Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the
Santa Clara County Health Authority
Quality Improvement Committee
Wednesday, August 10, 2016
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Dr. Paul	6:00	5 min.
2.	**Meeting Minutes**	Dr. Paul	6:05	5 min.

Review minutes of the May 11, 2016 Quality Improvement Committee meeting.
Possible Action: Approve 05/11/2016 minutes

3.	**Public Comment**	Dr. Paul	**6:10**	5 min.

Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.

4.	**CEO Update**	Ms. Tomcala	6:15	10 min.

Discuss status of current topics and initiatives.

5.	**Action Items**		6:25	20 min.

a. Review of Case Management Policies — Ms. Liu
- i. CM.01 Comprehensive Case Management
- ii. CM.02 Disease Management
- iii. CM.03 Transitions of Care
- iv. CM.04 MLTSS Care Coordination
- v. CM.05 BH Care Coordination
- vi. CM.06 Sensitive Services, Confidentiality, Right of Adults and Minors
- vii. CM.07 Care Coordination Staff Training
- viii. CM.08 Information Sharing with SARC

b. Review of Health Education Policies — Ms. Sheu-Ma
- i. QI.09 Health Education Program and Delivery System
- ii. QI.10 IHA and HEBA Assessment Policy
- iii. QI.11 Member and Non-monetary Incentives

Possible Action: Approve Case Management and Health Education policies

c.	Review of Case Management Program Description **Possible Action**: Approve Case Management Program Description	Ms. Liu		
d.	Review of Health Education Program Description **Possible Action**: Approve Health Education Program Description	Ms. Sheu-Ma		
e.	Review of Health Education Work Plan **Possible Action**: Approve Health Education Work Plan	Ms. Sheu-Ma		
6.	**Discussion Items**		6:45	20 min.
a.	Access and Availability	Mr. Aguirre		
b.	Appeals and Grievances	Mr. Johns		
c.	CAHPS- Reporting Year 2016	Mr. Aguirre		
d.	HEDIS Reporting Year 2015	Mr. Aguirre		
7.	**Committee Reports**			
a.	**Credentialing Committee** Review June 01, 2016 report of the Credentialing Committee. **Possible Action:** Accept June 01, 2016 Credentialing Committee Report as presented	Dr. Lin	7:05	5 min.
b.	**Pharmacy and Therapeutics Committee** Review minutes of the March 24, 2016 Committee Meeting. **Possible Action:** Accept March 24, 2016 Pharmacy and Therapeutics Committee minutes as presented	Dr. Lin	7:10	5 min.
c.	**Utilization Management Committee** Review minutes of the April 20 and June 02, 2016 Committee Meetings. **Possible Action:** Accept April 20 and June 02, 2016 Utilization Management Committee minutes as presented	Dr. Lin	7:15	5 min.
d.	**Dashboard**	Ms. Liu	7:20	
8.	**Adjourn to Closed Session**	Dr. Paul	7:25	
a.	Quality Review			
	i. Potential Quality Issue Follow Up	Dr. Boris		

Notice to the Public—Meeting Procedures

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

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

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

To obtain a copy of any supporting document that is available, contact Caroline Alexander at 408-874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 210 E. Hacienda Avenue, Campbell.

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

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, May 11, 2016

Voting Committee Members	Specialty	Present Y or N
Thad Padua, MD	Pediatrics	Y
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	Y
Jimmy Lin, MD	Internist	Y
Ria Paul, MD	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	Y
Christine Tomcala, CEO	N/A	Y
Sara Copeland, MD	Pediatrics	Y
Ali Alkoraishi, MD	Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Andres Aguirre	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	Y
Jennifer Clements	Director of Provider Operations	Y
Caroline Alexander	Administrative Assistant	Y
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Dan Johns	Appeals and Grievances Manager	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
INTRODUCTIONS	Chairman Thad Padua, MD called the meeting to order at 6:10 p.m. Quorum was established.			
Public Comment	No attendees from public.			
CEO Update	Christine Tomcala reported Quality Improvement Committee is now a committee of the Board. As a committee of the Board, it is appropriate to have a Board Representative on the Quality Improvement Committee. Darrell Evora, member of the Board, has agreed to sit on the Quality Improvement Committee. (Recently appointed by the Board). RFP for Complex Case Management/Disease Management Program is in process. 4 Vendors submitted responses. HEDIS cycle for the year is complete. Data has been submitted for validation. Plan participated in a joint Department of Managed Health Care and	Present HEDIS data feedback at next meeting	Andres Aguirre	Next Quality Improvement Committee Meeting August 10, 2016

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Department of Health Care Services (DMHC/DHCS) audit April 18th through 29th. Membership is currently at 271, 928. Plan will focus on more outreach to encourage enrollment in Cal Mediconnect.			
Follow Up Items	Dr. Robertson and Dr. Padua presented an update on the new committee organization structure. Quality Improvement Committee will now report up to the Board and is now subject to the Brown Act. Committee meetings will now be open to public attendees. Agenda will now be required to be published and posted within 72 hours prior to the committee meeting date.			
Consent Agenda	Motion made by Committee Chairman Dr. Padua to change Consent Agenda items to individual action items. It was moved, seconded to change consent agenda items to individual action items.	It was approved to change consent agenda items to individual action items.		
Action Items				
A. Review and Approval of February 10, 2016 minutes	The minutes of the February 10, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the February 10, 2016 meeting were approved as presented.		
B. Annual Review and Approval of Quality Improvement Policies	Six policies were presented and reviewed by the committee: QI01 Conflict of Interest QI02 Clinical Practice Guidelines QI03 Distribution of Quality Improvement Information QI04 Peer Review Process QI05 Potential Quality of Care Issues QI06 Quality Improvement Study Design/Performance Improvement Program Reporting After discussion, it was moved, seconded to approve all six policies as written.	All policies were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
C. Review and Approval of Quality Improvement Program 2016 Summary of Changes	Dr. Boris presented a summary of changes made to the 2016 Quality Improvement Program Description. After discussion, it was moved, seconded to approve changes to 2016 Quality Improvement Program	Changes to 2016 Quality Improvement Program were approved as presented. Submit copy to DHCS.	Beth Paige/Anna Vuong	
D. Review and Approval of 2015 Quality Improvement Program Evaluation	Andres Aguirre presented the 2015 Quality Improvement Program Evaluation for review. Committee recommends adding a comparison grid of each network's performance. After discussion, it was moved, seconded to approve 2015 Quality Improvement Program and Evaluation	2015 Quality Improvement Program Evaluation was approved as presented. Submit copy to DHCS.	Beth Paige/Anna Vuong	
Discussion Items				
A. Appointment of new Quality Improvement Committee Chair	Ria Paul, MD, Clinical Associate Professor at Stanford Senior Care Center was appointed as the new Quality Improvement Committee Chairman effective next committee meeting.			
B. Review of Quality Improvement Committee Charter	The updated Quality Improvement Committee Charter was presented to the committee for review.	Informational only; already approved by the Board		
C. Access and Availability	Jennifer Clements shared the results of the 2015 Timely Access Surveys with the committee. Reported a decrease in the number of providers that responded to the survey. Will continue to educate providers of Timely Access Standards.	Present Quarterly reports to the Quality Improvement Committee		
D. Appeals and Grievances	Dan Johns presented a summary of First Quarter 2016 Appeals and Grievances. Increased training with coordinators reduced the number of cases reported as Quality of Care.	Present Quarterly reports to the Quality Improvement Committee		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
E. CY 2015 Annual Review of SCFHP Cal MediConnect Population Demographics and Specific Health Conditions	Dr. Boris presented a summary of the Cal MediConnect (CMC) Population Demographics and Specific Health Conditions to the committee. Of the 9,070 CMC members, 3,860 or 43% have three or more chronic conditions and 5,006 or 55% receive eight or more prescriptions.			
F. Cal MediConnect Dashboard	Andres Aguirre presented the 2015 Cal MediConnect (CMC) Dashboard to the committee. Moving towards a new vendor that will complete HRA process from start to finish (Careplan, Data Entry, Data Analytics) effective November 2016.			
Report of Subcommittees and Approval of Minutes				
A. Credentialing Committee	Dr. Robertson presented the April 6, 2016 Credentialing Committee Report. New report format presents a summary of the detailed work of the credentialing committee. It was moved, seconded to approve Credentialing Committee report as presented.	Credentialing Committee report was approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the 4th Quarter 2015 Pharmacy and Therapeutics Committee minutes. Med Impact minutes will be reviewed in advance by Johanna Liu, PharmD, and presented as a summary at future committee meetings. It was moved, seconded to approve 4th Quarter 2015 Pharmacy and Therapeutics Committee minutes as presented.	4th Quarter 2015 Pharmaceutical and Therapeutics Committee minutes were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the 4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes. New report on Behavioral Health has been added. Tracking Underutilization as well as Overutilization in Utilization Management reports. It was moved, seconded to approve 4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes as presented.	4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes were approved as presented.		
Adjourn to Closed Session: PQI	Meeting adjourned to closed session at 7:40 p.m. The	Dr. Robertson to		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Discussion: Protected Information	committee discussed one PQI.	follow up on agreed upon items		
Next Meeting	Wednesday, August 10, 2016- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Thad Padua, MD
Quality Improvement Committee Chairperson

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Comprehensive Case Management**	**Policy No.:**	CM01
Replaces Policy Title (if applicable):	Case Management	**Replaces Policy No. (if applicable):**	CM030_05
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

III. Responsibilities

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

IV. References

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

POLICY

V. Approval/Revision History

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

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

Santa Clara
Family Health Plan

Policy Title:	**Disease Management**	**Policy No.:**	CM02
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

NCQA Guidelines. 2016
87890 2016 SCFHP Model of Care

V. Approval/Revision History

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Date	Date

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v1	**Original**			

Santa Clara
Family Health Plan

Policy Title:	**Transitions of Care**	**Policy No.:**	CM.03
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

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

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

III. Responsibilities

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

IV. References

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

V. Approval/Revision History

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v1	**Original**			

Santa Clara
Family Health Plan

Policy Title:	**Managed Long Term Services and Supports (MLTSS) Care Coordination**	**Policy No.:**	CM.04
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☒ 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

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v1.0	**Original**			

Santa Clara
Family Health Plan

Policy Title:	**Behavioral Health Care Coordination**	**Policy No.:**	CM05
Replaces Policy Title (if applicable):	**Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure**	**Replaces Policy No. (if applicable):**	**CM106_1**
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

C. The Plan defines processes for the provision of Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) 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

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v1	**Original**			

Santa Clara
Family Health Plan

Policy Title:	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Policy No.:**	CM06
Replaces Policy Title (if applicable):	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Replaces Policy No. (if applicable):**	CM036_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

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

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

III. Responsibilities

Health Services works with IT, 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 #s: 94-13, 96-09, 97-08, 98-11; T22, CCR, 50063.5, 51009, 50063.5; Family Code §6925 et. seq., W & I Code §14132. et seq., 14451 et. seq. ; T28, CCR, Knox-Keene Act; H & S Code §1340. et. seq., 120980, 120990, 121010, 121015, Civ. Code §56. et. seq; Insurance Code §791, et. seq.

V. Approval/Revision History

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v1	**Original**			

POLICY

Santa Clara
Family Health Plan

Policy Title:	Care Coordination Staff Training	**Policy No.:**	CM07
Replaces Policy Title (if applicable):	Long Term Support Services and Social Services Training	**Replaces Policy No. (if applicable):**	112_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

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

III. Responsibilities

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

IV. References

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

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

V. Approval/Revision History

First Level Approval	Second Level Approval
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Title	Title
Date	Date

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v1				

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Information Sharing with San Andreas Regional Center (SARC)**	Policy No.:	CM08
Replaces Policy Title (if applicable):	None	Replaces Policy No. (if applicable):	None
Issuing Department:	Health Services	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ Healthy Kids		☐ CMC

I. Purpose:

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

II. Policy

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

Santa Clara Family Health Plan

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

San Andreas Regional Center

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

POLICY

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

III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
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Title	Title
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v1	**Original**			

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

The purpose of this policy is to:

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

II. Policy

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

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

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

III. Responsibilities

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

IV. References

DHCS Contract Exhibit A, Attachment 10 Section 8.A,
NCQA 2016 Health Plan Accreditation Requirements MEM 8. and MEM 2

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Angela Sheu-Ma	Signature
Name Health Educator	Name
Title	Title
Date	Date

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

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

III. Responsibilities

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

IV. References

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

POLICY

V. Approval/Revision History

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

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

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

MMCD APL 16-005, February 25, 2016; AB 915 (Chapter 500., Statutes of 2007): Welfare and Institutions (W&I) Code 14407.1

Title 28. CCR. Section 1300.46, Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72.

POLICY

V. Approval/Revision History

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

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

Santa Clara Family Health Plan Health Services

Comprehensive Case Management
Program Description
2016

_____	_____
Date	Jeff Robertson, MD Chief Medical Officer
_____	_____
Date	Bob Brownstein Chairperson, Board of Directors

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I. SCFHP Background

Santa Clara Family Health Plan (SCFHP) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Santa Clara County. Established in January 1996, SCFHP was created by the Santa Clara County Board of Supervisors for residents and reflects the cultural and linguistic diversity of the community. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, behavioral health, dental and vision coverage through our health insurance programs: Medi-Cal, Cal MediConnect and Healthy Kids. Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program.

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families. We currently serve over 250,000 residents of Santa Clara County. For the Cal MediConnect Line of Business we are serve approximately 9,000 members.

SCFHP offers an array of care management services to support a collaborative patient and provider treatment process and to improve the health of the member population. Comprehensive case management is one such SCFHP service that assists members and providers in aligning effective healthcare services and appropriate community resources.

The activities of the comprehensive case management program support SCFHP members and providers to attain the highest level of functioning available to the member in relation to their overall health conditions. SCFHP oversees and maintains the following three case management service types in the comprehensive case management program: (1) Basic Case Management Services, (2) Moderate Case Management Services and (3) Complex Case Management.

The comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and individual program descriptions for each of the three case management services that comprise the comprehensive case management program.

II. Purpose and Scope

The purpose of the Santa Clara Family Health Plan (SCFHP or the "Plan") Comprehensive Case Management Program Description is to define the goals and objectives of the program, the methods and processes of identifying and assessing members, managing member care, and measuring the impact of Case Management (CM) interventions. . Case management is defined by the Case Management Society of America (CMSA) as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes." The Plan also abides by the principles of case management practice, as described in CMSA's Standards of Practice for Case Management, providing both episodic and complex case management, based on member needs and the intensity of service required.

The Case Management Program has three components: Basic Case Management, Moderate Case Management and Complex Case Management. All Case Management activities maintain the member's privacy, confidentiality and safety. The Case Manager advocates for the member and adheres to ethical, legal and accreditation/regulatory standards while reinforcing the member's Rights and Responsibilities as noted in the Member Handbook.

Case management activities are performed telephonically or in-person depending upon the member's needs. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, various payer sources and the community at large.

SCFHP promotes case management services through multidisciplinary teams that address member specific medical conditions, behavioral, functional, psychosocial issues in a single health care setting or during the member's transitions of care across the continuum of care.

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. The fundamental components of SCFHP case management services encompass: 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.

The SCFHP Care Delivery Model for comprehensive case management provides coordinated care across the full continuum of care including medical, Behavioral Health (BH) and Long Term Services and Supports (LTSS). This model reflects a person-centered, outcome-based, community-centered approach. The focus is on providing care in the most appropriate, safe, and least restrictive setting for members including monitoring of nursing facility utilization and facilitating successful care transitions between facilities and community. SCFHP comprehensive case management services span medical and LTSS systems, emphasizing coordination with county agencies, direct contractors for Behavioral Health and appropriate community resources. The CM Program focuses on the integration of the array of services and proactively facilitates the communication and collaboration between them.

The case management team, in conjunction with the member, and using the health risk assessment (HRA) will create and monitor a dynamic interdisciplinary care plan (ICP). Simultaneously, the interdisciplinary care team (ICT) which includes anyone the member deems important to their care and the PCP, will meet as needed to create, activate and monitor the individual care plan.

III. Goals and Objectives

A. Goals

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the SCFHP membership and to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long term services and supports; and further the goals of the Olmstead Decision1. In doing so, more specific goals for the program include:

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

B. Objectives

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

- Prevent and reduce hospital and facility readmissions as measured by admission and readmission rates
- Prevent and reduce emergency room visits as measured by emergency room visit rates
- Achieve and maintain member's high levels of satisfaction with case management services as measured by member satisfaction rates
- Improve functional health status and sense of wellbeing of comprehensive case management members as measured by member self-reports of health condition

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

IV. Program Oversight and Staff Responsibility

A. Quality Improvement Committee (QIC)

The QIC supports the objective and systematic monitoring and evaluation of the overall processes and procedures of the comprehensive case management program. The QIC is a standing committee of the SCFHP Board of Governors and meets a minimum of four times per year, and as often as needed to follow-up on findings and required actions. All meetings are open to the public, except when matters deal with peer review activities, contracting issues and other proprietary matters of business. Signed and dated minutes are maintained that summarize committee activities and decisions. The elected Chair of the QIC and members are appointed for two-year terms and include the following representatives:

- SCFHP Chief Medical Officer
- SCFHP Chief Executive Officer (ex officio)
- SCFHP Contracted physicians (3)
- Behavioral Health Practitioner / Specialist

The QIC holds oversight and monitoring responsibility for clinical activities, services and programs provided by the SCFHP health plans. These responsibilities include:

- Oversight of the utilization, case and disease management, and quality management programs.
- Review and approval of annual QI (Quality Improvement), CM (Case Management), DM (Disease Management) and UM (Utilization Management) program descriptions, work plans, and evaluations.
- Annual Population Assessment for Case Management and Disease Management programs
- Review results and effectiveness of quality improvement, case and disease management and utilization management activities and measures, and provide recommendations for priorities and corrective action interventions.
- Review and approval of medical necessity criteria and clinical practice guidelines.
- Oversight of all delegation arrangements to include review of summary reports and evaluations.
- Monitor and review regulatory and accreditation compliance activities.
- Monitor and review member grievance and appeals information.
- Review reports from the Pharmacy and Therapeutics Committee.
- Provide summary reports of clinical activities, services and programs to the Board of Governors.

Specific to the comprehensive case management program, the QIC maintains the following responsibilities and functions:

- Oversight of development, implementation, administration, and management of program.
- Integration of program activities with other SCFHP functions, including utilization management, disease management, Behavioral Health and Long Term Services and Supports, quality and performance improvement, member services, and provider network services.
- Recommendations for coordination and promotion of program to provider, community and consumer stakeholders.
- Review of annual program evaluation that includes analysis of performance measures, review of policies, procedures and program description, analysis of member population characteristics, and evaluation of the resources to meet the case management needs of membership.
- Recommendations for program improvement and approaches to address barriers to care.
- Assure overall effectiveness, efficiency, quality and satisfaction with the program.

B. Staff Resources

1. Chief Medical Officer

The Chief Medical Officer (CMO) has ultimate responsibility for and provides support to the Plan's Case Management Programs. The Plan's CMO, Medical Director, Director of Health Services along with the Plan President and CEO are the senior executives responsible for implementing the Case Management Programs including cost containment, quality improvement monitoring, medical review activities, outcomes tracking, recommendation of guidelines, oversight of annual membership analysis with monthly stratification, and reporting relevant to case management. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. The CMO provides guidance for all clinical aspects of the program. The CMO makes periodic reports to the QIC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with SCFHP network physicians to continuously improve the services that the comprehensive management program provides members and providers.
The CMO's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees

2. Medical Director

The Medical Director, a licensed physician, provides clinical leadership and stewardship to the Health Services programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of members enrolled in the disease management programs, utilization management, transitions of care, and care coordination. The Medical Director works collaboratively with the SCFHP network physicians to continuously improve the services that the disease management program provides members and providers. The Medical Director's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides clinical support to the case management staff in the performance of their case management responsibilities
- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed

- Educates practitioners regarding case management issues, activities, reports, requirements, etc.

3. Pharmacists

Pharmacists are an integral part of the Model of Care and the Interdisciplinary Care Team. SCFHP has an internal pharmacy director, clinical pharmacists and pharmacy technicians. The core functions of pharmacists are to ensure member access to appropriate medications, ensure safety, increase adherence, maximize medication outcomes, provide education and optimize medication therapy.
SCFHP Pharmacists target those members most in need of pharmacy management, including:

- Recently hospitalized members
- Members on multiple medications or with multiple prescribers
- Members on anticoagulants and other high risk drugs
- Members referred by CMs, PCPs or other team members for medication reviews
- Perform Medication Reconciliation at points of transition of levels of care

4. Manager, Case Management

The Manager of Case Management oversees the comprehensive case management program. Under the supervision of the Director of Health Services and the Medical Director, the scope of responsibilities of the Manager of Case Management includes management of daily operations, training of case management staff, tracking of program metrics, oversight of vendors and continuous quality and compliance reviews. The CM Manager is also involved in development of the operational plan; allocation and management of program resources, and accountability for quality of care and services.

5.Director of MLTSS Operations

The Director of Managed Long Term Services and Supports(MLTSS) serves as the point of contact within the Plan for Long Term Support Services (LTSS) and oversees planning, implementation and management of plan operations for LTSS programs and the provider network including In Home Supportive Services (IHSS), Multi Senior Services Program (MSSPC), BAS, Care Plan Options (CPO), Long Term Care and Home and Community Based Services (HCBS) waiver programs and other non-covered LTSS community-based providers.

6. Behavioral Services Manager

Reporting to the CMO, this positon is responsible for oversight of all Behavioral Health care coordination for SCFHP including BH Utilization management, compliance reporting and BH staff supervision. The BH Manager will review all complex cases and provide consultation to the rest of the Health Services staff as needed. This position is responsible for all utilization management under the contract with the County Behavioral Health Department. Any denials of Behavioral Health Service is reviewed first by the SCFHP CMO and then by the SCFHP consulting psychiatrist.

7. Case Manager

SCFHP uses licensed California registered nurses, licensed vocational nurses, social workers, Behavioral Health and LTSS professionals in the role of the Case Managers. The Case Manager provides case management services for members with highly complex medical conditions where advocacy and coordination are necessary to help the member reach the optimum functional level and autonomy within the constraints of the member's disease conditions. Working within a multi-functional team, the Case Manager coordinates with the member, member caregiver(s), Behavioral Health and LTSS and/or community resources, and health plan partners to assess member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. SCFHP uses staffing guidelines to assign caseloads to each Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of members, primary care provider, health plan product; and relevant case management responsibilities.

8. Personal Care Coordinator (PCC)

Personal Care Coordinators are unlicensed staff that support the Case Manager and member by performing a variety of operational functions that include assisting clinical staff in identifying and providing outreach, orientation, and educational materials. The PCC also assists Case Managers with facilitating access to services and supports for care transitions, providing information on community resources and tracking member referrals for LTSS and other services. They also arrange appointments and ensure that the member has transportation. The PCC may act as a bridge for the member between the health plan, health care providers, community resources and the member. The PCC may act as a patient navigator, patient educator and coordinator for the various care plans from community providers. The PCC may be directed to organize the interdisciplinary team meetings and provide information to each of the members of the team, including the care plan documents.

V. Eligibility Criteria & Risk Stratification

A. Criteria

Population Assessment includes annual review of the member population and program processes. In order to identify members who may benefit from Case Management services, the Plan annually assesses and maintains a defined set of case management population criteria for use with all members and including at a minimum:

- Children, adolescents, adults and seniors
- Children with special needs
- Individuals with disabilities, including the Developmentally disabled (DD)
- Individuals with serious and persistent mental illness (SPMI)
- Seniors and persons with disabilities (SPD)
- CalMediConnect (CMC)

At least annually, the population assessment will be reviewed and recorded by the Utilization Management and Quality Improvement Committees, which will include both the population assessment but also include:

- Review of the complex case management processes with updates as necessary to meet member needs
- Review of the complex case management resources with updates as necessary to meet member needs

SCFHP routinely assesses the characteristics and needs of the member population, including relevant subpopulations. SCFHP analyzes claims and pharmacy data, as well as enrollment and census data to obtain the population characteristics of its total membership. Population characteristics for member participation in the comprehensive case management program include:

- Product lines and eligibility categories
- Language and subpopulations
- Literacy
- Psycho-social needs
- Disabilities
- Social support
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Chronic and co-morbid medical conditions
- Utilization

In order to effectively address member needs, subsequent to the collection of member population data, the Manager of Case Management and Disease Management and the Medical Director(s) analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program.

The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- Department staffing – by analyzing the data SCFHP revises staffing ratios and roles, for example adding nurse case managers versus social workers when the level of higher risk members increases in the program.
- Evidence-based guidelines – as the mix of condition types increase the Medical Director assists in identifying clinical guidelines to be used in creating care plans for members.
- Member materials – SCFHP uses data, case manager feedback and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

B. Risk Stratification

The Plan or vendor uses internally established criteria to identify and stratify members for case management levels. No sooner than 60 calendar days prior to new member enrollment, DHCS and/or CMS electronically transmits historical Medicare and Medi-Cal FFS utilization and other applicable data to the MMP for its use in the risk stratification process. This data may include, but is not limited to:

Medicare Parts A, B, and D; Medi-Cal FFS; Medi-Cal In Home Supportive Services (IHSS); Multipurpose Senior Services Program (MSSP); Skilled Nursing Facility (SNF); Behavioral Health pharmaceutical utilization; outpatient; inpatient; emergency department; pharmacy; and ancillary services for the most recent 12 months. SCFHP has an established risk stratification mechanism designed for the purpose of identifying new members who are considered to be higher or lower risk. Higher risk for risk stratification purposes means a member who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive his or her initial contact by SCFHP within 45 calendar days of enrollment.

After analyzing the historical data, SCFHP identifies a member as **higher risk** if he or she, at a minimum, meets any one of the following criteria:

- Has been on oxygen within the past 90 calendar days;
- Has been hospitalized within the last 90 calendar days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases);
- Has In Home Supportive Services (IHSS) greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
- Is enrolled in MSSP
- Is receiving Community Based Adult Services (CBAS);
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
- Has cancer and is currently being treated;
- Has been prescribed anti-psychotic medication within the past 90 calendar days;
- Has been prescribed 15 or more medications in the past 90 calendar days; or
- Has other conditions as determined by SCFHP, based on local resources.

Diagnostic categories typically associated with high intensity of services and high cost of care may be in Basic, Moderate or Complex Case Management, depending of the member's individual needs, capabilities and resources. Typical conditions include:

- Newly diagnosed cancer
- Sickle Cell Anemia
- Tuberculosis
- Hepatitis C
- HIV / AIDS
- Children with special needs
- Life changing conditions

Specific to Behavioral Health needs, conditions may include:

- Anxiety disorders and phobias
- Bipolar Disorder
- Major / Chronic Depression
- Mood Disorder – other
- Substance Abuse / Substance Use
- Child Psychiatric Disorders
- Autism Spectrum Disorders
- Other Mental Health

SCFHP has a health risk assessment survey (HRA) tool that is used to assess a member's current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

VI. Case Management Clinical Systems

A. Clinical Information Systems

Delivery and documentation of case management services either directly provided by SCFHP staff or through a vendor is accomplished through a clinical information system. SCFHP uses a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic evidence based clinical guidelines or algorithms to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program.

Care plans are generated within the system and are individualized for each member and include short and long term goals, interventions and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; records actions or interactions with members, care givers and providers; and automatic date, time and user stamps. This feature automatically identifies the staff member, date and time of actions / interaction with member, practitioner or provider. To facilitate care planning and management, the clinical information system includes features to send automated prompts and reminders for next steps or follow-up contact as defined in the member's care plan.

B. Clinical Decision Support Tools

Evidence-based clinical guidelines are embedded into the clinical information system to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the SCFHP involves board certified specialists in the development of the appropriate guidelines. Assessment questions are based on evidence-based guidelines from The

National Guideline Clearinghouse (www.guideline.gov), medical and behavioral healthcare specialty societies and/or SCFHP guidelines of care. The clinical guidelines that are used by the SCFHP case manager and disease management program team are reviewed and approved by the QIC.

C. Integration of Case Management Services

Case Management services are integrated with the services of others involved in the member's care through a number of processes including, but not limited to

- Communication of Integrated Care Team with the PCP
- Case Management rounds
- Medication reconciliation activities
- Collaboration with the Disease Management program
- Integration with the SCFHP's wellness programs including member self-management tools
- Health Information line
- Behavioral Health services
- Hospice and palliative care programs

VII. Case Management Functions

A. The Comprehensive Case Management Program supports processes and efforts of the organizational mission, strategic goals and objectives through the following functions:

1. Early identification of members who have potential or actual CM needs
2. Assessment of member's risk factors
3. Development of an individualized plan of care in concert with the member and/or member's family and the Primary Care Provider (PCP)
4. Identification of barriers to meeting goals included in the plan of care
5. Referrals and assistance to support timely access to necessary providers
6. Active coordination of care linking members to providers, medical services, residential, social and other support services where needed
7. Ongoing monitoring and revision of the plan of care as required by the member's changing condition
8. Continuity of care and coordination of services
9. Ongoing monitoring, follow up, and documentation of all care coordination and case management activities
10. Addressing the right of the member to decline participation in the case management program or dis-enroll at any time
11. Accommodating member specific cultural, linguistic, literacy and disability needs
12. Conducting all case management procedures in compliance with HIPAA regulations and state laws

VIII. Levels of Case Management

A. Basic Case Management

1. Characteristics
    a. Typically has adequate family/caregiver support
    b. Moderate/Minimal case management needs
    c. Clinical needs for minor medical or behavioral health issues
    d. Basic CM by PCP in collaboration with the case manager
        i. Initial Health Assessment (IHA)
        ii. Initial Health Behavioral Assessment (IHEBA)
        iii. Identification of appropriate providers and facilities (such as medical, rehabilitation and support services)
            1. as needed to meet member needs
        iv. Direct communication between provider, member and family
        v. Member and family education
            1. Including healthy lifestyle changes as warranted
        vi. Coordination of carved out/linked services
        vii. Referral to appropriate community resources/agencies
2. Examples of Basic Case Management Services and Coordination of Care services are provided for members who may need support or interventions on a minimal basis, frequently once or twice a year. These members may have specific conditions requiring support but are generally self-managed with a strong understanding of their condition with sufficient support. These members may include but not be limited to the following:
    a. Dental services that are the responsibility of SCFHP
    b. Public Health Tuberculosis Services, including Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
    c. Women's, Infants, and Children (WIC) Supplemental Nutrition Program
    d. Stable diabetics
    e. Controlled hypertension
    f. Post-operative procedures
    g. Smoking cessation
    h. Mild weight management conditions
    i. Controlled asthma
    j. Hospice cases
    k. ER Diversion
3. Basic Case Management also supports member self-case management through on-line resources including interactive self-management tools developed through evidence-based resources to help members stay healthy and reduce risk. On-line interactive resources include tolls derived from available evidence that provide members with information on at least the following wellness and health promotion areas
    a. Health weight (BMI) maintenance
    b. Smoking and tobacco use cessation
    c. Encouraging physical activity
    d. Healthy eating
    e. Managing stress
    f. Avoiding at-risk drinking

B. Moderate Case Management

1. Characteristics
    a. Chronic disease well managed and meeting goals
    b. Chronic disease not well managed but have not developed complications
    c. Moderate use of healthcare resources
    d. Frequent Emergency Department use
    e. Goal of treatment with avoidance of serious complications
    f. Behavioral Health diagnosis that requires day treatment
    g. Psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services.
2. Examples of Services and Coordination of Care include
    a. Basic case management
    b. Record of Medication History
    c. Assessment and Health History
    d. Development of Care Plan (ICP)
        1. Specific to member needs
        2. Member and PCP input
        3. Updated at least annually

    e. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
    f. Direct communication between provider, member/family or caregiver and case manager/care coordinator
    g. Member/family or caregiver education, including healthy lifestyle changes as appropriate
    h. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex Case Management

1. Characteristics
    a. Identified through stratification activities
        1. HRA
        2. UM/Clinical
    b. Highest acuity requiring intensive CM
        1. Behavioral Health (BH) diagnosis with over 3 hospitalizations in a 12 month period
        2. BH conditions resulting in over 4 ED visits in a 12 month period
        3. Complex condition(s) or multiple co-morbidities generally well managed
        4. Members eligible for Home and Community Based Services (HCBS) waiver program or the Nursing Facility program
        5. Specialty CM members requiring
            i. Adaptive equipment

ii. Adult day health services
iii. Behavioral Services
iv. Day Habilitation
v. Emergency Home Response
vi. Environmental Accessibility Adaptations

c. Record of Medication History
d. Assessment and Health History
e. Basic CM Services
f. Development of Care Plan (ICP)
    1. Specific to member needs
    2. Member and PCP input
    3. Updated at least annually
g. Management of acute/chronic illness(s)
h. Management of emotional/social support issues
    1. By multidisciplinary team
i. Intense coordination of resources
    1. Goal for member to regain optimal health or improved functioning
j. Focused community based coordination of medical, BH and LTSS benefits and resources including IHSS, MSSP and CBAS.

2. Examples of Complex Case Management Services and Coordination of Care services are provided for members who may need more intense support to navigate the health care system, stabilize their condition or manage long term or terminal conditions. These members may include but not be limited to the following:
    a. 3 or more hospital admissions within 6 months for the same or related diagnosis
    b. Major or multiple system failure
    c. Multiple Trauma
    d. Med/Surg inpatient cases with extenuating complications
    e. Head or spine injuries with potential residual deficits (includes CVA)
    f. Severe burns over 20% of the body surface
    g. Complicated coordination of care or discharge planning (any disease/condition)
    h. Cancer with critical event or treatment requiring the extensive use of resources
    i. Chronic diseases with co-morbidities or complications leading to high dollar claims or high utilization
    j. High risk pregnancy
    k. Transplant – solid organ or bone marrow (excludes corneal)
    l. compliance with treatment plan or medications
    m. Extensive use of health care and/or community resources
    n. Newborn/Pediatric with critical event or diagnoses requiring the extensive use of resources
    o. NICU babies with a length of stay greater than 10 days

An annual evaluation of the effectiveness of the program and member and provider satisfaction will be implemented. Based on findings the program will be adjusted to reflect the needs of the members and providers population-wide

IX. Care Coordination and Case Management Services

A. Discharge Planning and Care Coordination

1. Discharge Planning

SCFHP utilization management and case management staff ensure discharge planning when a member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning activities ensure that necessary care, including Long Term Services and Supports (LTSS) and Behavioral Health (BH) Services are in place for the member once the member is discharged from a hospital or institution. This includes scheduling an outpatient appointment, conducting follow-up with the member and/or caregiver, facilitating access to and coordination with other LTSS or community resources. Minimum elements for discharge planning include:

a. Documentation of pre-admission status, including living arrangements, physical and mental functioning, social support, durable medical equipment (DME), and other services received
b. Documentation of pre-discharge factors, including an understanding of the medical condition by the member or a representative of the member as applicable, physical and mental functioning, financial resources, and social supports and community case managers
c. Services needed after discharge, type of placement preferred by the member and/or caregiver and hospital/institution, type of placement agreed to by the member and/or caregiver, specific agency/home agreed to by the member and/or caregiver, and pre-discharge counseling recommended
d. Coordination, as appropriate with County agencies for In Home Supportive Services (IHSS) and Behavioral Health services, LTSS providers including, Multipurpose Senior Services Program (MSSP) provider, Community Based Adult Services (CBAS) Centers, nursing facilities, specialized providers and others community organizations as deemed appropriate. For IHSS, the coordination process must be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning
e. Summary of the nature and outcome of member and/or caregiver of the member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action considered by the hospital or institution

2. Coordination of Care for Short Term Medical Needs

SCFHP Case Management staff maintains procedures to assist members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations of the complexity of the community-based services. Members are assigned to a Case Manager to assist with short term assistance with care coordination. Members, during the course of program enrollment, will also be assessed for longer term Complex Case Management and Disease Management.

3. Patient Safety

The SCFHP complex case management process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The complex case management program includes the following activities to ensure and enhance member safety

a. Completion of a comprehensive general and initial health risk assessment that supports proactive prevention or correction of patient safety risk factors.
b. Active management of transitions of care to ensure that the member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
c. Care plan development that ensures individualized access to quality, safe, effective and timely care.
d. Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care.
e. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety.
f. Appropriate setting assessments
g. Patient advocacy to ensure the care plan is followed by all providers.
h. Annual evaluation of satisfaction with the complex case management program.

4. Coordination of Care with Community Resources

SCFHP maintains procedures to identify and facilitate coordinated service delivery for members receiving comprehensive case management services. Case Managers provide appropriate referrals to carve out services, SCFHP Intensive Case Management to support access to community-based services and resources. SCFHP assists eligible members in obtaining access to the following services or programs:

a. Out-of-Plan Case Management and Coordination of Care
b. Specialty Mental Health
c. Alcohol and Substance Abuse Treatment Services
d. Dental services
e. Excluded Services Requiring Member Disenrollment
f. Home and Community Based Services Waiver Programs
g. Care Plan Options

B. Comprehensive Case Management

SCFHP oversees and maintains three case management services in the comprehensive case management program. These include Basic Case Management, Moderate Case Management and Complex Case Management. All three of these programs have the following case management elements:

a. Completion of a Health Risk Assessment (HRA)

b. Creation of an Individual Care Plan (ICP)
c. Formation of Interdisciplinary Care Team (ICT)
d. Care Plan implementation and care coordination

1. Basic Case Management Services

Basic Case Management services are made available to SCFHP members when appropriate and medically indicated. Basic Case Management services are provided by the primary care provider and or the SCFHP staff, in collaboration with SCFHP, and include the following elements:

- Review of clinical information from the provider
- Completion of the Health Risk Assessment
- Creation of the Interdisciplinary Care Plan (ICP)
- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- Identification and referral to appropriate providers and facilities (such as medical rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services and for covered and non-covered services) to meet member needs
- Direct communication between the provider and member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of services outside of the CalMediConnect Plan such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services

2. Moderate Case Management Services

SCFHP facilitates and coordinates care for eligible members through Moderate Case Management services. SCFHP staff follows preset criteria and collaborates with community partners when necessary to determine eligibility for Moderate Case Management services. SCFHP members may self-refer, or be referred to receive services through community partners, case managers, delegates and vendors.

SCFHP members eligible for Moderate CM services meet one or more of the following criteria:

- Member is already served with case management by community partners
- High utilizers of high cost services including multiple hospitalizations in the last three months, severely mentally ill, 10+ multiple medications
- Already receiving case management services from a community provider (County Behavioral Health, New Directions, MSSP, etc.)
- Care plan requires intensive coordination with a focus on local resources
- Member in transition from acute or long term care to lower level of care or member wishes to transition to lower levels of care
- Member is unable to be contacted

Once a member is identified and referred for Moderate case management, they are assigned to a lead Case Manager to take responsibility for screening, referrals, care planning, interdisciplinary care team management and communication and all other care coordination activities. Members are matched to a Case Manager that is specialized based on the prominence of medical, LTSS, or behavioral health needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed in order to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those members who are multiple diagnosed with medical, functional, cognitive, and psychosocial conditions.

For Members who are already connected to services through a community social service, LTSS, or behavioral health provider, the responsibilities of lead Case Manager will fall to that agency. Generally, ICM services performed by the external agency that demonstrates expertise in the area of the referred member's most pressing needs. For example, members who require primary support for housing assistance are referred to community partners for the provision of ICM services.

Lead case manager, whether SCFHP -based or community-based, is responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment that includes behavioral health
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

3. Complex Case Management Services

Complex Case Management services are made available to SCFHP members with chronic and complex medical conditions, across medical, LTSS and Behavioral Health domains. Complex case management services are offered through SCFHP Complex Case Management program. Complex Case Management includes but is not limited to the following elements:

- Basic Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure member regains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline and avoids institutionalization when appropriate and possible.

- Interdisciplinary Care Teams creation prior to the ICP, training and communication with member and input from Interdisciplinary Care Team
- Development of Individual Care Plans (ICPs) specific to member needs and updated at least annually.
- Referral to Disease Management Program
- Referral to Intensive Case Management

4. Behavioral Health and MLTSS Services

Behavioral Health and MLTSS Case Management may fall into different levels of Comprehensive Case Management. Although they follow the same program requirements unique requirements and procedures exist as described below.

a. Behavioral Health Services

1. Assesses the characteristics and needs of its member population and relevant subpopulations
2. Assesses the needs of children and adolescents
3. Assesses the needs of individuals with disabilities
4. Assesses the needs of individuals with serious and persistent mental illness
5. Reviews its complex case management processes and updates them, if necessary to address member needs
6. Reviews its case management resources and updates them, if necessary to address member needs
7. The Plan selects collaborative data to analyze for improving coordination of care and determine areas to carry over, specific to meet the behavioral health needs of the Plan's membership.

b. Coordination of Care Management and Long Term Services and Supports

SCFHP has processes and models in place to coordinate with external organizations for provision of covered services including LTSS benefits, as appropriate for the member. This includes referral mechanisms, coordinated assessment, eligibility determination and intake activities, coordination of benefits, delineation of roles and responsibilities for care management and participation on the interdisciplinary care team with:

1. Multipurpose Senior Services Program (MSSP), a program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides complex care management as an alternative to nursing facility placement.
2. Community Based Adult Services (CBAS), an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services and transportation to eligible members.
3. In-Home Supportive Services (IHSS), a program for aged, blind and disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help.

4. Nursing Facilities - to coordinate care for residents including care transition plans and programs to move members back into the community to the extent possible.
5. Care Plan Options – for the purchase of services and supports that are not covered benefits for Cal MediConnect members that meet the criteria.
6. Examples of Complex Case Management Services and Coordination of Care services are provided for members specific to the Cal MediConnect (CMC) member population for behavioral health and Long Term Services and Supports (LTSS). These members may include but not be limited to the following:
    a. Dementia
    b. Community Based Adult Services (CBAS) or Adult day care health services
    c. Coordination of Medical, Behavioral Health and LTSS
    d. Major mental health (severe, persistent mental illness) or substance abuse disorder or critical event: may be characterized by suicidal or homicidal ideation or behaviors, inability to carry out activities of daily living independently, or persistent issues with
    e. Member treatment is referred to community resources

7. Specially designated case management staff in dementia care are trained in:
    a. Understanding dementia
        i. Symptoms and progression
        ii. Understanding and managing behaviors
        iii. Communication problems
        iv. Caregiver stress and management

X. Basic Case Management Program Description

A. Identifying Members for Basic Case Management

SCFHP implements Basic Case Management when utilization or case management staff identifies that a member's condition or diagnosis indicates the appropriateness and necessity for services. This identification may take place through admission review, concurrent review processes, provider referral, or at the request of the member.

B. Basic Case Management Process

SCFHP maintains policies and procedures for Basic Case Management services. Basic Case Management procedures and processes include:

1. Intake

a. When a member is identified or a referral is received for basic case management, the case management staff enters the referral into the care management system and coordinates case management services with the member's PCP.

2. Health Risk Assessment, Initial Health Assessment and Behavioral Risk Assessment.

a. The HRA will be completed either by SCFHP vendor or provider. PCP schedules with the member and performs an Initial Health Assessment (IHA) and an Individual Health

Education Behavioral Assessment (IHEBA). The IHA includes a history and physical evaluation sufficient to assess the acute, chronic and preventive health needs of the member. The IHEBA includes a series of age specific questions to evaluate risk factors for developing preventable illness, injury, disability, and major diseases.

3. **Identification of care needs**
    a. The PCP in collaboration with SCFHP Health Services, case management staff identifies appropriate providers and facilities to meet the specific health condition needs of the member to ensure optimal care delivery to the member.

4. **Creation of Individual Care Plan with member and ICT**
    a. Development of an individualized case management plan is accomplished through input by the Interdisciplinary Care Team (ICT), including the following:

5. Prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan. Identification of barriers to a member meeting goals or complying with the plan.
6. Development of a schedule for follow-up and communication with members.
7. Development and communication of member self-management plans.
8. A process to assess members' progress against case management plans for members.

9. **Communication with membe**r
    a. The PCP communicates directly with the member to meet member specific health care needs, and includes family, caregivers and other appropriate providers, per the member's choosing facilitated through an Interdisciplinary Care Team (ICT). The ICT facilitates the participation of the member, and any family, friends, and professionals of their choosing to participate in any discussion or decisions regarding treatments, services, support and education. The PCP in collaboration with SCFHP Health Services case management staff ensures that the member receives all necessary information regarding treatment and services so that the member makes informed choices regarding case management, prioritized goals, and interventions.

10. **Creation of Individual Care Plan (ICP)**
    a. An ICP will be developed for each member that include member's goals, preferences, measurable goals and timetable that meets their medical, behavioral health and long term services and support needs. It will also include timeframes for reassessment and is developed with the ICT. ICPs will be developed within 30 days of the HRA completion for high risk members and 45 days for low risk members.

11. **Coordination of services**

a. The PCP in collaboration with SCFHP Health Services, Behavioral Health and LTSS case managers facilitate linkages between members and community organizations to enhance access to community resources and ensure members are able to utilize these resources. Health Services staff coordinates access to community services, monitors service delivery, advocates for member needs, and evaluates service outcomes.

12. Monitoring of PCP services

a. SCFHP Health Services monitors the member's condition, responses to case management interventions, and access to appropriate care. SCFHP ensures the PCP performs the necessary activities of Basic Case Management services such as the IHA and the IHEBA and identification of appropriate healthcare, behavioral health and LTSS services.

13. Identification of barriers to care

a. SCFHP Health Services case managers monitor barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues, housing and transportation problems. Case Managers identify intervention actions to reduce or resolve member specific healthcare barriers.

14. Case Closure

a. The PCP in collaboration with SCFHP case management staff terminate Basic Case Management services for members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require BCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

XI. Moderate Case Management Program Description

A. Identifying Members for Moderate Case Management

In accordance with SCFHP Model of Care, SCFHP provides Moderate Case Management services directly to members that meet the following criteria:

1. Already receiving case management services from a community provider
2. Care plan requires intensive coordination with a focus on community resources
3. Member in transition from acute or long term care to lower level of care
4. Members that are currently placed in nursing facilities
5. Members that are appropriate for and desire lower level of care
6. Members that are possibly at risk for institutional placement
7. Members identified with behavioral/mental health and substance use needs

SCFHP identifies members that may be eligible for case management services through admission review, concurrent review processes, provider referral, or at the request of the member.

B. Moderate Case Management Process

SCFHP maintains policies and procedures for intensive case management services. MCM procedures and processes include:

1. Referral

When a member is identified, self-refers or a referral is received for moderate case management, the staff enters the referral into the care management system (Altruista) and coordinates case management services with the provider or community partner, as appropriate.

2. Documented Assessment

The case manager conducts an Assessment of the member's health and psychosocial status to identify the specific needs of the member. If applicable, other member assessments that have been conducted on their behalf by providers will be obtained and reviewed. This may include LTSS providers such as IHSS, CBAS, MSSP, nursing facilities and community mental health providers.

3. Development of comprehensive service plan – Individual Care Plan (ICP).

The case manager develops an individualized, comprehensive care plan to include information from the member assessment as well as member input regarding preferences and choices in treatments, services, and abilities. If applicable, other member care plans that have been conducted on their behalf by providers will be obtained and reviewed. This may include LTSS providers such as IHSS, CBAS, MSSP, nursing facilities and community mental health providers.

4. Coordination of services and Interdisciplinary Care Team (ICT)

The intensive case management staff facilitates access to benefits and other community resources through established protocols with providers. This includes triage of multiple services and supports, monitoring service delivery, advocating for member needs, and evaluating service outcomes. An Interdisciplinary Care Team (ICT) is developed that includes anyone the member deems important to their care and the PCP. The ICT meets as needed to create, activate and

monitor the individual care plan. The Case Manager oversees communication among ICT members and SCFHP provider training, as needed for ICT.

5. Crisis Assistance

Case management staff coordinate and arrange crisis services or treatment for the member when immediate intervention is necessary or in situations that appear emergent in nature.

6. Identification of barriers to care

Case management staff identifies and monitors barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues, transportation or housing problems. The case management staff identifies intervention actions to reduce or resolve member specific healthcare barriers.

7. Case Closure

The PCP in collaboration with SCFHP utilization management, and case management staff terminate targeted case management services for members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines Case Management
- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

XII. Complex Case Management Program Description

SCFHP delegates to an NCQA-accredited entity to provide the majority of Complex Case Management services to CalMediConnect members. Delegated activities will be outlined in the Delegation Agreement and may include but not be limited to the following:

- Risk Stratification
- Individual Care Plan development telephonic Health Risk Assessment (HRA)
- Member communication & ICT development

- Individual Care Plan development with member
- Referrals to DM, and SCFHP for Moderate Case Management, Behavioral Health and LTSS benefits and services

Defined Case Management Functions, Services, and Processes

1. Identifying Members for Complex Case Management

A. Criteria

Highest acuity members requiring intensive case management are referred for Complex Case Management. Criteria for identifying members for complex case management are developed under the guidance of the Medical Director. Routinely, but no less than annually, SCFHP evaluates the criteria and its staff resources to determine if there are sufficient vendor staff resources to provide complex case management to those members who are at high risk and are potential participants in the complex case management program.

B. Data Sources

SCFHP uses the following data sources to continuously identify appropriate members for participation in complex case management:

- Claims data
- Hospital Discharge data
- Data supplied by purchasers as applicable
- Data supplied by members or caregivers
- Data supplied by practitioners (Referrals and Medical Records)
- Data supplied by community services
- Pharmacy Data (including Behavioral Health medications)
- Utilization management / authorization activity
- Re-admission data
- State data / CMS claims history
- Health Risk Assessments

C. Referrals to Complex Case Management

There are multiple referral avenues for members to be considered for complex case management services. Services are available to all SCFHP members who meet the general criteria for case management, regardless of specific line of business. Referral sources include:

1. Health Information line referral

SCFHP will have mechanisms in place to gather information from the phone-based health information line to identify members who are eligible for complex case management.

2. **Disease Management program referral**
The Disease Management vendor and staff have criteria to assist them in identifying high-risk members for case management.

3. **Hospital discharge planner referrals**
SCFHP has relationships with discharge planners and the case managers at the hospitals in the provider network and they will refer to case management members they believe are at high risk.

4. **Utilization Management referral**
The Utilization Management program identifies members in need of case management at admission, discharge, concurrent review and Transition of care.

5. **Member, caregiver and practitioner referrals**
The Member Services Department receives calls from members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the member would benefit from the service. The members and providers are informed about their ability to make referrals in the Provider and Member newsletters at least annually.

6. **LTSS and Community-based referrals**
Health Services may receive referrals for case management from LTSS providers (IHSS, CBAS, MSSP) and community organizations/partners including other community-based case management programs.

7. **Behavioral health referrals**
Health Services may also receive referrals for case management services from the County Behavioral Health or community-based behavioral health providers or institutions.

8. **Date of Eligibility for Complex Case Management**
Members identified or referred for complex case management are reviewed for health plan enrollment and eligibility prior to beginning a health risk assessment and general assessment.

9. **Complex Case Management Process**

SCFHP complex case management program uses a systematic approach to patient care delivery and management. Primary steps of SCFHP complex case management process include: member identification and screening; member assessment; ICT and care plan development, implementation and management; evaluation of the member care plan; and closure of the case.

SCFHP maintains policies and procedures for the complex case management process. Complex case management procedures and processes include:

D. Referral & Screening.

When a member is identified, or a referral is received for case management, the CM staff or vendor enters the referral into the care management system and verifies member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The case manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial health risk assessment. If the member does not meet criteria for complex case management, the member may be referred to the other SCFHP program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner.

E. Basic Case Manage Services: As detailed above

F. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team

G. Intense coordination of resources to ensure member regains optimal health or improved functionality

H. With member and primary care provider input, development of care plan specific to the individual needs, and updating these plans at least annually

I. Assessment of health status

The Care Coordinator initially conducts a Health Risk Assessment (HRA) which is a comprehensive assessment of the member's health specific to identified health conditions and comorbidities, for behavioral, functional and psychosocial status including living arrangements and LTSS. The HRA process is completed within 30 calendar days for high risk members and 90 days for low risk members in CalMediConnect. This also serves as a risk stratification tool. HRAs are conducted telephonically, by mail or in-person if the member chooses that option.

At the time of the health risk assessment, the case manager obtains consent from the member to participate in the complex case management program, obtains information about the member's primary care practitioner and identifies members of the interdisciplinary care team. If the member declines complex case management services, the member may be referred to the community services or assistance in identifying a primary care practitioner. The member is provided information about the case management program so that they may, at a later time, choose to participate in the program. The Case Manager informs the member that they will be calling them within six months to check in. The HRA is supported by a separate and detailed policy and procedure. Elements are assessed initially through the HRA and, if the member consents to case management, the member will continue to be assessed on an ongoing basis in the Health Assessment.

The Case Manager collects information and uses it to determine barriers to care and to identify issues to include in the member care plan. The Initial Assessment includes at a minimum the following:

1. Member health status, including condition-specific issues

2. Documentation of clinical history, including medications

a. Clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications including schedules and dosages. All clinical documentation is collected and stored in a secure clinical

information system and is organized in structured templates to facilitate efficient access and use of information.

3. Activities of daily living (ADL)
    a. The Case Manager evaluates member functional status related to activities of daily living such as eating, bathing and mobility.
4. Assessment of behavioral health status, including cognitive functions
    a. During the initial assessment and ongoing evaluations as appropriate, the Case Manager evaluates member mental health status, including cognitive functions, and depression. The Case Manager also completes an alcohol and drug use screen as part of the Health Assessment. Referrals are made to behavioral health clinicians for case management members that meet specified criteria.
5. Assessment of psychosocial issues
    a. The Case Manager evaluates the member's psychosocial status including an understanding of, beliefs or concerns about their condition or treatment about the likelihood that it will improve their health. Perceived barriers are identified that may hinder the member from participating in care such as financial, transportation, housing status or capacity
6. Assessment of life-planning activities
    a. Member preferences about healthcare and treatment decisions may impact the care plan. The HRA and Health Assessment and case management process includes an assessment of member life planning activities such as wills, living wills or advanced care directives, and health care powers of attorney. The Case Manager documents situations when life-planning activities are not appropriate, and mails appropriate information (e.g., advanced care directives) to member when needed
7. Evaluation of cultural and linguistic needs, preferences or limitations
    a. Communication issues can compromise effective healthcare for the member. In order to identify communication methods best suited for the member, cultural and linguistic needs, care preferences or limitations are assessed.
8. Evaluation of visual and hearing needs, preferences or limitations
    a. In order to ensure an appropriate care plan and healthcare needs are effectively met, member visual and hearing needs, preferences or limitations are assessed.
9. Evaluation of caregiver resources and involvement.
    a. The Case Manager evaluates caregiver resources such as family involvement and decision making about the member's individualized care plan. The Case Manager follows the member's direction about the level of involvement of his or her caregivers
10. Evaluation of health plan benefits, including Behavioral Health (Mental Health and Substance Use Disorder services) LTSS and community resources.

a. When indicated for the member, the Case Manager refers the member to SCFHP LTSS Team to access local, county, and state public agencies, and other community-based organizations to provide services such as housing assistance, home delivered meals, transportation or home modifications. When indicated for the member, the Case Manager refers to community Behavioral Health Services and/or to the BH department for consultation.

J. Development and Documentation Person-Centered Individualized Care Plan (ICP)

The ICP includes a person-centered planning and treatment approach that is collaborative and responsive to meet member specific health care needs. The ICP will be completed with the member and Interdisciplinary Care Team (ICT) input regarding preferences and choices in treatments, services, and abilities. Working with the member, the case manager establishes and documents a set of prioritized goals.

These goals are incorporated into the care plan which also includes:

1. Timeframe for re-evaluation
2. Resources to be used in meeting the goals and addressing the member's needs
3. Plans for addressing continuity of care needs, transitions and barriers
4. Involvement of the family and/or caregiver in the plan
5. Educational needs of the member
6. Plans for supporting self-management goals

The Case Manager facilitates the participation of the member, and any family, friends, behavioral health and LTSS providers and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support and education. The Case Manager ensures that the member receives all necessary information regarding treatment and services so that the member makes informed choices regarding care management, prioritized goals, and interventions. The Case Manager includes the member with appropriate and regular updates to the care management plan that occur at a minimum on an annual basis. Behavioral Health - Specialty Mental Health providers will be provided with a copy of the ICP and will be requested to sign and return the ICP.

K. Identification of barriers to goals or compliance with plan of care

The complex case management procedures address barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The care management plan identifies barriers to care and intervention actions to reduce or resolve member specific healthcare barriers.

L. Facilitation of member referrals to resources and follow-up process

The case management plan includes follow-up to reduce or eliminate barriers for obtaining needed health care services. The case management process facilitates linkages between members and community organizations to enhance access to community resources and ensure members are able to utilize these resources. Case management staff coordinates closely with

SCFHP LTSS and Behavioral Health staff to facilitate access to community services, monitor service delivery, advocate for member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers as they work with members, caregivers, and providers. Case Management and Disease Management department staff regularly compile and document resources available in Santa Clara County and update the directory when necessary.

M. Development of schedule for follow-up and communication

The member care plan includes a schedule for follow-up that includes, but is not limited to, counseling, referral to disease management, intensive case management providers, primary and specialty care, education or self-management support. Complex case management work flows and processes specify when and how the Case Manager follows up with a member.

N. Development and communication of member self-management plan

The Case Manager provides the member or member caregiver(s) instructions and/or materials to assist the member with self-management of his or her complex medical condition. The development and communication of a self-management plan includes member monitoring of key symptoms, activities, behaviors, and vital statistics as appropriate (i.e., weight, blood pressure and glucose levels). The Case Manager documents oral or written communication of self-management activities provided to the member or caregiver(s).

O. Crisis Assistance

Case management staff coordinate and arrange crisis services or treatment for the member when immediate intervention is necessary or in situations that appear emergent in nature.

P. Process to assess progress of the member care plan

The Case Manager continuously monitors and reassesses the member's condition, responses to case management interventions, and access to appropriate care. The case management plan includes an assessment of the member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

Q. Case Closure

The Case Manager terminates case management services for members based on established case closure guidelines. The criteria for case closure of complex case management (CCM) include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM

- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

XIII. Program Evaluation and Assessment of Effectiveness

The Chief Medical Officer/Medical Director and the Director of Case Management collaboratively conduct an annual evaluation of SCFHP complex case management program. The evaluation includes the following.

A. Measures/Process- The evaluation includes analysis of population characteristics and of the resources to meet the needs of the population. SCFHP selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. SCFHP annually measures the effectiveness of its complex case management program based on the following guidelines.

1. Measurement of effectiveness of Complex Case Management annually
    a. Minimum of three measures (annually defined). For each measure.
        1. Identify a relevant process/outcome
        2. Valid methods for quantitative results

            i. Numerator and denominator
            ii. Sampling methodology
            iii. Sample size calculation
            iv. Measurement periods and seasonality effects
        3. Setting a performance goal

            i. Explicit, quantifiable performance goal
        4. Using clearly identified measures

            i. Data source
            ii. Eligible population
            iii. Coding and other means
            iv. Adaptation of HEDIS if used
        5. Collecting data and analyzing results

            i. Quantitative and qualitative analysis with comparison against goals
                a. includes causal analysis as appropriate
        6. Identify opportunities for improvement as applicable

            i. Report to and follow through with QIC

B. Member Satisfaction/member experience

1. Achieve and maintain high levels of satisfaction with CM services

a. Member Satisfaction Rates

1. Feedback from members

SCFHP measures member satisfaction and experience with the complex case management program. A satisfaction survey is mailed after case closure. The member is asked to rate experiences and various aspects of the program's services, including interactions with the Case Manager. The survey also collects information involving member complaints and inquiries about the program. Data is collected and reported within a secure clinical information system.
The Health Services staff systematically analyzes the feedback from member surveys at least annually.

2. Analyze member complaints
   a. This includes complaints about
      i. Access to Case Manager
      ii. Dissatisfaction with Case Manager
      iii. Timeliness of Case Management services
   b. SCFHP tracks and trends complaints and grievances quarterly
      i. Summarizes annually
      ii. Compares with previous year
3. Satisfaction surveys
   a. SCFHP focuses at minimum on
      i. Complex Case Management
      ii. Usefulness of information
      iii. Member ability to adhere to recommendations

C. Performance measures

1. Purpose

SCFHP maintains performance measures for the case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. Likewise, a needs assessment is conducted to identify gaps in care and community resources. These findings are brought to the QIC, when appropriate and other community forums. An annual report of the effectiveness of this program will be provided to the QIC and the Board of Directors. The following are measured.

a. Improve member outcomes

i. **All-Cause Admission Rate**

SCFHP measures admission rates for all causes for members in the complex case management program who had an admission within six months of being enrolled in the complex case

management program. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services staff.

ii. **Emergency Room Visit Rate**

SCFHP measures emergency room visit rates of members enrolled in the complex case management program. The Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

b. Achieve optimal member functioning

i. **Health Status Rate**

SCFHP measures the percentage of members who received complex case management services and responded that their health status improved as a result of complex case management services. A satisfaction survey that includes questions to assess health status is administered after case closure. SCFHP collects data and reports within a secure clinical information system. The Health Services Staff systematically analyses the feedback from member surveys at least annually.

c. Use of Appropriate Health Care Services

i. **Use of Services**

SCFHP measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within SCFHP network. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

2. Procedure

For each of the performance measures, SCFHP completes the following procedures to produce annual performance measurement reports:

a. **Identify a relevant process or outcome**

The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

b. **Use valid methods that provide quantitative results**

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period.

c. **Set a performance goal**

The Manager of Case Management in collaboration with the Chief Medical Officer/Medical Director, establish a quantifiable performance goal for each measure that reflects the desired level of achievement or progress.

d. **Clearly identify measure specifications**

The Manager of Case Management in collaboration with analysts from the Healthcare Analytics department identifies measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources.

e. **Analyze results**

The Manager of Case and Management with data analytic support from the Healthcare Analytics Department complete an annual comparison of results against performance goals and an analysis of the causes of any deficiencies.

f. **Identify opportunities for improvement, if applicable**

The Director of Case and Disease Management in collaboration with the Chief Medical Officer/Medical Director and feedback from the HCQC use qualitative and quantitative analysis to prioritize opportunities to improve performance on the measure.

g. **Develops a plan for intervention and re-measurement**

The Manager of Case Management in collaboration with the Chief Medical Officer/Medical Director and feedback from the HCQC develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention. The Manager of Case Management coordinates with the Healthcare analytics department to report the results of the performance improvement intervention.

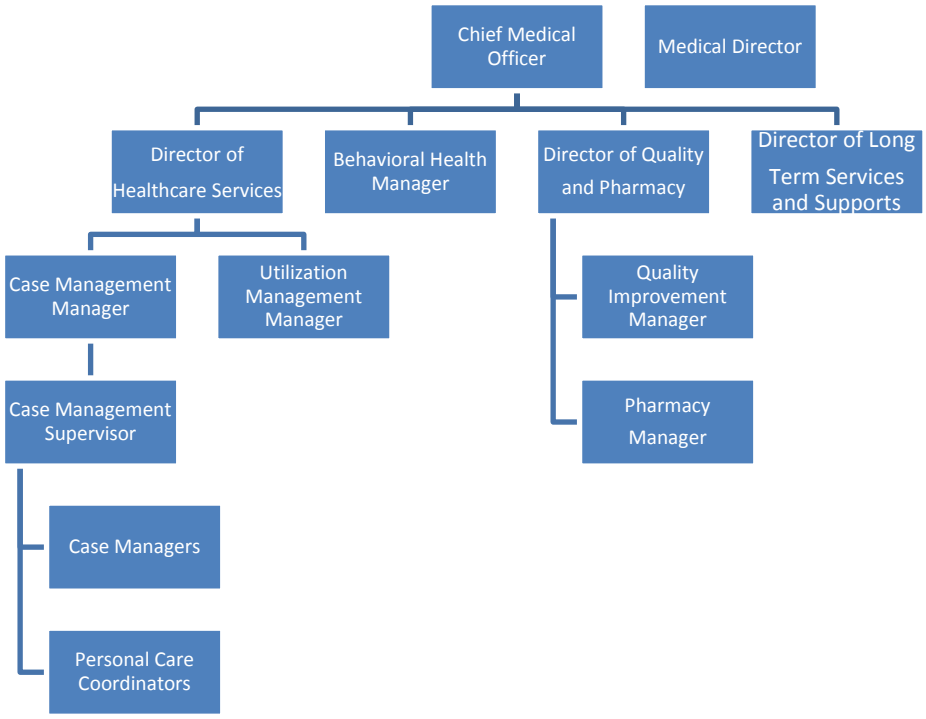
D. Evaluation Review/Follow-up

The results of the annual program evaluation are reported to the QIC for review and feedback. The QIC makes recommendations for corrective action interventions to improve program performance, as appropriate. The Manager of Case Management is responsible for implementing the interventions under the oversight of the Chief Medical Officer/Medical Director.

XIV. END NOTE

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

APPENDIX A: Case Management and Disease Management Organizational Chart



Health Education Program

2016

Angela Sheu-Ma, CHES, MPH, RDH

Santa Clara
Family Health Plan

SANTA CLARA FAMILY HEALTH PLAN

2016 HEALTH EDUCATION PROGRAM

Executive Summary

As a community based health plan, Santa Clara County Health Authority, a public agency operating business as Santa Clara Family Health Plan (SCFHP), strives to provide high quality health care to those who cannot access affordable health care. A component to achieving this goal is **SCFHP's Health Education Program** which assists and engages the community to reach their wellness goals.

The Health Education Program is under the direction of a full-time health educator with a Master's degree in public health with specialization in health education. The program identifies the health education needs of its members and utilizes findings for continuous development and improvement of health education programs and services. As part of the Quality Improvement Department, Health Education Program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

Implementation of the Health Education Program includes: 1) Providing programs, classes and/or materials free of charge to members, 2) Point of service education for members as part of their preventive and primary health care visits, 3) Practitioner education and training, 4) program evaluation, monitoring, and quality improvement, 5) Group needs assessment, and 6) The formation of a Community Advisory Committee (CAC).

Santa Clara
Family Health Plan

SANTA CLARA FAMILY HEALTH PLAN

2016 HEALTH EDUCATION PROGRAM

TABLE OF CONTENTS

I. INTRODUCTION

Santa Clara County Health Authority is a public agency which operates business as Santa Clara Family Health Plan (SCFHP) in order to provide medical coverage for persons with Medi-Cal Managed Care. Santa Clara Family Health Plan is licensed under the Knox Keene Act of 1975 and is subject to the regulations set forth by the State of California's Department of Managed Health Care (DMHC).

SCFHP is contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program.

SCFHP then entered into a series of contracts which extended care to a broader range of the population. From 2007 to 2009 SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) to serve as a Special Needs Plan in Santa Clara County. In 2014, SCFHP contracted with CMS and the State of California for the Managed Long Term Services and Supports (MLTSS) programs. And most recently in 2015, SCFHP contracted with CMS for the Cal MediConnect (CMC) Dual Demonstration Project.

SCFHP is dedicated to improving the health and well-being of the community and continues to uphold its vision of serving new enrollees, consistent with its mission and its core values.

II. MISSION

As a community based health plan, we strive to provide consistently high quality health care to those who cannot access affordable health care.

With a richly diverse population residing in the area, it is crucial for information to be presented in a manner that takes into account the culture and linguistic capability of those we serve. Because of this we strive to develop procedures to ensure the materials are appropriately structured for maximum clarity and effectiveness. SCFHP is committed to delivering culturally and linguistically appropriate health care services.

III. Statement of Purpose

The goal of SCFHP's Health Education program is to assist and engage the community to reach their wellness goals and structure informational and educational materials in a manner all plan members can easily read and understand. In order to accomplish this, the following components are included in the program:

- Health Education
- Community Advisory Committee (CAC)

IV. SCOPE OF PROGRAM

The scope of the Health Education program is to identify the health education needs of its members and to utilize the findings for continuous development and improvement of health education programs and services. In order to accomplish this, multiple reliable data sources, methodologies, techniques, and tools will be used to identify these needs.

V. PROGRAM GOALS AND OBJECTIVES

Community Advisory Committee (CAC)

- A community advisory committee will be in place.

Health Education

- Health Education system provides organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education.
- Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and complimentary and alternative care.
- Risk reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.
- Self-care and management of health conditions – pregnancy, asthma; diabetes; and hypertension
- Members receive point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracting medical providers in the delivery of health education services for Members.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for Members to have an IHA within 120 days of being eligible with the health plan.
- Ensure all written Member information is provided at a sixth grade reading level

VI. PROGRAM STRUCTURE AND ORGANIZATION

The Health education program is under the direction of a full-time health educator with a Master's degree in public health with specialization in health education.
The Health Education program is part of the Quality Improvement Department. Health education program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

V. PROGRAM IMPLEMENTATION

The Health Education Department will provide programs, classes and/or materials free of charge to members including, but not limited to the following topics:

1. Nutrition and physical activity
2. Healthy Weight(BMI) Management
3. Healthy eating
4. Healthy weight maintenance
5. Encouraging physical activity
6. Managing stress
7. Parenting
8. Smoking and Tobacco use cessation
9. Alcohol and drug use
10. Injury prevention
11. Prevention of sexually transmitted diseases, HIV and unintended pregnancy
12. Management of chronic diseases or health conditions, including asthma, diabetes, and hypertension
13. Pregnancy care
14. Identifying depressive symptoms

Point of Service Education

Individual members will receive health education services as part of their preventive and primary health care visits. Health risk behaviors, health practices and health education needs related to health conditions are identified. Educational intervention, including counseling and referral for health education services will be conducted and documented in the member's medical record.

Medical providers will use an Individual Health Education Behavioral Assessment tool and other relevant clinical evidence to identify member's health education needs and conduct educational intervention. SCFHP will provide resource information, educational material and other program resources to assist contracting medical providers to provide effective health education services for members.(DHS PL 02-004)

Practitioner Education and Training

SCFHP will provide education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members. Practitioner training will cover: a)Group needs assessment findings, b) The individual health education behavioral assessment; c) Techniques to enhance effectiveness of provider/patient interaction, d)Educational tools, modules, materials and staff resources, e) Plan specific resource and referral information, and f)Health Education requirements, standards, guidelines, and monitoring.

SCFHP will ensure providers are trained and administering the IHAs (initial health assessment) with the health education behavioral risk assessment for all members within 120 days of enrollment.

SCFHP will also implement a comprehensive risk assessment tool for all pregnant female members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

Program Standards, Evaluation, Monitoring, and Quality Improvement

The Health Education System will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving health education program goals and objectives. Policies and procedures will be in place for ensuring providers receive training on a continuing basis regarding DHCS developed cultural awareness and sensitivity instruction for Senior and Persons with Disability (SPD) beneficiaries.
SCFHP will monitor the performance of providers contracted to deliver health education programs and services to members. Strategies will be implemented to improve provider performance and effectiveness. (DHCS PL 13-001)

Group Needs Assessment

A group needs assessment will be conducted every 5 years to identify the health education and cultural and linguistic needs of our members. Multiple reliable data sources, methodologies, techniques, and tools will be used to conduct the group needs assessment. The findings will be utilized for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Documentation will be maintained of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

Community Advisory Committee

SCFHP shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876(c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers. SCFHP will ensure CAC is included and involved in policy decisions related to Quality Improvement educational, operational, and cultural competency issues affecting groups who speak a primary language other than English.

VII. CONFIDENTIALITY AND CONFLICT OF INTEREST

Confidentiality of practitioner, provider, and member identifying information is ensured in the administration of Health Education Services.

X. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

The Health Education Program will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of training, evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving health education program goals and objectives.

SCFHP will monitor the performance of providers contracted to deliver health education programs and services to members. Strategies will be implemented to improve provider performance and effectiveness (SCFHP/Medi-Cal contract Exhibit A, Attachment 10 Scope of Services).

Training

Initial Health Assessment

The Provider Services Department educates new PCPs about the IHA and IHEBA within the first 10 days of their effective date, during the new provider orientation and annually thereafter (Provider services policy PS019_03)

1) A log will be kept of Initial Health Assessment (IHA) training which is included in the new Provider handbook given to new providers.
2) The provider services department administers training for new providers which include IHA requirements.
3) Providers who are found to be noncompliant with IHA requirements during periodic Facility Site Reviews (FSR's) will receive retraining.

Monitoring

Facility Site Reviews

The QI Department monitors PCP's IHA and IHEBA process during periodic site reviews.

Facility Site Reviews (FSR's) will include medical chart reviews to monitor if providers are compliant with IHA requirements. IHA requirements will be included in providers' corrective action plans (CAP) for providers not passing any section of their FSR's.

Health Education Workplan 2016											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Services for Adults	Exhibit A, Attchmnt 10 Scope of Services Exhibit A Attchmnt 11 Case Management and Coordination of Care Exhibit A, Attchmnt 18 Implementation Plan and Deliverables	-Ensure IHA for adult members is performed within 120 calendar days of enrollment -Ensure performance of initial complete history and physical exam for adults to include health education behavioral risk assessment and member and family education.	-Chart audits and provider training -FSR (every 3 yrs)	-P&P for administration of a disease management program -P&P for case management coordination of care of LEA (local education agencies)services	Baseline<	QI and Health Educator		Continous	
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attchmnt 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	Provider Training and FSR results	Baseline	QI & Health educator, provider services		Continous	
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attchmnt 10 Scope of Services, DHS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for ptoential health ed partherships	List of health ed classes that cover all required health ed topic areas.		Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioural change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	Health Education Program	Organized delivery of health ed program	Health Educator		Continuous	

Health Education Workplan 2016											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using SMOG, etc, -Field test material at CAC meetings	-Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)				Continuous	
	Health Ed			-Contracter shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions		MI incentives Health Ed courses/activities	Baseline	Health Educator		Continuous	
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attchmnt 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make infromed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing and Health Educator		Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.		Marketing, Health Educator	Annually		Jun-16

Health Education Workplan 2016											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Provider Training	Health Ed	Practitioner Education and Training	DHS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training	Certification log of provider training	All providers trained	Health Educator, Provider operations, QI		Continuous	
Incentives	Health Ed	MMCD on-going monitoring activities	MMCD PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaulation summary	Health Educator	30 days after end of program incentive	Continuous	
Incentives	Health Ed	-Justify continuation of on-going incentive program	MMCD PL 12-002	Justify continuation of MI program	-Provide brief explanation(update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submitted to MMCD	All continuous MI incentives with justificaton	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	
Website	Health Ed and C&L	Health Ed and member informing resources on SCFP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attchmnt 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make infromed health decisions -Address appropriate reading level and translation of materials.	Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	

Health Education Workplan 2016											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attchmnt 4 Quality Improvement System, pg. 140 Exhibit A, Attchmnt 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services		-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers -Submit P&P for application and use of Health Information Form (HIF) data submitted thru the Member Evaluation Tool (MET)		QI (FSR) & Health Educator		Jun-16	
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanentely prevent or delay pregnancy.	pg. 57 Exhibit A, Attchment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	Written information in Evidence of Coverage		Marketing, Health Educator			Jun-16

Health Education Workplan 2016											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Quality of Services	Access and Availability	Conduct group needs assessment to identify health education and cultural and linguistic needs	pg. 61 Exhibit A, Attchment 9 Access and Availability,DHS APL Policy Letter 10-012		Conduct GNA	GNA Summary Report submitted to DHCS within 6 mos of completion of each GNA -Annual GNA update electronically submitted every yr on October 15th, except in yrs when full GNA report is completed and executive summary submitted to MMCD. -Electronically submit an Executive Summary of GNA Report every yrs	Every 5 yrs perform GNA Update Annual update GNA summary report	QI manager and Health Educator	Every 5 yrs & Annual update	October 15th, 2016	
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attchmnt 9 Access and Availability , MMCD PL 99-01	-Form a Community Advisory Committee pursuant to Title 22 CCR Section 53876 (c)(CAC) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues affecting groups who speak a primary language other than English.	-Meeting minutes -Record of plan members on CAC		QI and Health Educator, Marketing		Continuous	

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: June 1, 2016

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Total number of practitioners in network (includes delegated providers) as of 03/31/16	3525	Threshold
Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	10	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	7	
Number practitioners recredentialed within 36-month timeline	7	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	

	Stanford	LPCH	NT 20	NT 40	NT 50	NT 60
Total # of Initial Creds	0	8	14	4	5	2
Total # of Recreds	148	44	32	80	28	6
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0

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

Santa Clara
Family Health Plan
The Spirit of Care

Access and Availability

QIC August 10, 2016

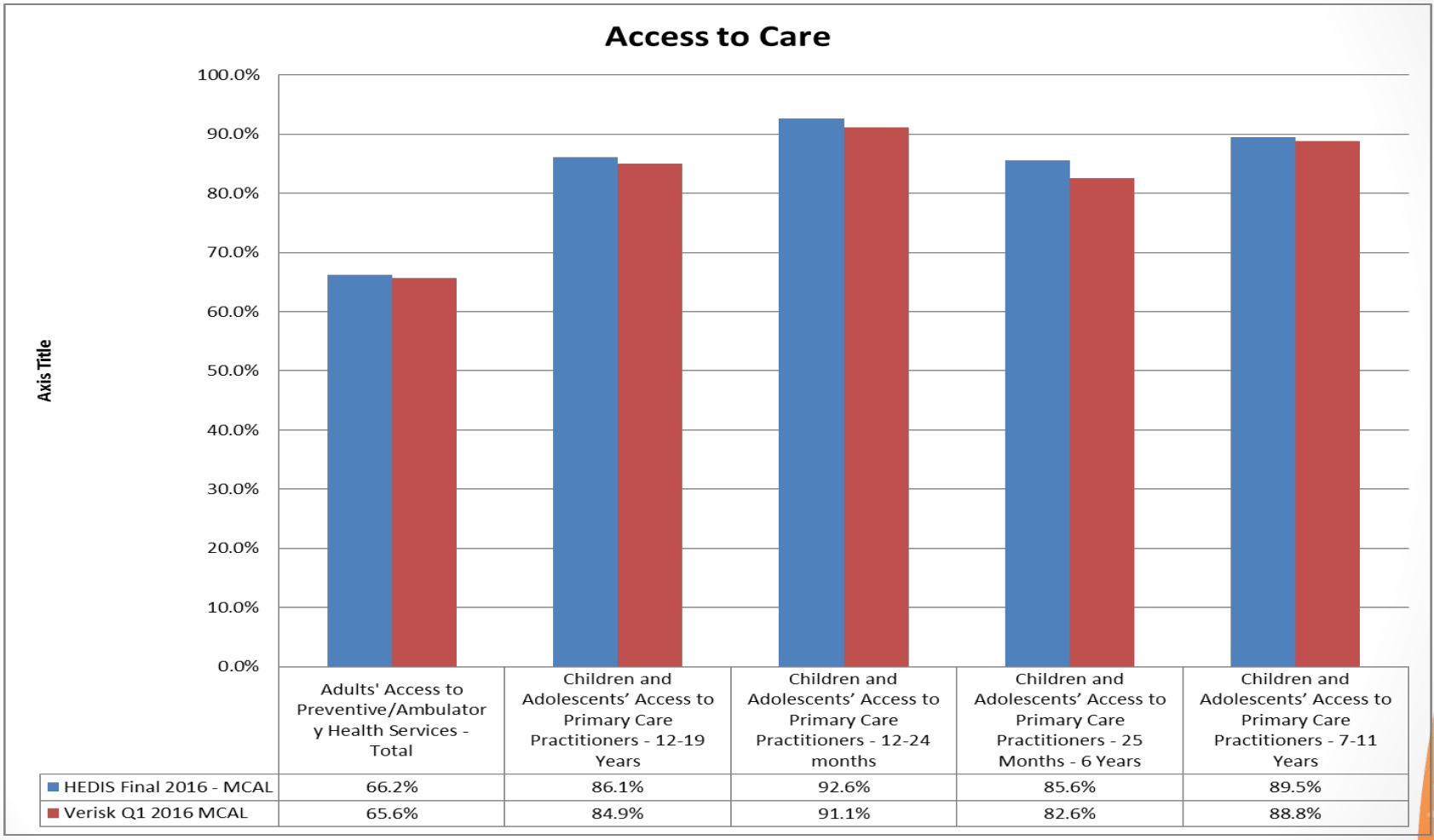
Access and Availability

- What is Access and Availability?
  - Mandated by the State to do an annual access survey
  - Expanded measurement
    - HEDIS data

HEDIS Data

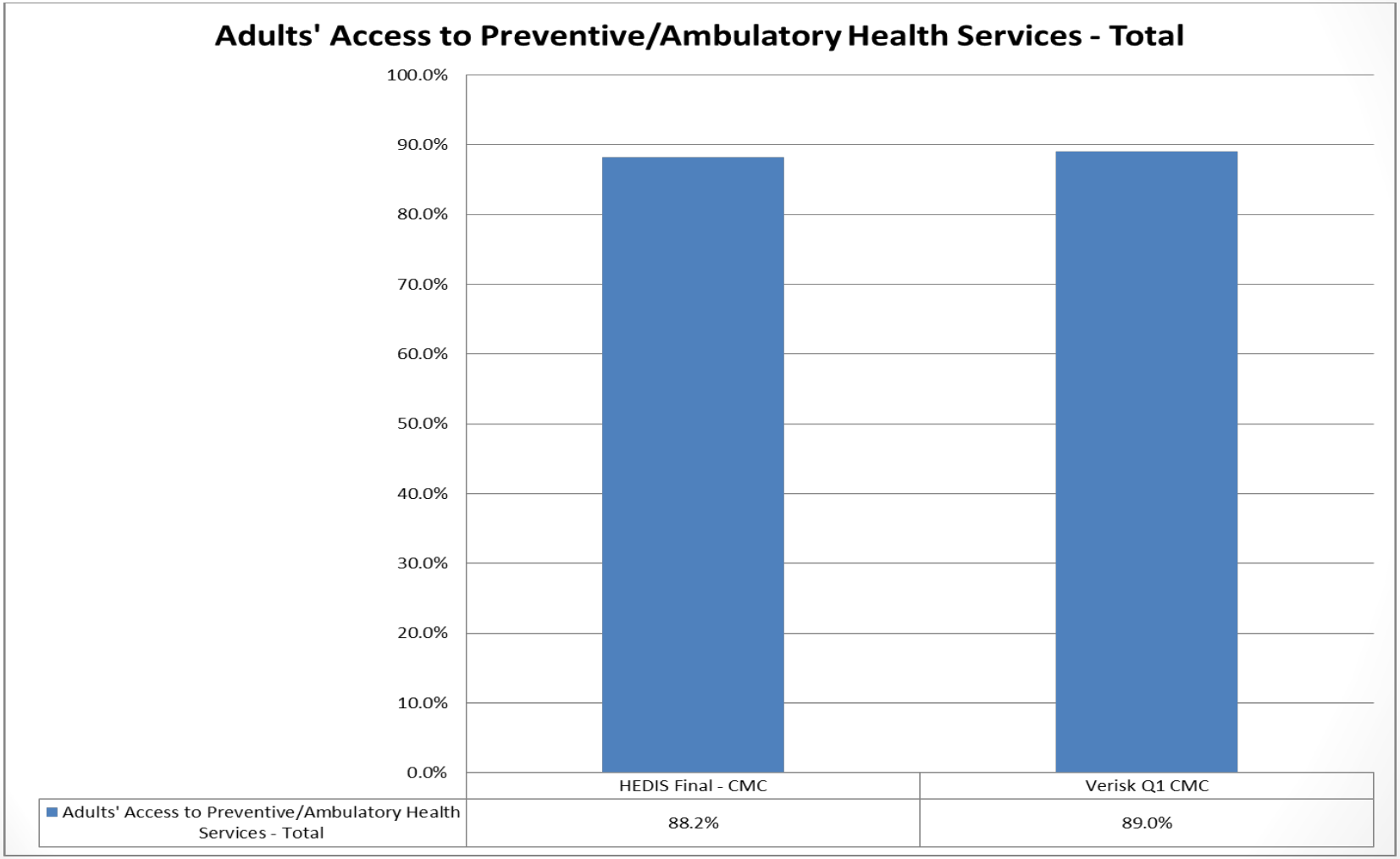
- Use Access/Availability of Care Measures
  - Adults Access to Preventive/Ambulatory Health Services (AAP)
  - Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - Prenatal and Postpartum Care (PPC)
  - Ambulatory Care Measures for
    - Outpatient Visits
    - ED Visits

HEDIS

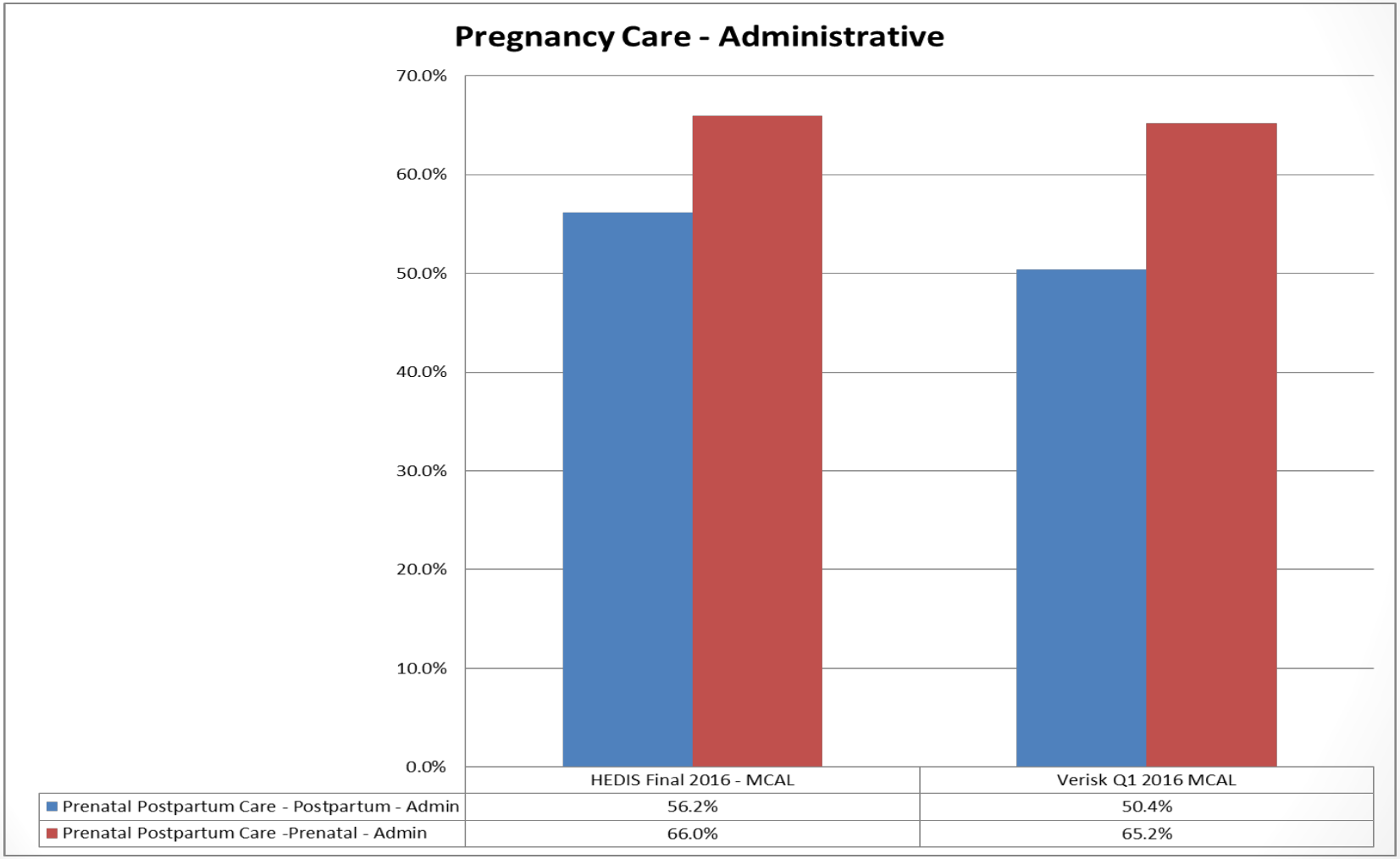


	Adults' Access to Preventive/Ambulatory Health Services - Total	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years	Children and Adolescents' Access to Primary Care Practitioners - 12-24 months	Children and Adolescents' Access to Primary Care Practitioners - 25 Months - 6 Years	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years
HEDIS Final 2016 - MCAL	66.2%	86.1%	92.6%	85.6%	89.5%
Verisk Q1 2016 MCAL	65.6%	84.9%	91.1%	82.6%	88.8%

HEDIS

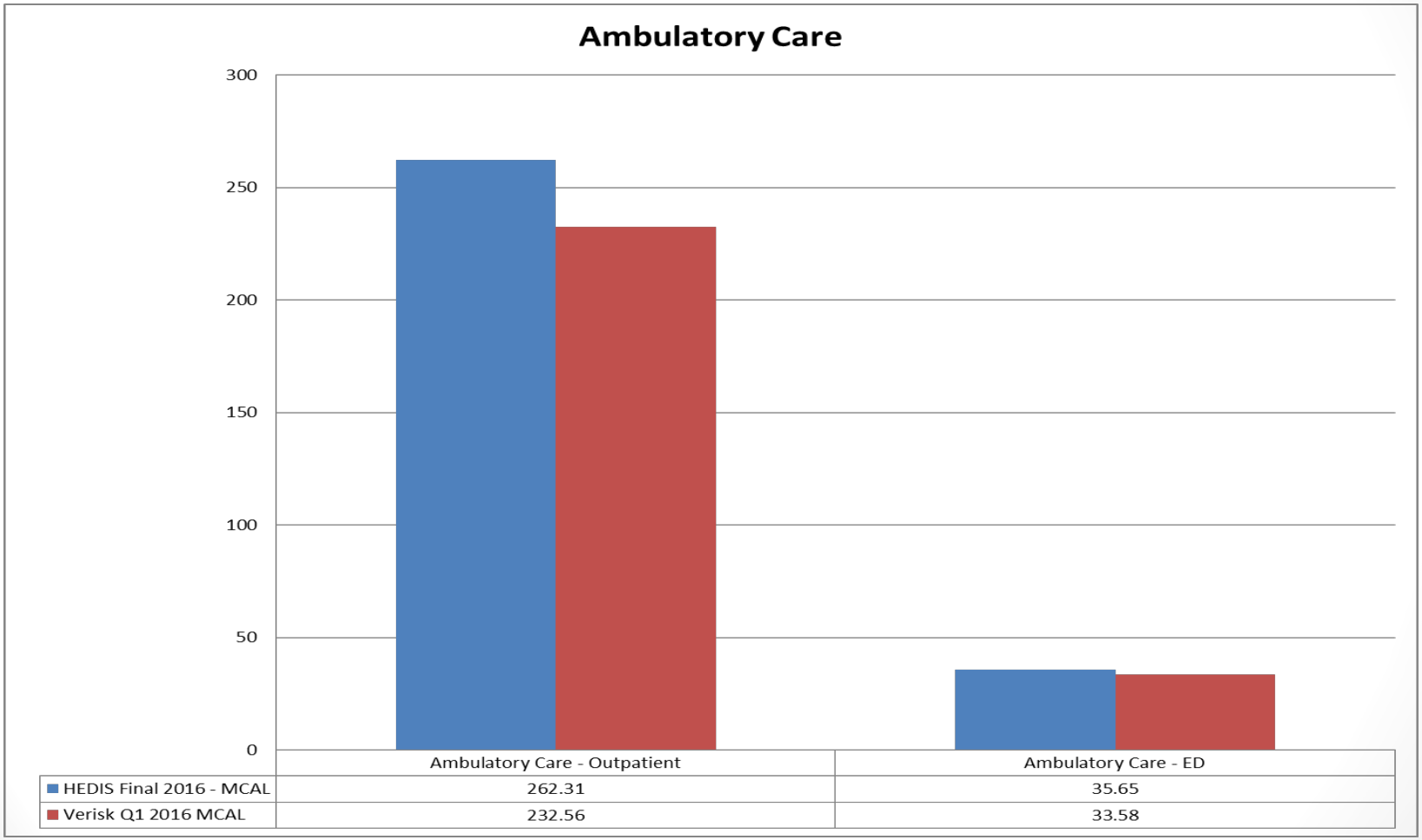

Adults' Access to Preventive/Ambulatory Health Services - Total
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
HEDIS Final - CMC
Verisk Q1 CMC
Adults' Access to Preventive/Ambulatory Health Services - Total
88.2%
89.0%

HEDIS



	HEDIS Final 2016 - MCAL	Verisk Q1 2016 MCAL
Prenatal Postpartum Care - Postpartum - Admin	56.2%	50.4%
Prenatal Postpartum Care -Prenatal - Admin	66.0%	65.2%

HEDIS



Santa Clara Family Health Plan
The Spirit of Care

Questions?

Santa Clara
Family Health Plan
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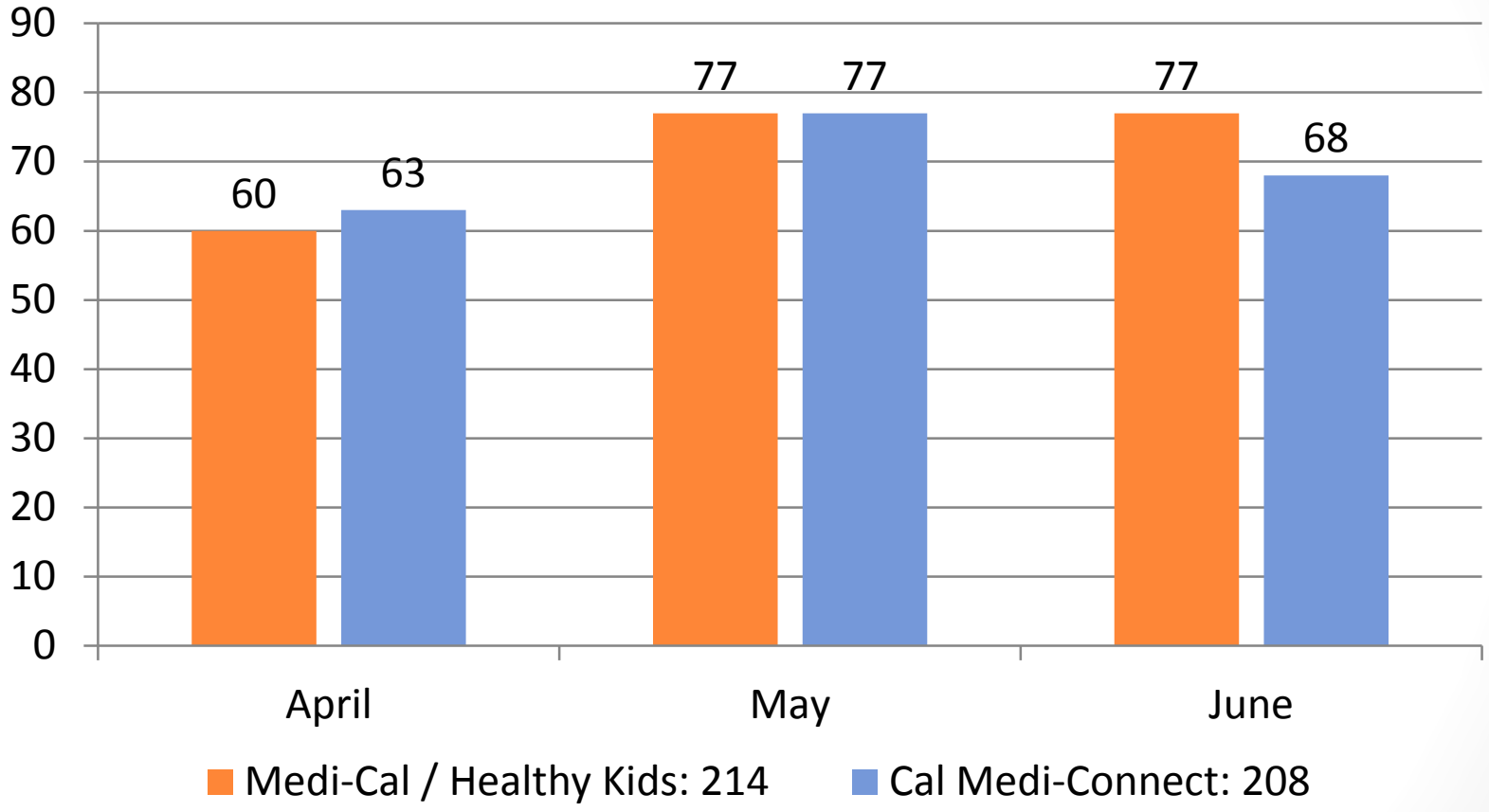
Grievance & Appeal Report Q2 2016

Medi-Cal / Healthy Kids cases received: 214

Cal MediConnect cases received: 208

Q2 2016 Total Cases by Month



Note: Numbers do not include cases processed by KP

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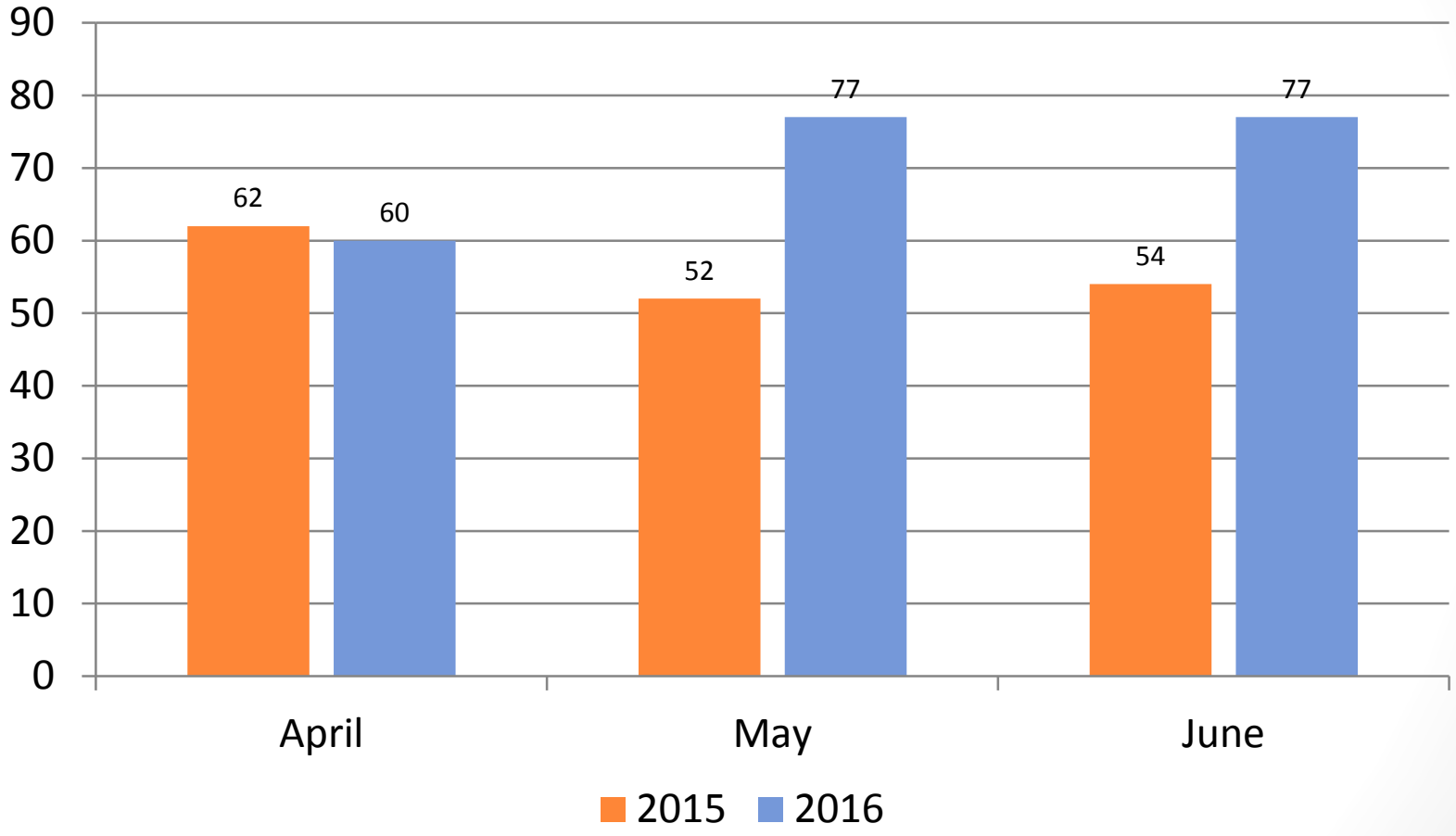
Medi-Cal / Healthy Kids 2015/2016 Q2 Comparison



Note: Numbers do not include cases processed by KP

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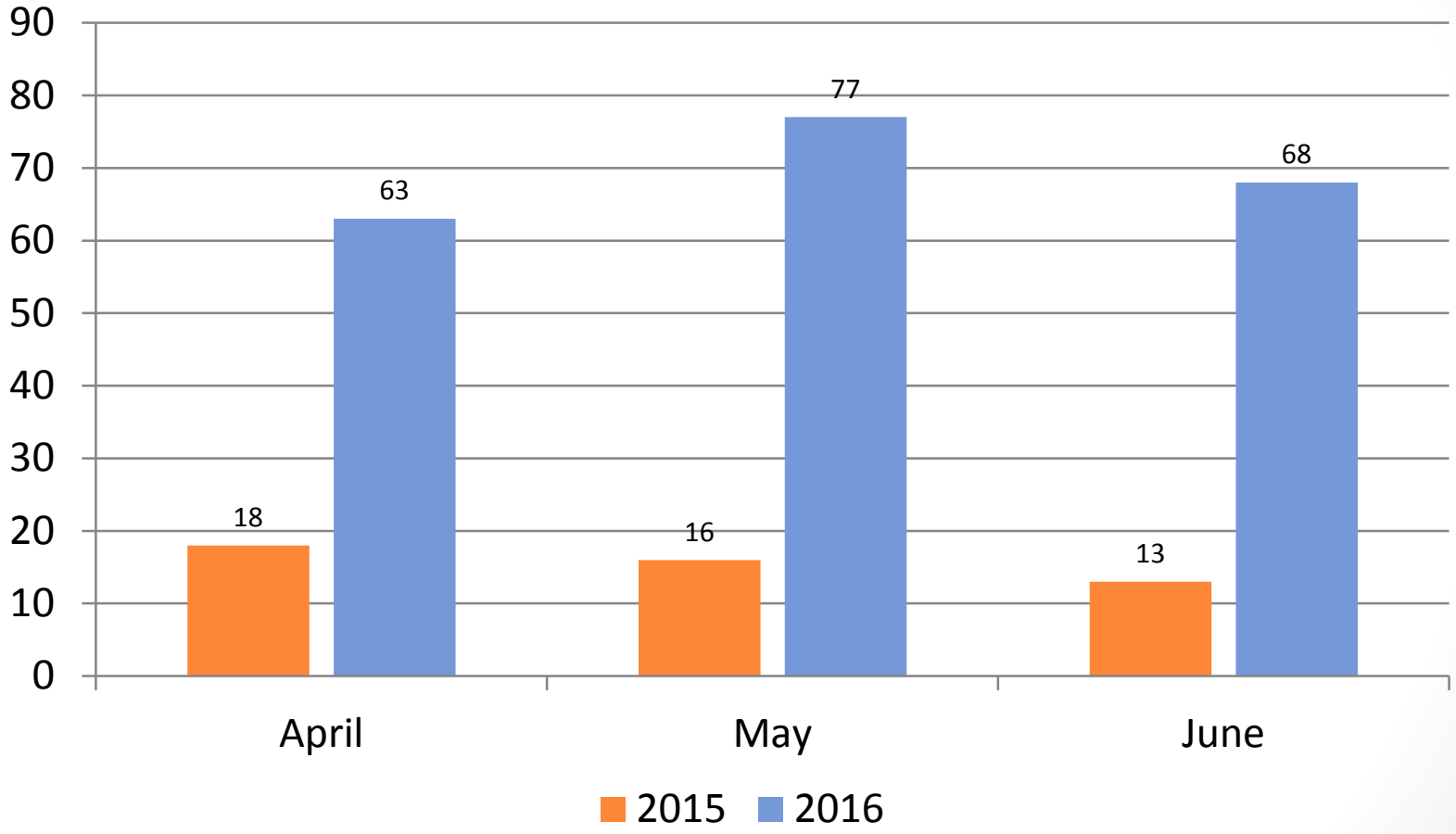
11/10/2016

CMC
2015/2016 Q2 Comparison



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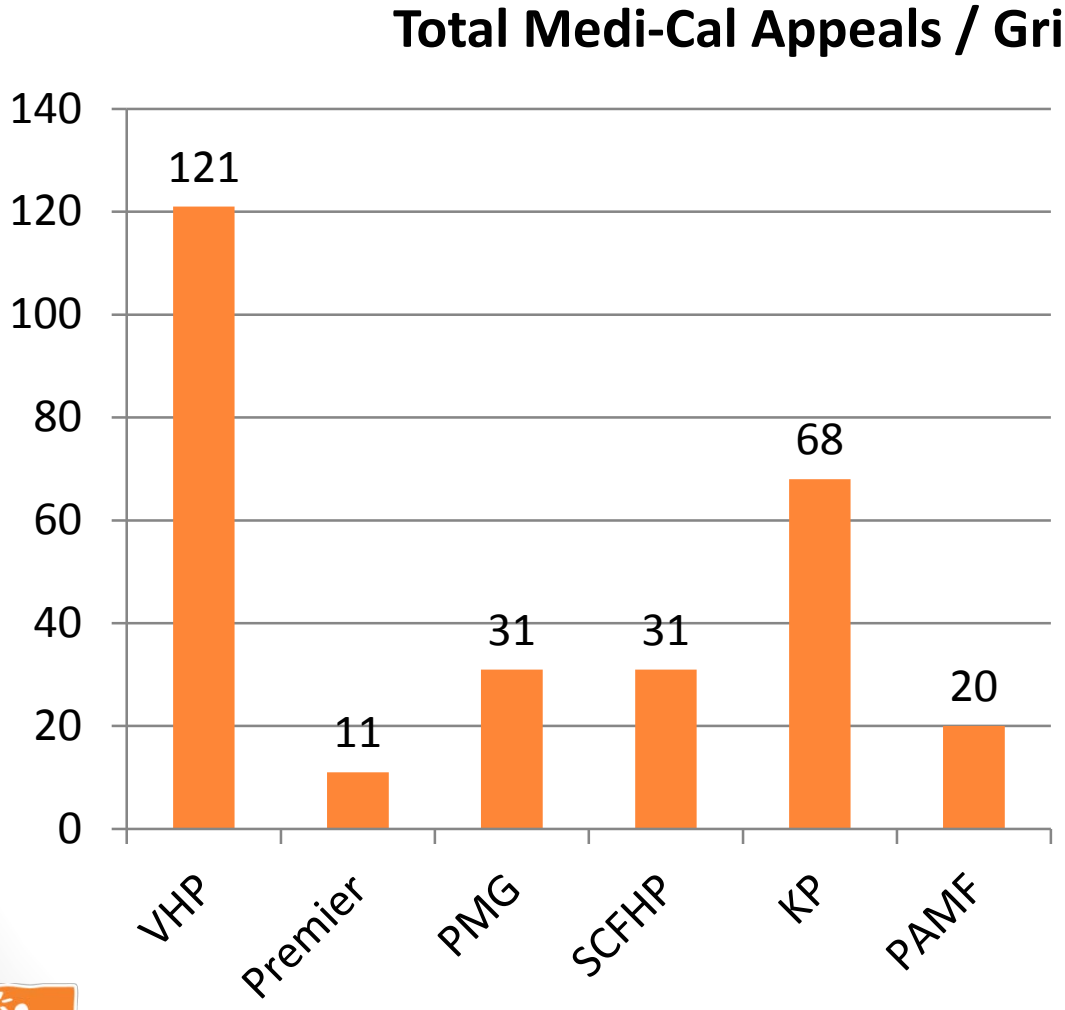
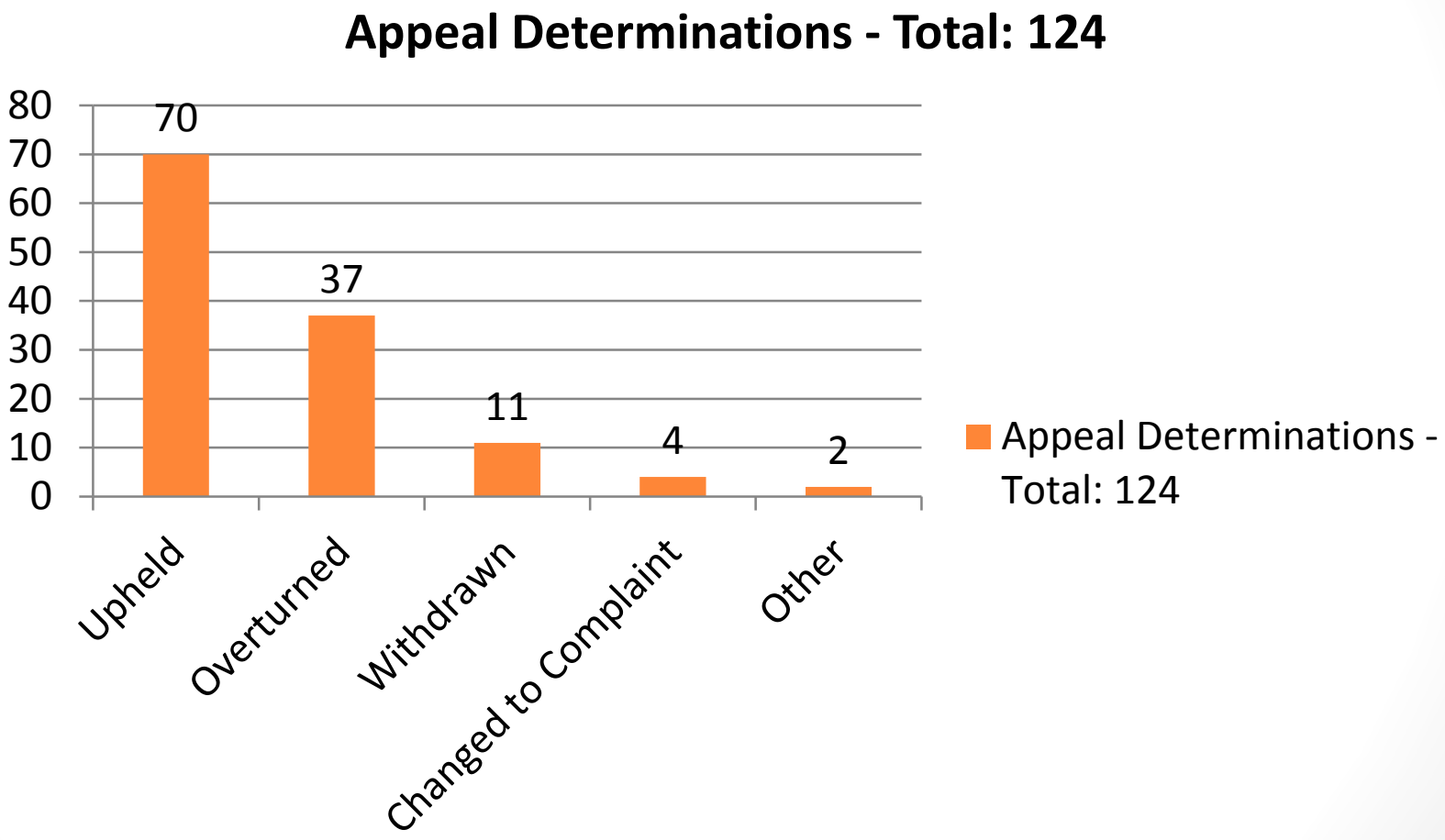
Medi-Cal / Healthy Kids Q2 2016 Cases by IPA

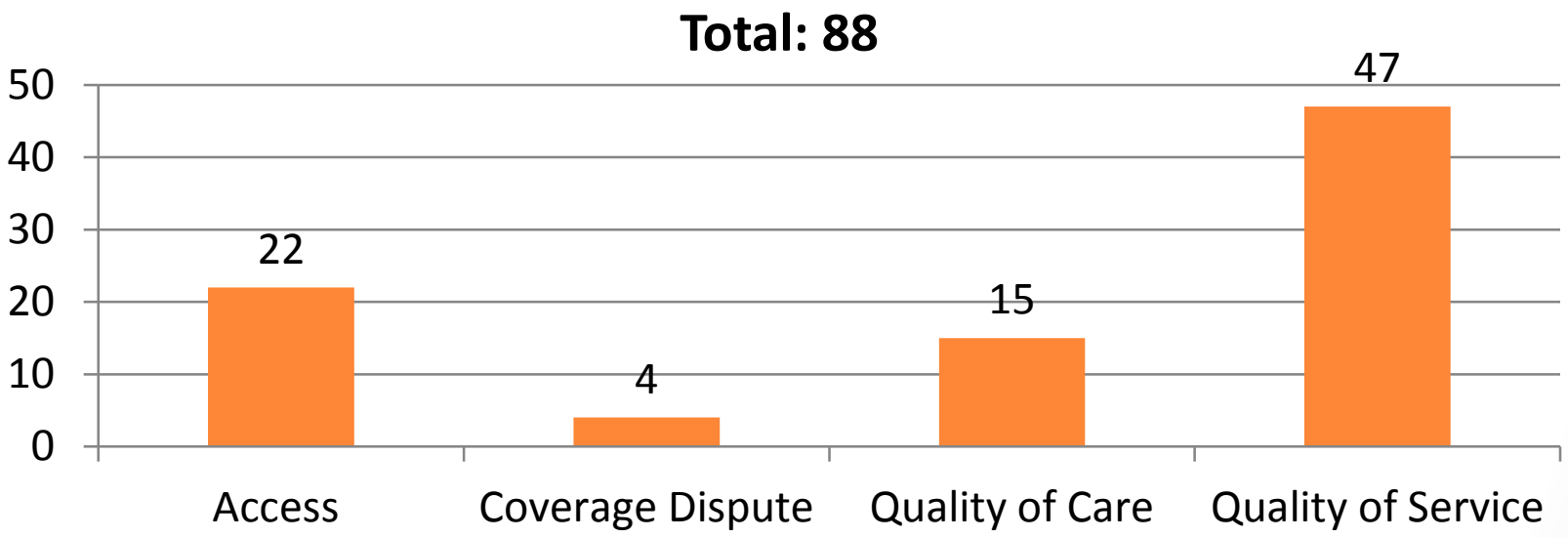


Note: KP numbers reflect cases processed directly by KP. KP numbers are not reflected elsewhere.

Medi-Cal Q2 2016 Appeal Determinations



Medi-Cal Q2 2016 Grievances by Type



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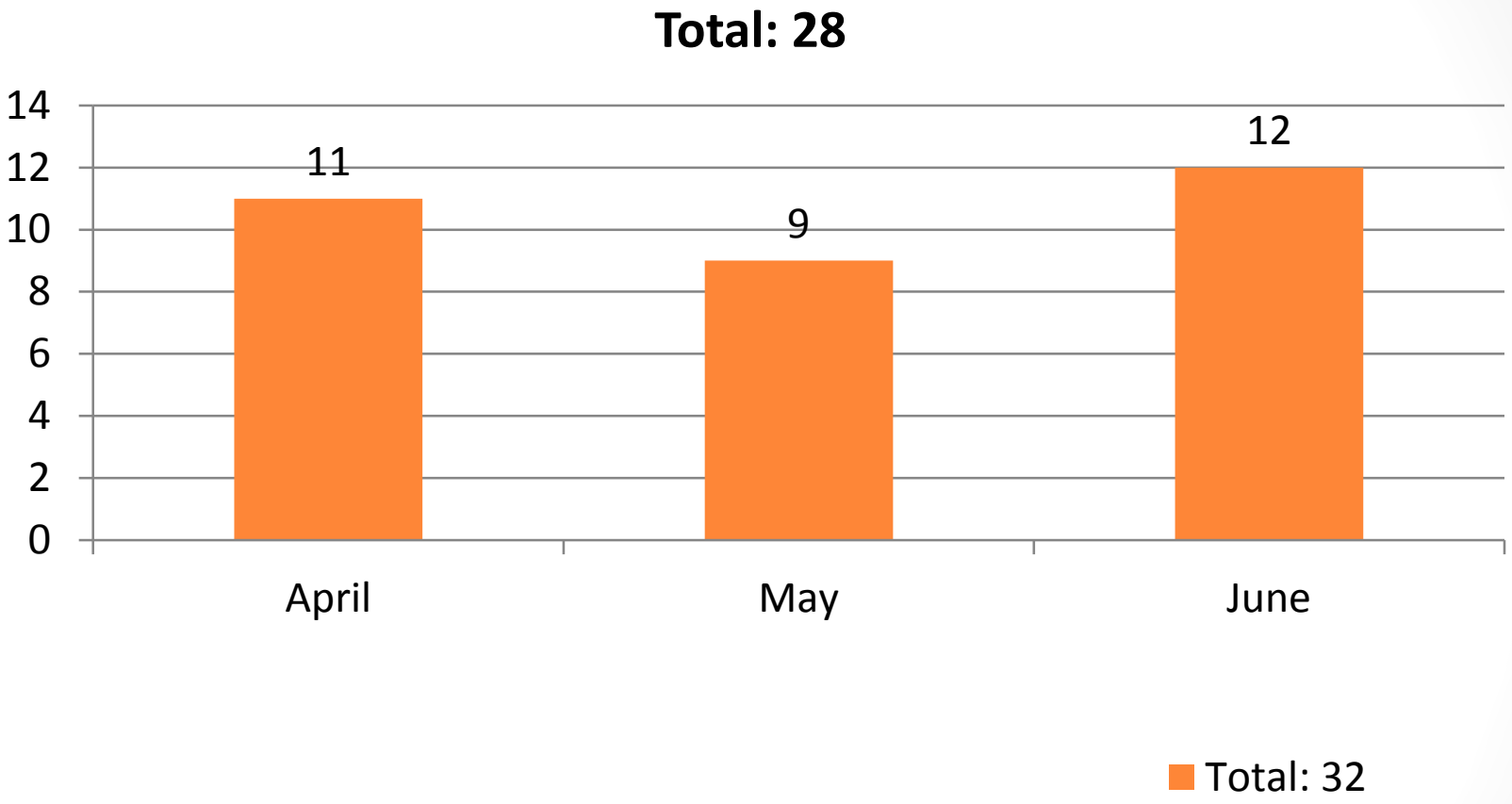
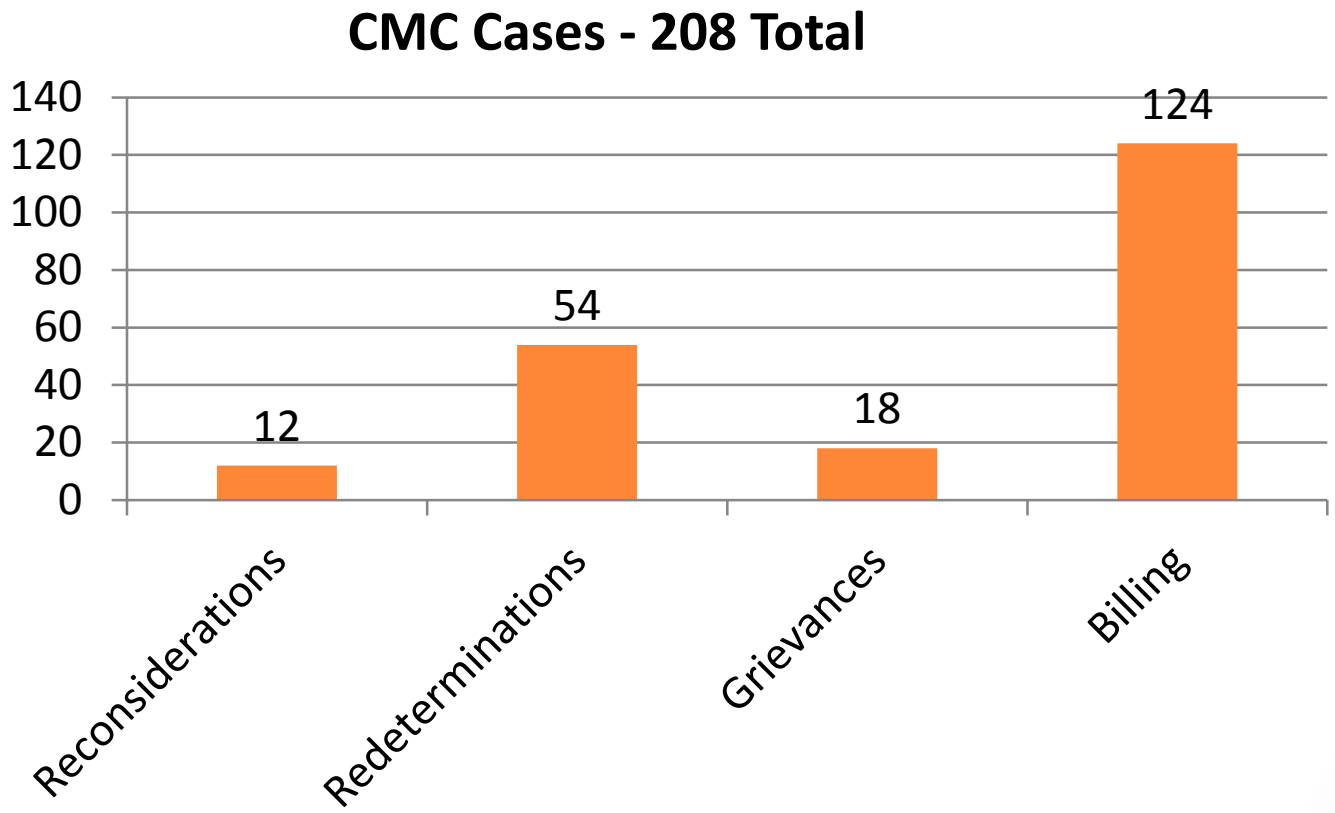
Q2 State Fair Hearings



CMC Q2 2016 Cases by Type



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SCFHP CAHPS 2016

QIC 8/10/16

CAHPS

- What is CAHPS?
  - Consumer Assessment of Healthcare Providers and Systems
  - Developed by the Agency for Healthcare Research and Quality
  - Survey driven - Telephonic and Mail
  - Administered in English and Spanish
  - Not available at provider level
  - Frequency
    - Annually for CMC
    - Every two years for MCAL

By the numbers

- Final Sample Size
  - MCAL = 1373
  - CMC = 800
- Total Response Rate
  - MCAL = 27.28%
  - CMC = 20.05%

Summary Rates

- Rating of the Health Plan
  - 9+10
    - MCAL = 51.95%
    - CMC = 55.63%
- Rating of Personal Doctor
  - 9+10
    - MCAL = 58.58%
    - CMC = 69.49%
- Rating of Health Care Quality
  - 9+10
    - MCAL = 52.44%
    - CMC = 45.77%

Provider Access

- Access [Always + Usually]
  - Got routine care as soon as needed
    - MCAL = 33.78%
    - CMC = 73.83%
  - Got urgent care as soon as needed
    - MCAL = NA
    - CMC = 80%

PCP Experience

- Doctor explained things in a way you could understand
  - MCAL = 60.66%
  - CMC = 91.60%
- Doctor showed respect for what you had to say
  - MCAL = 69.67%
  - CMC = 90.76%
- Doctor spent enough time with you
  - MCAL = 55.92%
  - CMC = 86.67%

Health Plan

- Rating of the Health Plan
  - 9+10
    - MCAL = 51.95%
    - CMC = 55.63%
- Care Coordination
  - Always + Usually
    - MCAL = 76.19%
    - CMC = 87.68%

Summary

- Members showed the similar experience with the health plan across both LOB's
- CMC members showed a better experience with both provider access and provider interaction than MCAL members
- CMC members were more satisfied with the personal doctor than MCAL members

Questions?

Santa Clara
Family Health Plan
The Spirit of Care

HEDIS 2016

QIC 8/10/16

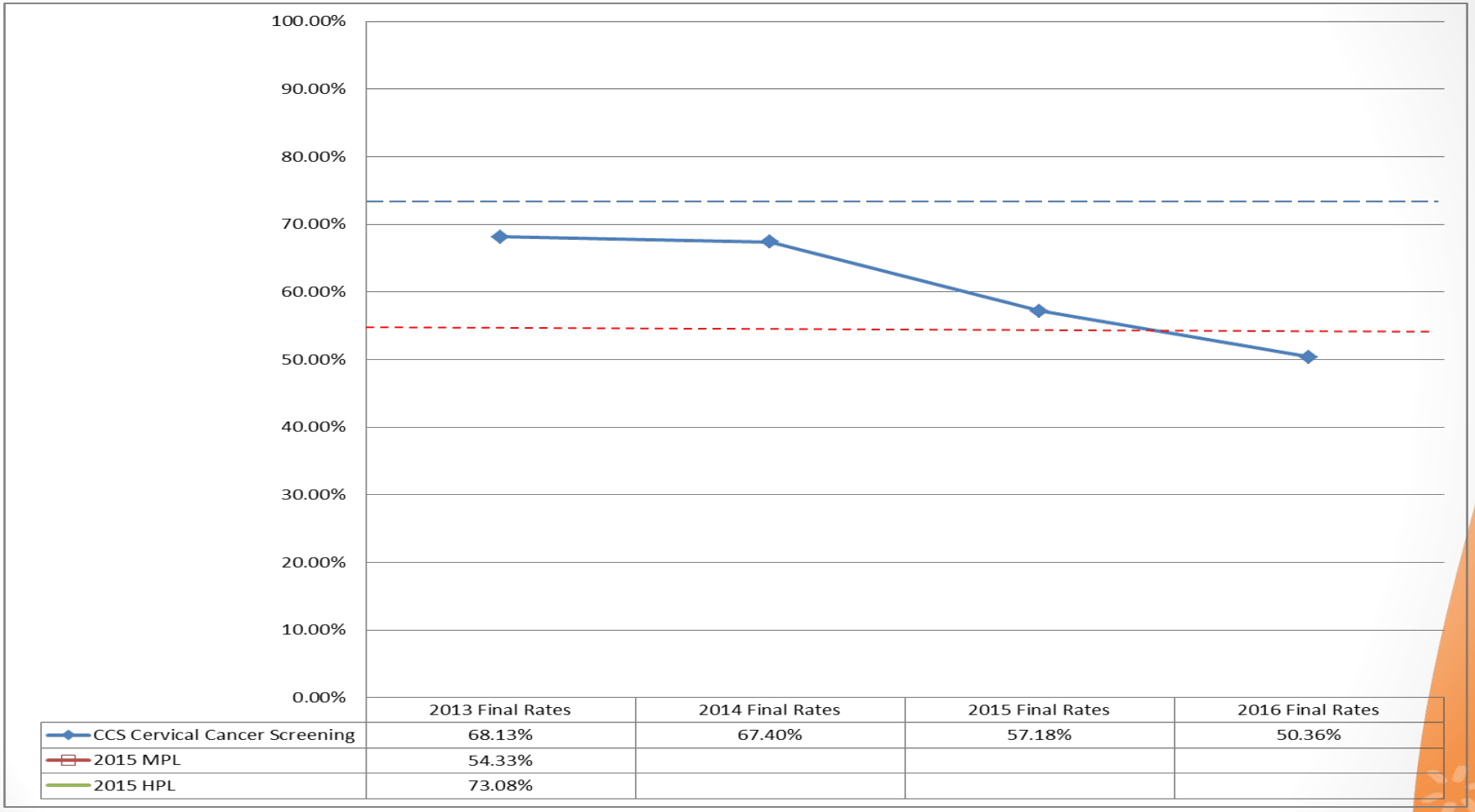
Reporting

- New Challenges
  - Reporting CMC
    - Different claims system
    - Behavioral health measures
    - Provider board certification measures
    - Patient Level Detail files
  - Medi-Cal
    - Patient Level Detail files
    - MLTSS reporting
- HEDIS medical record collection started 2 months late

Reporting

- Plus
  - Remote access to Valley Medical Center records
  - Remote access to Palo Alto Medical Foundation
  - Medical Record Review Validation passed the first time
- Delta
  - 2 months late resulted in;
    - Medi-Cal : Three measures below the MPL
    - CMC: One measure received a No Report

MCAL – Cervical Cancer Screening



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CCS Cervical Cancer Screening	68.13%	67.40%	57.18%	50.36%
2015 MPL	54.33%			
2015 HPL	73.08%			

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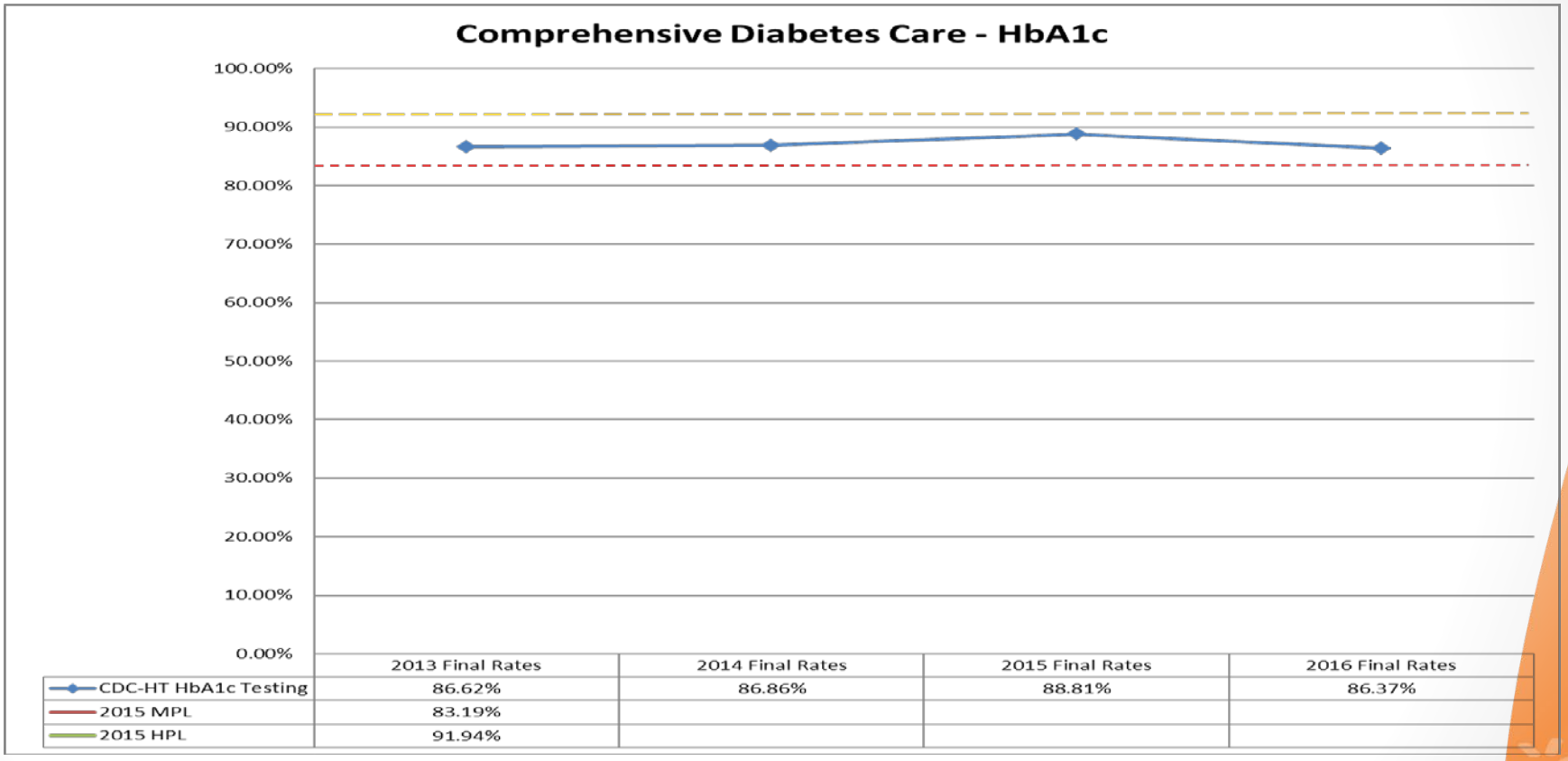
MCAL – HbA1c Testing



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CDC-HT HbA1c Testing	86.62%	86.86%	88.81%	86.37%
2015 MPL	83.19%			
2015 HPL	91.94%			

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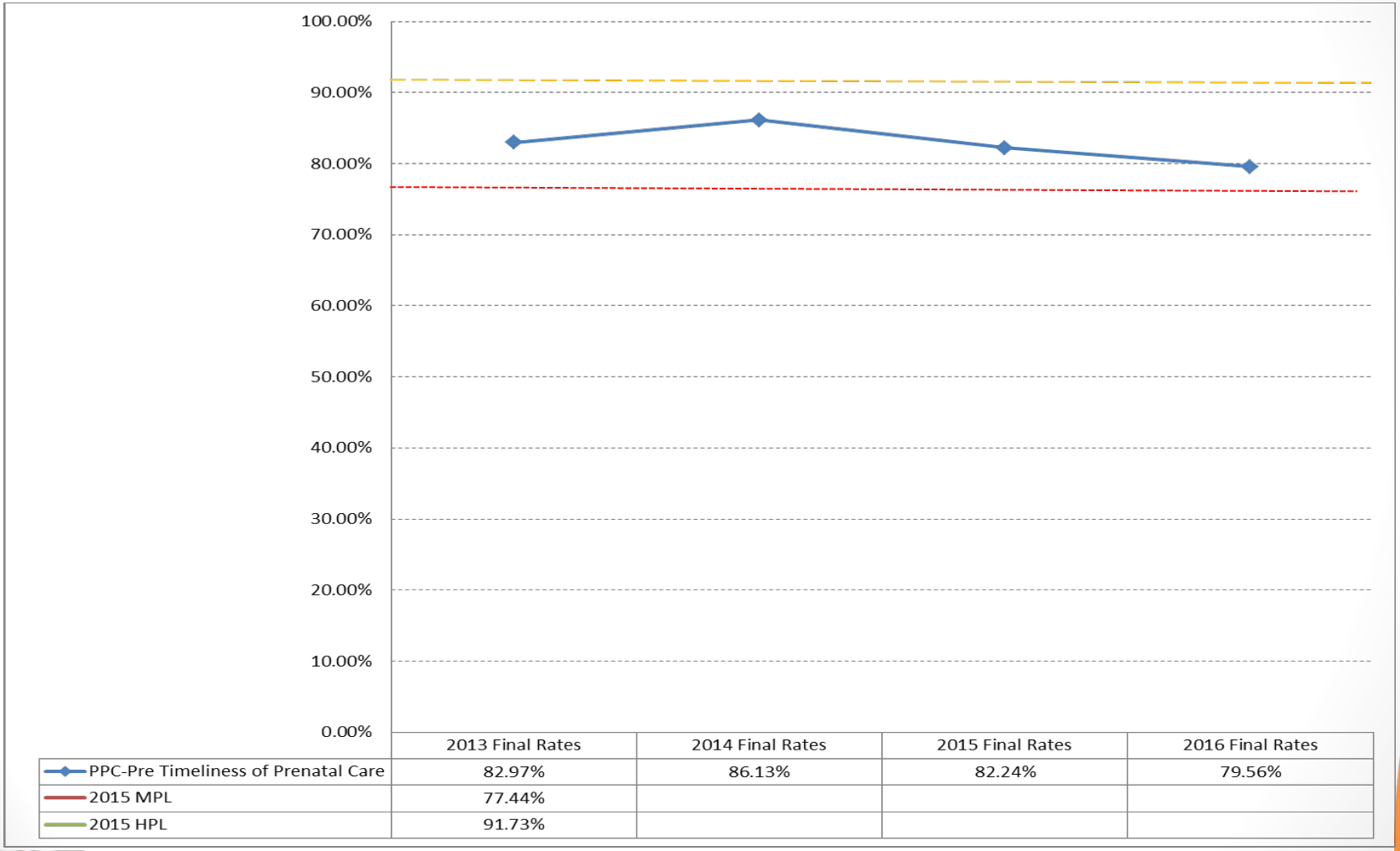
MCAL – Timeliness of Prenatal Care



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
PPC-Pre Timeliness of Prenatal Care	82.97%	86.13%	82.24%	79.56%
2015 MPL	77.44%			
2015 HPL	91.73%			

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MCAL – Controlling High Blood Pressure

	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CBP Controlling High Blood Pressure	52.80%	52.55%	54.99%	36.01%
2015 MPL	49.88%			
2015 HPL	70.32%			

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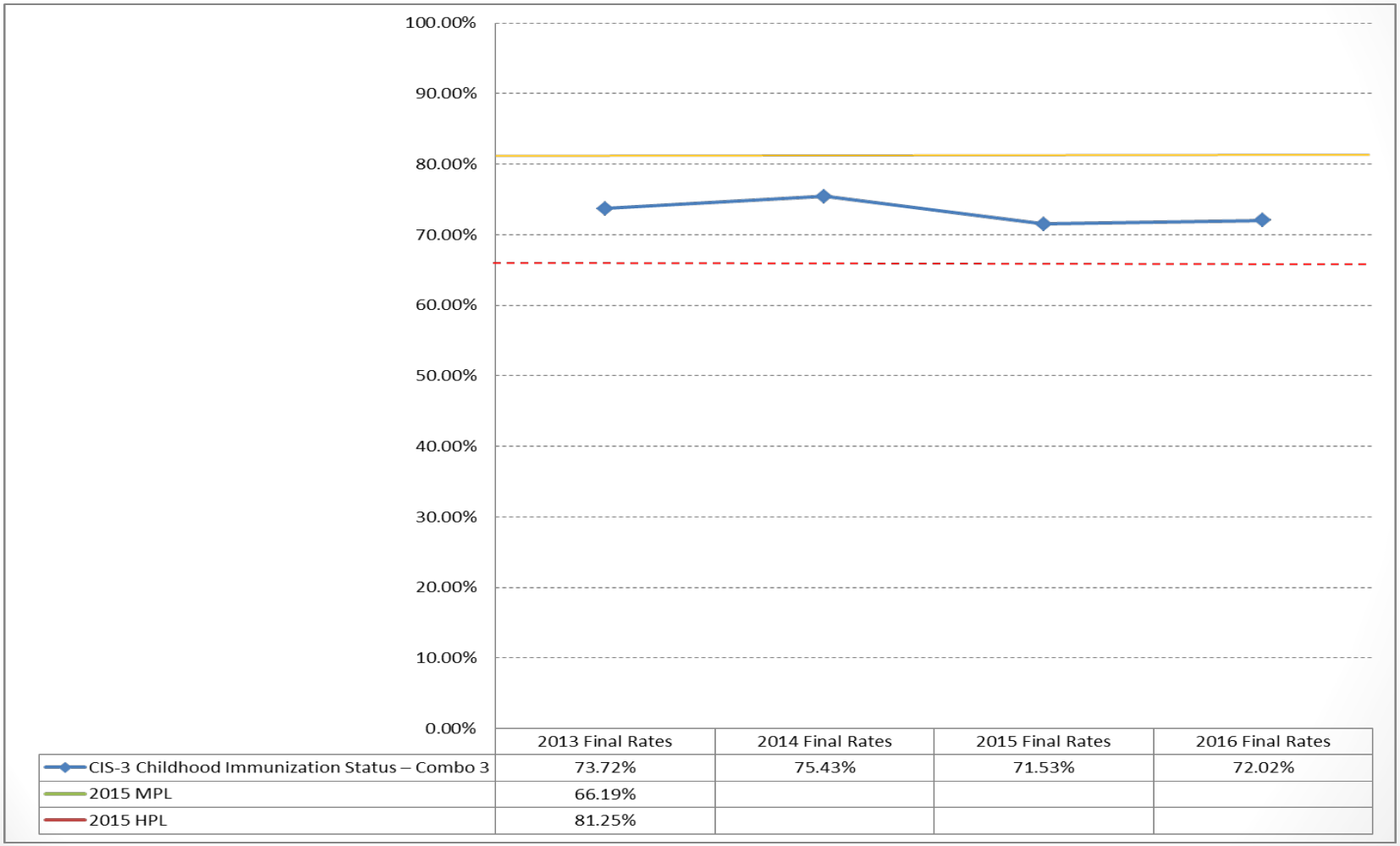
MCAL – Childhood Immunization Status – Combo 3



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CIS-3 Childhood Immunization Status – Combo 3	73.72%	75.43%	71.53%	72.02%
2015 MPL	66.19%			
2015 HPL	81.25%			

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Family Health Plan
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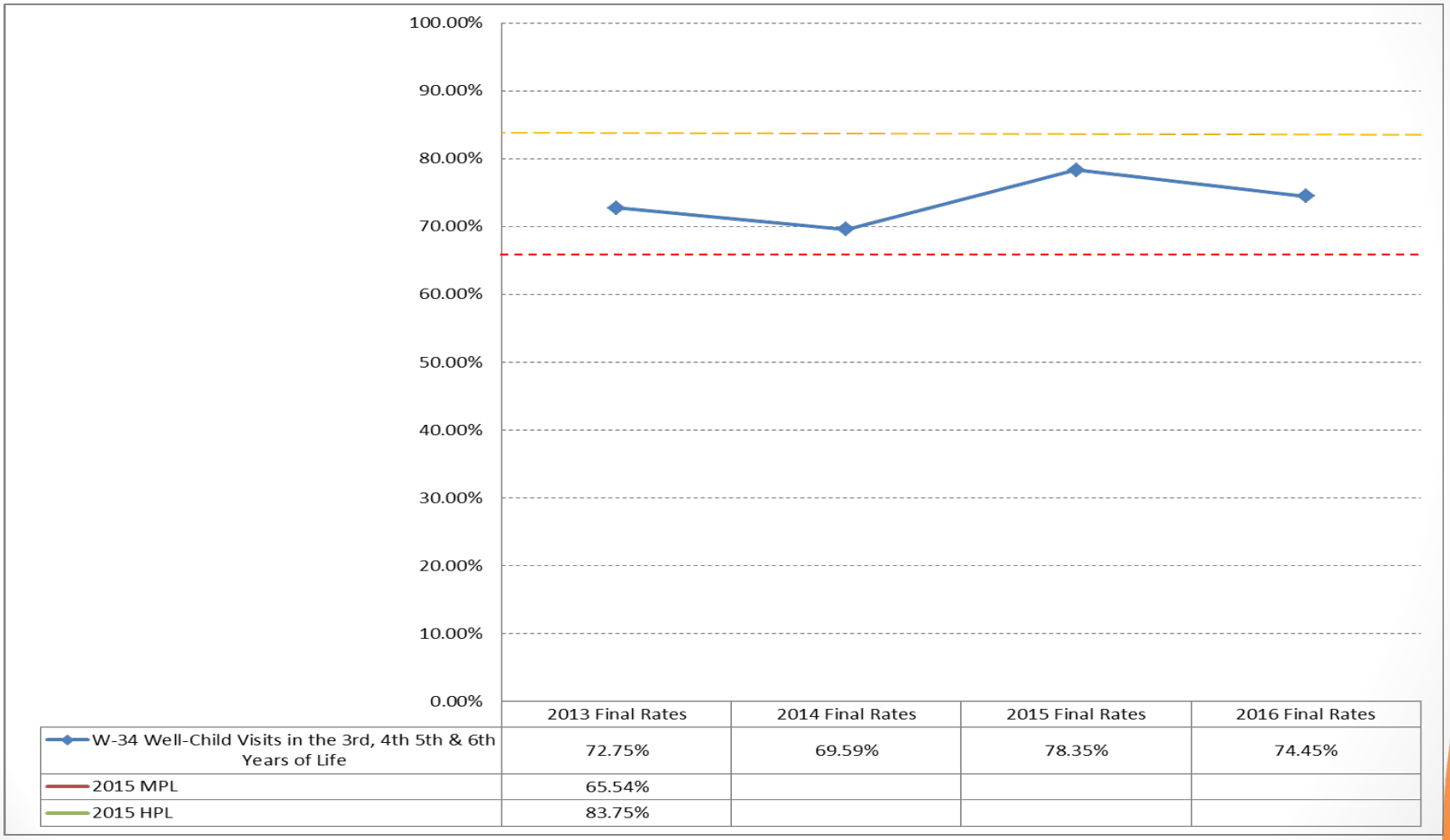
MCAL – Well Child Visits 3-6 Years of Life



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	72.75%	69.59%	78.35%	74.45%
2015 MPL	65.54%			
2015 HPL	83.75%			

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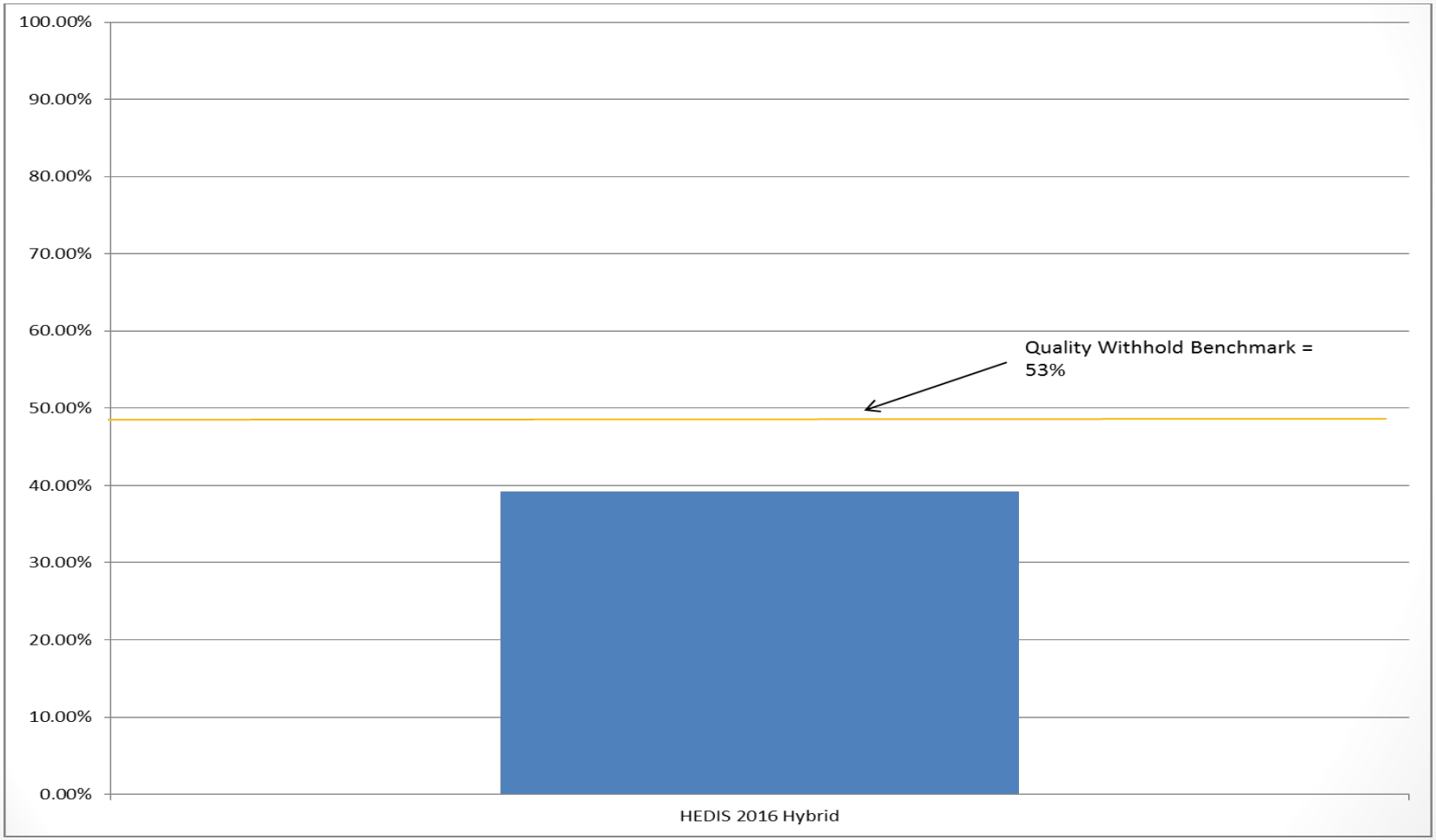
CMC – Controlling High Blood Pressure



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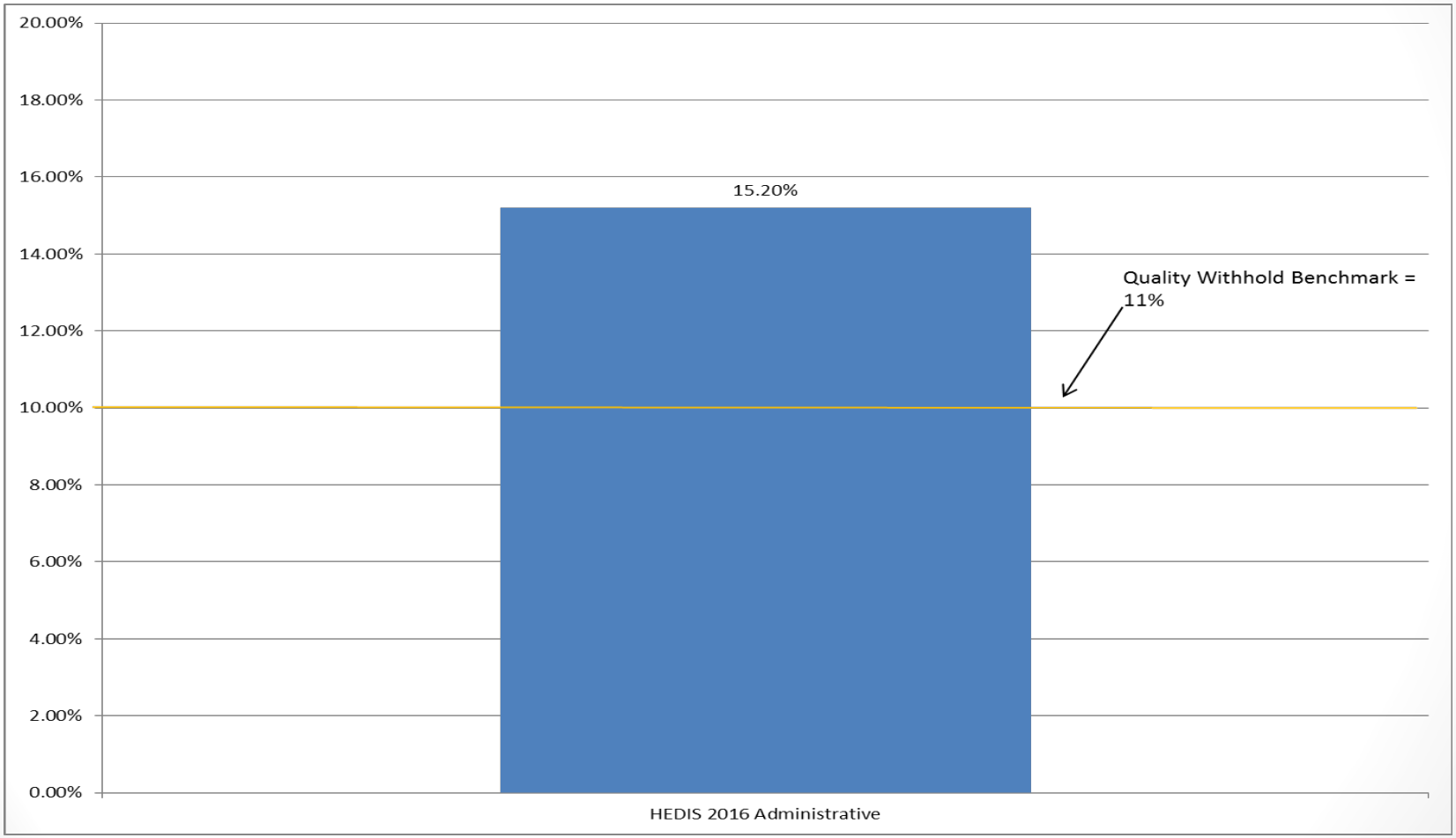
CMC – Plan All Cause Readmissions



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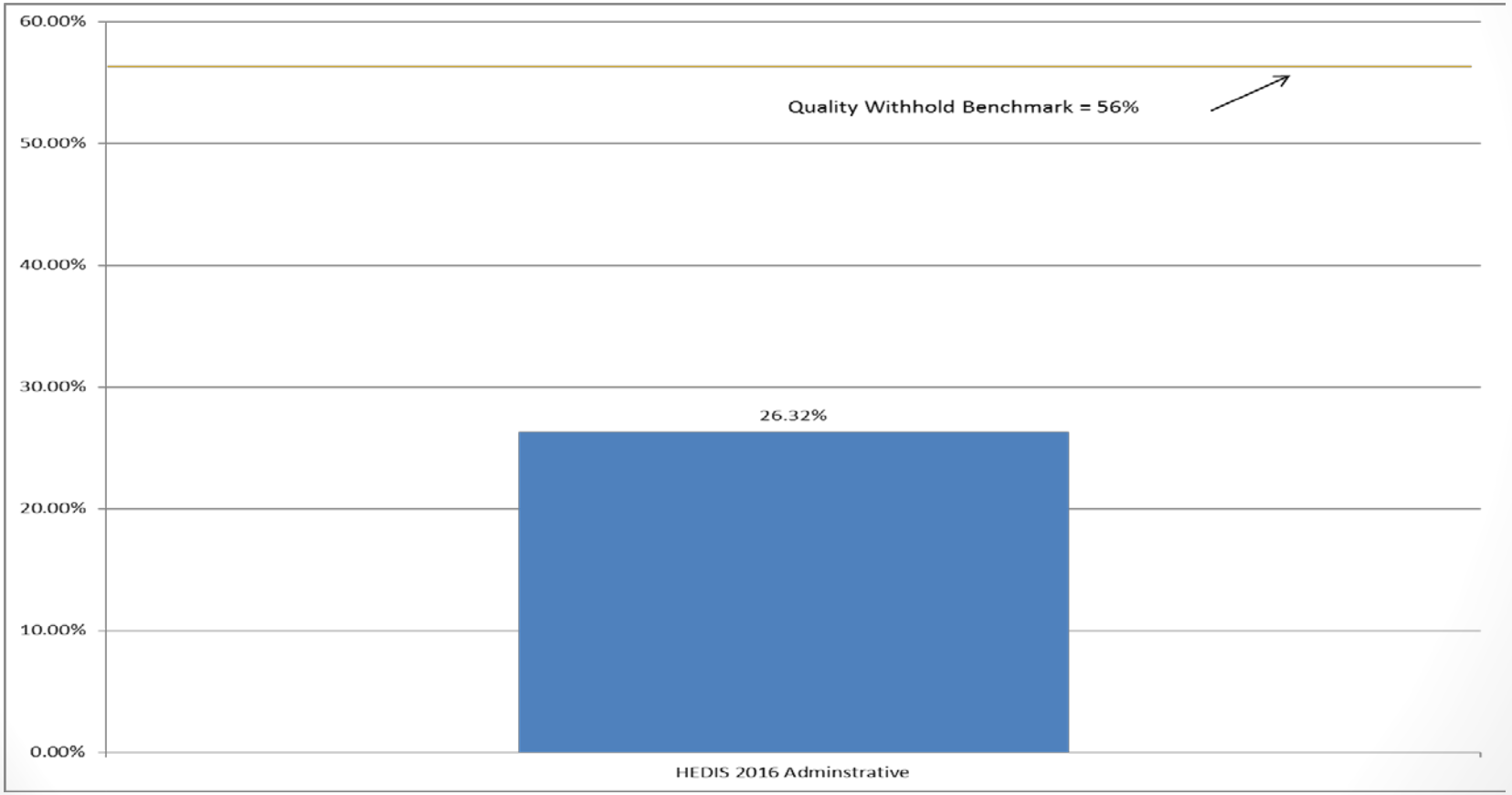
CMC – Follow up After Hospitalization for Mental Illness - 30 day follow up



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Next Steps

- Improvement Plans – MCAL
  - Cervical Cancer Screening
    - Mailing campaign and incentives
  - Controlling High Blood Pressure
    - Performance Improvement Project
  - Diabetes – Blood Pressure Control
- Cal Medi-Connect
  - Continue doing interim Verisk builds to correct problems from HEDIS 2016

Questions ?

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
March 24, 2016
CONFIDENTIAL

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

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	Y
Christine Tomcala	Chief Executive Officer	N
Tami Ogino	Clinical Pharmacist	Y
Joseph Cherian, PharmD	MedImpact	N
Angelique Tran	Pharmacy Coordinator	Y

Item	Discussion	Follow-Up Action
	The meeting convened at 6:10 PM.	
I.	**REVIEW, REVISE, AND APPROVE MEETING MINUTES of December 10, 2015.** The minutes were reviewed by Committee as submitted.	Upon motion duly made and seconded, the P&T Committee minutes of **December 10, 2015** were approved as submitted and will be forwarded to the QI Committee and Board of Directors.

II.	**SCFHP UPDATES – Jeff Robertson, MD, CMO** Dr. Robertson reported that membership is currently at 272, 916 members. Received notification from Department of Managed Health Care and Department of Health Care Services of joint audit to take place during the last two weeks of April (April 18-22; and April 25-29). Surveyors will also audit provider offices (Primary Care Physicians only, not Specialists). Will be looking for key elements in medical records: Name, Date of Birth, allergies list, required screenings, and immunizations. Current focus for SCFHP is fostering a culture of compliance and preparing for NCQA accreditation. Recently worked with WeiserMazars consultants to review and revise policies to be consistent with state guidelines.	
III.	**OLD BUSINESS/DISCUSSION ITEMS** No old business to discuss since interim from last meeting.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
March 24, 2016
CONFIDENTIAL

Item	Discussion	Follow-Up Action
IV.	**NEW BUSINESS/ACTION ITEMS**	
	a. Formulary Modifications	
	i. Prior Authorization Guideline Review Project/Archive List Presented 2015 and 2016 Formulary Modifications. Presented proposals to archive PA guidelines for drugs that are currently on formulary without restriction and for drugs that are no longer on formulary.	Upon motion duly made and seconded, Formulary Modifications and proposed changes to Prior Authorization Guidelines were approved as submitted
	b. MedImpact P&T Minutes	
	i. Presented 4Q15 MedImpact minutes for approval	Upon motion duly made and seconded, the MedImpact minutes were approved as submitted.
	c. Pharmacy Policy Review	Motion approved to accept policies as written
	Presented 9 policies for review: PH01 Pharmacy and Therapeutics Committee PH02 Formulary Development and Guideline Management PH03 Prior Authorization PH04 Pharmacy Clinical Programs and Quality Monitoring PH05 Continuity of Care for Pharmacy Services PH06 Pharmacy Communications PH07 Drug Recalls PH08 Pain Management Drugs for Terminally Ill PH09 Medications for Members with Behavioral Health Conditions	
	d. New Drugs	
	i. Zepatier-Presented as informational only AASLD Guidelines updated end of February. Updated SCFHP Hepatitis C Treatment Guidelines.	
	ii. Uptravi Presented as a new Pulmonary Hypertension medication. Recommendation: Leave as non-formulary Add Generic Revatio (sildenafil 20mg) with prior authorization.	Motion approved

Item	Discussion	Follow-Up Action
	e. Class Reviews i. Long Acting Insulins 3 new medications: Basaglar, Ryzodeg, and Tresiba Recommendation: Remove Levemir Flextouch from formulary (to match Levemir vial non-formulary status).	Motion approved
	ii. Multiple Myeloma 3 new agents: Ninlaro, Darzalex, Empliciti Recommendation: Leave as non-formulary.	
	iii. ADHD Non-Stimulant Request for recommendation on what to do with Strattera. 3 options: 1) Keep on formulary with no prior authorization 2) Keep on formulary and add prior authorization 3) Make non-formulary and grandfather in those currently taking Strattera	
	Motion made to keep on formulary with no prior authorization for those under 18 years old and require prior authorization for those above 18 years old.	Motion approved
	f. 1Q2016 Drug Trend and Utilization Review	Informational only
	g. Medi-Cal Formulary Drug Updates Recommend add Bexsero and Menveo to formulary Recommend add Gardasil to formulary Recommend add Cytoxan to formulary	 Motion approved Motion approved Motion approved
	h. Generic Pipeline-Presented as informational only	
V.	**REPORTS** a. Membership Report – presented by Jeff Robertson, MD b. Prior Authorization Report – presented by Jeff Robertson, MD	

VI.	**ADJOURNMENT** The meeting was adjourned at 7:45 PM.	

Submitted by:

Date: 6/16/16
Caroline Alexander
Administrative Assistant

Internal Approved By:

Date: 6/16/16
Johanna Liu, PharmD
Pharmacy Director, SCFHP

External Approved by:

Date: 6/16/16
Jimmy Lin, MD
Pharmacy & Therapeutics Chair

Santa Clara
Family Health Plan

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MINUTES
UTILIZATION MANAGEMENT COMMITTEE
April 20, 2016

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

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	N
Lori Andersen	LTSS Operations Director	Y
Gregg Bernhard	Interim Health Services Director	N
Andres Aguirre	Quality Improvement Manager	N
Sherry Holm	Behavioral Health Manager	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:10 p.m. Introduced Lori Anderson, LTSS Operations Director to the group. The minutes of the February 24, 2016 meeting were approved as presented.	
II. CEO Update	Ms. Tomcala presented the update for Santa Clara Family Health Plan. DMHC/DHCS audit is currently taking place and will continue through next week. Updated policies and procedures as part of preparation for audit UM Committee will now report to the Quality Improvement Committee which is now a committee of the Board.	

ITEM	DISCUSSION	ACTION REQUIRED
III. Old Business	No old business to present.	
IV. Action Items	a. Review of Policies and Procedures Dr. Robertson reported reduced number of policies from 51 to a total of 9 policies and revised to be consistent with regulatory requirements. Presented a summary of the revised policies and reviewed with committee. b. DM Program Description 2016 Dr. Robertson presented the DM Program Description. Currently going through RFP to obtain vendor to do Disease Management and Complex Case Management for Chronic Conditions. Program will be implemented no later than October 2016. (Pending approval) c. UM Program Description 2016 Dr. Robertson presented the UM Program Description for 2016. d. UM Committee Charter Dr. Robertson presented the UM Committee Charter. Recommend add in sentence indicating members are appointed by the CEO, not the Board. No maximum or minimum number of committee members indicated per Charter. e. CPO Overview Ms. Andersen presented an overview of Care Plan Options (CPO). Allows Cal MediConnect plans to offer services beyond those covered by Medi-Cal and MediCare. CPO services help to enhance member's care, prevent unnecessary hospitalizations or prolonged care in institutional settings, and allow plans to respond more quickly to changes in an enrollee's health. CPO is added only after assessing for existing LTSS benefits such as IHSS, CBAS, MSSP and LTC.	Approved by committee. Will finalize drafts, obtain approval signatures Approved as written. Approved with recommendation of adding in phrase regarding CEO appointing members.
V. Reports	a. Membership Dr. Robertson reported membership is at 270, 934 in April. Cal MediConnect membership is at 8,488 and MediCal is at 257, 469. Plan will continue to increase marketing effort to Providers to encourage members to enroll in Cal MediConnect.	

ITEM	DISCUSSION	ACTION REQUIRED
	b. UM Reports 2016 Turn Around Time/ Denial Approval Dr. Robertson presented an update on UM Referrals for the 1st Quarter of 2016. A total of 3,074 referrals were received during the 1st Quarter of 2016: 89% approved, 5% denied, 1% Pending, 5% cancelled. MediCal Authorizations Turnaround time is 98% for routine, 97% for urgent, 99% for retroactive. Cal MediConnect turnaround time is 100%. c. Pharmacy Authorizations Dr. Robertson presented an update on Pharmacy authorizations. Medi-Cal authorization turnaround time within 24 hours is at 100% over the last six months. Cal MediConnect authorization turnaround time is also at 100% over the last six months. d. Mental Health Update Dr. Robertson presented an update on Behavioral Health Treatment for the 1st Quarter 2016. Numbers of members actually receiving services through Santa Clara Family Health Plan (SCFHP) is inclusive of those transitioning from Regional Center to SCFHP. 136 referrals were made for comprehensive diagnostic evaluation. 88 members had a completed diagnostic evaluation. 87 members are receiving behavioral health therapy services. 38 members are transitioning from San Andreas Regional Center (SARC); excluding Kaiser members. 104 Cal MediConnect member with Care Coordination and Specialty Mental Health. e. LTSS Ops Report Ms. Andersen presented the LTSS Operations Report Summary from April 2015 to March 2016. As of March 2016: 562 in CBAS; 11, 998 receiving assistance from IHSS (In Home Supportive Services); 269 MSSP (Multi Purpose Senior Services Program); 1,649 LTC (Long Term Care) Number of LTSS referrals has increased.	

ITEM	DISCUSSION	ACTION REQUIRED
VI. Adjournment	Meeting adjourned at 7:35 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, July 20, 2016, 6:00 PM	All: Calendar this event and plan to attend.

Prepared by:

Caroline Alexander
Administrative Assistant

Date 7/20/16

Reviewed and approved by:

Jimmy Lin, M.D.
Committee Chairperson

Date 7/20/16

Santa Clara
Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE AD HOC MEETING
June 02, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	N
Ngon Hoang Dinh, DO	Head and Neck Surgery	N
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	Pyschiatry	N

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

ITEM	DISCUSSION	ACTION REQUIRED
I. Review and Approval of Agenda	Dr. Boris reviewed the agenda with the committee. It was moved, seconded to approve agenda as written.	Agenda approved
II. Review and Approval of UM Policies	Three policies were presented and reviewed by the committee: HS10 Financial Incentives HS11 Informed Consent HS12 HS Preventive Guidelines After discussion, it was moved, seconded to approve all three policies as written.	All policies were approved as presented.
III. Review and Approval of 2016 UM Workplan	Dr. Boris presented a summary of the 2016 UM Workplan to the committee. After discussion, it was moved, seconded to approve 2016 UM Workplan. The UM workplan outlines the years activities and highlighted were the CMC and Medi-Cal reporting, compliance with TAT, Inter Rater Reliability, Quality of Service categories and Quality of Clinical Care.	2016 UM Workplan was approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
IV. Medi-Cal, Healthy Kids, and CMC Updated Prior Authorization Grids	Dr. Boris presented a summary of the updates to the Medi-Cal, Healthy Kids, and Cal MediConnect authorization grids. Highlighted is the removal of Chemotherapy from Prior Authorization requirements. The Committee and CMO requested that there be a combined two lists into a common format which is easier to read. After discussion, it was moved, seconded to approve updates to Medi-Cal and Cal MediConnect Authorization Grids. The UM Manager and Supervisor will create a combined grid and present it at the next meeting.	Updates to Medi-Cal, Healthy Kids, and Cal MediConnect Authorization Grids approved
V. Review and Approval of Clinical Practice Guidelines (Medical and Behavioral) and Preventative Guidelines	Santa Clara Family Health Plan uses clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances. These clinical practice guidelines are also used in related programs such as disease and population management. Practice guidelines are developed from scientific evidence or a consensus of health care professionals in the particular field. Practice guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. Santa Clara Family Health Plan monitors compliance and member outcomes related these clinical guidelines for quality improvement initiatives. These clinical practice guidelines are intended to assist providers in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. The guidelines are not intended to replace clinical judgment but are provided to assist our practitioners with making decisions about a range of clinical conditions. The treating practitioner should make the ultimate decision in determining the appropriate treatment for each patient. a. Clinical Practice Guidelines Dr. Boris presented 5 recommended guidelines for discussion. Recommendation to keep Antithrombotic Guidelines. After discussion, it was moved, seconded to approve Clinical Practice Guidelines as presented. b. Behavioral Health Guidelines Dr. Boris presented 3 recommended guidelines for discussion. After discussion, it was moved, seconded to approve Behavioral Health Guidelines as presented.	Clinical Guidelines approved as presented. Behavioral Health Guidelines approved as presented. Preventative Care Guidelines approved as presented. Marketing to post links to guidelines on Provider Website

ITEM	DISCUSSION	ACTION REQUIRED
	c. Preventative Care Guidelines Dr. Boris presented 5 recommended guidelines for discussion. After discussion, it was moved, seconded to approve Preventive Care Guidelines as presented.	

Prepared by: Caroline Alexander Date 7/20/16

Caroline Alexander
Administrative Assistant

Reviewed and approved by: Jeff Robertson Date 7-20-16

Jeff Robertson , M.D.
Committee Chairperson
ACTING

Dashboard Reporting

Facility Site Reviews

Second Quarter 2016

19 sites reviewed

2 sites medical record review only

Potential Quality Issues

Second Quarter 2016

32 issues referred to QI

CMC

Case Management