4.93%
⊞ Referral Grv	17	2.62%
⊞ Transportation	14	2.16%
Grand Total	649	100.00%

Individual call records were grouped and assessed by issue type and their descriptions. “Benefit Inquiry” was the highest occurrence in individual call records at 55.47%. Within calls of this type, the call descriptions were ranked by prevalence. The top four most frequent descriptions were:

1. Pharmacy	12.17%
2. Case Management	6.47%
3. Specialist	5.55%
4. Dental	4.31%

A sample of call notes were reviewed within these top four categories to identify noticeable trends and opportunities for improvement. Themes identified in the call notes are summarized in the table below.

Samples of Call Types:

Pharmacy	MedImpact claim reversal
	Confusion over medication changes
Case Management	Insurance changed, affecting coverage and benefits
	Help filling out HRA form
Specialist	Finding specialist according to member’s specific needs
	Inquiry on member’s share of cost
Dental	Dental benefit is provided by Denti-Cal through Medi-Cal FFS; SCFHP does not manage dental benefit

In summary, calls related to pharmacy, case management, and specialists were diverse and specific to each member. In many cases, the appropriate course of action for the member to

take is to call the plan to resolve a specific issue. The Plan determined that it would be difficult to address these areas in a broad and cost efficient manner that would be relevant to all membership. However, the Plan identified “INQ Benefit Dental Service” as an actionable opportunity to improve member understanding because the majority of the call notes indicated members were asking the same, specific questions about how dental services are covered and how to find a dentist. Member education via a mass communication vehicle would be an effective way to improve new member understanding of this benefit.

Conclusions: Volume of call records specific to issue type “Inquiry Benefit” and description “INQ Benefit Dental Services” identified opportunity to improve communication to new members about their dental benefits. New members were unaware that their dental benefits are provided through Denti-Cal. They were unsure how to find a provider. Content was subsequently developed for Summer 2018 Cal MediConnect member newsletter to communicate this information.

Santa Clara Family Health Plan
Provider Appointment Availability
Non-Compliant Provider Resurvey Results
MY2017

Prepared by: Carmen Switzer, Provider Network Access Manager
For review by the Quality Improvement Committee
October 10, 2018

Santa Clara Family Health Plan™

INTRODUCTION

Santa Clara Family Health Plan ("SCFHP or "Plan") administers the Provider Availability Appointment Survey ("PAAS") on an annual basis. Per Plan policies, providers who show non-compliance are issued a corrective action plan ("CAP") letter. The CAP letter states that the provider is required to submit a corrective action plan, and that the Plan will repeat the survey within 60-days. This report includes the resurvey results for measurement year 2017.

METHODOLOGY

The Department of Managed Health Care ("DMHC") survey methodologies and tools were used to conduct the resurveys. SCFHP utilized a survey vendor, CSS, to administer the resurveys.

The resurvey results are reviewed by the Provider Network Access Manager, who will list the providers who show continued non-compliance on a provider outreach matrix. The provider outreach matrix is submitted to the provider relations team who will make contact with the providers and offer training/education on timely access standards. As instructed, the provider relations team documents all outreach efforts and completed training sessions within the matrix. Resurvey results are also reviewed in the Joint Operation Committee meetings with our delegated provider groups, and they are advised that a corrective action plan must be submitted to the Plan, and that access training will be required.

Note: To address survey results that state the provider is no longer in practice, non-respondents and/or telephone issues, the provider outreach matrix includes this information for follow-up by PNM staff to ensure our provider profiles are updated as required.

A. RESURVEY RESULTS - PROVIDER APPOINTMENT AVAILABILITY

Table I: ANCILLARY – Standard: Non-urgent appointment within 15-days

A. Individually Contracted Provider (N=2)

Provider Type	Provider	Compliant
Mammogram	Valley Radiology Medical Association	Y
Physical Therapy	San Jose Physical Therapy	Y

Table II A-C: PRIMARY CARE PROVIDER – Standard: Urgent appointment within 48-hours

A. Directly Contracted Providers (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	3	0	2	1	0	2
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	NA	NA	NA	NA	NA	NA
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	0	1	1	0	1

B. Palo Alto Medical Foundation (N=31)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	15	11	4	0	5	6
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	9	7	1	1	6	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	7	7	0	0	2	5

C. Physician Medical Group of San Jose (N=9)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	4	3	1	0	3	1
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	1	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	2	0	0	1	1

D. Premier Care of Northern California (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	2	2	0	0	2	0
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	1	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	NA	NA	NA	NA	NA	NA

Table III A-D: PRIMARY CARE PROVIDER – Standard: Non-urgent appointment within 10-days

A. Directly Contracted Providers (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	3	0	2	1	0	2
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	NA	NA	NA	NA	NA	NA
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	0	1	1	0	1

B. Palo Alto Medical Foundation (N=31)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	15	11	0	4	8	3
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	9	7	1	1	7	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	7	7	0	0	5	2

C. Physicians Medical Group of San Jose (N=9)

Provider Group	Total to Survey	Responded	Refused/ No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	4	3	1	0	2	2
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	2	0
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	2	0	0	2	0

D. Premier Care of Northern California (5)

Provider Group	Total to Survey	Responded	Refused/ No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	2	2	0	0	2	0
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	2	0
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	NA	NA	NA	NA	NA	NA

Table IV A-C: SPECIALITS – Standard: Urgent appointment within 96-hours

A. Directly Contracted Providers (N=38)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	9	3	5	1	1	8
Pediatric Cardiology	5	2	1	2	2	1
Endocrinology	14	2	11	1	1	13
Gastroenterology	6	1	4	1	0	5
Psychiatry	4	1	1	2	0	2

B. Palo Alto Medical Foundation (N=23)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	0	2	1	0	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	4	2	2	0	0	4
Gastroenterology	16	5	10	1	0	15
Psychiatry	NA	NA	NA	NA	NA	NA

C. Physician Medical Group of (N=13)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	2	1	0	1	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	3	2	0	1	2	0
Gastroenterology	7	5	1	1	2	4
Psychiatry	NA	NA	NA	NA	NA	NA

Table V A-C: SPECIALISTS – Standard: Non-urgent appointment within 15-days

A. Directly Contracted Providers (N=38)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	9	3	5	1	2	6
Pediatric Cardiology	5	2	1	2	0	3
Endocrinology	14	2	11	1	0	13
Gastroenterology	6	1	4	1	0	5
Psychiatry	4	1	1	2	0	2

B. Palo Alto Medical Foundation (N=23)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	0	2	1	0	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	4	2	2	0	1	3
Gastroenterology	16	5	10	1	1	14
Psychiatry	NA	NA	NA	NA	NA	NA

C. Physicians Medical Group of San Jose (N=13)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	3	1	0	3	1
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	3	3	0	1	3	0
Gastroenterology	7	5	1	1	4	2
Psychiatry	NA	NA	NA	NA	NA	NA

Quantitative Analysis:
In Table I A, the resurvey results showed that the Ancillary groups (Valley Radiology Medical Association and San Jose Physical Therapy) were found to be compliant with access standards to schedule an appointment within 15-days.

In Table II A-D, the primary care provider ("PCP") results for the urgent appointment within 48-hours showed that out of the 50 resurveyed, there were 38 that responded and the results showed that 23 were compliant, which indicates that 61% of providers who responded to the survey now meet the standard. In Table III A-D, the PCP results for the appointment within 10-days showed that out of the 38 that responded, 32 were compliant, which indicates that 84% of providers who responded to the resurvey now meet the standard.

In Table IV A-C, the specialist provider results for the urgent appointment within 96-hours showed that out of the 65 resurveyed, there were 22 that responded and the results showed that 8 were compliant, which indicates that only 36% of the providers who responded to the resurvey now meet the standard. In Table V A-C, the specialist provider results for the appointment within 15-days showed that out of 27 that responded, 12 were compliant, which indicates that only 44% of providers who responded to the resurvey now meet the standard.

Conclusion:
The findings showed some improvement in PCPs meeting the urgent appointment within 48-hours at 61%, and a marked improvement in meeting the appointment within 10-days at 84%, with an average improvement of 73%. Findings on specialists providing access to urgent appointments within 96-hours and appointments within 15-days only showed an average improvement of 40%. The Provider Network Access Manager has submitted the provider outreach matrix to the Provider Relations team to ensure that notification of continued non-compliance, timely access training and education is completed and documented.

A resurvey report (specific to the group) was presented at the Joint Operating Committee meetings for both Physicians Medical Group of San Jose and Premier Care of Northern California on September 13, 2018. To ensure SCFHP policies and procedures are met, both groups were advised to submit a CAP to SCFHP by September 28, 2018. The CAP will be reviewed and the group(s) will be notified if SCFHP accepts the proposed CAP, or if additional information is required. Both groups were also advised that SCFHP's provider relations team will make contact to schedule access training.

SCFHP maintains provider corrective action plans and access training sign-in sheets to document actions taken to improve patient access in accordance with regulatory requirements.

Santa Clara Family Health Plan™

Quality Improvement Committee

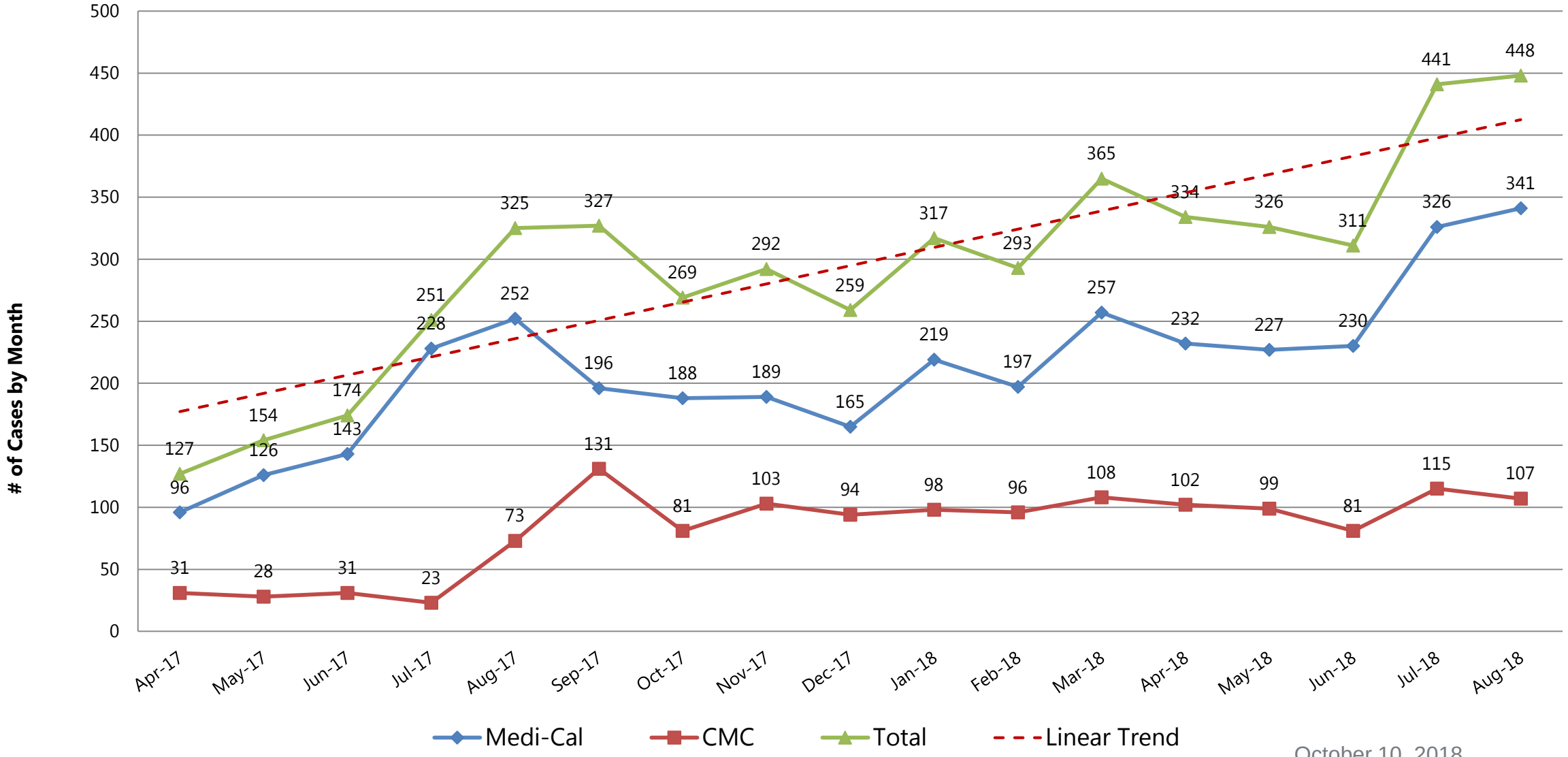
Grievance and Appeals Q2 2018 Reporting

Regulatory Reporting

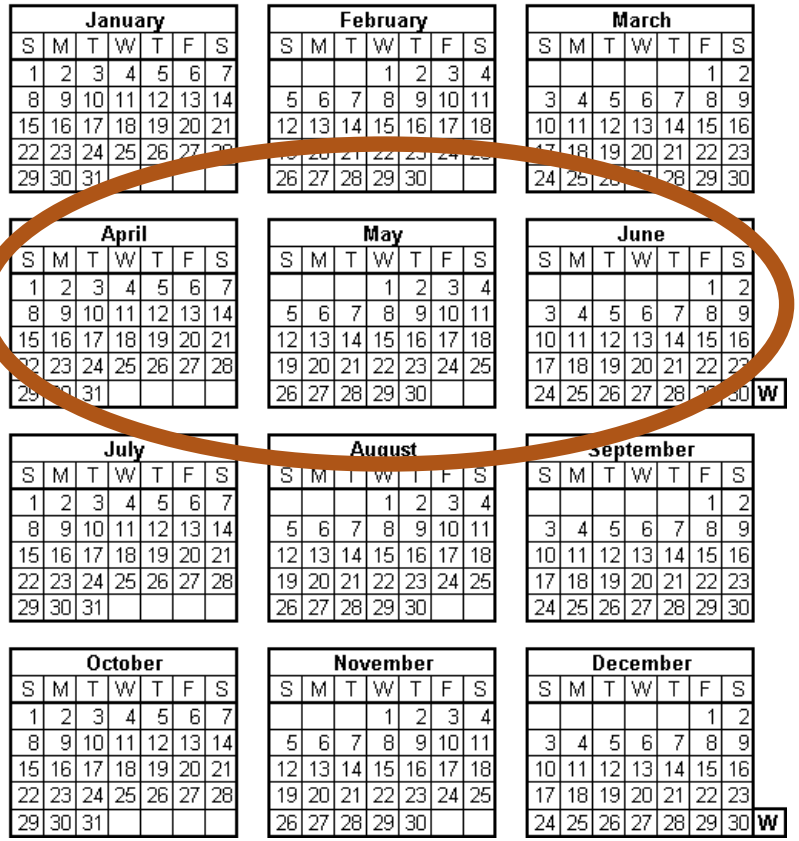
Grievance & Appeals Review Committee

1. Reporting
    a. Regulatory reports submitted
        I. Q2 CMC Complaints & Resolution
        II. Q2 CBAS Report
        III. Q2 DHCS BHT Report
        IV. Q2 DHCS Grievance Report
        V. Q 2 Mental Health Report
        VI. Q2 DMHC Grievance Report Bundle
        VII. Monthly NMT/NEMT Reports
    b. JOC Q2 reports:
        I. Premier Care of Northern California (PCNC)
        II. Physicians Medical Group (PMG)
        III. Valley Health Plan (VHP)

G&A Department Caseload



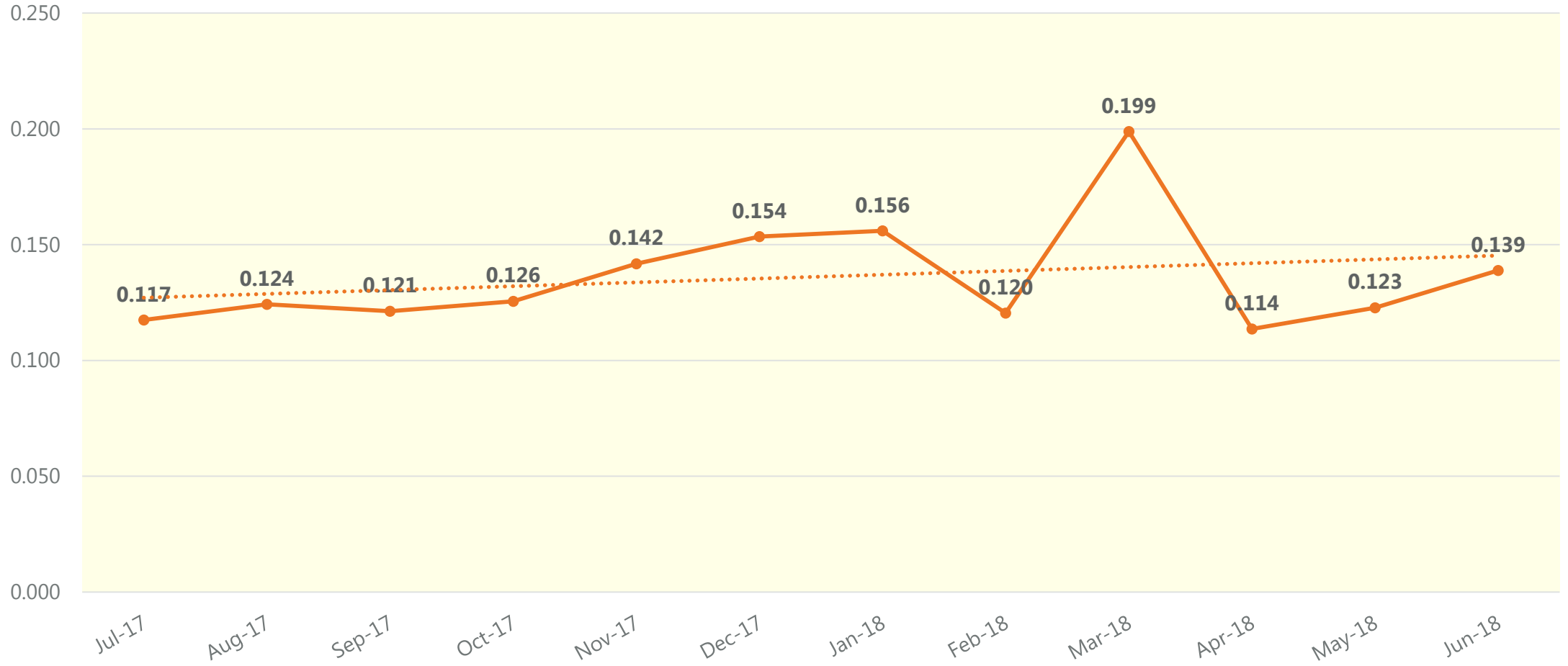
Medi-Cal & Healthy Kids



Q2 2018

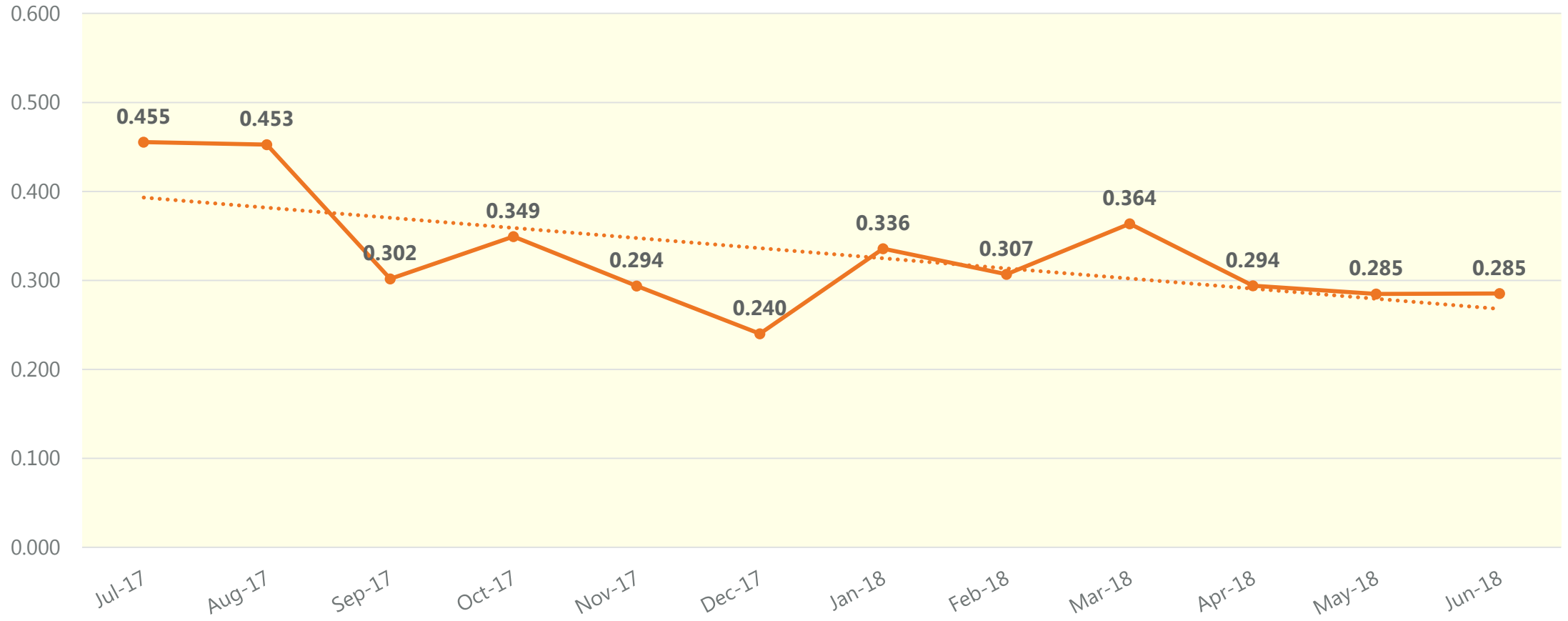
Q3 2017 – Q2 2018: Medi-Cal Appeals

Medical Appeals Per 1000 Members



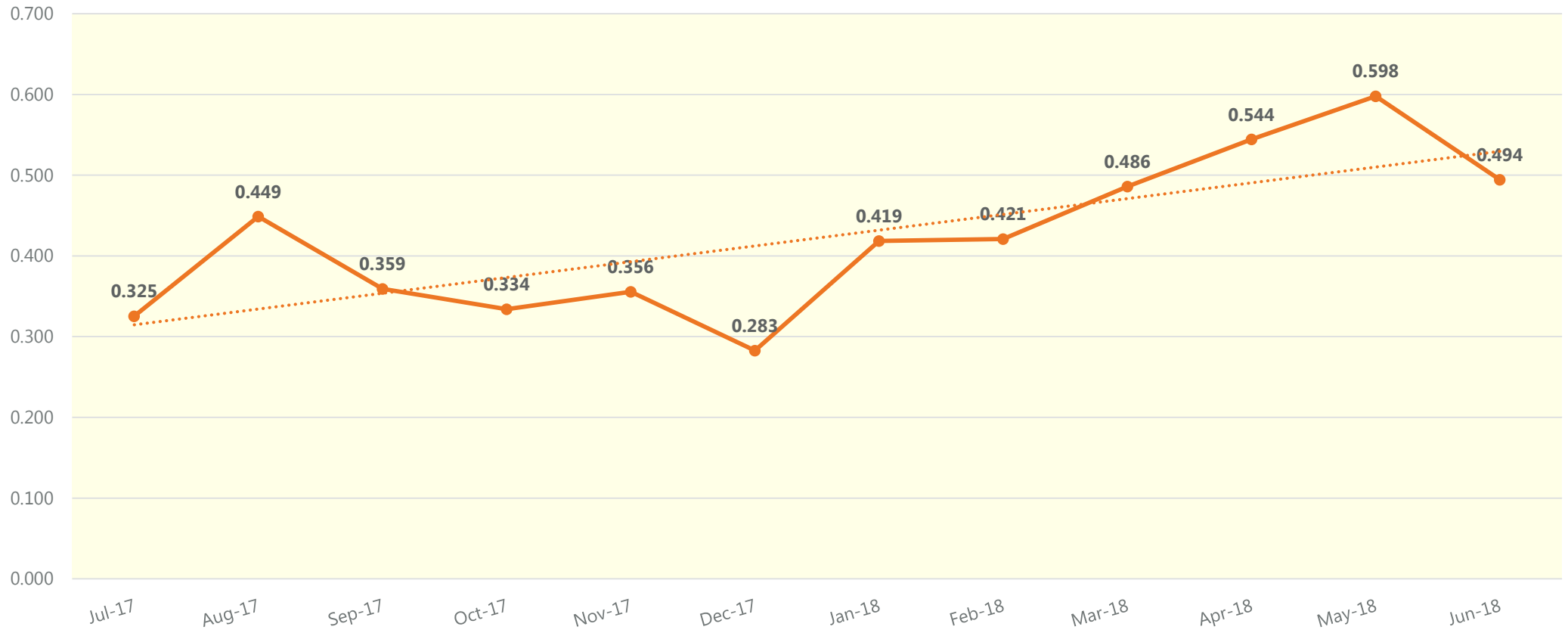
Q3 2017 – Q2 2018: Medi-Cal Appeals

Rx Appeals Per 1000 Members

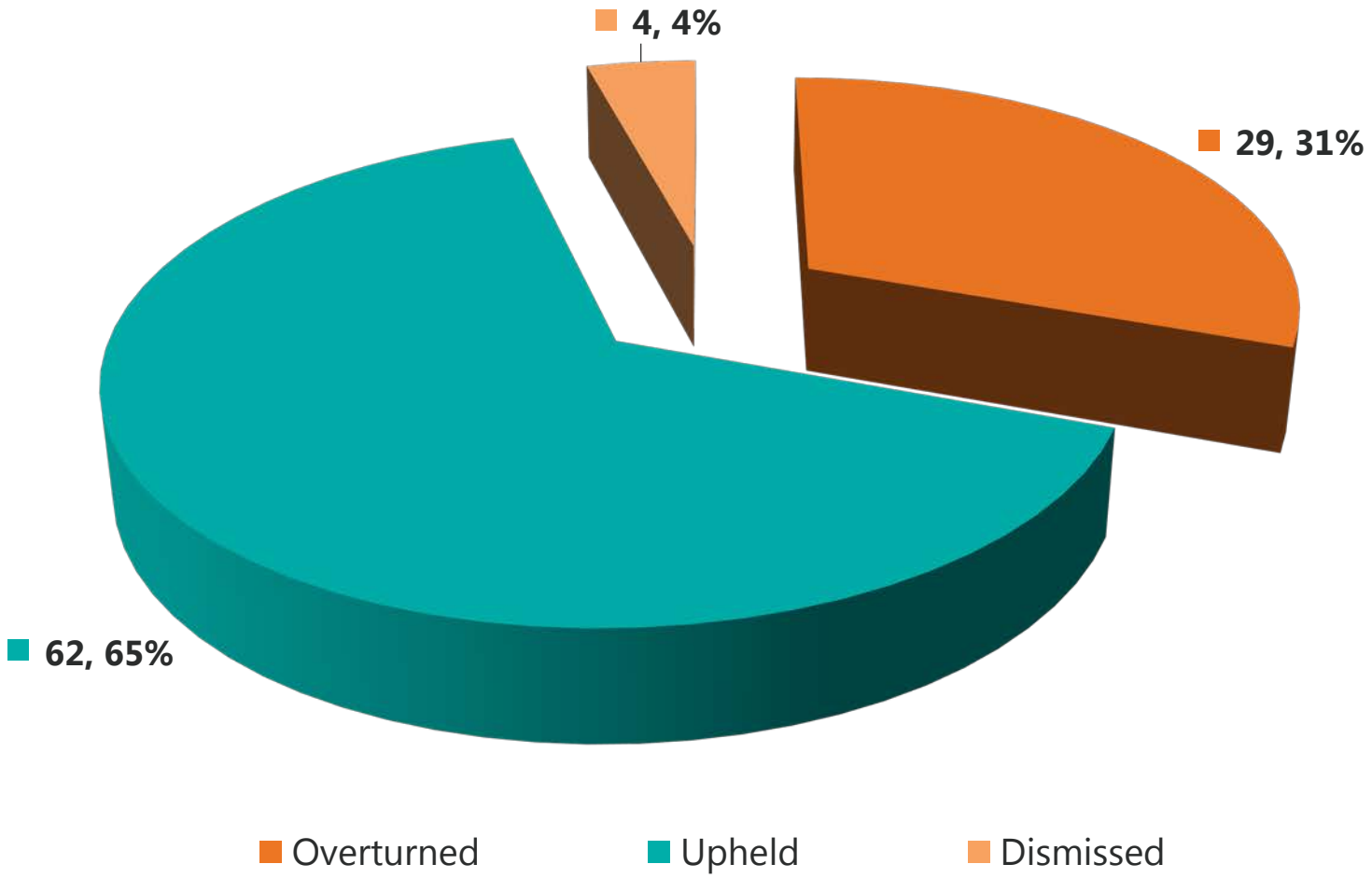


Q3 2017 – Q2 2018: Medi-Cal Grievances

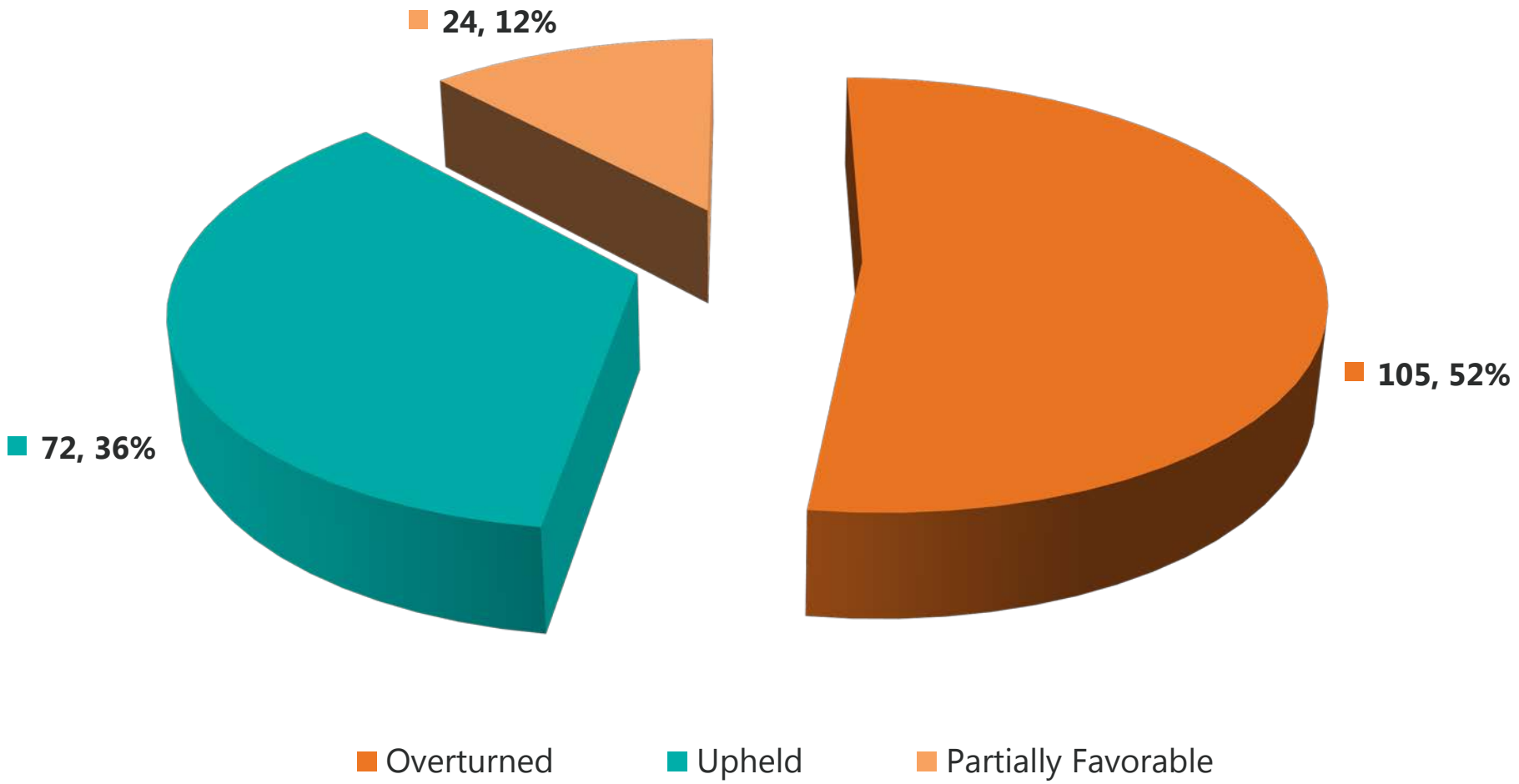
Grievances Per 1000 Members



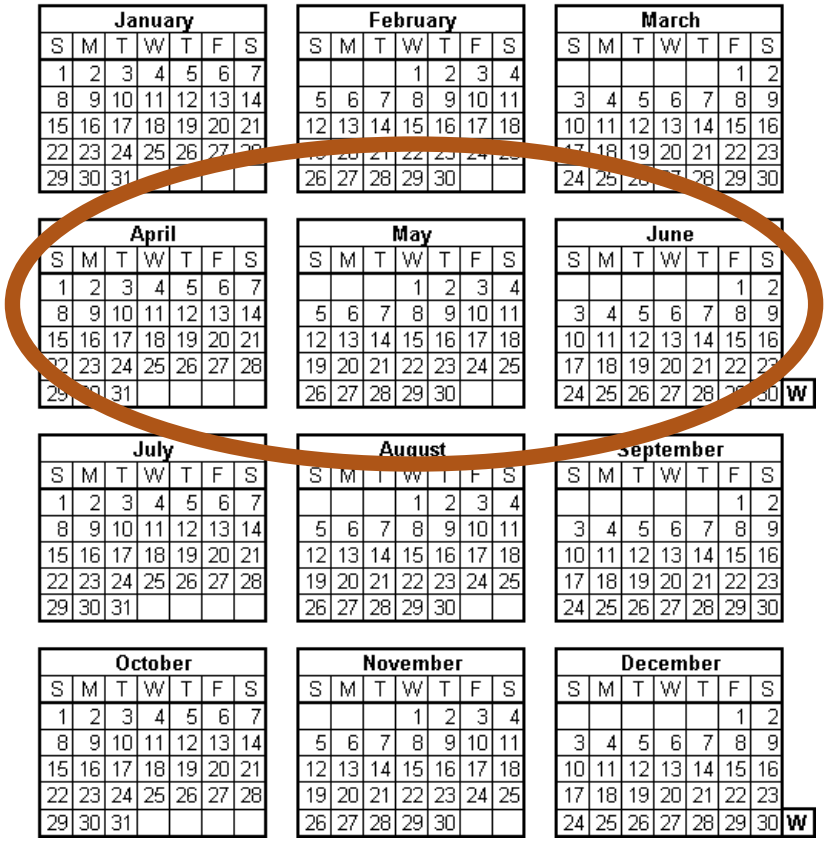
Q2 2018 Medical Appeals by Determinations



Q2 2018 Pharmacy Appeals by Determinations



Cal Medi-Connect



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
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		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

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				

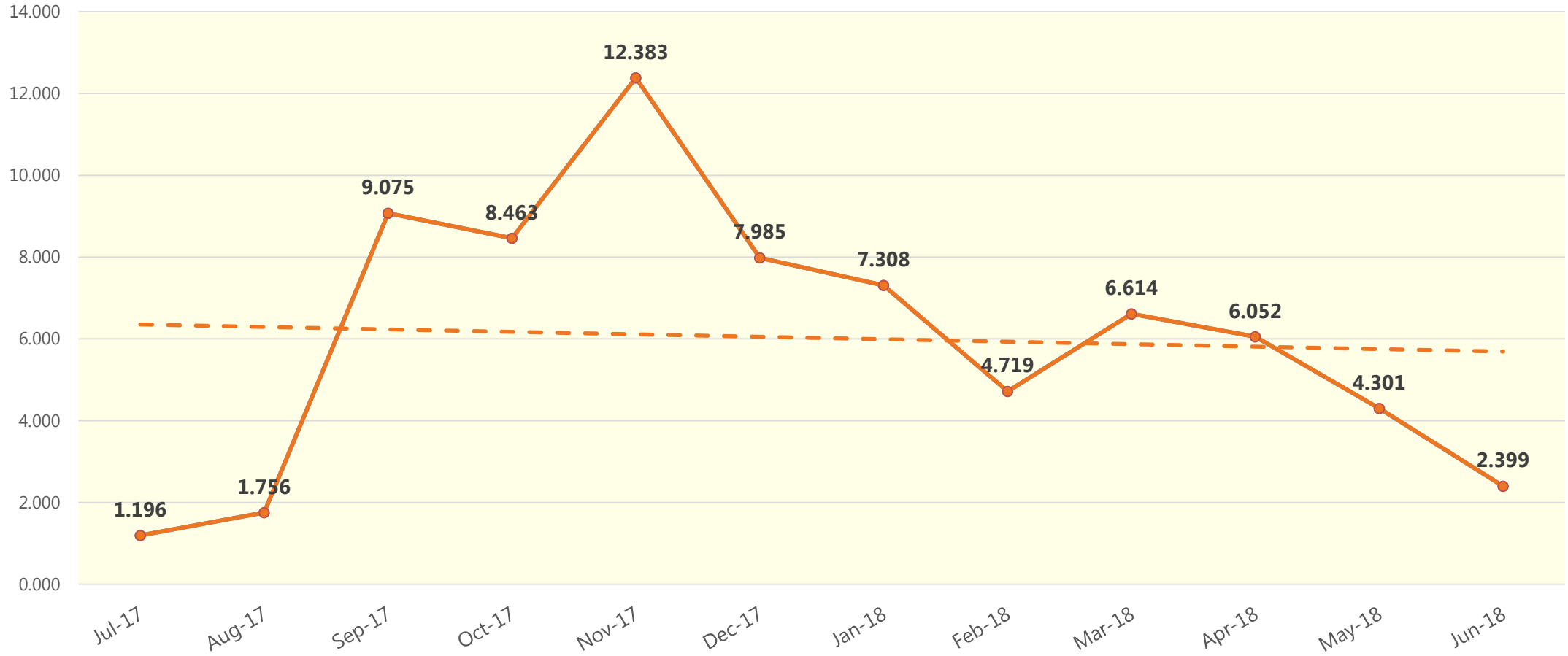
November						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

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

Q2 2018

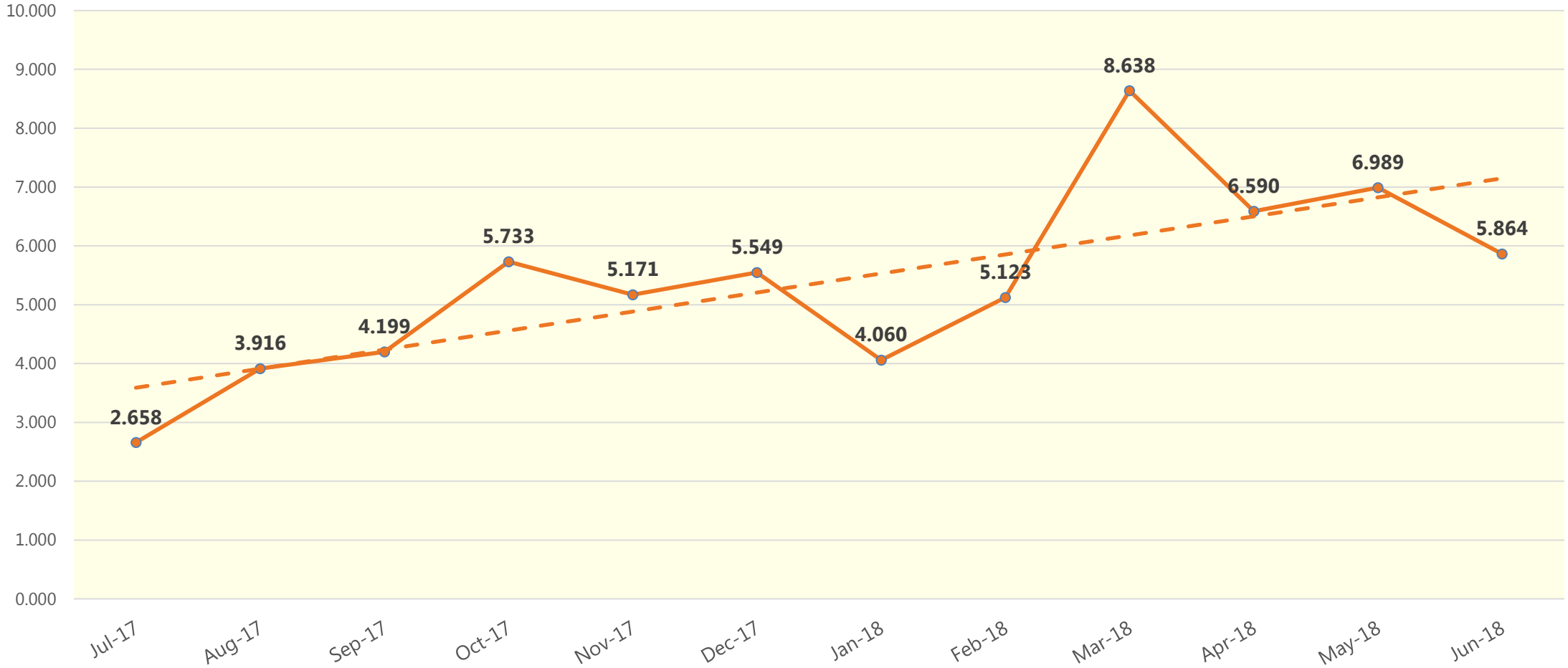
Q3 2017 – Q2 2018: CMC Appeals

Part C & D Appeals Per 1000 Members

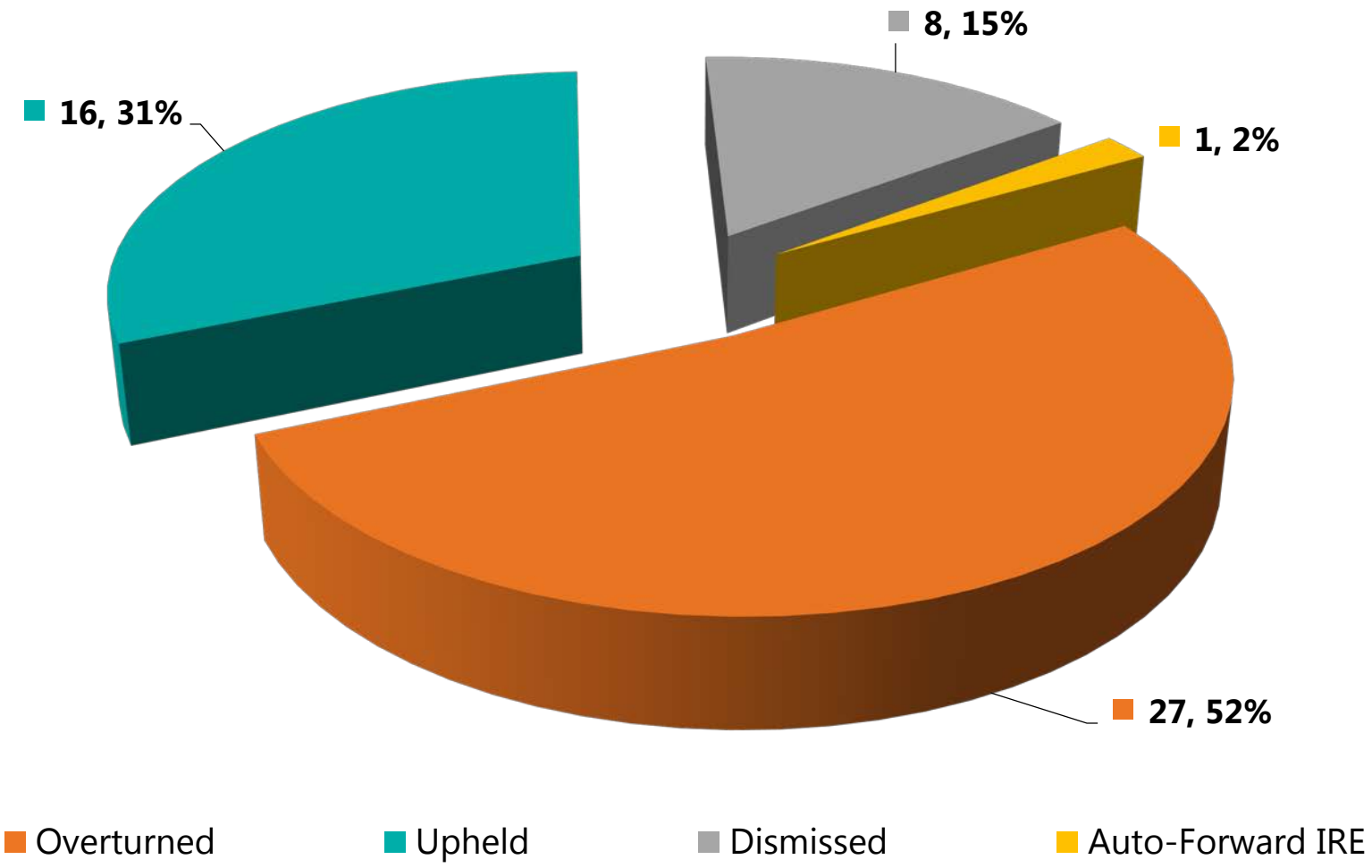


Q3 2017 – Q2 2018: CMC Grievances

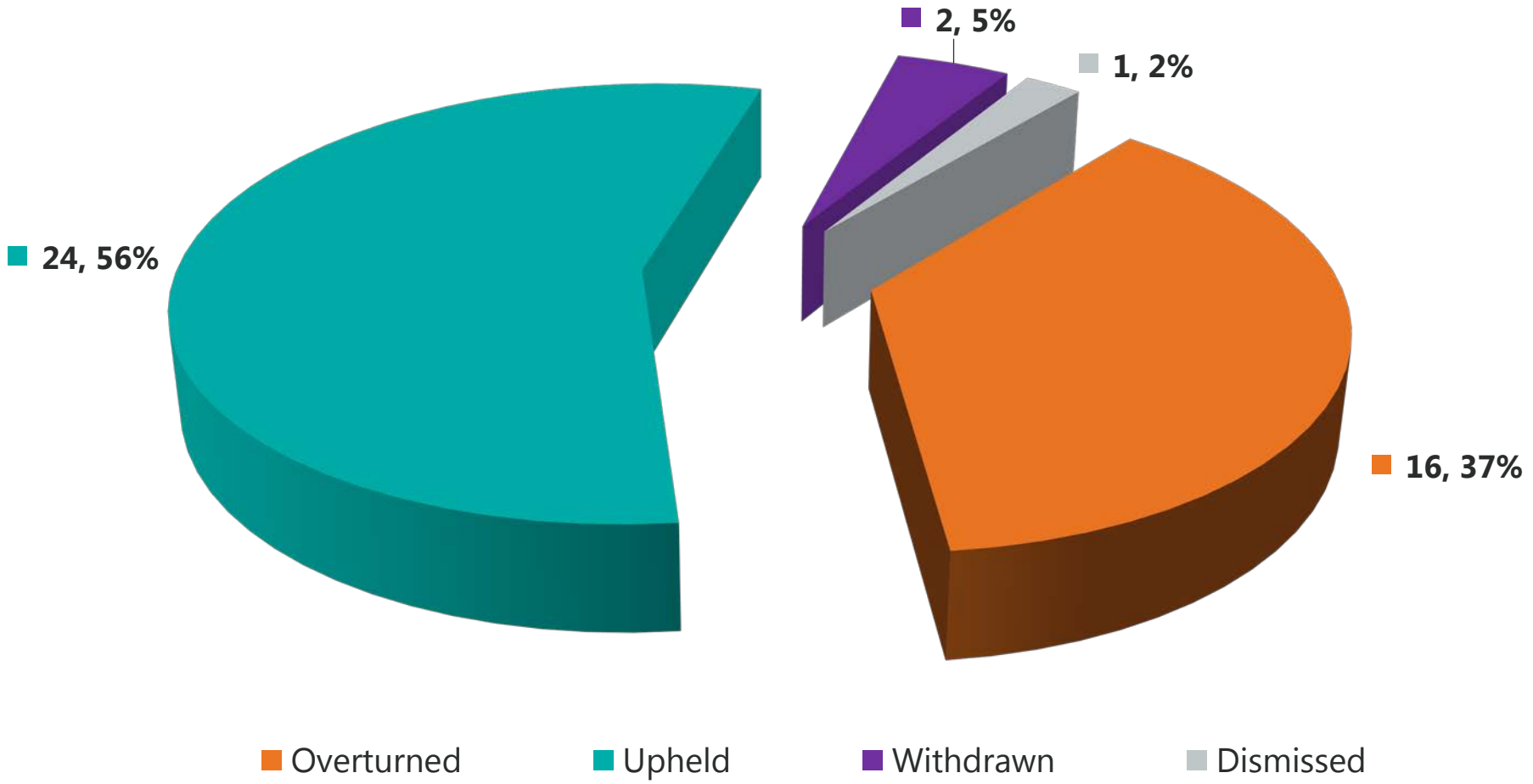
Grievances Per 1000 Members



Q2 2018 Reconsiderations by Determination



Q2 2018 Redeterminations by Determination



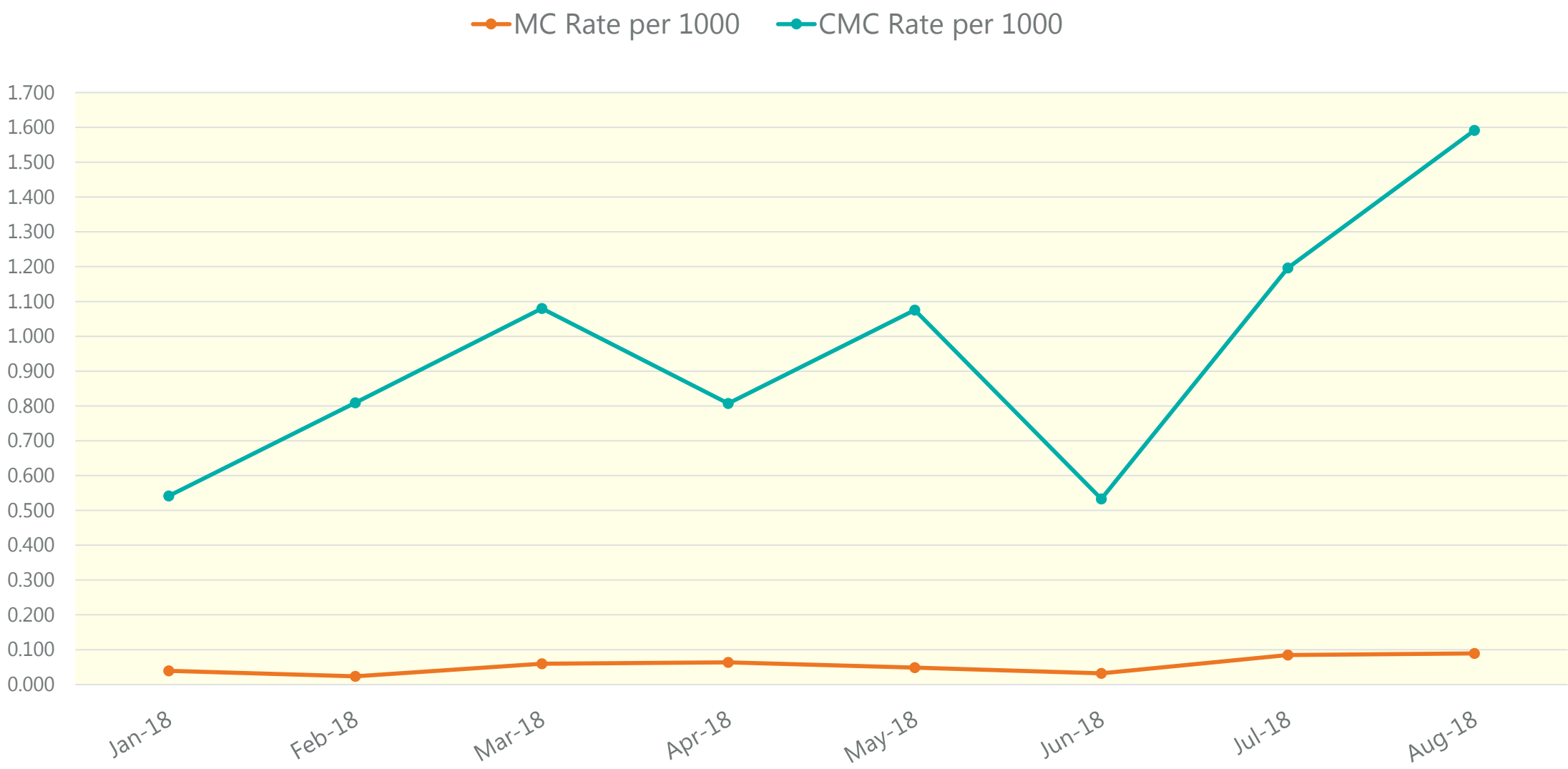
CHME Grievances

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Total CHME Grievances	10	6	15	16	12	8	21	22
Healthy Kids Membership	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187
Medi-Cal Membership	253,257	254,141	253,025	251,680	249,188	248,776	247,755	245,954
TOTAL Membership	256,466	257,391	256,440	255,134	252,408	251,972	251,033	249,141
Rate per 1000	**0.039**	**0.024**	**0.059**	**0.064**	**0.048**	**0.032**	**0.085**	**0.089**

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Total CHME Grievances	4	6	8	6	8	4	9	12
CMC Membership	7,389	7,417	7,409	7,435	7,440	7,503	7,523	7,540
Rate per 1000	**0.541**	**0.809**	**1.080**	**0.807**	**1.075**	**0.533**	**1.196**	**1.592**

Totals 167 Complaints filed since 1/1/18

CHME Complaints: Rate per 1000



Santa Clara Family Health Plan™

Darryl Breakbill

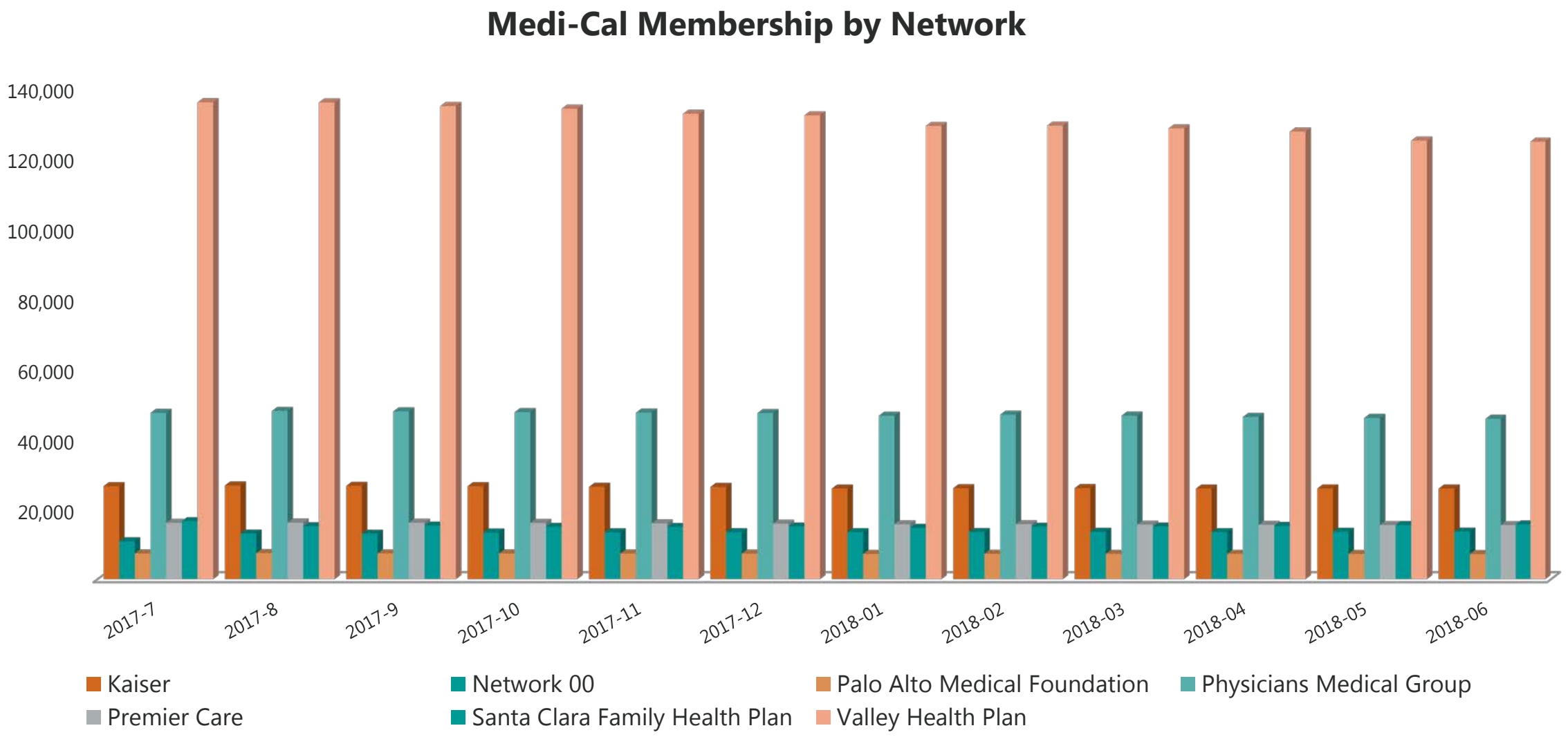
Manager, Grievance & Appeals Operations

Santa Clara Family Health Plan™

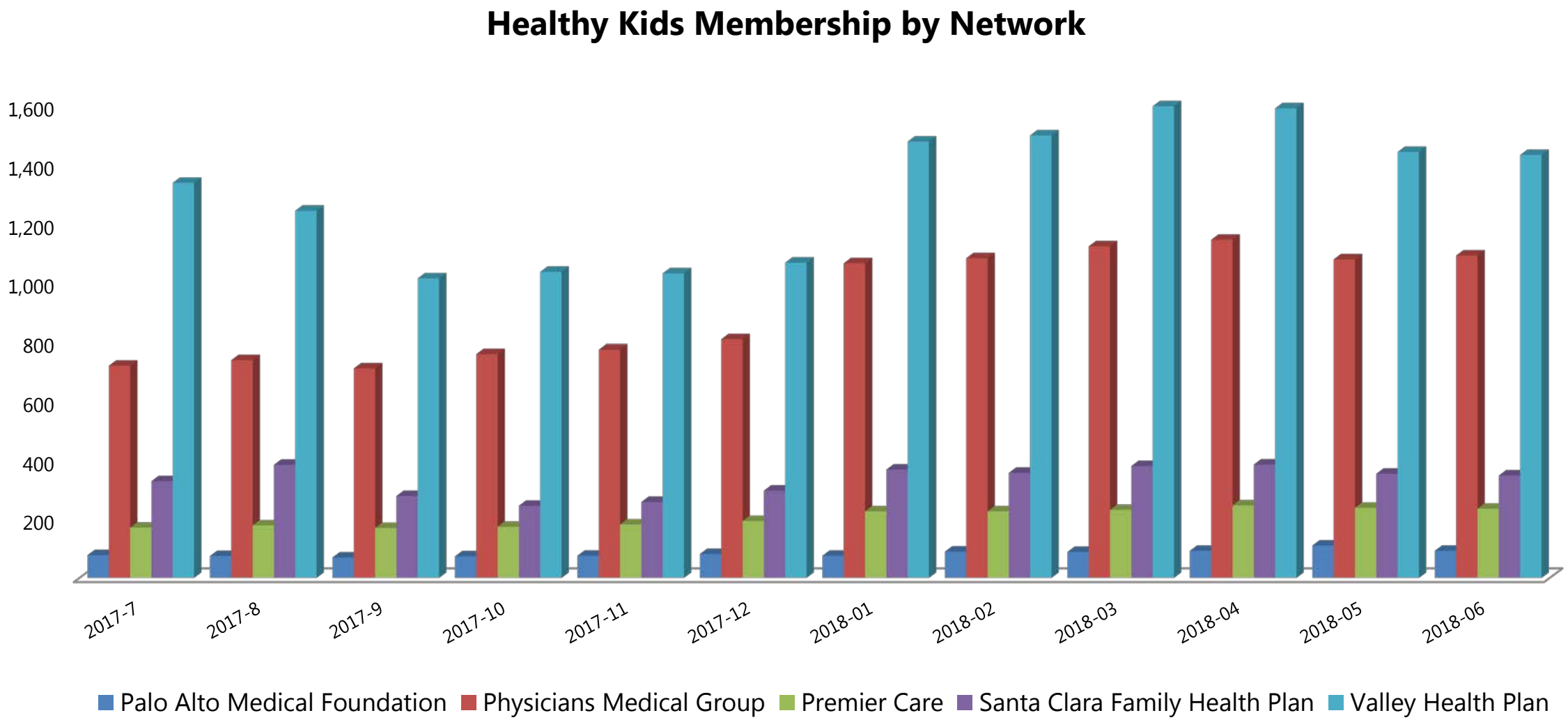
Additional Notes

Grievance and Appeals Q2 2018 Reporting

Enrollment and Market Share



Enrollment and Market Share



Q3 2017 – Q2 2018: Medi-Cal Per 1000 Rates

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Medical Appeals	31	33	32	33	37	40	40	31	51	29	31	35
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196
Medi-Cal Membership	261,287	262,871	261,702	260,518	258,633	258,106	253,257	254,141	253,025	251,680	249,188	248,776
TOTAL Membership	263,920	265,489	263,945	262,806	260,954	260,553	256,466	257,391	256,440	255,134	252,408	251,972
Rate per 1000	**0.117**	**0.124**	**0.121**	**0.126**	**0.142**	**0.154**	**0.156**	**0.120**	**0.199**	**0.114**	**0.123**	**0.139**

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Rx Appeals	119	119	79	91	76	62	85	78	92	74	71	71
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196
Medi-Cal Membership	261,287	262,871	261,702	260,518	258,633	258,106	253,257	254,141	253,025	251,680	249,188	248,776
TOTAL Membership	263,920	265,489	263,945	262,806	260,954	260,553	256,466	257,391	256,440	255,134	252,408	251,972
Rate per 1000	**0.455**	**0.453**	**0.302**	**0.349**	**0.294**	**0.240**	**0.336**	**0.307**	**0.364**	**0.294**	**0.285**	**0.285**

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Grievances	85	118	94	87	92	73	106	107	123	137	149	123
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196
Medi-Cal Membership	261,287	262,871	261,702	260,518	258,633	258,106	253,257	254,141	253,025	251,680	249,188	248,776
TOTAL Membership	263,920	265,489	263,945	262,806	260,954	260,553	256,466	257,391	256,440	255,134	252,408	251,972
Rate per 1000	**0.325**	**0.449**	**0.359**	**0.334**	**0.356**	**0.283**	**0.419**	**0.421**	**0.486**	**0.544**	**0.598**	**0.494**

Q4 2017–Q2 2018: Medi-Cal Per 1000 Rates: Premier Care

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Medical Appeals	1	1	1	1	1	1	1	0	0
PCNC MC Membership	15,130	15,110	15,223	14,844	15,168	15,208	15,394	15,641	15,829
Rate per 1000	**0.066**	**0.066**	**0.066**	**0.067**	**0.066**	**0.066**	**0.065**	**0.000**	**0.000**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Rx Appeals	1	1	5	3	3	4	6	3	1
PCNC MC Membership	15,130	15,110	15,223	14,844	15,168	15,208	15,394	15,641	15,829
Rate per 1000	**0.066**	**0.066**	**0.328**	**0.202**	**0.198**	**0.263**	**0.390**	**0.192**	**0.063**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Grievances	2	3	2	6	1	4	4	2	2
PCNC MC Membership	15,130	15,110	15,223	14,844	15,168	15,208	15,394	15,641	15,829
Rate per 1000	**0.132**	**0.199**	**0.131**	**0.404**	**0.066**	**0.263**	**0.260**	**0.128**	**0.126**

Q4 2017–Q2 2018: Medi-Cal Per 1000 Rates: Physician's Medical Group

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Medical Appeals	6	5	6	4	6	3	4	2	4
PMG MC Membership	47,740	47,619	47,472	46,721	47,003	46,748	46,377	46,113	45,881
Rate per 1000	**0.126**	**0.105**	**0.126**	**0.086**	**0.128**	**0.064**	**0.086**	**0.043**	**0.087**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Rx Appeals	20	18	11	11	9	21	11	18	18
PMG MC Membership	47,740	47,619	47,472	46,721	47,003	46,748	46,377	46,113	45,881
Rate per 1000	**0.419**	**0.378**	**0.232**	**0.235**	**0.191**	**0.449**	**0.237**	**0.390**	**0.392**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Grievances	16	8	18	12	9	23	22	18	10
PMG MC Membership	47,740	47,619	47,472	46,721	47,003	46,748	46,377	46,113	45,881
Rate per 1000	**0.335**	**0.168**	**0.379**	**0.257**	**0.191**	**0.492**	**0.474**	**0.390**	**0.218**

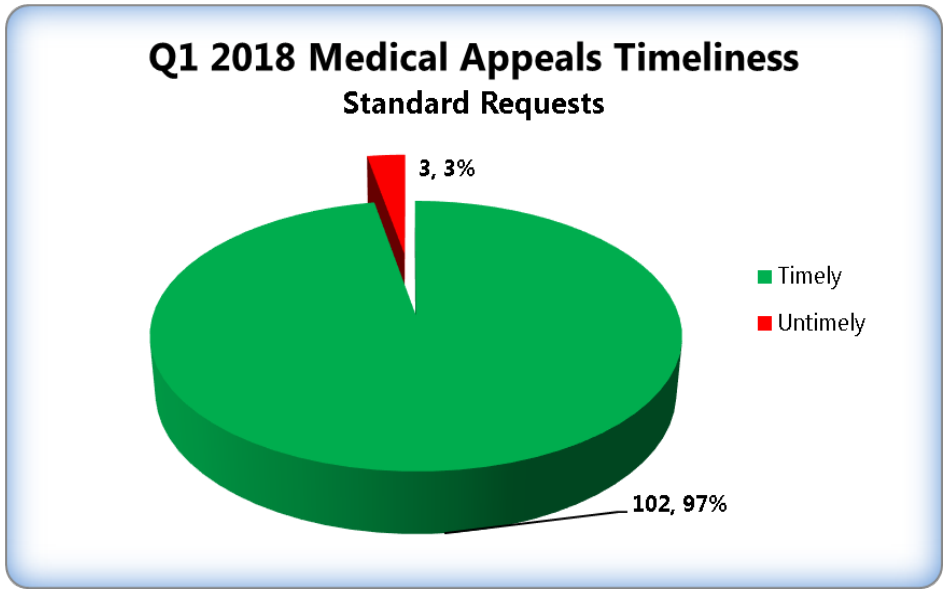
Q4 2017–Q2 2018: Medi-Cal Per 1000 Rates: Valley Health Plan

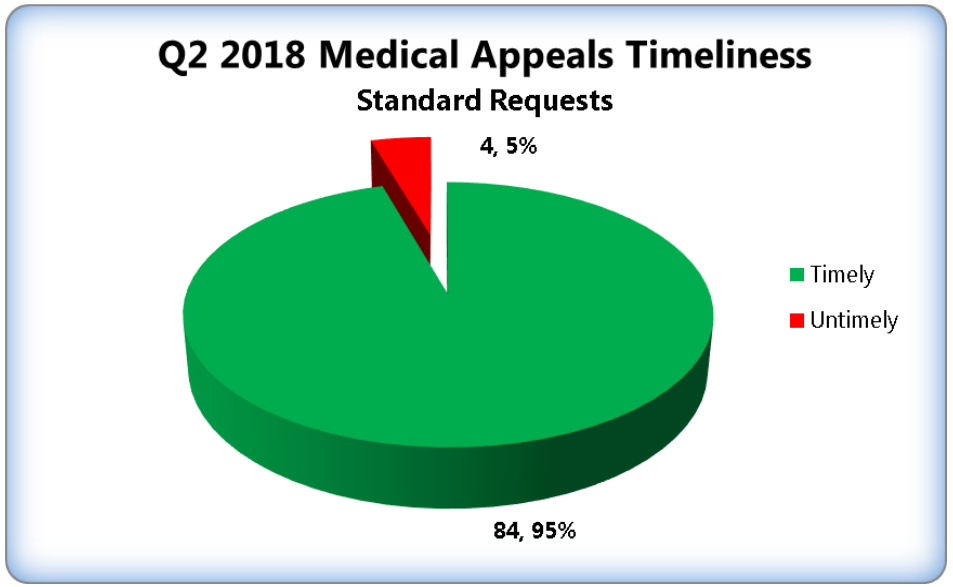
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Medical Appeals	21	21	16	20	13	29	17	23	23
VHP MC Membership	133,784	132,321	131,889	128,876	128,971	128,178	127,282	124,724	124,419
Rate per 1000	**0.157**	**0.159**	**0.121**	**0.155**	**0.101**	**0.226**	**0.134**	**0.184**	**0.185**

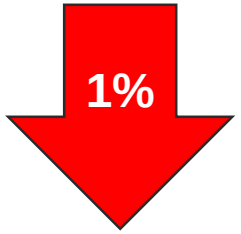
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Rx Appeals	40	35	27	48	37	41	29	29	26
VHP MC Membership	133,784	132,321	131,889	128,876	128,971	128,178	127,282	124,724	124,419
Rate per 1000	**0.299**	**0.265**	**0.205**	**0.372**	**0.287**	**0.320**	**0.228**	**0.233**	**0.209**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Grievances	51	52	37	55	57	51	62	77	74
VHP MC Membership	133,784	132,321	131,889	128,876	128,971	128,178	127,282	124,724	124,419
Rate per 1000	**0.381**	**0.393**	**0.281**	**0.427**	**0.442**	**0.398**	**0.487**	**0.617**	**0.595**

Medi-Cal Timeliness: Standard Medical Appeals

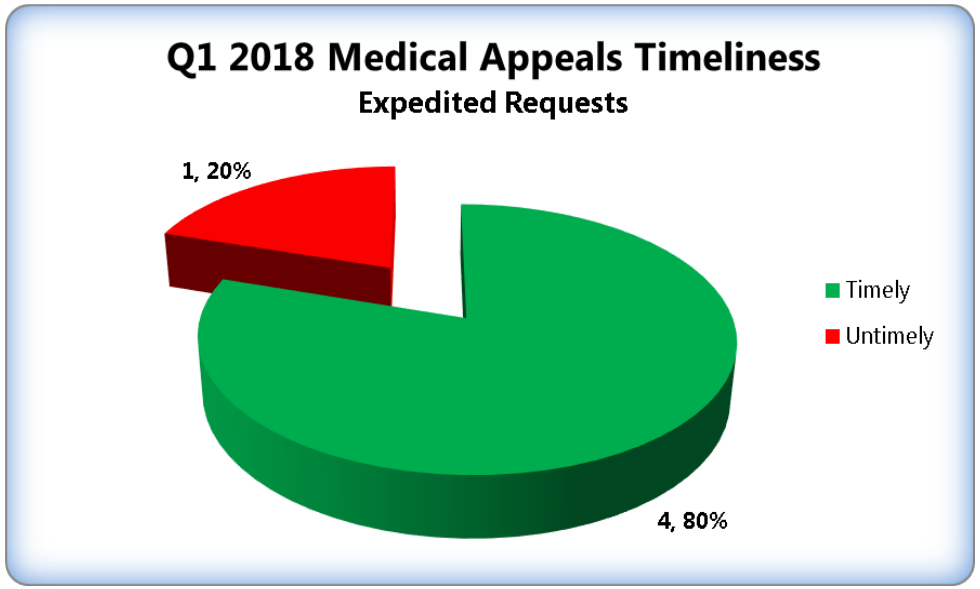


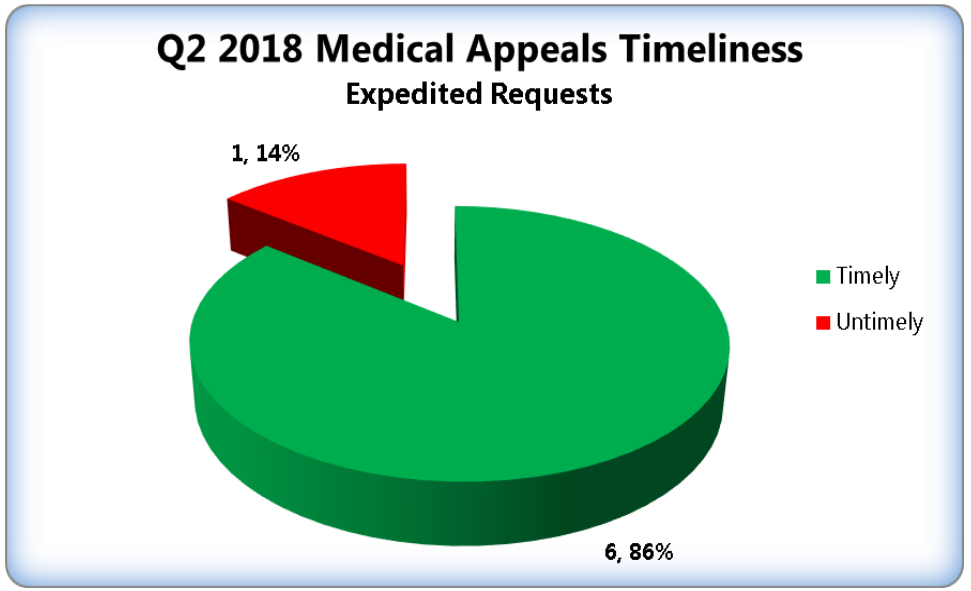




STANDARD: **30** calendar days or as quickly as the member's health condition requires.

Medi-Cal Timeliness: Expedited Medical Appeals





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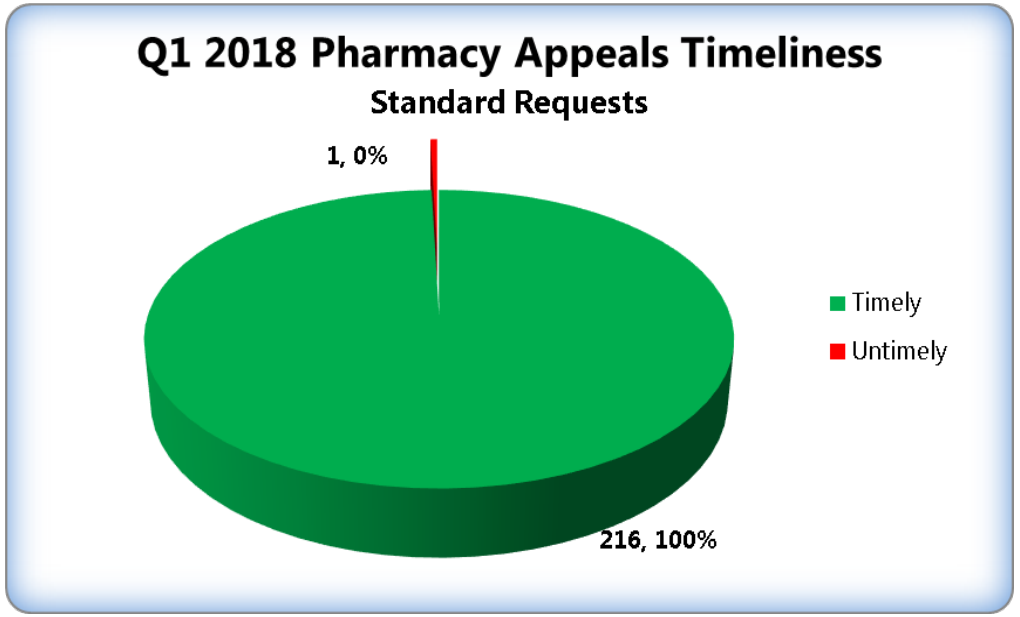
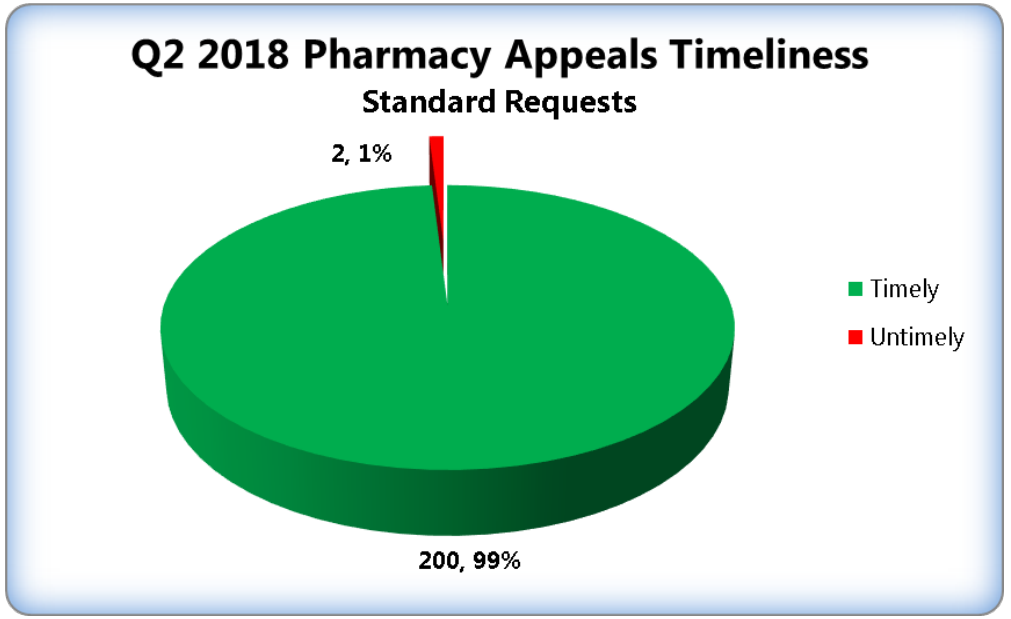
STANDARD: Within **72 hours** from the date that the appeal is received ,or as quickly as the member's health condition requires.

Medi-Cal Timeliness: Standard Rx Appeals





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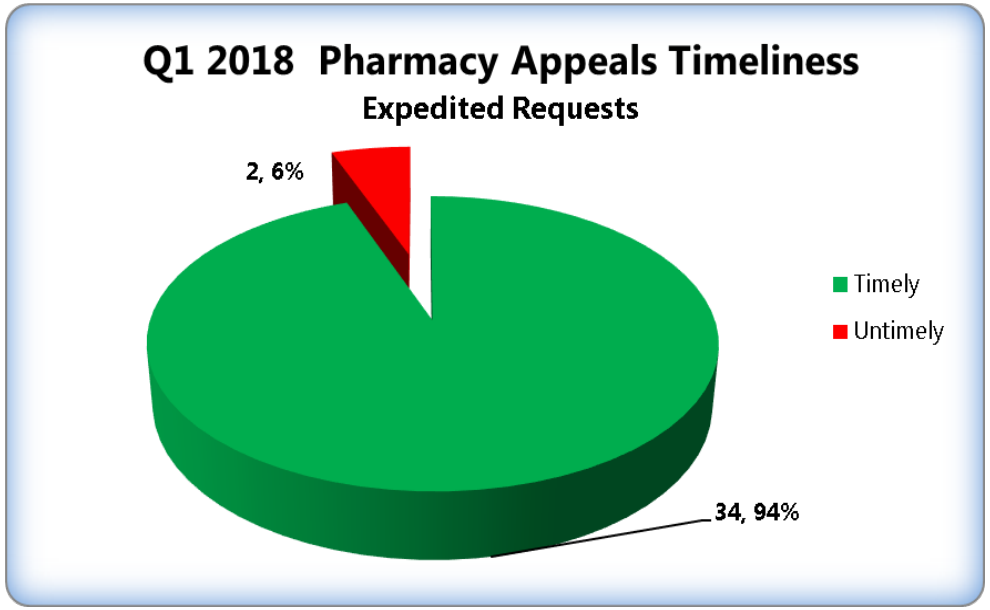
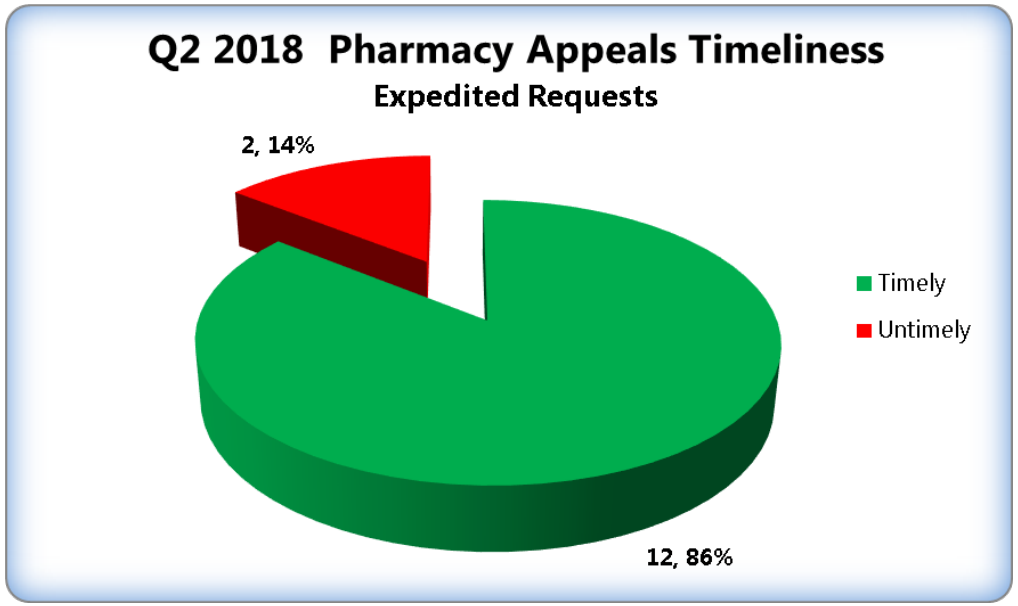
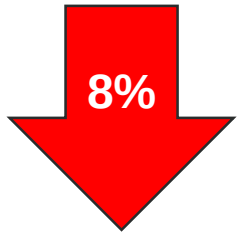
STANDARD: **30** calendar days or as quickly as the member's health condition requires.

Medi-Cal Timeliness: Expedited Rx Appeals

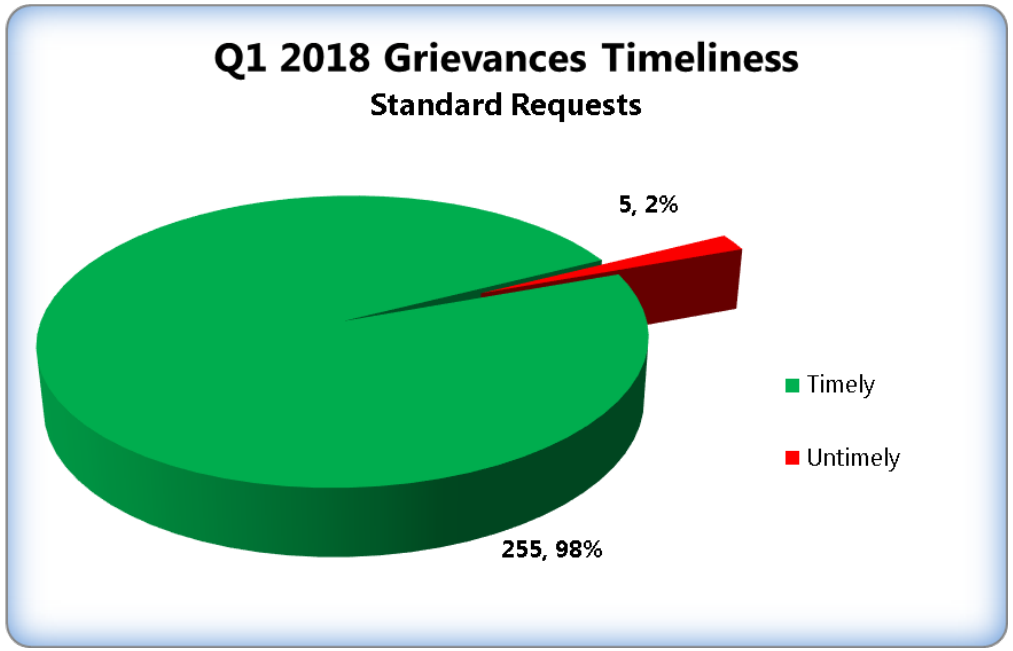


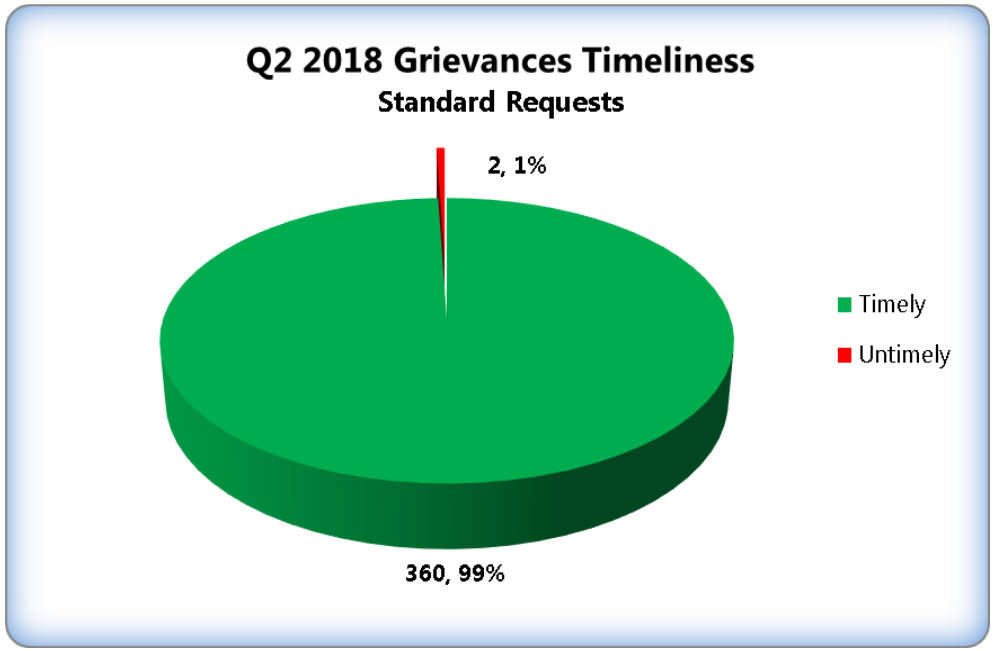




STANDARD: Within **72 hours** from the date that the appeal is received, or as quickly as the member's health condition requires.

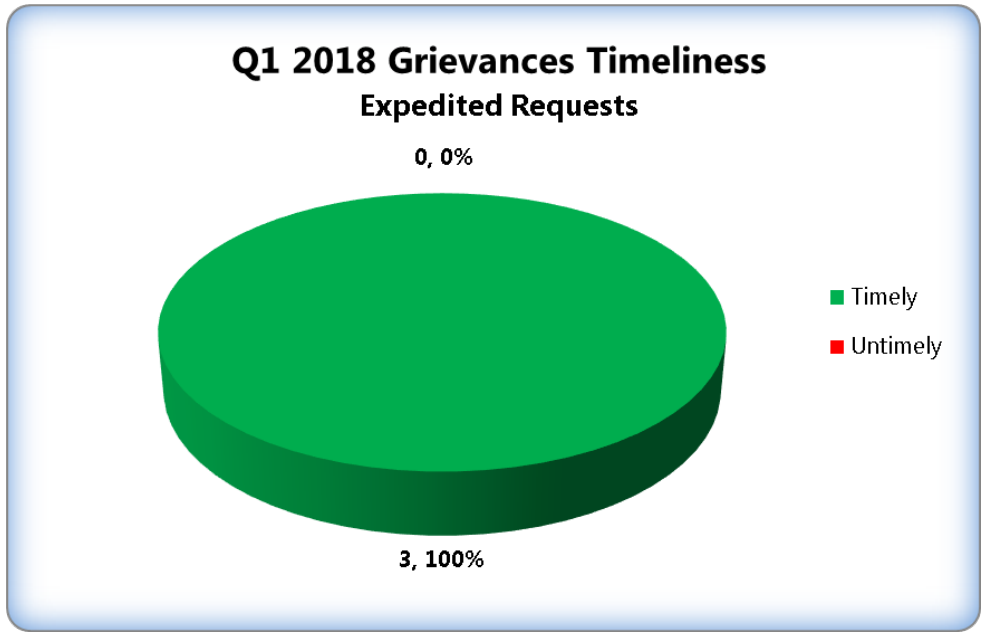
Medi-Cal Timeliness: Standard Grievances

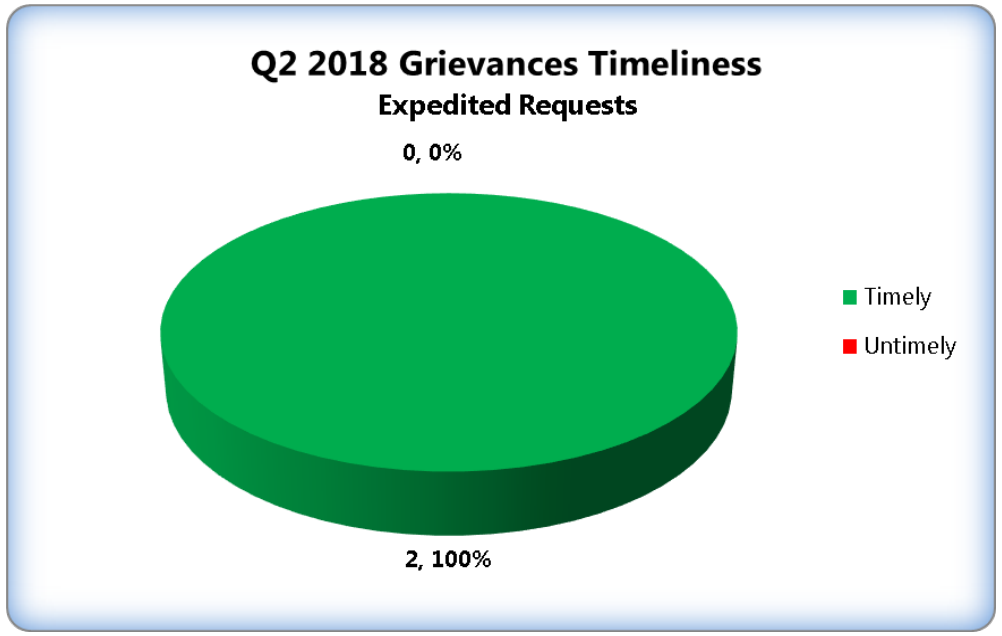




STANDARD: **30** calendar days or as quickly as the member's health condition requires.

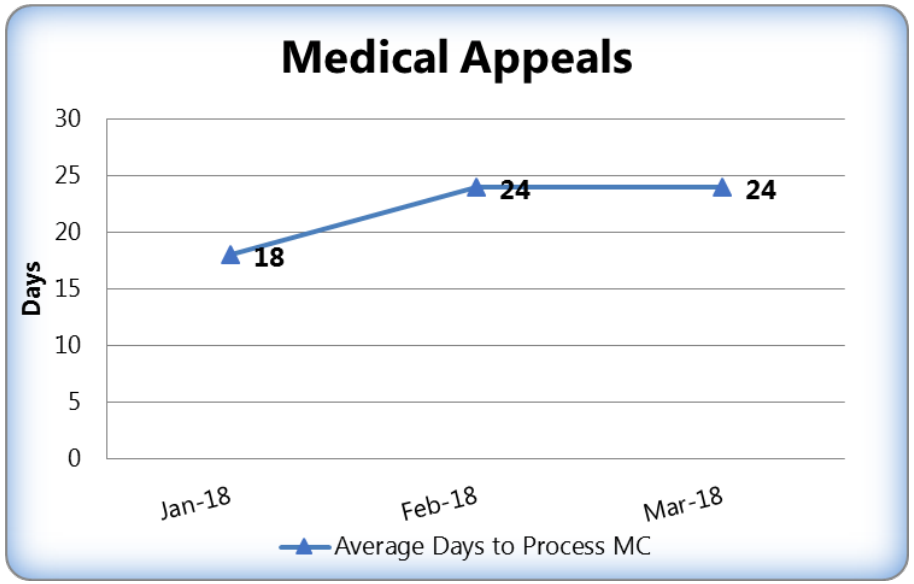
Medi-Cal Timeliness: Expedited Grievances



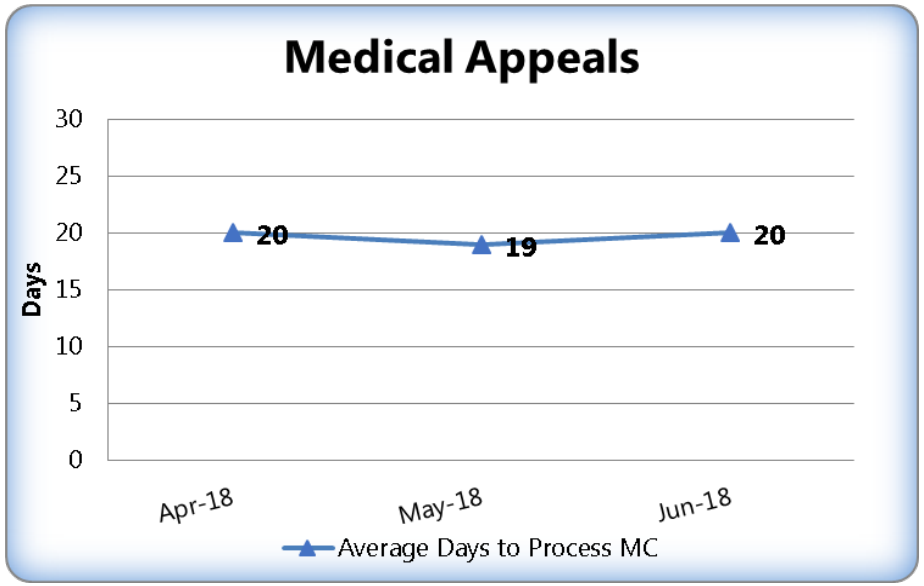


STANDARD: Within **72 hours** from the date that the appeal is received, or as quickly as the member's health condition requires.

Medi-Cal Processing Days

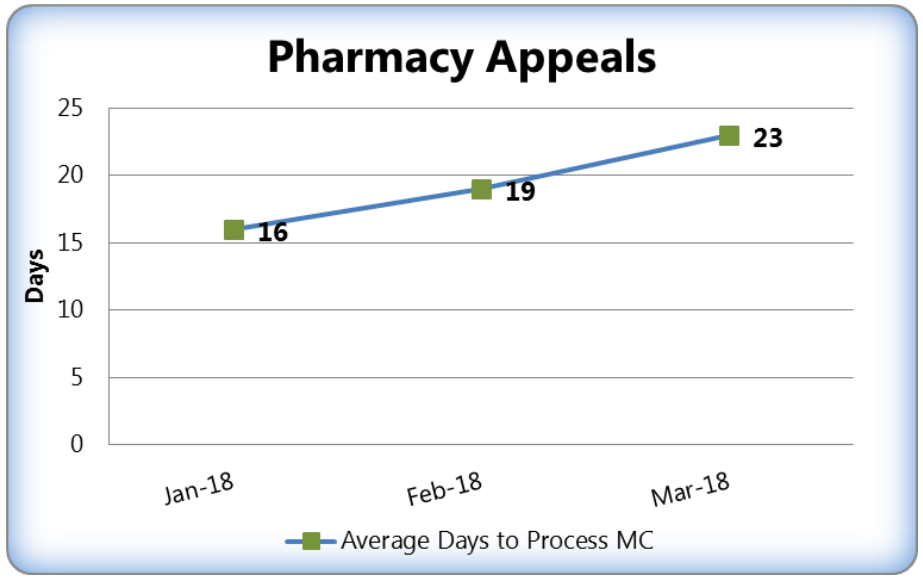


Q1 2018

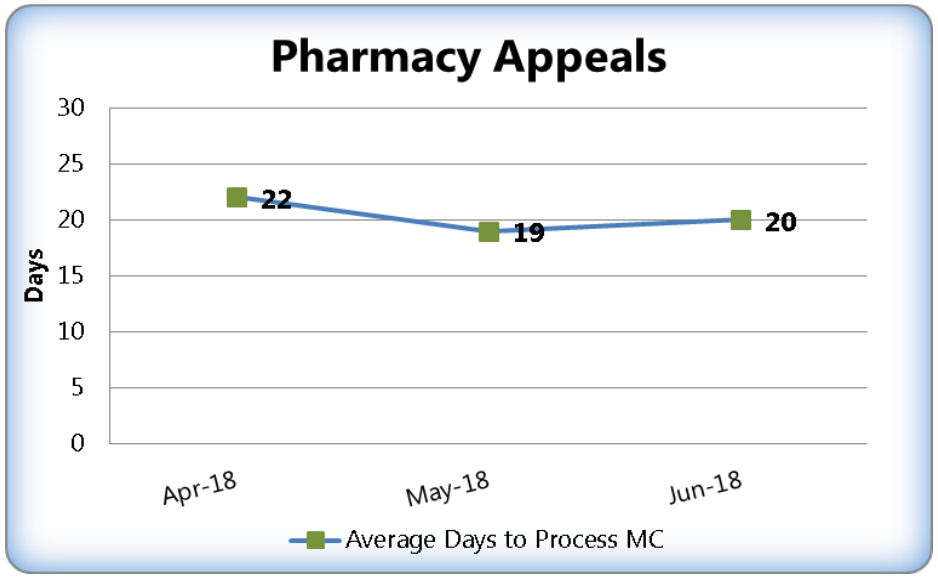


Q2 2018

Medi-Cal Processing Days

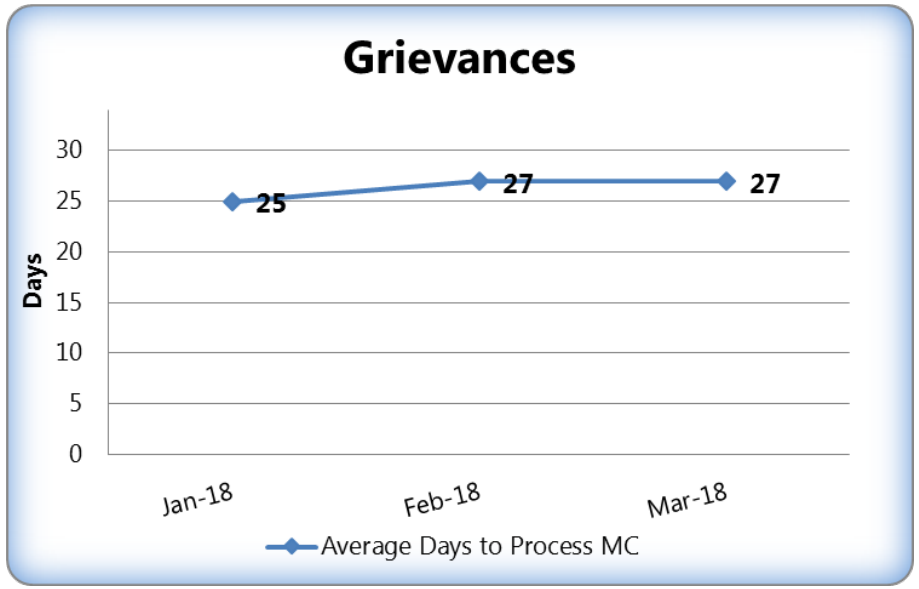


Q1 2018

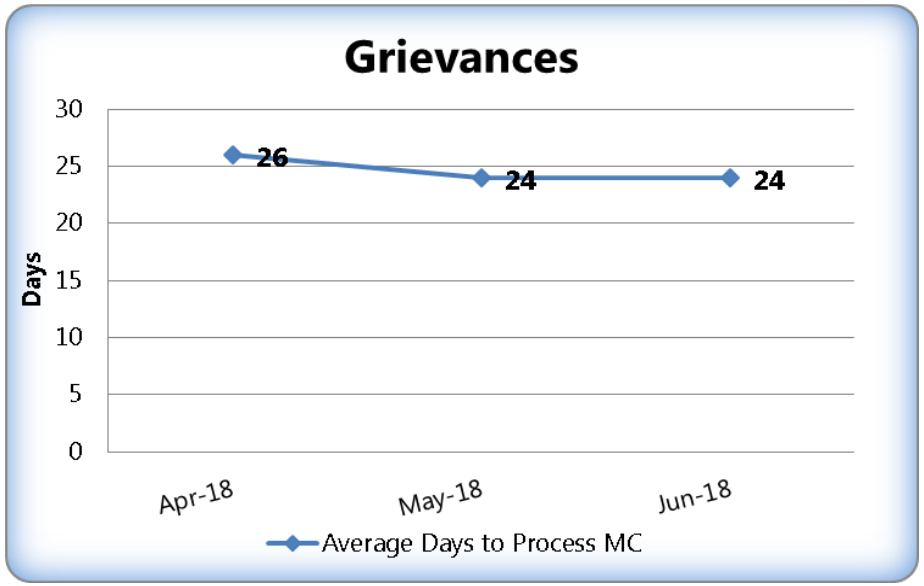


Q2 2018

Medi-Cal Processing Days



Q1 2018



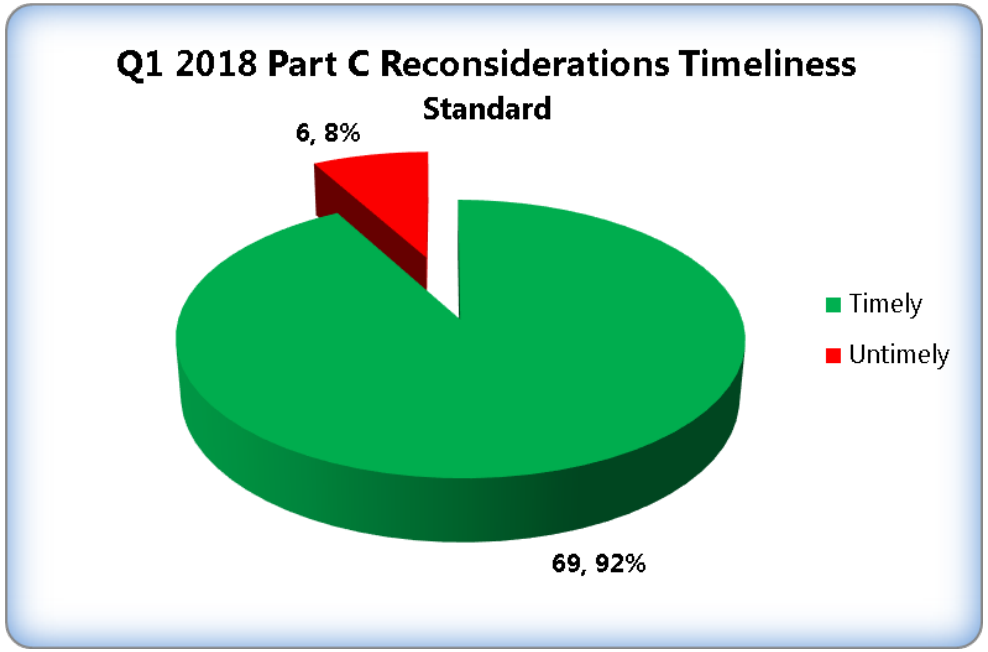
Q2 2018

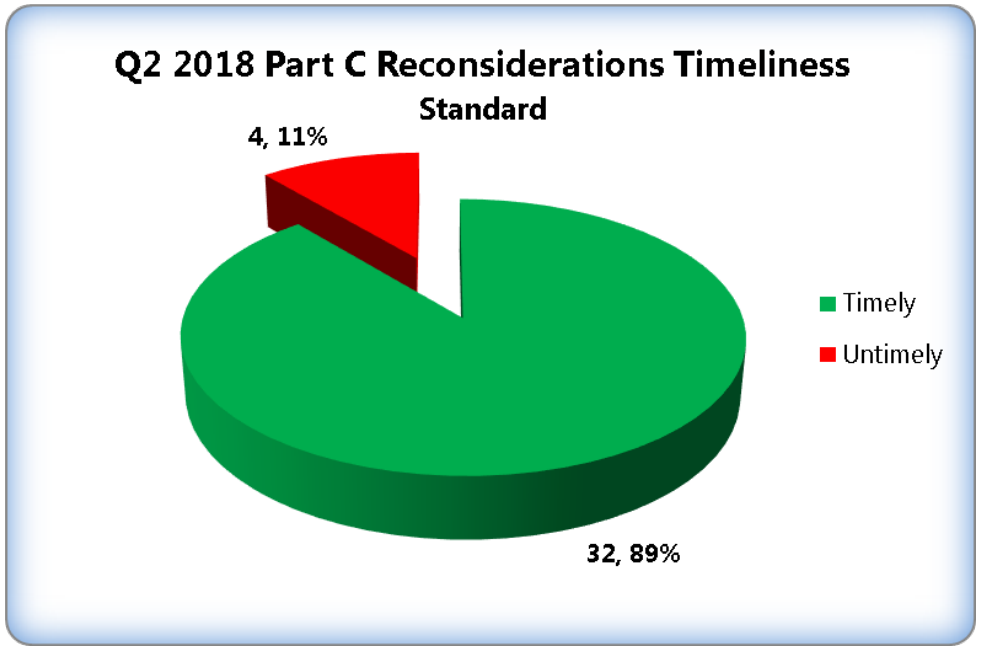
Q3 2017 – Q2 2018: CMC Per 1000 Rates

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Appeals	9	13	67	62	91	59	54	35	49	45	32	18
CMC Membership	7,525	7,405	7,383	7,326	7,349	7,389	7,389	7,417	7,409	7,435	7,440	7,503
Rate per 1000	**1.196**	**1.756**	**9.075**	**8.463**	**12.383**	**7.985**	**7.308**	**4.719**	**6.614**	**6.052**	**4.301**	**2.399**

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Grievances	20	29	31	42	38	41	30	38	64	49	52	44
CMC Membership	7,525	7,405	7,383	7,326	7,349	7,389	7,389	7,417	7,409	7,435	7,440	7,503
Rate per 1000	**2.658**	**3.916**	**4.199**	**5.733**	**5.171**	**5.549**	**4.060**	**5.123**	**8.638**	**6.590**	**6.989**	**5.864**

CMC Timeliness: Standard Reconsiderations

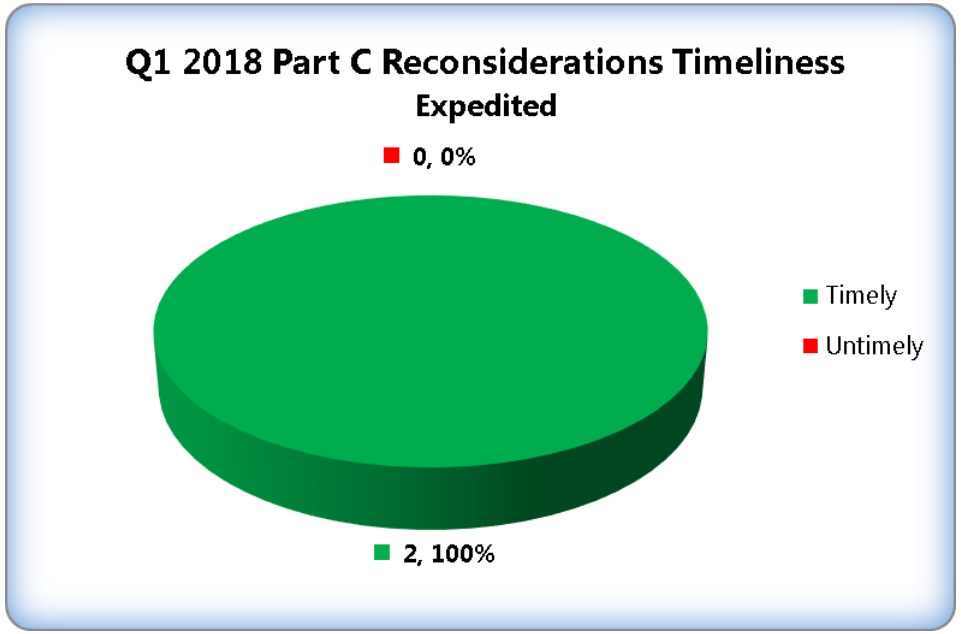


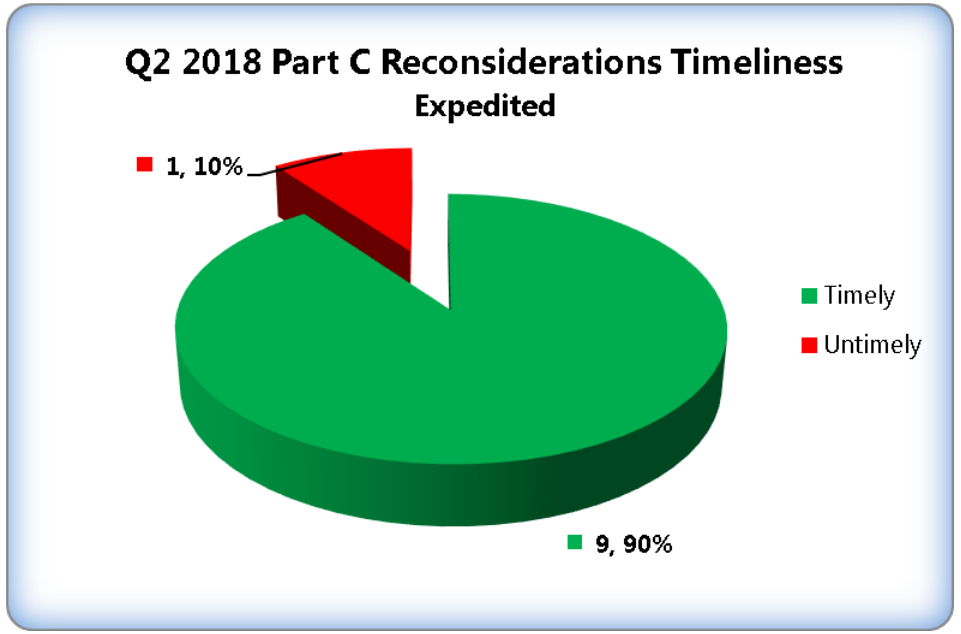


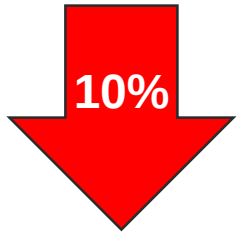
3%

Pre-Service Standard = 30 calendar days
Post-Service Standard = **60** calendar days

CMC Timeliness: Expedited Reconsiderations

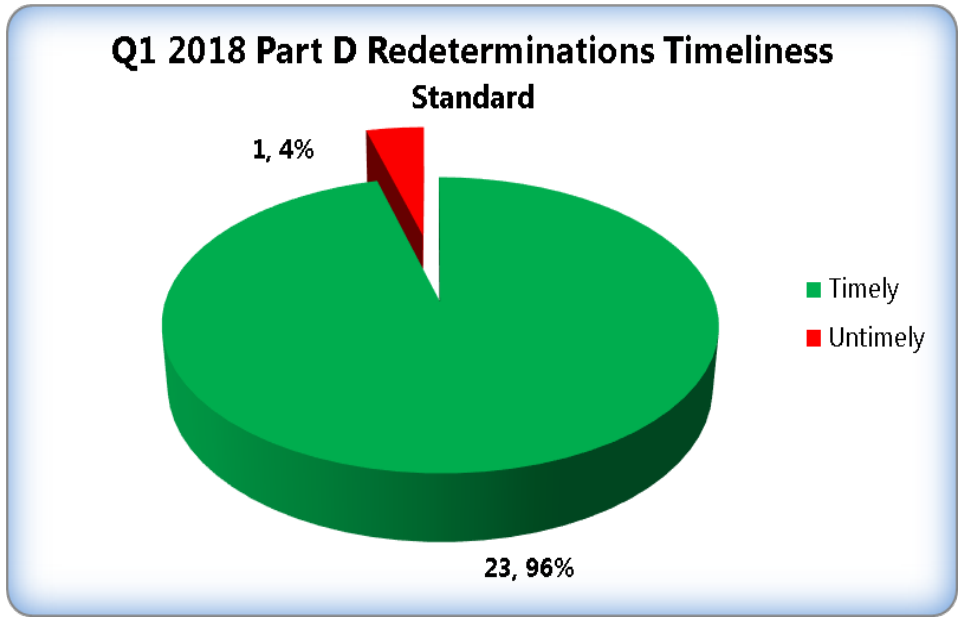


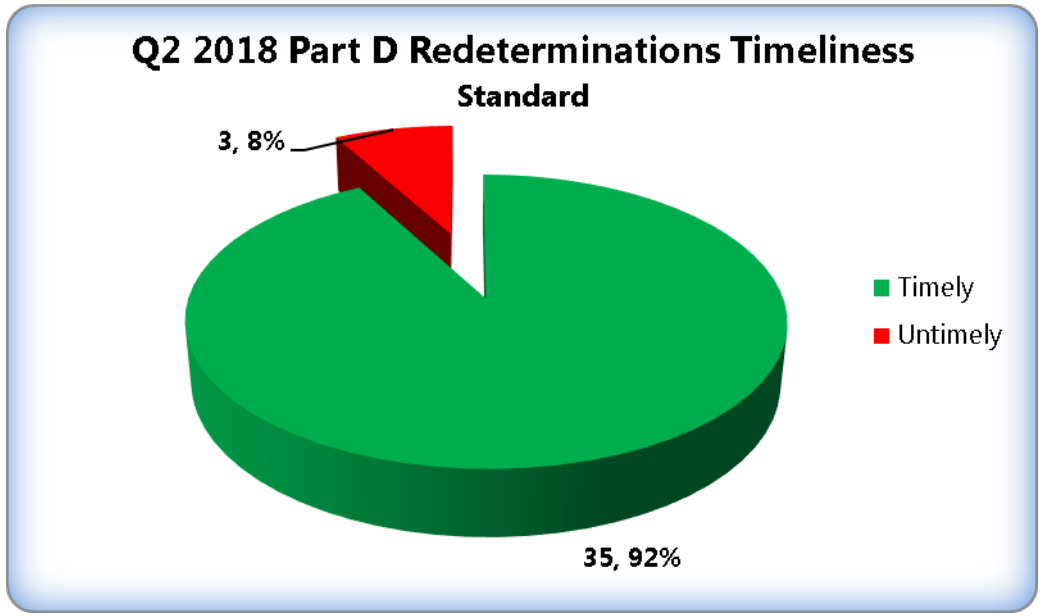




Expedited = 72 hours

CMC Timeliness: Standard Redeterminations

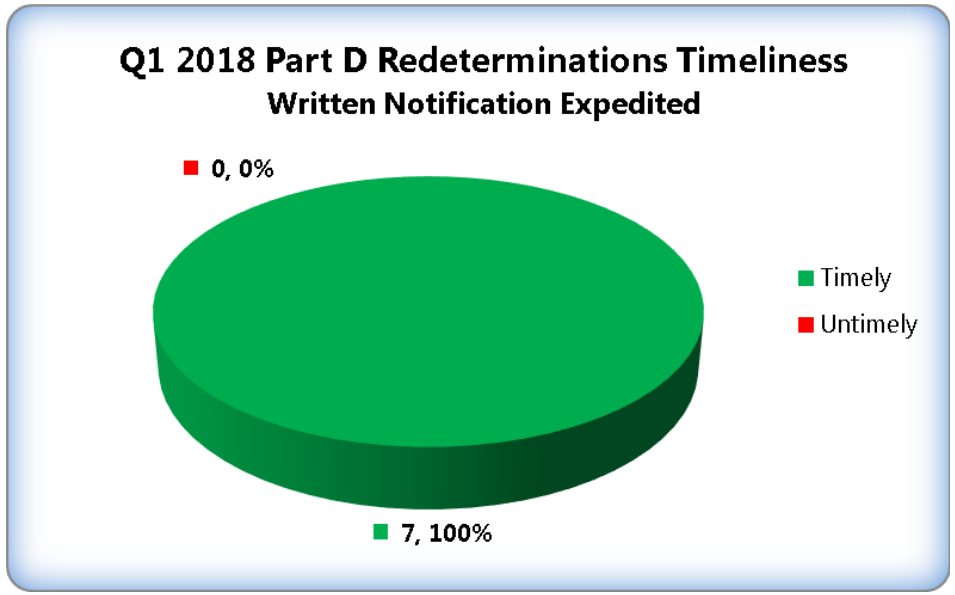


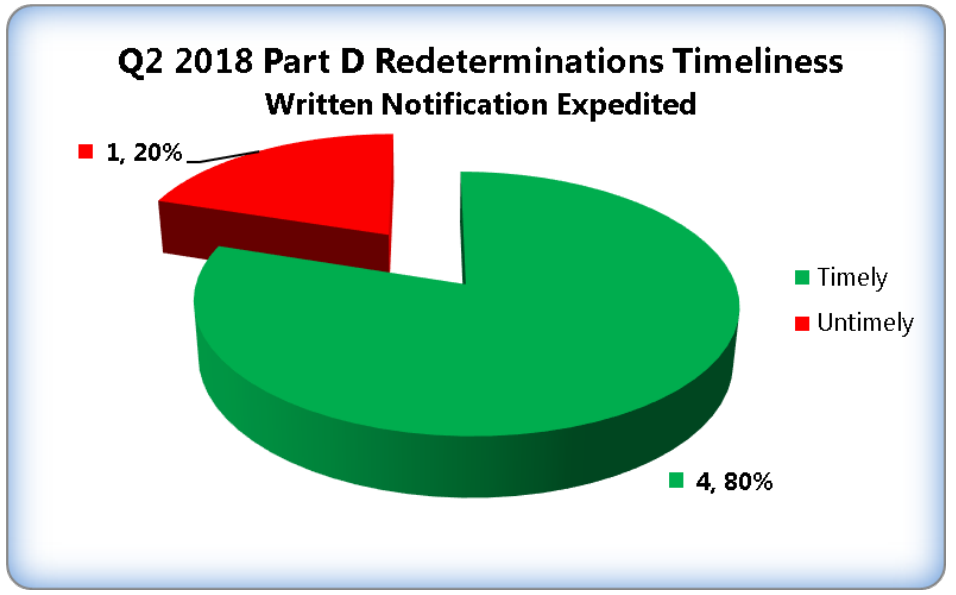


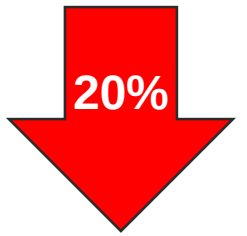
4%

Standard = 7 calendar days

CMC Timeliness: Expedited Redeterminations

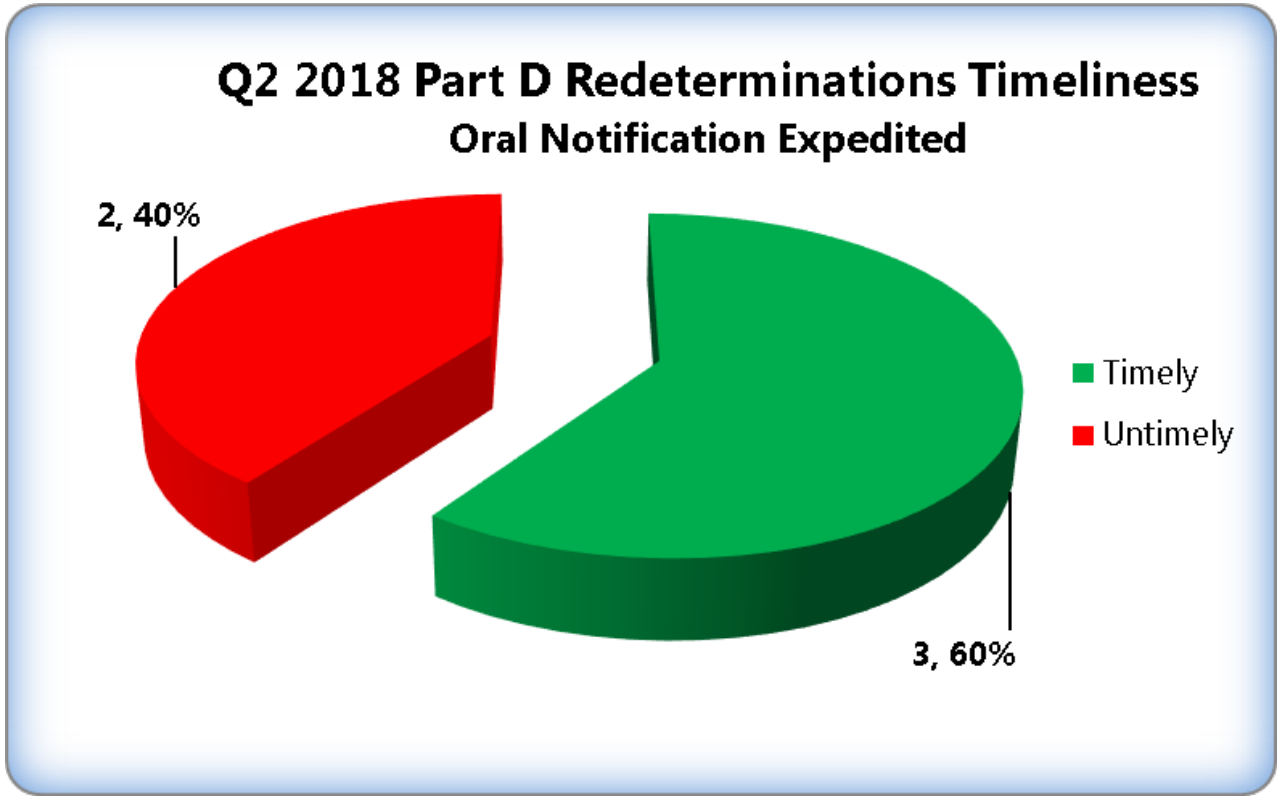






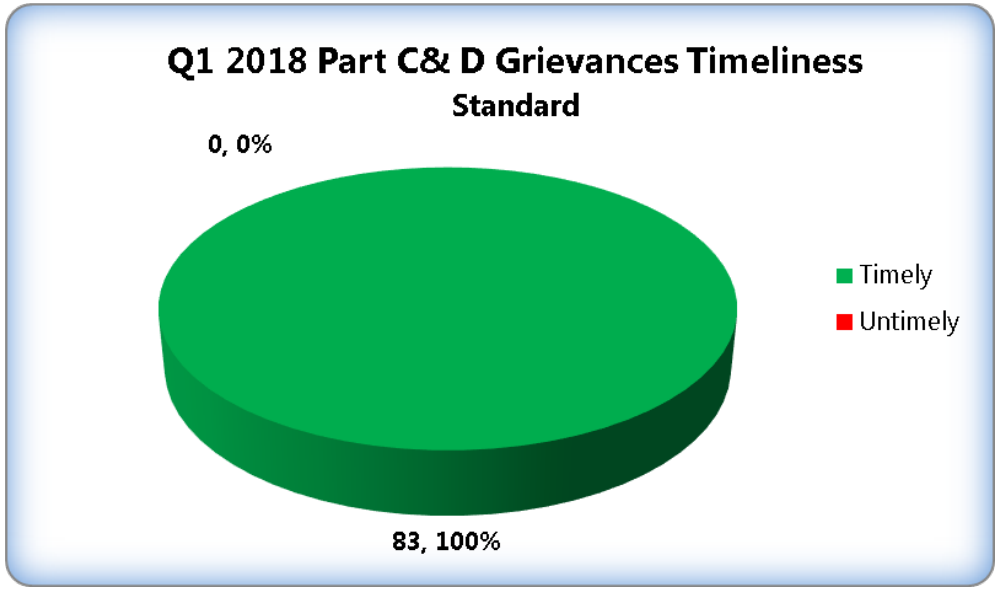
Standard = 72 hours

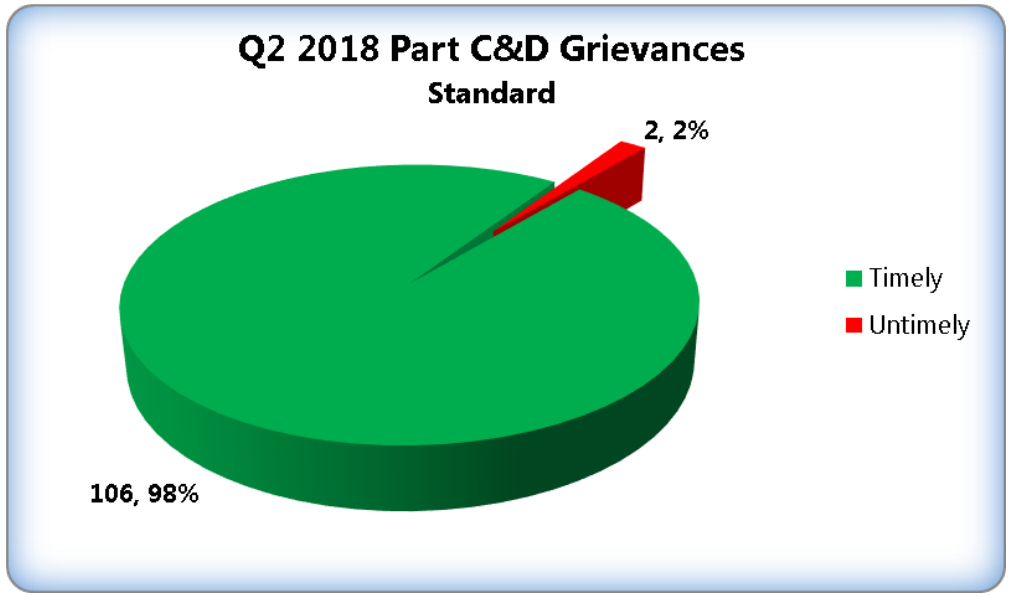
CMC Timeliness: Expedited Redeterminations

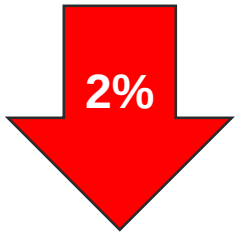


Standard = 72 hours

CMC Timeliness: Standard Grievances

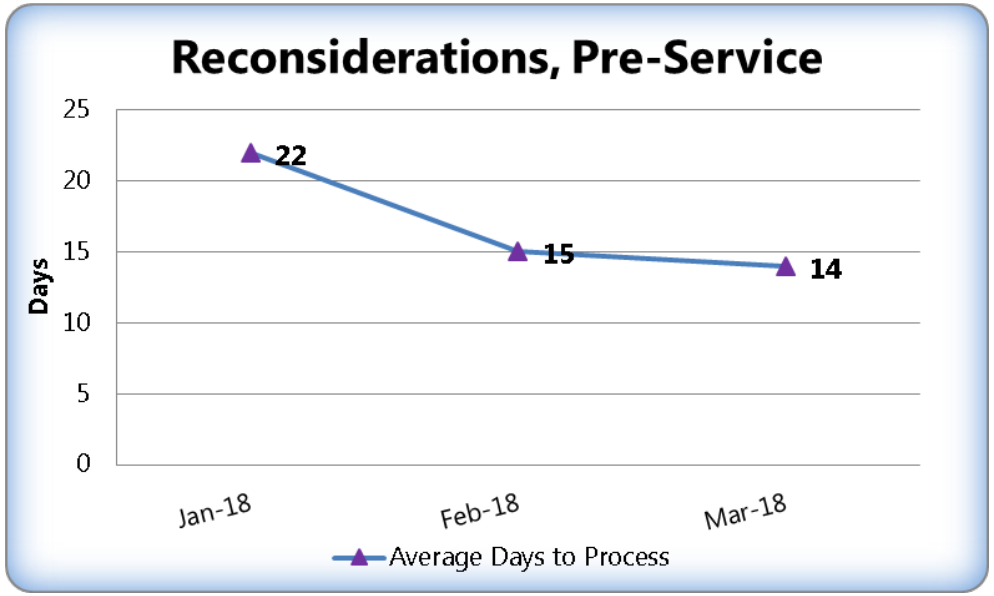




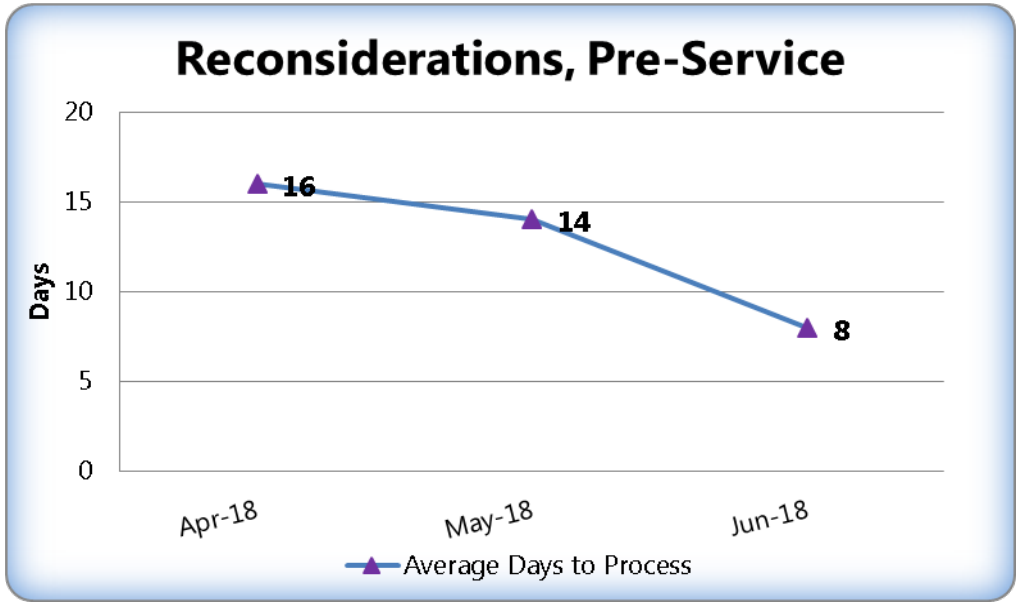


STANDARD: 30 calendar days.

CMC Processing Days

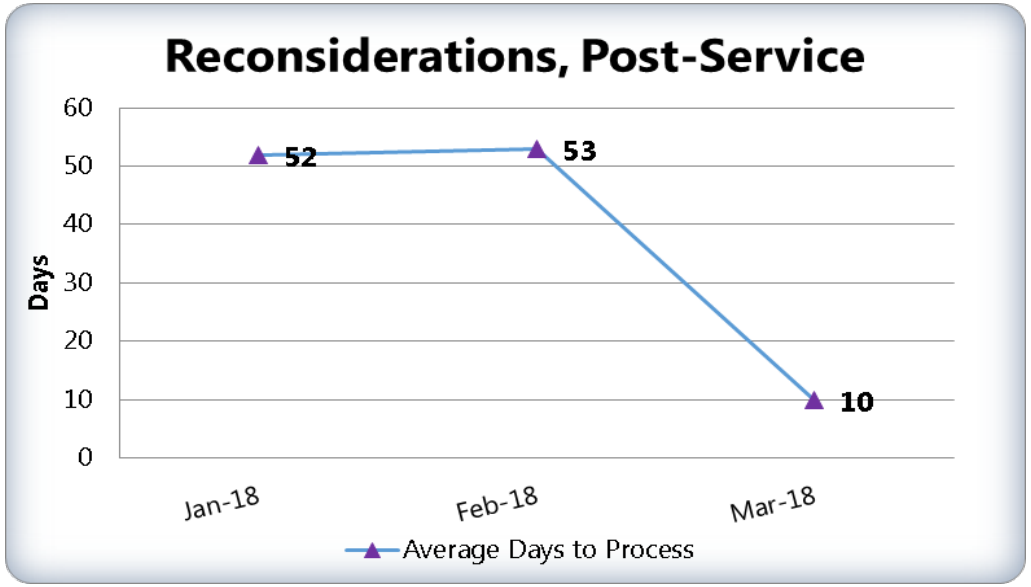


Q1 2018

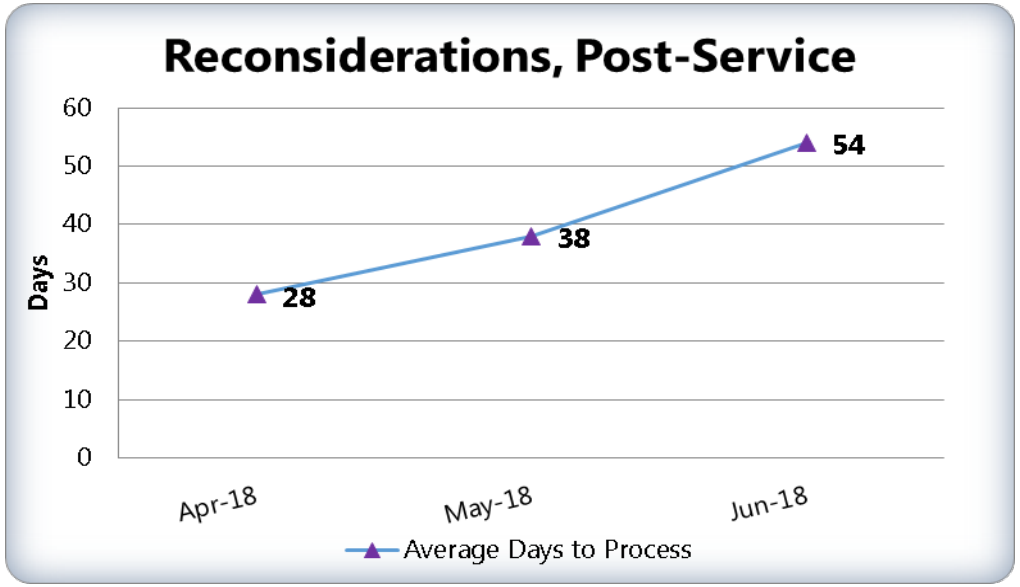


Q2 2018

CMC Processing Days

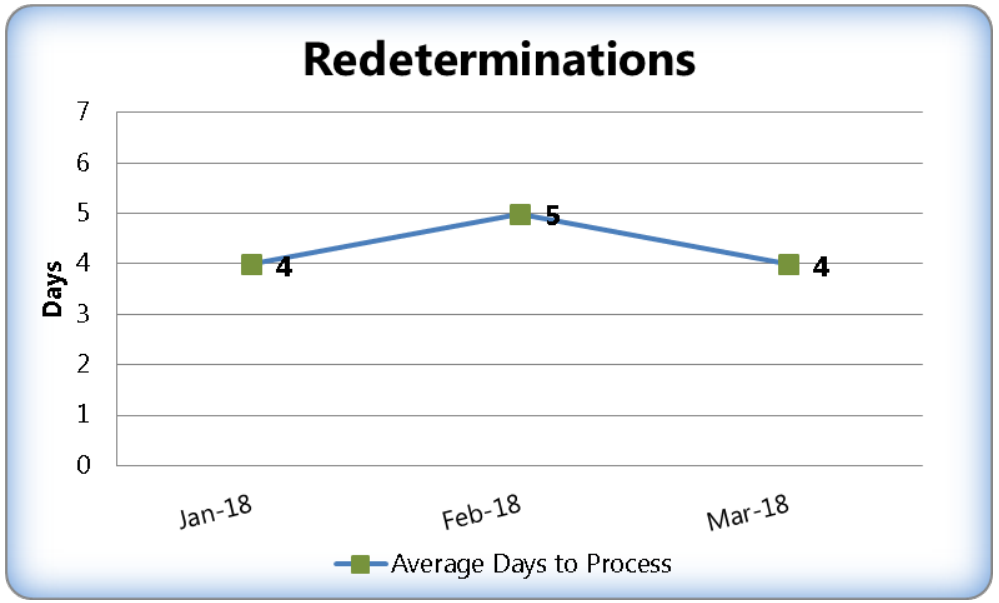


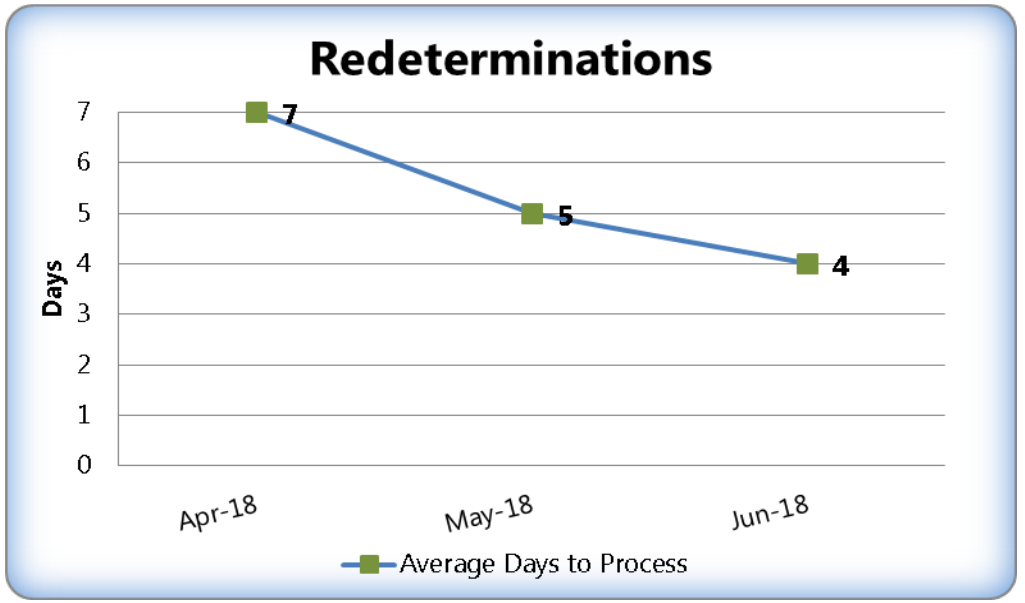
Q1 2018



Q2 2018

CMC Processing Days

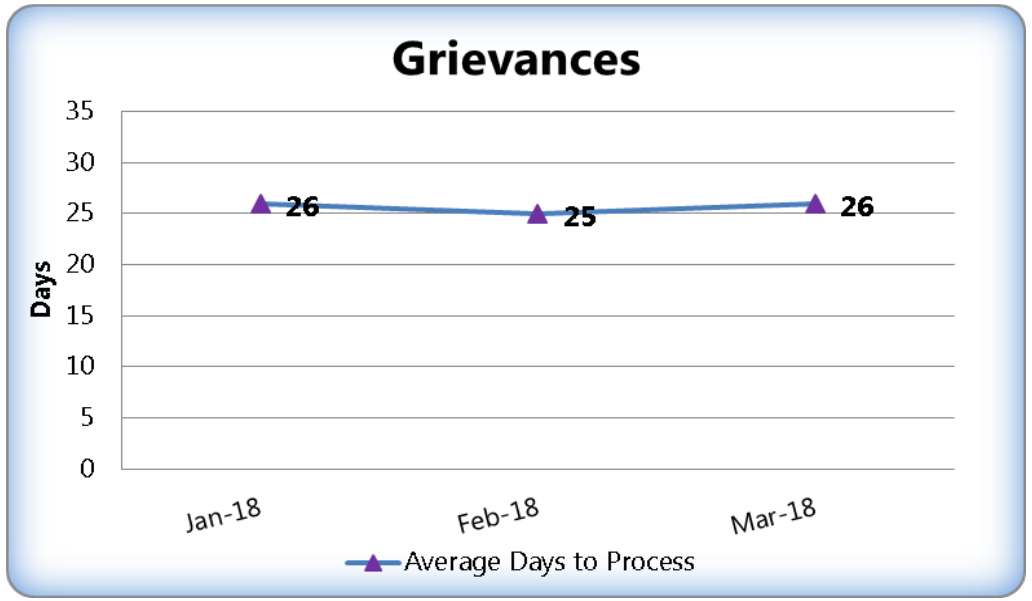




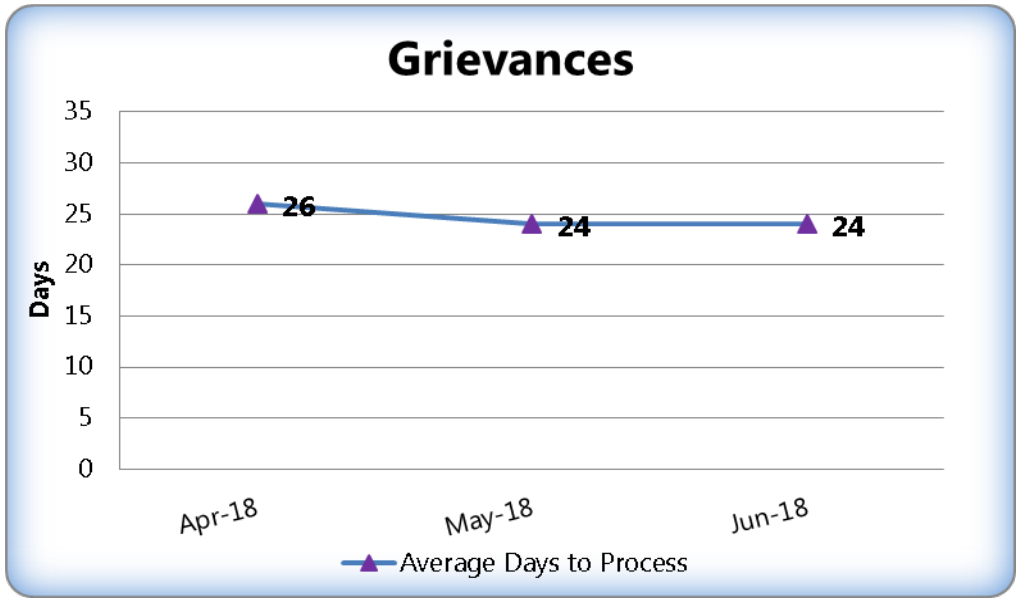
Q1 2018

Q2 2018

CMC Processing Days



Q1 2018



Q2 2018

Santa Clara Family Health Plan™

Experience with Complex Case Management

(NCQA Requirement PHM 5 Element F)

Presented to: Quality Improvement Committee on October 10, 2018

Presented by: Shawna Cagle, Manager of Case Management

Experience with Case Management

- The Case Management Department evaluates member's experience with Complex Case Management (CCM) Services by obtaining feedback from members and analyzing member complaints for the purpose of identifying opportunities for improvement.
- 100% of members enrolled in CCM are provided the opportunity to complete the survey with in 30 days of their transition to a lower level of CM services.
- Specific feedback measured:
  - Information about the overall program
  - The program staff
  - Member's ability to adhere to the recommendations
  - Percentage of members indicating that the program helped them achieve health goals
  - Complaints
- Sample questions:
  - Did the case manager treat you with courtesy and respect?
  - Did the case manager return your phone calls in a timely manner?
  - Did your case manger involve you discussing and planning your care?

CCM Satisfaction Survey

- Members who were enrolled in CCM for 60 days or more are provided telephonic outreach by coordination staff not directly involved in their care.
- Survey responses are collected on an ongoing basis and reported monthly. And are analyzed and interpreted as part of Evaluating PHM Strategy Effectiveness on an annual basis.
- Feedback data is documented in and reported from the CM software platform Essette.
- Questions are scored on a 0-5
    - **0** = refused to answer
    - **5** = Strongly agree
    - Highest score possible is 44
- Overall goal is to have members respond “agree” or ‘strongly agree” for questions 1-8 and “satisfied” or “very satisfied” for question 9 for a total score of 35 or better or 90% overall satisfaction. Members are also encouraged to provide comments and feedback.
- Members do have the right to refuse to participate in all or parts of the survey.

CCM Satisfaction Survey

	Strongly Agree		Agree		Not Sure		Disagree		Strongly Disagree		Refused To Answer	Sample Size	90% Goal Met
	N	%	N	%	N	%	N	%	N	%	N		
My case manager treated me with respect.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager listened to what I had to say.	5	71%	2	29%	0	0%	0	0%	0	0%	0	7	Y
My case manager returned my phone calls in a timely manner.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager helped me find services that I needed	5	71%	0	0%	2	29%	0	0%	0	0%	0	7	N
I better understand my disease or condition after being in the case management program.	4	57%	1	14%	1	14%	1	14%	0	0%	0	7	N
I am able to better manage my health and health care after being in the case management program.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
My situation is better because of my case manager's help.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
	Very Satisfied		**Satisfied**		**Somewhat Satisfied**		**Not at all satisfied**		**Refused to Answer**				
Overall, how satisfied are you with the Case Management Services you received?	5		1		1		0		0			7	Y

CCM Satisfaction Survey

Quantitative Analysis/Summary

Survey data collected and reported Monthly and evaluated quarterly.

- Overall 100% of members stated they were **overall** satisfied or somewhat satisfied resulting in meeting the 90% goal for this measure.
- 100% percent of members believe that their assigned case manager treated them with respect and listened to what they had to say.
- 100% of members felt their assigned case manager returned phone calls in a timely manner.
- 71% of member believe that their case manager helped them find the services they needed. 29% stated they were unsure.
- 71-72% of members responded that they better understand their disease or condition, are better able to manage their health and their situation is better because of their case mangers help. 14% were not sure, and another 14% disagreed.

CCM Satisfaction Survey

Quantitative Analysis/Summary (Continued)

- SCFHP did not meet the 90% performance goal in four areas:
  1. Help in finding services needed (71%)
  2. Increased understanding of the members' condition (71%)
  3. Improved ability to manage own health (72%)
  4. Improved overall health situation (72%)
- However, in areas 2-4, only one person answered that they "Disagreed".
- In area 1, two people answered "Not Sure" which equated to 28% outlier status.
- Although the majority of of people surveyed expressed satisfaction, the performance rates indicate possible areas of improvement within the CCM program

Survey Participants Comments

- “… stated she's not sure of suggestions for improvement because the case management services provided by the CCM case managers were very excellent. Even though the member didn't speak English, they did a great job caring/helping by listening, being understanding, and accommodating.”

- “… was highly satisfied with the CCM Program and reported high praise for the CCM case managers. She suggested that there should be more case workers like them, showing the type of understanding, compassion, helpfulness, interest, and involvement they had experienced.”

- “… I don't have any suggestions; They have been great every time they call me to check on my mother. They are always there."

CCM Satisfaction Survey

Discussion

- General discussion with our QIC Providers:
  - Any barriers to consider as to why our members …..?
    - *Potential known barriers:*
  - What opportunities for improvements to this process exist?
  - What interventions can be implemented to address the identified opportunities?

CCM Member Complaints

- Grievance and Appeals (G&A) notifies the CM Supervisory team via direct email of members' complaints regarding the CCM program
- There are currently (0) CCM grievance cases open for members enrolled in CCM since June 1, 2018
- This is expected, as SCFHP's CCM program is relatively new and enrollment has not yet reached its peak. The CMC line of business is also quite small (<8,000 members).
- CCM care managers provide information to enrolled members about how to and/or will assist members to file a grievance or appeal if necessary
- Since there are no complaints regarding CCM, a qualitative analysis cannot be conducted. SCFHP will continue to monitor for complaints in CY 2019.

Thank you for your participation!

Your feedback is valuable. These discussions help us improve the quality of our Complex Case Management Program.

If you have any questions or suggestions for ways we can improve this program, please contact:

- Shawna Cagle, Manager, Case Management (scagle@scfhp.com)
- Jamie Enke, Manager, Process Improvement (jenke@scfhp.com)

Santa Clara Family
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Analysis of Continuity and Coordination of Medical Care

(NCQA Requirement QI6 Elements A)

Presented to: Quality Improvement Committee on October 10, 2018

Presented by: Jamie Enke, Process Improvement Manager, on behalf of Sandra Carlson, Director of Medical Mgmt.

Continuity and Coordination of Medical Care

Overview

- Santa Clara Family Health Plan (SCFHP) monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities.
- Annually, SCFHP reviews four data measures associated with member movement between practitioners and member movement between settings. Through analysis, SCFHP identifies four opportunities for improvement.

Movement Across Settings	Movement Across Practitioners
• 1. Ambulatory Care Follow-Up Visit 30 Days Post Discharge • 2. HEDIS: Plan All-Cause Readmissions (PCR)	• 3. PCP Experience Survey • 4. HEDIS: Comprehensive Diabetes Care – Eye Exam Rate (CDC)

30 Day Follow-Up Post Discharge

Overview and Methodology

- Quarterly, SCFHP monitors CMC members that have been discharged from an acute inpatient hospital stay and subsequently had an ambulatory care follow-up visit within 30 days of discharge.
- Required measure for Medicaid-Medicare Plans (MMPs) participating in the duals demonstration – CA 1.11
- **SCFHP's UM Management team determined the performance goal to be 90%.**
  - *Rigorous goal considering member non-compliance, however will ensure that we are constantly reassessing our interventions for continued improvement*

30 Day Follow-Up Post Discharge

Results

Measure 3: Ambulatory Care Follow Up 30 Days After Discharge		Q1	Q2	Q3	Q4	2017 Total
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	280	254	217	239	**990**
Denominator	Total number of hospital discharges.	345	331	271	315	**1,262**
	Rate:	81%	77%	80%	76%	**78%**

30 Day Follow-Up Post Discharge

Quantitative Analysis/Summary

- **The performance goal set for Measurement Year 1 (2017) of 90% was not met cumulatively for 2017, nor was it met at any point in Q1-Q4.**
- Q1 and Q3 achieved the highest rates of 30 day follow-up visits with 81% and 80% respectively. Rates dipped back down in Q2 and Q4 by 4 percentage points. Overall, rates were consistent across quarters.
- The 2017 cumulative rate of 78% shows that SCFHP is 12 percentage points away from meeting the goal of 90%.
- This gap indicates opportunities for improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay.

30 Day Follow-Up Post Discharge

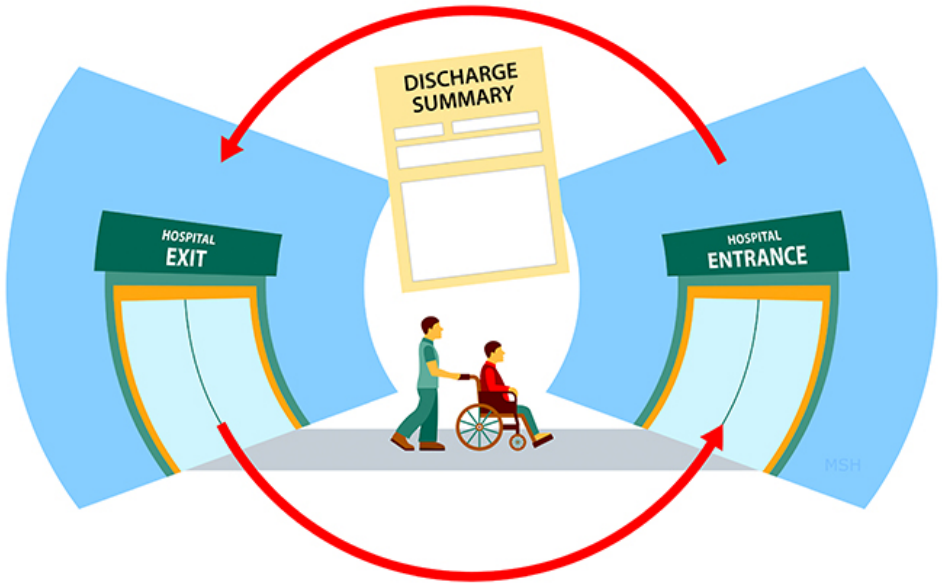
Discussion

- General discussion with our QIC Providers:
  - Any barriers to consider as to why our members cannot seek ambulatory follow up care within 30 days of an acute inpatient discharge?
    - *Potential known barriers: Physicians are not always notified of admissions*
  - What opportunities for improvements to this process exist?
  - What interventions can be implemented to address the identified opportunities?

HEDIS: Plan All-Cause Readmissions (PCR)

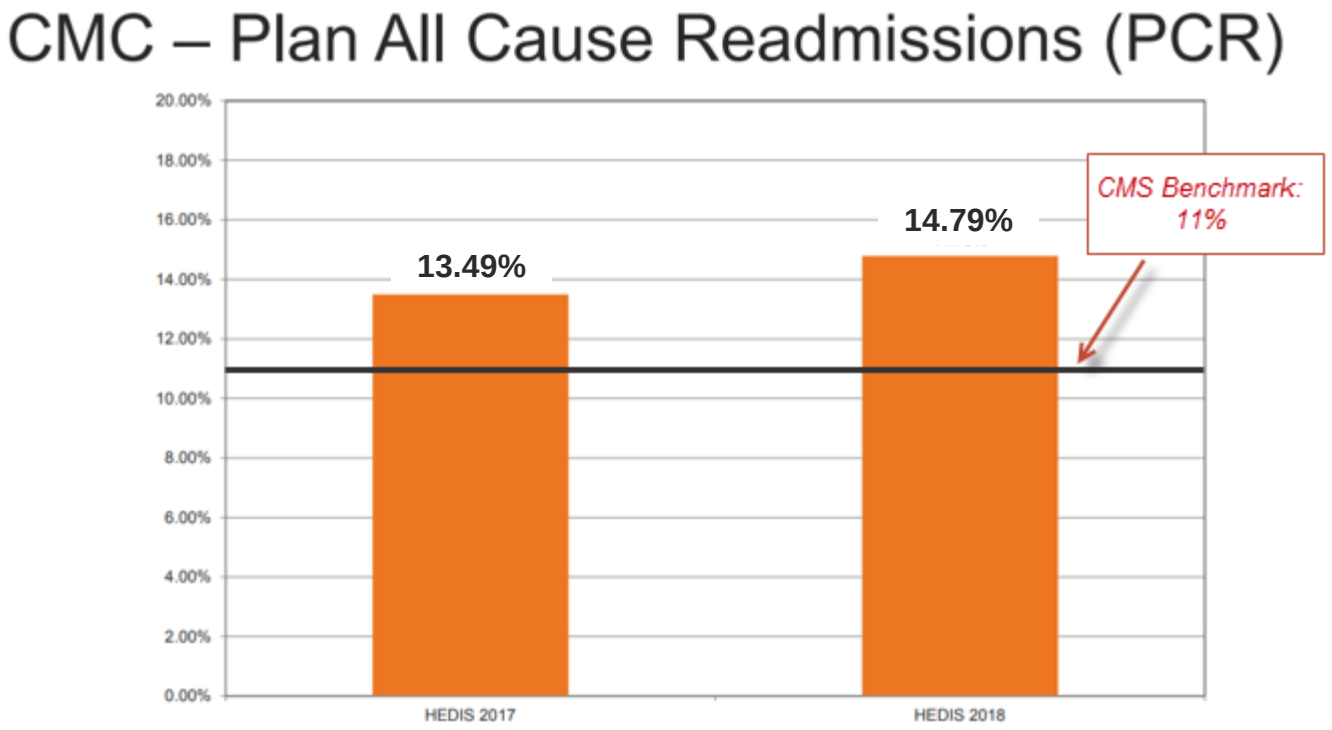
Overview and Methodology

- SCFHP monitors all-cause acute readmissions annually as part of HEDIS reporting and as part of the Quality Withhold data set
- **Included**: Members >= 18 years old with an inpatient acute hospital stay within the measurement year, followed by an unplanned acute readmission for any diagnosis, within 30 days of discharge
- **Performance Goals** *(lower is better!):*
  - CMS 2018 Benchmark: 11%



HEDIS: Plan All-Cause Readmissions (PCR)

Results



HEDIS: Plan All-Cause Readmissions (PCR)

Quantitative Analysis/Summary

- SCFHP missed the performance goal of 11% by 2.5 percentage points in 2017, and 3.8 percentage points in 2018
- The slight decrease in 2017 indicates an opportunity to improve existing processes in place to prevent unplanned acute readmissions

HEDIS: Plan All-Cause Readmissions (PCR)

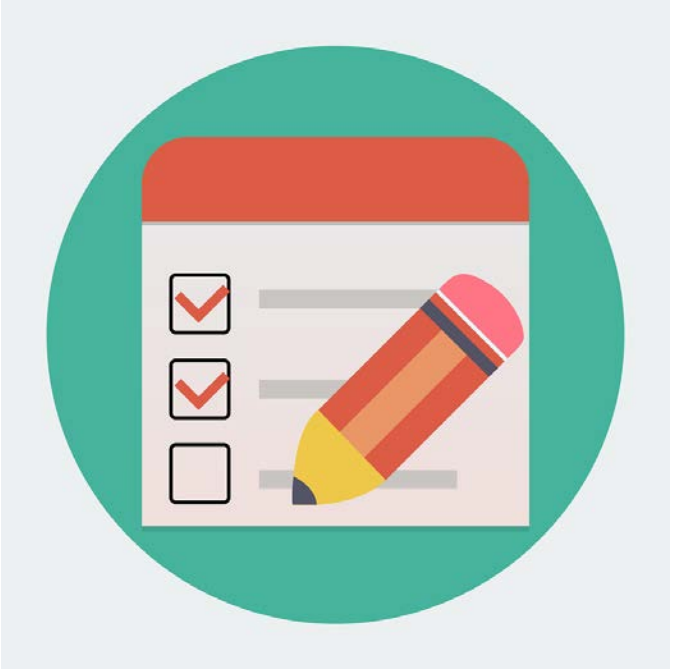
Discussion

- General discussion with our QIC Providers:
  - Any barriers to consider as to why our members may experience unplanned acute readmissions within 30 days of discharge from the hospital?
    - *Potential known barriers:*
      - *SCFHP TOC program focused on Regional Hospital only*
  - What opportunities for improvements to this process exist?
    - *Increased collaboration between SCFHP UM and CM departments to identify transitions of care*
    - *Expand scope of TOC calls*
  - What interventions can be implemented to address the identified opportunities?

PCP Experience Survey

Overview and Methodology

- SCFHP conducts an annual PCP survey to assess experience with continuity and coordination of care between primary care and specialty care.
- Survey Sample = 59 PCPs
  - *Selected from a universe of 428 claims from Q2 2018 where a PCP-assigned member visited a Specialist.*
- Conducted telephonically in September 2018. Three call attempts made over a span of two weeks.
- PCPs were given the option to complete telephonically, via fax or online (using surveymonkey.com).



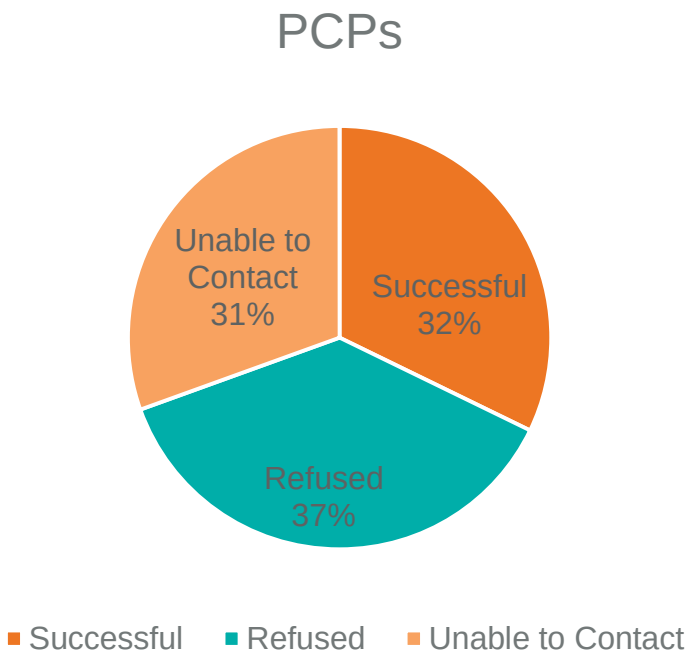
PCP Experience Survey

Methodology (continued)

- **Question 3**: On a scale from 0 (not at all satisfied) to 10 (extremely satisfied) please rate your satisfaction with the overall continuity and coordination of care for your patients.
  - Numerator: The number of providers who answered on a scale of 6-10.
- **Question 4**: Please rate your satisfaction with hand-off of care from Specialty Care to Primary Care (0 = not at all satisfied, 10 = extremely satisfied)
  - Numerator: The number of providers who answered on a scale of 6-10.
- **Question 5**: How often do you receive information about YOUR patients from Specialty Care?
  - Numerator: The number of providers who answered “Always” or “Frequently”
- **Question 6**: Please rate the effectiveness of information you typically receive about care your patients received from Specialty Care.
  - Numerator: The number of providers who answered “Very Effective” or “Effective”
- **Question 7**: Please rate the timeliness of information provided to you by Specialists/Consulting Physicians. (0 = Not at all timely, 10 = Extremely timely)
  - Numerator: The number of providers who answered from 6-10.
- **Question 8**: Please rate the usefulness of information provided to you by Specialists/Consulting Physicians. (0 = Not at all useful, 10 = Extremely useful)
  - Numerator: The number of providers who answered from 6-10.

PCP Experience Survey

Results



Survey Question	Numerator	Denominator	Performance Rate	Performance Goal	Goal Met? (y/n)
3. Satisfaction of continuity and coordination of care for patients	18	18	100%	90%	Y
4. Satisfaction with hand-off of care from Specialty Care to Primary Care	19	19	100%	90%	Y
5. Frequency of receiving information about patients from Specialty Care	10	19	53%	90%	N
6. Effectiveness of information received about care patients received from Specialty Care	16	19	84%	90%	N
8. Timeliness of Information from Specialty Care	17	18	94%	90%	Y
9. Usefulness of Information from Specialty Care	18	18	100%	90%	Y

PCP Experience Survey

Quantitative Analysis/Summary

- 100% of PCPs surveyed were generally satisfied with their patients continuity and coordination of care and the process for hand-off between specialty and primary care
- 100% of PCPs reported that information from Specialty care was generally useful, and 94% reported that the information was generally timely
- **The performance goal was not met in two areas:**
  - Effectiveness of information from Specialty Care: 84% of PCPs surveyed reported that the information was generally effective
  - Frequency of information from Specialty Care: 53% of PCPs surveyed reported that the information was provided frequently

PCP Experience Survey

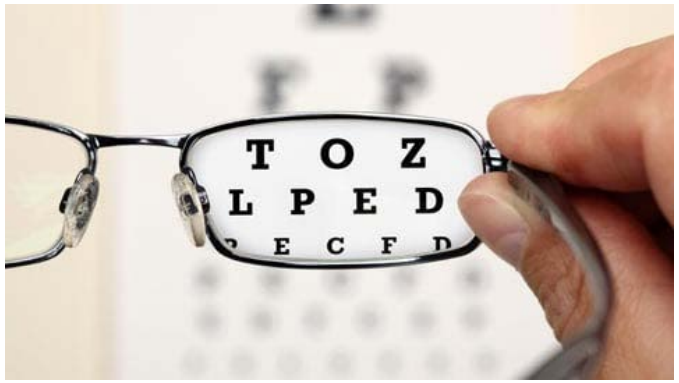
Discussion

- General discussion with our QIC Providers:
  - Any barriers to consider as to why our PCPs do not receive information from Specialty Care as frequently as needed?
    - *Potential known barriers:*
      - *Lack of EHR integration between providers*
  - Any barriers to consider as to why the information from Specialty Care is not as effective as it could be?
    - *Potential known barriers:*
      - *Referring providers not always specific in identifying the reason for specialty referrals*
  - What opportunities for improvements to this process exist?
  - What interventions can be implemented to address the identified opportunities?

HEDIS: CDC – Eye Exam Rate

Overview and Methodology

- SCFHP monitors the CDC - Eye Exam HEDIS rate to assess the movement of diabetic patients between practitioners.
- Measures the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.
- Time Frame: 1/1/2017 – 12/31/2017 and reported for year 2018.
- The performance goal set by Quality Improvement is to meet or exceed the previous year rate.
- In MY1 2016, a performance goal of 47.41% was set and in MY2 2017, the target goal was to maintain or exceed the rate of 62.53% achieved from MY1 2016.



HEDIS: CDC – Eye Exam Rate

Results

Measure 1: CDC Eye Exam Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2016	257	411	62.53%	47.41%	Y
Measurement Y2 2017	297	411	72.26%	62.53%	Y

Quantitative Analysis/Summary:

Performance goal met for both measurement years, no qualitative analysis required.

Thank you for your participation!

Your feedback is valuable. These discussions help us improve the quality of care and service provided to our members.

If you have any questions or suggestions for ways we can improve the continuity and coordination of our medical care, please contact:

- Jamie Enke, Manager, Process Improvement (jenke@scfhp.com)
- Sandra Carlson, Manager, Medical Management (scarlson@scfhp.com)

Santa Clara Family
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QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: August 15, 2018

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	11	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	21	
Number practitioners recredentialed within 36-month timeline	21	
% 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 07/31/2018	199	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
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	1551	972	704	700	383	105

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.

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

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.

Santa Clara Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, June 21, 2018
6:00 PM - 8:00 PM
210 E. Hacienda Avenue Campbell, CA 95008

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	Y
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	N
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	Y
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Lily Boris, MD	SCFHP Medical Director	N
Caroline Alexander	SCFHP Administrative Assistant, Medical Management	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:07 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	
	The SCFHP 1Q2018 P&T Minutes from March 15, 2018 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 1Q2018 P&T Minutes from March 15, 2018 were approved as

		submitted and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	Health Plan Updates Dr. Robertson presented the Health Plan Updates. Santa Clara Family Health Plan is moving to the new building on 6201 San Ignacio Avenue in July. Discussion was had and a vote taken regarding Pharmacy Committee meeting time on a move forward basis in the new building. Proposed start meeting at 6:30 p.m. or continue to meet at 6 pm. Committee voted and it was unanimous to continue meeting at 6 p.m. Health Plan is busy working towards NCQA accreditation. Review period started June 1st. Site visit will take place in February.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q1 2018. There was a spike in Medi-Cal appeals from December 2017 to January 2018. Q1 2018 58% overturn rate, 23% upheld, 11% partially favorable, 7% withdrawn, and 1% dismissed. For CalMediConnect (CMC), Q12018 Part C&D appeals slight increase from January 2018 to March 2018. Redeterminations Q1 2018, 70% overturned, 27% upheld, 3% partially favorable, 0% dismissed.	
	SCFHP Global DUR Dr. Liu presented and update on Global DUR. Streamlined requirements for managed Medi-Cal plans. Retrospective DUR of opioids. Concomitant use of anticholinergics and antipsychotics. Will present at Pharmacy Committee to share updates.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:30 p.m. to discuss the following items: Membership Report, Pharmacy Dashboard, Drug Use Evaluation Results, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect Formulary and Prior Authorization Criteria, Recommendations for changes to Medi-Cal and Healthy Kids Formulary and Prior Authorization Criteria, DHCS Medi-Cal CDL Updates & Comparability, Prior Authorization Criteria and New Drugs.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Robertson presented the membership report.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard.	

Santa Clara Family Health Plan

	Drug Utilization & Spend Review Dr. McCarty presented the Drug Use Evaluation Results.	
	Drug Utilization & Spend Review Dr. McCarty presented the Spend and Trend Overview.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 1Q2018 P&T minutes as well as the MedImpact 2Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 1Q2018 P&T Minutes, and MedImpact 2Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting.	Upon motion duly made and seconded, formulary modifications were approved as presented.
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented DHCS Medi-Cal CDL Updates & Comparability.	
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: 1. Diabetic Supplies 2. Androgel 3. Humira 4. Enbrel	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
	New Drugs and Class Reviews Dr. McCarty presented the following new drug reviews: 1. Aimovig 2. Erleada 3. PCSK9 Inhibitors Line Extensions: 1. Noctiva 2. Sinuva 3. Sublocade 4. Lonhala Magnair	Upon motion duly made and seconded, all recommendations were approved as presented.

	5. Firvanq 6. Bonjesta 7. Zypitamag	
	Reconvene in Open Session Committee reconvened to open session at 7:50 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 1Q2018. High impact drugs: Symdeko, Erleada, Trogarzo, Ilumya, Andexxa, Aimovig, Epidiolex, baricitinib, lorlatinib, Nuvaring, Adcirca, Remodulin, Letairis, Ampyra, Cialis, Tracleer, Kaletra and medium/low impact drugs: Delzicol, Onexton, Zortress, Acanya, Levitra, Androgel, Moviprep, Flector, Proventil HFA, Rapaflo.	
9	**Adjournment at 7:55 PM**	

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
July 18, 2018

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y
Sherry Holm	Behavioral Health Director	Y
Andrea Smith	Utilization Review and Discharge Planning Nurse	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the April 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items:	

ITEM	DISCUSSION	ACTION REQUIRED
	Health Plan will start moving to the new location in South San Jose July 27th. It will be a two phase move. July 30th will be the first day of business in the new location. CMS audit will start August 20th and will be via WebEx. Auditors will be onsite the week of September 3rd.	
V. Discussion/Follow up items	Discussion was had on time for future meetings in the new location. Committee unanimously decided to keep the meeting at the current time of 6 p.m.	
VI. Action Items	a. Care Coordinator Guidelines Ms. Castillo presented two new care coordinator guidelines. Outpatient physical therapy: Care coordinator can approve up to 12 visits. Requests exceeding 12 visits must be forwarded to the nurse for review. Wheelchair repair: Care coordinator can approve if wheelchair is 3 years old or less. After motion duly made, seconded, two new care coordinator guidelines were approved as presented. b. UM Program Evaluation 2017 Dr. Boris presented the 2017 UM Program Evaluation for Medi-Cal and Healthy Kids. Added findings in last column of evaluation.	Present UM Program Evaluation for Cal MediConnect at next UM Committee meeting.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	a. Membership Dr. Robertson presented the update on membership. As of July, membership is at 258,500. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.1% of compliance for routine requests, 97.2% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 97.4% compliant for routine, urgent 97 %, retro 100%. ii. Standard Utilization Metrics Data is for April 1, 2017 to March 31, 2018. For MediCal/non SPD, discharges per thousand is at 3.76, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 15.07. Average length of stay 4.83. For CMC population 5.70 days average length of stay. Discharges per thousand 246.9. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is 50th percentile ranking for average length of stay. Medi-Cal SPD's 180.9 discharges per thousand, CMC is at 246.9 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 5.70 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 14.6. Goal is around 11 to 12% for Non SPD population. SPD Inpatient Readmissions for Medi-Cal overall average of 21.8%. Readmissions on CMC at 15.6%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 19.93%; Ages 65+ readmission rate of 14.23%. For age 18 to 64, greater than 75th percentile ranking, age 65+, less than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures: Back Surgery comparison to benchmark, lower. Mastectomy higher in females age 15 to 44, lower age 45-64. Bariatric surgery higher in females age 20 to 44, lower in males age 20 to 44. Medi-Cal Behavioral Health Metrics based on 3 areas: ADHD Medication, Antidepressant Medication Management, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. Initiation phase and continuation maintenance phase for ADHD Medication is at less than 10th percentile rank. Antidepressant Medication Management Acute Phase Treatment and Continuation Phase Treatment is at greater than 75th percentile rank. Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia is at greater than 90th percentile.	Pull authorization data for next UM Committee meeting. Present criteria for gastric bypass: BMI, age, diagnosis

ITEM	DISCUSSION	ACTION REQUIRED

c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q2 18)
Ms. Castillo presented the Q2 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 2nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 2nd Quarter review of 2018, the findings are as follows:

A. For the dates of services and denials for January, February and March of CY 2018 were pulled in the 1st quarter sampling year.
   a. 30 unique authorizations were pulled with a random sampling.
      i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB
      ii. Of the sample 100% or 30/30 were denials
      iii. Of the sample 27% or 8/30 were expedited request; 73% or 22/30 were standard request.
         1. 100% or 8/8 of the expedited authorizations met regulatory turnaround time of 72 calendar hours
         2. 65% or 15/20 of the standard authorizations met regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
      iv. 63% or 19/30 are medical denials, 37% or 11/30 are administrative denials
      v. 100% or 30/30 of cases were denied by MD or pharmacist.
      vi. 100% were provided member and provider notification.
      vii. 90% or 28/30 of the member letters are of member's preferred language.
      viii. 100% of the letters were readable and rationale for denial was provided.
      ix. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director.

Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows:

- Continue QA report monitoring process
- Manage reviews to meet turnaround time requirements

ITEM	DISCUSSION	ACTION REQUIRED
	d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q218. Required to have a rolling report for any authorizations that does not have a claim attached. Looking at lag time of claims. Need to follow up on why service was not rendered if no claim attached. At end of year will conduct outreach calls to members who have not had services rendered yet. In January, 64% of all authorizations had services rendered for all lines of business. Total number of authorized services not rendered is at 5,727. Percentage of authorizations with no services rendered is 45.2%. e. Procedure for documentation requirements for Prior Authorization when no clinical notes attached Ms. Castillo presented the procedure for documentation requirements when no clinical notes are attached to an authorization request. Any requests without clinical documentation, UM staff makes 3 documented attempts to acquire necessary documentation for review before considering denial for insufficient information. This avoids unnecessary denials. f. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 2,024 calls, Healthy Kids 50 calls, Cal MediConnect calls 93 during the first quarter of 2018. For Medi-Cal the highest number of dispositions rendered was see provider within 24 hours, followed by home/self-care. For Cal MediConnect, see provider within 24 hours, followed by see ED immediately. For Health Kids, no services necessary, followed by see provider within 24 hours. Highest volume for Triage Guidelines used for call types: Medi-Cal-information only, abdominal pain, chest pain, allergic reactions Healthy Kids-information only, bites and stings Cal MediConnect- information only, abdominal pain	

ITEM	DISCUSSION	ACTION REQUIRED
VIII. Behavioral Health UM Reports	Turn Around Time	

ITEM	DISCUSSION	ACTION REQUIRED
	Ms. Holm presented an update on turnaround time. Discussion on ways to improve access to Cal MediConnect members. Required to place with follow up appointment within ten days of discharge. Dr. Alkoraishi mentioned Urgent Care for behavioral health is available at Valley Medical Center. Urgent Care is underutilized. Developmental Screening Summary Ms. Holm presented developmental screening summary. Encourage all children screening with age specific screening tools or age appropriate screening tool for developmental, behavioral, social delays. To be done during regularly scheduled well child visit appointments. Santa Clara Family Health Plan will pay the 96110 code as a Fee for Service to practitioner offices when billed with a well-child diagnosis to Independently contracted providers, PAMF, PMG, and PC. Next steps involve provider education, engagement of delegated provider networks, Valley Health Plan discussion and group discussion.	
IX. Adjournment	Meeting adjourned at 7:30 PM	
NEXT MEETING	The next meeting is scheduled for Wednesday, October 17, 2018, 6:00 PM	

Prepared by:

_____ Date _____

Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

	2017	2018								
Quality & Case Management	**YTD**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**YTD**
Initial Health Assessment										
# of members eligible for an IHA	**48,934**	2,766	2,839	3,013	2,967	4,177	3,298	3,302	3,344	**25,706**
# of IHA completed within 120 days of enrollment	**18,558**	1,284	1,245	1,315	1,259	1,600	1,422	1,525	1,442	**11,092**
% of IHA completed within 120 days of enrollment	**37.9%**	46.4%	43.9%	43.6%	42.4%	38.3%	43.1%	46.2%	43.1%	**43.1%**
Facility Site Reviews										
# of Facilities Due for FSR within the month	**29**	1	3	4	3	5	2	3	0	**21**
# of FSRs completed	**29**	1	3	4	3	5	2	3	0	**21**
# of FSRs that passed	**27**	1	3	4	2	5	2	3	0	**20**
# of FSRs with corrective action	**27**	1	3	4	3	5	2	3	0	**21**
% of FSRs completed timely	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	**100%**