



Santa Clara  
Family Health Plan  
*The Spirit of Care*



## Regular Meeting of the Santa Clara County Health Authority Quality Improvement Committee

Wednesday, August 09, 2017

6:00 PM - 7:30 PM

210 E. Hacienda Avenue

Campbell, CA 95008

### AGENDA

- |           |   |                      |      |         |
|-----------|---|----------------------|------|---------|
| <b>1.</b> | <b>Introduction</b>   | Ms. Tomcala/Dr. Paul | 6:00 | 5 min.  |
| <b>2.</b> | <b>Meeting Minutes</b><br>Review minutes of the May 10, 2017 Quality Improvement Committee meeting.<br><b>Possible Action:</b> Approve 05/10/2017 minutes   | Dr. Paul             | 6:05 | 5 min.  |
| <b>3.</b> | <b>Public Comment</b><br>Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes. | Dr. Paul             | 6:10 | 5 min.  |
| <b>4.</b> | <b>CEO Update</b><br>Discuss status of current topics and initiatives.  | Ms. Tomcala          | 6:15 | 10 min. |
| <b>5.</b> | <b>Action Items</b>   | Mr. Aguirre          | 6:25 | 25 min. |
|           | a. HEDIS Reporting  |                      |      |         |
|           | b. Initial Health Assessment  |                      |      |         |
|           | c. Review of Quality Improvement Policies   | Mr. Aguirre          |      |         |
|           | i. QI.13 Comprehensive Case Management  |                      |      |         |
|           | ii. QI.14 Disease Management  |                      |      |         |
|           | iii. QI.15 Transitions of Care  |                      |      |         |
|           | iv. QI.16 MLTSS Care Coordination   |                      |      |         |
|           | v. QI.17 BH Care Coordination   |                      |      |         |
|           | vi. QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors  |                      |      |         |
|           | vii. QI. 19 Care Coordination Staff Training  |                      |      |         |
|           | viii. QI. 20 Information Sharing with SARC  |                      |      |         |
|           | <b>Possible Action:</b> Approve Quality Improvement policies  |                      |      |         |

<b>6. Discussion Items</b>		6:50 15 min.
a. Access and Availability		Mr. Aguirre
b. Appeals and Grievances		Mr. Breakbill
c. HOS		Mr. Aguirre
<b>7. Committee Reports</b>		
<b>a. Credentialing Committee</b>	Dr. Lin	7:05 5 min.
Review June 07, 2017 report of the Credentialing Committee. <b>Possible Action:</b> Accept June 07, 2017 Credentialing Committee Report as presented		
<b>b. Pharmacy and Therapeutics Committee</b>	Dr. Lin	7:10 5 min.
Review minutes of the March 16, 2017 Committee Meeting. <b>Possible Action:</b> Accept March 16, 2017 Pharmacy and Therapeutics Committee minutes as presented		
<b>c. Utilization Management Committee</b>	Dr. Lin	7:15 5 min.
Review minutes of the April 19, 2017 Committee Meeting. <b>Possible Action:</b> Accept April 19, 2017 Utilization Management Committee minutes as presented		
<b>d. Quality Dashboard</b>	Mr. Aguirre	7:20 10 min.
Review Quality Metrics including Potential Quality Issues <b>Possible Action:</b> No action required.		
<b>e. Consumer Advisory Board</b>	Ms. Andersen	7:30 10 min.
<b>Possible Action:</b> No action required.		
<b>8. Adjournment</b>	Dr. Paul	7:40
Next meeting: Wednesday, November 8, 2017 6 p.m.		

**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](http://www.scfhp.com).

Meeting Minutes  
**SCCHA Quality Improvement Committee**  
 Wednesday, May 10, 2017

<b>Voting Committee Members</b>	<b>Specialty</b>	<b>Present Y or N</b>
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	N
Christine Tomcala, CEO	N/A	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Jeffrey Arnold, MD	Emergency Medicine	Y
Darrell Evora, Board Member	N/A	Y

<b>Non-Voting Staff Members</b>	<b>Title</b>	<b>Present Y or N</b>
Johanna Liu, PharmD	Director of Quality and Pharmacy	N
Andres Aguirre, MPH	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	Y
Jennifer Clements	Director of Provider Operations	N
Darryl Breakbill	Grievance and Appeals Operations Manager	N
Sandra Carlson, RN	Director of Health Services	Y
Angela Sheu-Ma	Health Educator	Y
Lori Andersen	Director of LTSS	Y
Sherry Holm	Director of Behavioral Health	Y
Caroline Alexander	Administrative Assistant	N

<b>AGENDA ITEM</b>	<b>DISCUSSION/ACTION</b>	<b>ACTION</b>	<b>RESPONSIBLE PARTIES</b>	<b>DUE DATE</b>
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:05 p.m. Quorum was established. Ms. Tomcala introduced new committee members Jeffrey Arnold, MD, and a member of the SCFHP Governing Board Mr. Darrell Evora to the committee.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Review and Approval of February 08, 2017 minutes	The minutes of the February 08, 2017 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the February 08, 2017 meeting were approved as presented.		
Public Comment	No public comment.			
CEO Update	<p>Ms. Tomcala reported that a bill regarding the Affordable Care Act passed in the House and now will go on to the Senate. There will be administrative and legislative change, as well as more state control.</p> <p>Membership is currently at 276,000.</p> <p>The April 2017 DHCS audit went well. Some findings are anticipated. There were 34 findings last year and anticipate half as many this year. Auditors acknowledged the good progress in operations done by the health plan.</p> <p>SCFHP is currently working on implementing new claims system for MediCal product line (QNXT). July 1<sup>st</sup> is the expected cutover date for MediCal into QNXT.</p> <p>SCFHP submitted DSNP with CMS on the chance the state budget no longer supports Cal MediConnect (CMC) product line.</p> <p>CMC was supported in initial Governor budget, revise to be released in May. If CMC is supported in the budget of the state, the plan will no longer move forward with DSNP.</p>			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
<p>Action Items</p> <p>A. Review of Quality Improvement Committee Charter</p> <p>B. Review of Quality Improvement Policies</p> <p>C. Adult Preventive Health Guidelines</p> <p>D. Review of QI Work Plan, QI Program Evaluation, and QI Program Description</p>	<p>Mr. Aguirre presented the Quality Improvement Committee Charter for annual review. There are no changes, it is presented for annual review.</p> <p>Twelve policies were presented to the committee:            QI.01 Conflict of Interest            QI.02 Clinical Practice Guidelines            QI.03 Distribution of Quality Improvement Information            QI.04 Peer Review Process            QI.05 Potential Quality of Care Issues            QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting            QI.07 Physical Access Compliance            QI.08 Linguistics Culture            QI.09 Health Education Program and Delivery System Policy            QI.10 IHA and HEBA Assessments Policy            QI.11 Member Non-Monetary Incentives            QI.12 SBIRT</p> <p>Dr. Boris presented the Adult Preventive Health Guidelines. Of note is that Breast Cancer Screening (Mammography) guideline remained as every 1 to 2 years for women 40 years of age and older.</p> <p>Mr. Aguirre presented the QI Work Plan, QI Program Evaluation and QI Program Description. In QI Program Description, added some language around providers that comprise the Quality Improvement Committee on page 23 in order to meet NCQA regulations:            “The QIC actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan’s QIC is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and QI staff may also attend the QIC as appropriate.”</p> <p>QI Program Evaluation 2016, has more material than previous years. Picked high priority measures. On schedule and data is looking great. Pages 9 to 11 are CMC, Page 12 describes Quality Improvement Projects. QIP’s are mandated by the state. Will</p>	<p>No action required. Informational only.</p> <p>All policies were approved as presented.</p> <p>Guidelines approved as presented.</p> <p>Bring HEDIS 2017 results to next meeting</p> <p>Approved as presented.</p>	<p>Andres Aguirre</p>	

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
<p>E. Review of Complex Case Management Outcomes for 2016 and CM Program Evaluation</p>	<p>select new projects around 4<sup>th</sup> Quarter. Bring to committee as agenda item. Page 13 LTSS project, admissions from hospital to SNF. Pages 14 and 15 are patient safety measures and potential quality of care issues. QI Work plan new additions are on the last two pages of work plan: Initial Health Assessments, NCQA Accreditation, ADA Workplan, Quality of Care and Model of Care.</p> <p>Ms. Carlson presented the Complex Case Management Outcomes and CM Program Evaluation as well as Disease Management Outcomes for 2016. SCFHP's 2016 Comprehensive Case Management program was approved when initially presented to the QIC on August 10th, 2016. At that time, SCFHP recognized that their existing Case Management software program (Altruista) was not designed to document all required regulatory reporting elements related to case management and care coordination interventions. Additionally at that same time, SCFHP was experiencing reduced staffing within their case management team. Since 8/10/2016, SCFHP has filled vacant positions for their Director of Health Services and Manager of Case Management. Three additional Nurse Case managers and one administrative Personal Care Coordinator (PCC) have also been added to this team. Beginning November 15th, 2016 SCFHP 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. Additionally, Optum has an NCQA accredited Complex Case management and Disease management program which is part of the Scope of Work between Optum and SCFHP. Optum has a team of (27) Registered Nurses who are licensed in the state of California to conduct Case management and Disease management services.</p> <p>As of 12/31/2016, the volume of CMC members with HRA's completed by Optum: 1,531</p> <p>As of 12/31/2016, the volume of CMC members are enrolled in Optum NCQA programs is as follows:</p> <ul style="list-style-type: none"> <li>• Coronary Artery Disease: 435</li> <li>• Depression: 435</li> <li>• Diabetes: 914</li> <li>• Complex Case management: 32</li> </ul>	<p>Bring data to next Quality Improvement Committee meeting</p> <p>Approved as presented.</p>	<p>Sandra Carlson</p>	<p>08/09/2017</p>

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
<p>F. Review of Health Education Program Evaluation and Health Education Work plan</p> <p>G. Review of Americans with Disabilities Act Work plan</p>	<p>In December 2016, SCFHP secured a contract for the purchase and implementation of a new Case Management software program, “Essette”. Development and configuration began in January 2017 with a scheduled operational launch date of June 1<sup>st</sup>, 2017. At that time, SCFHP intends to reconsider plans for outsourcing HRA and Case Management functions to external vendors.</p> <p>Ms. Sheu-Ma presented the Health Education Program Evaluation and Work plan. Updates given at JOC’s regarding classes available and languages offered in. Member incentives, focusing to communicate with state so they are aware of programs conducting. Group Needs Assessment conducted. Submitting annual work plan to the state instead of annual updates on Group Needs Assessment. Work plan a lot of carryover from 2016, deeper dive into processes. Alcohol and Drug Use self-management tools, as well as tools to identify depressive disorders on member portal. Continuation of member incentive programs ongoing.</p> <p>Mr. Aguirre presented the Americans with Disabilities Act Work plan. Patient Safety metrics reported are:</p> <ul style="list-style-type: none"> <li>• Number of Critical incidents reported in an MLTSS setting.</li> <li>• Number of Potential Quality of Care Issues identified at IHSS</li> </ul> <p>Access metrics reported are:</p> <ul style="list-style-type: none"> <li>• Number of LTSS sites reviewed</li> <li>• Number of CBAS sites reviewed</li> <li>• Number of referrals to CBAS</li> <li>• Number of referrals to IHSS</li> <li>• Number of High Volume Specialists</li> <li>• Number of Ancillary sites reviewed</li> </ul> <p>Preventive Care:</p> <ul style="list-style-type: none"> <li>• HEDIS: Care of Older Adults-Functional Status Assessment</li> <li>• Medication Reconciliation Post-Discharge</li> </ul> <p>Health Education:</p> <ul style="list-style-type: none"> <li>• Number of referrals for CMC members</li> </ul>	<p>Approved as presented.</p> <p>Approved as presented.</p>		



AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
H. Review and Adoption of Optum Complex Case Management Policies	Five Optum Complex Case Management Policies were presented for approval and adoption per NCQA requirements. CM-010 Care Plans and Goals CM-007 Data Collection Tools and Assessments CM-009 Identification-Case Opening and Closure Criteria QI-004 Program Content Development Review and Approval Process QI-020 Program Satisfaction-Feedback	Approved and adopted as presented.		
I. Review and Approval of Optum 2016 Quality Improvement Program Description and Work Plan	Ms. Carlson presented the Optum 2016 Quality Improvement Program Description and Work Plan to the committee for adoption per NCQA requirements.	Approved and adopted as presented.		
Discussion Items				
A. Access and Availability	Mr. Aguirre presented the Access and Availability report. The following access standards are monitored by the health plan: <ul style="list-style-type: none"> <li>• Time and distance requirements</li> <li>• Appointment availability</li> <li>• Minimum number of providers for each specialty type</li> </ul> The Access and Availability Workgroup works on identifying and preventing potential barriers to care related to access issues using the following tools: <ul style="list-style-type: none"> <li>• Grievances related to access issues</li> <li>• Survey data from CAHPS and timely access surveys</li> <li>• Referral and claims data</li> <li>• Quest Analytic Reports</li> </ul> 50 Specialties were analyzed and Met All Requirements. There was 100% compliance for both measures for physician and facility measures.	Report results from the following surveys at next QIC: <ul style="list-style-type: none"> <li>-DMHC Appointment Availability</li> <li>-DMHC After Hours</li> <li>-DMHC Provider Satisfaction</li> <li>-DMHC Member Satisfaction</li> <li>-Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS)</li> </ul>	Jennifer Clements	08/09/2017
B. Appeals and Grievances	Mr. Aguirre and Dr. Boris presented the Grievance and Appeals report for the 1st Quarter of 2017. For Medi-Cal: Number of Medical Appeals increased from 23 in January to 32 in March. Pharmacy Appeals increased from 12 in January to 14 in March. State Fair Hearings decreased from 6 in January to 3 in March. Access to Care Grievances decreased from 35 in January to 18 in March. Quality of Service/Customer Service Grievances			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
<p>C. Disease Management Outcomes for 2016</p> <p>D. CY 2017 Annual Review of SCFHP CMC Population Demographics &amp; Specific Health Conditions</p>	<p>increased from 9 in January to 22 in March. 52% of Medi-Cal Medical Appeals were upheld and 40% were overturned. 39% of Pharmacy Appeals were upheld and 51% were overturned. For Cal MediConnect: Number of Part C Appeals Reconsiderations increased from 8 in January to 9 in March. Part D Redeterminations increased from 10 in January to 12 in March. Access to Care Grievances decreased from 24 in January to 16 in March. Quality of Service/Customer Service Grievances increased from 2 in January to 8 in March. Part C Determinations Breakdown was as follows: 27% Overturned, 11% in process, 31% Upheld; 31% Withdrawn and 0% dismissed. Part D Redeterminations Breakdown was as follows: 25% Overturned, 40% Upheld, 26% Withdrawn, 6% dismissed, 3% in process.</p> <p>*Refer to Action Item E.</p> <p>Dr. Boris presented an overview of the Cal MediConnect population. The top chronic conditions unique to County of Santa Clara, as well as Santa Clara Family Health Plan CMC members include: hypertension, high cholesterol, and diabetes. CMC Specific Languages from 2015 CY include:</p> <ul style="list-style-type: none"> <li>• English</li> <li>• Spanish</li> <li>• Vietnamese</li> <li>• Chinese</li> </ul> <p>CMC Specific Diagnoses from 2015 CY include:</p> <ul style="list-style-type: none"> <li>• Hypertension, Essential NOS</li> <li>• DM, Uncomplicated, Type II</li> <li>• Essential (primary) hypertension</li> <li>• Hyperlipidemia NEC/NOS</li> <li>• Type 2 diabetes mellitus without complications</li> <li>• Atrial fibrillation</li> <li>• Hypertension, Benign essential</li> <li>• DM, Uncomplicated, Type II Uncontrolled</li> <li>• Chest pain, NOS</li> <li>• Depressive Disorder, NEC</li> </ul>			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
<p>Committee Reports</p> <p>A. Credentialing Committee</p> <p>B. Pharmaceutical and Therapeutics Committee</p> <p>C. Utilization Management Committee</p> <p>D. Dashboard</p> <p>E. Consumer Advisory Report</p>	<p>Dr. Lin presented the February 01 and April 05, 2017 Credentialing Committee Reports. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.</p> <p>Dr. Lin presented the 4th Quarter 2016 Pharmacy and Therapeutics Committee minutes. Plan removed OTC cough and cold medications from formulary. It was moved, seconded to approve Pharmaceutical and Therapeutics Committee minutes as presented.</p> <p>Dr. Lin presented the January 18 and March 22, 2017 Utilization Management Committee minutes. Cal MediConnect timeliness goal is 95%. It was moved, seconded to approve Utilization Management Committee meeting minutes as presented.</p> <p>Mr. Aguirre presented the 1st Quarter Dashboard report, including data through April 2017. Nine facility site reviews performed. 76 Potential Quality Issues total were identified, to include April 2017. 59 Level 1 PQI's: No quality issue determined. 13 Level 2 PQI's: Opportunity for improvement. 4 Level 3 PQI's. No Level 4 PQI's were identified. Initial Health Assessment Rate for 1<sup>st</sup> Quarter was 40%, and for April 2017 was 37%. Quality Improvement Activities included Member Incentives for the following:</p> <ul style="list-style-type: none"> <li>• Cervical Cancer Screening</li> <li>• Retinal Eye Exam</li> <li>• Hypertension</li> </ul> <p>Return rates were low for member incentives. Suggestion made by committee member Dr. Dawood that member incentive forms be sent directly to provider offices so providers can assist with filling out at member visits.</p> <p>Ms. Andersen presented the 1<sup>st</sup> Quarter Consumer Advisory Board (CAB) report to the committee. Issues of Cal MediConnect (CMC) program management and enrollee care</p>	<p>Credentialing Committee reports were approved as presented.</p> <p>4th Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.</p> <p>January 18 and March 22, 2017 Utilization Management Committee minutes were approved as presented.</p> <p>Present report to committee quarterly</p>	<p>Lori Andersen</p>	

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	<p>identified by CMC members during monthly Consumer Advisory Board meetings. Santa Clara Family Health Plan is required to share this member input with the Quality Improvement Committee quarterly.</p> <p>Summary of issues included the following:</p> <ul style="list-style-type: none"> <li>• Phone</li> <li>• SCFHP After-Hours Nurse Line</li> <li>• Customer Service/Case Management Support for Member</li> <li>• Pharmacy Co-Pay</li> </ul> <p>Additional Input on CMC Program Management and Enrollee Care included:</p> <ul style="list-style-type: none"> <li>• Satisfied Working with their case managers and getting the help they need</li> <li>• Appreciation for case manager “check-in” call, particularly in her own language</li> <li>• Excellent service received from nursing staff and doctors at a Specialty Clinic</li> <li>• Excellent service from SCFHP and Pharmacy for prescriptions not typically covered</li> <li>• Suggestion made to provide members with a written summary of how transportation benefit can be arranged including what’s different, if after hours</li> </ul>			
Adjournment	Meeting adjourned by Dr. Ria Paul at 7:35 p.m.			
Next Meeting	Wednesday, August 09, 2017- 6:00 PM	Calendar and attend.	All	

**Reviewed and approved by:**

\_\_\_\_\_ Date \_\_\_\_\_  
 Ria Paul, MD  
 Quality Improvement Committee Chairperson



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# HEDIS 2017

Quality Improvement



# Reporting

- New Challenges
  - Missing Claims files
  - Patient Level Detailed file for CMC
  - Provider Specialty Mapping
  - New measure: Healthcare-Associated Infections (HAI)



# Reporting

- Plus
  - Remote access to Valley Medical Center records
  - Remote access to Palo Alto Medical Foundation
  - Medical Record Retrieval Rate was high (86%)
  - Medi-Cal: No measures fell below MPL
  - CMC: Quality Withhold measures improved by at least 10%
- Delta
  - 2 Administrative Refreshes due to missing claim files



# Measure Statistics

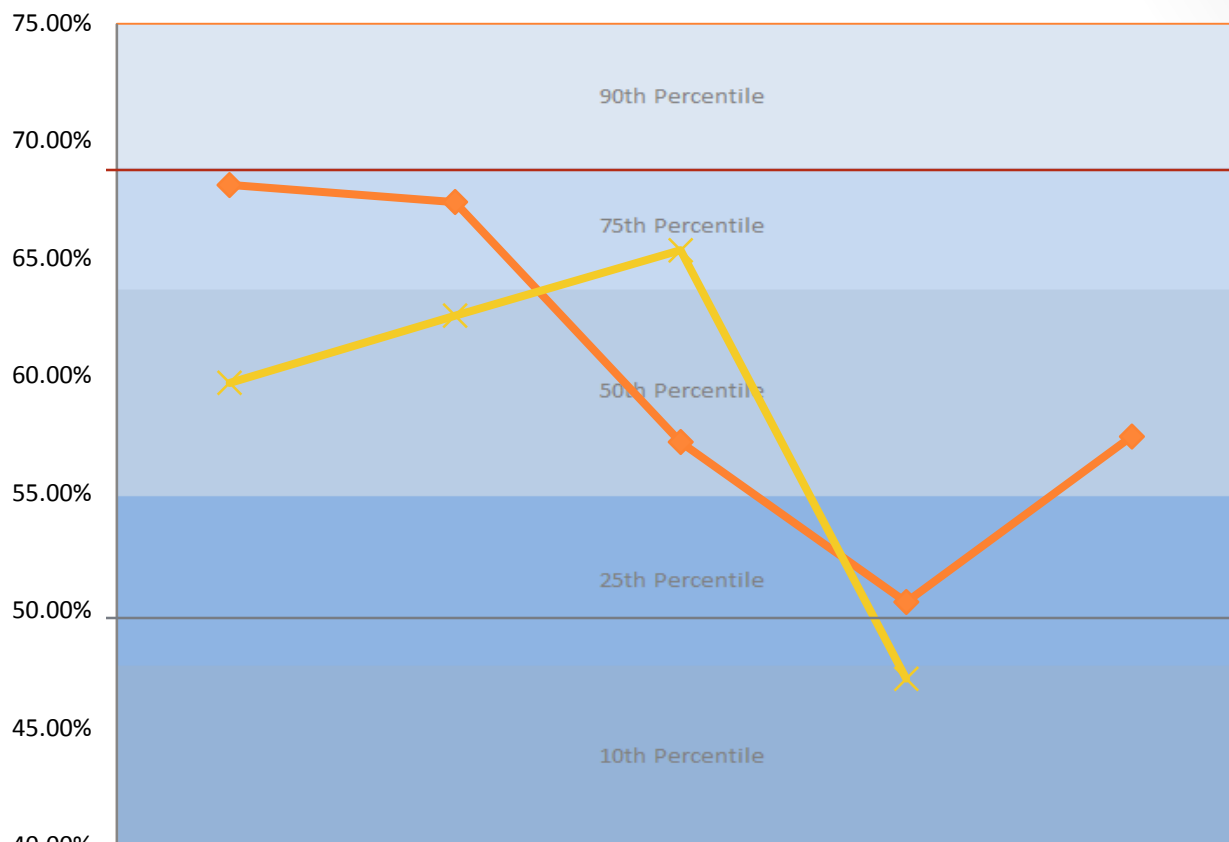
Measure Statistics for Medi-Cal	2016	2017
# of measures in 90th percentile	7*	0
# of measures in 75th percentile	6	8
# of measures in 50th percentile	7	11
# of measures in 25th percentile	1	2
# of measures in 10th percentile	1	0
# of measures moved up at least 1 percentile	5	8
# of measures moved up at least 2 percentiles	0	4
# of measures moved up at least 3 percentiles	0	1
# of measures moved down at least 1 percentile	11	6

\*includes over 90th percentile





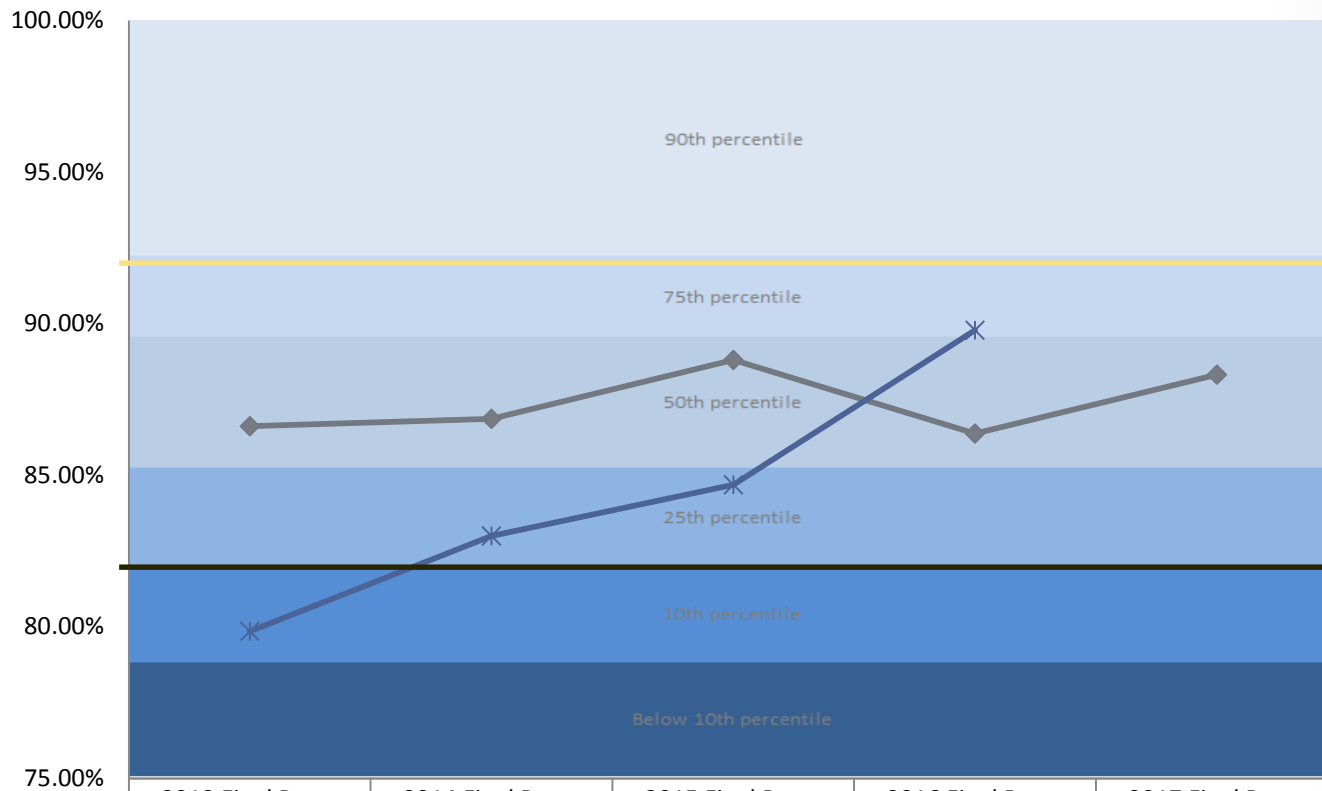
# MCAL – Cervical Cancer Screening (CCS)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
SCFHP - Cervical Cancer Screening	68.13%	67.40%	57.18%	50.36%	57.42%
ABC - Cervical Cancer Screening	59.70%	62.56%	65.35%	47.10%	
2017 MPL	48.26%				
2017 HPL	69.89%				



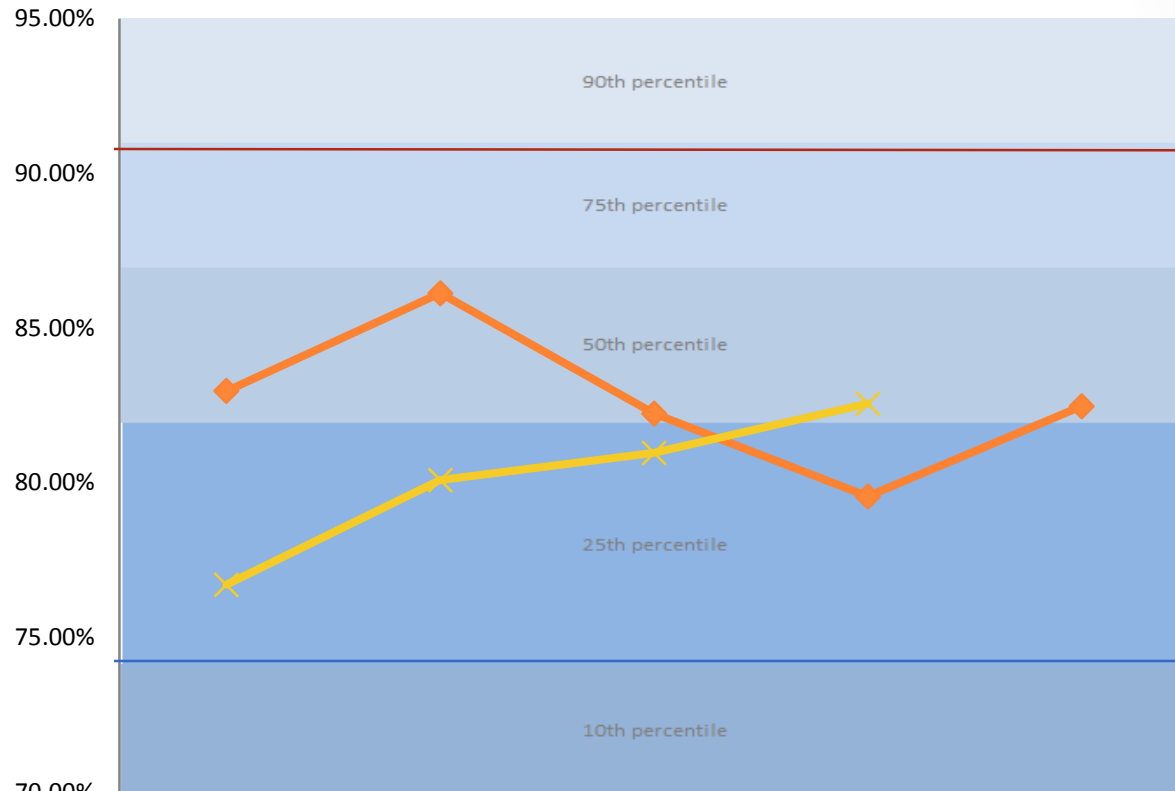
# MCAL – HbA1c Testing (CDC-HT)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
◆ SCFHP - HbA1c Testing	86.62%	86.86%	88.81%	86.37%	88.32%
* ABC - HbA1c Testing	79.85%	83.00%	84.69%	89.79%	
— 2017 HPL	92.88%				
— 2017 MPL	82.98%				



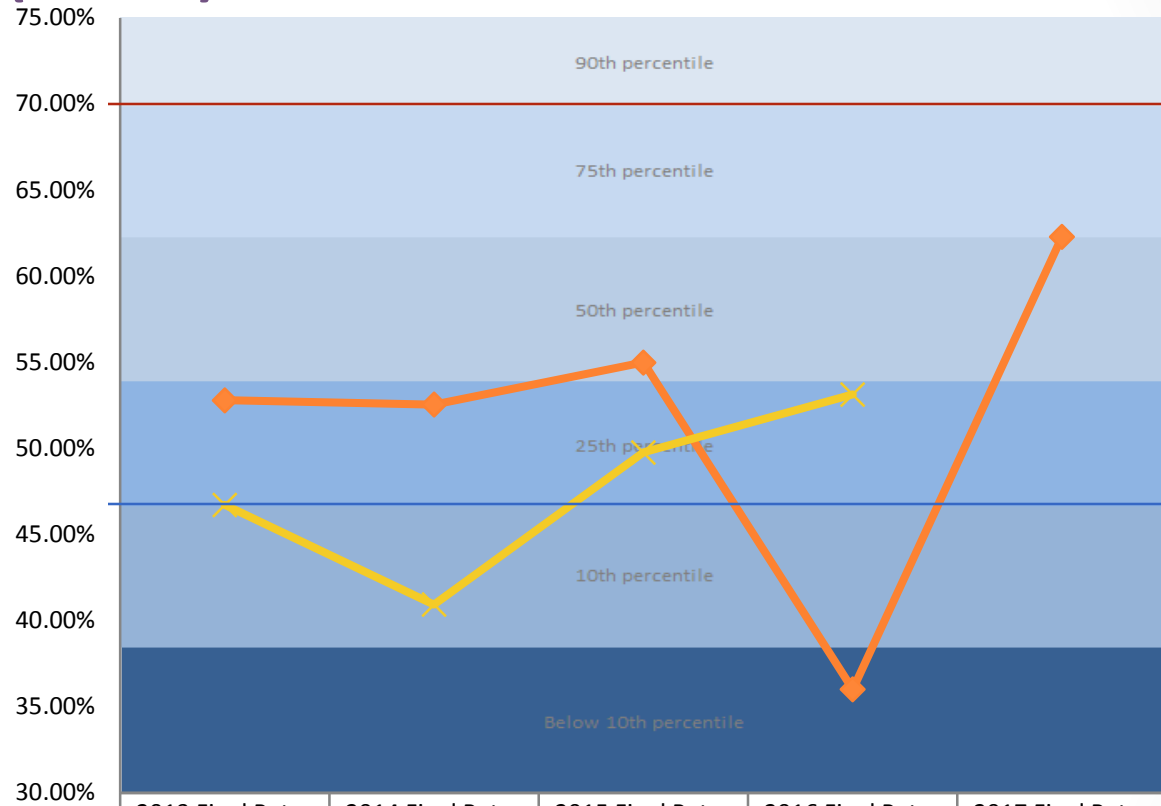
# MCAL – Timeliness of Prenatal Care (PPC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
SCFHP - Timeliness of Prenatal Care	82.97%	86.13%	82.24%	79.56%	82.48%
ABC - Timeliness of Prenatal Care	76.71%	80.09%	80.97%	82.56%	
2017 MPL	74.21%				
2017 HPL	91.00%				



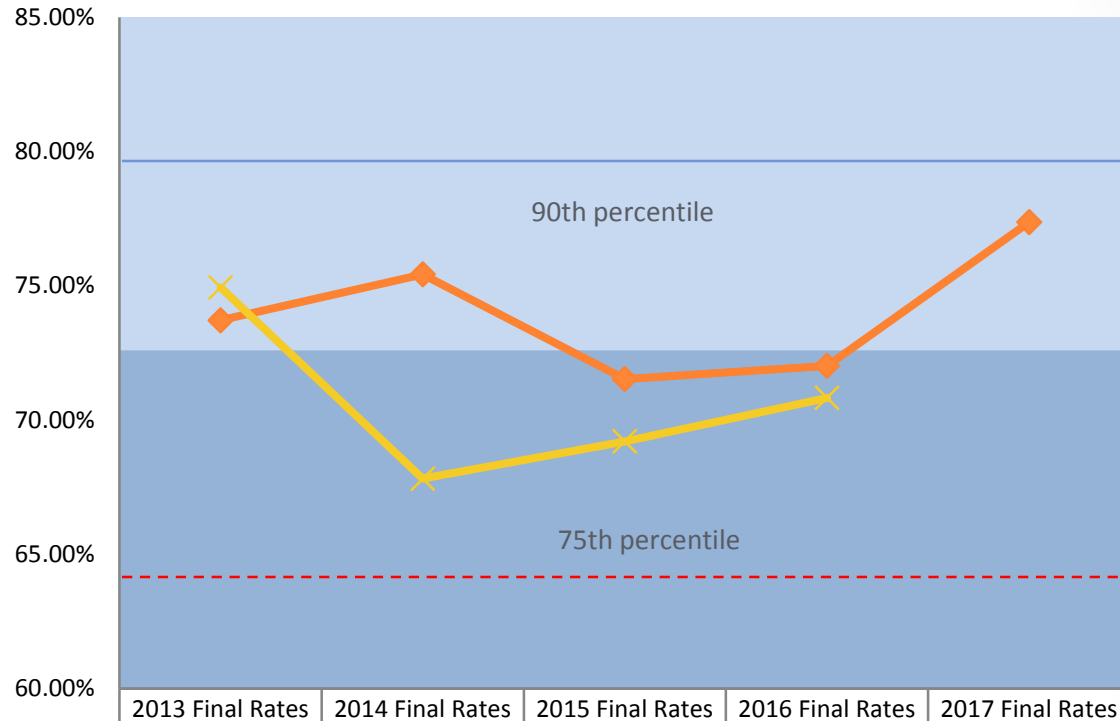
# MCAL – Controlling High Blood Pressure (CBP)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
SCFHP - Controlling High Blood Pressure	52.80%	52.55%	54.99%	36.01%	62.29%
ABC - Controlling High Blood Pressure	46.72%	40.93%	49.77%	53.13%	
2017 MPL	47.03%				
2017 HPL	70.55%				



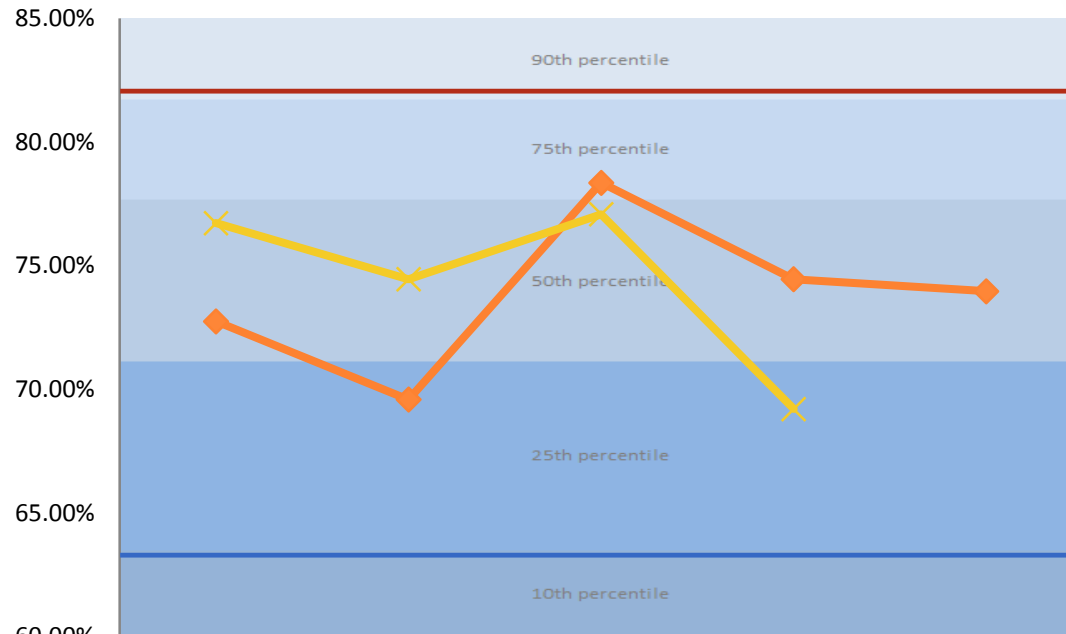
# MCAL – Childhood Immunization Status – Combo 3 (CIS-3)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
SCFHP - Childhood Immunization Status – Combo 3	73.72%	75.43%	71.53%	72.02%	77.37%
ABC - Childhood Immunization Status – Combo 3	74.94%	67.82%	69.21%	70.83%	
2017 MPL	64.30%				
2017 HPL	79.81%				



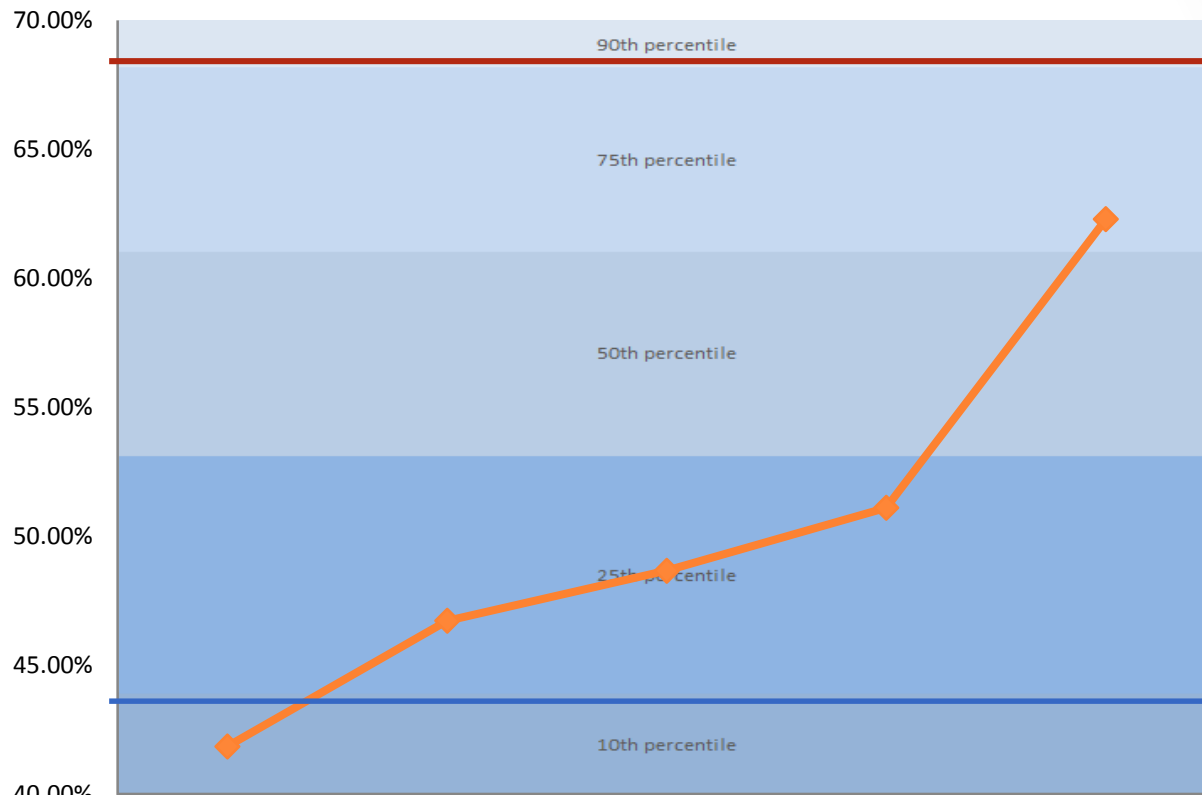
# MCAL – Well Child Visits 3-6 Years of Life (W34)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
—◆— SCFHP - Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	72.75%	69.59%	78.35%	74.45%	73.97%
—×— ABC - Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	76.72%	74.45%	77.08%	69.21%	
— 2017 MPL	64.72%				
— 2017 HPL	82.97%				



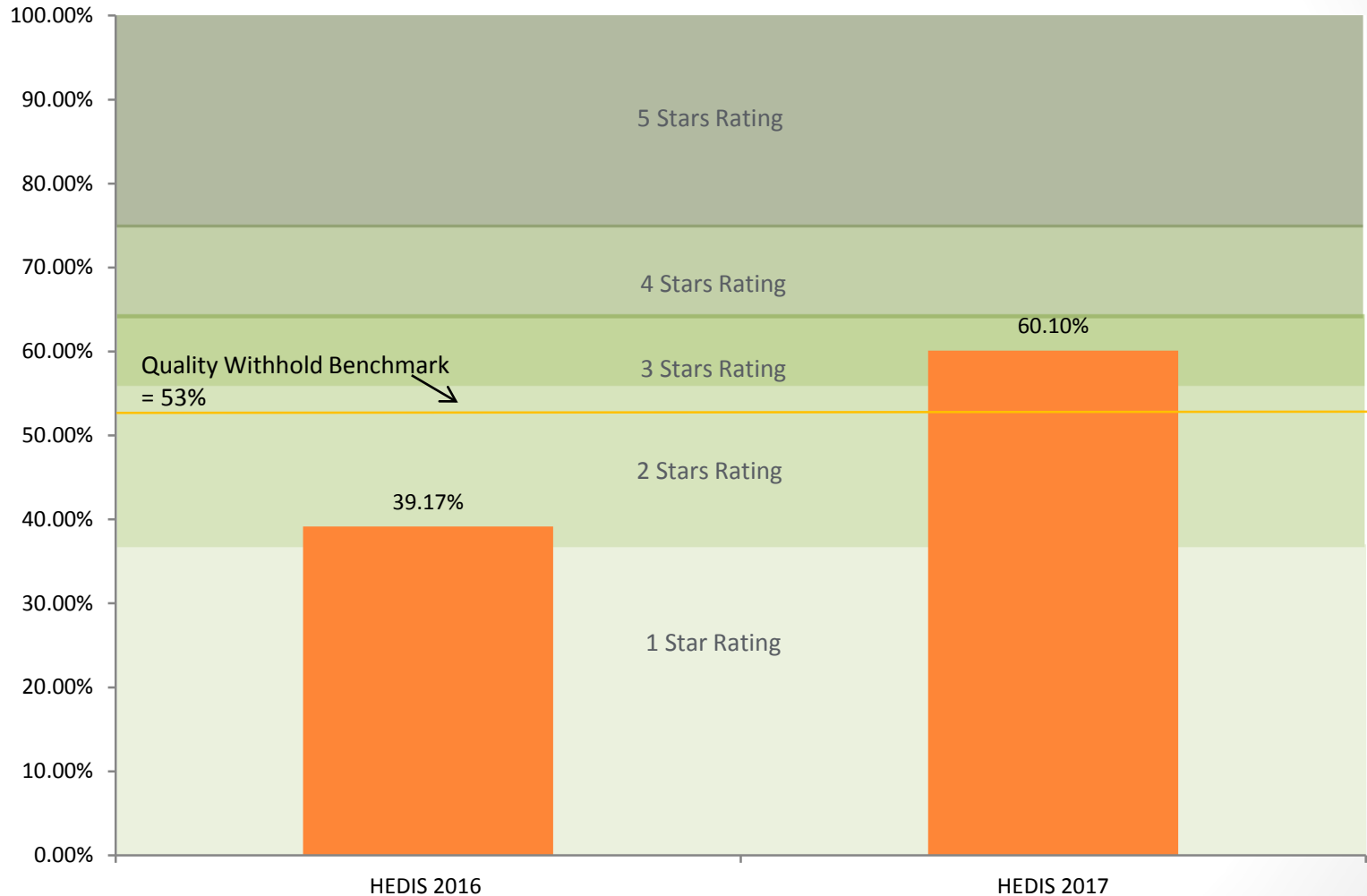
# MCAL PIP – Diabetic Eye Exam (CDC-E)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates
Eye Exam (Retinal) Performed	41.85%	46.72%	48.66%	51.09%	62.29%
2017 MPL	44.53%				
2017 HPL	68.09%				

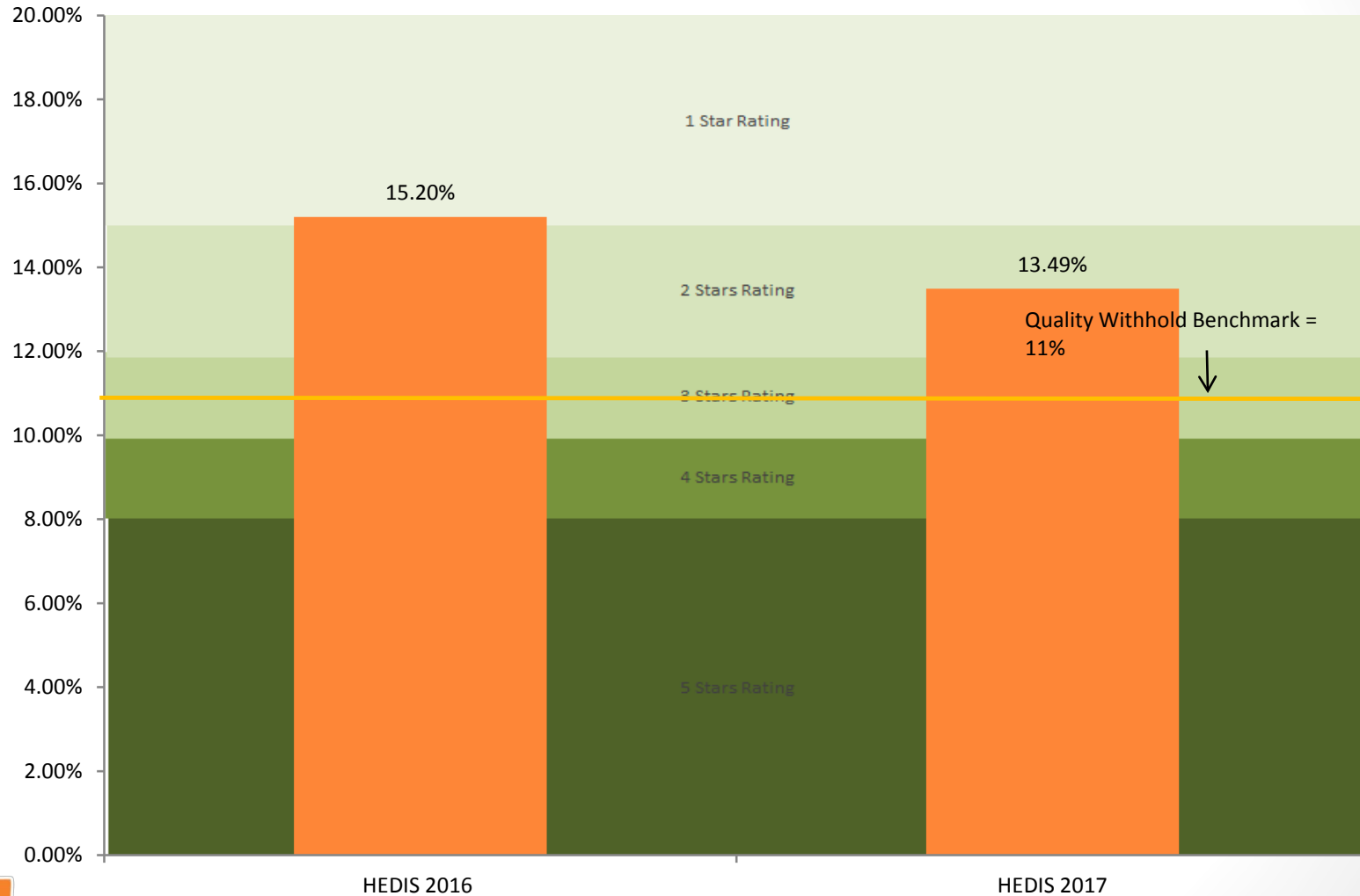


# CMC – Controlling High Blood Pressure (CBP)

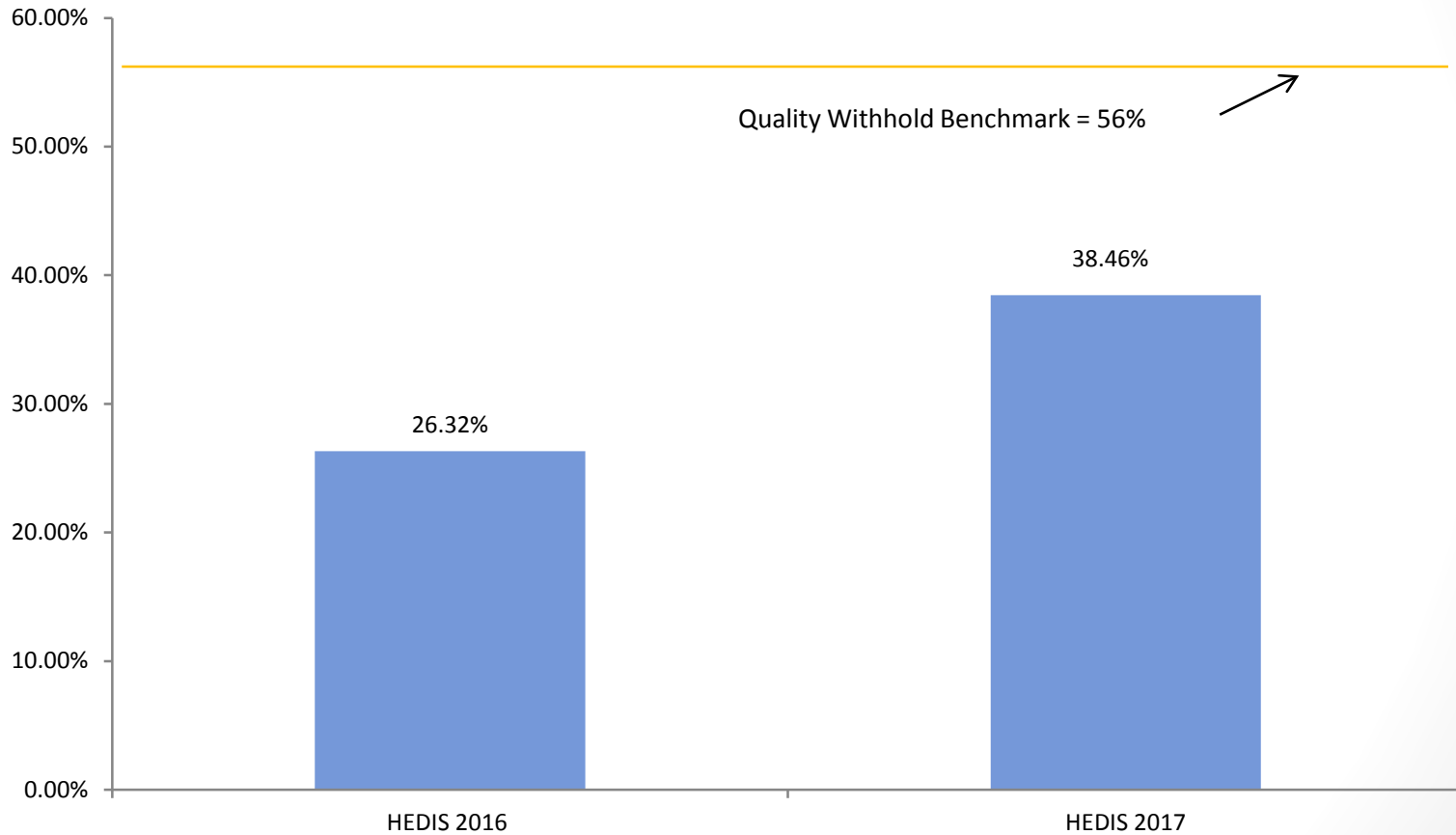




# CMC – Plan All Cause Readmissions (PCR)



# CMC – Follow up After Hospitalization for Mental Illness - 30 day follow up (FUH)



# Next Steps

- Improvement Plans – MCAL
  - Childhood Immunization Status – Combo 3
    - Performance Improvement Project – Disparate Group
      - Target Vietnamese Members
  - Controlling High Blood Pressure
    - Performance Improvement Project
  - Prenatal Care
    - Member incentive
  - Texting Campaign for all Auto-Assignment Measures
- Cal Medi-Connect
  - Call campaign for the following measures:
    - Controlling High Blood Pressure
    - Cervical Cancer Screening
    - CDC – HbA1c



Questions ?



Santa Clara  
Family Health Plan  
*The Spirit of Care*

8/3/2017



# Initial Health Assessment Report

June 2017

## Background

The Initial Health Assessment (IHA) is a comprehensive assessment that is completed during the member's initial encounter(s) with a selected or assigned primary care physician (PCP), appropriate medical specialist, or non-physician medical provider and must be documented in the member's medical record. The IHA enables the PCP to assess and manage the acute, chronic, and preventive health needs of the member.

The five different components of the IHA are:

1. Comprehensive History
2. Administration of preventive services
3. Comprehensive Physical and Mental Status Exam
4. Diagnosis and Plan of Care
5. Staying Healthy Assessment (SHA) Questionnaire

SCFHP contracted PCPs are responsible for checking the Provider Portal on the SCFHP website to find their list of newly assigned members on a monthly basis. The provider is also responsible for scheduling appointments with the members to complete the IHAs.

## Purpose

The IHA is a Medi-Cal requirement for all new member to SCFHP that must be completed within 120 calendar days of enrollment. Medical record review was an opportunity to do two things; one, validate the methodology that SCFHP uses to identify the provision of IHA services, and two, provide feedback to network providers on what a complete IHA visit is.

## Methodology

SCFHP conducted a randomized review of 13 contracted clinics in Santa Clara County

Medical records were reviewed and assessed for complete IHAs during the 120 day timeframe requirement. Clinics did have compliant medical records, but not all the records for any clinic were 100% compliant

For ease of scoring purpose, each IHA visit record was broken down into 4 elements:

1. Element A – History of present illness, past medical history, social history, and systems review
2. Element B – Preventative services
3. Element C – Complete exam, diagnosis, and plan
4. Element D – Staying Health Assessment (SHA) questionnaire

## Findings

Element B and C had the highest compliance rate, with 55% of the records reviewed having Preventive services and complete exam, diagnosis and plan. 43% of records reviewed had history of present illness, past medical history, social history and systems review (Element A). Within Element A, the social history assessment was frequently missing from the charts reviewed. Administration of the SHA (Element D) was the lowest performing element with a compliance rate of 15%. The overall compliance rate was 11%, with only 7 of 53 reviewed charts having completed the IHAs within the 120 day timeframe. (See Table 1).

**Table 1: Initial Health Assessment Compliance Rates**

<b>Element A (HPI, medical history, social history, systems review)</b>	43%
<b>Element B (Preventative services)</b>	55%
<b>Element C (Complete exam, diagnosis, and plan)</b>	55%
<b>Element D (Staying Health Assessment (SHA) questionnaire)</b>	15%

Other findings: a few of the clinics reported that at least one of the members on the list was not their patient. Health Plan systems do show the members were assigned to the clinic during the measurement period.

## Conclusion

Based on the findings, the majority of SCFHP contracted PCPs are not providing a complete IHA for new members within the 120 day required timeframe. This may be due to providers not using the required SHA questionnaires or other state approved forms during their office visits with new patients, providers not checking the SCFHP portal on a regular basis for newly assigned members, and lack of training about the IHAs.

## Next Steps

This was the first medical record review of the health plan's IHA methodology and it resulted in a lot of actionable data. Going forward, the plan will continue to do the medical record review on an annual basis, with the final report going to the plan's Quality Improvement Committee. The plan has also posted information about the components of the IHA to the plan's external website as a reference for network providers. The plan will also do more in-depth training to providers on the importance of completing the IHA, in addition to following-up on a regular basis, may help increase compliance rates. This training will happen using multiple methodologies including in person training as well as provider newsletter articles alerting providers to requirements as well as educational resources available.

# POLICY



Santa Clara  
Family Health Plan

<b>Policy Title:</b>	<b>Comprehensive Case Management</b>	<b>Policy No.:</b>	QI13
<b>Replaces Policy Title (if applicable):</b>	Case Management	<b>Replaces Policy No. (if applicable):</b>	CM030_05
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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

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 08/05/2016		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			





<b>Policy Title:</b>	<b>Disease Management</b>	<b>Policy No.:</b>	QI14
<b>Replaces Policy Title (if applicable):</b>	None	<b>Replaces Policy No. (if applicable):</b>	None
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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 08/05/2016		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			



<b>Policy Title:</b>	<b>Transitions of Care</b>	<b>Policy No.:</b>	QI.15
<b>Replaces Policy Title (if applicable):</b>	None	<b>Replaces Policy No. (if applicable):</b>	None
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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 08/05/2016		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			



<b>Policy Title:</b>	<b>Managed Long Term Services and Supports (MLTSS) Care Coordination</b>	<b>Policy No.:</b>	QI.16
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

**I. Purpose**

Santa Clara Family Health Plan (SCFHP) identifies members that are possibly at risk for institutional placement, that are currently placed in nursing facilities or those that want to move to a lower level of care. The Plan promotes coordination of services with the goal of achieving optimal well-being and functionality at the least restrictive level of care most beneficial to individual members.

**II. Policy**

- A. In addition to following the Comprehensive Case Management policy, the Plan coordinates and monitors access, availability, continuity and coordination of care to Managed Long Term Services and Supports (MLTSS) for members. Additional procedures are specific to this form of care coordination.
- B. The Plan defines MLTSS procedures to include:
  - LTSS Assessment Review
  - Community Based Adult Services (CBAS): Eligibility/Determination and Coordination, Referrals
  - Referrals and Coordination for Multipurpose Senior Services Program
  - LTC Case Management and Care Transitions
  - Home and Community Services (HCBS) Coordination
  - Individual Care Team (ICT): Specific providers required
  - Individual Care Plan (ICP): Specific requirements
  - Training: Additional needs for providers and staff
- C. The Plan maintains procedures specific to the above mentioned areas as well as Comprehensive Case Management and Utilization Management procedures that provide details.

**III. Responsibilities**

Health Services collaborates with internal departments (IT, Claims) to identify members for MLTSS Care Coordination and to coordinate services as well as contracted providers, community resources and facilities.

**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.

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
				
Signature Lori Andersen		Signature Jeff Robertson, MD		
Name Director of MLTSS		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)
v1.0	Original			



<b>Policy Title:</b>	<b>Behavioral Health Care Coordination</b>	<b>Policy No.:</b>	QI.17
<b>Replaces Policy Title (if applicable):</b>	<b>Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure</b>	<b>Replaces Policy No. (if applicable):</b>	<b>CM106_1</b>
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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) services such as Applied Behavioral Analysis (ABA) and other evidence based behavioral intervention services that develop or restore. The plan provides BHT for members with Autism Spectrum Disorder (ASD). 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.

**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		
				
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			





<b>Policy Title:</b>	Sensitive Services, Confidentiality, Rights of Adults and Minors	<b>Policy No.:</b>	QI.18
<b>Replaces Policy Title (if applicable):</b>	Sensitive Services, Confidentiality, Rights of Adults and Minors	<b>Replaces Policy No. (if applicable):</b>	CM036_04
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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, benefits, 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 #: 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 08/05/2016		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)
v1.0	Original			

# POLICY



Santa Clara  
Family Health Plan

<b>Policy Title:</b>	Care Coordination Staff Training	<b>Policy No.:</b>	QI.19
<b>Replaces Policy Title (if applicable):</b>	Long Term Support Services and Social Services Training	<b>Replaces Policy No. (if applicable):</b>	112_01
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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.

## POLICY

### 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		Signature		
Johanna Liu, PharmD		Jeff Robertson, MD		
Name		Name		
Director of Quality and Pharmacy		Chief Medical Officer		
Title		Title		
08/05/2016		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				

# POLICY



Santa Clara  
Family Health Plan

<b>Policy Title:</b>	<b>Information Sharing with San Andreas Regional Center (SARC)</b>	Policy No.:	QI.20
<b>Replaces Policy Title (if applicable):</b>	None	Replaces Policy No. (if applicable):	None
<b>Issuing Department:</b>	Health Services	Policy Review Frequency:	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input type="checkbox"/> 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		Signature		
Sherry Holm, LCSW		Jeff Robertson, MD		
Name		Name		
Director of Behavioral Health		Chief Medical Officer		
Title		Title		
08/05/2016		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

*The Spirit of Care*

# Quality Improvement Committee

## *Grievance and Appeals Q2 2017 Report*

August 9, 2017



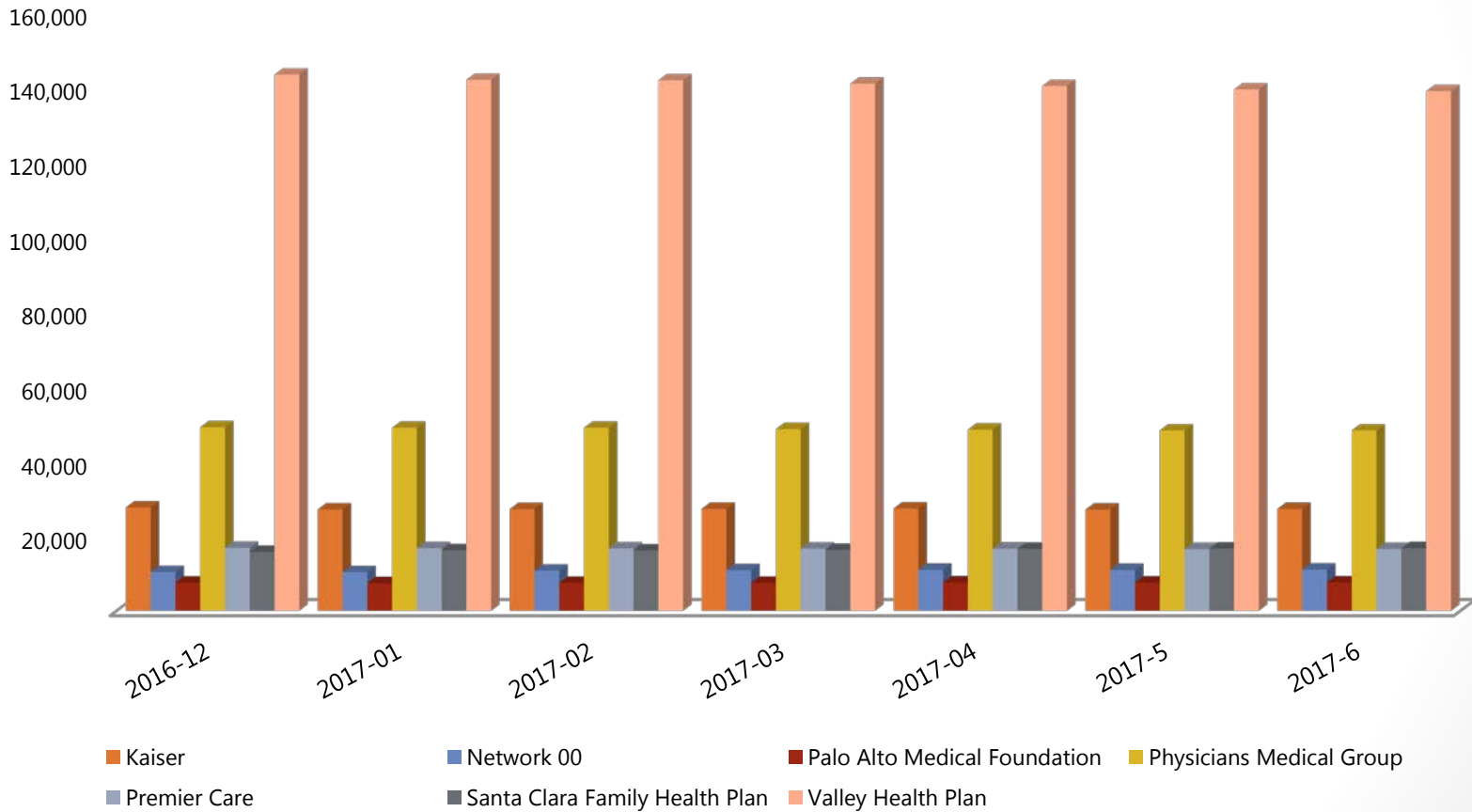




# Medi-Cal Enrollment



## Medi-Cal Membership by Network

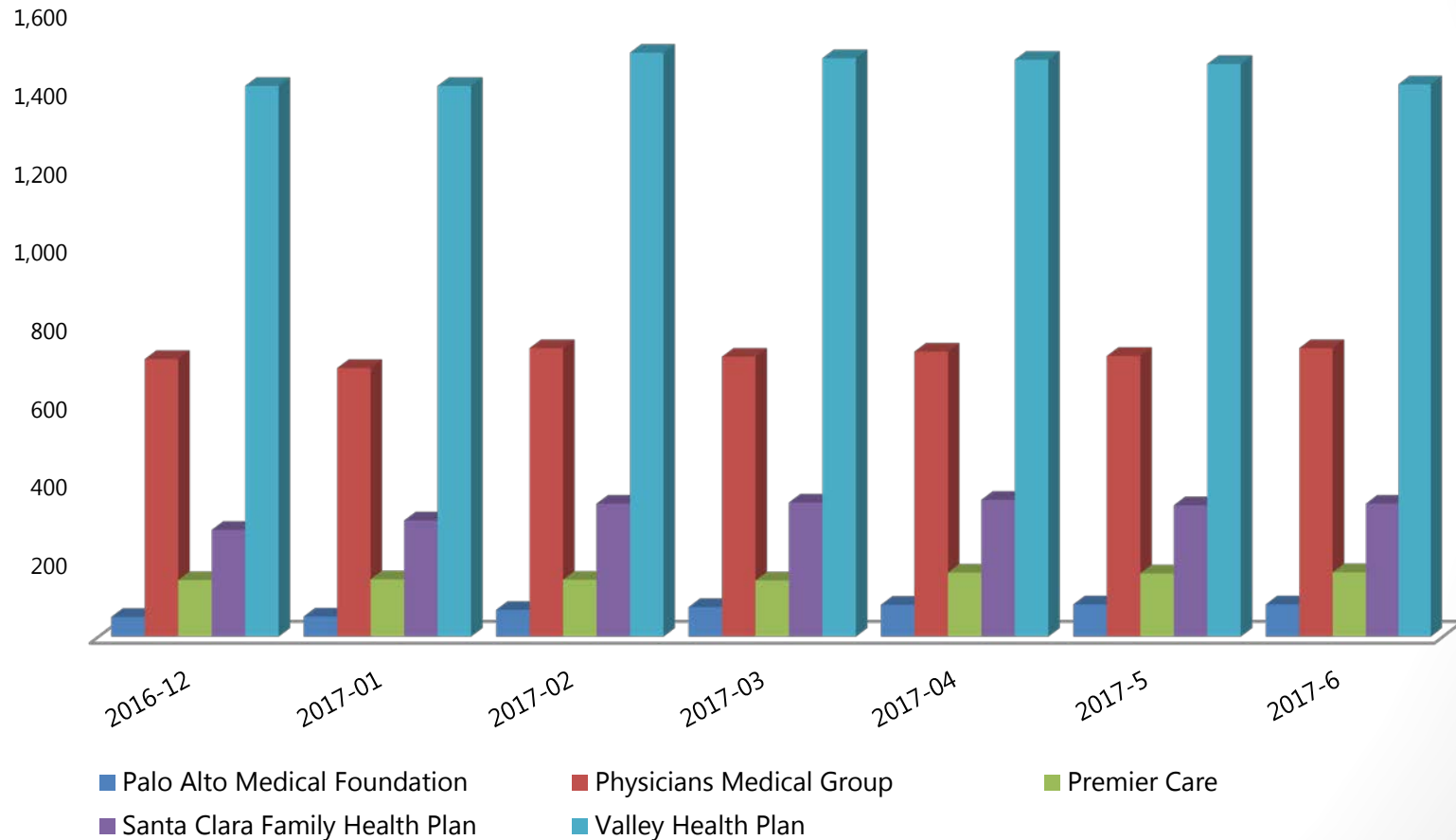


# Healthy Kids Enrollment



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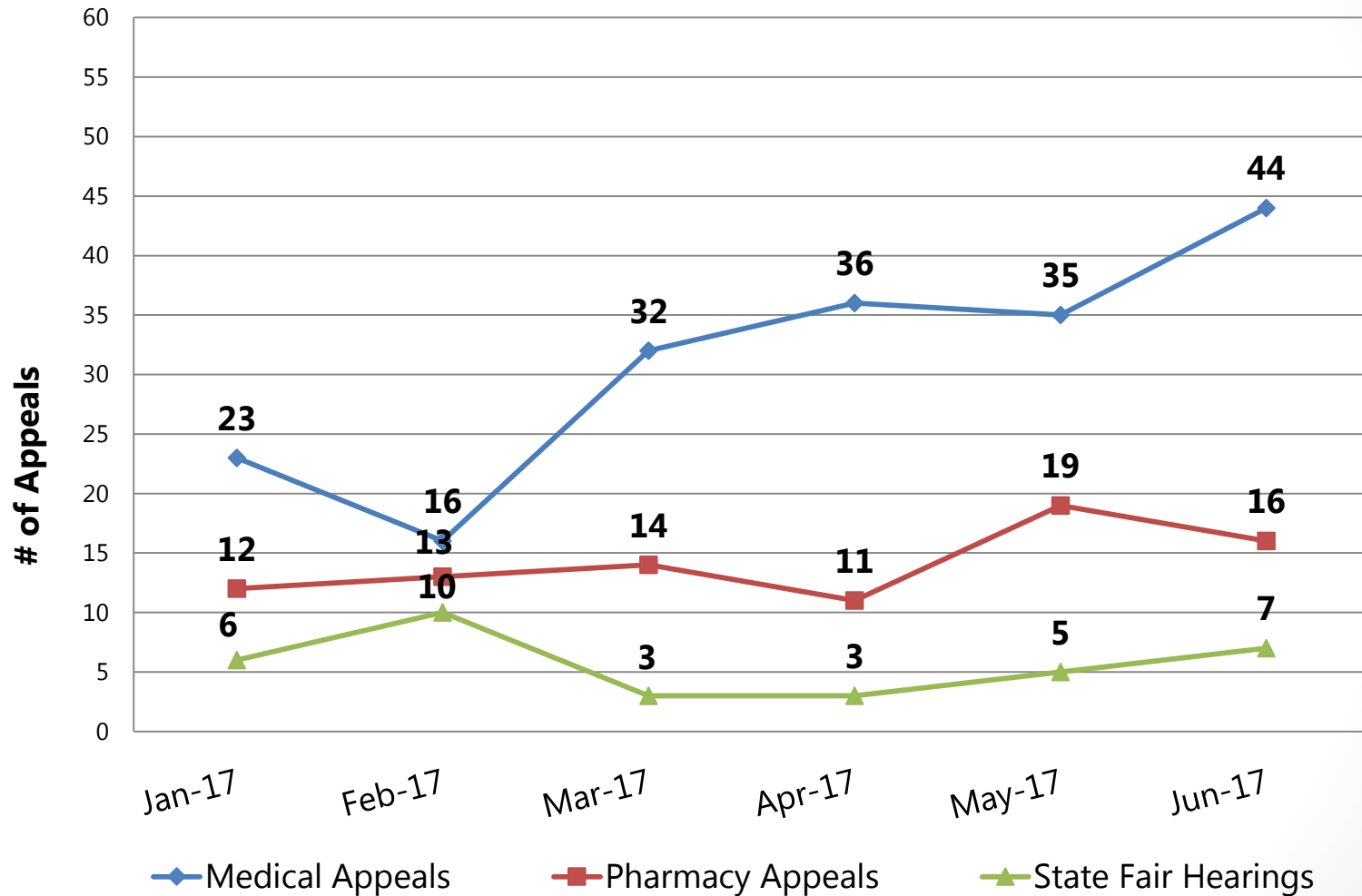
## Healthy Kids Membership by Network



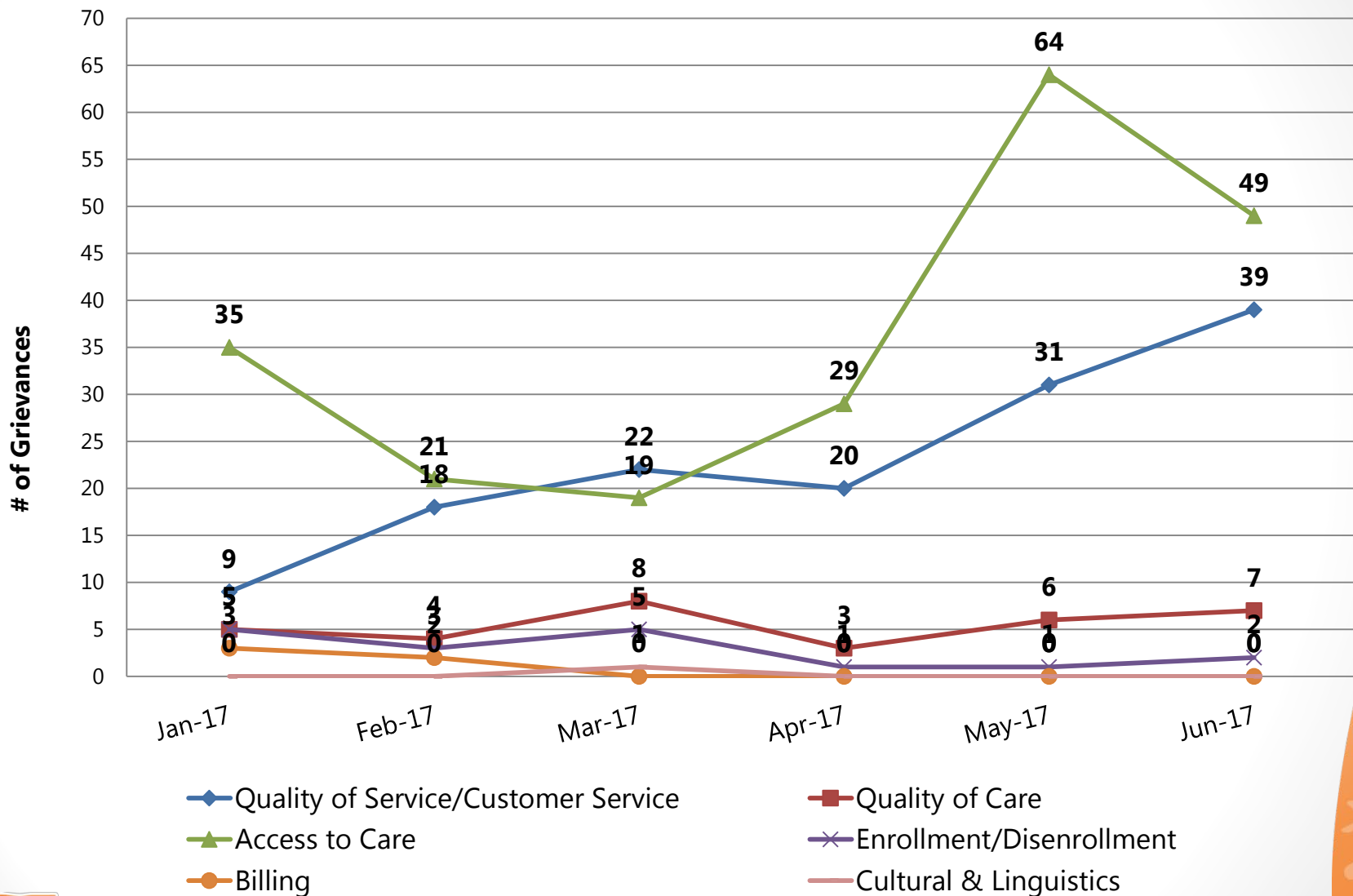
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8/9/2017

# Q1-Q2 2017: Medi-Cal Appeals



# Q1-Q2 2017: Medi-Cal Grievances



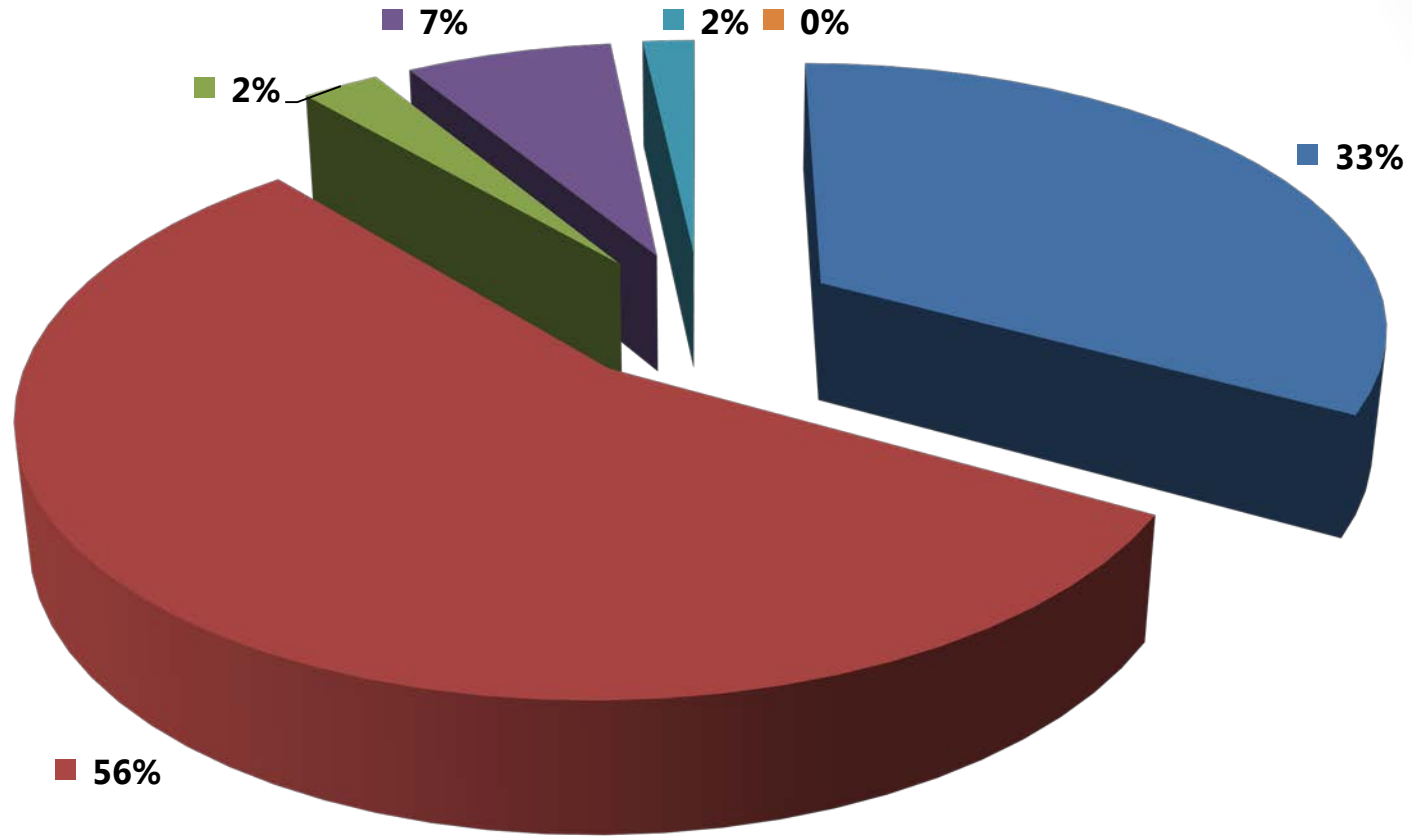
# Q1-Q2 2017: Medi-Cal Grievances

Grievances	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Quality of Service/ Customer Service	9	18	22	20	31	39
Quality of Care	5	4	8	3	6	7
Access to Care	35	21	19	29	64	49
Enrollment/Disenrollment	5	3	5	1	1	2
Plan Benefits	0	0	0	0	0	0
Billing	3	2	0	0	0	0
Marketing	0	0	0	0	0	0
Cultural & Linguistics	0	0	1	0	0	0
Other	0	0	0	0	0	0

**NOTE: Includes Exempt Grievances**



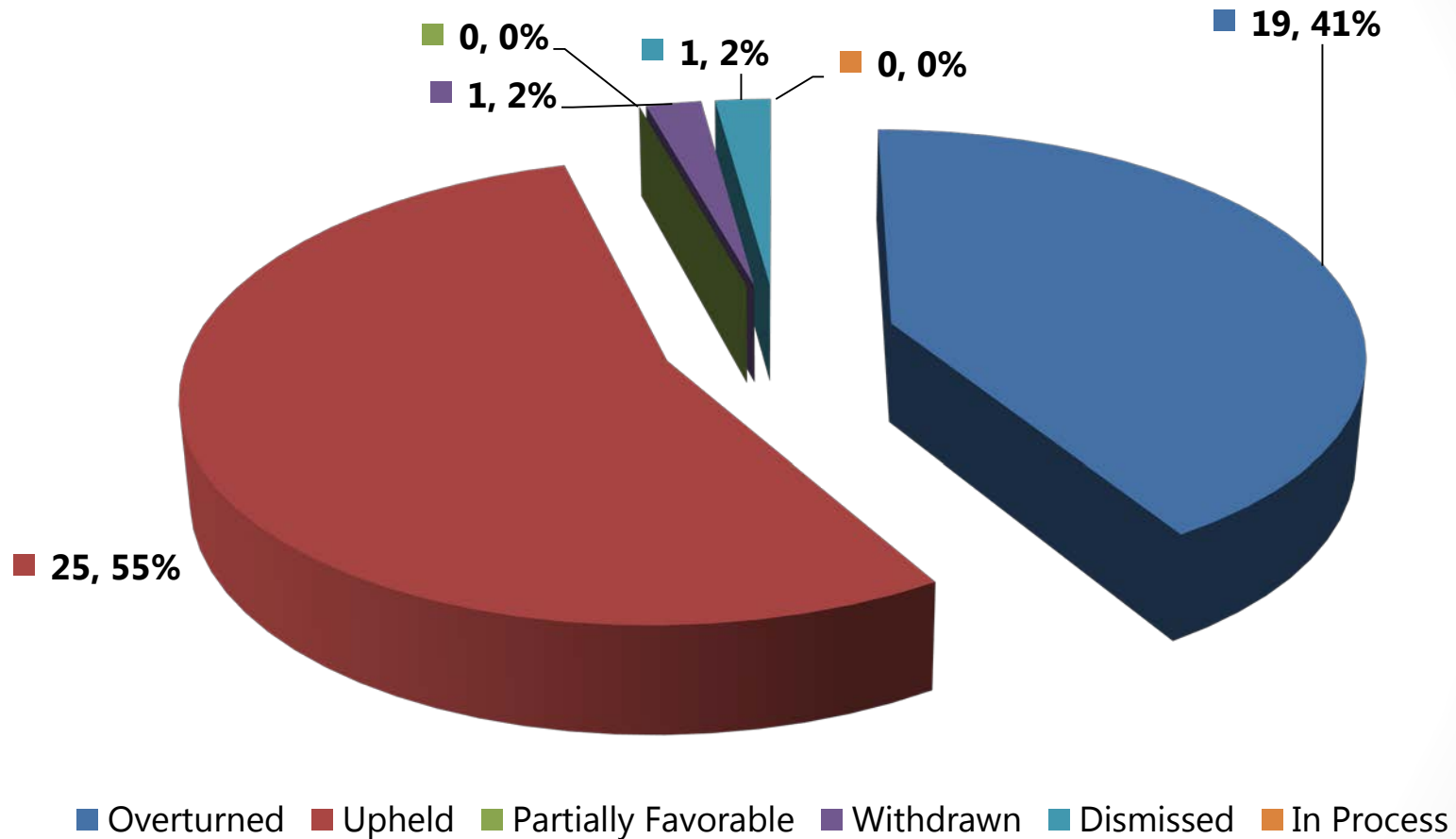
# Q2 2017 Medi-Cal Medical Appeals



■ Overturned ■ Upheld ■ Partially Favorable ■ Withdrawn ■ Dismissed ■ In Process



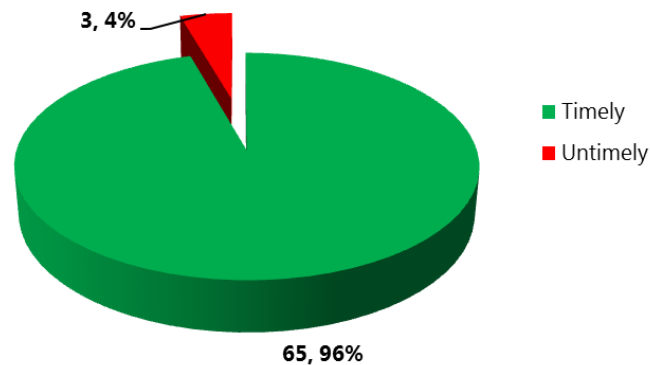
# Q2 2017 Medi-Cal Pharmacy Appeals



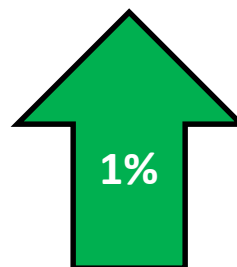
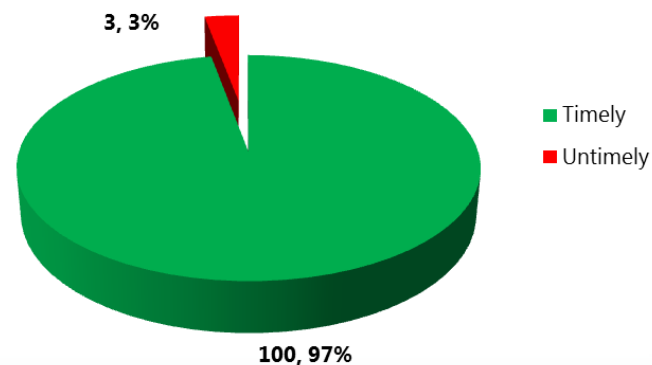
# Q1-Q2 2017: Medi-Cal Timeliness



**Q1 Medical Appeals Timeliness**  
Standard Requests



**Q2 Medical Appeals Timeliness**  
Standard Requests



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





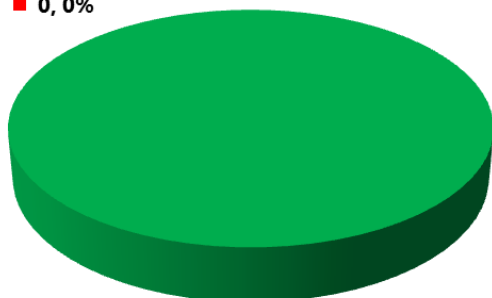
# Q1-Q2 2017: Medi-Cal Timeliness



## Q1 Medical Appeals Timeliness

Expedited Requests

■ 0, 0%



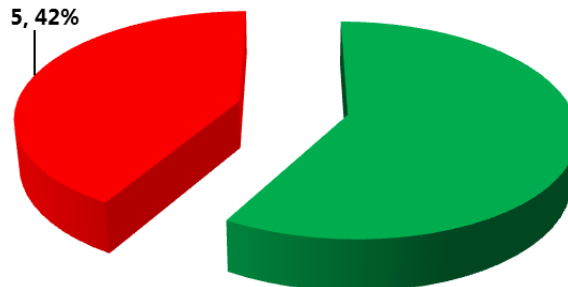
■ Timely  
■ Untimely

3, 100%

## Q2 Medical Appeals Timeliness

Expedited Requests

■ 5, 42%



■ Timely  
■ Untimely

7, 58%

42%

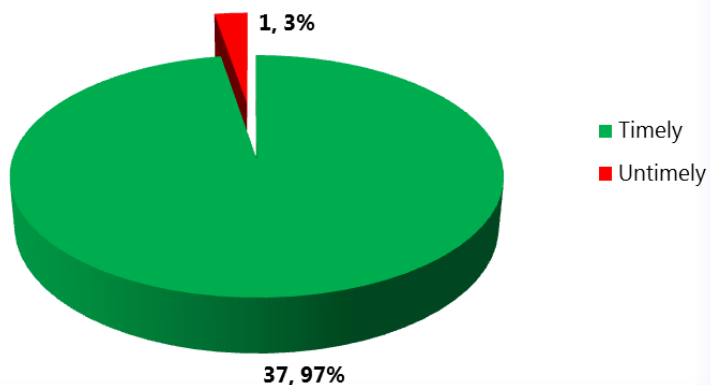
**STANDARD:** Within **3 working days** from the date that the appeal is received, or as quickly as the member's health condition requires.



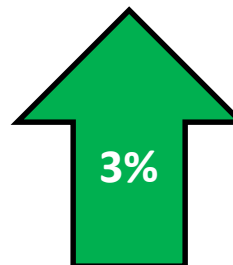
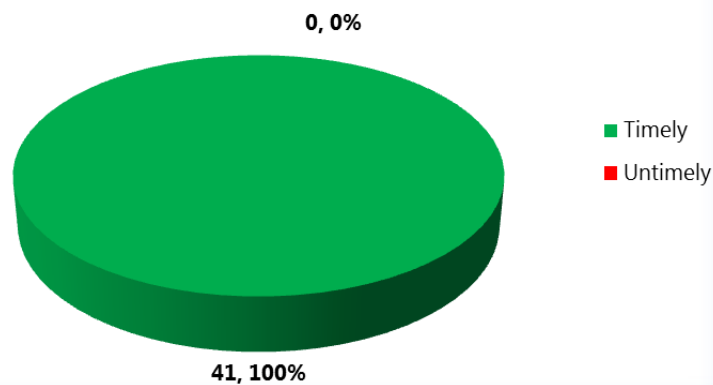
# Q1-Q2 2017: Medi-Cal Timeliness



**Q1 Pharmacy Appeals Timeliness**  
Standard Requests



**Q2 Pharmacy Appeals Timeliness**  
Standard Requests



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



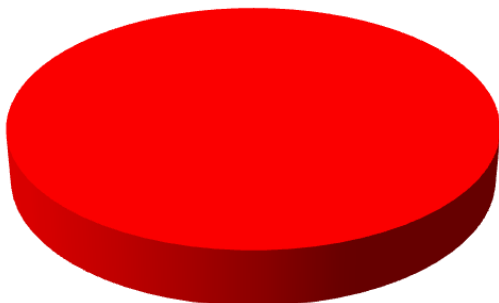
# Q1-Q2 2017: Medi-Cal Timeliness



## Q1 Pharmacy Appeals Timeliness

Expedited Requests

■ 0, 0%



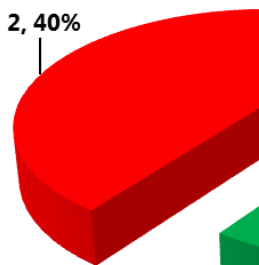
1, 100%

■ Timely  
■ Untimely

## Q2 Pharmacy Appeals Timeliness

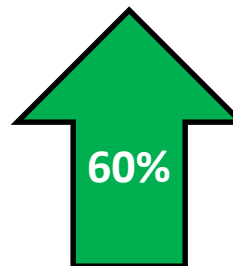
Expedited Requests

2, 40%



3, 60%

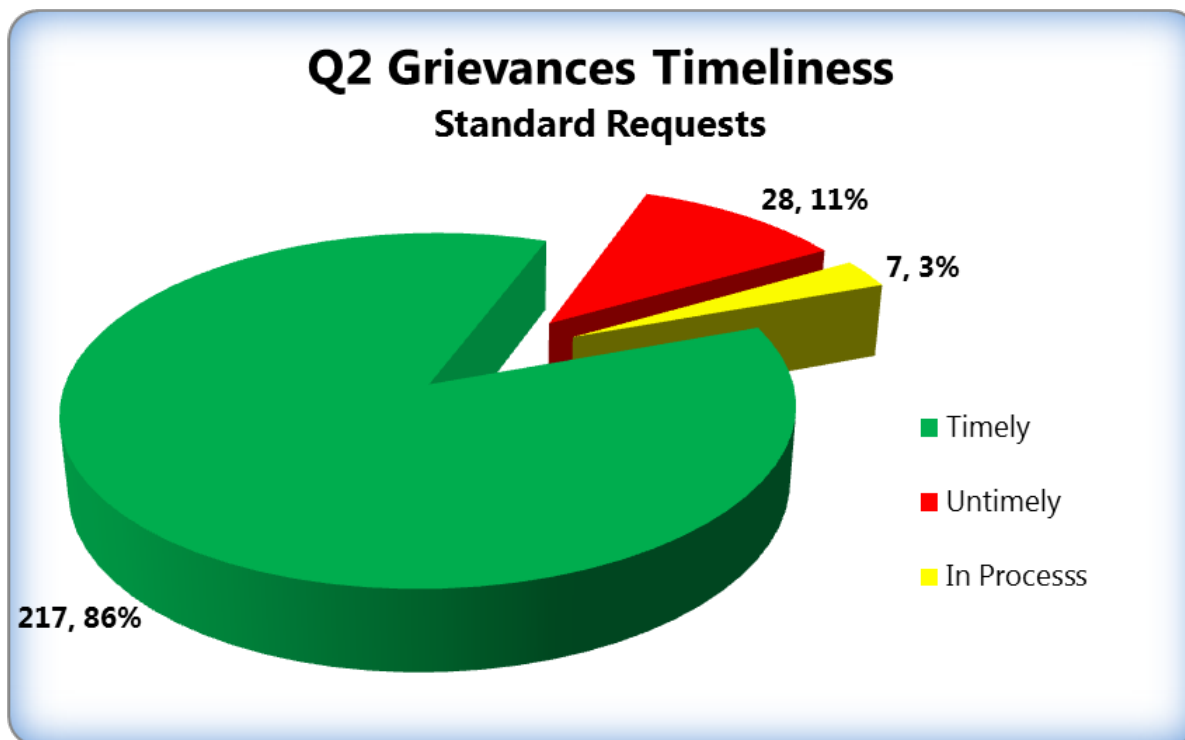
■ Timely  
■ Untimely



**STANDARD:** Within **3 working days** from the date that the appeal is received, or as quickly as the member's health condition requires.



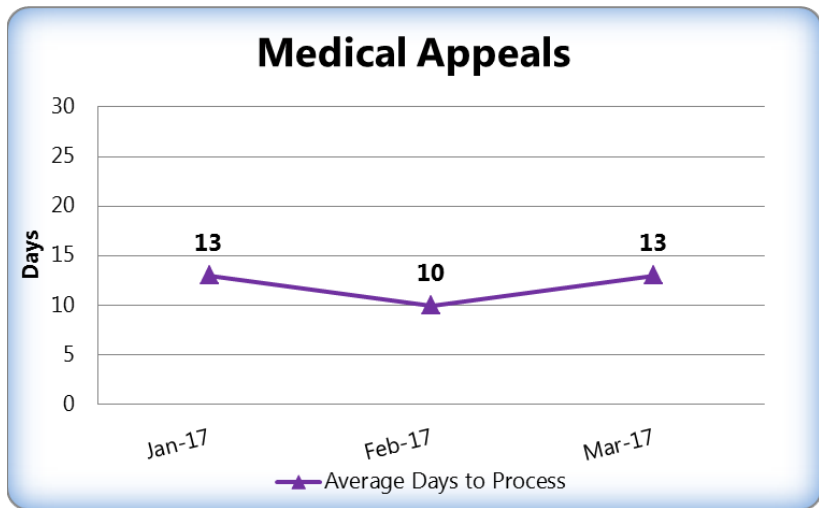
# Q2 2017: Medi-Cal Timeliness



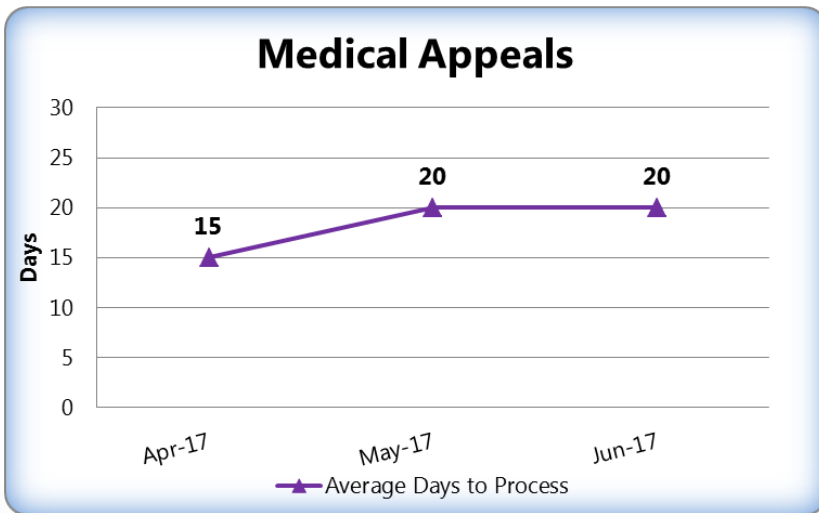
**STANDARD:** 30 calendar days or as quickly as the member's health condition requires.



# Medi-Cal Processing Days



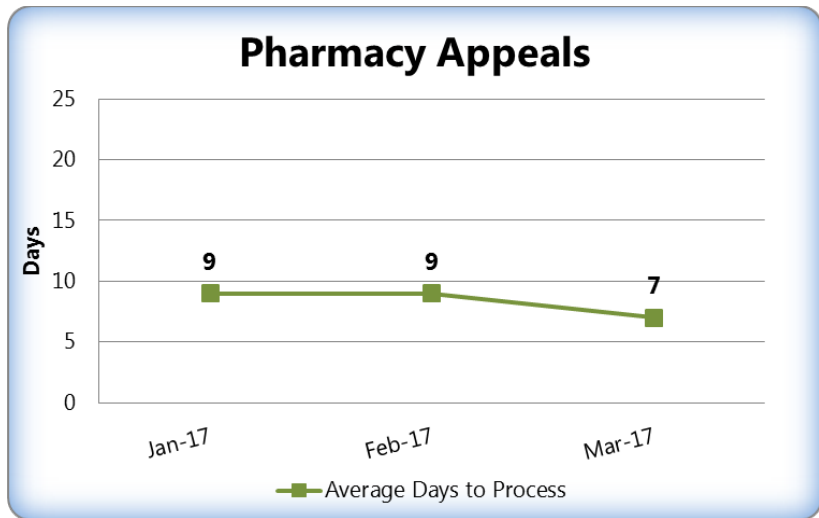
Q1 2017



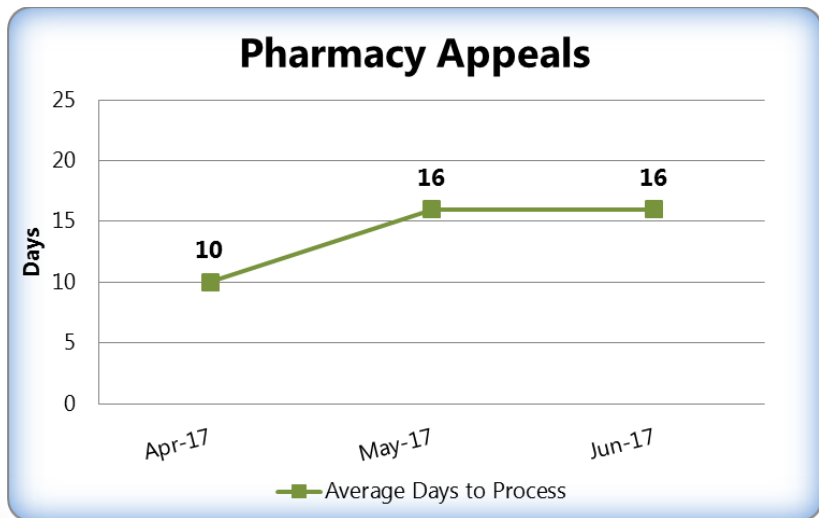
Q2 2017



# Medi-Cal Processing Days



Q1 2017



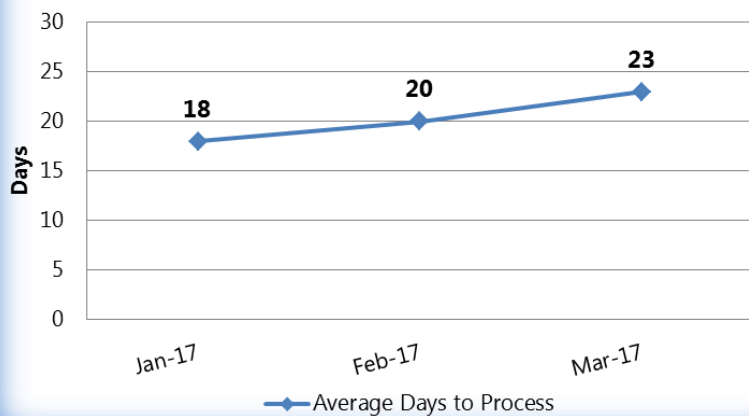
Q2 2017



# Medi-Cal Processing Days

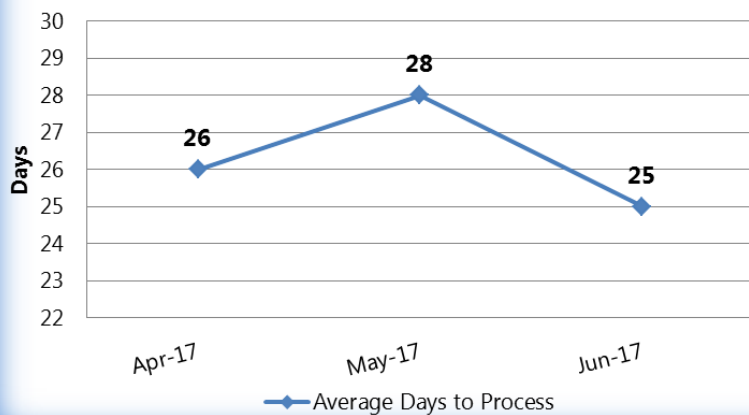


## Grievances



Q1 2017

## Grievances



Q2 2017



# Medi-Cal Rates per 1000

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Total Medical Appeals	23	16	32	36	35	44
Healthy Kids Membership	2,585	2,780	2,752	2,794	2,757	2,732
Medi-Cal Membership	268,008	268,360	267,437	267,199	265,711	265,649
TOTAL Membership	270,593	271,140	270,189	269,993	268,468	268,381
<b>Rate per 1000</b>	<b>0.086</b>	<b>0.060</b>	<b>0.120</b>	<b>0.135</b>	<b>0.132</b>	<b>0.166</b>

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Total Rx Appeals	12	13	14	11	19	16
Healthy Kids Membership	2,585	2,780	2,752	2,794	2,757	2,732
Medi-Cal Membership	268,008	268,360	267,437	267,199	265,711	265,649
TOTAL Membership	270,593	271,140	270,189	269,993	268,468	268,381
<b>Rate per 1000</b>	<b>0.045</b>	<b>0.048</b>	<b>0.052</b>	<b>0.041</b>	<b>0.072</b>	<b>0.060</b>

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
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# Cal Medi-Connect

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

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

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

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

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

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

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

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

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

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

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

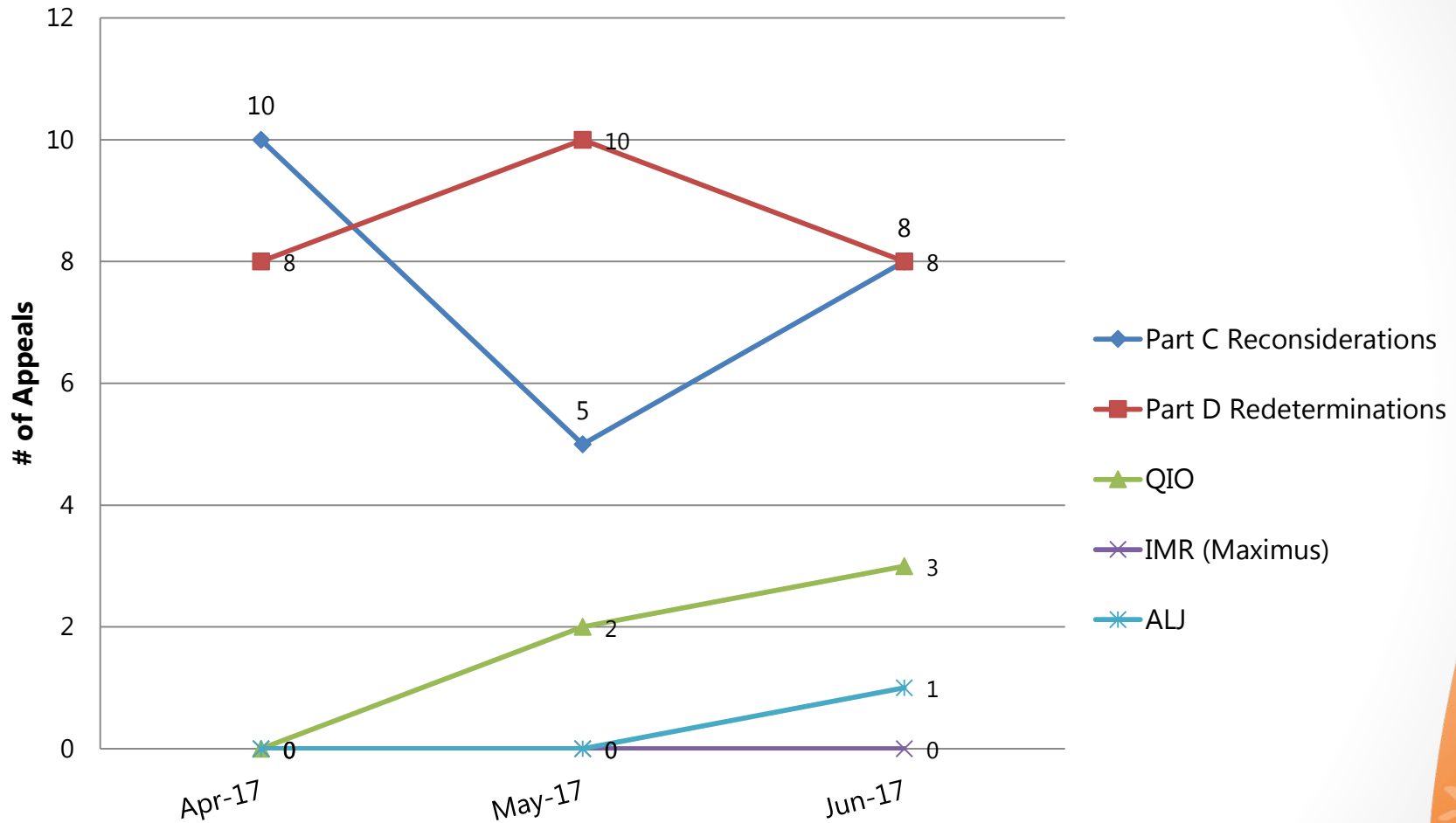
December						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30



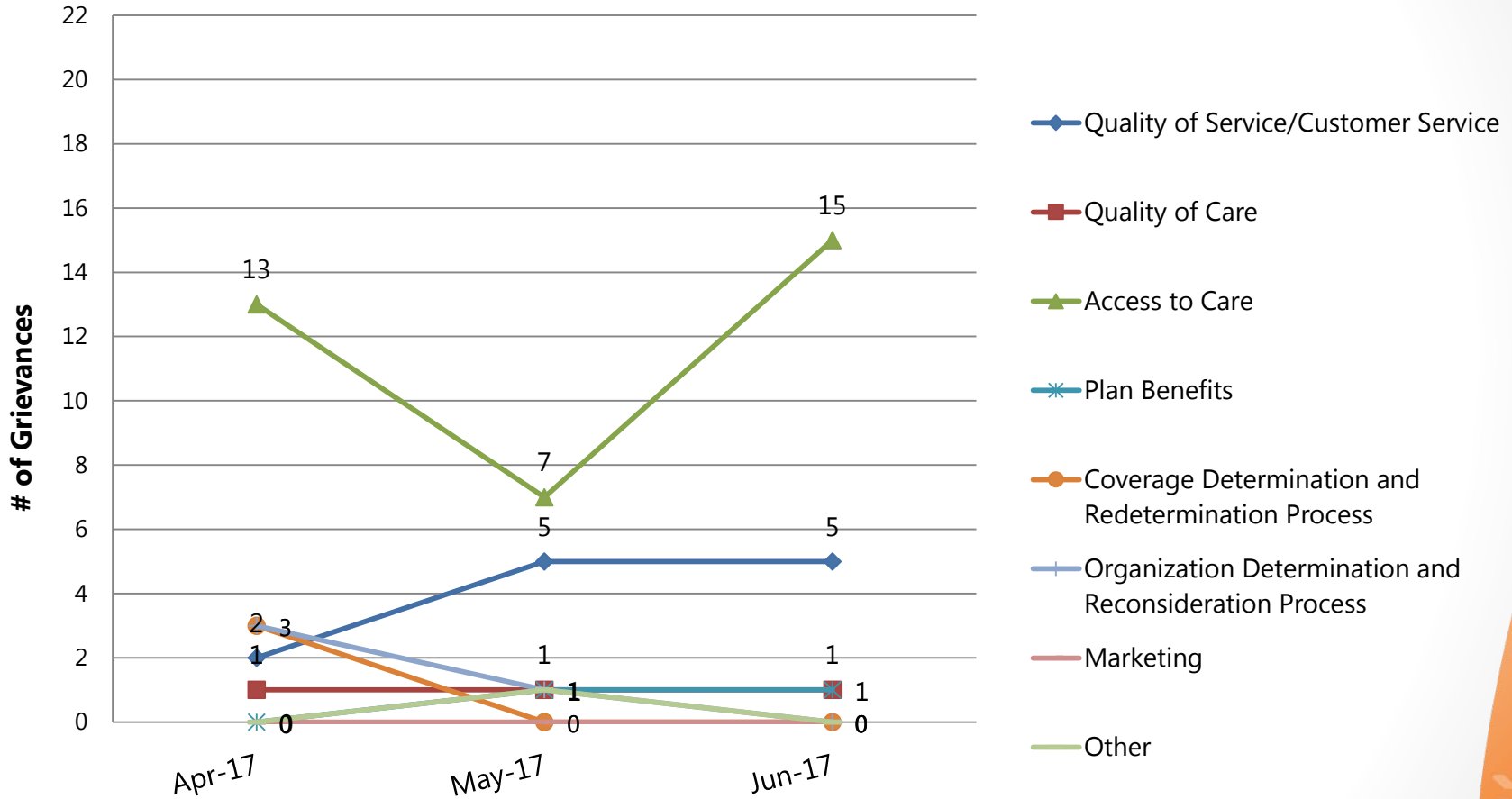
**Q2 2017**



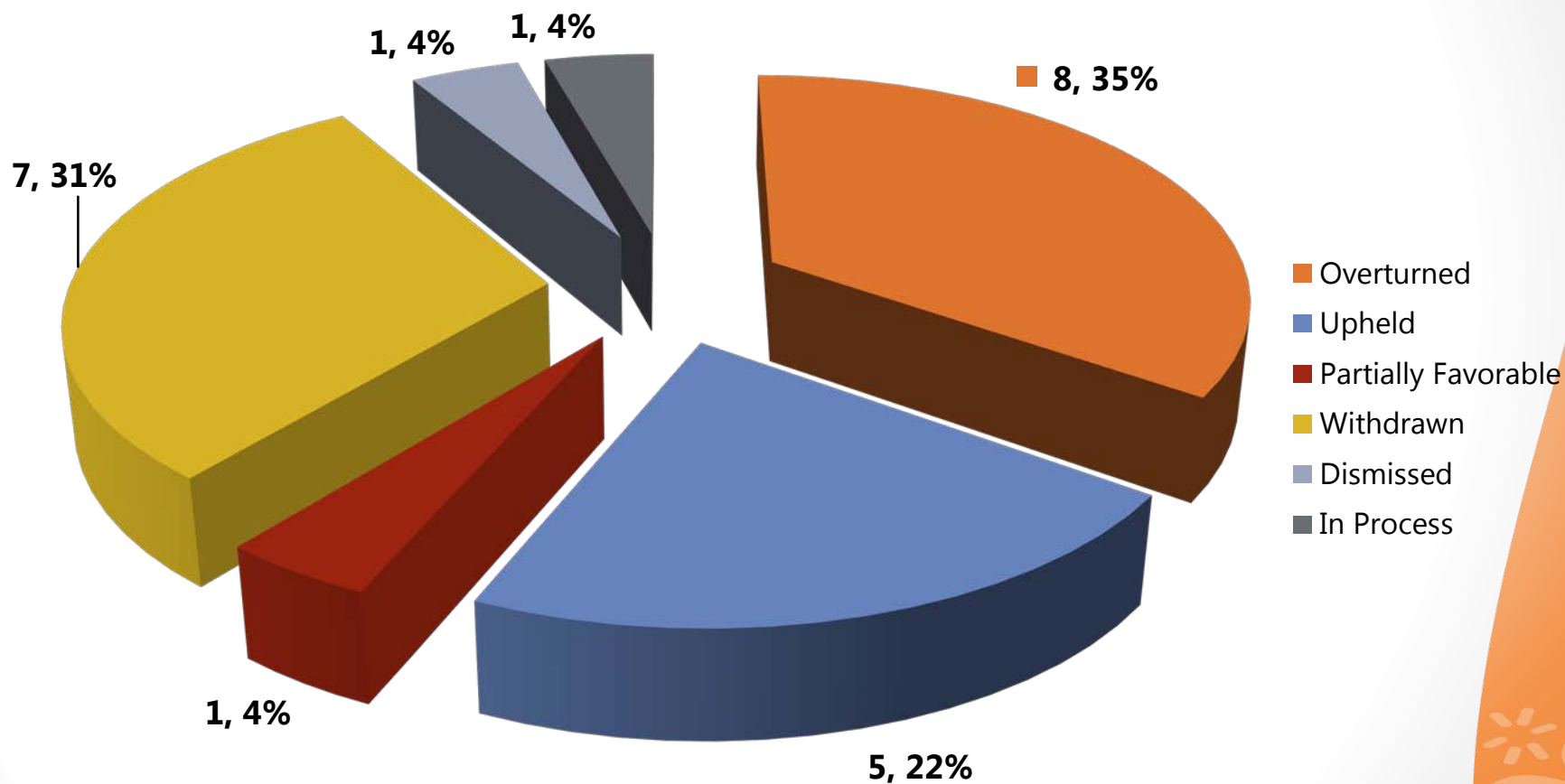
# Q2 2017: Part C&D Appeals



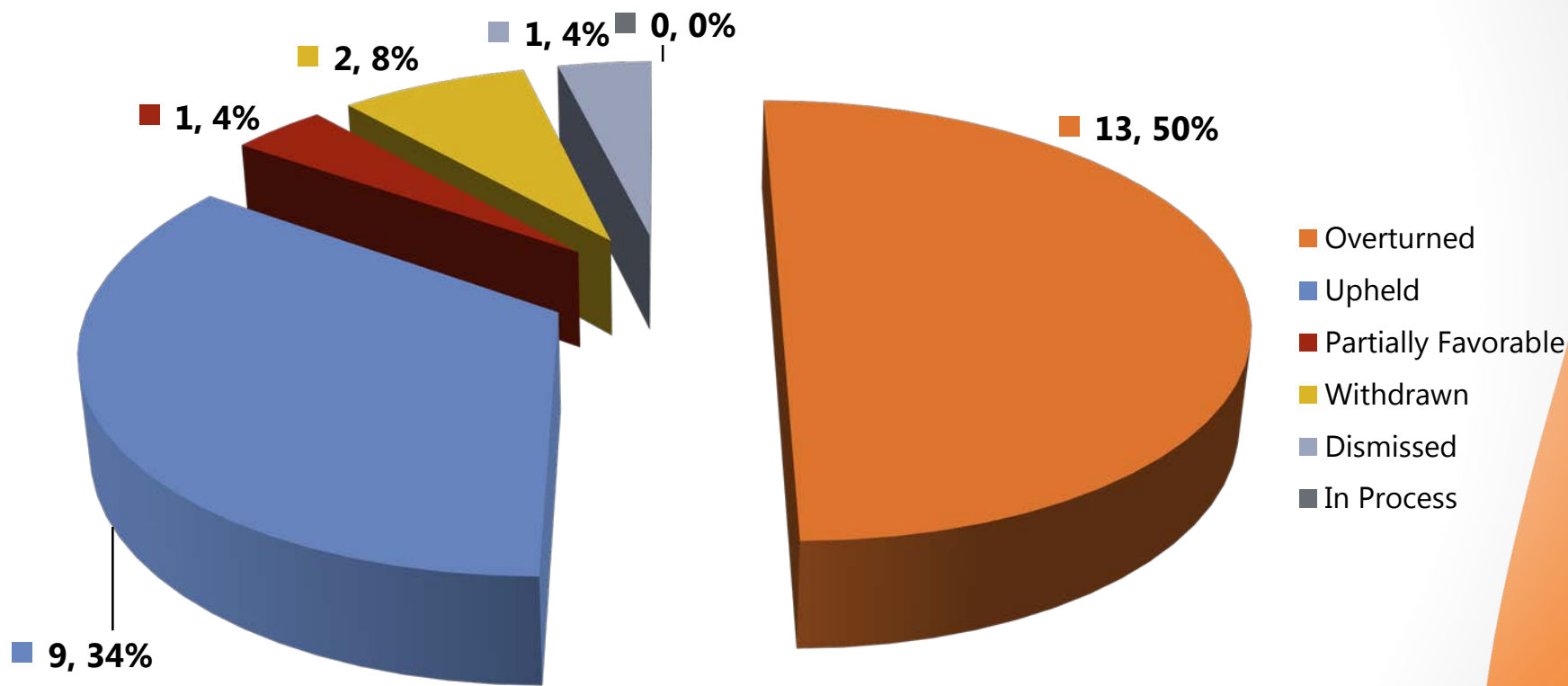
# Q2 2017: Part C&D Grievances



# CMC Part C Reconsiderations by Determination Q2 2017



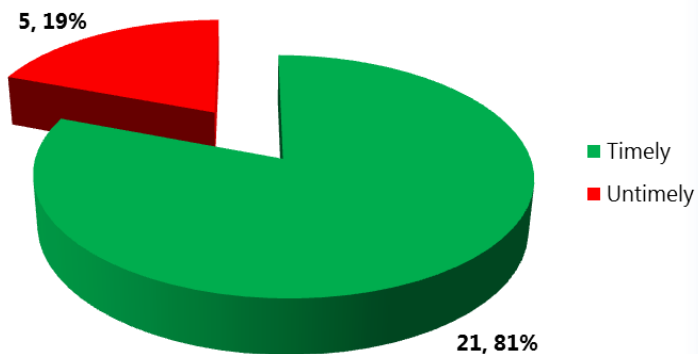
# CMC Part D Redeterminations by Determination Q2 2017



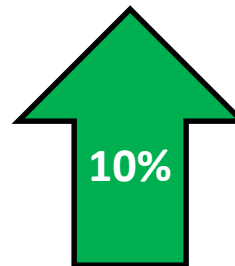
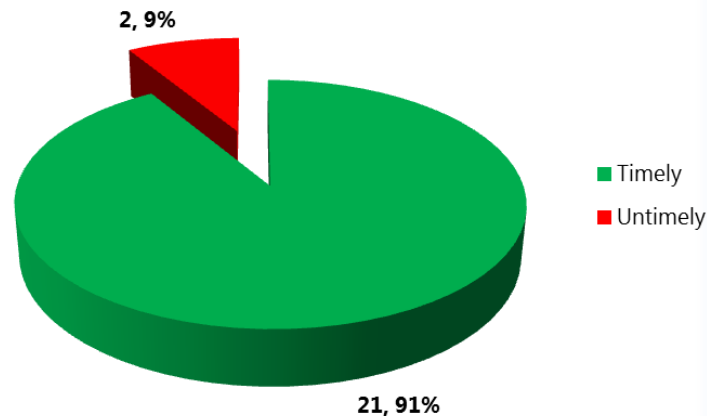
# Q1-Q2 2017: CMC Timeliness



**Q1 Part C Reconsiderations Timeliness**



**Q2 Part C Reconsiderations Timeliness**



**Standard Requests = 30 calendar days**  
**Expedited Requests = 7 calendar days**

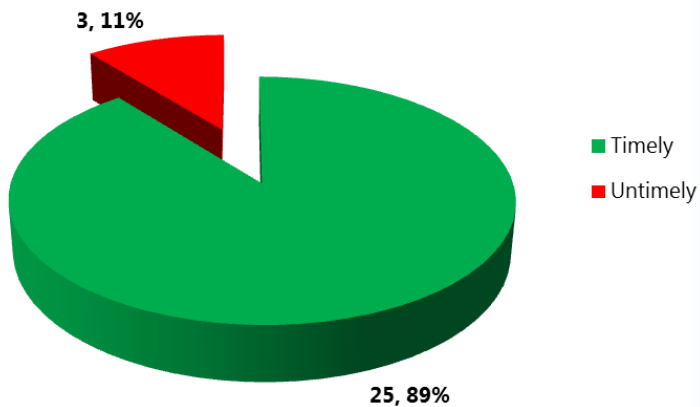


# Q1-Q2 2017: CMC Timeliness



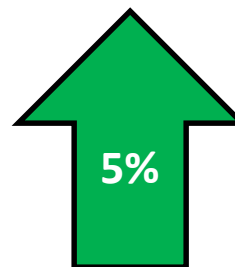
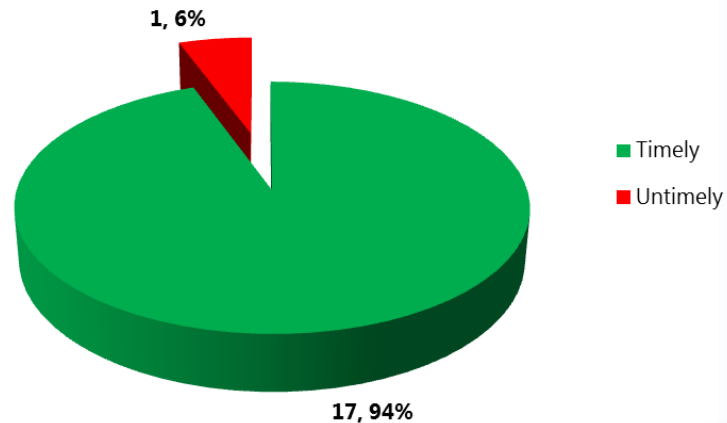
### Q1 Part D Redeterminations Timeliness

Standard



### Q2 Part D Redeterminations Timeliness

Standard



Standard Requests = 7 calendar days

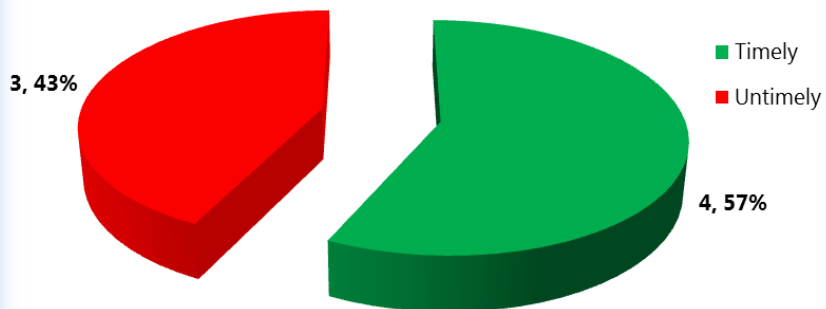


# Q1-Q2 2017: CMC Timeliness



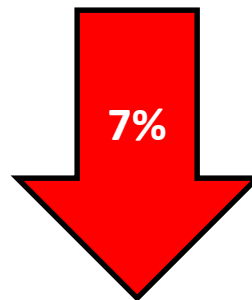
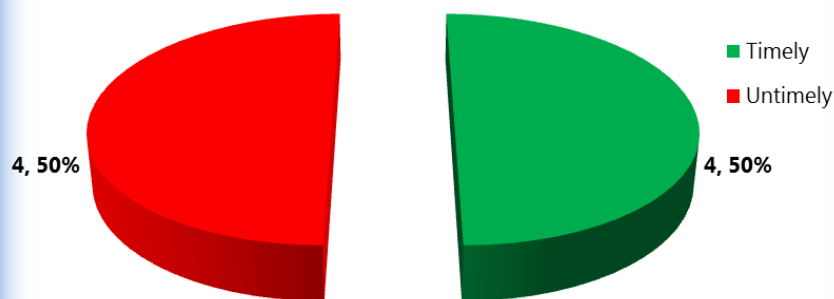
### Q1 Part D Redeterminations Timeliness

Expedited



### Q2 Part D Redeterminations Timeliness

Expedited

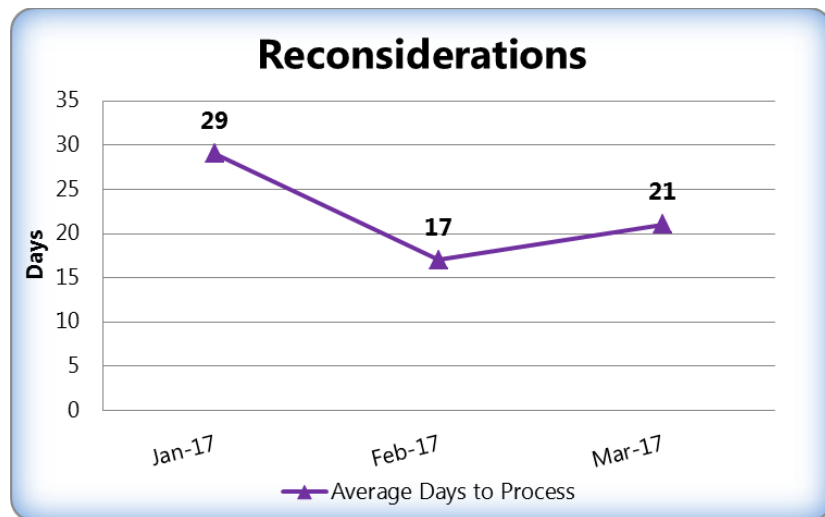


Expedited Requests = 72 hours

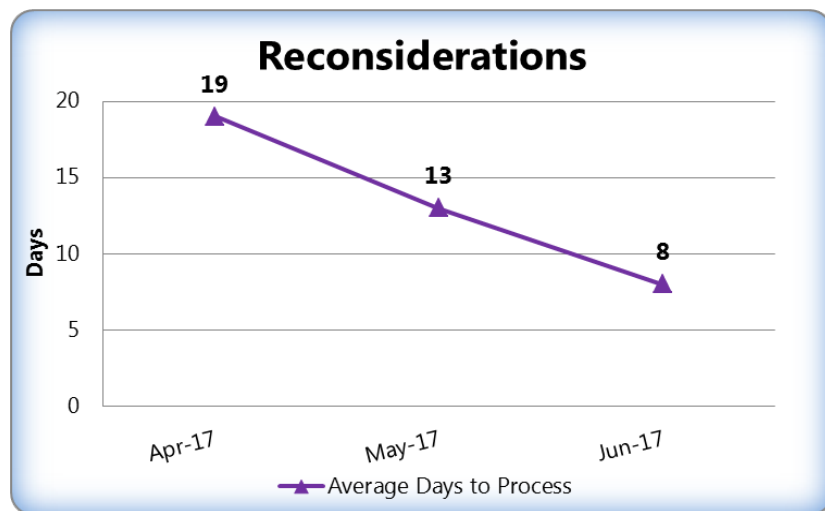




# CMC Processing Days



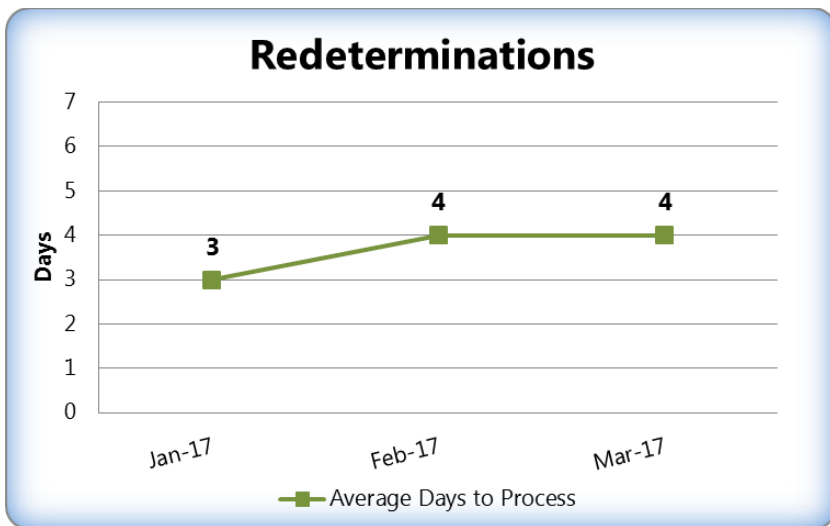
Q1 2017



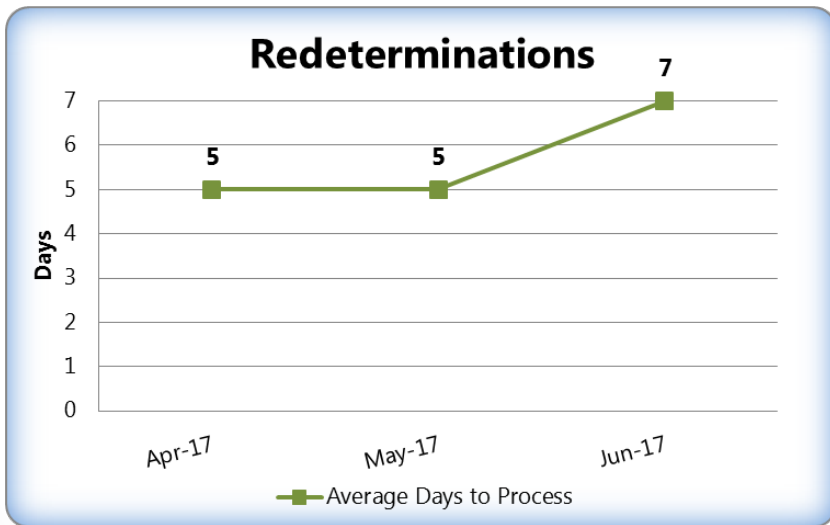
Q2 2017



# CMC Processing Days



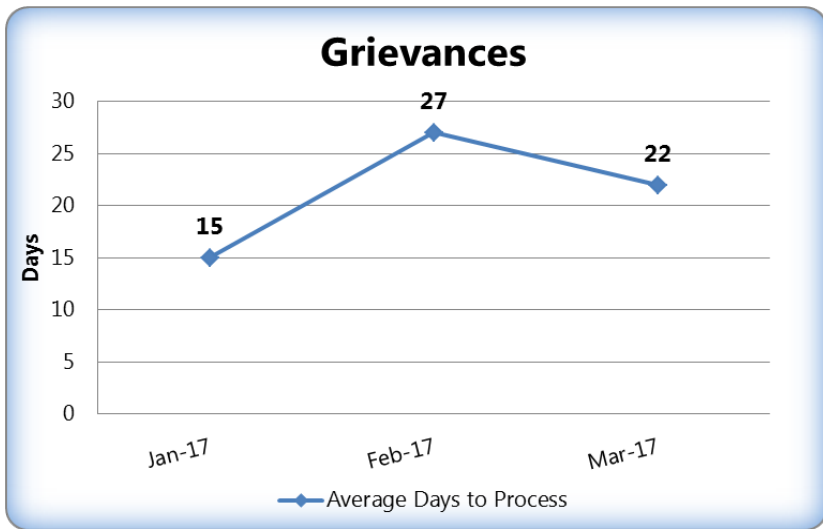
Q1 2017



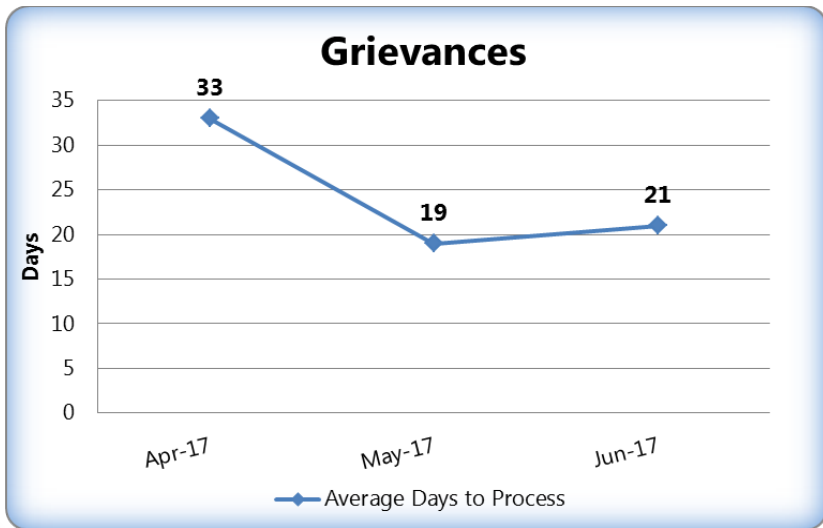
Q2 2017



# CMC Processing Days



Q1 2017



Q2 2017



# Cal Medi-Connect Rates per 1000

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
<i>Total Appeals</i>	21	29	21	18	15	16
<i>CMC Membership</i>	7,527	7,598	7,622	7,567	7,545	7,543
<b><i>Rate per 1000</i></b>	<b>2.790</b>	<b>3.817</b>	<b>2.755</b>	<b>2.379</b>	<b>1.988</b>	<b>2.121</b>

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
<i>Total Grievances</i>	39	27	31	22	16	22
<i>CMC Membership</i>	7,527	7,598	7,622	7,567	7,545	7,543
<b><i>Rate per 1000</i></b>	<b>5.181</b>	<b>3.554</b>	<b>4.067</b>	<b>2.907</b>	<b>2.121</b>	<b>2.917</b>



QUALITY IMPROVEMENT  
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity:

Monitoring or Meeting Period:

Credentialing Committee

June 7, 2017

**Areas of Review or Committee Activity**

Credentialing of new applicants and recredentialing of existing network practitioners

**Findings and Analysis**

<b>Initial Credentialing (excludes delegated practitioners)</b>		
Number initial practitioners credentialed	26	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
<b>Recredentialing</b>		
Number practitioners due to be recredentialled	2	
Number practitioners recredentialled within 36-month timeline	2	
% recredentialled 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%
<b>Terminated/Rejected/Suspended/Denied</b>		
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 3/31/17	225	

	Stanford	LPCH	NT 20	NT 40	NT 50	NT 60
<b>Total # of Initial Creds</b>	25	11	25	53	14	1
<b>Total # of Recreds</b>	265	149	55	121	40	22
<b>(For Quality of Care ONLY)</b>	<b>Stanford</b>	<b>LPCH</b>	<b>NT 20</b>	<b>NT 40</b>	<b>NT 50</b>	<b>NT 60</b>
<b>Total # of Suspension</b>	0	0	0	0	0	0
<b>Total # of Terminations</b>	0	0	0	0	0	0
<b>Total # of Resignations</b>	0	0	0	0	0	0
<b>Total # of practitioners</b>	1212	677	866	771	456	131

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  
Pharmaceutical and Therapeutics Committee  
March 16, 2017**

<b>Voting Committee Members</b>	<b>Specialty</b>	<b>Present Y or N</b>
Jimmy Lin, MD	Internist	Y
Hao Bui, BS, PharmD	Walgreens	N
Minh Thai, MD	Family Practice	Y
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	N
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, Pharm D	SCVMC Pharmacy Director	N
Ali Alkoraishi, MD	Psychiatry	N
Johanna Liu, PharmD	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

<b>Non-Voting Staff Members</b>	<b>Title</b>	<b>Present Y or N</b>
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	N
Christine Tomcala	Chief Executive Officer	N
Tami Otomo, PharmD	Clinical Pharmacist	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Dang Huynh, PharmD	Pharmacy Manager	Y

<b>Item</b>	<b>Discussion</b>	<b>Follow-Up Action</b>
<b>I.</b>	<p>The meeting convened at 6:17 PM.</p> <p><b>REVIEW, REVISE, AND APPROVE MEETING MINUTES of December 15, 2016.</b> The minutes were reviewed by Committee as submitted.</p>	<p>Upon motion duly made and seconded, the P&amp;T Committee minutes of <b>December 15, 2016</b> were approved as submitted and will be forwarded to the QI Committee and Board of Directors.</p>
<b>II.</b>	<p><b>REPORTS</b></p> <p><b>a. Health Plan Updates &amp; Membership</b> Dr. Robertson shared that total membership is currently down to 277,914 members – 270,292 Medi-Cal/Healthy Kids members and 7,622 Cal MediConnect members.</p>	

**Santa Clara Family Health Plan  
Pharmaceutical and Therapeutics Committee  
March 16, 2017**

Item	Discussion	Follow-Up Action
	<p>Unsure about how planned repeal of the Affordable Care Act will impact SCFHP's future membership. Although the CMC demonstration project is supposed to be done at the end of this year, there is a possibility that it may be continued. If the governor decides to stop funding CMC, SCFHP's contingency plan is to implement a dual eligible special needs plan (D-SNP) so members will not lose coverage. SCFHP has already submitted a D-SNP application to prepare for this outcome.</p> <p><b>b. Pharmacy Dashboard</b> Dr. Otomo presented the Pharmacy Dashboard for Medi-Cal and CMC. For Medi-Cal, PA volume has been steady over the last four months. Above 95% turnaround time for both urgent and standard PAs. For CMC, a few PAs were forwarded to independent review entity (IRE) in the last 4 months. Continue to conduct oversight of CMC PAs. Recently submitted PAs for MedImpact to research timeliness and/or appropriateness of clinical review. Will update the pharmacy dashboard once MedImpact provides responses on those PAs.</p> <p><b>c. Appeals and Grievances</b> Dr. Liu presented the Appeals and Grievances report. Steady number of CMC appeals in the last quarter. For the total number of CMC appeals per thousand members, this was slightly higher in November, but starting to decrease. Dr. Parashar-Rokicki inquired about the reason for the high number of CMC appeals in August 2016. Dr. Liu answered that there was nothing significant during that month; there was a high number of appeals for high-risk medications (HRM). For CMC grievances, coverage determinations and redeterminations make up a small amount of overall grievances at SCFHP. Zolpidem had the highest number of CMC appeals in the last 6 months. For Medi-Cal, will bring more robust reporting at the next P&amp;T meeting.</p> <p><b>d. Emergency Rx Access Monitoring</b> Dr. Huynh presented the Emergency Prescription Access Report. This report was created to address the requirement per the 2016 DHCS Audit CAP. SCFHP had a total of 30,820 ER visits in 3Q16. The top diagnosis with a prescription filled within 72 hours of the ER visit date was urinary tract infection (UTI). Also analyzed service providers where the ER visit for UTI did not have a prescription filled within 72 hours; Regional Medical Center of San Jose and Kaiser San Jose topped the list. Open</p>	



**Santa Clara Family Health Plan  
Pharmaceutical and Therapeutics Committee  
March 16, 2017**

Item	Discussion	Follow-Up Action
	<p>pharmacies should not be a barrier to access since there are seven 24-hour network pharmacies within Santa Clara County and the majority of retail chain pharmacies are open until 9 PM. Overall, there was a minimal shift between 2Q16 and 3Q16 findings. In the future, SCFHP will focus specifically on the diagnosis of UTI, since this is diagnosis that patients typically receive a prescription for. Will look to present this data at network joint operation committee (JOC) meetings. Dr. Robertson also wants to investigate members who did not get a prescription following an ER visit for UTI so that Dr. Liu can report them as PQI referrals.</p>	
<p><b>III.</b></p>	<p><b>OLD BUSINESS</b></p> <p><b>a. OTC Cough and Cold</b></p> <p>Dr. Huynh revisited this discussion from last P&amp;T meeting. In 2011, CA law was passed to eliminate OTC cough and cold medications as a covered pharmacy benefit. This law went into effect in 2012. DHCS specifically called out products containing guaifenesin and dextromethorphan. Utilization over the last year showed total of 7,148 members, prescription count of 11,428, and plan paid amount of \$59,067. Dr. Huynh discussed with SCFHP chief officers to determine if the plan could pay for these medications despite not getting reimbursed by the state. It was determined that there is an opportunity to pay for these medications as long as it makes sense for members and is clinically appropriate. SCFHP added guaifenesin products back to formulary and retrodated the change to 11/1/16. Guaifenesin/dextromethorphan combo can be approved for requested length of therapy through PA, if medically necessary. The committee requested to consider adding guaifenesin/dextromethorphan back to formulary.</p>	<p>Motion to add guaifenesin/dextromethorphan products for &gt;12 years old with quantity limit and without prior authorization. Motion made, seconded and approved.</p>
<p><b>IV.</b></p>	<p><b>NEW BUSINESS</b></p> <p><b>a. Policies Annual Review</b></p> <p>Dr. Liu shared that the internal annual review of Pharmacy Department policies has been completed. Policy PH08 ‘Pain Management Drugs for Terminally Ill’ needed to be revised to add a statement saying that if SCFHP fails to make a determination for a terminally ill member within 72 hours of receipt, the treatment should be deemed authorized. This is a direct requirement from the DMHC Rx TAG. Proposed to accept all pharmacy policies with the revision to PH08.</p>	<p>Upon motion duly made and seconded, all pharmacy policies were approved as presented.</p>

**Santa Clara Family Health Plan  
Pharmaceutical and Therapeutics Committee  
March 16, 2017**

Item	Discussion	Follow-Up Action
	<p><b>b. Formulary Modifications</b> Dr. Otomo presented the formulary changes since the last P&amp;T meeting. Notable changes included removal of authorized generics of EpiPen manufactured by Lineage, addition of guaifenesin products to formulary, and addition of step therapy to Renagel to look for history of calcium acetate.</p> <p><b>c. PA Guideline Review Project</b> Dr. Otomo presented the following PA criteria for approval by the committee:</p> <ul style="list-style-type: none"> <li>- Diabetic Supplies (Test Strips &amp; Lancets)</li> <li>- Quantity Limit/Dose Consolidation for Formulary Drugs</li> <li>- Pain Medications for Terminally Ill</li> <li>- Non-formulary Oral Liquids</li> <li>- Reauthorization (updated)</li> <li>- Temodar (temozolomide)</li> <li>- Cotellic (cobimetinib)</li> <li>- Farydak (panobinostat)</li> <li>- Odomzo (sonidegib)</li> </ul> <p><b>d. MedImpact P&amp;T Minutes</b> Dr. Liu and Dr. Huynh reviewed the MedImpact 4Q16 P&amp;T Minutes and the MedImpact 1Q17 P&amp;T Actions and approved as written.</p> <p><b>e. New Drugs/Review</b></p> <ul style="list-style-type: none"> <li>- Siliq – Informational only</li> <li>- Trulance – Informational only</li> </ul> <p><b>f. Class Reviews</b> Dr. McCarty presented the following drug class reviews and updates:</p> <ul style="list-style-type: none"> <li>- Atopic dermatitis – Two new drugs: Eucrisa and Dupixent. No recommended action.</li> <li>- Multiple sclerosis – Informational only</li> <li>- Topical acne/rosacea agents – Informational only</li> <li>- Epoetin alfa – Main difference between Epogen and Procrit is that Procrit is supplied in a 40,000 unit vial. Proposed removing Procrit from formulary.</li> </ul>	<p>Upon motion duly made and seconded, formulary modifications were approved as presented.</p> <p>Upon motion duly made and seconded, prior authorization criteria were approved as presented.</p> <p>Upon motion duly made and seconded, MedImpact P&amp;T minutes were approved as presented.</p> <p>Upon motion duly made and seconded, all recommendations were approved as presented.</p>

**Santa Clara Family Health Plan  
Pharmaceutical and Therapeutics Committee  
March 16, 2017**

Item	Discussion	Follow-Up Action
	<ul style="list-style-type: none"> <li>- DPP-IV inhibitors – Alogliptin is the newest drug in this class and the only DPP-IV inhibitor available as generic. Proposed adding alogliptin and alogliptin/metformin to formulary with QL and same ST as Januvia and Janumet (history of metformin and another oral antihyperglycemic or GLP-1 agonist).</li> <li>- Endothelin receptor antagonists – All three agents in this class have REMS. Most utilization in Letairis. Proposed adding Letairis to formulary with QL and PA.</li> </ul> <p><b>g. 4Q2016 Drug Trend and Utilization Review</b> Dr. McCarty presented the 4Q2016 drug trend and utilization review. There has been a shift in utilization of Hepatitis C agents to the preferred agents, Eplclusa and Zepatier. Not much change in the Medi-Cal top drug categories; diabetes continued to be the top spend. For CMC, the top spend was viral agents. Spend on diabetic supplies increased. Will investigate overutilization of diabetic supplies in CMC.</p> <p><b>h. Medi-Cal Formulary Drug Updates</b> Dr. McCarty presented the Medi-Cal formulary drug updates. In December, the state added age limits to behavioral health drugs. Some of these drugs are carved out for SCFHP, but others are on formulary without age limits. No recommended action at this time, but will look into the impact of implementing age limits.</p> <p>Quorum was lost at 7:46pm. Need to take proposed action on olaratumab to next P&amp;T meeting.</p> <p><b>i. Generic Pipeline</b> Informational only</p>	<p>Investigate overutilization of diabetic supplies in CMC line of business.</p> <p>Analyze impact of implementing age limits on formulary behavioral health drugs</p> <p>Take olaratumab proposed action to 2Q17 P&amp;T meeting</p>
<b>V.</b>	<b>ADJOURNMENT</b> – The meeting was adjourned at 7:48pm	



**MINUTES**  
**UTILIZATION MANAGEMENT COMMITTEE**  
**April 19, 2017**

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

<b>Non-Voting Staff Members</b>	<b>Title</b>	<b>Present Y or N</b>
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Sherry Holm	Behavioral Health Manager	Y
Lori Andersen	MLTSS Director	Y
Caroline Alexander	Administrative Assistant	N

<b>ITEM</b>	<b>DISCUSSION</b>	<b>ACTION REQUIRED</b>
<b>I. Introductions Review/Revision/Approval of Minutes</b>	<p>Meeting was started with a Quorum at 6:05 PM.</p> <p>There was a motion to approve the January 18, 2017 minutes by Ali Alkoraishi, MD and second by Dung Van Cai, MD.</p> <p>There was a motion to approve March 22, 2017 minutes by Jeff Robertson, MD, CMO and seconded by Habib Tobaggi, MD.</p>	Minutes approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
<p><b>II. CEO Update</b></p>	<p>Christine Tomcala , CEO discussed the following items:</p> <ol style="list-style-type: none"> <li>1. ACA: or Affordable Care Act: currently repeal and replace is uncertain and California is still are at risk of ACA repeal and replace. No one really has the answer.</li> <li>2. IHSS: payment for services and service decisions will go back to the Santa Clara County system. And the California May budget revise will be clearer on the fiscal impacts.</li> <li>3. Whole Person Care: SCFHP participated with the county on a second round of applications. The application passed the first hurdle. The primary goal is to help members that can leave LTC and transition to either home or stable housing.</li> <li>4. DHCS had an annual site visit and audit over the last two weeks. The auditors did an exit conference and SCFHP did very well. The emphasis on compliance and development to P&amp;P's and staff changes has shifted audit compliance positively. The auditors could see the progress and good work. We expect some findings and will share them when they are available.</li> <li>5. SCFHP is in the middle of implementing QNXT for Medi-Cal LOB. Effective date 7/1/2017.</li> </ol>	<p>None.</p>
<p><b>III. Old Business</b></p>	<p>HEDIS 2017: Dr. Boris shared the committees requested follow up on the: Specifications for HEDIS for CV Monitoring for people with Cardiovascular Disease and Schizophrenia. The HEDIS specs are provided in the packet and the bullet points were reviewed.</p> <p>Dr. Alkoraishi noted that only Cholesterol lab completion is looked at and the levels are not part of the HEDIS review.</p>	<p>Committee appreciated the follow up.</p>
<p><b>IV. Action Items</b></p>	<ol style="list-style-type: none"> <li>a. Ms. Castillo Manager UM presented the 2017 UM Work plan: Ms. Castillo reviewed the UM Work plan in detail. SCFHP has 24 areas of monitoring for UM activities. The CAHPS and provider satisfaction were removed from the UMC work plan for 2017 as they are reviewed in the QIC.</li> <li>b. Ms. Castillo UM Manager presented the 2016 UM Program Evaluation: She highlighted these areas: <ol style="list-style-type: none"> <li>a. Monitoring of quality of service is completed through the dashboard on a monthly basis and brought to the committee quarterly. The IRR will now be bi-annually and it will start next week. Member and Provider experience will be provided in the QIC and removed for 2017. For scope and safety of Care, SCFHP was to assess communication between members and providers within 30 days. At the time we did not have the systems to capture this info. In 2017 on QNXT conversion we</li> </ol> </li> </ol>	<p>Motion was moved by Dr. Alkoraishi to approve the 2017 UM Work plan and the 2016 UM Program Evaluation: the motion was seconded by Dr. Robertson. All were in favor.</p>

ITEM	DISCUSSION	ACTION REQUIRED
	<p>will complete this.</p> <p>c. Review SCFHP UM Guideline Recommendations:</p> <p>Dr. Boris presented the recommendation to retire the list of guidelines (see insert in the UM packet) and convert some to procedures and/or use the industry standard MCG criteria which is updated on an ongoing basis. In addition, the hierarchy of criteria outlines the use of MCG where available. Questions were answered on the recommendations: for example the Wheelchair guidelines are specifically outlined by Medicare in Noridian guidelines and Medi-Cal has a specific APL which SCFHP will follow. Therefore Wheelchairs requests will be reviewed against Noridian for Medicare and procedures matching the APL for Medi-Cal. Dr. Vemuri asked about the Gender Identity disorders, and there is a specific DHCS APL on this item and SCFHP has a procedure to follow. Dr. Robertson explained that the current stand-alone guidelines were not being kept up and that there are national and state guidelines (MCG or APL's from DHCS to follow).</p> <p>d. Behavioral Health Care Coordinator Guidelines Ms. Holm presented the BH guidelines. Licensed clinicians and care coordinators function in BH to assist with building and approving authorizations based on guidelines. SCFHP is asking for approval of page 14 BH CC guidelines. Approved. Moved Cai Seconded Tobaggi</p> <p>e. Review &amp; Approval of CM.09 Nurse Advice Line Policy: Ms. Carlson reviewed the Nurse Advice line policy. Dr. Alkhoraisi asked if the RN advice line phone number is on the member/patient card. Ms. Carlson stated: Yes. Dr. Tobaggi asked about office staff telling the member to call the RN line before routine appointment questions. And the members agreed that this practice would be appropriate. Ms. Carlson agreed to bring to the next UMC the stats on RN advice line. And to develop with provider services a fax blast about the uses of RN advice line and its availability.</p>	<p>Motion was made by Dr. Alkoraishi and seconded by Dr. Cai to accept the recommendations for the guidelines retirement. All were in favor.</p> <p>The motion was moved by Dr. Cai and seconded by Dr. Tobaggi. All were in favor.</p> <p>Dr. Cai moved to approve the policy and it was seconded by Dr. Dinh. All were in favor.</p> <p>Ms. Carlson to bring RN advice line stats to next meeting and to develop with Provider services a notice to providers.</p>

ITEM	DISCUSSION	ACTION REQUIRED
<p><b>V. Standing Reports</b></p>	<p>a. Membership report updated: MCal approx. 5k MCal lives lost from 2016 to current. We are looking at reasons why. There is some anecdotal information about increase in the number of non-renewals for fears of new immigration policies...</p> <p>b. UM Reports 2017</p> <p>i. Turn Around Time (Cal MediConnect/Medi-Cal)</p> <p>a. Dr. Boris reviewed the Turn-Around Time (TAT) reports from the combined dashboard. The month of March had slight decrease in TAT in Medi-Cal, this will be reviewed for causes. And starting in 2017, the CMC TAT stats are to be at a goal of 100% compliance. Dr. Boris will be reviewing the Medicare Medicaid Plan monitoring standards for confirmation.</p> <p>ii. Standard Utilization Metrics</p> <p>a. Dr. Boris reviewed the entire PowerPoint on UM metrics. Of note: starting in 4<sup>th</sup> quarter of 2016, the UM team did biweekly meetings on inpatients which resulted in the decreases seen in the readmission rates for CMC 13.6% to 11.26% and for Medi-Cal SPD 24.52% to 19.78%.</p> <p>b. Ms. Carlson stated that the Case Management team also has started outreach to all network 1 discharge patients.</p> <p>c. Quarterly Quality Monitoring in accordance to procedure HS. 04.01 report (1<sup>st</sup> Quarter 2017)</p> <p>a. Ms. Carlson presented the quality quarterly monitoring report. The UM team is selecting in accordance to the policy 30 charts for review each quarter on denials. It is noted that TAT is mostly compliant, however denial reasons need improvement. Ms. Carlson and Ms. Castillo are working on template language for denials.</p> <p>d. LTSS Ops Report</p> <p>a. Ms. Anderson presented the LTSS operations report. Noted are the following: there are approx. 8800 members in IHSS in Medi-Cal and 2900 in CMC. CBAS is at its near capacity with almost 600 member for both CMC and Medi-Cal. MSSP is also at near capacity with approx. 280 members.</p> <p>i. The committee members asked about how many CBAS centers there are: the answer is 5</p> <p>b. Of the 527 members reviewed in LTC, 379 received a face to face, 46 were identified for transition and 11 successfully transitioned to the community. Stable housing is the number one need.</p>	<p>None</p> <p>TAT informational only. Ms. Castillo to bring back root cause for low TAT's in March.</p> <p>Information Pull Cal Duals metrics's for comparison</p> <p>Information only</p> <p>Ms. Carlson to bring stats on the number of successful calls by CM.</p> <p>Information only. Ms. Carlson and Ms. Castillo are preparing template language for denials.</p> <p>Informational.</p>

ITEM	DISCUSSION	ACTION REQUIRED
	<p>Un-agenda items:</p> <p>Dr. Tobaggi: was requesting information on the provider handbook for new providers. Dr. Robertson: every new provider gets a manual with facts and information. Ms. Tomcala: the provider manual is in need of some re-write which is in the works.</p>	
<b>VI. Adjournment</b>	Meeting adjourned at 7:45 PM	
<b>NEXT MEETING</b>	The next meeting is scheduled for Wednesday, July 19, 2017, 6:00 PM	



Prepared by:

Caroline Alexander

Caroline Alexander  
Administrative Assistant

Date

7/19/17

Reviewed and approved by:

Jimmy Lin

Jimmy Lin, M.D.  
Committee Chairperson

Date

7/19/17



## Quality Improvement Committee Cal MediConnect Consumer Advisory Board – Member Feedback Q2 - 2017

The following issues were raised by Cal MediConnect Consumer Advisory Board members at their monthly meetings during Qu2. SCFHP is required to share this member input with the QI Committee quarterly.

### Summary of Issues:

**Physical Activity Benefit:** Request for SCFHP CMC members to have gym membership benefits similar to the Silver Sneakers program through Anthem?

**Action Taken:** SCFHP benefits include access to the Indian Health Center programs, but currently do not include Silver Sneakers or any type of gym membership. Other options are being explored with senior centers throughout the county that have gyms and physical activity programs as an expansion of the SCFHP Health Education program.

**Pharmacy Co-Pay** - Two members reported being charged new copays for pharmacy, and this was a surprise. Some members commented they have already reached the ‘catastrophic’ level of use for meds in April.

### Additional Input on CMC Program Management and Enrollee Care

- Case Management/Care Coordination
  - Family member is working with Case Manager and it’s going very well.
  - One SCFHP member reported that she feels ‘guilty’ she is receiving such excellent care. She is very happy.