Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, May 09, 2018
6:00 PM - 8:00 PM
210 E. Hacienda Avenue
Campbell, CA 95008
Creekside

Via Teleconference
Residence
3411 S. Conway Ct.
Kennewick, WA 99337

AGENDA

1.	**Introduction**	Dr. Paul	6:00	5 min.
2.	**Meeting Minutes**	Dr. Paul	6:05	5 min.
	Review minutes of the February 21, 2018 Quality Improvement Committee meeting.			
	Possible Action: Approve 02/21/2018 minutes			
3.	**Public Comment**	Dr. Paul	6:10	5 min.
	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.			
4.	**CEO Update**	Dr. Robertson	6:15	10 min.
	Discuss status of current topics and initiatives.			
5.	**Action Items**		6:25	30 min.
a.	Review of QI Workplan		Dr. Liu	
	Possible Action: Approve QI Workplan			
b.	Review of QI Program Evaluation 2017		Dr. Liu	
	Possible Action: Approve QI Program Evaluation			
c.	Review of Population Health Management Description		Ms. Carlson	
	Possible Action: Approve Population Health Management Description			
d.	Review of Case Management Program Evaluation 2017		Ms. Carlson	
	Possible Action: Approve Case Management Program Evaluation			

e. Review of Health Education Workplan — Ms. Shah
Possible Action: Approve Health Education Workplan

f. Review of Health Education Program Evaluation 2017 — Ms. Shah
Possible Action: Approve Health Education Program Evaluation

g. Annual Review of Quality Improvement Policies — Dr. Liu

i. QI.01 Conflict of Interest
ii. QI.02 Clinical Practice Guidelines
iii. QI.03 Distribution of Quality Improvement Information
iv. QI.04 Peer Review Process
v. QI.05 Potential Quality of Care Issues
vi. QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting
vii. QI.07 Physical Access Compliance
viii. QI.08 Cultural and Linguistically Competent Services
ix. QI.09 Health Education Program and Delivery System Policy
x. QI.10 IHA and HEBA Assessments Policy
xi. QI.11 Member Non-Monetary Incentives
xii. QI.12 SBIRT
xiii. QI.13 Comprehensive Case Management
xiv. QI.14 Disease Management
xv. QI.15 Transitions of Care
xvi. QI.17 BH Care Coordination
xvii. QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors
xviii. QI.19 Care Coordination Staff Training
xix. QI.20 Information Sharing with SARC
xx. QI. 21 Information Exchange Between Santa Clara Family Health Plan and County of Santa Clara Behavioral Services Department
xxi. QI.22 Early Start Program (Early Intervention Services)

Possible Action: Approve Quality Improvement policies.

6. Discussion Items — 6:55 — 20 min.

a. Access and Availability — Ms. Turner

-Timely access survey results

b. Appeals and Grievances — Mr. Breakbill

c. Initial Health Assessment (IHA) Quality Study — Dr. Liu

7. Committee Reports

a. Credentialing Committee — Dr. Lin — 7:15 — 5 min.
Review February 07, 2018 and April 04, 2018 reports of the Credentialing Committee.
Possible Action: Accept February 07 and April 04, 2018 Credentialing Committee Reports as presented

b. Pharmacy and Therapeutics Committee — Dr. Lin — 7:20 — 5 min.
Review minutes of the December 14, 2017 Committee Meeting.
Possible Action: Accept December 14, 2017 Pharmacy and Therapeutics Committee minutes as presented

c.	**Utilization Management Committee** Review minutes of the October 26, 2017 and January 17, 2018 UM Committee Meetings. **Possible Action:** Accept January 17, 2018 and October 26, 2017 Utilization Management Committee minutes as presented	Dr. Lin	7:25	5 min.
d.	**Consumer Advisory Board**	Ms. Andersen	7:30	10 min.
e.	**Compliance Report**	Ms. Larmer	7:40	10 min.
f.	**Quality Dashboard**	Ms. Liu	7:50	10 min.
8.	**Adjournment**	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

Persons wishing to address the Quality Improvement Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.

The Quality Improvement Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.

In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify 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 210 E. Hacienda Avenue, Campbell.

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

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, February 21, 2018

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

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Andres Aguirre, MPH	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	N
Chris Turner	Chief Operating Officer	Y
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	N
Darryl Breakbill	Grievance and Appeals Operations Manager	Y
Sandra Carlson, RN	Director of Health Services	Y
Lori Andersen	Director of LTSS	Y
Sherry Holm	Director of Behavioral Health	Y
Caroline Alexander	Administrative Assistant	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:05 p.m. Quorum was established at this time.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Review and Approval of November 08, 2017 minutes	The minutes of the November 08, 2017 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the November 08, 2017 meeting were approved as presented.		
Public Comment	No public comment.			
CEO Update	Dr. Robertson presented the CEO update on behalf of Ms. Tomcala. Membership relatively stable. Health Plan is undergoing major initiatives, preparing for annual DHCS audit. DMHC will be auditing in June (normally every 3 years but now coming every 2 years). HEDIS season starting. Data collection for HEDIS will start in March, along with chart pulling at doctor's offices.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Action Items A. Review of Clinical, Behavioral, and Medical Preventative Practice Guidelines	Mr. Aguirre presented the updates to the 2018 Clinical and Preventive Guidelines. Guidelines are updated every 2 years, also in provider manual. Updated American Diabetes Association to 2018 guidelines. Classification change made to Joint National Committee Treatment of Hypertension Clinical Guidelines. Updated American Association of Family Physicians Adult Preventive Guidelines to 2017 guidelines. Updated CDC's Advisory Committee of Immunization Practices Adult Preventive Guidelines to 2018 guidelines. Also updated Child and Adolescents Preventive Guidelines to 2018 guidelines. Updated Child Health and Disability Prevention-CPSP Prenatal Preventive Guidelines to reflect CPSP guidelines. Updated CDC's Advisory Committee of Immunization Practices Seniors Preventive Guidelines to 2018 guidelines.	Clinical, Behavioral and Medical Preventative Practice Guidelines approved as presented.		
B. Review of QI Program Description	Ms. Liu presented a summary of the QI Program Description. The Quality department reviews the QI Program on an annual basis and makes updates as needed to ensure compliance with all regulatory requirements. The QI Program is reviewed and approved by the Quality Improvement Committee (QIC). The following is a high level list of changes made to this year's QI Program. • **Section V. Goals**- Specific goals found in the 3-way Medicare Medicaid plan contract were added to this section. • **Section VI. Functions**- this entire section was removed because the information was redundant with information found in other sections. • **Section X QI Methodology**- Principles of Continuous Quality Improvement were added to this section. • **Section XI. Quality Issue Identification**- Items A. Ambulatory, and B. Institutional Settings were removed as unnecessary. The In-Home Support Services and Long Term Care Facilities sections were removed as unnecessary. • **Section XV. Committee Structure**- the description of the Governing Board was clarified	QI Program Description approved as presented.		

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	and expanded. • **Section XVI. Role of Participating Practitioners**- the Pharmacy Services section was removed as unnecessary. • **Section XVIII. Utilization Management**- the detail in this section was mostly removed and instead the section references the Utilization Management Program for more detailed information. • **Section XIX**. **Care of Members with Complex Needs**-this section was reduced to include only elements required to be in the QI Program by NCQA with a reference to the Case Management Program for more detailed information.			
C. Review of Case Management Program Description	Note: Update to title on agenda; should be Case Management Program Description not Case Management Program Strategy. Ms. Carlson presented the Case Management Program Description. The objectives of the Complex Case Management (CCM) Program are to regain optimum health and improved functional capability, facilitate access to community resources to meet the needs of members with serious health problems and multiple co-morbidities, identify members who may qualify for and benefit from Long Term Services and Supports (LTSS), optimize available health plan benefits, in the right setting and in a cost-effective manner. Optimal outcomes are achieved through early identification of members at high risk for preventable adverse outcomes and costly care that is amenable to case management intervention; and collaboration with the member, family and physician(s) or other health care providers to address health care needs. The CCM Program involves assessing member needs through the use of a comprehensive health risk assessment; facilitating access to appropriate cost-effective care including community based services; determining the availability of benefits and resources; developing and implementing an individualized care plan (ICP) to include person-centered prioritized goals. Each individualized plan is monitored to assess progress against the goals. The care plan is updated as determined by the member's progress or a sentinel event such as an acute inpatient admission. An annual Member	Bring population health management strategy description to next meeting. Ongoing evaluation of QI measures, policies and procedures to be brought to QI Committee Case Management Program Description approved as presented.		

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	experience survey specific to CCM participation will be conducted at least once annually, to evaluate for any areas needing improvement and/or to improve member satisfaction and engagement. The program specific goals and effectiveness measures for the CCM population include: • Keeping members healthy • Managing members with emerging risk • Patient safety or outcomes across settings • Managing multiple chronic illnesses			
D. Review of Health Education Program Description	Mr. Aguirre presented the Health Education Program Description. Removed Executive Summary, revised statement of purpose and revised program implementation section. Removed Individual Health Assessment (IHA) section and added in section on Population Health Management (PHM). The purpose of the Health Education Program is to deliver general health education, health promotion, and patient education to assist SCFHP beneficiaries to maintain and improve their health and manage their illnesses. SCFHP's Health Education Program complies with the Health Education requirements outlined in the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS and the SCFHP Medi-Cal contract. The Health Education Program supports SCFHP's Population Health Management (PHM) strategy. Operationally for 2018 health education is looking to become more integrated with Case Management, LTSS, and Behavioral Health to make aware of programs in order to refer appropriately.	Health Education Program Description approved as presented.		
E. Review of Cultural and Linguistics Program Description and Evaluation	Mr. Aguirre presented the Cultural and Linguistics (C & L) Program Description for 2018. The goal of the SCFHP C&L Services Program is to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with LEP, sensory	Cultural and Linguistics Program Description and Evaluation approved as presented.		

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	impairment, diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity. The Program ensures that beneficiaries have access to covered services delivered in a manner that meets their needs. It also ensures processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. The program formalizes ongoing efforts to provide culturally and linguistically appropriate services (CLAS) at all clinical and administrative points of contact in a consistent and measurable fashion. Since the effort to provide culturally and linguistically competent care is an on-going process, the C&L Services staff periodically identifies new objectives and activities based on the findings of the Health Education and C&L Group Needs Assessment (GNA) which is administered every 3 years or as often as required by DMHC or DHCS. SCFHP also incorporates beneficiary, provider and staff feedback expressed at Consumer Advisory Committee (CAC), Provider Advisory Committee (PAC), and Quality Improvement Committee (QIC) meetings, area demographic research and organizational priorities into the development of its C&L Services Program.			
F. Behavioral Health Policies for Approval	Ms. Holm presented two Behavioral Health policies for approval: QI.23 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care QI.24 Outpatient Mental Health Services: Mental Health Parity Amend to indicate Quality Improvement as issuing department.	Behavioral Health Policies approved as amended. Dr. Alkoraishi to send resource on Title 42 CFR		
G. Palliative Care Policies for Approval	Ms. Carlson presented one Palliative Care policy for approval: QI.25 Intensive Outpatient Palliative Care Amend to include Cal MediConnect line of business.	Palliative Care Policies approved as amended.		
H. LTSS Policies for Approval	Ms. Andersen presented one LTSS policy for approval: QI.16 Managed Long Term Services and Supports (MLTSS) Care Coordination	LTSS Policies approved as amended.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Amend to add frequency of review.			
Discussion Items				
A. Access and Availability	Ms. Turner presented the Access and Availability update. Report is due March 31st. Several surveys conducted related to access and availability. Valley Health Plan and Kaiser conduct their own surveys, which are excluded from Santa Clara Family Health Plan survey results. Identify networks to survey, create provider contact list and determine survey questions. All has to be approved by DHCS. Survey conducted in the 4th Quarter of 2017 (started in October 2017). Currently calculating compliance rates and will validate with ADVENT (outside vendor used to validate results). 261 surveys conducted in 2017 with contracted providers and ancillary providers. Surveys include Provider Satisfaction Survey and Customer Satisfaction Survey. Identified providers needing Corrective Action Plan (CAP) regarding afterhours access. Increased oversight of access, internal cross functional workgroup, provider education/outreach.	Return with survey results at next Quality Improvement Committee meeting Provider Network Access manager to attend next Quality Improvement Committee meeting		
B. Appeals and Grievances	Mr. Breakbill presented the Appeals and Grievances update. Focusing on trends and how to capture issues. Taking action on how to resolve issues. Specifically focusing on Cal MediConnect (CMC) non-contracted provider appeals, transportation grievances, and Kaiser EPO process. Non contracted provider appeals are about payment, specifically wound care appeals. Pre services appeal process if does not meet medical necessity criteria. Non contracted providers going into contracted facilities and providing services. Goal is to engage providers and see if services are needed. Transportation grievances focused on no shows. Intervention to include member education that return home trip needs to be booked separately, not provided. Monitoring this and still have education portion to go through. EPO process established members only. 6 months or family member in Santa Clara Family Health Plan that has Kaiser as their network. In the final stages of posting to Santa Clara Family Health Plan website and added to Evidence of Coverage.			
Committee Reports				

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
A. Credentialing Committee	Dr. Robertson presented the October 4th and December 6th Credentialing Committee meeting minutes. 100% timely credentialing and re-credentialing. No termination or suspension of providers.	Minutes of the October 4 and December 6, 2017 Credentialing Committee meeting were approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the September 21st Pharmaceutical and Therapeutics Committee meeting minutes. Almost 50% overturn of grievances and appeals. Formulary modifications were presented to the committee. Two pharmacy policies were presented for approval.	Minutes of the September 21, 2017 Pharmaceutical and Therapeutics Committee meeting were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the October 18th Utilization Management Committee minutes. Of the 773 admitted to Skilled Nursing Facilities, 400 converted to Long Term Care. Reviewed 2018 Prior Authorization Grid. Colonoscopy no longer requires prior authorization. Presented dashboard metrics. Annual out of network report.	Minutes of the October 18, 2017 Utilization Management Committee meeting were approved as presented.		
D. Dashboard	Ms. Liu presented the Quality Dashboard. October there were 3 Facility Site Reviews (FSR's), November 2, and in December 0. October there were 61 Potential Quality Issues (PQI's), November 93, December 62. One level 3 PQI was identified in October involving patient harm. FSR is done every 3 years and before provider gets credentialed.			
E. Compliance Report	Deferred until 2nd Quarter. Still working with Chief Compliance Officer to determine components of report.			
F. Consumer Advisory Board	Ms. Andersen presented the Consumer Advisory Board Report. Meets monthly in collaboration with Anthem Blue Cross.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Recruitment for CMC CAB membership was done in the past quarter and 3 new members were added to the Board. **Summary of Issues**: • Community Based Adult Services: Two SCFHP members encountered some challenges using CBAS services. They found that their language was not spoken at the CBAS near their homes, and the CBAS site without a language barrier was too far away. • Fitness Benefit: Members continue to ask if SCFHP will provide free fitness services. • Valley Medical Center - Valley Connections process: Member complained about the protocol of Valley Connections on how to leave a message to their physician or how to ask a question. Member was informed she had to log in the "My Help Line" to get her question answered. Member stated she has trouble using the navigation of the services. Charlene suggested the member could call Member Services and they can call Valley Connections together to ask how to navigate "My Help Line". • Call Center Delays Member complained about the wait time when calling Member Services; you receive a recording "No calls ahead of you" and the member still has a wait time of 5 to 10 minutes. **Questions:** • Out of Town Medical Needs Member asked about travel out of county to visit family and the need to go the clinic for PICC Line dressing changes weekly. The question about paying for services if seen by an out of area clinic was raised and Member was referred to the SCFHP Customer Services to facilitate coordination with the physicians' office for authorizing member's visits out of town. • Durable Power of Attorney for Heath Care			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Member asked about designating a DPA for Health Care if they do not have any family members or friends they can appoint. A referral to the Health Insurance Counseling and Advocacy (HICAP) program was made. • Member Assessments Clarification was sought by several members about the differences between Health Risk Assessment, other assessments and the annual PCP visit and exam, as well as the overall process including phone calls and mailings.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Ria Paul at 7:33 p.m.			
Next Meeting	Wednesday, May 9, 2018- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD

Quality Improvement Committee Chairperson

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Quality of Care	**QI Program Evaluation**	QI Program Annual Evaluation	CMC 2.16.3.3.4 NCQA 2018 QI1B	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annually	May-19		Approved by QIC: Adopted by Board:	
Quality of Care	**Member Safety**	SCFHP provides members with the information they need to understand and use their pharmacy benefit.	NCQA 2018 MEM2C	Ensure pharmacy benefit information provided to members on an ongoing basis is accurate	- The Pharmacy Department will collect data and review for accuracy and ensure quality of information being provided to members	- Bi-annually the Pharmacy Department will report -data collection - assessment -actions	100%	Pharmacy Manager	Bi-annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2018 MEM3C	Ensure members can use personalized information to navigate health plan services effectively	- The Customer Service Department will collect data on the quality and accuracy provided, compare information against goals, and determine deficiencies in delivery of information act to improve deficiencies identified	- Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions to improve data	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2018 MEM3D	Ensure quality and timely email communication to members is happening on an ongoing basis	- The Customer Service Department will collect data email responses to members is happening on an ongoing basis in a timely manner	Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions of email responses to members	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1A	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- SCFHP assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	Analysis of cultural, ethnic, racial and linguistic needs of it's members relative to the provider network	100%	Provider Network Access Program Manager,	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1B	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Analyze performance against primary care availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1C	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high-volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	Analyze performance against specialists (including high volume and high impact) availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1D	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	Analysis of behavioral health care practitioners access standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services	NCQA 2018 NET2A -C	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services.	Collect and preform analysis of data for primary care, specialty, and behavioral health 1. Regular and routine care appointments. 2. Urgent care appointments. 3. After-hours care	Analysis and report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors access to healthcare services and takes action to improve it	NCQA 2018 NET3A-C	SCFHP provides members adequate network access for needed healthcare services.	- SCFHP annually: 1. Analyzes data from member experience, complaints and appeals about network adequacy for non-behavioral healthcare, behavioral, and overall services 2. Analyzes data from member experience, complaints and appeals about network adequacy for behavioral healthcare services, behavioral, and overall services 3. Compiles and analyzes requests for and utilization of out-of-network services. 4. Prioritizes opportunities for improvement identified, 5. implements intervention 6. measure effectiveness of interventions	Annual report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP systematically collects, integrates and assesses member data to inform its population health management programs	NCQA 2018 PHM2B	SCFHP assesses the needs of its population and determines actionable categories for appropriate intervention.	- SCFHP annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Assesses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI)	Annual report	100%	Health Educator	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP coordinates services for its highest risk members with complex conditions and helps them access needed resources.	NCQA 2018 PHM5	SCFHP helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.	-SCFHP implements on an annual basis a member survey on members experience with case management -collects member complaint data on an ongoing basis from grievance process	Annual report	100%	Case Management Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement	NCQA 2018 PHM6A	- Quantitative results for relevant clinical, cost/utilization and experience measures -Comparison of results with a benchmark or goal. -Interpretation of results	-collect data on relevant cost, utilization and experience measure	Annual report	100%	Case Management Manager	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors member experience with its services and identifies areas of potential improvement	NCQA 2018 QI4A	-Using valid methodology, the organization collects and performs an annual analysis to measure its performance against its standards for access to Member Services by telephone	- Annual analysis to measure telephone access against standards	Annual report	100%	Customer Service Director	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4C	To assess member experience with its services, the organization annually evaluates member complaints and appeals	Collect valid measurement data for each of the following categories -quality of care -access -attitude and service -billing and financial issues -quality of practitioner office site	Annual report	100%	Grievance Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4D	SCFHP annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis	Analyze and identify opportunities for improvement from the following sources -Member complaint and appeal data -CAHPS survey	Annual report	100%	Performance Improvement Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4E & F	Assess member experience with Behavioral Health services Evaluate and identify opportunities for improvement	-Evaluate member complaints and appeals --conduct member survey -Improve members experience with behavioral healthcare and service --Assess data from complaints and appeals or from member experience surveys --Identifying opportunities for improvement --implementing interventions --measuring effectiveness of interventions	Annual report	100%	Behavioral Health Director	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	Assessing Experience With the UM Process	NCQA 2018 QI4G	SCFHP annually assessment of experience with the UM process	Collect and analyzing data on member experience to identify improvement opportunities. Collects and analyzing data on practitioner experience to identify improvement opportunities.	Annual report	100%	Utilization Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Quality of Care	**QI Program**	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4 .7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2017 QI Evaluation and 2018 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annually	May-18		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.	NCQA 2018 QI5A - C	SCFHP annually identifies opportunities to improve coordination of medical care, act on opportunities identified, measuring effectiveness of improvement actions taken	A. Collect 1. Collect data on member movement between practitioners 2. Collect data on member movement across settings 3. Conduct quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting four opportunities for improvement B. Act Annually act to improve coordination of care activities identified in the Collect phase C. Measure Annually measure the effectiveness of improvement actions taken in the Act phase	Quantitative and qualitative analysis with identification of four opportunities for improvement documented in a report	100%	Health Services Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Medi-Cal and CMC	**UM Program**	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annually	September-18		Approved by QIC: Adopted by Board:	
Quality of Service	**CAHPS**	Annual Oversight of CAHPS Survey and Work Plan		Complete Annual Survey, Analyze Results,	Develop Improvement Plans based on results	Areas for improvement identified in the CAHPS 2018 survey	Annual recommendation	QI Project Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Quality of Service	**HOS**	Annual Oversight of HOS Survey and Work Plan		Complete Annual Survey, Analyze Results, Develop Improvement Plans based on results	Develop Improvement Plans based on results	Areas for improvement identified in the HOS survey	Annual recommendation	QI Project Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Quality of Service	**NCQA Plan Ratings**	Annual Oversight of NCQA Plan Ratings and Work plan		Analyze Results	Develop Improvement Plans based on results	N/A	Starting in 2020					Approved by QIC: Adopted by Board:	
Timely Access	**Access/Availability**	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1		Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hours 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity		97%	Provider Services Director	Quarterly	April 2018 Sept 2018 Dec 2018		Approved by QIC: Adopted by Board:	
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews New applicants processed within 180 calendar days of receipt of application		100%	Credentialing Manager	Quarterly	Feb 2018 April 2018 Sept 2018 Dec 2018		Approved by QIC: Adopted by Board:	
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews Recredentialing is processed within 36 months		100%	Credentialing Manager	Quarterly	Feb 2018 April 2018 Sept 2018 Dec 2018		Approved by QIC: Adopted by Board:	
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.		90%	Provider Services Director	Annually	August-18		Approved by QIC: Adopted by Board:	
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution		90%	Provider Services Director	Annually	August-18		Approved by QIC: Adopted by Board:	
Medi-Cal and CMC	**Utilization Management**	CM Program Annual Evaluation			CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis		Annual Evaluation	CM Manager	Annually	May-18		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Medi-Cal and CMC	**HEDIS Reporting**	Report HEDIS successfully by 6/15/2018	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 15, 2018 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/5/2018 - Have no Medi-Cal HEDIS measures below the NCQA Medicaid 25th percentile (MPL)	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV	- Submission of the IDSS to NCQA by 6/15/2018 - CMC Test warehouse	Annual Submission	HEDIS Project Manager	Annually	June-18	-	Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Statewide Disparity Performance Improvement Projects**	Increase rate of childhood immunization status combo 3 for vietnamese children	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	6.3% percent increase in immunization rates over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2018	25% for Network 60 by the end of the PIP 6.3% increase over baseline rate of 18.7%	QI Project Manager	Quarterly	August-18		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal**	Controlling blood pressure for members with hypertension	Medi-Cal Exhibit A Attachment 4.9.C.a	23.53% percent increase in CBC rate over the 18 month life of the project	Use Member Incentive to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2018	50% for Network 10 by the end of the PIP. 23.53 percent increase over baseline rate of 26.47%	QI Project Manager	Annually	August-18		Approved by QIC: Adopted by Board:	23.53
Quality of Service	**Internal Performance Improvement Projects CMC**	Increase number of members with an ICP and discussion of care goals	CMC 2.16.4.3.1.2.1	Increase the percentage of members with an ICP completed and percentage of members with documented discussion of care goals	- Plan will further develop and implement new processes and training materials to improve consistency of documentation within SCFHP's case management software program	Annual Submission	By December 31st 2018, increase by 5% from baseline in all three submeasures	Health Services Director	Annually	January-19		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Internal Performance Improvement Projects CMC**	HEDIS Measure: Reducing readmissions within 30 days of discharge (PCR)	CMC 2.16.4.3.1.2.1	Successfully submit PIP for the CMC line of business	- HEDIS test run of CMC data for barrier analysis - Collaborate within the Medical Management department to start an initial PDSA cycle	submit a final PIP resubmission to CMS for approval	- Three percent reduction in readmission rates from baseline - 9/17/14 - 10/16/15 PCRB 16.41% -CY 2016 PCRB 16.86% -CY 2017 PCRB 12.69%	QI Project Manager	Annually	October-18		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2018 External Accountability Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS - Reminder letters on birthday month - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 25th percentile (48.26%) - 57.42% HEDIS 2017	QI Manager or designee	Quarterly	October-18		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Childhood Immunization Status (CIS) – Combination 3	DHCS 2018 External Accountability Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 3	- Develop and implement interventions based on a barrier analysis for CIS Combo 3 - Televox reminder calls for non compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 3 rate over the Medicaid 50th Percentile (71.06%) - 77.37% HEDIS 2017	QI Manager or designee	Quarterly	Ongoing - Monthly		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Project: Diabetes**	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2018 External Accountability Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 90th percentile (89.43%) - 88.32% HEDIS 2017	QI Manager or designee	Quarterly	November-18		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Quality of Clinical Care	**Project: Cardiovascular Conditions**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2018 External Accountability Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (54.80%) -66.91% HEDIS 2017	QI Manager or designee	Quarterly	November-18		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Project: Access & Availability of Care**	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - do a meta analysis of the interventions done by other Medi-Cal health plans in the region to find the most effective type of prenatal program - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (82.25%) -82.48% HEDIS 2017	QI Manager or designee	Quarterly	November-18		Approved by QIC: Adopted by Board:	
Quality of Clinical Care	**Project: Utilization**	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (82.97%) - 73.97% HEDIS 2017	QI Manager or designee	Quarterly	November-18		Approved by QIC: Adopted by Board:	
Quality of Service	**Project: 120 Initial Health Assessment**	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations	- Medicaid rate 100%	QI Manager or designee	Quarterly	December-18		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	NCQA Accreditation of the CMC line of business	CMC	Obtain full accreditation status by CY 2019	- obtain full accreditation by Q1 2019	-full accreditation for CMC line of business	Achieve full accreditation	Performance Improvement Manager	Annually	October-18		Approved by QIC: Adopted by Board:	
Safety of Clinical Care	**Facility Site Review**	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow/up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis		QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:	
Safety of Clinical Care	**Quality of Care**	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQI's originating from Grievance and Appeals within 30 days Complete all PQI's from other sources in 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQI's - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	100%	QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues	Sort
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 A	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders 5. Primary or secondary preventive behavioral healthcare program implementation 6. Special needs of members with severe and persistent mental illness	Aggregate available data	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 B	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identify and selecting two opportunities for improvement from QI6A 4. Taking collaborative actions to address two identified opportunity for improvement from QI6A	Analyze data identified in QI6A	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 C	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually measures the effectiveness of improvement actions taken for activities identified in QI6B	measure effectiveness of collaborative actions take as part of QI6B	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:	

2018 Quality Improvement Work Plan

Jeff Robertson, MD
Chief Medical Officer
Santa Clara Family Health Plan

Date

Santa Clara Family Health Plan

The Spirit of Care

2017 QUALITY IMPROVEMENT PROGRAM EVALUATION

☑ Annual Evaluation

A. CLINICAL IMPROVEMENT ACTIVITIES

NCQA 2017 Quality HEDIS Measures: (2016 Measurement Year)

HEDIS Hybrid Measure Key:

- Childhood Immunization Status – CIS (MC & HK)
- Well Child Visits in First 15 Months – W15 (HK)
- Well Child Visits 3,4,5,6 – W34 (MC & HK)
- Cervical Cancer Screening – CCS (MC)
- Timely Prenatal and Postpartum Care – PPC (MC)
- Comprehensive Diabetes Care – CDC (MC & CMC)
- Weight Assessment and Counseling –WCC (MC)
- Immunization for Adolescents – IMA (MC & HK)
- Controlling High Blood Pressure – CBP (MC & CMC)
- Adolescent Well Care Visits – AWC (HK)
- Adult BMI Assessment – ABA (CMC)
- Colorectal Cancer Screening – COL (CMC)
- Medication Reconciliation Post-Discharge – MRP (CMC)
- Care of Older Adults – COA (CMC)

HEDIS Administrative Measure Key:

- Chlamydia Screening – CHL (HK)
- All Cause Readmission – ACR (MC) / PCR (CMC)
- Ambulatory Care – AMB (MC)
- Use of Imaging Studies for Low Back Pain –LBP (MC)
- Appropriate Treatment for Children w/ Upper Respiratory Infection – URI (HK)
- Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis – AAB (MC)
- Appropriate Testing for Children w/ Pharyngitis – CWP (HK)
- Use of Appropriate Medication for People w/ Asthma – ASM (HK)
- Children's & Adolescent's Access to PCPs – CAP (MC & HK)
- Annual Monitoring for Patients on Persistent Medication – MPM (MC)
- Annual Dental Visit – ADV (HK)
- Follow-Up After Hospitalization for Mental Illness – FUH (CMC)
- Asthma Medication Ration – AMR (MC)
- Breast Cancer Screening – BCS (MC & CMC)
- Osteoporosis Management in Women Who Had a Fracture – OMW (CMC)
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis – ART (CMC)

A.1 Goal:

- Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL) ALL Medi-Cal HEDIS Measures
- Develop and implement interventions for MMCD Auto-Assignment Measures and for CMS Quality Withhold Measures
- Increase administrative (claims and encounter) data submissions across Networks

A.2. Interventions:

- Collect and report Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) rates for ALL Product Lines within specified timeframe
- Developed member incentives to support CDC – Retinal Eye Exam, Controlling High Blood Pressure, and Cervical Cancer Improvement Projects
- HEDIS results and analysis presented to:
  - SCFHP Board of Directors & SCFHP Quality Improvement Committee,
- Quality Improvement Activities:
  - Continued immunization reminder postcards to parents with children at 17 months of age to receive recommended immunizations
  - Education in Quarterly Member Newsletters, Provider eNewsletters, for immunizations, well child visits, diabetic care, prenatal and postpartum care and dental care

2017 QUALITY IMPROVEMENT PROGRAM EVALUATION
☑ Annual Evaluation

A.3. Results:

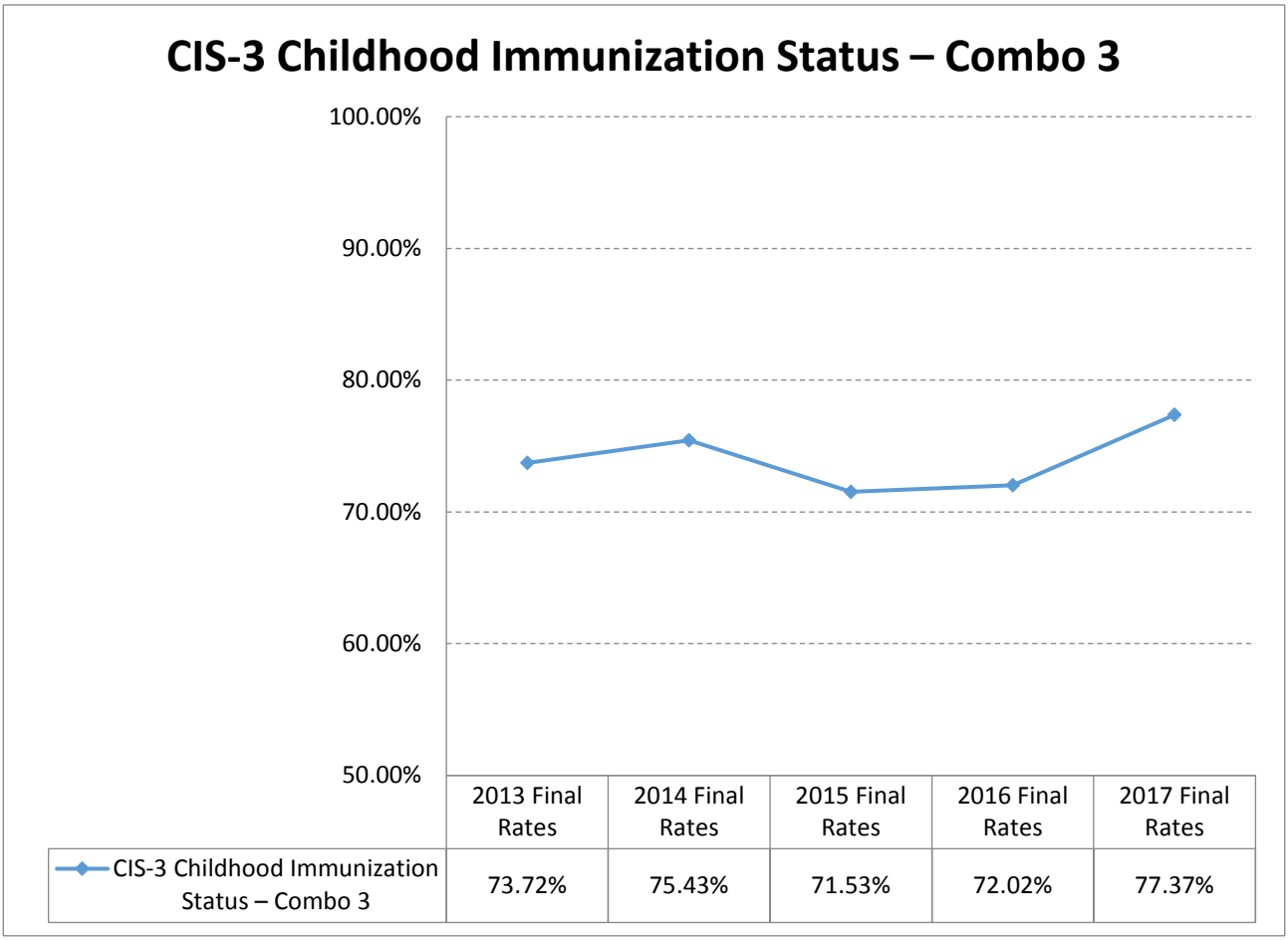
- Exceeded MMCD Minimum Performance Level (MPL) for all measures
- No Medi-Cal measures exceeded the HPL
- Medi-Cal measures that have improved significantly (>5%) from the prior year; Cervical Cancer Screening, Childhood Immunization Status – Combo 3, Comprehensive Diabetes Care – Retinal Eye Exam, Comprehensive Diabetes Care – Blood Pressure Control, Controlling High Blood Pressure, Weigh Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents – Counseling for Physical Activity
- Medi-Cal measures that decreased significantly (>5%); Medication Management for People with Asthma – Medication Compliance 50% Total, Medication Management for People with Asthma – Medication Compliance 75% Total, and Comprehensive Diabetes Care – HbA1c Control (<8%)
- All CMC measures reportable for 2017. There are no MPL's for the CMC line of business.

A.4. Analysis of Findings/Barriers/Progress

- Due to Administrative Data Volume being flat, continued chart abstraction and Pinpoint chart chase logic is necessary to improve key measures.
- A Provider/Network dashboard for each measure is necessary to define further provider interventions.
- HEDIS Member outreach and incentives is important to increase key measures.
- Providers / Networks continue to require assistance for data issue improvements:
  - Provider Address discrepancies
  - Coding issues
  - Timely data submission

Immunization Measures Findings

CIS – Childhood Immunization Status (Combo 3) (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
CIS-3 Childhood Immunization Status – Combo 3	73.72%	75.43%	71.53%	72.02%	77.37%

Analysis and Findings/Barriers/Progress

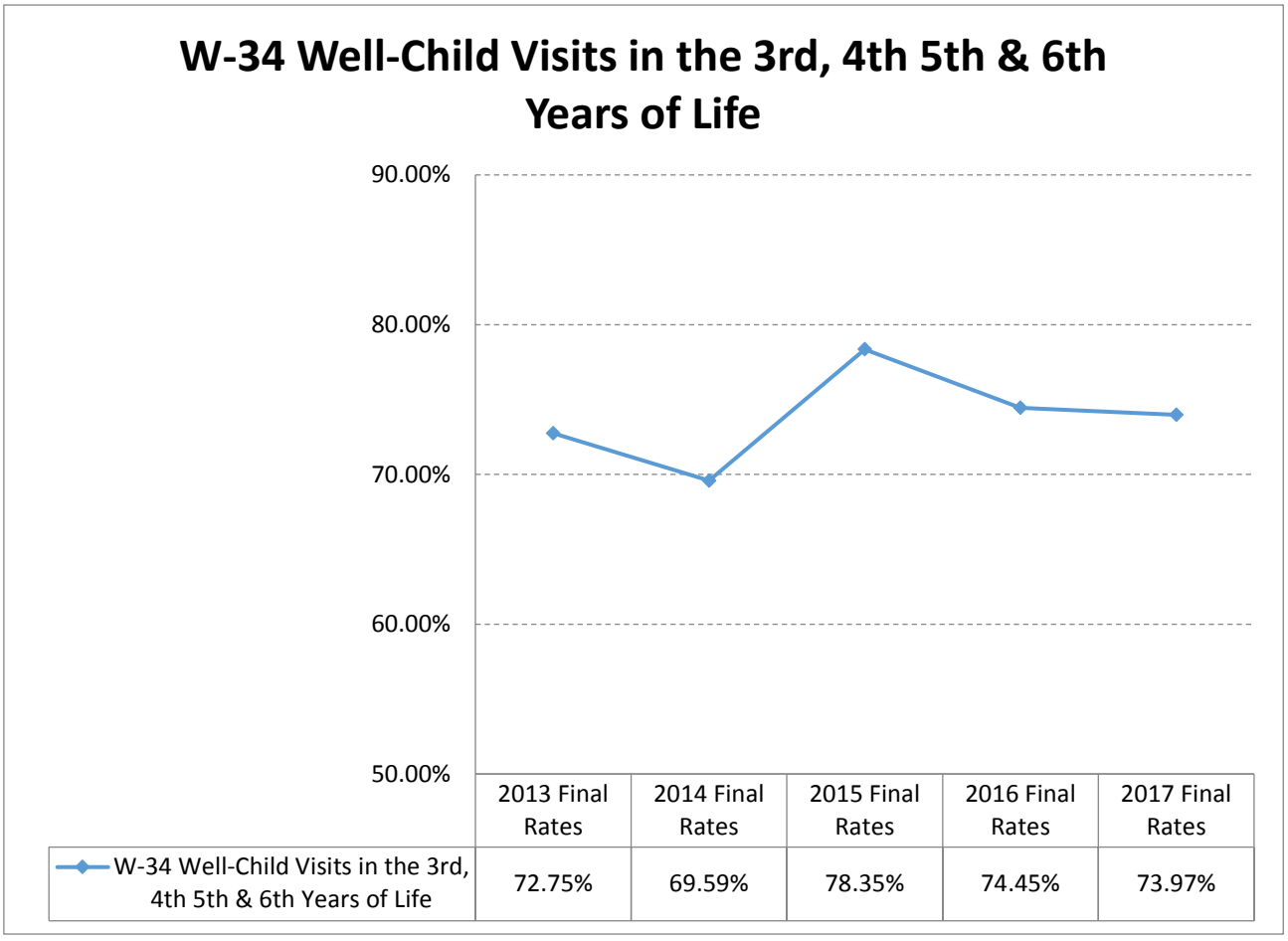
- Above the MPL of 64.30% and remains below the HPL of 79.81%.
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2.

Follow up/Actions:

- New interventions in place for 2018 for providers on immunization schedule.
- New interventions in place for 2018 for member outreach and incentives.
- Continue to utilize CAIR for missing immunization status in claims and/or PCP medical record.
- Mine CAIR for additional numerator events that were not matched from the HEDIS extract.

Well Child Visits Key Findings

W34 – Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	72.75%	69.59%	78.35%	74.45%	73.97%

Analysis and Findings/Barriers/Progress

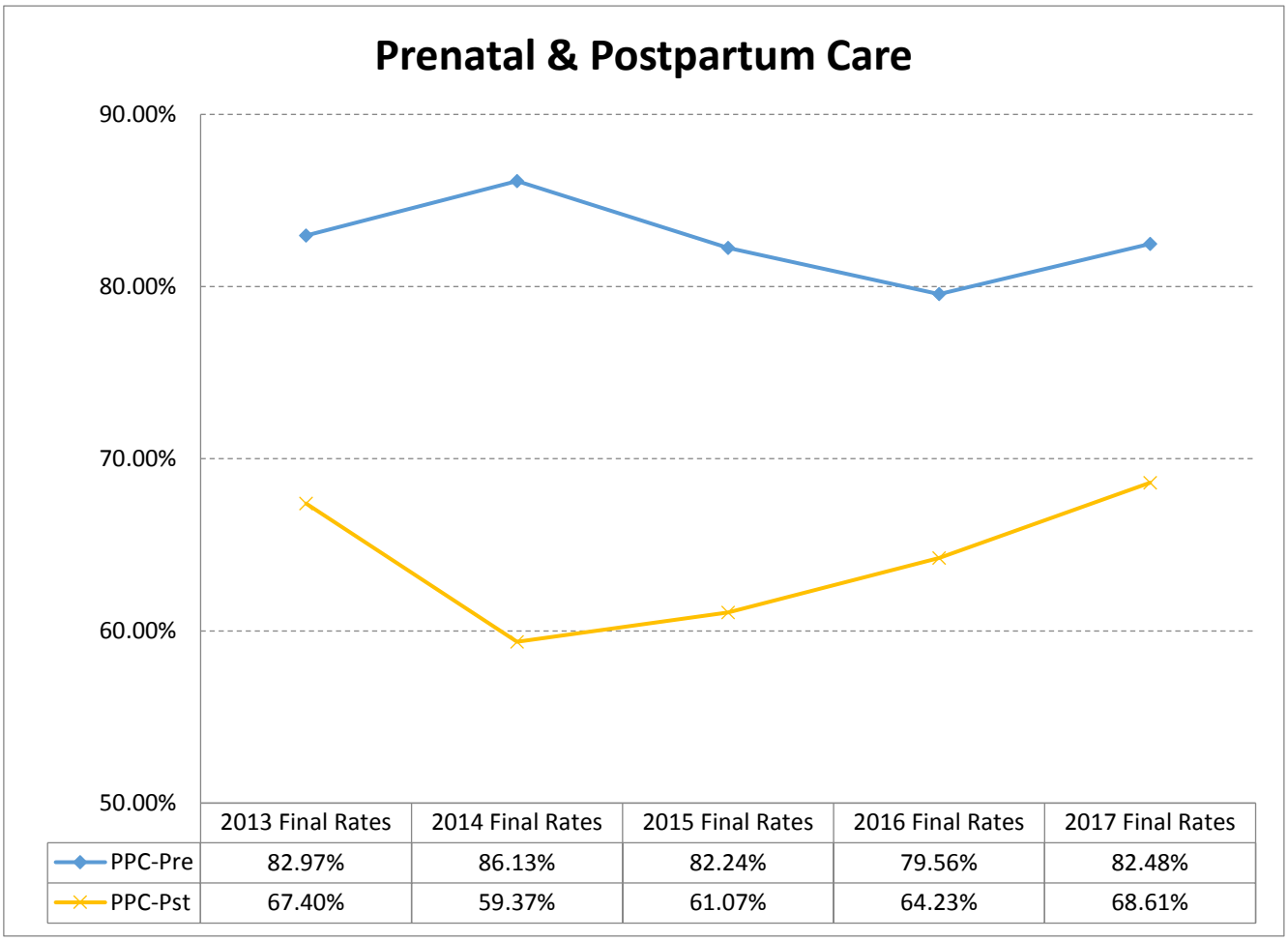
- Above the MPL of 64.72% and remains below the HPL of 82.97%.
- 2017 rate dropped by .48% from HEDIS 2016.

Follow up/Actions:

- Focus ideas on new interventions in 2018 for member outreach with incentives.
- Focus ideas on new interventions in 2018 for Providers on well child visit schedule.
- Pinpoint chart chases for this measure for 2017 data.

Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
PPC-Pre	82.97%	86.13%	82.24%	79.56%	82.48%
PPC-Pst	67.40%	59.37%	61.07%	64.23%	68.61%

Analysis and Findings/Barriers/Progress

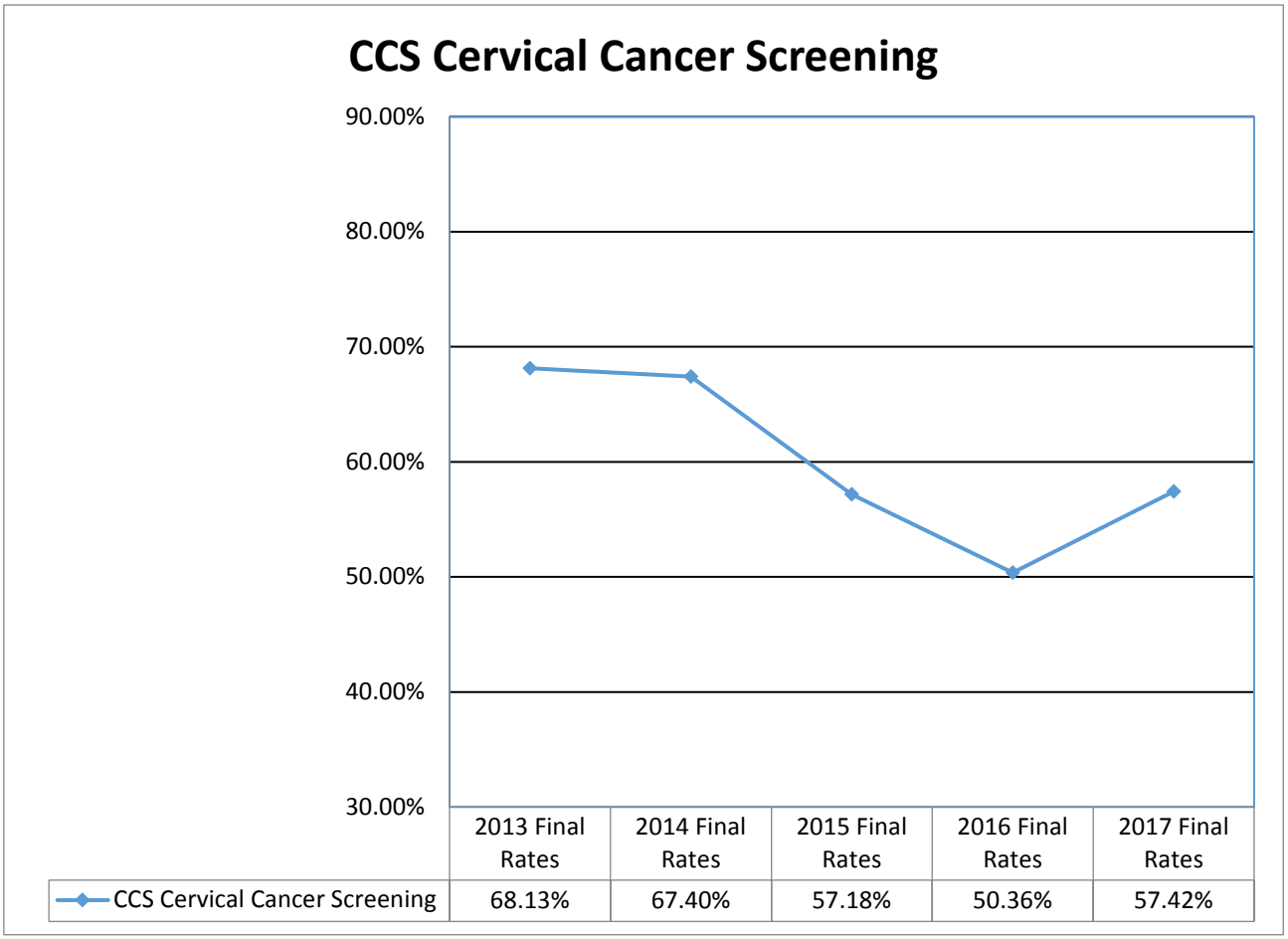
- Above the MPL's and remains below the HPL's of both indicators.
- For Prenatal visits, rates increased by 2.92%; Postpartum visits, rate increased by 4.38%.

Follow up/Actions:

- Focus ideas on new intervention in 2018 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2018 data.

Adult Measures: Cervical Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
CCS Cervical Cancer Screening	68.13%	67.40%	57.18%	50.36%	57.42%

Analysis and Findings/Barriers/Progress

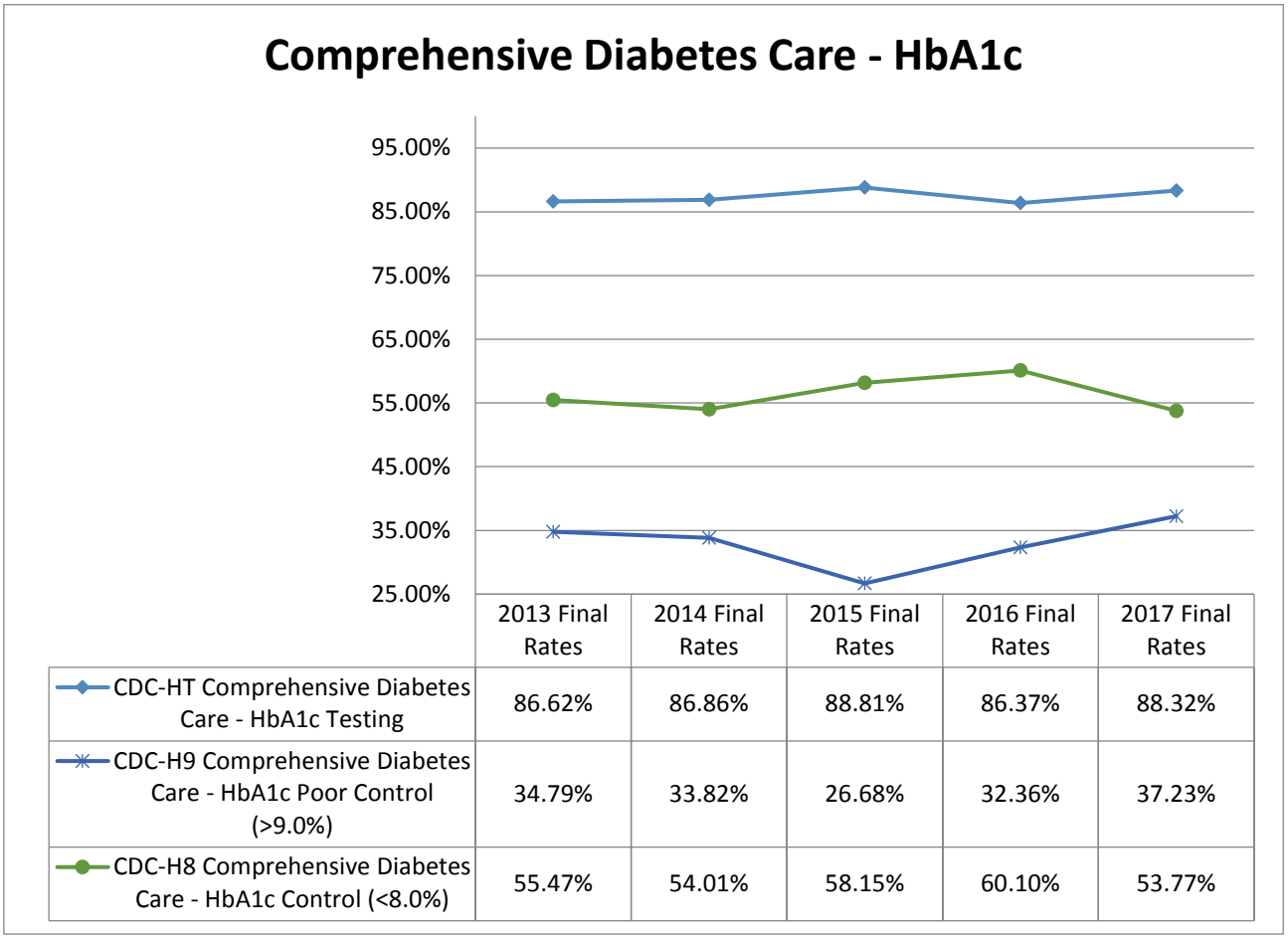
- Measure is below MPL of 48.26% but below HPL of 69.89%.
- Rate increased 7% from HEDIS 2016.

Follow up/Actions:

- Focus ideas on new intervention in 2018 for member reminders.
- Pinpoint chart chases for this measure for 2017 data.
- The plan implemented a member incentive of a $15 Target gift card.

Chronic Care/Disease Management Measures: Comprehensive Diabetes Care (CDC)

CDC – Comprehensive Diabetes Care (MC) HbA1c



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
CDC-HT Comprehensive Diabetes Care - HbA1c Testing	86.62%	86.86%	88.81%	86.37%	88.32%
CDC-H9 Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	34.79%	33.82%	26.68%	32.36%	37.23%
CDC-H8 Comprehensive Diabetes Care - HbA1c Control (<8.0%)	55.47%	54.01%	58.15%	60.10%	53.77%

Analysis and Findings/Barriers/Progress

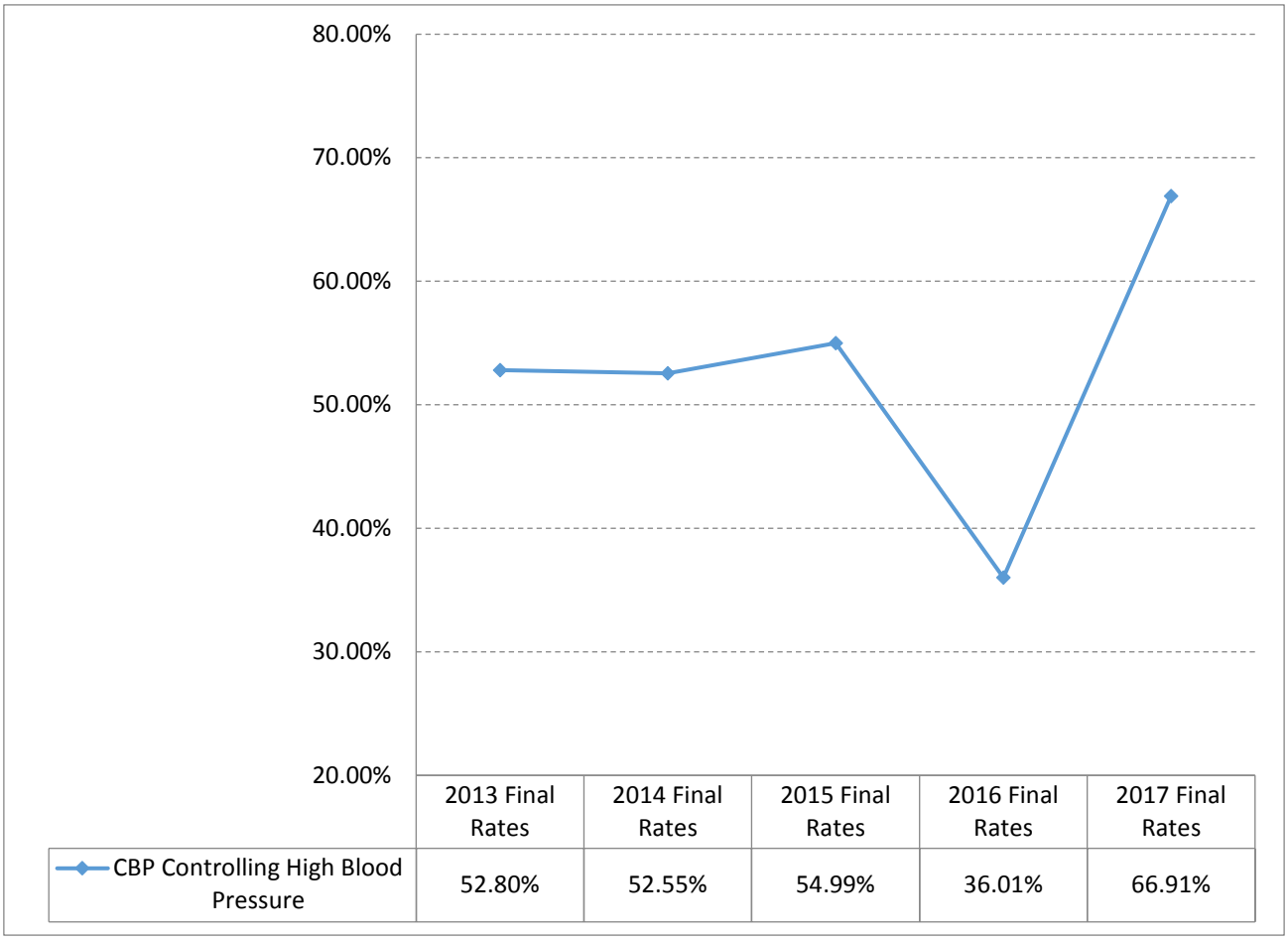
- Above the MPL for all the CDC HbA1c indicators.
- Rate decreased 6.33% for CDC HbA1c Control from HEDIS 2016.

Follow up/Actions:

- Focus ideas on new intervention in 2018 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2017 data.

Chronic Care/Disease Management Measures CBP - Controlling High Blood Pressure (MC)

CBP - Controlling High Blood Pressure (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
CBP Controlling High Blood Pressure	52.80%	52.55%	54.99%	36.01%	66.91%

Analysis and Findings/Barriers/Progress

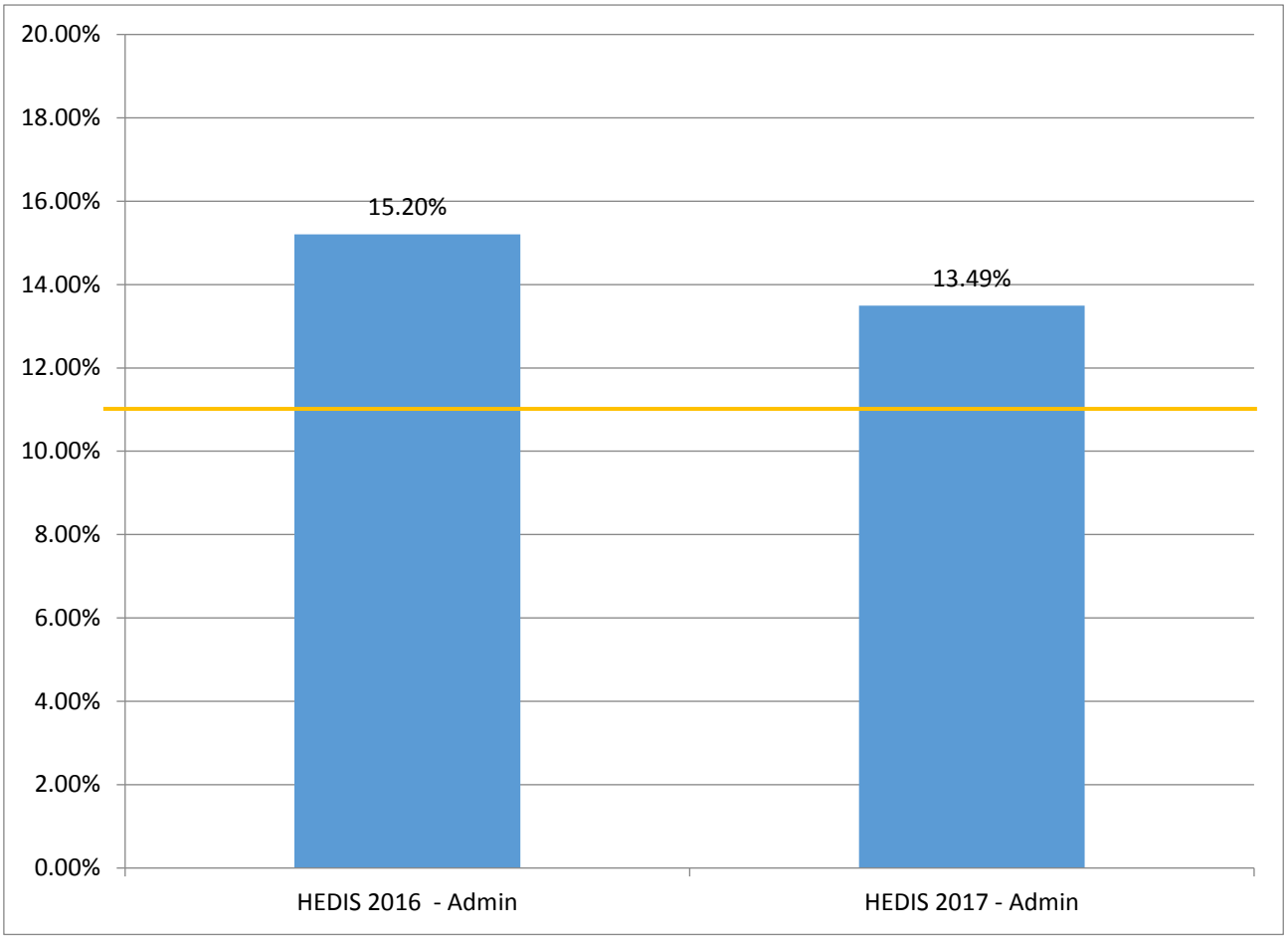
- Blood Pressure Control is above the MPL of 47.03% and below HPL of 70.55%.
- Rate increased by 30.90% due to interventions focused on member compliance and medical chart review.

Follow up/Actions:

- Continue to focus ideas on new intervention in 2018 for member reminders and outreach.
- MMCD/DHCS Improvement Plan:
  - Combined Improvement Plan with Performance Improvement Project. The project offered a $25 gift card for members who discussed hypertension with their PCP. The incentive form to be signed by the PCP.

Quality Withhold Measure: Plan All-Cause Readmission

PCR – Plan All-Cause Readmission – (CMC)



Analysis and Findings/Barriers/Progress

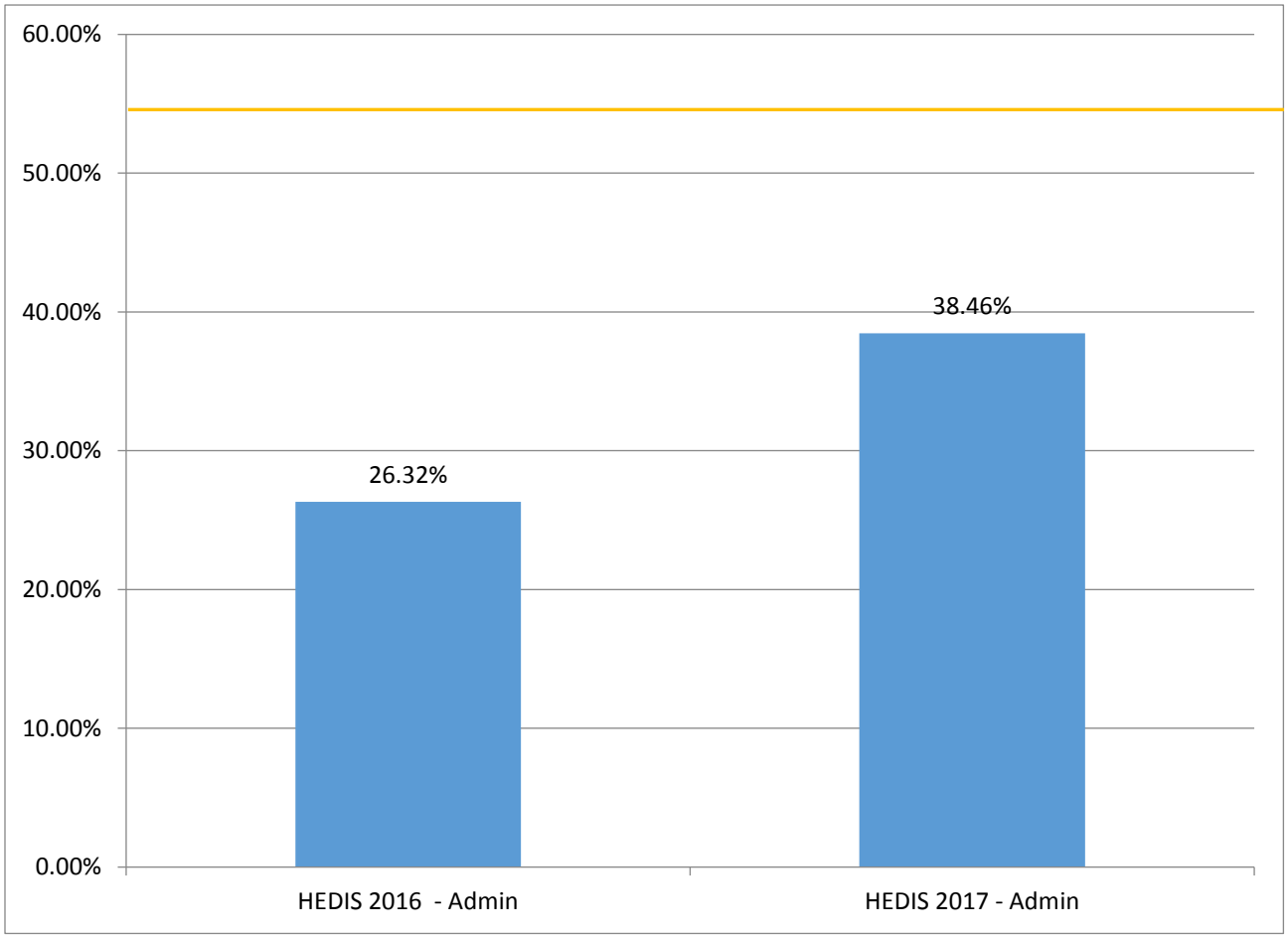
- Measure is higher than the 2017 benchmark, a lower rate is better.

Follow up/Actions:

- Focus on case management processes and follow up with members with transition discharge telephone calls.

Quality Withhold Measure: Follow-Up After Hospitalization for Mental Illness

FUH – Follow-Up After Hospitalization for Mental Illness – (CMC)



Analysis and Findings/Barriers/Progress

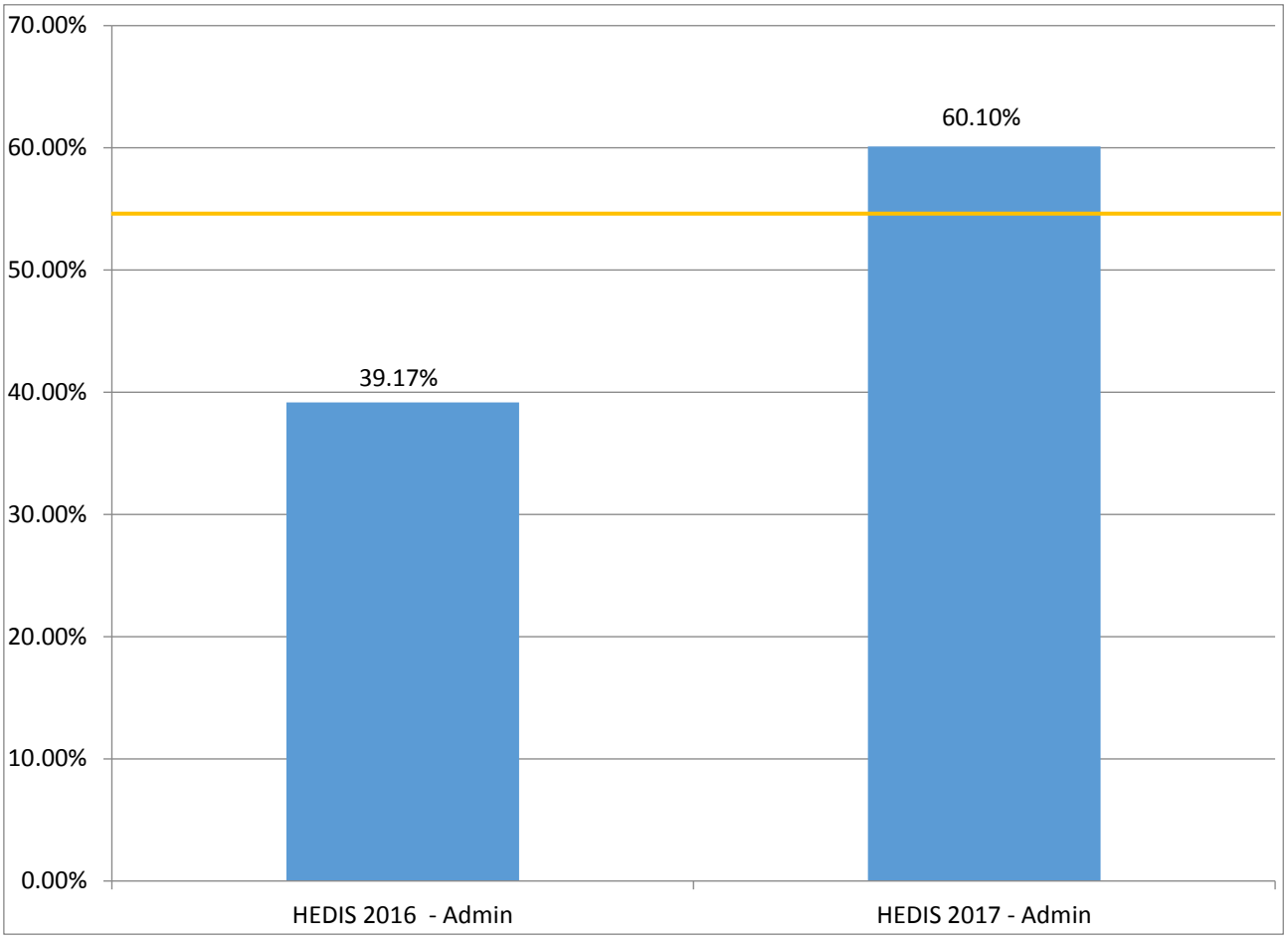
- Measure is below the 2017 benchmark.

Follow up/Actions:

- Monitor and collaborate with Behavioral Health delegates to ensure members obtain follow-up appointment after hospitalization for mental illness.
- Establish process with County Behavioral Health Department for obtaining data from clinic Electronic Health Record system.

Quality Withhold Measure: Controlling High Blood Pressure

CBP – Controlling High Blood Pressure – (CMC)



Analysis and Findings/Barriers/Progress

- Measure is above 2017 benchmark.

Follow up/Actions:

- Continue interventions in 2018 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2017 data.

B. Clinical Improvement Activities
External and Internal QIP's (2017 Measurement Year)

All Cause Readmissions CMS Quality Improvement Project –

B.1 Goal: To decrease readmission rates for any reason to below 11% by the end of 2018.

B.2 Intervention: Contact 90% of members within 72 hours of discharge from Regional Medical Center, to conduct a transition of care discharge call.

B.3 Design

This three year QIP began in January of 2016 and will continue until December of 2018. Case Managers use a daily census report from Regional Medical Center to identify all discharged members. The Case Manager makes three attempts to contact the member within 72 hours of discharge to conduct a successful transition of care discharge call that helps prevent a readmission to the hospital within 30 days of discharge.

B.4 Year 2 (2017)Results
The reported percentage of enrollees who experienced a readmission within 30 days of discharge for 2017 was 12.69%. This is a decrease from the 2016 rate of 16.86%. CMS and DHCS evaluated the 2017 QIP Annual Update 2 submission and found that it met CMS and state requirements.

Diabetes Retinopathy Eye Exam–DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the rate of diabetic eye exams among Medi-Cal Type 1 and Type 2 diabetic members aged 18 to 75 who reside in Santa Clara County, who have a Physicians Medical Group(PMG)/Network 50 Primary Care Provider and had a retinopathy diagnosis in the previous rolling 12 month period from 44.89% to 49.89%.

B.2 Intervention: Promote a reminder flyer and incentive for eligible PMG members for completing annual eye exams.

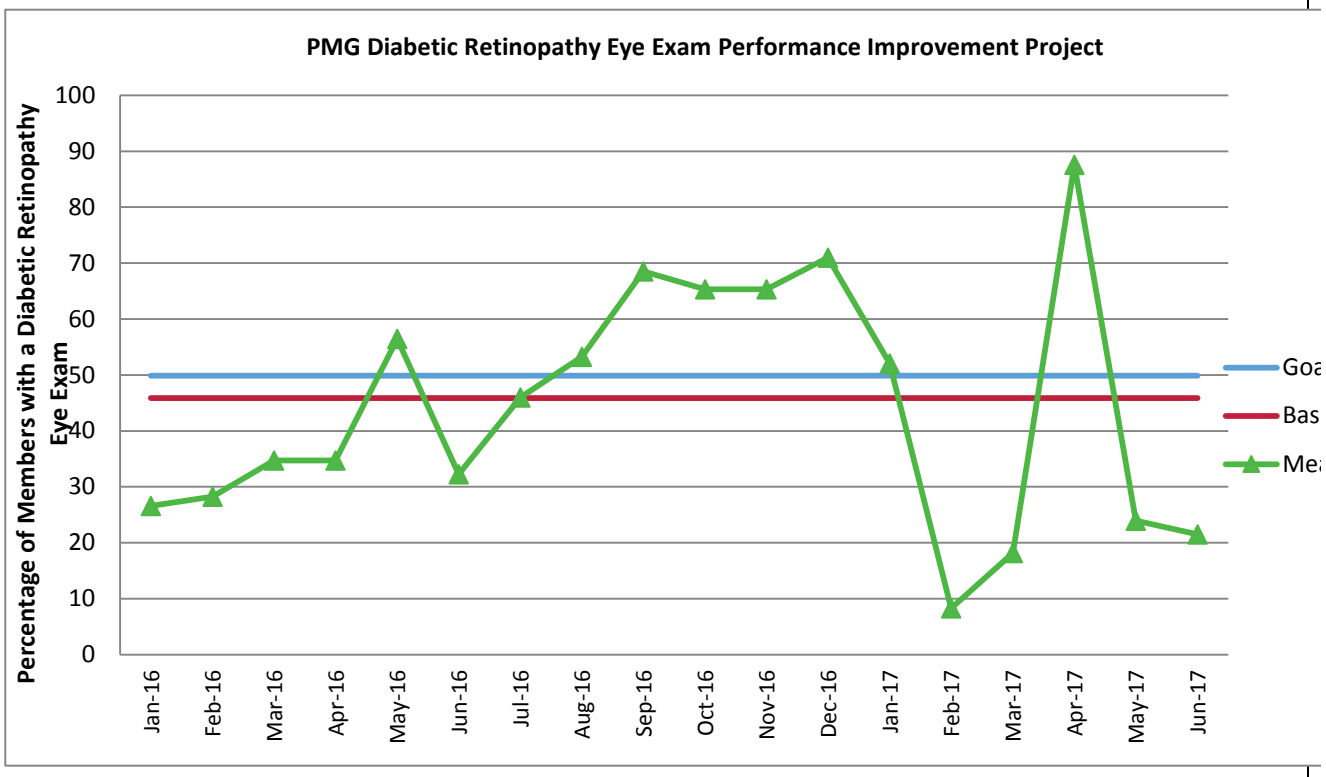
B.3 Design

This 18 month PIP began in January of 2016 and continued through June of 2017. On a monthly basis, a list of eligible members was generated to identify those that have not completed a diabetic retinopathy eye exam. The members were mailed a Health Education flyer with a reminder to complete a diabetic eye exam. Members were informed that if they submit proof of a completed eye exam to Health Education they would receive a $15 Target gift card.

B.4 Final Results

One intervention was tested during the life of this PIP. The intervention, testing whether providing a $15 gift card, member incentive to Network 50 members would increase the percentage of members with a completed diabetic retinopathy eye exam was initiated in July of 2016. The intervention appeared to result in some improvement and did impact the SMART Aim during some data points. Overall, 3.95% of eligible members submitted their results and claimed their incentive. The SMART Aim data showed an increase above the baseline for eight monthly data points while the intervention was being tested. The SMART Aim remained above the goal in 7 non-consecutive months that the intervention was being tested which indicates the incentive may have influenced member's behavior to get the diabetic eye exam but the results were not consistent and because the results did not meet the goal in the last few months of the intervention testing, SCFHP decided that it would abandon this incentive intervention as designed.

The final Smart Aim Chart was:



The lessons learned in this Plan, Do, Study, Act(PDSA) cycle included:

- The incentive amount may have been too low. SCFHP will consider raising the incentive rate for future member incentive programs.
- SCFHP and our Network partners should collaborate more when designing member interventions so that provider buy in is obtained.

- A survey would help identify if the incentive is motivating members
- Additional channels beyond mailing could be used to engage the member in this incentive.

The Plan will continue to track diabetic retinopathy eye exam rates to monitor results through its HEDIS processes. The HEDIS Project Manager is responsible to identify patterns in the rate that may signify the need for new improvement activities.

Controlling Blood Pressure -DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the percentage rate of Network 10 members aged 18-85, with a diagnosis of hypertension, whose blood pressure is adequately controlled, during the previous rolling 12 months from 45.8% to 50%.

B.2 Interventions: Promote a reminder and incentive for eligible Network 10 members for completing a blood pressure check.

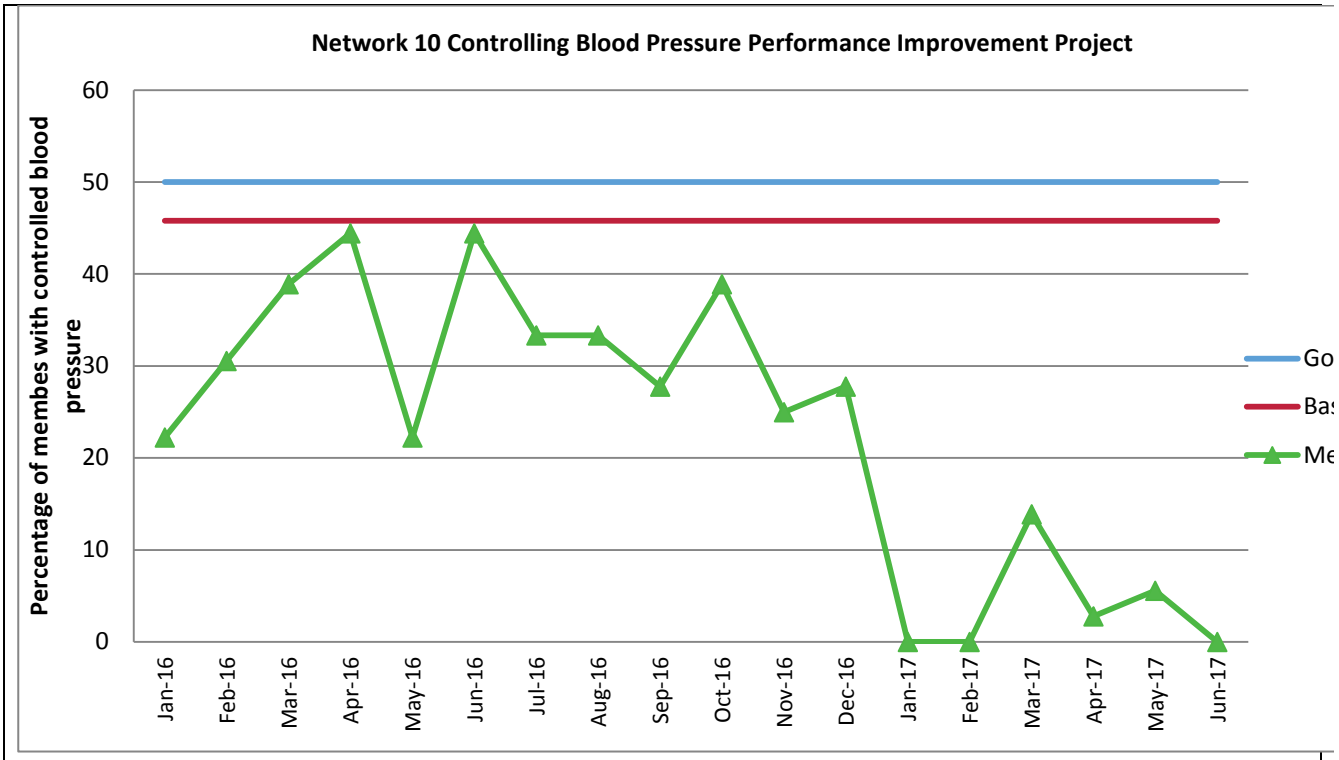
B.3 Design

This 18 month PIP began in January of 2016 and continued through June of 2017. On a monthly basis, a list of eligible members was generated to identify those that have not completed an annual blood pressure exam. The members were mailed a Health Education flyer with a reminder to complete a blood pressure exam. Members were informed that if they submit proof of a completed blood pressure exam to Health Education they would receive a $15 Target gift card.

B.4 Results

One intervention was tested during the life of this PIP. The intervention, testing whether providing a $15 gift card, member incentive to Network 10 members would increase the percentage of members with a completed blood pressure check exam was initiated in November of 2016. The intervention did not result in improvement and did not positively impact the SMART Aim during any of the data points. The SMART Aim goal of 50 % was not met during the intervention testing and in fact the rate remained below 50% for the duration of the PIP cycle. Overall, 4.98 % of eligible members submitted their results and claimed their incentive. The SMART Aim data never showed an increase above the baseline monthly data points while the intervention was being tested. The SMART Aim remained below the goal during the months that the intervention was being tested. Based on these results, SCFHP decided that the member incentive intervention as designed would be abandoned.

The Final Smart Aim Chart was:



Lessons learned in this PDSA cycle include:

- The incentive amount may have been too low. SCFHP will consider raising the incentive rate for future member incentive programs.
- SCFHP and our provider partners should collaborate more when designing member interventions so that provider buy in is obtained.
- Additional channels beyond mailing could be used to engage the member in this incentive

The Plan will implement a redesigned member incentive intervention for this measure within the new 18 month PIP cycle. The Plan tracks CBP rates to monitor results through its HEDIS processes.

Decreasing Potentially Avoidable Readmissions –LTSS Performance Improvement Project(PIP)

B.1 Goal: By June 30th, 2017, decrease rate of potentially avoidable hospital readmissions within 30 days of hospital discharge of CMC members from all SNFs to hospitals from 22.8% to 17.8%.

B.2 Interventions: SNF community partners will submit 100% of member, hospital interfacility transfer forms (IFTFs) to SCFHP for review.

B.3 Design

The timeline for this 18 month PIP was January of 2016 through June of 2017. The plan was for IFTF forms to be reviewed by SCFHP and appropriate level of care coordination to be provided by SCFHP to insure follow up care goals were met. This in turn would decrease potentially avoidable readmissions.

B.4 Final Results

SCFHP was unable to implement the interventions approved for this PIP and was therefore unable to achieve the SMART Aim goal. However, two of the last three months of the PIP had readmission rates below the target value of 17.8% (April – 9.2%, June – 8.4 %.) This may represent the observer effect on the part of SNF staff that the Plan was monitoring readmissions, causing SNF staff to be more diligent in how they addressed the needs of recently readmitted members. Alternately, the large variation between data points may represent a normal variation that is not evident when readmissions are averaged over a 12 month period. This suggests closer monitoring of the month-to-month rate might reveal a seasonal or other pattern, including no pattern at all (such as a greater number of readmissions in the winter when respiratory illness is more common in SNFs) that would be amenable to more targeted interventions, such as emphasizing infection control measures and flu shots.

SCFHP encounter barriers that prevented it from implement interventions.

Barriers included:

- The number of facilities (47 were included in the PIP) should be considered with regard to staff and resource availability. The PIP initially produced a large amount of data that required manual review, which hindered overall progress. Identifying facilities with the greatest number of readmissions to include enough facilities to achieve a satisfactory N (i.e.: 411, similar to HEDIS) would allow statistically satisfactory results without producing an overwhelming number of facilities to keep track of.
- There was no consistent single point of entry for receipt of the inter-facility transfer forms (IFTFs). Staff changes due to departmental reassignments left the PIP without a clear path of distribution for the IFTFs. This increased the chance that a data point could be lost. In hindsight, it might have been more advantageous to have the forms come first to QI for logging and copying, then passed on to UM/CM for further management. This would allow QI to collect data up front, monitor the process and follow up if there was a problem or concern, and for UM/CM to expeditiously follow up with the SNFs.
- UM staff described a lack of clarity at beginning of the process so that staff didn't clearly understand what the goal and process was.
- The following points would help our process be sustainable:
    - Identification of key plan staff and staff responsibilities.
    - Process for transitioning when staff (both Plan and SNF) are reassigned or otherwise no longer participating in PIP.

- Identification of the most appropriate contact staff at the SNFs.
- Monitor return of forms on a weekly or biweekly schedule. Follow up if readmissions occur and forms are not returned.
- Monitor return of plan staff survey tool. [Included below Failure Modes and Effects Analysis Table]
- Provide clarity of goals and methods. Encourage questions from staff at SNF and Plan.
- Identify and adjust as soon as possible if study population is too large for resources available.
- At end of PIP, meet with stakeholders for input on process improvement.

C. Initial Health Assessment (IHA)

C.1 Goal:

To ensure all SCFHP members completes an Initial Health Assessment (IHA) within 120 days of enrollment into the health plan and a Stay Healthy Assessment (SHA) form in accordance with the timeframes appropriate by age and that documentation is evidenced in their medical record.

C.2 Interventions:

- SCFHP provides information on IHA to the members and providers annually in the Member and Provider Newsletters and on the SCFHP website.
- SCFHP continues to promote provider education on the IHA with its delegate and independent network providers.
- Plan updated its IHA specifications to align with the methodology of other health plans in the geographic area.
- Plan runs IHA compliance reports on a quarterly basis.

C.3 Results:

- Plan's IHA compliance rate increased slightly (less than 5%) over the previous methodology.

C.4 Analysis of Findings/Barriers/Progress

- QI Nurse will audit medical records based on the new methodology to determine validity of the methodology
- QI Nurse will provide internal staff trainings for member facing teams
- QI Nurse will continue to work with Provider Services team to train providers and delegates

D. Patient Safety: Facility Site / Medical Record Review

D.1 Goal:

All contracted SCFHP PCP's receive a Facility Site Review Part A, B and C every three years. All newly contracted SCFHP PCP's complete and pass Facility Site Review Part A and C. FSR Part C is completed within 90 days.

D.2 Intervention:

- Complete FSR/MRR Review on all PCP sites that were due for a three year review.
- Complete FSR review for all newly contracted sites.
- Transition Part C reviews from Provider Services to Quality Nurse.
- Continue to Collaborate with Anthem Blue Cross.
- Review and update Medical Record Standards

D.3 Results:

- 43 PCP sites completed FSR reviews
- 40 MRRs completed
- Three Initial FSRs completed
- Two Collaboration meetings held with Anthem Blue Cross to share data.
- 38 FSR Part C reviews completed. (Providers with a FSR-C review in the last six years may attest no changes rather than having FSR-C completed.)

D.4 Analysis of Findings/Barriers/Progress

- 30 FSR Corrective Action Plans (CAPs) issued, monitored and validated. 26 CAPs closed (remainder issued have closure dates in 2018).
- 34 MRR CAPs issued, monitored and validated. 28 CAPs closed (remainder issued have closure dates in 2018)

E. Patient Safety: Provider Preventable Conditions (PPCs)

E.1 Goal:
To report 100% of identified PPCs to DHCS.

E.2 Intervention:
- Reviewed encounter data submitted by network providers for evidence of PPCs that must be reported
- Issued a special notice informing network providers that they must report PPCs to DHCS using the online reporting portal

E.3 Results:
- **0 PPCs identified 1/2017 – 4/2017**

E.4 Analysis of Findings/Barriers/Progress
- **No issues identified**

F. Potential Quality of Care Issues Summary

F.1 Goal:

To increase awareness of the PQI process within the health plan and to require quality improvement intervention(s) for substantiated quality of care issues. This includes Critical Incidents and Provider Preventable Conditions

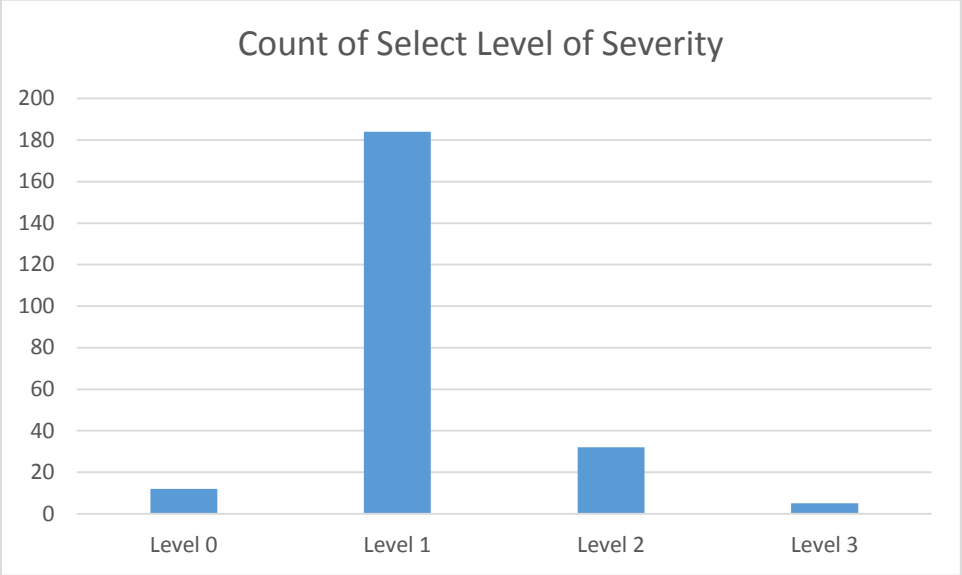
F.2 Intervention:
- Continue to monitor/track and trend member grievances for analysis of issues and correlation with other reports for identification of areas requiring improvement activities
- Continue to submit quarterly member grievances to the QIC for review and appropriate action related to access of care, quality of care, and denial of services
- Continue to monitor/track and trend PQI for identification of quality of care and systems issues.
- Continue to submit quarterly PQI report to QIC for review and appropriate action.

F.3 Results:
- 233 PQI's reported in 2017
- 12 were Level 0 – Does not meet PQI criteria, Not our member/Not our provider
- 184 were Level 1 –Quality of Care is Acceptable
- 32 were Level 2 - Opportunity for Improvement, no adverse occurrence
- 5 were Level 3 – Opportunity for Improvement, adverse occurrence
- 0 Critical Incidents

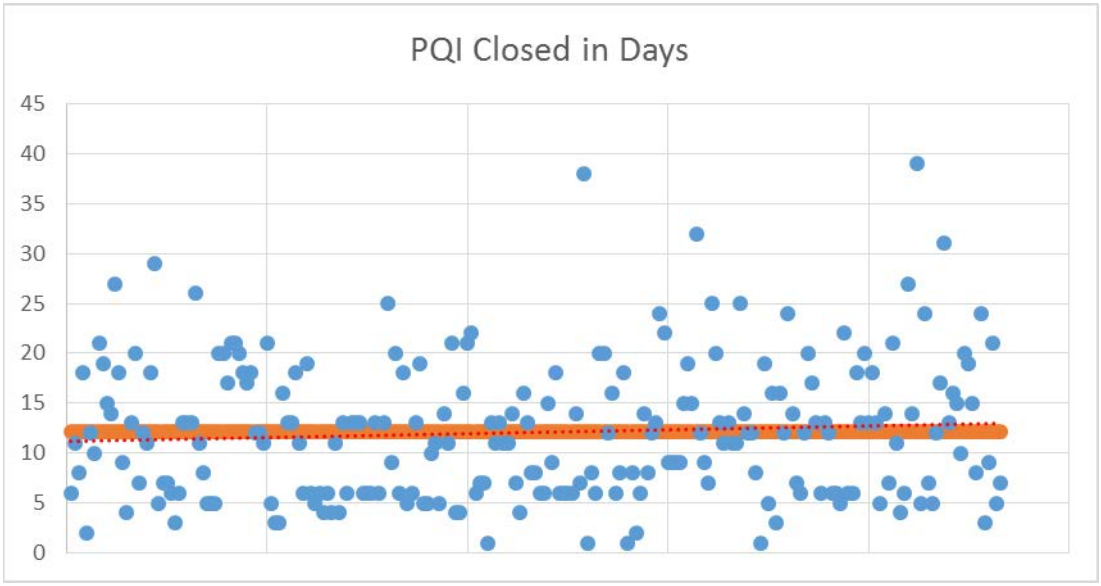
- 0 Provider Preventable Conditions

F.4 Analysis of Findings/Barriers/Progress

- 2 PQIs were downgraded from level 2 or higher to a level 1. This happened because SCFHP closed the PQI without all information or not all requested information was shared with SCFHP in a timely manner. Once SCFHP received additional documentation, it was verified there was no quality of care issue and the case was downgraded.
- Of the 37 level 2 and higher PQIs, 5 PQIs required additional follow up and extended due date to receive the requested follow up documentation from the provider to show quality improvement had been implemented.
- The majority of PQIs taken were unsubstantiated, or closed as level 1, as seen by the following chart.



2017 QUALITY IMPROVEMENT PROGRAM EVALUATION
☑ Annual Evaluation



G. Timely Access and Availability

G.1 Goal:

To measure and monitor timely access to health care against SCFHP's standards annually.

G.2 Intervention:

- Complete the following surveys annually:
  - DMHC Provider Appointment Availability Survey (PAAS)
  - After Hours Survey
  - DHCS Third Available Appointment Survey
  - Provider Satisfaction Survey
  - Member Satisfaction Survey (Customer Service
- Providers in violation of access standards received a written corrective action letter with a description of the violation and a request to correct it.

G.3 Results:

- **Specialist – Urgent** Appointment within **96hrs**

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent)	31	20	11	64%
Palo Alto Medical Foundation	19	10	25	53%
PMG-San Jose	25	16	12	64%
Premier Care of North CA	1	1	0	100%
Total	76	47	72	62%

- **Specialist – Non-Urgent** Appointment within **15-days**

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent	48	17	31	35%
Palo Alto Medical Foundation	33	16	17	48%
PMG-San Jose	28	22	6	79%
Premier Care of North CA	1	1	0	100%
Total	110	56	54	51%

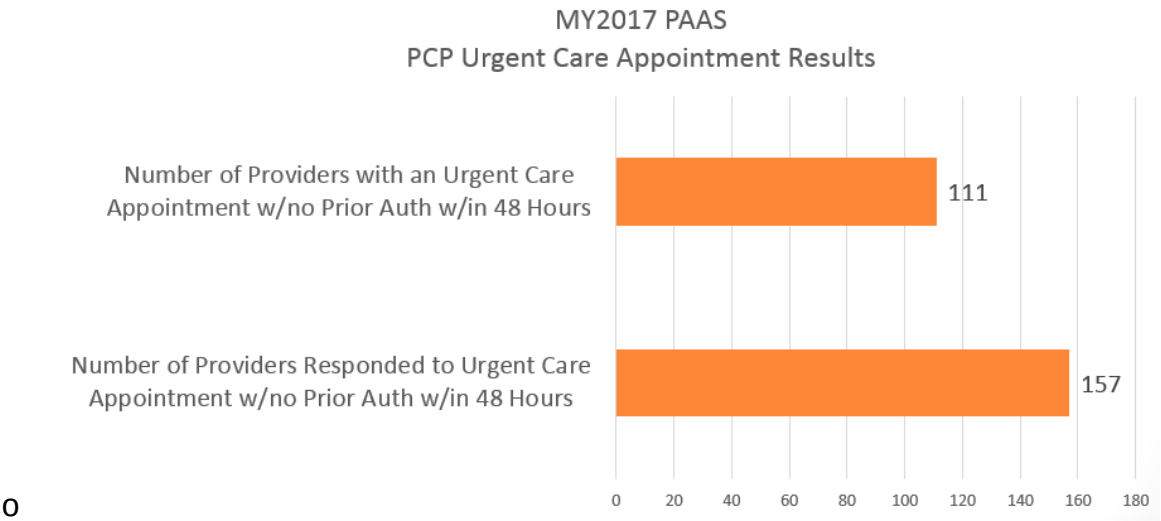
- **PCP – Urgent Appointment within 48hrs**

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent)	27	22	5	81%
Palo Alto Medical Foundation	60	29	31	48%
PMG-San Jose	48	41	7	85%
Premier Care of North CA	22	19	0	86%
Total	157	111	43	71%

- **PCP – Non-Urgent Appointment within 10-days**

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent)	26	26	0	100%
Palo Alto Medical Foundation	60	56	4	93%
PMG-San Jose	48	42	6	87%
Premier Care of North CA	21	19	2	90%
Total	155	143	12	92%

Standard: Urgent Care Appointment within **48hrs**



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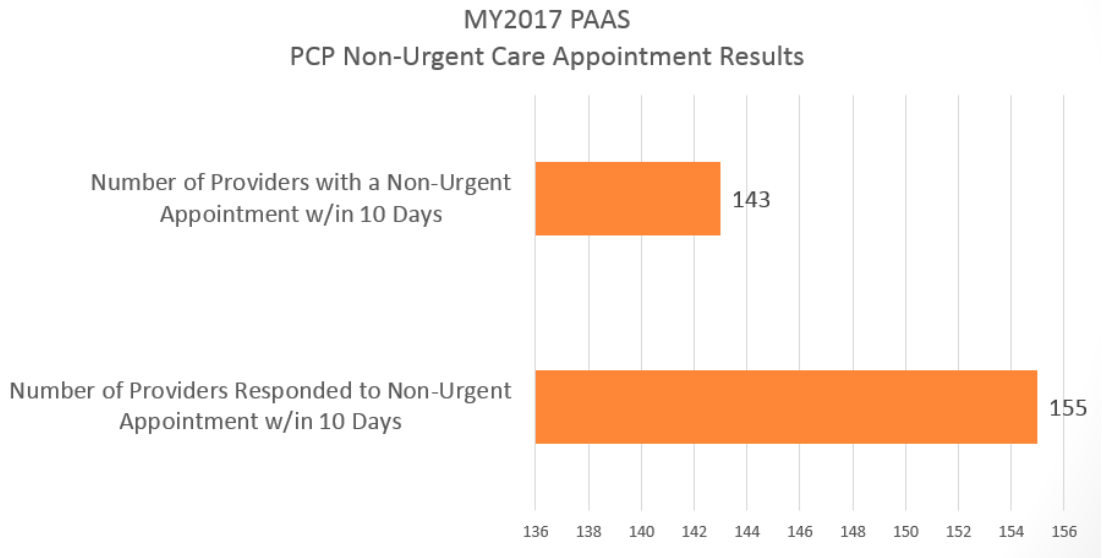
Standard: Non-Urgent Care Appointment within **10-days**



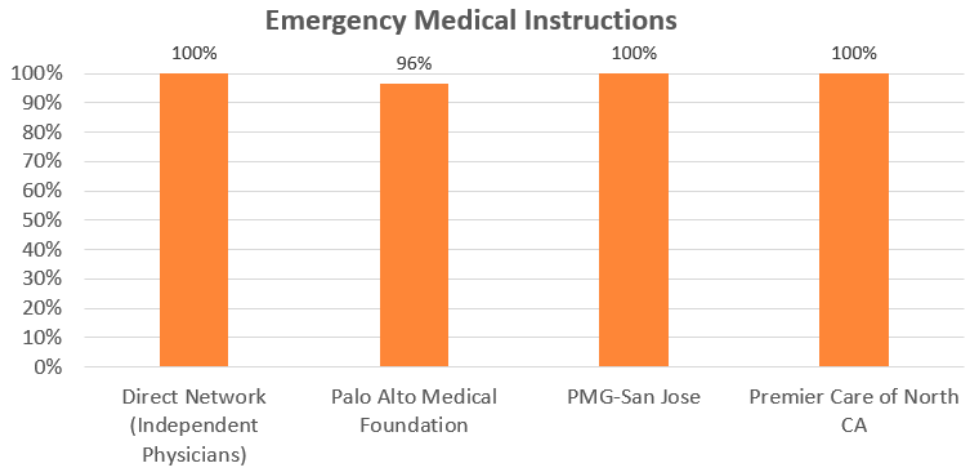
Ancillary – Non-Urgent Appointment within **15-days**

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	24	22	2	92%
Total	24	22	2	92%

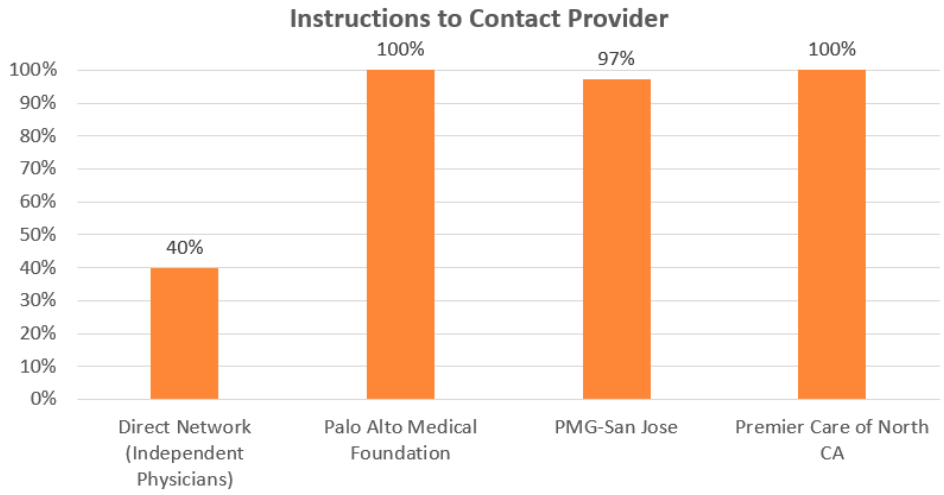
After-Hours Standards:

- Providers are required to notify SCFHP members that in the event of a medical emergency they should:
  - Go to the nearest emergency room
  - Hang up and dial 911
- Should a member need to speak to a provider, they must be available after-hours.
- Members should receive a return call within 30-minutes by a provider.

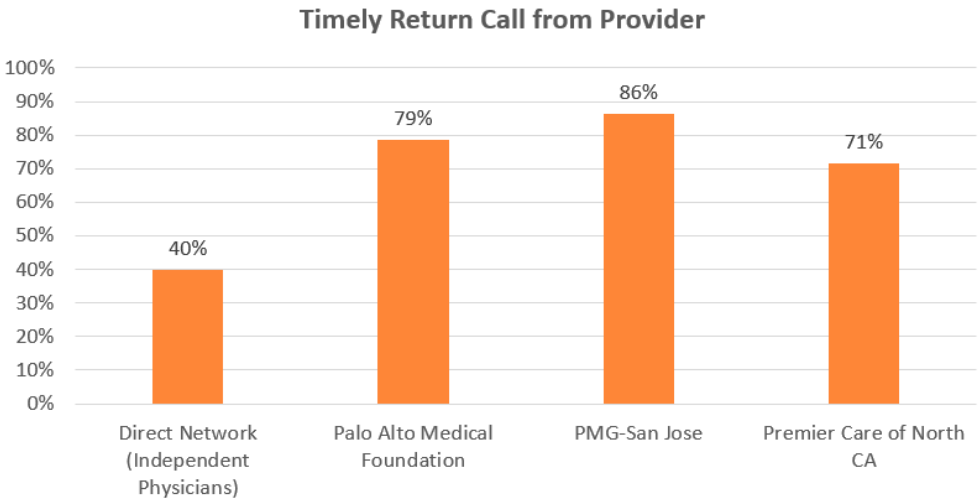
After-Hours Rate of Compliance:



After-Hours Rate of Compliance:



After-Hours Rate of Compliance:



Third Available Appointment (TAA) Survey Standards:

Providers are required to meet the following TAA standards:

- Member phone calls should be picked up within 60 seconds during business hours.
- **PCP**: Non urgent appointment - within ten (10) business days of request.
- **Specialist**: Non urgent appointment - within fifteen (15) business days of request.
- **OB/GYN**: First Prenatal Visit -Is this within two (2) weeks.
- Member should not wait more than 30 minutes for scheduled appointments
- Member should not wait more than 30 minutes for medical triage and/or screening call to be returned.
- Member should not wait more than 1 business day for a non-medical related question (administrative) call to be returned.
- Provider must have an answering service or an answering machine during non-business hours, which provide instructions regarding how members may obtain urgent or emergency care.

Total Survey Participants = 25

Standard	# Compliant	# Non-Compliant	Rate of Compliance
Call Pick-Up-60 sec	25	0	100%
After-hours message to access care	25	0	100%
PCP/Spec/OBGYN -Urgent Appointments	25	0	100%
PCP/Spec/OBGYN Non-Urgent Appointments	16	9	74%
In-office wait times	25	0	100%
Return calls - triage/screening during business hours	1	24	4%
Return calls - non-medical during business hours	22	3	88%

G.4 Analysis of Findings/Barriers/Progress

- Providers in violation of access standards received a written corrective action letter with a description of the violation and a request to correct it.

Group Type	Survey Ct	PCP Non-Urgent Appt 10-days	PCP Urgent Appt 48hrs	Spec Non-Urgent Appt 15-days	Spec Urgent Appt 96hrs	PCP & Spec Non & Urgent Appt	Total CAP
Ancillary	24			2			**2**
PCP	165	5	38			7	**7**
Specialist	186			18	48	19	**85**
Totals =	**441**	**5**	**38**	**20**	**48**	**26**	**137**

- Most providers who were surveyed answered the series of Interpreter Services questions and the response was positive in terms of their understanding that the Plan (SCFHP) is responsible to offer language line assistance.
- SCFHP will continue to increase oversight of timely access through Timely Access & Availability Work Group, quarterly network access reviews, and annual surveys
- SCFHP will complete provider education on timely access standards through provider orientations, training programs and newsletters
- SCFHP has created a new position in part to oversee and manage the annual appointment availability surveys

H. CAHPS

SCFHP

H.1 Goal:

Increase member satisfaction and quality of service delivered to SCFHP members

H.2 Intervention:

- Process
  - Year one of the CAHPS showed a very low response rate of under 16%. The plan added a second language flag to the survey in year two.
  - The plan sent reminder post cards to members on the importance of the CAHPS survey and providing the plan with feedback.
- Measure improvement
  - Plan did training to member and provider facing departments on the results from year one and two to brain stormed ideas on how to improve rates.
  - Plan shared results with provider advisor committee and quality improvement committee

H.3 Results:

- Year one of survey had a very low response rate of 15%. The rate was one of the lowest in the MMP program with the state wide average being 22%. As a result, there was a lack of actionable data because the sample size was too low. Year two of survey, the response rate increased to 29% which was higher than the state wide average of 27.7%.
- The plan had N/A in the following measures
  - Doctors Who Communicate Well
  - Customer Service
  - Overall Rating of Personal Doctor and Specialist
  - Getting Needed Prescription Drugs

- The plan performed lower than the MMP average in Health Plan Composite Measures;
  - Getting Needed Care
  - Getting Appointments Quickly
  - Care Coordination
- The plan performed lower than the MMP average in Overall Health Plan Ratings;
  - Rating of Health Plan
  - Rating of Health Care Quality

H.4 Analysis of Findings/Barriers/Progress

- The health plan improved its response rate and accomplished the process goal of getting more actionable data.
- The intervention between year one and year two identified specific opportunities for improvement in Health Plan Composite measures and Overall Health Plan rankings.
- With changes from CMS process, the plan did a pilot of addition additional languages beyond English/Spanish and will gauge impact of the additional languages on response rate and overall performance.
- The plan integrated provider level data as part of its 2018 pilot to get specific actionable information for pin pointed improvement efforts.
- Plan is developing scripts to be integrated into its current phone tree to gather additional data on an ongoing basis as well as remind members on importance of participating in CAHPS.
- Plan has reached out to its providers directly and shared results as well as broad areas for improvement.

I. Appeals and Grievance

SCFHP

I.1 Goal:

Increase member satisfaction by addressing member grievances within mandated timelines

I.2 Intervention:

- Process
  - Timely resolution of grievances within mandated time frames
- Measure improvement
  - Appeal and Grievance data is reported on the cooperate compliance dashboard and offers ongoing monitoring to rapidly identify variances and address the variances in a timely manner

I.3 Results:

- 2017 showed an improved compliance rate of 88.3% for standard grievances resolved in the mandated time frames, this was an improvement of just over 10% from the prior year's rate of 78%.
- The lowest performing time frame was Q2 where the compliance rate dipped to 56% in the month of May

I.4 Analysis of Findings/Barriers/Progress

- Low number of number of grievance staff compared the volume of grievances received has presented a barrier
- Staff turnover also presented a barrier throughout the year
- As evidenced by the fourth quarter both issues were successfully addressed with the number of grievances within the mandated timelines being above 94%

J. Member Services Phone Statistics

SCFHP

J.1 Goal:

Increase member satisfaction by answering inbound calls in 30 seconds or less

J.2 Intervention:

- Process
  - Timely telephone answering of inbound calls
- Measure improvement
  - Call answer timeliness data is reported on the cooperate compliance dashboard and offers ongoing monitoring to rapidly identify variances and address the variances in a timely manner

J.3 Results:

- 2017 showed an improved compliance rate of 56 seconds to answer, which was almost double the goal of 30 seconds to answer, this was a decrease in performance from 2016 where the time to answer was 6 seconds over the goal of 30 seconds

J.4 Analysis of Findings/Barriers/Progress

- Low number of number of customer service staff compared the volume of inbound calls received has presented a barrier
- Staff turnover also presented a barrier throughout the year
- A new system to enable quicker onboarding time should reduce the negative impact of staff turnover as well as building out a training and QA team to assist with call monitoring should increase overall call timeliness and call hold performance

QI Program Effectiveness

The 2017 Quality Improvement Program was effective in demonstrating improvements in both the clinical and service areas for Medi-Cal, Healthy Kids and Cal MediConnect members. The QI

Committee structure, practitioner participation, both external and internal, along with the plan's leadership, have shown to be sufficient resources in meeting the QI program's goals and objectives; which includes utilization management, in 2017. The Quality Committee structure was revised to in 2017 to meet NCQA requirements. There is no need to restructure or change the QI program or utilization management structure for 2018.

Santa Clara Family Health Plan

The Spirit of Care

2017 Comprehensive Case Management Program
Annual Evaluation

Program Goals:

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the Santa Clara Family Health Plan (SCFHP) membership, to promote member health and well-being, and to offer quality accessible care coordination among medical care, behavioral health, and long term services and supports; and further the goals of the Olmstead Decision. In doing so, more specific goals for the program include:

- Identification of the most vulnerable members;
- Interact with members as a "whole person," not as a condition or event;
- Provide support, education and advocacy to members;
- Identify barriers that may impede member's functionality;
- Work collaboratively with the member, family and caregivers to develop goals and assist member is achieving these goals;
- Enhance member health self-management skills and knowledge regarding their health;
- Promote early and timely interventions that prevent avoidable emergency room visits and hospitalizations;
- Help members achieve optimum health or regain functional capability;
- Treatment of the member in the least restrictive setting appropriate.
- Promote utilization of participating providers;
- Engage the providers and community as collaborative partners in the delivery of effective healthcare;
- Support the foundational role of the primary care physician and care team to achieve high quality, accessible, efficient health care;
- Integrate seamlessly into the primary care office workflow to ease use of program by physicians and staff;
- Coordinate with community services to promote and provide member access to available resources in the Santa Clara County service area;
- Provide financial stewardship and diligence, while ensuring the provision of high quality, evidence-based health care services;
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

Program Objectives:

The objectives of the comprehensive case management program is to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the SCFHP membership. The Chief Medical Officer, Director of Health Services and Manager of Case Management develop measurable goals and objectives and monitor them. The Quality Improvement Committee (QIC) reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Prevent and reduce hospital and facility readmissions as measured by admission and readmission rates
- Prevent and reduce emergency room visits as measured by emergency room visit rates
- Achieve and maintain member's high levels of satisfaction with case management services as measured by member satisfaction rates

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• Improve functional health status and sense of wellbeing of comprehensive case management members as measured by member self-reports of health condition

The comprehensive case management program is a supportive and dynamic resource that SCFHP uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

Evaluation of Program Goals and Objectives:

On July 1st, 2017, SCFHP's Case Management team completed the development of their new case management software program called,"Essette" and launched it's use for all Cal MediConnect members. Further system development included the addition of the entire Medi-Cal member population into this program to enhance DHCS regulatory HIF-MET and SPD member Health Risk Assessment (HRA) compliance.

In November 2016, SCFHP had contracted with Optum (Alere) to provide additional resources and supports to increase Cal MediConnect HRA outreach and improve regulatory compliance for Individual Care Plan completion. In August of 2017, CMS notified SCFHP that the organization had failed to meet satisfactory rates of Health Risk Assessment (HRA) completion, in compliance with contractual standards, citing January 2017 Q1 data reflecting the Percent of CMC members who were reached, were willing to participate, and had an HRA completed within 90 days was 32.9% (California State average for this measure was 91.9%).

As part of a CMS mandated Performance Improvement Plan, SCFHP initiated their plans to further build and develop their internal Case Management team and transition this outsourced scope of work away from Optum.

In early 2017, the Medical Management Case Management team had been budgeted to include a total of 11 clinical and non-clinical positions. By the end of January 2017, this team had grown to include 21 total budgeted positions, with an additional 8 positions expected to be added in 2018 as part of NCQA Population Health program development. The development of this NCQA program includes adding Licensed Clinical Social Workers, one additional Supervisor and a Program Manager to the team. In accordance with the NCQA 2018 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care including the community setting, through participation, engagement and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, while using CMC required methods via health risk assessment (HRA) and individualized care planning (ICP) through an interdisciplinary care team (IDT) approach.

A significant organizational focus on IT reporting improvements during 2017 allowed SCFHP's internal CM team to better identify it's most vulnerable members, how to accurately capture pertinent data documented within Essette and how to integrate external data such as Eligibility files to meet Case management needs.

By the end of February 2018, SCFHP's internal Case Management team had improved the HRA Completion rate to over 90% and had reduced their member Unable to Contact rate below 10%. As a result, CMS dismissed SCFHP of the mandated Performance Improvement Plan in March 2018.

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POPULATION HEALTH STRATEGY

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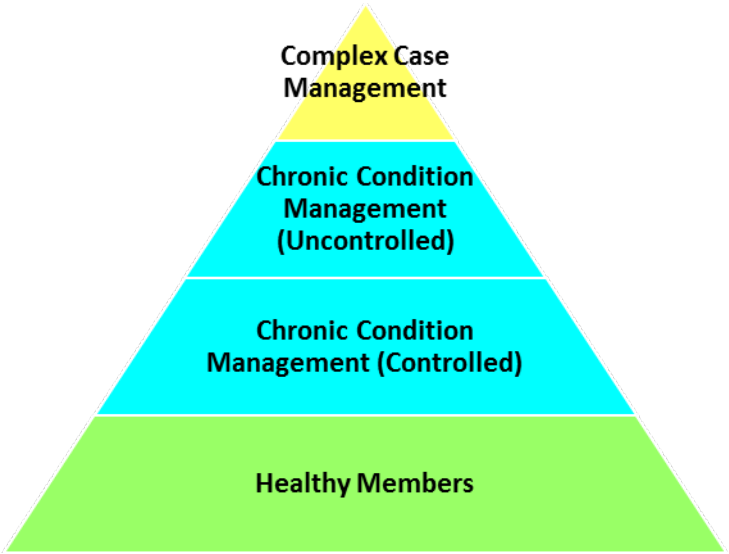
Comprehensive Population Health Management (PHM) Strategy

In accordance with the NCQA 2018 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care including the community setting, through participation, engagement and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, while using CMC required methods via health risk assessment (HRA) and individualized care planning (ICP) through an interdisciplinary care team (IDT) approach.
At a minimum, annual evaluations of various elements of this PHM strategy will assess the Plan's performance against the Institute for Healthcare Improvement (IHI) Triple Aim dimensions to improve patient experience of care, improve the health of populations and reducing the per capita cost of healthcare.
A detailed 2018 SCFHP Population Assessment is attached as Appendix A, to this PHM Strategy document and serves as the basis of identifying the member population served by SCFHP.
The member population is segmented into subset targeted populations based off assessment of population needs and there are specific programs and services to address the four focus areas. To accomplish this, SCFHP has developed a tier of programs and qualifying populations that would be eligible for each program.

*Please reference Appendix B, for full description of SCFHP Population Health Management (PHM) Program Summary
I. Populations Targeted for PHM



Tier 1 Complex Case Management Member Eligibility criteria Members have 3+ hospitalizations in the past year and one other Tier 1 Criteria OR

Members meet 3 or more Tier 1 criteria:

- Age 75+ with 3 ADLs
- >3 ED visits in the past year
- Hospitalized in the past 180 days
- 3+ Chronic Conditions and at least one uncontrolled*

*Uncontrolled is defined as 1 ED Visit or Inpatient stay within the past year, with a primary diagnosis of the member's chronic condition)

Tier 2 Chronic Condition Management Uncontrolled Member Eligibility
Newly enrolled members with no claims or utilization history **OR**
Members that have at least one of the below criteria AND have at least one Chronic Condition that is uncontrolled:

- 75+ with 3 ADLs
- >3 ED Visits in the Past Year
- Hospitalized in the Past 90 Days 180 Days
- 3+ Hospitalizations in the Past Year
- 1+ Social Determinant of Health (includes members with addresses indicative of homelessness), **OR**

Members enrolled in the Multipurpose Senior Services Program (MSSP)

Tier 3 Chronic Condition Controlled Member Eligibility criteria
Members that do not meet criteria for Tier 1 or 2 AND have 1+ Chronic Condition Controlled, and greater than $3,000 claims cost per year OR

- Homeless
- Long Term Care (LTC) or
- Hospice within last 12 months

Tier 4 Healthy Members Eligibility
All other members that do not meet criteria for Tiers 1-3.

II. Focus Areas
The following four areas of this strategy focus on a "whole-person" approach to identify members at risk, provide strategies, programs and services to mitigate or reduce that risk and maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions.

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

III. Focus Areas and Goals

SCFHP's plan of action for each of the focus areas include measurable goals for specific targeted populations as follows:

1. **Keeping members healthy**
    a. **Goal:**
        - Reach a 5% increase in the number of Cal MediConnect members with at least one annual wellness visit
        - Goal justification statement: Based on analysis of risk adjustment data, SCFHP discovered that we did not have utilization information on many of our CMC members. Annual Wellness visits are critical to maintaining the health of our Tier 4 population as well as improving the health of our members with multiple chronic conditions (Tier 1-3).

    b. **Goal Population:**
        - All CalMediConnect members (not in LTC facility)
        - Initial baseline claims data obtained from all provider types, will be established for dates of service 10/1/2016 to 9/30/2017, using Wellness visit codes HCPCS G0438 or G0439, CPT 99385-87 and/or 99395-99397.
    - Ongoing quarterly evaluation of ongoing claims data using the same Wellness visit codes for dates of service 10/01/2017 will be monitored for comparison to baseline data and results documented. Any data elements identified as needing improvement during these quarterly evaluations will be adjusted to facilitate that objectives and goals are met.

2. **Managing members with emerging risk**
    a. Goal: Increase HbA1c control rate by 2 percentage points compared to baseline
    Goal Justification: Data will be run according to HEDIS specifications.

    b. Goal **Population: Within SCFHP CMC line of business, there are 1,450 or 18% of members that meet the HEDIS definition of diabetes.**
    c. Targeting the Tier 3 member population with a controlled chronic condition of Diabetes
    d. Data will be run according to HEDIS specification
    e. Baseline TBD

.

3. **Patient safety or outcomes across settings**
    a. Goal: Decrease 30 Day Readmission rate by 1 percentage point
    The intent is to promote transitions of care for members discharged from an acute or skilled nursing facility setting and improve continuity of care across acute care, long term care, behavioral health and home and community-based settings.

b. Goal Populations:
    a. Members readmitted within 30 days of discharge represent approximately 14% of our CMC population.

4. Managing multiple chronic illnesses

a. GOAL: Reduce the number of members with multiple chronic conditions with 4+ ED Visits in the past year by 10%

b. **Goal Population**

All CMC members that are assigned to Tiers 1 and 2 have multiple chronic conditions that are not being well-managed. Through development of the stratification of our Population Health Tiers 1 and 2, we determined that 545 Cal MediConnect members visited the emergency department 4 or more times in the past year. Unmanaged multiple chronic conditions often results in avoidable ER utilization.

CMC members with emerging risk are identified through the health risk assessment, utilization data including pharmacy and claims, frequency of ED visits and hospitalizations, medication noncompliance and referrals from providers and community partners. The HRA identifies both health risks and social determinants of health including deficits in ADLs and IADLs and member reported changes in conditions.

*** Molly to provide all ED Visits and primary diagnosis for group to determine goal**

IV. Programs and Services by Focus Area

Under Cal MediConnect, SCFHP seeks to promote a system that is both sustainable, person-and family-centered, and enables beneficiaries to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community- based services and behavioral health services.

Programs and Services by Focus Area:

Programs & Services	Focus Area #
Complex Case Management	
Moderate Case Management	
Basic Case Management	
Long Term Care	
Transitions of Care	
MSSP	
Behavioral Health Severe Mental Illness	
Provider Engagement	
Nurse Advice Line	
Utilization Management & Concurrent Review	
Health Education	
Community Resources	

A. Case Management Programs

Members are identified for case management through multiple sources, including eligibility files, medical and pharmacy claims data, and utilization management data. Members may also self-refer, or be referred by providers, delegates, vendors and community partners.

Members are assigned to CM programs based on risk stratification, member's responses to the health risk assessment, additional assessments, clinical evaluation and consultation with member's to determine their willingness to participate. Members can move between programs as appropriate to provide the right level of management at the right time. All CMC members receive case management services that include the following components:

i. Completion of a Health Risk Assessment (HRA)

The HRA identifies the need for further case management assessment and helps to identify wellness goals and appropriate assignment for case management programs and other services. Additional assessments which may be utilized include all assessments in Essette such as:

- Asthma
- Heart failure
- PHQ-9 Depression assessment
- CAGE Alcohol Screening Tool

ii. Development of an individualized care plan.

Members work with their case manager to develop a member centric individualized care plan (ICP). During development of the care plan, members are educated by the case manager on how to achieve their goals, including preventive care, exams and annual wellness visits, and includes a goal to complete an annual wellness visit.

iii. Ongoing case management includes coordination with other providers and external partners in the implementation of the care plan, and an annual reassessment and care plan update.

Case management programs encompass all focus areas and include:

a) Complex Case Management is provided to all eligible members in Tier 1 and is described in detail in the attached Complex Case Management summary
b) Moderate Case Management is provided to members in Tier 2 and includes those members with multiple chronic conditions and complex social determinants of health. It includes members receiving MSSP services and care coordination around severe mental illness (SMI).
c) Basic Case Management is provided to members in Tiers 3 and 4 and includes at a minimum, the completion of an HRA, ICP, and benefit coordination in close collaboration with the PCP.

d) Transitions of Care is provided across all CM Tiers for members and is episodic CM with UM coordination to support discharges and transitions from acute hospital and long term care facilities. This service is also provided to support continuity of care for members transitioning between providers. Transition of Care (TOC) calls are made for members within 72 business hours of discharge by Utilization Management nurses who complete a TOC assessment to ensure a safe transition to the appropriate level of care and minimize risk of re-admission.

Case management services include integration of the discharge plan into the current individual care plan including facilitating follow up visits to the member's providers, post-discharge medication reconciliation, and confirmation that the discharge plan has been implemented.

For members discharged from psychiatric facilities, it is the BH CM responsibility to coordinate the transition of care for the SMI members. If a member is not connected to a BH care team in the community, both the discharging hospital and the BH need to refer to the County Call Center for a referral to a Specialty MH clinic. If no immediate openings are available, the Mental Health Urgent Care clinic may offer the follow up Behavioral Health contact which is required. The BH team will provide the TOC call, assistance with follow up care, any other BH or medical needs within their scope. The medication reconciliation will be provided by the BH team in collaboration with the community BH provider.

e) Long Term Care (LTC) Transition case management is provided to the subgroup of nursing facility members who are authorized for custodial, long term care but have been identified as able to discharge back to the community. Case management includes working with the member and their family or caregivers and the nursing facility team to assess readiness for discharge and coordinate on a discharge plan. The LTC RN CM visits the member to conduct a face-to-face assessment, provides information about long term services and supports (LTSS) benefits and other community-based resources that support transition, and facilitates arrangement of and authorization for services and supports needed post-discharge. This includes addressing social determinants that may be a barrier to discharge including income benefits, lack of housing and family support and coordination with community resources.

f) Multipurpose Senior Services Program (MSSP) is a case management program that is available as a managed Medi-Cal Long Term Services and Supports (LTSS) benefit for members that are over age 65 and meet criteria for nursing home placement. MSSP is a delegated case management program and members in MSSP are assigned to a SCFHP Social Work CM within Tier 2.

f) Behavioral Health – Severe Mental Illness (SMI) Members who are diagnosed with SMI may be found in any tier, based on their level of stability. The members will likely be assigned to Tier 2 and will be carved out internally to the BH CM team. These members may be served in either a Specialty Mental Health Clinic or may be stable enough to be served in a Federally

Qualified Health Care (FQHC) setting with psychiatry and potentially counseling. The internal BH team will participate with the CM teams to coordinate the medical case management services as needed.

B. Provider Engagement:

Providers are engaged in different ways with case management the member's care. Member PCPs are provided their specific CMC enrollment data monthly so that they can identify new members requiring an Initial Health Assessment (IHA). They also receive a copy of the member's ICP, which includes the Annual Wellness Visit Goal.

Members are encouraged through case management and providers network to access preventative medicine services, for example, regular screenings, maintenance therapies, free health education that includes nutrition programs, physical activity, annual physician wellness screening.
Providers are provided education and information through materials and training offered on the website and a regular provider newsletter.
Member Portal messaging and/or mail reminders

C. 24/7 Nurse Advice Line is a nurse-driven telephonic support program that empowers members to better manage their health. Highly trained registered nurses help participants navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors.

D. Utilization Management and Concurrent Review
(Sandra to include)
Utilization management, concurrent review and discharge planning nurses identify members that will be discharged and collaborate with the facility and other providers to coordinate discharge needs and follow up care. This may include referring to cm programs and arranging benefits across health care settings, such as DME, home health, Long Term Services and Supports (LTSS), behavioral health and outpatient services.

E. Health Education (Johanna?)

F. **Community Resources Integration**
This program addresses the social determinants of health experienced by SCFHP members and is managed by the Long Term Services and Supports staff in support of all case management programs. As part of the care plan development and goal setting, to facilitate coordination of benefits and community resources, referrals may be made to community based programs and other resources. These are coordinated through case management or provided by community based organizations, public agencies and hospitals.

Community resources information and contacts are made available to CMs for integration into the member care plan as needed and include programs that address needs for food, housing, transportation, isolation, caregiver support and respite, protective services and specialized case management (e.g. HIV), disease management, falls prevention and physical activity, legal services and other public services such as adult protective services.

An initial training on community-based programs is provided to all CMs with detailed information on programs scope, eligibility, referral processes and key contacts. This information is also available on the SCFHP shared drive for staff and is updated at least annually. CMs have access to trainings, face-to- face visits and presentations by providers with new resources shared on an ongoing basis.

Information on community resources is also provided on the SCFHP website for member access.

Factor 3: ***Activities that are not direct member interventions***

Activities conducted by the Plan that support PHM programs or services not directed at individual members.

1. Data and information sharing with providers: case management sharing with providers: HRAs, ICPs, supplemental assessments,
2. Targeted Provider education and required trainings with provision of CMUs. These include: cultural competency, SBIRT screening, brief intervention and referral to treatment, communicating across language barriers, LTSS, Staying Health Assessment
3. Quarterly newsletter
4. Provider Resource page on the SCFHP Website
5. Provider Memorandums
6.. Provider Advisory Council presentations
7. Provider education on LTSS
8. Lori add info on community initiatives re. housing and other
9. Participation in Safety Net Network meetings
10. Integrating with Community Resources
11. Coordination with Housing Services Information System

Factor 4: ***Coordination of member programs***

Internal and external programs and services are coordinated across settings, providers and levels of care to minimize confusion to members from being contacted from multiple sources.

Santa Clara Family Health Plan (SCFHP) endeavors to have no wrong door for members and to provide care in a coordinated manner. There are several programs offered by SCFHP to members, depending on their clinical conditions and psychosocial needs. The health plan strives to provide the right care at the right time to the members.

Case management and interdepartmental coordination are key to effective service coordination. The new software system for case management acts as the documentation for the coordination and provides the glue.

A. Member Outreach Coordination SCFHP has initiated the categorization all internal and external outreach to members specifically about member programs and to ensure consistent messaging from all health plan callers. This catalog of outbound call types will also be used to demonstrate and support interactive contact with members. All Quality, Pharmacy, Case Management (CM), Long Term Services and Supports (LTSS), Behavioral Health (BH) program types that have been integrated directly into Essette, will have corresponding policies or procedures which will reflect how members become eligible for the program, how to use the program services and also how to opt-in or opt-out of the program.
SCFHP requires pre-service authorization for certain types of services such as Home Health and outpatient physical therapy visits, even when services are initiated as part of acute hospital and skilled admission discharge orders. All authorization requests are processed within regulatory timeframes beginning with the date and time the request was received. – How are these coordinated for communication? Are there any other programs internally or externally that should be coordinated?

B. Concurrent Review, TOC and IP – UM role and IDT (Sandra), Meeting including BH IP and LTC transitions
USE OR NOT…

Inpatient Care

Utilization management/concurrent review nurses are responsible for receiving the face sheets from the acute care hospital settings, including psychiatric hospitals. They are responsible for issuing the authorization for the hospital stay and receiving medical records at intervals. The UM/concurrent review nurses are responsible for monitoring and facilitating the discharge for the member from medical acute care hospitals. Psychiatric hospital stays for CMC members are also authorized by the UM/concurrent review nurses, however the facilitation of the discharge planning for these members is provided by the Behavioral Health case managers. The UM/concurrent review nurses are to complete the Transition of Care (TOC) assessment protocol for those members being discharged to home from acute care. The TOC is to ensure that adequate provision is made for home care, including Home Health, Durable Medical Equipment (DME) and follow up outpatient appointments. The UM/concurrent review nurse will be responsible for the medical acute care follow up to home for the first 30 days.

Psychiatric Inpatient Care

For psychiatric hospitalizations, the BH CM team also assesses for adequate home care, but is also responsible for ensuring that a follow up visit with a Behavioral Health practitioner occurs within 30 days of the discharge. The follow up visit is typically with a psychiatrist, but can be with any licensed behavioral health provider. The BH CM staff coordinates with the County Behavioral Health Services

Department (CBHSD) as needed to ensure that an appointment is provided. Transportation is arranged as needed by the BH CM.

Intra-Departmental Transitions

The UM/concurrent review nurses will provide referrals via the Case Management Referral form and routing process in Essette for those members who will need additional support after the first 30 days of discharge. A case conference or interdisciplinary care team meeting (ICT) may be held to ensure that all necessary information is provided to the CM team for follow up.

For post-psychiatric hospitalizations, the Behavioral Health case management team will already be following the member, however, an alert from the UM/concurrent review nurse team via a Behavioral Health referral form, email or ICT is optimal.

C. CM Coordination (Shawna)– internal (case conferencing including ICP development and implementation of goals including LTSS and BH coordination and external (ICT with LTSS and BH)

USE OR NOT…

Outpatient case management services are provided according to the Tiers identified under the Population Health Program. Every member will have an identified case manager or care coordinator. Upon receipt of a CM referral or BH referral, the respective CM or BH team will review every case to identify the following:

Is there a current Health Risk Assessment (HRA) , within the last year or does a new HRA need to be completed due to a change in member circumstances such as a change in health or psychosocial situation?

Is there a current care plan or ICP reflecting the member's current goals or circumstances? If not, a new ICP will need to be created by the case manager. The ICP must include two-way communication between the SCFHP and the primary care provider.

Is there a need for an Interdisciplinary Care Team (ICT) meeting to discuss the member's needs for case management services?

There may be an internal case conference at any juncture to discuss the availability of benefits and resources for the member within the agency. These internal case conferences will be scheduled on a regular basis to maximize the coordination of care across departments and services.

External case conferences or ICT meetings will include invitations to the PCP or primary medical provider; In Home Supportive Services (IHSS) and any other participant the member identifies and wishes to participate.

Managed Long Term Services and Supports (MLTSS)

Santa Clara Family Health Plan is part of the Coordinated Care Initiative (CCI) under the Cal Medi-Connect program. The goal of MLTSS is to provide coordination of care and benefits across all settings for the members. The programmatic areas under CCI include:

Multipurpose Senior Services Program (MSSP) providing members who are at risk of institutionalization intensive community based services and care coordination.

In Home Supportive Services (IHSS) providing members with in home care and support, paid for by the IHSS program.

Community Based Adult Services (CBAS) providing adult day health care for members needing more intensive support by a professional team on a daily basis.

Long Term Care Service (LTC) s for those members who are temporarily or permanently disabled to the point of needing out of home care in a LTC facility.

The MLTSS team manages and coordinates services for these, our most vulnerable members. The MLTSS team will have representation at the ICT meetings in order to ensure that these services and benefits are accessed and coordinated. In addition, for those in LTC, the completion of a HRA and ICP will be managed by this team to allow an assessment of whether the member can be placed at a lower level of care. The Whole Person Care Program is a new and exciting opportunity to provide intensive case management and housing assistance to the LTC population who may be able to return to the community.

Behavioral Health

The Behavioral Health (BH) Department is responsible for all things BH with the exception of the inpatient authorizations which are provided by the UM team upon notification by the psychiatric hospitals.

The primary focus of BH case management for CMC is the work with the Severely Mentally Ill (SMI) population. There are approximately 900 CMC members who meet this criteria per our Claim system. Ideally, these members are served in the community through a network of County and community-based organizations (CBO's) designed to meet their mental health needs.

The BH CM team has primary responsibility for three compliance-related issues:

Care coordination with the Specialty Mental Health providers for these members. There are requirements to contact and work with these providers to ensure that the member has access to SCFHP benefits, medical and psycho-social needs are met. The information sharing requirements and agreements between the County, CBO's and SCFHP are outlined in a MOU between the County and SCFHP.

Ensuring follow up after psychiatric hospitalizations with a BH provider. Typically, this is a psychiatrist, but services may be provided by other levels of staff. The requirement is that the member must be seen by 30 days post hospitalization. The SCFHP BH CM team will also provide the TOC calls and assessments to ensure that the member is safe post-discharge.

Intervention with those who have any SMI diagnosis and who visit an Emergency Room (ER)

As these members are identified, the BH CM provides outreach and care coordination to ensure that the member's needs are met on an outpatient basis. This includes both medical and behavioral health care coordination.

D. MLTSS coordination across providers and community resources
E. BH with cm and county

How Member Programs are coordinated to minimize confusion of members being contacted by multiple sources

For SCFHP team members, the key issue is to ensure that the member needs are met with the benefits and services which are available. Coordination of care internally to SCFHP is best provided through case conferencing to discuss the involvement of various teams including UM. The case conferences include case presentation and identification of the needs of the members and the role the various departments can plan.

Externally, the Interdisciplinary Care Team (ICT) is the mechanism for including the stakeholders in the community in decision making and care planning. The primary care physicians (PCP) is the primary case manager for member care and needs to receive initial care plans and be included in all medical care coordination as a primary player. Other players externally include, IHSS, Behavioral Health providers, housing partners, Board and Care operators and managers, home health providers and other social services providers.

Factor 5: Informing members (enhanced by Sandra)

Members are informed about all available PHM programs and services at any level of contact including the Plan's website, direct mail, e-mail, text or other mobile applications, telephone or in-person.

Members deemed eligible for inclusion in any PHM program involving interactive contact may opt out of participation at any time. Members or their Authorized Representatives may request to Opt-out by calling SCFHP's Customer Service department at 408-376-2000, sending a *secure* email to the SCFHP's case management department at www.CaseManagementhelpdesk@scfhp.com, or via USPS mail delivery.

Population Identification

SCFHP systematically collects, integrates and assesses member data to determine the needs of the population and develop actionable interventions. The Plan limits integration of data sources

to the minimum necessary to adequately identify members for focus area internal and external programs, determine activities involving collaboration with community-based organizations to improve transitions of care and to consider various methods of communication to members about PHM to support their medical and psychosocial needs.
Sources for data integration include:

Medical and behavioral health claims encounter data has been configured for input from an internal claims database program known as QNXT, directly into SCFHP's case management software program "Essette". Data transfers between both systems have been configured to update every 24 hours.

- Pharmacy claims

  TBD: Dependent on IT data integration into Essette from MedImpact. No expected delivery date from IT
- Laboratory results

  TBD: Not sure where this data will come from
- Health Risk Assessment (HRA) results

  Essette programming has been developed to include the Cal MediConnect CMS-approved Health Risk Assessment which is contractually required to meet regulatory standards for this population. Member responses to the HRA are completed telephonically or in-person as a Face to Face assessment with the member or their authorized representative, or are completed by mail with a manual data input directly into Essette. All HRA's received by mail are also scanned and attached as a supplemental supporting document to the member's individual case management file.

  TBD: Partial dependency on IT data integration into Essette from Advanced Health Risk assessment data. No expected delivery date from IT
- Electronic health records
- Health service programs within the organization
- Advanced data sources

Delivery System Supports

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Program Goals:

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the Santa Clara Family Health Plan (SCFHP) membership, to promote member health and well-being, and to offer quality accessible care coordination among medical care, behavioral health, and long term services and supports; and further the goals of the Olmstead Decision. In doing so, more specific goals for the program include:

- Identification of the most vulnerable members;
- Interact with members as a "whole person," not as a condition or event;
- Provide support, education and advocacy to members;
- Identify barriers that may impede member's functionality;
- Work collaboratively with the member, family and caregivers to develop goals and assist member is achieving these goals;
- Enhance member health self-management skills and knowledge regarding their health;
- Promote early and timely interventions that prevent avoidable emergency room visits and hospitalizations;
- Help members achieve optimum health or regain functional capability;
- Treatment of the member in the least restrictive setting appropriate.
- Promote utilization of participating providers;
- Engage the providers and community as collaborative partners in the delivery of effective healthcare;
- Support the foundational role of the primary care physician and care team to achieve high quality, accessible, efficient health care;
- Integrate seamlessly into the primary care office workflow to ease use of program by physicians and staff;
- Coordinate with community services to promote and provide member access to available resources in the Santa Clara County service area;
- Provide financial stewardship and diligence, while ensuring the provision of high quality, evidence-based health care services;
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

Program Objectives:

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In November 2016, SCFHP had contracted with Optum (Alere) to provide additional resources and supports to increase Cal MediConnect HRA outreach and improve regulatory compliance for Individual Care Plan completion. In August of 2017, CMS notified SCFHP that the organization had failed to meet satisfactory rates of Health Risk Assessment (HRA) completion, in compliance with contractual standards, citing January 2017 Q1 data reflecting the Percent of CMC members who were reached, were willing to participate, and had an HRA completed within 90 days was 32.9% (California State average for this measure was 91.9%).

As part of a CMS mandated Performance Improvement Plan, SCFHP initiated their plans to further build and develop their internal Case Management team and transition this outsourced scope of work away from Optum.

In early 2017, the Medical Management Case Management team had been budgeted to include a total of 11 clinical and non-clinical positions. By the end of January 2017, this team had grown to include 21 total budgeted positions, with an additional 8 positions expected to be added in 2018 as part of NCQA Population Health program development. The development of this NCQA program includes adding Licensed Clinical Social Workers, one additional Supervisor and a Program Manager to the team. In accordance with the NCQA 2018 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care including the community setting, through participation, engagement and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, while using CMC required methods via health risk assessment (HRA) and individualized care planning (ICP) through an interdisciplinary care team (IDT) approach.

A significant organizational focus on IT reporting improvements during 2017 allowed SCFHP's internal CM team to better identify it's most vulnerable members, how to accurately capture pertinent data documented within Essette and how to integrate external data such as Eligibility files to meet Case management needs.

By the end of February 2018, SCFHP's internal Case Management team had improved the HRA Completion rate to over 90% and had reduced their member Unable to Contact rate below 10%. As a result, CMS dismissed SCFHP of the mandated Performance Improvement Plan in March 2018.

Santa Clara Family Health Plan

The Spirit of Care

2017 Comprehensive Case Management Program
Annual Evaluation

Health Education Workplan 2018											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Pregnant Women	Pg. 73 Exhibit A, Attachment 10 Scope of Services	- Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	- Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services	Annually	Continuous	
Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS PL 02-004	- Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	- P&P's for health education system - List of health ed classes that cover all required health ed topic areas. - Provider/Vendor Contracts/MOU's	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	
Services for All Members	Health Education	Ensure effective health ed program	Pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002	- Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	- Use findings from GNA to select educational strategies and methods - Measure pre and post educational intervention behavior	- P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator	Annually	Continuous	
Services for All Members	Health Education		DHCS APL 11-018	- Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	- Test reading materials using flesch readability formula, etc., - Field test material at CAC meetings	- P&P's that define appropriate reading levels - Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)	100%	Health Educator	Ongoing	Continuous	
NCQA	Health Ed		Pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2018 Health Plan Accreditation Requirements PHM4	- Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions - Alcohol and drug use, including avoiding at risk drinking - Identifying depressive symptoms	- Contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities - Health Educator or designee to audit all health education classes	- 75% of vendors to have signed contracts (new or renewed) by 12/31/2018 - 100% of vendors audited by 12/31/18	Health Educator	Annually	Continuous	

Health Education Workplan 2018											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Member Services	Health Ed	Member Services	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials.	- Written Member informing materials will be translated into identified threshold and concentration languages.	- P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication - P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator	Annually	Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually		
Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	- Practitioner education and training by provider services - Health ed updates during JOC's	- Sign in sheet of provider training - JOC minutes	All providers trained	Health Educator, Provider Services, QI	Ongoing	Continuous	
Incentives	Health Ed	MMCD on-going monitoring activities	DHCS APL 16-005	Evaluation summary	- Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	- Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation/update summary	Health Educator	45 days after end of program incentive	Continuous	
Incentives	Health Ed	- Justify continuation of on-going incentive program	DHCS APL 16-005	Justify continuation of MI program	- Provide brief explanation (update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submission to DHCS	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials	- Ensure member informing resources are at sixth grade level or lower and translated into threshold languages	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower	Health Educator and Marketing	Ongoing	Continuous	Member newsletters Translated Health Ed referral forms on website

Health Education Workplan 2018											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Health Education		Written Health Education Materials	DHCS APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using Readability and suitability checklist by qualified health educator	- Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Continuous	
Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2018 Health Plan Accreditation Requirements PHM4	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	- Develop an evaluation tool/survey	- Evaluation results summary	Baseline	Health Educator	Every 36 months	Continuous	
Health Education		Review plan's online web-based self-management tools.	NCQA 2016 Health Plan Accreditation Requirements PHM 4	To ensure online web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	- Updated web-based self-management tools	Baseline	Health Educator	Ongoing	Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	- Ensure member medical records include health education behavioral assessment and referrals to health education services		- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Continuous	
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	Pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	- Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	- Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator	Annually		
Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002		- Incorporate GNA findings and annual and ongoing review of data into work plan - Approval of Health Ed Workplan by QI Committee - Submit Health Ed Workplan to MMCDHealthEducationmailbox@dhcs.ca.gov	- Approved Health Ed Workplan	Baseline	QI Manager and Health Educator	Annually	July '18	

Health Education Workplan 2018											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Community Advisory Committee	Access and Availability	Community Advisory Committee	Pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, APL 17-002	- Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from GNA findings.	- CAC Meeting minutes - Report GNA findings to CAC	Baseline	QI, Health Educator, and Marketing	Quarterly	Continuous	

Health Education Workplan 2017-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Services for Adults	Exhibit A, Attachment 10 Scope of Services Exhibit A Attachment 11 Case Management and Coordination of Care Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure IHA for adult members is performed within 120 calendar days of enrollment -Ensure performance of initial complete history and physical exam for adults to include health education behavioral risk assessment and member and family education.	For 2017, Stand alone project: See IHA work plan -Chart audits and provider training -FSR (every 3 yrs)	-IHA Medical Record Review Results -Provider Newsletter - Added quality measure to the Provider Performance Program	Baseline	QI Nurse		Continuous	Dec. '17 Policy QI.09 & QI.10
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attachment 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	-Provider Training and FSR results	Baseline	QI Nurse, Health Educator and Provider Services		Continuous	Risk Assessment tool implemented in 2016
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attachment 10 Scope of Services, DHCS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	-List of health ed classes that cover all required health ed topic areas.		Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	Policy QI.09 & Procedure QI.09.01 Health Ed referral form Health Ed page and referral form on SCFHP website
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	-Health Education Program Description	Organized delivery of health ed program	Health Educator		Continuous	Policy QI.09 & Procedure QI.09.01 Ongoing search for classes/materials in threshold languages Class audits
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using flesch readability formula, etc, -Field test material at CAC meetings	-Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)		Health Educator		Continuous	Readability & Suitability checklists: no field testing needed for '17

Health Education Workplan 2017-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
	Health Ed			-Contractor shall maintain a health ed system that provides educational intervention addressing: a) Appropriate use of health care services, b) Risk-reduction and healthy lifestyles, and c) Self-care and management of health conditions	- Maintain health education vendors	-Health Ed courses/activities	Baseline	Health Educator		Continuous	Hypertension MI incentive Childhood Immunization MI incentive Health Ed Classes April '17
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing and Health Educator		Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Member Newletter: Enrollee Rights	Inform members of their rights in CMC Member Member newsletter	-Inform members in writing of their rights annually	-Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.		Marketing, Health Educator	Annually		June '17
Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training	-Certification log of provider training -JOC meeting minutes of health ed updates	All providers trained	Health Educator, Provider Services, QI		Continuous	Ongoing Certification of Training logs by provider services JOC Health Ed updates
Incentives	Health Ed	On-going monitoring activities	DHCS PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	-Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation summary	Health Educator	30 days after end of program incentive	Continuous	Cervical Cancer MI eval summary submitted Diabetic Eye Exam MI eval summary submitted

Health Education Workplan 2017-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Incentives	Health Ed	-Justify continuation of on-going incentive program	DHCS PL 12-002	- Justify continuation of MI program	-Provide brief explanation(update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submitted to DHCS	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	Immunization, Prenatal, and Hypertension incentives submitted to DHCS for 2018 implementation
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	-Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	Ongoing member newsletters
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining DHCS approval	-Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	Ongoing
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services	For 2017, Stand alone project: See IHA work plan -Chart audits and provider training -FSR (every 3 yrs)	-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including SHA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers		QI Nurse		Dec' 17	Policy QI.10 IHA and HEBA Assessments Policy and Procedure Health Ed Referral form on provider tab on SCFHP website IHA webpage on SCFHP Website

Health Education Workplan 2017-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	-Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	-Written information in Evidence of Coverage		Marketing, Health Educator			Evidence of Coverage Dec'17
Quality of Services	Access and Availability	Conduct group needs assessment to identify health education and cultural and linguistic needs	pg. 61 Exhibit A, Attachment 9 Access and Availability, DHCS APL Policy Letter 10-012		-Conduct GNA	-GNA Summary Report submitted to DHCS within 6 mos of completion of each GNA -Annual GNA update electronically submitted every yr on October 15th, except in yrs when full GNA report is completed and executive summary submitted to MMCD. -Electronically submit an Executive Summary of GNA Report every yrs	Every 5 yrs perform GNA Update Annual update GNA summary report	QI Manager and Health Educator	Every 5 yrs & Annual update	October 15th, 2016	Policy QI.09 & Procedure QI.09.01 GNA report completed and submitted to DHCS Next due date is 2020
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01	-Form a Community Advisory Committee pursuant to Title 22 CCR Section 53876 (c)(CAC) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues affecting groups who speak a primary language other than English.	-Meeting minutes -Record of plan members on CAC		QI and Health Educator, Marketing		Continuous	Ongoing

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Conflict of Interest**	**Policy No.:**	QI.01
Replaces Policy Title (if applicable):	Conflict of Interest	**Replaces Policy No. (if applicable):**	QI-03
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To avoid a conflict of interest from occurring as related to Quality Improvement Committee (QIC) activities.

II. Policy

Practitioners and Santa Clara Family Health Plan (SCFHP) staff serving as voting members on any QI Program related Committee or the Quality Improvement Committee (QIC), are not allowed to participate in discussions and determinations regarding any case where the committee member was involved in the care received by a Plan member under review by the committee. Additionally, committee members may not review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issue.

All employees and committee participants sign a Conflict of Interest Statement on an annual basis. Fiscal and clinical interests are separated, as SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care, and there are no financial incentives for UM decision-makers that could encourage decisions that would result in under-utilization.

III. Responsibilities

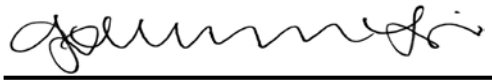
The Quality Improvement Department provides and maintains a Conflict of Interest statement to all Plan Committees that report up to the QIC annually. The Utilization Management Committee, Pharmacy and Therapeutics Committee, and Credentialing and Peer Review Committee all sign the agreement and are obligated to report any potential conflict of interest related to committee activities their committee chairperson.

IV. References

Dept. of Plan Surveys; CalMediConnect; Quality Management System (TAG). (2015, October 27). Retrieved April 12, 2016, from Department of Managed Healthcare; CA: https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey.aspx#.Vw1T1e_n-Uk

Quality Improvement 1115 Waiver(TAG). (2015, February 11). Retrieved April 12, 2016, from California Department of Managed Healthcare: https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/MedicalTechnicalAssistanceGuides/1115_qi_02_11_15.pdf

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/15/2017	05/15/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	QI.02
Replaces Policy Title (if applicable):	Development of Clinical Practice Guidelines	**Replaces Policy No. (if applicable):**	QM008_001
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To ensure a consistent process for development and revisions of Clinical Practice and Preventive Care Guidelines.

II. Policy

Santa Clara Family Health Plan (SCFHP) adopts and disseminates Clinical Practice and Preventive Care Guidelines relevant to its members for the provision of preventive, acute and chronic medical services and behavioral health care services. These guidelines are adopted to help practitioners make appropriate decisions for specific clinical circumstances, preventive health and behavioral healthcare services.

A. These guidelines are based on up to date evidence and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Quality Improvement Committee (QIC).

D. The guidelines are available for viewing on the provider web page of the health plan website, in the Provider Manual and upon request.

E. In addition to the clinical practice guidelines, SCFHP adopts preventive care guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Care Guidelines through analysis demonstrating a valid methodology to collect data.
   a. The QI Department analyzes pertinent HEDIS scores and claims data. The analysis includes quantitative and qualitative analysis or performance.
   b. Member satisfaction and grievances are tracked and reported to the QIC at least annually and acted upon as recommended by the QIC.

III. Responsibilities

Health Services Department, Quality Improvement Department and plan providers develop and adhere to Clinical and Preventive Practice Guidelines which are reviewed / revised at least annually. Evaluation of the guidelines occurs every 2 years.

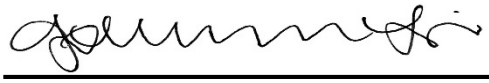
IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 2/2/2017	Title 2/2/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
v**2**	**Revised**	**Quality Improvement**	**Approve 5/10/2017**	

POLICY

Santa Clara Family Health Plan

Policy Title:	**Distribution of Quality Improvement Information**	**Policy No.:**	QI.03
Replaces Policy Title (if applicable):	Dissemination of Approved Information Following Quality Improvement Committee	**Replaces Policy No. (if applicable):**	QM007_01
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) requires staff to follow a standard process for distributing Quality Improvement (QI) information to providers and members.

II. Policy

a. At least annually, SCFHP communicates Quality Improvement (QI) program information to practitioners, providers and members. Information about QI program processes, goals, and outcomes are shared, as they relate to member care and services, in language that is easy to understand.
b. The Plan may distribute information through regular mail, e-mail, fax, the Web or mobile devices. If posted on the Web, practitioners, providers and members will be notified of the posting and given the opportunity to request the information by mail.

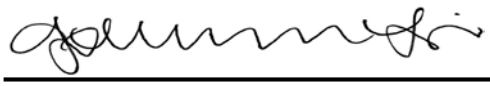
III. Responsibilities

QI forwards information for approval to appropriate departments (HS, Marketing, CEO/COO, DHCS) prior to distribution. Distribution takes place through the approved and appropriate departments after approval.

IV. References

NCQA, 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/15/2017	05/15/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	

POLICY

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Peer Review Process**	**Policy No.:**	QI.04
Replaces Policy Title (if applicable):	Peer Review Process	**Replaces Policy No. (if applicable):**	QM009_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide a fair, comprehensive peer review process for participating Santa Clara Family Health Plan (SCFHP) providers.

II. Policy

Santa Clara Family Health Plan (SCFHP) Quality Improvement Program provides methods to continuously monitor and evaluate the quality of care and services delivered by the contracted network of practitioners and providers.

The Chief Medical Officer (CMO), overseeing the QI Program activities, is responsible for oversight of peer review activities. Peer Review is coordinated through the Quality Improvement (QI) Department and communicated to the Credentialing Department. Credentialing and Peer Review Committee is a subcommittee of the Quality Improvement Committee

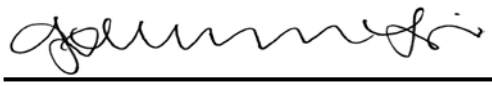
III. Responsibilities

QI continuously monitors, evaluates and develops plans to improve upon PQIs. QI, Health Services, Customer Service, IT, Grievances & Appeals and Credentialing monitor for PQIs. The QI Department tracks and trends valuable data which can identify PQIs. All PQIs have the potential for peer review.

IV. References

CA Health and Safety Code section 1370
28 CCR 1300.70(a)(1)
28 CCR 1300.70(b)(2)(C) through (E)
California Business and Professions Code Section 805

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/15/2017	05/15/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Potential Quality of Care Issue (PQI)**	**Policy No.:**	QI.05
Replaces Policy Title (if applicable):	Potential Quality of Care Issues	**Replaces Policy No. (if applicable):**	QM002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's policy to identify, address and respond to Potential Quality of Care Issues (PQI).

II. Policy

Santa Clara Family Health Plan (SCFHP) monitors, evaluates, and takes actions to support the quality of care and services delivered to members. The plan identifies and addresses PQI's in order to address potential safety concerns and improve member outcomes.

Potential Quality of Care issues are considered for all providers and provider types such as individual practitioners, groups and facilities. All service types, such as preventive care, primary care, specialty care, emergency care, transportation and ancillary services are considered and are subject to disciplinary action. Availability of care, including case management for the SPD population, continuity of care and coordination of care are also considered. The Plan monitors and analyzes data to determine if services meet professionally recognized standards of practice. Any grievance or PQI referral that involves quality of care or (a) potential adverse outcome to a member is referred to a Medical Director.

III. Responsibilities

PQIs may initially be identified by multiple departments within the plan: Health Services, Customer Service, Appeals and Grievances, Credentialing, Provider Services, Compliance, IT, QI, or Claims. All areas are responsible for reporting PQIs to the QI department.

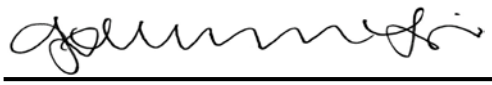
IV. References

California Code and Regulations:

1. 28 CCR 1300.68(a)(e)
2. 28 CCR 1300.70(b)(2)(I)(2)
3. 28 CCR 1300.70(a)(1)
4. 28 CCR 1300.70(b)(2)(C) through (E)

California Health and Safety Code section 1367.1

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/15/2017	Title 05/15/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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Santa Clara
Family Health Plan

Policy Title:	**Quality Improvement Study Design/Performance Improvement Program Reporting**	**Policy No.:**	QI.06
Replaces Policy Title (if applicable):	Quality Improvement Study Design/Performance Improvement Program Reporting	**Replaces Policy No. (if applicable):**	QM005_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To develop a standard design and/or format for Quality Improvement (QI) Studies and Performance Improvement Program Reporting.

II. Policy

Santa Clara Family Health Plan (SCFHP) continuously monitors and develops ways to improve quality of care for plan members. This is achieved through a variety of measures including, quality of clinical care, safety in clinical care, quality of service, members' experience, trends in potential quality of care issues, chronic care improvement projects, and quality improvement activities.

SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document Q1.06.01 Quality Improvement Study Design/Performance Improvement Program Reporting.

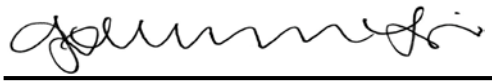
III. Responsibilities

Health Services, Customer Service, Claims, A & G and IT provide data to QI for quality monitoring and reporting. QI then develops a work plan and further monitors and reports on progress and further actions.

IV. References

The Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual Chapter 5, Quality Assessment
The National Committee for Quality Assurance (NCQA), 2018
NCQA HEDIS Specifications, 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Title 05/15/2017	Title 05/15/2017
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v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 05/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI.07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the process Santa Clara Family Health Plan (SCFHP) follows to monitor that ADA requirements are assessed and compliance is maintained at practice sites for Primary Care Practices, high volume specialists, Community-Bases Adult Services (CBAS) and ancillary practices.

II. Policy

Santa Clara Family Health Plan (SCFHP) conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, Community-Based Adult Services (CBAS) and ancillary practice site listed in the Plan's provider directory.

To drive corrective actions when needed, and monitor the results of the physical assessment review which are made available to SCFHP members following the Department of Healthcare Services (DHCS) requirements.

III. Responsibilities

SCFHP Quality Improvement Department (QI) performs site reviews and reports to the Quality Improvement Committee. Complaints regarding related office accessibility issues are reported by QI to PR/Credentialing as appropriate. Customer Service/IT reports track/trend provider access complaints.

IV. References

Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section

DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

PL 12-006 - Revised Facility Site Review Tool

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
DHCS/SCFHP Contract:
Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM

4. Quality Improvement Committee

8. Quality Improvement Annual Report

10. Site Review

Exhibit A, Attachment 7 - PROVIDER RELATIONS

5. Provider Training

Exhibit A, Attachment 9 - ACCESS AND AVAILABILITY

11. Access for Disabled Members

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/15/2017	Title 05/15/2017
Date	Date

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v1	**Original**	**Quality Improvement**	**Approve:11/9/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Cultural and Linguistically Competent Services**	**Policy No.:**	QI.08
Replaces Policy Title (if applicable):	Cultural and Linguistic Services Program Policy	**Replaces Policy No. (if applicable):**	CU 002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's (SCFHP) process for accessing and monitoring that services provided to members are culturally and linguistically appropriate to meet member needs.

II. Policy

It is the policy of SCFHP to promote Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population served. SCFHP is committed to providing all services, both clinical and non-clinical, in a culturally competent manner that are accessible to all members, including those with non-English speaking/limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural, ethnic backgrounds, disabilities and regardless of race, gender, sexual orientation or gender identity. SCFHP maintains a Cultural and Linguistics Program that is reviewed and approved by the Quality Improvement Committee on an annual basis. SCFHP completes the Group Needs Assessment every three years to assess member cultural and linguistic needs.

SCFHP assesses monitors and evaluates services for Cultural and Linguistic appropriateness. SCFHP involves member input through the Consumer Advisory Committee.

See associated procedures Cultural and Linguistically Competent Services, Language Assistance Program, Member Document Translations, Standing Requests for Member Materials in Alternate Formats, and Ad Hoc Requests for Member Materials in Alternate Format for detailed process for meeting these objectives.

III. Responsibilities

i. DHCS updates threshold language data at least once every three years, to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal managed care counties. Quality Improvement complies with the update requirements within three months of the publication of the update.

ii. Quality Improvement and Provider Network Management ensure Health Plan Staff and Providers are adequately trained, have access to resources, and provide culturally competent services to all Plan members.

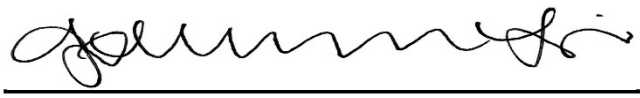
iii. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages which is reviewed and updated as needed based on member assessment needs but no later than every three years based on the results of the Group Needs Assessment survey.

iv. Quality Improvement notifies SCFHP staff and departments of changes to member threshold languages via the Quality Improvement Committee and internal memos or department training sessions.

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA 2018
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract
Title 22 CCR Section 53876
Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5) and Section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL -99 03
APL 99005
CFR 42 § 440.262

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Johanna Liu, PharmD	Jeff Robertson, MD
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Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
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v1	**Original**	Quality Improvement	Approve 05/10/2017	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Health Education Program and Delivery System	**Policy No.:**	QI.09
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

The purpose of this policy is to:

A. Describe the Health Education Department and its functions.
B. Define the standards and quality of health education classes and materials.

II. Policy

The Health Education Department of Santa Clara Family Health Plan (SCFHP) seeks to educate and empower health plan members to:

A. Appropriately use the managed care system, preventive and primary health care services
B. Improve their well-being and reduce their risk of disease and injury through adoption of healthy behaviors
C. Understand and adhere to self-care and treatment regimens in the management of chronic and acute conditions.

It is the policy of SCFHP that the Health Education Department will coordinate member educational material and care guidance with the Health Services Department to make certain that recommendations and guidelines to members are aligned with Clinical Practice Guidelines and Utilization Management medical necessity criteria

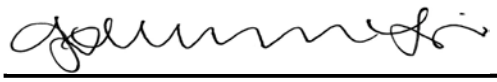
III. Responsibilities

The Health Education Department within the Quality Improvement department of Santa Clara Family Health Plan is responsible for ensuring the policy is enforced with the assistance of the Marketing and Provider services department, and whichever department support is needed to ensure this policy is followed.

IV. References

DHCS Contract Exhibit A, Attachment 10 Section 8.A,
NCQA 2018 Health Plan Accreditation Requirements and PHM4

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
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Date	Date

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v1	**Original**	**Quality Improvement Committee**	**Approved; 08/10/2016**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approved: 5/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA)	**Policy No.:**	QI.10
Replaces Policy Title (if applicable):	Initial Health Assessments (IHA's) and Behavioral Assessment (HEBA)	**Replaces Policy No. (if applicable):**	HE004_05
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

1. The purpose of this policy is to describe the required completion of the Initial Health Assessments (IHA's) and the Individual Health Education Behavior Assessment (IHEBA) by contracted providers.
2. To define the process that Santa Clara Family Health Plan (SCFHP) will oversee the completion of the SHAs, IHAs and IHEBAs

II. Policy

1. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of the SHA to all Medi-Cal members as part of the Initial Health Assessment (IHA) and to periodically re-administer the SHA according to contract requirements in a timely manner
2. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for an IHA and an IHEBA is to be performed within 120 days of a member's enrollment in SCFHP and that the subsequent IHEBA is re-administered at appropriate age intervals.

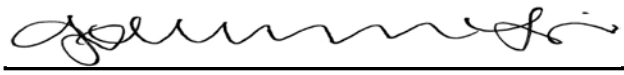
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance of the policy and to collaborate with the Health Education and Provider Services department to train/educate providers on SHA requirements.

IV. References

MMCD Policy Letter 13-001, DHCS Contract Exhibit A Attachment 10, Provisions 3, 4, 5 A and B, and 6.
MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
Staying Healthy Assessment Questionnaires and Counseling and Resource Guide
American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
Web site for SHA Questionnaires and Resources
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approve: 05/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Member Non-Monetary Incentives**	**Policy No.:**	QI.11
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

The purpose of this policy is to establish guidelines for the administration of rewarding members who demonstrate effort and success in adopting health-promoting behaviors.

II. Policy

SCFHP may utilize non-monetary incentives to reward members who demonstrate effort and success in adopting health-promoting behaviors or changing health risk behaviors.

A. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
B. SCFHP will submit annual updates to justify the continuation of an ongoing MI program and an end of program evaluation to describe whether or not the MI program was successful.
C. For Focus Group Incentives (FGIs), SCFHP submits an evaluation that incudes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives, SCFHP will submit a copy of the survey, along with an evaluation that includes findings and recommendations.
D. No member incentives are offered to CMC members (Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72).

III. Responsibilities

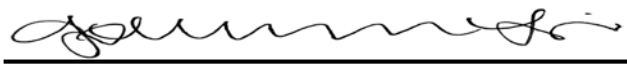
It is the responsibility of the Quality Improvement (QI) department and all departments within the QI department and departments administering incentives, focus groups, and surveys to ensure SCFHP is in compliance with relevant regulations.

IV. References

MMCD APL 16-005, February 25, 2016
AB 915 (Chapter 500., Statutes of 2007): Welfare and Institutions
(W&I) Code 14407.1
Title 28. CCR. Section 1300.46
Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approve: 05/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol**	**Policy No.:**	QI.12
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☐ CMC

I. Purpose

The purpose of this policy is to describe the required administration of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for Medi-Cal members ages 18 and older who misuse alcohol.

II. Policy

A. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of SBIRT when indicated during administration of the Staying Healthy Assessment or at any time the PCP identifies a potential alcohol misuse problem.

B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for identification, referral, and coordination of care for members requiring alcohol abuse treatment services.

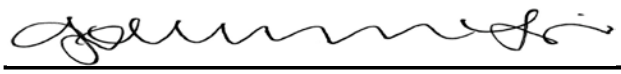
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance with the policy and collaborate with the assistance of the Health Education and Provider Services department to train/educate providers on SBIRT.

IV. References

1. DHCS All Plan Letter 14-004: Screening Brief Intervention, and Referral to Treatment for Misuse of Alcohol
2. DHCS Contract Exhibit A, Attachment 11, Provisions 1A.
3. United States Preventive Task Force (USPSTF) alcohol screening recommendation http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care
4. Website for SHA Questionnaires http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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v1	**Original**	**Quality Improvement**	**Approve: 11/9/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Comprehensive Case Management**	**Policy No.:**	QI13
Replaces Policy Title (if applicable):	Case Management	**Replaces Policy No. (if applicable):**	CM030_05
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To promote access to appropriate, coordinated services with the intent that members with case management needs may achieve optimal health and functionality.

II. Policy

A. The comprehensive case management program is established to provide case management processes and procedures that enable SCFHP to improve the health and health care of its membership.
B. To define the fundamental components of SCFHP case management services which include: member identification and screening; member assessment; individual care plan development, interdisciplinary team meetings including primary care, implementation and management; evaluation of the member care plan; and closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.
C. SCFHP defines the process of how the Plan coordinates services for members with complex conditions and helps them access needed resources.

III. Responsibilities

Health Services collaborates with other SCFHP departments (IT, claims, benefits, provider services) as well as providers and community services to identify, coordinate services, coordinate benefits and provide members with complex case management.

IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.
Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA.
NCQA Guidelines. 2016.
87890 2016 SCFHP Model of Care
DPL 15-005

POLICY

V. Approval/Revision History

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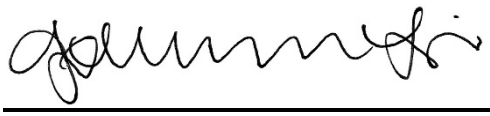	
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Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

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v1	**Original 08/05/16; Reviewed 08/09/17**	**Quality Improvement**	**Approve:08/09/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Disease Management**	**Policy No.:**	QI14
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

To support processes so the Plan may actively work to improve the health status for members with chronic health conditions.

II. Policy

A. The Disease Management Program is designed to support the mission of SCFHP by improving the quality of care and disease outcomes for the Santa Clara Family Health Plan CalMediConnect members. The plan takes an active role in helping providers assist members in managing chronic conditions. An evaluation of the Plan's population is conducted annually to identify medical and behavioral health conditions to be included in the Disease Management Program

B. To define how each Disease Management program will be established on evidence based Clinical Practice Guidelines adopted by the Quality Improvement (QI) Committee. These guidelines are evidence based and widely accepted clinical practices, based on literature or other practice guidelines.

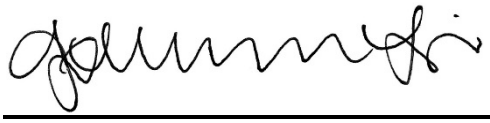
III. Responsibilities

Health Services works with IT, Member Services, Provider Services, Providers, Quality Improvement, Behavioral Health Services, Pharmacy Management, and community based services to support members with Disease Management services.

IV. References

NCQA Guidelines. 2016
87890 2016 SCFHP Model of Care

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original 08/05/16; Reviewed 08/09/2017**	**Quality Improvement Committee**	**Approve: 08/09/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Transitions of Care**	**Policy No.:**	QI.15
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the process the Plan adopts to monitor and take action to improve continuity and coordination of care across the health care network, including medical care settings, medical with behavioral health care settings, and for transitioning members between levels of care.

II. Policy

A. The Plan supports and promotes appropriate transitions between care settings which is critical to improving member quality of care and health outcomes. The Plan's Care Transitions Program goal is to improve transitions between settings to the most appropriate and safe level of care for that member. Objectives include:
- Curtail medical errors
- Identify issues for early intervention
- Minimize unnecessary hospitalizations and readmissions
- Support member preferences and choices
- Reduce duplication of processes and efforts to more effectively utilize resources
- Promote the exchange of information
- Support appropriate use of medications
- Meet special needs of members with behavioral disorders commonly seen in primary care

B. The Plan implements processes that arrange for/ authorize and coordinate services and care needed for members after inpatient discharge, nursing facility residents or at other levels of care into the community or to the least restrictive setting possible. This includes ensuring access to necessary medical/behavioral health care, medications, durable medical equipment, supplies, transportation, and integration of Long Term Support Services (LTSS) benefits and community based resources.

C. The Plan uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system
    a. Between medical care settings
    b. Between medical and behavioral health care settings

Process is detailed in the associated Procedure document Transitions of Care.

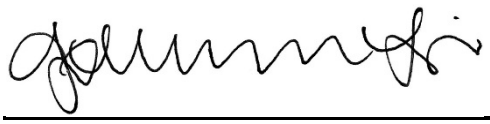
III. Responsibilities

Health Services works with internal departments, providers and community resources for referrals and to transition members to appropriate levels of care.

IV. References

WIC section 14182.17(d)(4)(H).
NCQA, 2016
87890 2016 SCFHP Model of Care
DHCS/Plan Renewed Contract 2013
DHCS/CMS/Plan 3-Way Contract

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original 08/05/16; Reviewed 08/09/2017**	**Quality Improvement**	**Approve: 08/09/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Behavioral Health Care Coordination**	**Policy No.:**	QI.17
Replaces Policy Title (if applicable):	**Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure**	**Replaces Policy No. (if applicable):**	**CM106_1**
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

The plan promotes and coordinates seamless access and availability to appropriate behavioral health providers, community services and support for members identified with behavioral/mental health and substance use needs so that member may achieve optimal health and functionality.

II. Policy

A. To complement the Comprehensive Case Management policy, the Plan optimizes access to services for members by coordinating care and facilitating referrals to Behavioral Health (Mental Health and Substance Use Disorders) services for Medi-Cal and Cal MediConnect (CMC) members. This includes emergent, non-emergent, in-patient or outpatient referrals. Referrals may encompass community services, a community triage service, a community crisis line, contracted plan providers.

B. The Plan promotes continuity and coordination of care between behavioral healthcare providers and medical providers. Information is gathered regarding exchange of information, appropriate diagnoses, treatment, referrals, medications and follow-up. Successful collaboration is monitored and improvement plans implemented as appropriate.

C. The Plan defines processes for the provision of Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) including Applied Behavioral Analysis, but not excluding other evidence based behavioral intervention services that develop or restore functioning. The plan provides BHT for members without regard to Autism Spectrum Disorder (ASD) diagnosis. The Plan requires Primary Care Physicians (PCP) to administer the Department of Health Services approved assessment tool as detailed in the procedure.

D. To define how the Plan provides guidelines to PCPs regarding management and treatment for members with Behavioral Health conditions as outlined in the procedure Mental Health Services Provided by PCPs.

III. Responsibilities

Behavioral Health Services collaborates with other Health Services areas to coordinate care, and with QI to monitor coordination of care, for under/over utilization. Behavioral Health Serivces collaborates with the

County Behavioral Health Services Department and other Community Based Organizatons (CBO) to provide comprehensive care and services for SCFHP members.

IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

NCQA Guidelines 2016

WIC Sections 14182.17(d)(4) and 14186(b)

28 CCR 1300.74.72(g)(3) through (5)

H7890 2016 SCFHP Model of Care

V. Approval/Revision History

First Level Approval	Second Level Approval
Sherry Holm LCSW	
Signature Sherry Holm, LCSW	Signature Jeff Robertson, MD
Name Director of Behavioral Health	Name Chief Medical Officer
Title 08/05/2016	Title 08/05/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**			

Santa Clara
Family Health Plan

Policy Title:	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Policy No.:**	QI.18
Replaces Policy Title (if applicable):	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Replaces Policy No. (if applicable):**	CM036_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To promote timely access to sensitive, confidential medical services for adult and minor children when needed and/or requested.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) allows minor children and adult members to have access to sensitive, confidential medical services without the need for prior authorization.

I. The following services are considered confidential and sensitive services for adult and minor children aged 12 and older without parental consent:

1. Sexually transmitted diseases
2. Family planning
3. Sexual assault
4. Pregnancy testing
5. HIV testing and counseling
6. Abortion
7. Drug and alcohol abuse
8. Outpatient mental health care

B. Requirements for consent, confidentiality and rights for these sensitive services are defined in the associated procedure CM.06.01.

III. Responsibilities

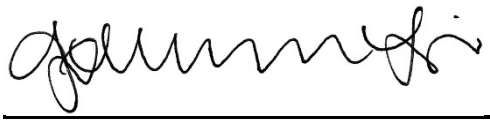
Health Services works with IT, Provider and Customer Services, providers and community services to provide sensitive and confidential services to members without requiring prior authorization.

IV. References

Fed. Law 1987 OBRA, Sec. 4113 (c)(1)(B), 1905 (a)(4)(c); BBA
DHS Contract A-12, Exhibit A, Attachments 5, et. seq, 9, Items 1, 3, 8, 2. C
MMCD Pol. Letter #s: 94-13, 96-09, 97-08, 98-11
T22, CCR, 50063.5, 51009, 50063.5; Family Code §6925 et. seq., W & I Code §14132. et seq., 14451 et. seq. ; T28, CCR

Knox-Keene Act; H & S Code §1340. et. seq., 120980, 120990, 121010, 121015
Civ. Code §56. et. Seq
Insurance Code §791, et. seq.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original 08/05/16; Reviewed 08/09/2017**	**Quality Improvement**	**Approve: 08/09/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Care Coordination Staff Training	**Policy No.:**	QI.19
Replaces Policy Title (if applicable):	Long Term Support Services and Social Services Training	**Replaces Policy No. (if applicable):**	112_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide staff the skills to meet member needs related to care coordination principals.

II. Policy

A. Care Coordination Staff training includes but is not limited to the following:

1. Overview of regulatory / contractual requirements including ICP and ICT training
2. Accessibility and accommodations; independent living;
3. Wellness principles
4. Criteria for safe transitions, transition planning, care plans after transitioning
5. Along with other required training as specified by DHCS—both initially and on an annual basis
6. Dementia care management for specially designated care coordination
7. LTSS operations including:
    a. LTSS benefits
    b. Eligibility and Service Authorization process
    c. Program limitations
    d. Referrals
    e. Interface with Case Management
    f. Overview of characteristics and needs of LTSS target population
8. Self-direction
9. Behavioral Health coordination
10. Community Services
11. Model of Care
12. Cultural and Linguistic Services
13. Care Plan Options
14. Person centered planning process
15. Home and Community Based Services

B. Training content is reviewed and updated as needed in regards to state and federal regulations as well as other best practices. Staff training is completed upon hire, reviewed annually and additional reviewed as needed.

III. Responsibilities

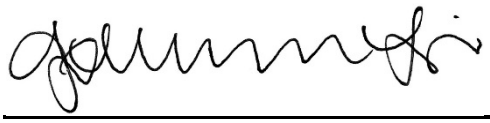
Health Services management works with internal departments, external partners and providers to provider staff training.

IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

Cal MediConnect Prime Contract (§2.9.10.10.)
H7890 2016 SCFHP Model of Care

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original 08/05/16; Reviewed 08/09/2017**	**Quality Improvement**	**Approve: 08/09/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Information Sharing with San Andreas Regional Center (SARC)**	Policy No.:	QI.20
Replaces Policy Title (if applicable):	None	Replaces Policy No. (if applicable):	None
Issuing Department:	Health Services	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ Healthy Kids		☐ CMC

I. Purpose:

This policy supports the agreement between San Andreas Regional Center (SARC) and the Santa Clara Family Health Plan (SCFHP) to perform care coordination and information exchange activities when Medi-Cal beneficiaries are accessing medically necessary Behavioral Health Treatment Services (BHT). The agreement addresses both new referrals for BHT and clients/beneficiaries receiving BHT when funding for this service is transitioning from SARC to SCFHP.

II. Policy

SCFHP is responsible for the provision of BHT as a managed care health benefit, including the coordination of the client's care with SARC and the BHT provider(s). SARC will support SCFHP's care coordination by providing necessary client information to SCFHP and vendors in accordance with any and all privacy laws and regulations.

Santa Clara Family Health Plan

- SCFHP is responsible for coordination of services including primary care, California Children's Services, Specialty Mental Health Services.
- SCFHP shall arrange for and pay for diagnostic evaluations and BHT services according to criteria outlined in DHCS APL 15-025.
- SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.

San Andreas Regional Center

- SARC shall provide client information, including comprehensive diagnostic evaluation(s), treatment plan(s), utilization data and assessment information to SCFHP upon receipt of appropriate release of information (ROI)
- SARC shall refer clients under age 21 who are diagnosed with Autism Spectrum Disorder (ASD) for evaluation for medically necessary BHT services.
- SARC shall provide case management & care coordination services related to SARC's Early Start Program clients.
- SARC shall provide case management and care coordination to eligible clients and assist those clients in maintaining an ongoing relationship with the SCFHP's assigned primary care provider when medical needs arise.
- SARC will identify a staff person to be the primary liaison to SCFHP. The liaison will meet not less than quarterly to ensure continuous communication and resolve any operational, administrative and policy complications.

POLICY

- SARC will share information on community resources.
- SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families
- SARC agrees to provide periodic training to SCFHP's staff.
- SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.

III. Responsibilities

Health Services works collaboratively with plan benefits, compliance, QA , IT, plan and community providers to coordinate members' Behavioral Health Treatment services and members' Behavioral Health managed care.

IV. References

Center for Medicare & Medicaid Services approved California State Plan Amendment (SPA) 14-026 Section 1915 C waiver, CA.336 HCBS Waiver for Californians with Developmental Disabilities
Department of Health Services (DHCS) All Plan Letter (APL) 15-025

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sherry Holm, LCSW	Signature Jeff Robertson, MD
Name Director of Behavioral Health	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original 08/05/16; Reviewed 08/09/2017**	**Quality Improvement**	**Approve: 08/09/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara Behavioral Health Services Department**	**Policy No.:**	QI.21
Replaces Policy Title (if applicable):	Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara County	**Replaces Policy No. (if applicable):**	HS 409
Issuing Department:	Health Services: Behavioral Health	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal ☐ Healthy Kids		☒ CMC

I. Purpose

To provide detailed instructions for how Santa Clara County Behavioral Health Services Department and Santa Clara Family Health Plan (SCFHP) will perform activities to support the provision of Medi-Cal Specialty Mental Health and/or drug Medi-Cal services as a managed care benefit under the Medi-Connect program. SCFHP and the County of Santa Clara Behavioral Health Services Department (formerly known as Santa Clara County Mental Health Department and Santa Clara County Department of Alcohol and Drugs) entered into a MOU effective January 1, 2014 to specify how roles and responsibilities between the two entities were to be performed.

II. Policy

It is the policy of the SCFHP to provide coordination of care for the purpose of providing services to CMC members which are coordinated with Santa Clara County BHSD, their mental health clinics and contractors. The SCFHP and the CBHSD will follow the medical necessity criteria for Medi-Cal specialty mental health 1915 (b) waiver services described in Title 9, California Code of Regulations. DHCS has developed a matrix of Roles and Responsibilities "Behavioral Health Benefits in the Duals Demonstration" which is attached to the MOU. Medical necessity for Drug Medi-Cal Substance Abuse Services will be as found in Title 22, California Code of Regulations (CCR).

III. Roles and Responsibilities

1. Assessment Process

The SCFHP and CBHSD shall develop and agree to written policies and procedures regarding screening And assessment processes that comply with all federal and state requirements. SCFHP completes a Health Risk Assessment (HRA) pursuant to the CMC three way contract guidelines. SCFHP Behavioral Health Department reviews and/or completes the HRA with special attention to the depression Indicators as well as Severe Mental Illness indicators. The HRA, in conjunction with claims and pharmacy Information, is utilized to create a preliminary interdisciplinary care plan (ICP). The ICP is reviewed with the member and sent to the member's primary care physician and the member's Specialty Mental Health provider for their review and changes.

2. Referrals

The SCFHP and the CBHSD shall develop and agree to written policies and procedures regarding referral processes including:

a. CBHSD will accept referrals from SCFHP staff, providers, and members' self-referral for determination of medical necessity
b. SCFHP will accept referrals from CBHSD for services needed are provided by the SCFHP and not the CBHSD and the member does not meet the Medi-Cal Specialty mental health and/or Drug Medi-Cal medical necessity criteria. This will include mild to moderate levels of care needs which are the responsibility of SCFHP.

3. Information Exchange
a. CBHSD will develop and agree to information sharing policies and procedures. CBHSD Director has provided a memo to County Clinics and Sub-contractors stating that basic information may be shared in order to determine if a member is being seen and who is the provider in the agency.
b. SCFHP will create a list of members who are receiving Medi-Cal specialty mental health services, and/or Drug Medi-Cal services.
c. A signed mental health release of information is obtained from the member in order to 1. Share information with behavioral health services agencies; 2. Provide care coordination and 3. Complete and updated ICP and an interdisciplinary care team (ICT) meeting as needed.
d. The information sharing policies and procedures developed by the CBHSD and SCFHP will include milestones agreed upon for shared roles and responsibilities for sharing personal health information. Meetings with County BHSD providers and their contractors will be held to provide training to discuss the policies and procedures which have been agreed upon for sharing of personal health information.

4. Care Coordination
a. The SCFHP and CBHSD will develop and agree to policies and procedures for coordinating Medical and behavioral health care for members enrolled in SCFHP and receiving Medi-Cal specialty mental health or Drug Medi-Cal services.
b. The policies and procedures will include:
- An identified point of contact from both CBHD and SCFHP who will initiate and maintain ongoing care coordination
- CBHSD and their contractors will participate in ICT's for members receiving County services and identified as needing an ICT.
- At the County's request, the SCFHP will assist the CBHSD in developing behavioral health care plans
- SCFHP will have a process for reviewing and updating the care plans as clinically indicated and following a hospitalization or significant change such as level of care.
- SCFHP will have regular quarterly meetings to review the care coordination process
- SCFHP will coordinate with the County to perform an annual review, analysis & evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

IV. References

- California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
- Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
- DHCS Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Enrollees, D. Mental Health Services
- MMCD Policy Letter 00-01

- Title 9, CCR, Chapter 11, Division 1, Section (s) 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205 (b) (1); 1830.210; 1850.210 (I); 1850.505
- Title 22, CCR, Chapter 3, Article 4, Section (s) 51305; 51311; 51313; 51183
- Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (1) and the State of California Alcohol and/or Other Drug Program Certification Standards
- Welfare and Institutions Code Section 5600.3; and 14016.5

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

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

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Early Start Program (Early Intervention Services)**	**Policy No.:**	QI.22
Replaces Policy Title (if applicable):	Early Start Program (Early Intervention Services): Developmental Delay Identification, Referral and Care Coordination	**Replaces Policy No. (if applicable):**	CM.005_03
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

To ensure that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

II. Policy

Santa Clara Family Health Plan (SCFHP) identifies members (aged 0 to 2.9 years) who have, or are at risk of acquiring developmental delays or disabilities and need early intervention services. SCFHP will coordinate the referral of members to the Early Start Program, which is a collaborative effort between the San Andreas Regional center (SARC) and the Santa Clara County Office of Education.

III. Responsibilities

The Health Services Department of the SCFHP is responsible for referring members to Early Start as they are identified by the primary care physicians, case managers and others. The Department is also responsible to notify SCFHOP delegates of their responsibilities to refer to Early Start.

IV. References

V. Approval/Revision History

First Level Approval	Second Level Approval
Sherry Holm LCSW	
Signature Sherry Holm, LCSW	Signature Jeff Robertson, MD
Name Behavioral Health Manager	Name Chief Medical Officer
Title January 25, 2017	Title January 25, 2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V4	**Original**	**Quality Improvement Committee**	**2/8/17 Approve**	

Santa Clara Family Health Plan
The Spirit of Care

SANTA CLARA FAMILY HEALTH PLAN (SCFHP)
MY2017 Provider Appointment Availability Survey Report

SCFHP's Provider Network staff continue to monitor timely access compliance among its Provider Groups through the annual Provider Appointment Availability Survey (PAAS). The results of the survey are summarized in this report.

Methodology

The methodology utilized for this survey was completed as outlined by the DMHC approved format and methodology, with some noted exceptions below. The survey was completed in 2017 by PNM staff and the results were validated by Advent Advisory Group, LLC.

Due to unforeseen circumstances the following exception to the methodology occurred:

- **De-duplicating the Provider Contact List** was overlooked; therefore it appears that the sample size for the following provider types/groups were not met due to this oversight:
  - **Ancillary –**Physical Therapy / Individually Contacted Providers
  - **PCP –** Individually Contracted Providers, Palo Alto Medical Foundation and Premier Care of Northern California
  - **Specialist –**
    - **Cardiology** / Individually Contracted Providers, Palo Alto Medical Foundation and Premier Care of Northern California
    - **Child and Adolescent Psychiatry** / Individually Contracted Providers
    - **Endocrinology** / Palo Alto Medical Foundation
  - **Gastroenterology** / Individually Contracted Providers, Palo Alto Medical Foundation and Premier Care of Northern California
  - **Psychiatry** / Individually Contracted Providers, Palo Alto Medical

SCFHP understands the importance of following the DMHC methodology to ensure the number of surveys for each PG and Provider type is met. This item has been noted as a lessoned learned and we will make a concerted effort to improve our survey implementation for MY2018.

- The DMHC requires the surveys to be administered May 1 through Dec 31 in two waves spaced at least six weeks apart. **Due to SCFHP staff turnover, the surveys were administered late in 2017 in two waves without a 6-week break.**

In an effort to ensure the annual provider appointment availability surveys are completed as outlined by the DMHC, SCFHP created a new position in part to oversee and manage the annual appointment availability surveys. The title for the new position is Provider Network Access Manager, and our new hire start date was on January 22, 2018.

Santa Clara Family Health Plan
The Spirit of Care

Rate of Compliance

Specialist – Urgent Appointment within 96hrs

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	44	20	24	45%
Palo Alto Medical Foundation	31	10	21	32%
PMG-San Jose	28	16	11	57%
Premier Care of North CA	1	1	0	100%
Total	**104**	**47**	**57**	**45%**

Specialist – Non-Urgent Appointment within 15-days

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	48	17	31	35%
Palo Alto Medical Foundation	34	17	17	50%
PMG-San Jose	28	22	6	79%
Premier Care of North CA	1	1	0	100%
Total	**111**	**57**	**54**	**51%**

Santa Clara Family Health Plan
The Spirit of Care

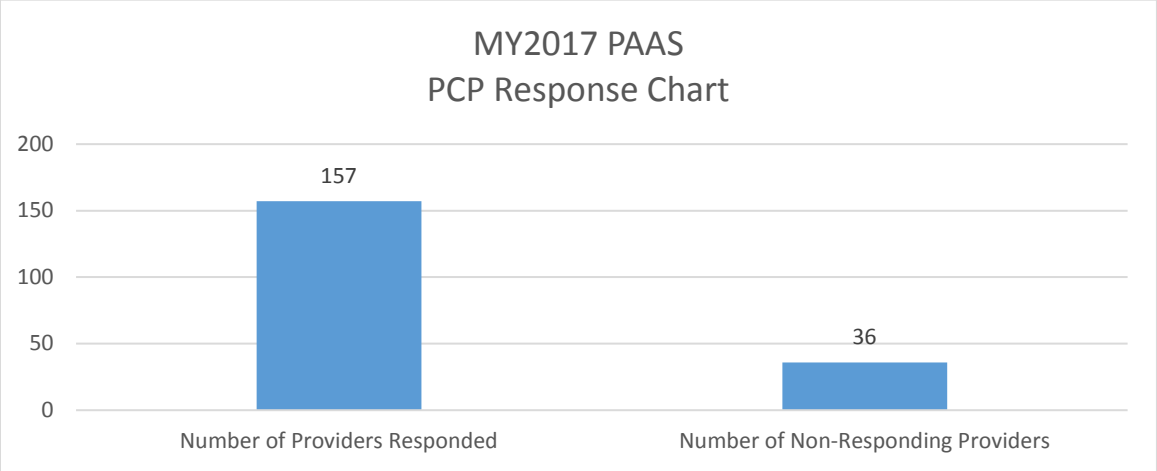
PCP – Urgent Appointment within 48hrs

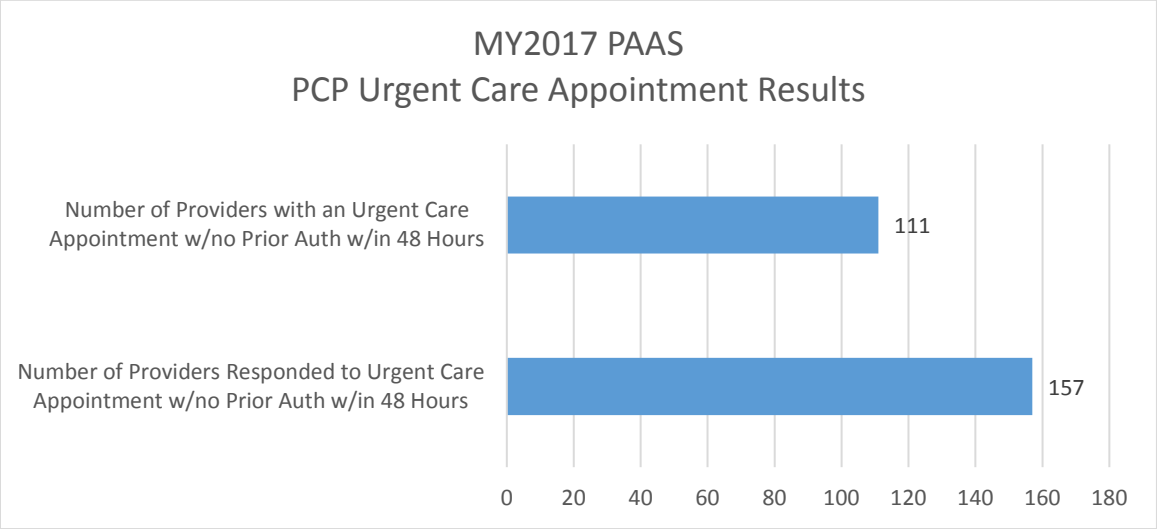
Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	27	22	5	81%
Palo Alto Medical Foundation	60	29	31	48%
PMG-San Jose	48	41	7	85%
Premier Care of North CA	22	19	0	86%
Total	**157**	**111**	**43**	**71%**

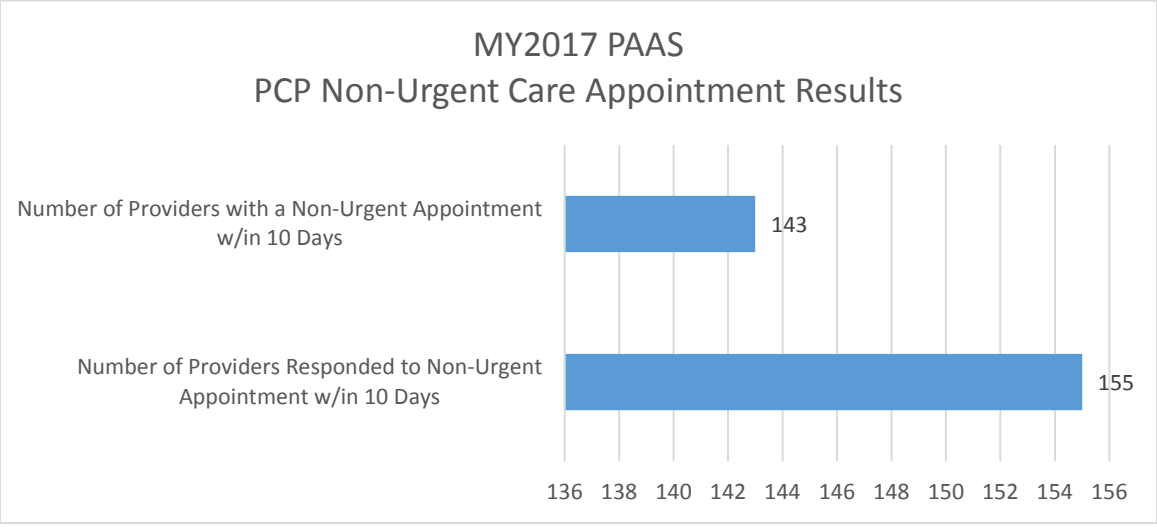
PCP– Non-Urgent Appointment within 10-days

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	26	26	0	100%
Palo Alto Medical Foundation	60	56	4	93%
PMG-San Jose	48	42	6	87%
Premier Care of North CA	21	19	2	90%
Total	**155**	**143**	**12**	**92%**

Santa Clara Family Health Plan
The Spirit of Care







Ancillary – Non-Urgent Appointment within 15-days

Provider Group	# Surveyed	Compliant	Non-Compliant	% of Compliance
Direct Network (Independent Physicians)	24	22	2	92%
Total	**24**	**22**	**2**	**92%**

Interpreter Services Questions

Most providers who were surveyed answered the series of Interpreter Services questions and the response was positive in terms of their understanding that the Plan (SCFHP) is responsible to offer language line assistance and support.

Corrective Action Plan:

Providers found to be in violation of access standards received a written corrective action letter with a description of the violation and a request to correct it.

Narratives (submitted in the MY2017 DMHC submission)

1. **Stanford**

The following narratives were submitted through the DMHC submission to explain some of the challenges and oversights for MY2017:

Stanford medical group providers were included in our survey contact lists and a sample of providers were targeted to complete the survey.

As survey calls were being made, SCFHP staff were readily advised that Stanford would not participate in the survey.

After further call attempts to find a Stanford staff member to answer the survey, only in very few cases would they participate and complete the survey.

Stanford staff were advised that their participation was required by the DMHC; however, they continued to refuse to participate in the survey.

2. **Non-Physician Mental Health Providers**

Due to unforeseen circumstances the following exception to the methodology occurred:

- **The DMHC requires the surveys to include Non-Physician Mental Health Providers and due to staff turnover, this survey was overlooked and was not completed.**

Santa Clara
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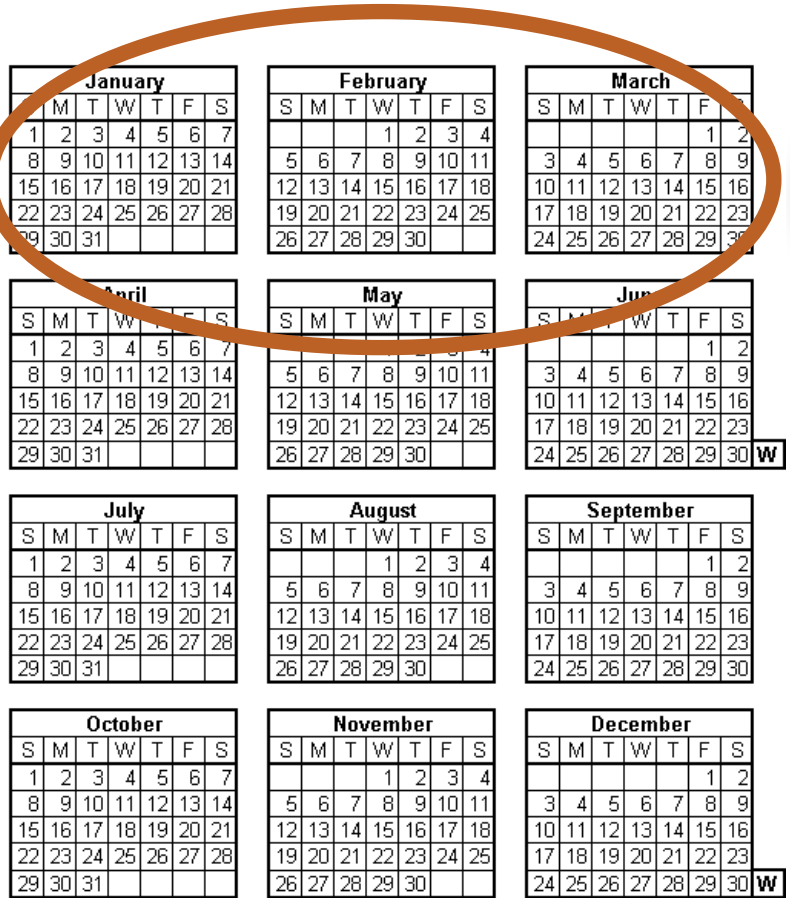
Quality Improvement Committee

May 9, 2018

Medi-Cal & Healthy Kids



January						
	M	T	W	T	F	S
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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February						
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26	27	28	29	30		

March						
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

April						
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15	16	17	18	19	20	21
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29	30	31				

May						
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Jun						
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July						
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22	23	24	25	26	27	28
29	30	31				

August						
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12	13	14	15	16	17	18
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26	27	28	29	30		

September						
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24	25	26	27	28	29	30

October						
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22	23	24	25	26	27	28
29	30	31				

November						
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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						
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					1	2
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

Q1 2018

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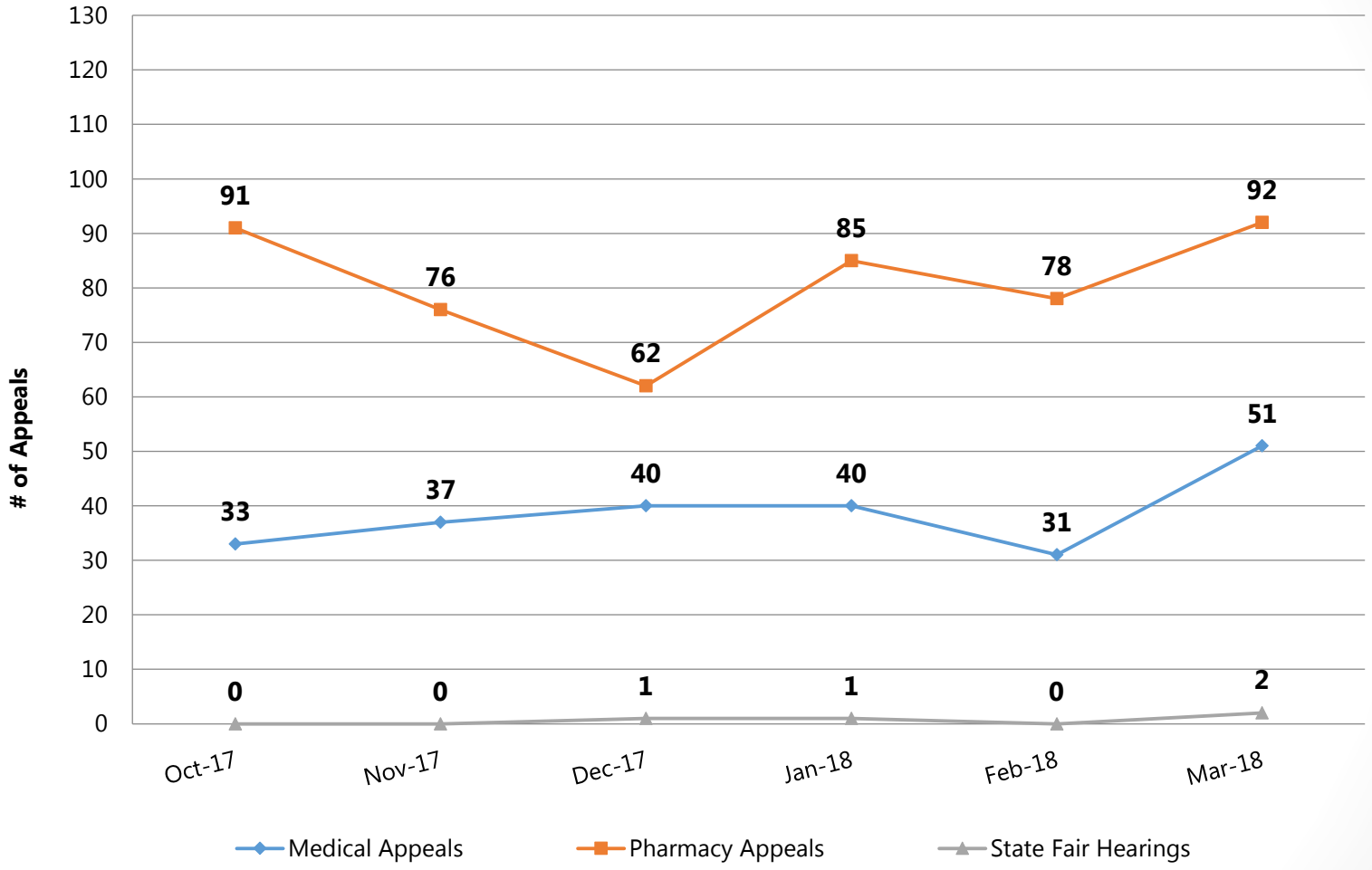
Q4 2017-Q1 2018: Medi-Cal Appeals



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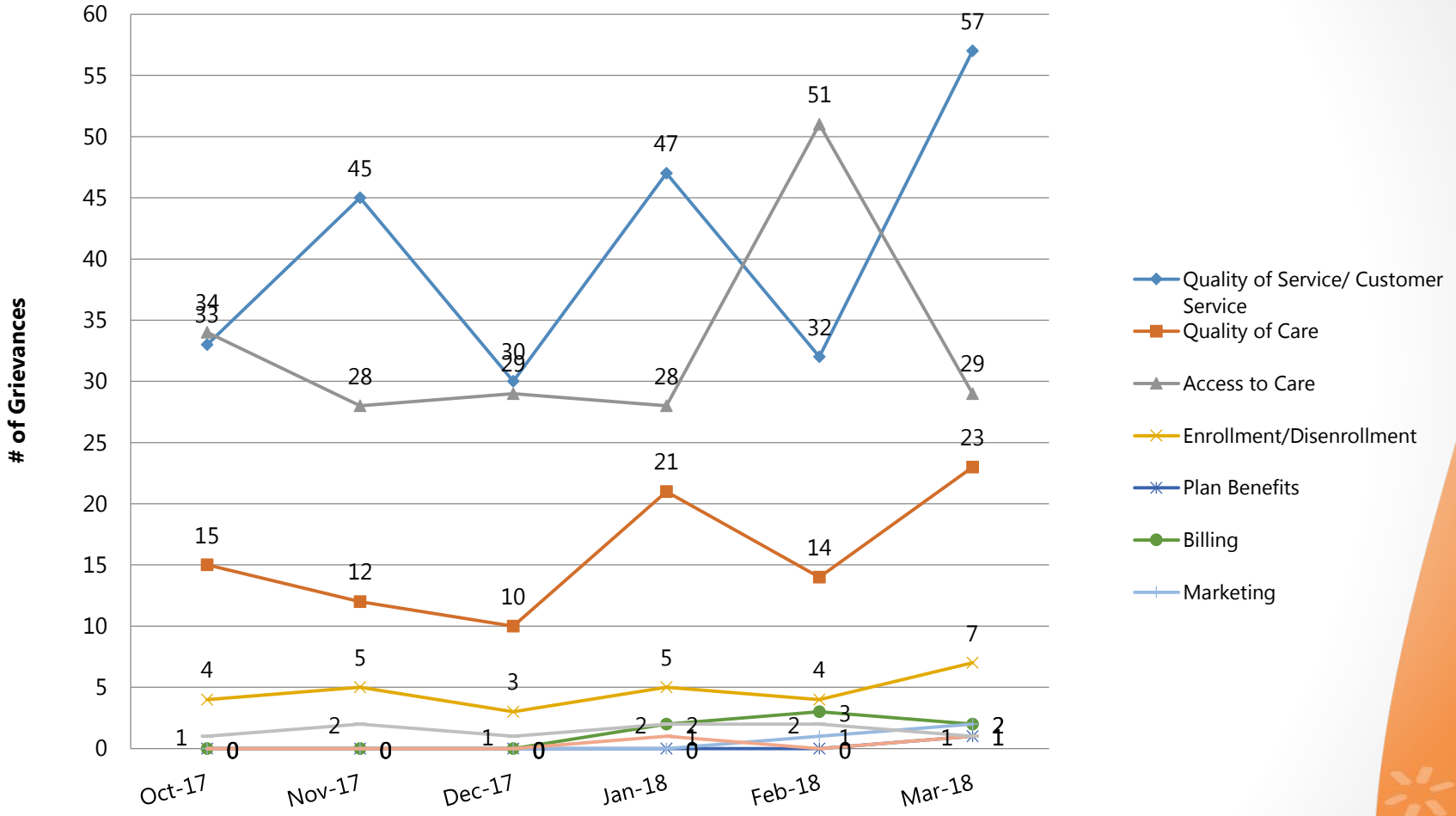
Q4 2017-Q1 2018: Medi-Cal Grievances

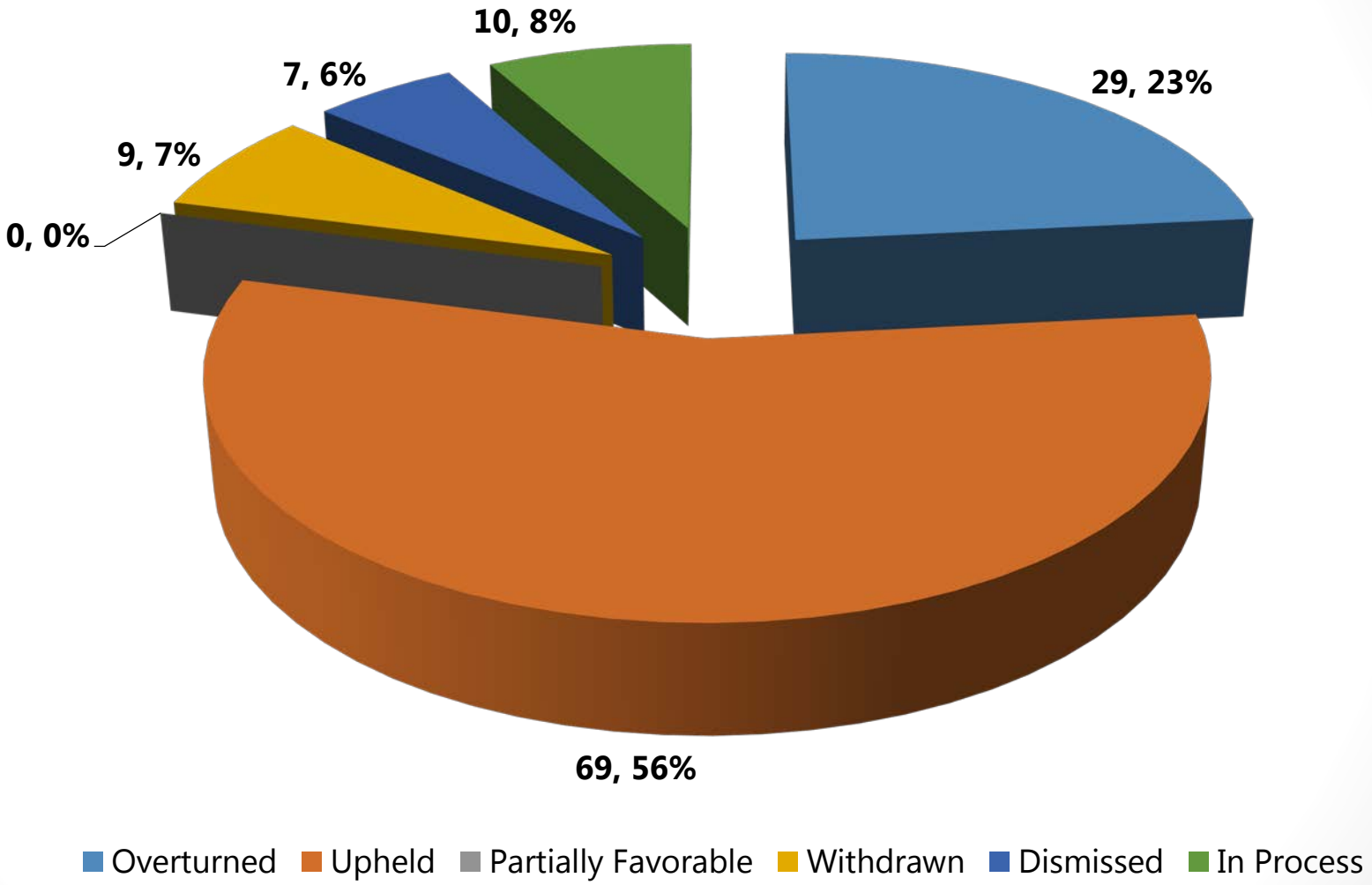


NOTE: Includes Exempt Grievances

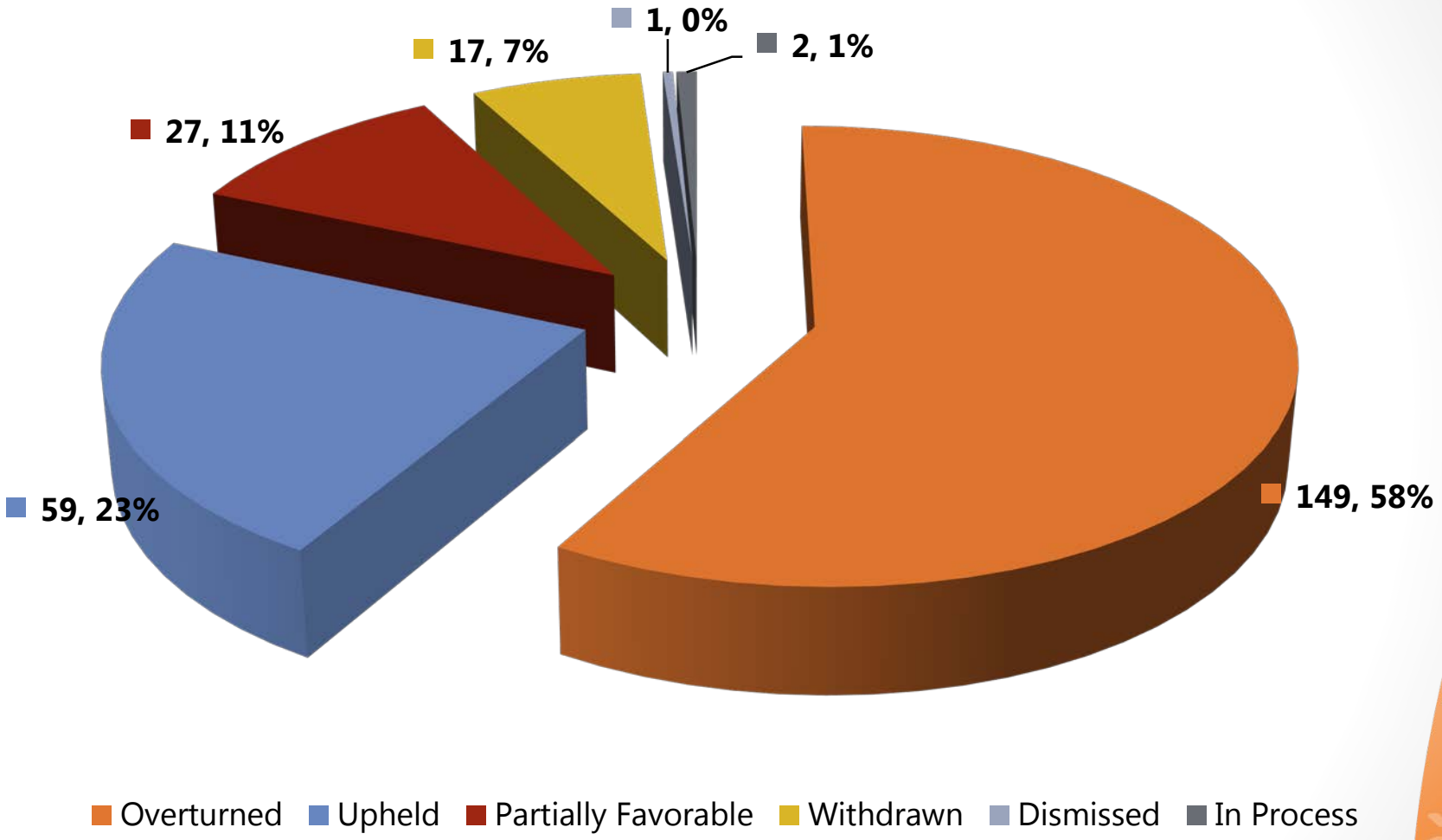
Q4 2017-Q1 2018: Medi-Cal Grievances

TYPE OF GRIEVANCE	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Quality of Service/ Customer Service	33	45	30	47	32	57
Quality of Care	15	12	10	21	14	23
Access to Care	34	28	29	28	51	29
Enrollment/Disenrollment	4	5	3	5	4	7
Cultural & Linguistics	0	0	0	1	0	1
Marketing	0	0	0	0	1	2
Other	1	2	1	2	2	1

Q1 2018 Medi-Cal Medical Appeals



Q1 2018 Medi-Cal Pharmacy Appeals



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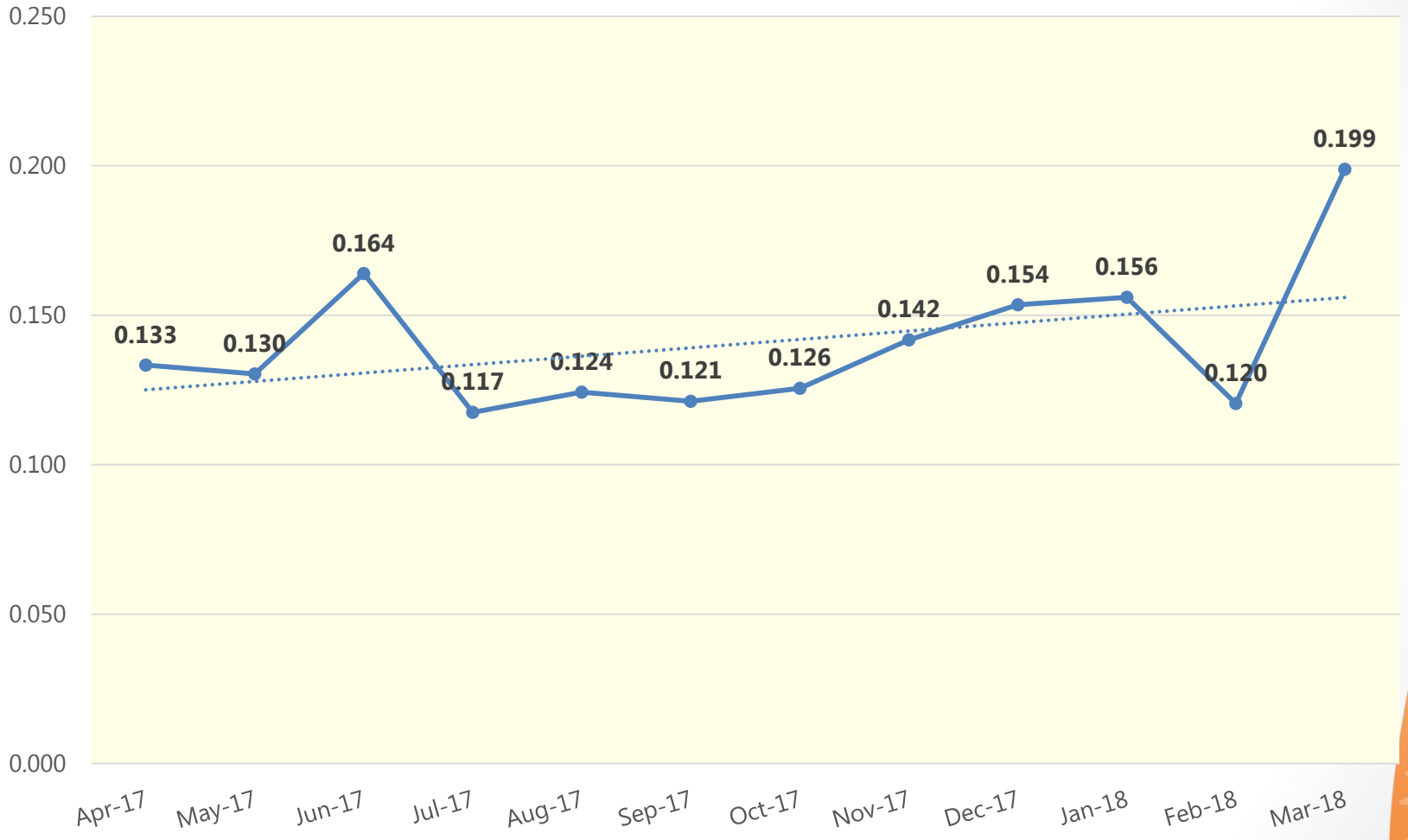
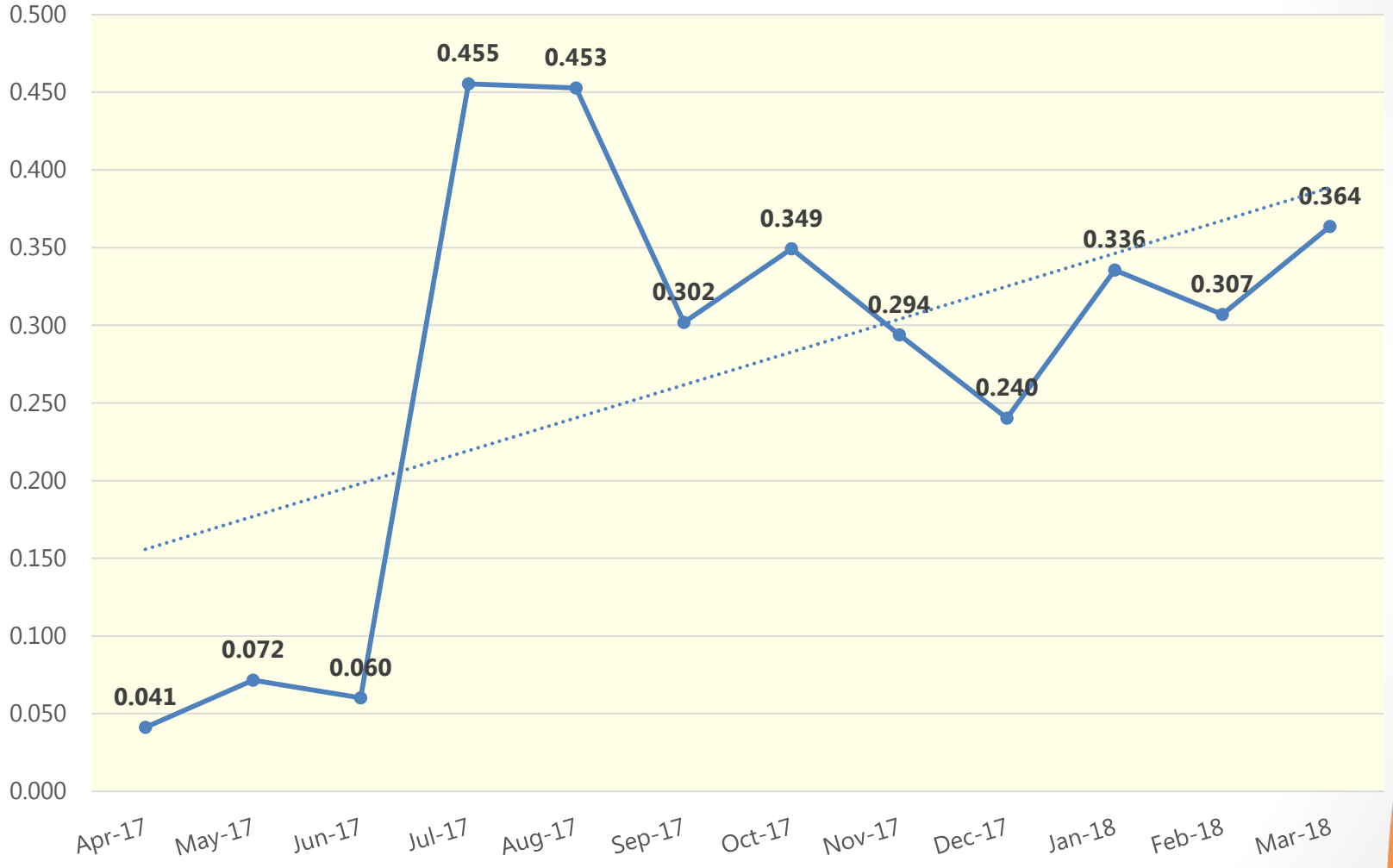
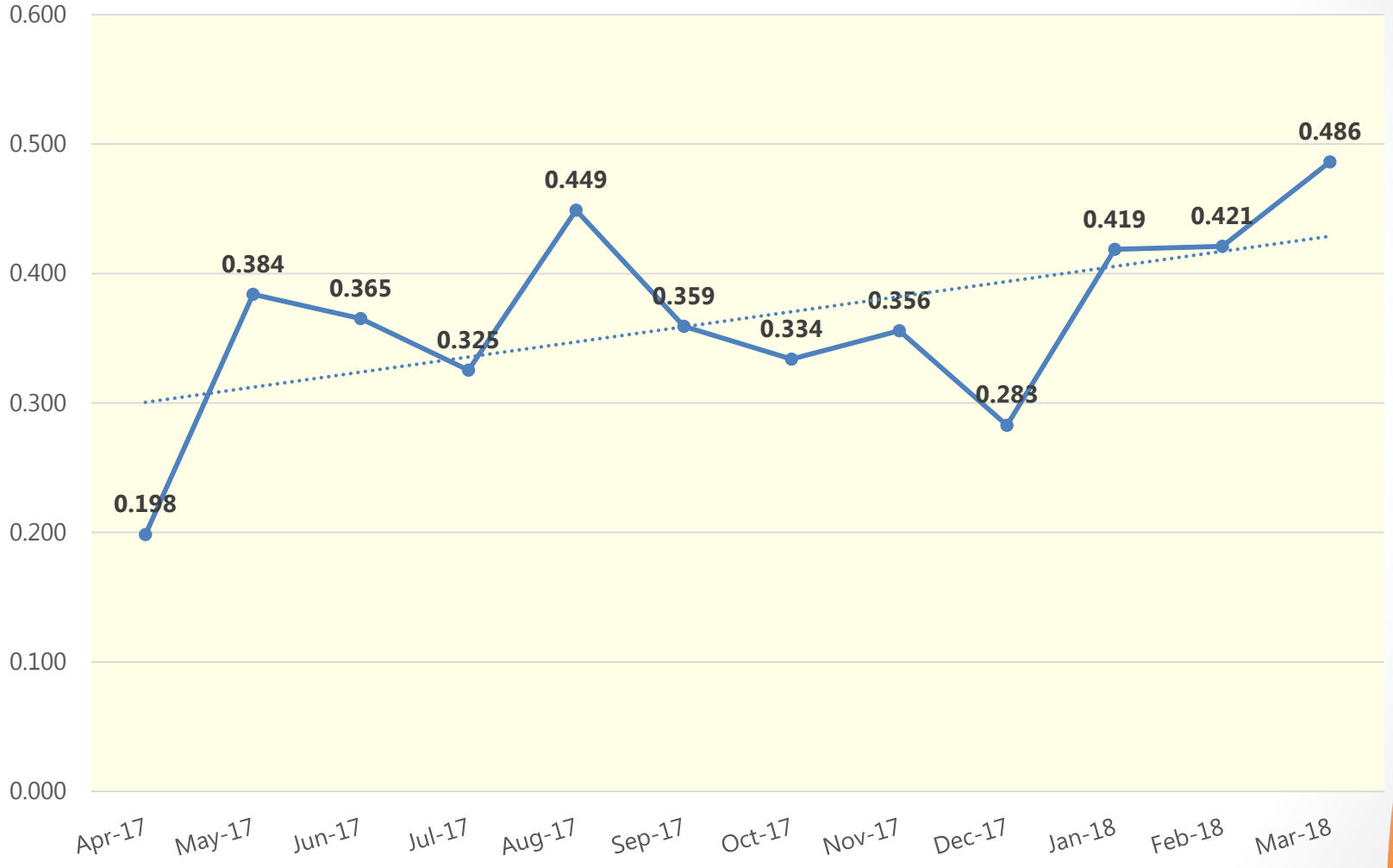
Medi-Cal Rates per 1000: Medical Appeals



Medi-Cal Rates per 1000: Rx Appeals



Medi-Cal Rates per 1000: Grievances



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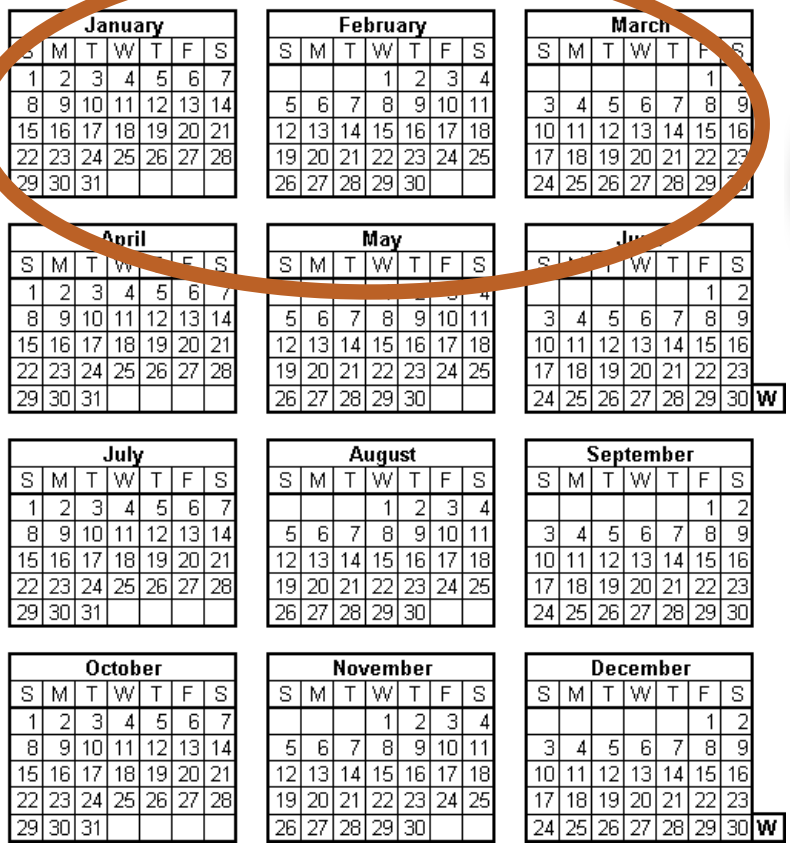
Cal Medi-Connect



Q1 2018

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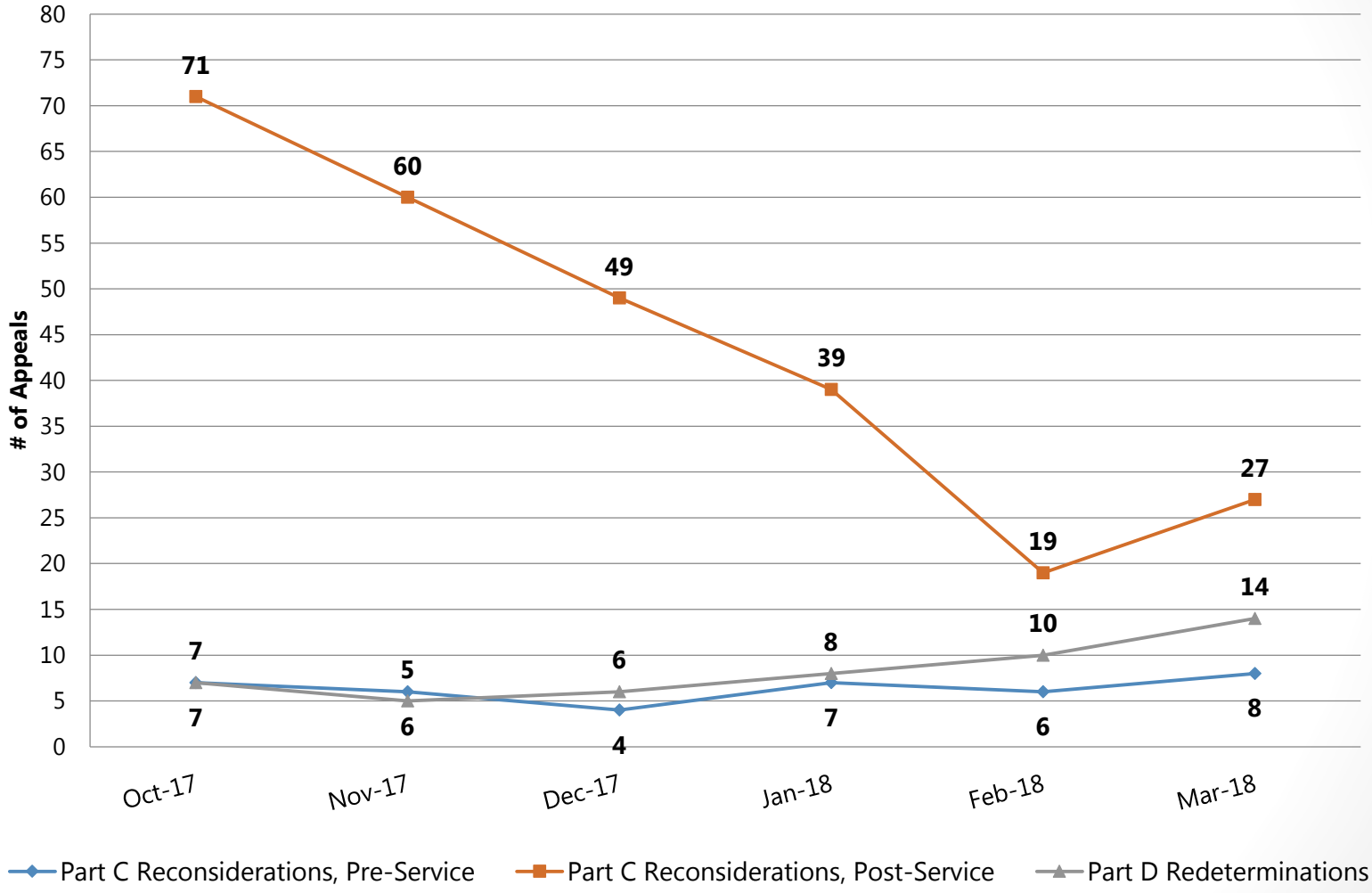
Q4 2017-Q1 2018: Part C&D Appeals



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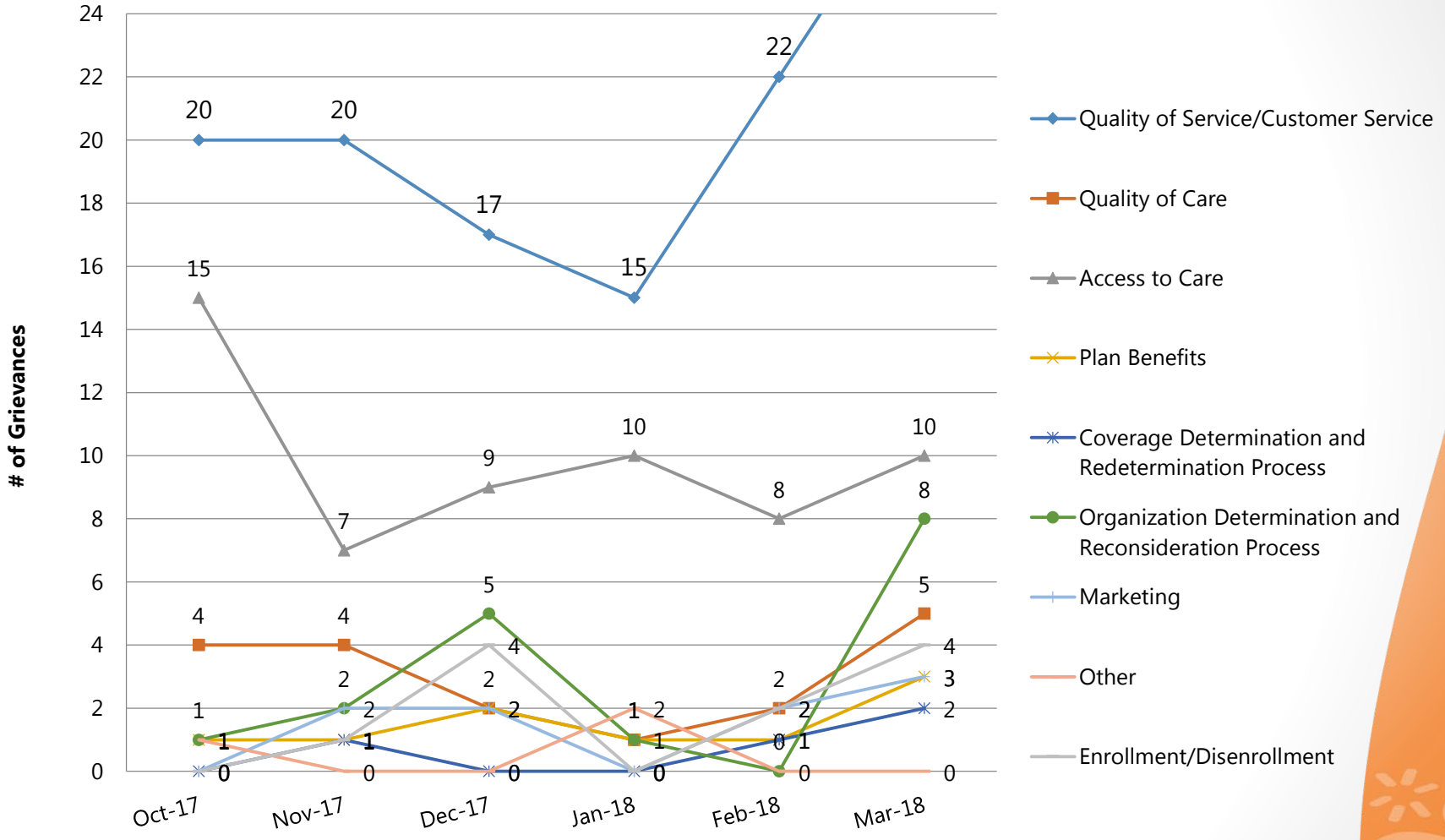
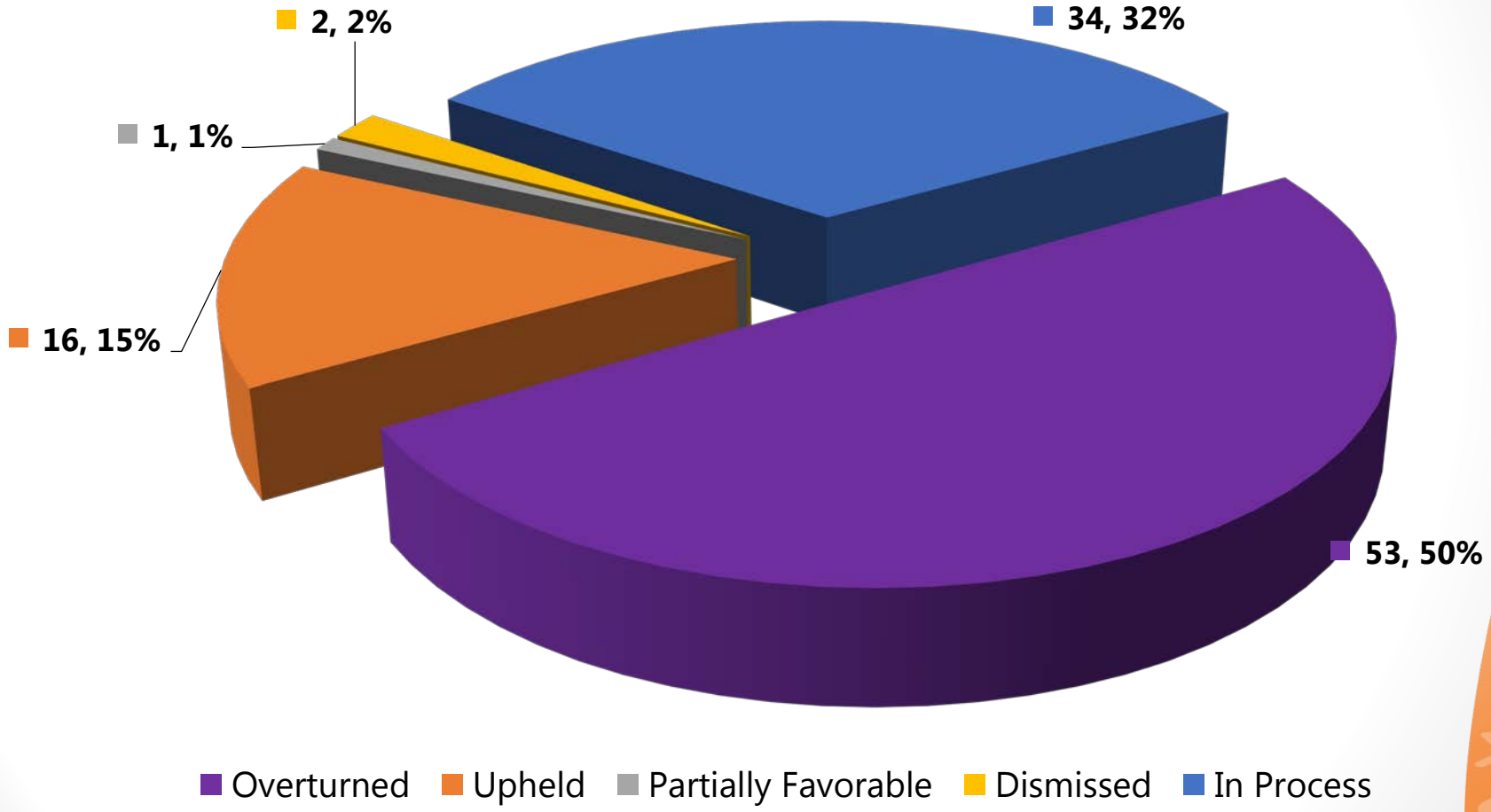
Q4 2017-Q1 2018: Part C&D Grievances



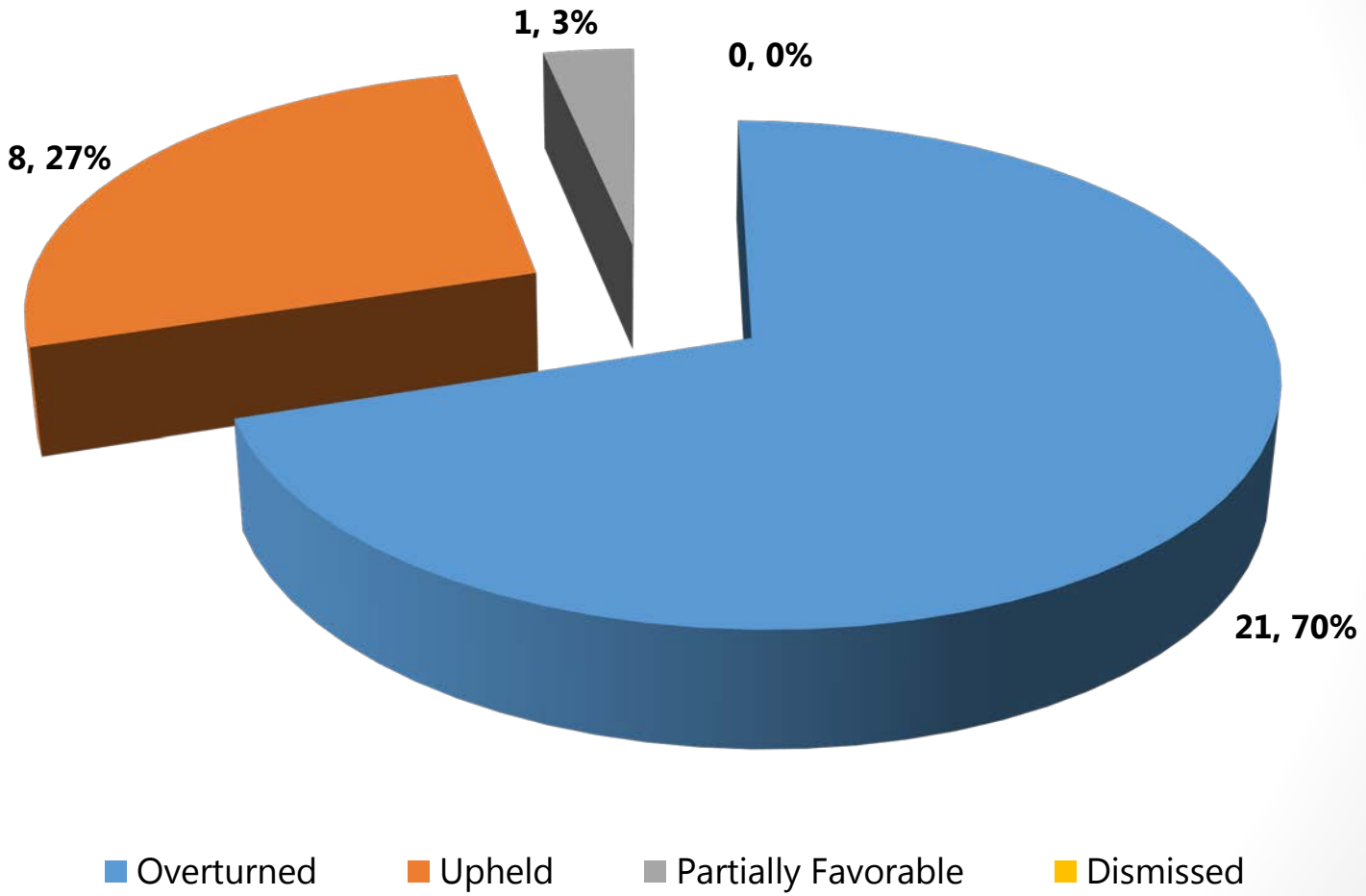
Q4 2017-Q1 2018: Part C&D Grievances

TYPE OF GRIEVANCE	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Quality of Service/Customer Service	20	20	17	15	22	29
Quality of Care	4	4	2	1	2	5
Access to Care	15	7	9	10	8	10
Plan Benefits	1	1	2	1	1	3
Coverage Determination and Redetermination Process	0	1	0	0	1	2
Organization Determination and Reconsideration Process	1	2	5	1	0	8
Marketing	0	2	2	0	2	3
Other	1	0	0	2	0	0
Enrollment/Disenrollment	0	1	4	0	2	4

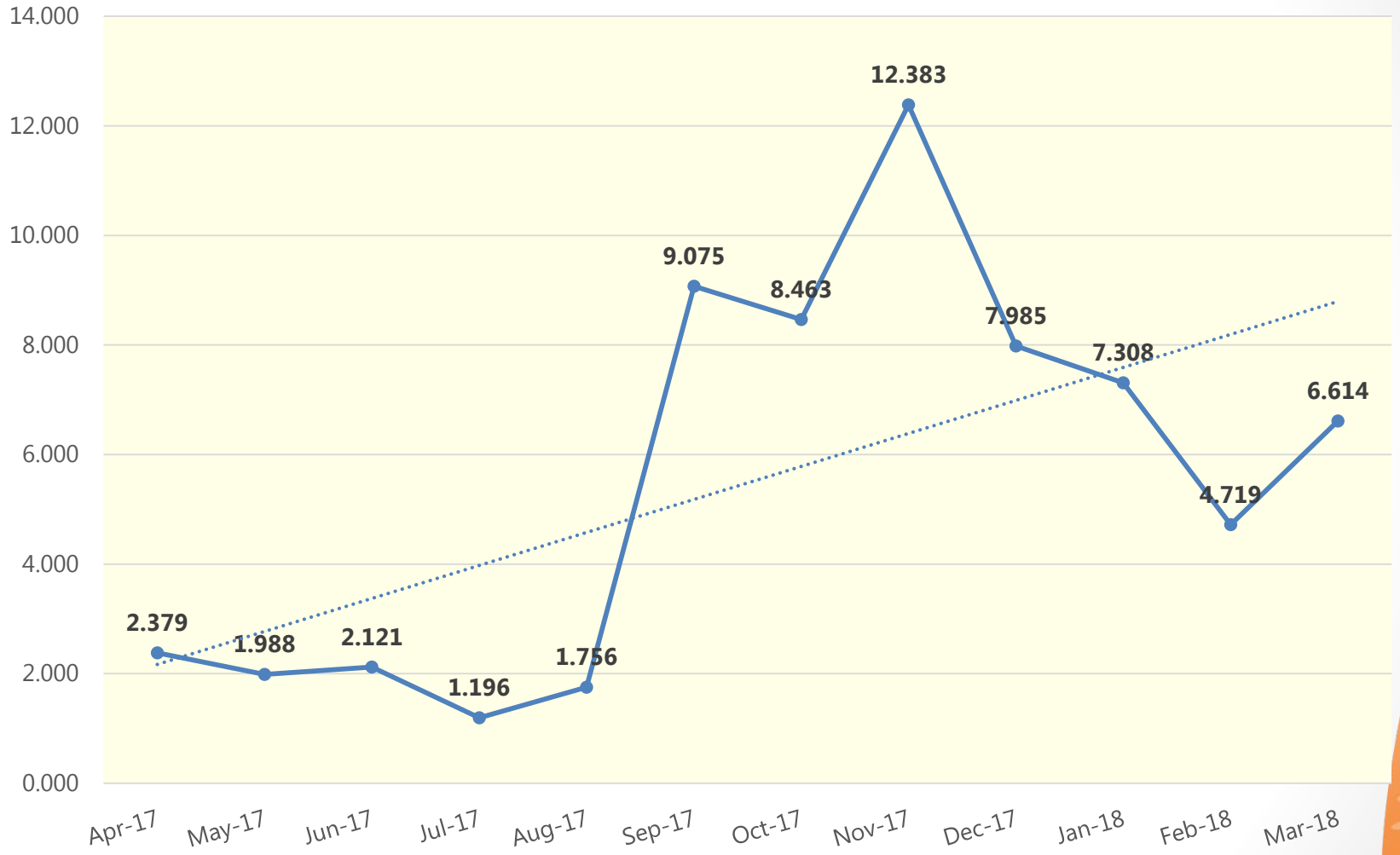
CMC Part C Reconsiderations by Determination Q1 2018



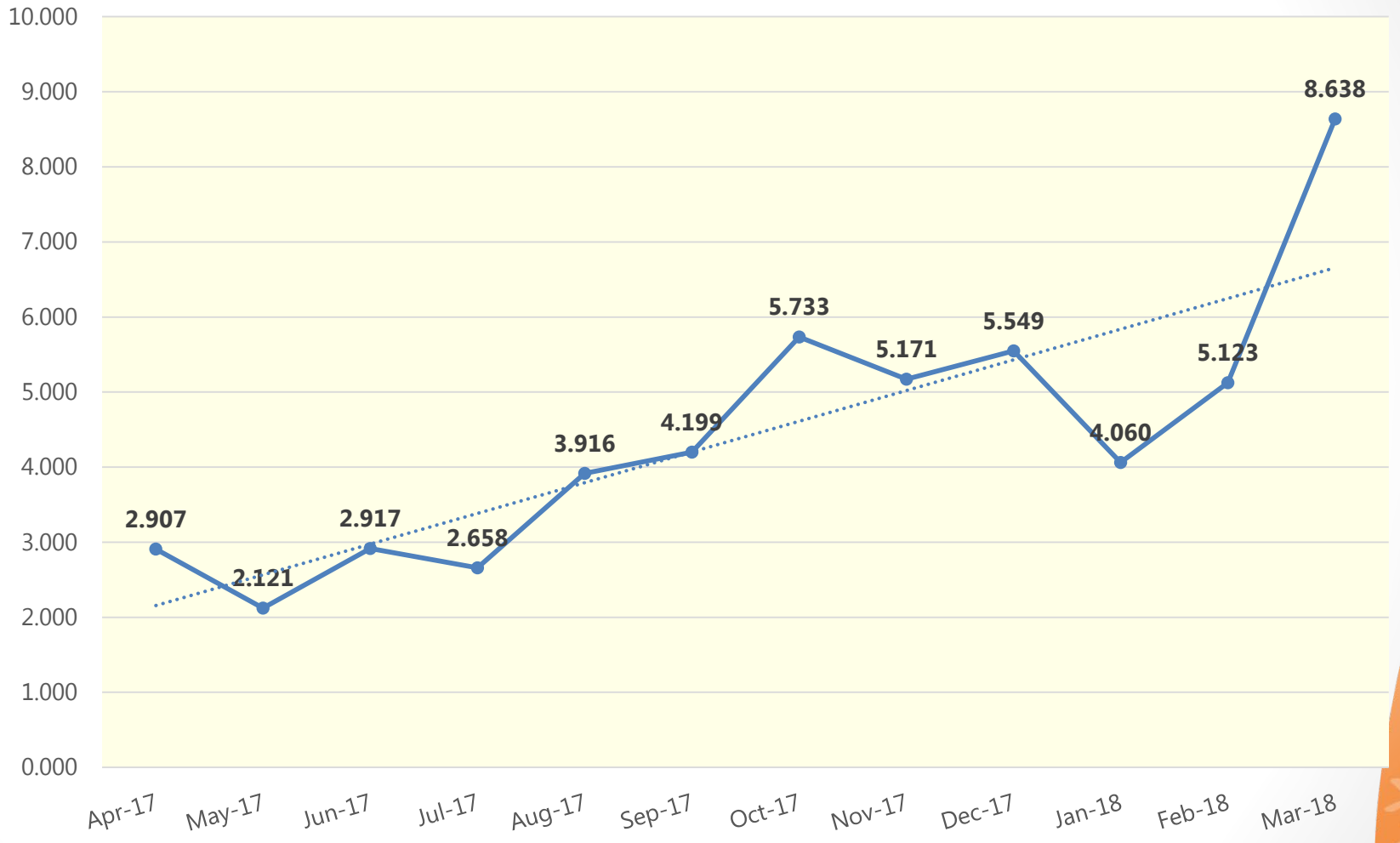
CMC Part D Redeterminations by Determination Q1 2018



Cal Medi-Connect Rates per 1000: Appeals



Cal Medi-Connect Rates per 1000: Grievances



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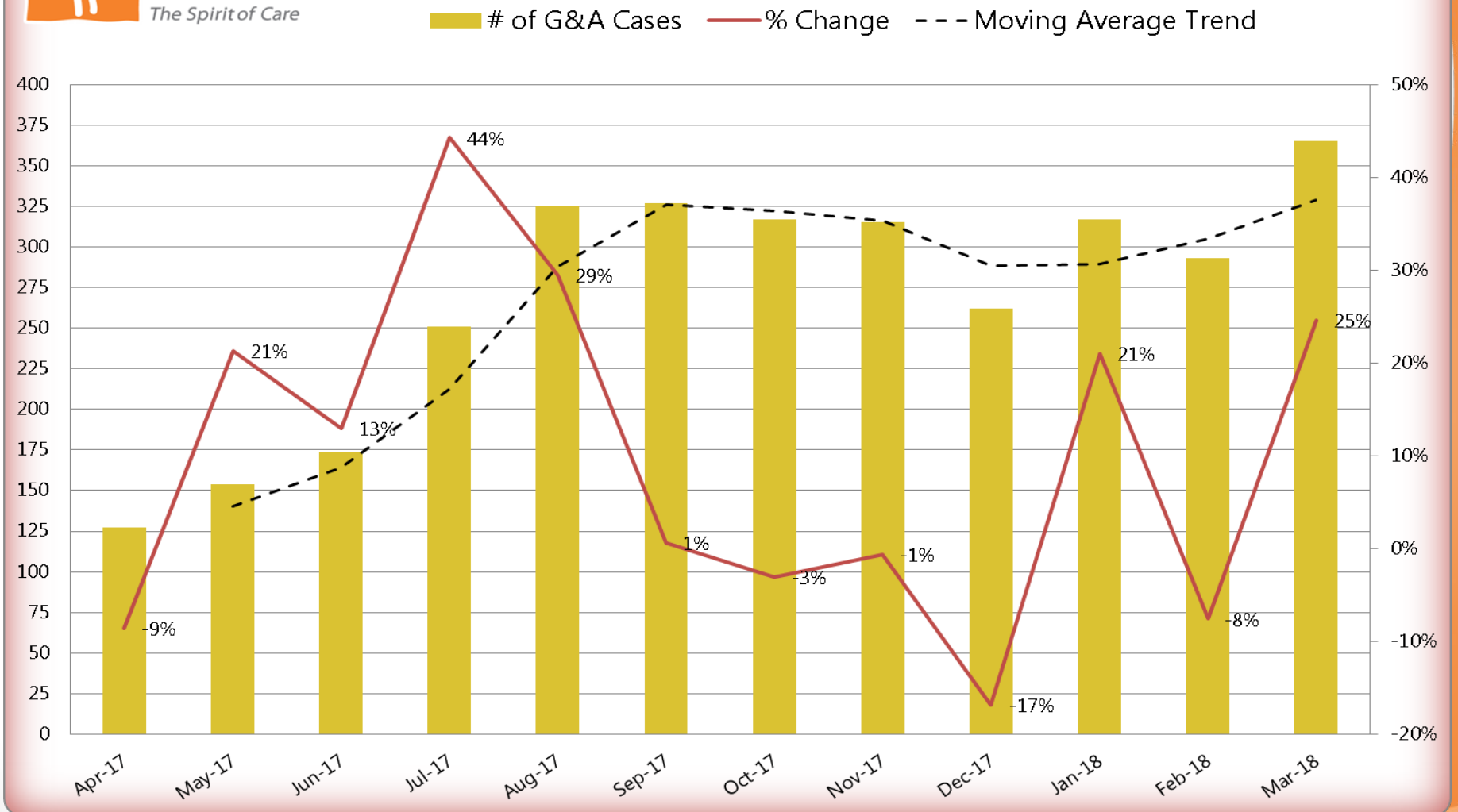
Month over Month Growth Rate



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New Process Discussions:

G&A Interventions

1. DME Ordering and Delivery
2. Kaiser EPO Process - *Update*

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: February 7, 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	12	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	8	
Number practitioners recredentialed within 36-month timeline	8	
% 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 01/31/2018	199	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds						
Total # of Recreds						
(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	763	775	736	703	386	121

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.

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: April 4, 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	8	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	18	
Number practitioners recredentialed within 36-month timeline	18	
% 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 03/31/2018	196	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	47	26	28	45	13	0
Total # of Recreds	176	90	37	134	17	14
(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	674	884	718	706	418	112

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
Pharmacy & Therapeutics Committee
Thursday, December 14, 2017
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)	Y
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	N
Jesse Parashar-Rokicki, MD	Family Practice	N
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	N
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	N

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	N
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Dawn Davis	SCFHP Grievance and Appeals Consultant	Y (via telephone)
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	Y
Guests	**Specialty**	**Present (Y or N)**
Jade Vitug, PharmD	VHP Pharmacy Resident	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:10 PM. Introduced Duyen Nguyen, SCFHP Clinical Pharmacist, Tiffanie Pham, SCFHP Pharmacy Coordinator and guest Jade Vitug, Pharmacy Resident at Valley Health Plan.	
2	**Past Meeting Minutes**	
	The SCFHP 3Q2017 P&T Minutes from September 21, 2017 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 3Q2017

		P&T Minutes from September 21, 2017 were approved as submitted and will be forwarded to the QI Committee and Board of Directors.
3	**Public Comment**	
	No public comment.	
4	**Informational Updates**	
	Health Plan Updates Deferred until next committee meeting. **Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Revised Form 61-211)** Dr. Huynh presented the update on Form 61-211. A memo was sent to providers via FAX blast and will be attached to prior authorization decisions in the next few weeks. DHCS requires form 61-211 which was revised December 2016 and became effective July 1, 2017. Effective January 1, 2018, the plan will no longer accept the old form.	
	Appeals & Grievances Ms. Davis presented the Appeals and Grievances report for Pharmacy and Part D. There was an increase in Medi-Cal appeals. Change in process, data is being collected through appeals department. Q2 2017 41% overturn rate, 55% upheld. Q3 2017 56% overturn rate, 20% upheld, 11% withdrawn. For Cal MediConnect Q3 Part C&D redeterminations have remained steady. Low during Q3: 4 in July, 8 in August, 7 in September. Part D redeterminations Q2: 50% overturned, 34% upheld, 8% withdrawn. Q3: 20% upheld, 30% overturned, 40% withdrawn.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:42 p.m. to discuss the following items: Membership, Pharmacy Dashboard, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect, Medi-Cal, Healthy Kids Formulary and Prior Authorization Criteria, Medical Pharmacy Prior Authorization Grid, DHCS Medi-Cal CDL Updates & Comparability, and New Drugs and Class Reviews.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Liu presented the membership report. Slight decline in Medi-Cal line of business membership. Slight increases in Cal MediConnect (CMC). Attribute the growth in CMC to more fully developing Medi-Care Outreach department. Outreach to our existing Medi-Cal population that are also full dual and may be eligible for CMC.	
	Pharmacy Dashboard	

	Dr. Huynh presented the Pharmacy Dashboard. For Medi-Cal line of business, prior authorization approval rate increased from 55% to 70% during the timeframe of September to October. 24 hour turnaround time is compliant at 100%. Expedited 24 hour turnaround time approval rate is from 62 to 77%. Interrater reliability done 10/19/2017. For Cal MediConnect line of business, prior authorization volume increased in the previous quarter. 72 hour turnaround time is 100%. Expedited increased from 58% to 68%. Met goal of CMR completion rate of 20% earlier than the previous calendar year. Percent shifted slightly, still on track to meet goal. Denied claims reviewed: 96%, on track with formulary submission to CMS.	
	Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria Dr. Huynh presented an overview of the MedImpact 3Q2017 P&T minutes as well as the MedImpact 4Q2017 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 3Q2017 P&T Minutes, and MedImpact 4Q2017 P&T Part D Actions were approved as submitted.
	Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria Formulary Modifications Dr. Huynh presented the formulary changes since the last P&T meeting. Of note: added Mavyret to formulary with prior authorization and quantity limit of 3/day. Added Vitamin D3 50,000 unit capsule to formulary. Added Tears Again, Lubrifresh PM, and Tears Naturale PM ophthalmic ointment products to formulary. Added Shingrix with age limit of greater than or equal to 50 years old and quantity limit. Remove Glatopa 20mg/ml from formulary. Added Makena 250mg/ml (1 ml vial) to formulary with prior authorization. Recommend: Add Leucovorin 25mg tablet to formulary. Remove Trianex ointment to formulary. Remove Zepatier from formulary.	Upon motion duly made and seconded, formulary modifications were approved as presented.

	Prior Authorization Criteria
	- Dr. Nguyen presented the following PA criteria for approval by the committee:
	  - Hepatitis C
	  - Ciclopirox 8%
	  - Non-formulary
	  - Brand Name
	  - Off-Label
	  - Compounded Medications
	  - General Criteria-UM Medical Drugs
	  - Eosinophilic Asthma
		Upon motion duly made and seconded, prior authorization criteria were approved as requested.

	- Cotellic - Duragesic - Emend - Exelon - Farydak - Iressa - Keytruda - Lyrica - Marinol - Myrbetriq - Nebupent - Nexavar - Odomzo - Restasis - Revatio - Targretin - Temodar - Tymlos - Xarelto - Xolair - Zarxio	
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented the DHCS Medi-Cal Updates and Comparability. For September 2017, two drugs added and one dosage form added. No proposed action for September 2017. For October 2017, one drug with strength removed. No proposed action for October 2017. For November 2017, one drug with quantity limit and fill limit. November 2017 propose add quantity limit and match CDL for Promethazine w/Phenylephrine and Codeine.	Upon motion duly made and seconded, all recommendations were approved and presented.
	New Drugs and Class Reviews New Drug Reviews Dr. McCarty presented the following new drug reviews: - Shingrix –Add age limit to allow in 50 and older; add quantity limit of 2 doses per lifetime. Remove Zostavax from formulary. - Diabetes – Jardiance/Synjardy/Synjardy XR-Add to formulary, add step therapy (required trial of Metformin + oral/GLP-1RA), add quantity limit Jardiance & Synjardy XR 1/day, Synjardy 2/day - Diabetes-Januvia/Janumet/Janumet XR-remove from formulary - Car T Cell Therapies –Kymriah for pediatric, Yescarta for Adults; administered via single IV infusion bag	Upon motion duly made and seconded, all recommendations were approved as presented.

Santa Clara
Family Health Plan

	Drug Utilization and Spend Review Dr. McCarty presented the Drug Utilization and Spend Review report. Diabetes remains the top spend. Drop in infectious disease. Pulmonary arterial hypertension has doubled. A lot more utilization of calcium by members of Santa Clara Family Health Plan.	
	Reconvene in Open Session Committee reconvened to open session at 7:35 p.m.	
6	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Informational Only	
7	**Adjournment at 8:02 PM**	

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 26, 2017

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	N
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Roll Call	Meeting was called to order by Dr. Boris with a Quorum at 12:15 PM. All telephonic attendees were confirmed via roll call.	
II. Public Comment	No public comment.	
III. Review Prior Authorization Grids for Cal MediConnect and Medi-Cal	Reviewed Medi-Cal, Healthy Kids prior authorization grid. Cochlear implant will remain in both the outpatient and inpatient categories. There is removal of any preventative services from PA grid. Of note: colonoscopy is also removed from Medi-Cal PA grid. (This was already true on CMC side). Motion made to approve Medi-Cal, Healthy Kids authorization grid. Motion approved, seconded, and carried.	SCFHP staff will now forward these grids for publi to the website, submission to CMS, provider notific via website, and for creation of claims payment rul removal of claims payment edits (whichever appli QNXT. For a 1/1/2018 go live.

ITEM	DISCUSSION	ACTION REQUIRED
	Reviewed Cal MediConnect prior authorization grid. The plan added cataract surgery, TMJ surgery to outpatient in order to mirror Medi-Cal authorization grid. Also added sleep studies to the PA grid, and collection of autologous blood to Outpatient Services. Deleted are penile implant, as well as stereotactic radiosurgery and radiotherapy from prior authorization grid. Motion made to approve Cal MediConnect authorization grid. Motion approved, seconded and carried.	
Adjournment	Meeting adjourned at ____12:26 PM__	
r MEETING	The next meeting is scheduled for Wednesday, January 17, 2018, 6:00 PM	

d by:
Alexander
trative Assistant

Date 4/18/18

Reviewed and approved by:
Jimmy Lin, M.D.
Committee Chairperson

Date 4/9/18

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
January 17, 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	N
Ali Alkoraishi, MD	Adult and Child Psychiatry	N

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	N

ITEM	DISCUSSION	ACTION REQUIRE
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:07 PM. There was a motion to approve the October 18, 2017 minutes.	Minutes approv presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items: Membership as of January, down about 6,300 members, at 263,855 total. Largest portion of that loss was in this month. Medicaid dropped by 5,000 members. Possibly attributed to holidays and processing of paperwork. Healthy Kids increased by 1,000. Parents may be eligible for Covered California and some children are defaulted to Healthy Kids. Cal MediConnect remaining stable at 7,389. State will default enrollment to one of the health plans when Medi-	None.

ITEM	DISCUSSION	ACTION REQUIRED
	Cal beneficiaries do not select a health plan. HEDIS measures determine how many will be auto-assigned to health plan. Auto-assignment percentage is up to 66% this year versus 49% last year. CHIP funding: State saying there are 32,000 children and pregnant moms affected. 100 members at risk. Community will look for way to close the gap if funding is not continued.	
scussion Items/Follow) Items **ction Items**	None. a. Hierarchy of UM Criteria: Ms. Castillo presented the Hierarchy of UM Criteria. Part of the UM Program Description. Item does not require approval. b. Review of Policies: Ms. Alegre presented a summary of changes to the UM policies. Thirteen policies were presented for review and approval. • HS.01 Prior Authorization: No prior authorization required for urgent care. • HS.02 Medical Necessity Criteria: No changes • HS.03 Appropriate Use of Professionals: No changes • HS.04 Denial of Services Notification: Added verbiage regarding letter issued in member specific language • HS.05 Evaluation of New Technology: Removed Section F which tells next steps when review takes place, verified no subcommittees of Medical Advisory Council so removed from policy. Verbiage placed or removed is tied to NCQA standards. • HS.06 Emergency Services: Plan does not require prior authorization for Urgent services for contracted and non contracted providers • HS.07 Clinical Practice Guidelines: No changes • HS.08 Second Opinion: No changes • HS.09 InterRater Reliability: Updated section on Corrective Action Plan. • HS.10 UM Financial Incentives: No changes • HS.11 Informed Consent: No changes • HS.12 Preventive Health Guidelines: No changes • HS.13 Nurse Advice Line: No changes After motion duly made, seconded, all policies were approved as presented.	None.

ITEM	DISCUSSION	ACTION REQUIRED
	c. UM Program Description 2018 Dr. Boris presented a summary of the changes to the UM Program Description. Added additional documentation and description of mental health parity that came along with current requirements. NCQA requirements on UM staffing. Added additional NCQA language for UM program evaluation to be presented next quarter. Removed appeals language. Added adoption of criteria for behavioral health, LTSS and medical. Included Hierarchy of Criteria reference to policy and procedure. Added Behavioral Health, MLTSS, Pharmacy staff to IRR. UM decision making based on appropriateness of care and service and existence of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Added long term services requirements to discharge planning. Corrected some manager and director titles. Added information on Cal MediConnect and Behavioral Health. After motion duly made, seconded, UM Program Description changes were approved as presented. d. Care Coordinator Guidelines 2018 Ms. Castillo presented the proposed change to Long Term Care authorization. Were approving one year authorization for long term care. Discussed the request to change the Long Term Care authorizations to 6 months versus one year. Approve initially for 6 months, do face to face and extend authorization to one year. After motion duly made, seconded, proposed change to Care Coordinator Guidelines was approved as presented.	Bring data on Lo Term Care authorizations to UM Committee meeting

ITEM	DISCUSSION	ACTION REQUIRED
Reports	a. Membership Presented during CEO Update. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. For Cal MediConnect, 14 calendar day turnaround time for routine, for urgent 72 hours. Numbers dropped below 100% during October, November, and December due to staffing changes. For Medi-Cal, 5 business day turnaround time for routine, for urgent 72 hours. Reached goal for October, November, and December. ii. Standard Utilization Metrics Data is for fiscal year 2017. For MediCal/Non SPD, average length of stay over the four quarters had not significantly changed. SPD/Cal MediConnect, average length of stay is 5 days, discharge per 1,000 member months is climbing. Cal MediConnect, discharges per 1,000 is at 256. Average length of stay remains the same. MediCal inpatient utilization average length of stay is at 50%, SPD average length of stay is higher. At category of loosely managed, NCQA. MediCare Median, plan is at the mean. Non SPD: significant readmission rate. SPD: 25% readmission rate. MediCare readmissions: goal is 11%, slightly above that in every quarter. Looked at 18-64 group: at 10.9% Readmission strategy should focus on age 65 and above. For behavioral health, measures include follow up care for children prescribed ADHD medication. Less than 25% on initiation phase and less than 10% on continuation and maintenance phase. For Antidepressant Medication Management, acute phase treatment is at greater than 75% and continuation phase treatment is at greater than 50%. Cardiovascular monitoring for people with cardiovascular disease and schizophrenia is at greater than 90%. Follow up items: a. Primary diagnosis for readmits by Line of Business Received data from analytics group. CMC admissions by primary diagnosis were sepsis, heart disease, and heart failure, kidney disease/kidney failure, and serious mental illness. For MediCal diagnosis were other, heart disease, COPD, kidney failure. Will be focus area for case management.	

ITEM	DISCUSSION	ACTION REQUIRED

b. CPT codes for all members with bariatric surgery (what was most frequent procedure requested?): Dr. Boris presented the update on CPT codes for all members with bariatric surgery. 43644 is the most common followed by 43645.

Bariatric Surgeries by Procedure Code
7/1/2016 to 6/30/2017, LOB Medi-Cal

Code	Description	# of Procedures	Percentage
43644	LAP GASTRIC BYPASS/ROUX-EN-Y	44	69.8%
43645	LAP GASTRIC BYPASS INC SMLL I	16	25.4%
43772	LAP REMOVE GASTRIC ADJ DEVICE	2	3.2%
43774	LAP REMOVE GASTRIC ADJ ALL PARTS	1	1.6%
Grand Total		63	100.0%

c. CMC readmit rates Q12017 was 9% (review change)
Corrected to 13% from last report.

d. Data on OB inpatient admissions by hospital: Dr. Boris presented the update on OB inpatient admissions by hospital. Data is for Medi-Cal line of business only and does not include Kaiser and Valley Health Plan. Also does not include QNXT Medi-Cal claims.

Inpatient OB Stays 7/1/16 - 6/30/17 by Hospital
LOB Medi-Cal: Not including Kaiser or VHP

Location Of Care	# of OB Inpatient Stays
O'Connor Hospital	216
El Camino Hospital	100
Good Samaritan Hospital	70
Regional Medical Center of SJ	61
Santa Clara Valley Medical Ctr.	41
St Louise Regional Med Ctr.	41
El Camino Los Gatos Hospital	22
Kaiser Hospital San Jose	4
Lucile Packard Children's Hospital	3

ITEM	DISCUSSION	ACTION REQUIRED

Hazel Hawkins Memorial Hospital	2
Memorial Hospital Of Los Banos	2
Alta Bates Medical Center	1
Clovis Comm. Med Ctr.	1
Cypress Fairbanks Medical Ctr.	1
St Josephs Hospital	1

c. Interrater Reliability Behavioral Health
Dr. Boris presented the Interrater Reliability report for Behavioral Health. In accordance with Policy HS.09, the 2nd bi-annual Calendar Year 2017, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is complete. This is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random BH authorizations are selected to test all of our Behavioral Health (BH) staff with the authority to Authorize services. Our BH staff consist of non-licensed Personal Care Coordinators (PCC) and our Director of Behavioral Health (LCSW). In the 1st testing, 100% or 3/3 of our staff are proficient during this review. 100 percent of BH staff who complete authorizations completed IRR testing. Staff who are authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go for clarification. The corrective action plan after identifying the common findings are mandatory remedial training with post testing for all non-proficient staff (should this be required-not needed at this time). Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled.

d. Annual Specialty Referral Tracking of Procedures HS.01.02
Dr. Boris presented the Annual Specialty Referral Tracking report. In accordance with the SCFHP Referral Tracking Procedure HS. 01.02, SCFHP tracks all authorizations, for completion of the "authorization to claims paid" cycle, to identify opportunities for improvement. By definition all authorizations are defined as: 1. both contracted and non-contracted prior authorizations and 2. behavioral health and non-behavioral health authorizations are tracked to completion. SCFHP (The Plan) has a referral tracking system which tracks approved, modified, deferred medical and behavioral health prior authorizations to completion on an ongoing basis. The first report was completed for the rolling month look back of December 2016 to November 2017. There were 14,447 unique authorizations for all lines of business (roughly 1200 authorizations per month). 9, 197 authorizations had no claims match. Attribute to administrative barriers, claim lag time. Looked at Behavioral Health claim to authorization mismatch and found the total numbers were very small. 152 total authorizations without claims. The October and November higher numbers are likely related to billing not

ITEM	DISCUSSION	ACTION REQUIRED

yet submitted. UM management team did a strategic focused calling campaign. Based on the outbound call campaign, the major reasons for authorizations not completed were:

- Authorization denied: 22
- Closed: 2
- Done per patient: 15
- Per patient missed appointment: 1
- Per patient not done: 3
- Member term: 52
- Unable to reach member by phone: 80

The report has areas which are needed to improve and there is an IT/ UM meeting next week to discuss the needed changes with the report. The IT team must remove the patient's which are not eligible and the auths that were denied from the report. The reporting also needs to include turnaround time for the procedure. These are under development.

e. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q4 17)
Ms. Castillo presented the Q4 2017 Q Report. Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 4th Quarter review of 2017, the findings are as follows:

A. For the dates of services and denials for October, November and December of CY 2017 were pulled in the 4th quarter sampling year.
   a. 30 unique authorizations were pulled with a random sampling.
      i. 93% or 28/30 Medi-Cal LOB and 7% or 2/30 CMC LOB
      ii. Of the sample 100% or 30/30 were denials
      iii. Of the sample 37% or 11/30 were expedited request; 63% or 19/30 were standard request
         1. 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours
         2. 100% or 19/19 of the standard authorizations met regulatory turnaround time
      iv. 20% or 6/30 are medical denials, 80% or 24/30 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. 6% or 2/30 have poor letter quality, 94% or 28/30 have good letter quality.
      viii. 53% or 16/30 included criteria or EOB in the letter, 47% or 14/30 did not include criteria or EOB language for administrative denials.

ITEM	DISCUSSION	ACTION REQUIRED
	ix. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director. x. 100% of the member letters are of member's preferred language. 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: • Include EOB language for admin denials • Provide staff education to re-read denial letters for letter quality • Continue QA report monitoring process f. Review of the Physician Peer to Peer process Dr. Boris presented the Review of the Physician Peer to Peer process year to date for 2017. In accordance with Procedure HS.02.02, the provider dispute process also includes a Peer to Peer (P2P) review with the SCFHP physician who makes the determination (in cases of denials of service). It is the goal of SCFHP medical director team to ensure quality of service and return of calls when there is a requested P2P. The telephone number to schedule those calls is sent out with each of the denied cases. For YTD 2017, there were 22 total requests for Peer to Peer reviews. SCFHP selected 10 random samples. This was to ensure that the Peer to Peer process is working and that community physician requests for call back are completed and do in fact occur. The selection included sampling for each of the two physicians at SCFHP. 90% of calls were completed with the SCFHP physician and the requesting physician. 90% had documentation of the call, however, not in our claims payment system. Most documentation was via an email to the team and the admin assistant. 40% of decisions had documentation in the QNXT or Xpress systems. 33% of decisions were upheld and the rest were overturned. Corrective action: since 6/2017, QNXT is the one system that now holds authorizations for all lines of business. As such both physician know the system and have agreed to enter their call documentation into QNXT. The Procedure HS 02.02 was also updated to include the annual review of the P2P process and presented to the Chief Medical Officer for approval. The Annual Review of the Peer to Peer Process was added to the Yearly UM Committee review items and will be conducted yearly.	
Adjournment	Meeting adjourned at 7:30 PM	
r MEETING	The next meeting is scheduled for Wednesday, April 18, 2018, 6:00 PM	

Prepared by:

Caroline Alexander
Administrative Assistant

Date 4/18/18

Reviewed and approved by:

Jimmy Lin, M.D.
Committee Chairperson

Date 4/18/18

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY
REPORT

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

Cal MediConnect Consumer Advisory Board Q1, 2018

Areas of Review or Committee Activity

Consumer input on Cal MediConnect program

Findings and Analysis

Issues raised at monthly meetings
Provider billing and in one case, a subsequent collection request letter. Related concerns about impact on credit score. Denti-Cal provider requiring payment up front
Delays or lack of pickup for members who have requested transportation services
Questions Addressed
Denti-Cal coverage and benefits including yearly limit
Role of Customer Service in addressing issues and when to call
Cal MediConnect benefits for non-emergency transportation
How to get reimbursed for any payments made to providers
Other Input
Satisfaction with prescription coverage
Satisfaction with Cal MediConnect
Presentation Topics provided to Committee
Update on benefits
Cal MediConnect Ombudsman Program
Transportation Options in the community