



AGENDA

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

Wednesday, May 11, 2016

6:00 PM

Santa Clara Family Health Plan
210 E. Hacienda Avenue
Campbell CA 95008

1. Introduction	Thad Padua, MD	6:00
Public Comment		
Members of the public may speak to any item not on the agenda; two minutes per speaker.		
The committee reserves the right to limit the duration of public comment period to 30 minutes.		
2. CEO Update	Christine Tomcala	6:10
3. Follow Up Items	Thad Padua, MD	6:20
Org Structure		
4. Consent Agenda	Thad Padua, MD	6:30
a. Review minutes of the February 10, 2016 QI Committee Meeting		
b. Quality Improvement Policies for approval		
c. QI Program Description Summary of Changes		
d. 2015 QI Program Evaluation		
5. Discussion Items		7:00
a. Selection and Appointment of new QI committee chair		
b. QI Committee Charter	Jennifer Clements	
c. Access and Availability	Dan Johns	
d. Appeals and Grievances		
e. CY 2015 Annual Review of the SCFHP CMC Population Demographics and specific health conditions	Lily Boris	
f. Dashboard CMC	Andres Aguirre	
6. Report of Committees and Approval of Subcommittee Minutes		7:30
a. Credentialing Committee	Attachment B	Jeff Robertson, MD
b. Pharmacy and Therapeutics Committee	Attachment C	Jimmy Lin, MD
c. Utilization Management Committee	Attachment D	Jimmy Lin, MD
7. PQI Discussion: Protected Information: Closed Session		
Next Meeting: Wednesday – August 10, 2016 - 6:00 p.m.		

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Caroline Alexander 24 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
Quality Improvement Committee
Wednesday, February 10, 2016

Voting Committee Members	Specialty	Present Y or N
Thad Padua, MD	Pediatrics	Y
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	N
Jimmy Lin, MD	Internist	Y
Ria Paul, MD	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	Y
Christine Tomcala, CEO	N/A	Y
Sara Copeland, MD	Pediatrics	N
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	N
Pat McClelland	Vice President of Member Operations	N
Caroline Alexander	Administrative Assistant	Y
Patricia Smith	Quality Improvement Nurse	N
Katrina Leestma	Medical Management Manager	N
Johanna Liu, PharmD	Pharmacy Director	Y
Dan Johns	Appeals and Grievances Manager	Y

AGENDA ITEM	DISCUSSION/ACTION	FOLLOW-UP	RESPONSIBLE PARTIES	DU DATE
INTRODUCTIONS	Meeting called to order at 6:07 p.m. Introduced Jimmy Lin, MD as voting member of Quality Improvement Committee. Also introduced Lily Boris, MD, as the new Medical Director, and Dan Johns as the new Appeals and Grievances manager for Santa Clara Family Health Plan.			
CEO Update	Ms. Tomcala presented an update for Santa Clara Family Health Plan. Primary objective for the health plan is compliance. Weiser Mazars Consultants were onsite to assist in identifying any gaps that need to be addressed prior to the upcoming audits. Assisting Santa Clara Family Health Plan with preparation for	Share Industry Collaborative Effort (ICE) format with the Committee	Lily Boris, MD	Next Quality Improvement Committee Meeting May 11th

AGENDA ITEM	DISCUSSION/ACTION	FOLLOW-UP	RESPONSIBLE PARTIES	DUE DATE
	the upcoming MediCare audit, as well as NCQA Accreditation. Some committee restructuring will take place in order to meet all compliance and accreditation standards. Quality Committee will become a committee of the Board, reporting to the Board. Peer Review will now report up to Credentialing Committee, instead of previous practice, where peer review was presented at the Quality Improvement Committee. Credentialing Committee will report up to Quality Improvement Committee in the standard Industry Collaborative Effort (ICE) format. The new ICE format will be presented as a summary, no provider names will be included. DHCS/DMHC will be conducting a joint audit the second half of April. CMS audit may be soon after that to audit Cal MediConnect product.			
Follow Up Items	No follow up items from November 18 th meeting.			
Action Items A. Approval of 11-18-15 meeting minutes B. Core QI Workplan 2016 Update C. Quality Improvement Program 2016	<p>The Minutes were approved as presented.</p> <p>Mr. Aguirre presented the Quality Improvement Workplan for 2016. Goals/Baseline was added. Will track Quality Improvement Program Evaluation. UM components are being added to the workplan and evaluation. Metrics around Networks and Credentialing. Proposed Workplan presented for approval to committee.</p> <p>Dr. Boris presented a summary of the key components for the 2016 Quality Improvement Program. More detail was added to Section Three: Scope of Program. In Section Eight: Quality Improvement Program Design and Process, emphasized the large focus on Section B (Access to Service), as well as Section C: Member Satisfaction. Section D Reviews Health Information Systems. Section D Health Information Systems was reviewed.</p>	<p>Motioned/Seconded/Approved</p> <p>Add title to document to indicate Workplan 2016</p> <p>Motioned/Seconded/Approved</p> <p>Bring Grid of Delegated Functions per network to the next committee meeting</p>	<p>Andres Aguirre</p> <p>Andres Aguirre</p>	

AGENDA ITEM	DISCUSSION/ACTION	FOLLOW-UP	RESPONSIBLE PARTIES	DUE DATE
	<p>Section Nine: Quality Program Effectiveness and Accountability was reviewed. This is measured through the Quality Improvement Workplan, which must be updated and presented yearly. Recommendation by Dr. Padua that for next cycle of Quality Improvement Project selection, the committee be allowed to give input as to which Quality Improvement Project should be done.</p> <p>The committee recommended the following update: Add Altruista and QNXT and Medi Impact to the Health information section. Fix the title of the document.</p> <p>With those revisions, the committee voted to approve</p>	<p>Bring back to next committee meeting as finalized</p> <p>Motioned/Seconded/Approved to accept changes</p>	Andres Aguirre	Next Quality Improvement Committee Meeting May 11th
<p>Discussion Items</p> <p>A. Quality Improvement Projects</p> <p>B. B.CCIP-BP Ahderence (reported out with above item A)</p> <p>C. Access and Availability</p>	<p>Mr. Aguirre presented the Cal MediConnect and Medi-Cal Quality Improvement Projects for 2016: Reducing Readmissions 30 days post discharge and diabetic retinal eye exams. DHCS gives 4 areas to choose from : Chronic Care, Hypertension, Well Child Visits and Pregnancy follow up visits/care. Will focus on Case Management Transition of Care. Sending topic proposal this month.</p> <p>Using SMART AIM data collection. Will need assistance from Quality Improvement Committee on this. Recommendation by Dr. Boris to look at adherence to picking up medications.</p> <p>Recommendation by Dr. Robertson to do a chart pull and review for verbal intervention to change medication dose. (Possible indication of non-control of hypertension)</p> <p>Dr. Boris gave an update on Timely Access and Provider Satisfaction Reporting on behalf of Jennifer Clements, Director of Provider Operations. Health Plans must ensure that appointments of various types of non-emergent care are offered within specified timeframes. Health care service plans are required to have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop. Provider Directories are to be updated on a regular basis. Provider Directory Accuracy will be looked at in next audit.</p>	<p>Committee members requested that there be information shared on the provider satisfaction survey results at the next meeting.</p>	Jennifer Clements	

AGENDA ITEM	DISCUSSION/ACTION	FOLLOW-UP	RESPONSIBLE PARTIES	DUe DATE
D. Appeals and Grievances	Mr. Johns presented the Appeals and Grievances Overview for 2015. 686 Medi-Cal cases were opened, and 224 Cal MediConnect for the year of 2015. As far as Medi-Cal Determinations 202 Appeals were upheld, 85 were overturned, 9 Withdrawn, 23 changed to complaint. 2015 Cal MediConnect Tracker did not capture necessary data for this report. 2015 Medi-Cal decisions were not consistently entered.	The committee requested to have: a Presentation of the Medi-Cal and Pharmacy appeals overturned by external review (State Fair Hearing) next reporting cycle. Separate out Part C and Part D data. Grievance and Appeal committee to report out quarterly.	Dan Johns	
Report of Subcommittees and Approval of Minutes				
A. Credentialing Committee	Dr. Robertson presented the October and December 2015 minutes to the committee. Next set of minutes will be presented in the ICE (Industry Collaborative Effort) format. Voting capacity was increased by 33% with Dr. Jimmy Lin now a voting member of the Credentialing Committee. Recruiting for a mid-level provider to join the committee. Seeking a behavioral health provider (SW or LMFT) to join committee.	Approved		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the September 2015 minutes to the committee. Agreed Johanna Liu, PharmD, would review MedImpact minutes in advance and present highlights at future Pharmacy and Therapeutics Committee meetings. Approved adding Tuberculosis medication Priftin to formulary without restrictions.	Approved		
C. Utilization Management Committee	No minutes to present.	Present minutes from October 14, 2015 and February 24, 2016 Minutes at next meeting		
D. Grievance and Appeals Committee	No minutes to present.			
Adjourn	Meeting adjourned at 7:44 p.m.			
Next Meeting	Wednesday, May 11, 2016- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

Thad Padua, MD
Quality Improvement Committee Chairperson

POLICY



Santa Clara
Family Health Plan

Policy Title:	Conflict of Interest		Policy No.:
Replaces Policy Title (if applicable):	Conflict of Interest	Replaces Policy No. (if applicable):	QI-03
Issuing Department:	Quality Improvement	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose

The purpose of this policy is to avoid a conflict of interest from occurring as related to Quality Improvement Committee (QIC) activities.

II. Policy

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

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

III. Responsibilities

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

POLICY

IV. References

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

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

V. Approval/Revision History

First Level Approval		Second Level Approval		
Version Number	Change (Original/Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	Original			

POLICY



Santa Clara
Family Health Plan

Policy Title:	Clinical Practice Guidelines		Policy No.:	QI02
Replaces Policy Title (if applicable):	Development of Clinical Practice Guidelines		Replaces Policy No. (if applicable):	QM008_001
Issuing Department:	Quality Improvement		Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC	

I. Purpose

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

II. Policy

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

III. Responsibilities

Health Services, UMC and plan providers develop and adhere to Clinical and Preventive Practice Guidelines which are developed and reviewed / revised at least annually.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: <https://www.dmhc.ca.gov/>
Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: <https://www.cms.gov/medicare-coverage-database/>
NCQA Guidelines. 2016

V. Approval/Revision History

First Level Approval	Second Level Approval

POLICY

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:	Distribution of Quality Improvement Information		Policy No.:
Replaces Policy Title (if applicable):	Dissemination of Approved Information Following Quality Improvement Committee	Replaces Policy No. (if applicable):	QM007_01
Issuing Department:	Quality Improvement	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose

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

II. Policy

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

III. Responsibilities

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

IV. References

NCQA, 2016

V. Approval/Revision History

First Level Approval			Second Level Approval	
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:	Peer Review Process		Policy No.:	QI04
Replaces Policy Title (if applicable):	Peer Review Process		Replaces Policy No. (if applicable):	QM009_02
Issuing Department:	Quality Improvement		Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC	

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

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

POLICY

V. Approval/Revision History

First Level Approval		Second Level Approval		
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:	Potential Quality of Care Issue (PQI)		Policy No.:	QI05
Replaces Policy Title (if applicable):	Potential Quality of Care Issues		Replaces Policy No. (if applicable):	QM002_02
Issuing Department:	Quality Improvement		Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> Healthy Kids		<input checked="" type="checkbox"/> CMC	

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

California Code and Regulations:

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

California Health and Safety Code section 1367.1

POLICY

V. Approval/Revision History

First Level Approval		Second Level Approval		
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 Title:	Quality Improvement Study Design/Performance Improvement Program Reporting		Policy No.:	QI06
Replaces Policy Title (if applicable):	Quality Improvement Study Design/Performance Improvement Program Reporting		Replaces Policy No. (if applicable):	QM005_02
Issuing Department:	Quality Improvement		Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC	

I. Purpose

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

II. Policy

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

SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document Q106_01 Quality Improvement Study Design/Performance Improvement Program Reporting.

III. Responsibilities

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

IV. References

The Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual Chapter 5, Quality Assessment

The National Committee for Quality Assurance (NCQA), 2016.
NCQA HEDIS Specifications, 2016

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)
v1.0	Original			

Quality Improvement Program Description

Summary of Changes

May 11, 2016

The Quality Improvement Committee (QIC) approved the Quality Improvement Program Description, 1st Quarter, February 10, 2016. Edits and additions have been applied in order to meet the National Committee of Quality Assurance (NCQA), DMHC and DHCS standards and requirements. A summary of changes are as follows:

Rewards	Description
Purpose	Describes additional Program Description purpose as related to description of meeting regulations, compliance standards, and for demonstrating the Plan's intent to provide members with quality care that meet professional standards .
QI Work Plan	Outlines each area that the Program guides what will be included in the QI Work Plan
Program Structure	Added new positions(HEDIS/QI Project Managers) and further defined existing positions
Quality Measures, Reporting, Projects	Quality Indicators defines as well as reporting process, statistical relevance and improvement projects
Communication of QI Information	Describes how QI Evaluations, Plans, Activities, Results and Follow-up are communicated to stakeholders and members
Pharmacy/Behavioral Health Services	Additional activities around drug recall follow-up described
Care of Members with Complex Needs	Additional details around QI activities around member with Complex needs
Delegation Oversight	Defines Delegation Oversight process now reporting up to
Additions	
Authority and Accountability	Describes Santa Clara County Health Authority and SCFHP Board of Directors
QI Methodology	Describes the Act, Plan, Study, Do Methodology used
Cultural and Linguistics	Added description of activities around Cultural and Linguistics

Santa Clara Family Health Plan

Quality Improvement Program

2016

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Introduction

The Santa Clara County Health Authority, operating business as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP commenced providing health care to children enrolling in the Healthy Kids Program. The Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP from 2007 – 2009 to serve as a Special Needs Plan (SNP) in Santa Clara County. In 2014, CMS and the State of California contracted with SCFHP for the Managed Long Term Services and Supports (MLSS) programs. In 2015, CMS contracted with SCFHP for the Dual Demonstration Project.

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

Mission Statement

The Mission of Santa Clara Family Health Plan (SCFHP) is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with select practitioners and providers, SCFHP acts as a bridge between the health care system and those who need coverage.

One of SCFHP's core values is our belief that as a publicly funded, local health plan, we have a unique responsibility to work toward improving the health status of the community in which we are based. SCFHP continually promotes community health by incorporating a comprehensive approach to health care and wellness. SCFHP maintains a comprehensive Quality Improvement (QI) Program that systematically monitors and continually drives improvements to the quality of care to our members, provides for culturally and linguistically appropriate services, identifies over- and under- utilization and substandard care, monitors member satisfaction and member safety and takes corrective actions and interventions when necessary.

Authority and Accountability

The Santa Clara County Health Authority is an independent public agency that governs Santa Clara Family Health Plan (SCFHP). Appointed by the County Board of Supervisors, the 13-member Governing Board seeks to improve access to quality health care, maintain and preserve a health care safety net for Santa Clara County, and ensure the fiscal integrity of SCFHP. With the health care industry rapidly evolving, SCFHP benefits greatly from the innovative ideas and perspectives of this diverse group of people with backgrounds in business, finance, managed care, hospital administration, information technology, medicine, health care policy, and law.

SCFHP's Board of Directors assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function. The Board passed a resolution defining the QI Program Description as an organization-wide commitment. This resolution supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QI Program Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer.

Purpose

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple customers (members, health care providers, and community agencies):

- A. It is organized to identify and analyze significant opportunities for improvement in care and service.
- B. It will foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- C. It is focused on QI activities carried out on an ongoing basis to promote efforts which support quality of care issues are identified and corrected.

SCFHP recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, the Plan will provide for the delivery of quality care with the primary goal of improving the health status of Plan members. Where the member's condition is not amenable to improvement, the Plan will implement measures to possibly prevent any further decline in condition or deterioration of health

status or provide for comfort measures as appropriate and requested by the member. The QI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Plan's QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members, and services received promoting patient safety at all levels of care.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Board of Directors (BOD) has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Board of Directors.

Goals

Quality improvement goals and objectives are to monitor, evaluate and improve:

- A. The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- B. The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risk, and disease profiles for both acute and chronic illnesses, and preventive care
- C. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners
- D. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- E. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
- F. Member and provider satisfaction, including the timely resolution of complaints and grievances
- G. Risk prevention and risk management processes
- H. Compliance with regulatory agencies and accreditation standards
- I. The effectiveness and efficiency of the Medi-Cal and CMC internal operations
- J. The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- K. The effectiveness of aligning ongoing quality initiatives and performance measurements with the organization's strategic direction in support of its mission, vision, and values
- L. Compliance with Clinical Practice Guidelines and evidence-based medicine
- M. Compliance with regulatory agencies and for CMC the accreditation standards (NCQA)
- N. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
- O. Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
- P. Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care

Functions

The QI Program Description supports and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that our members receive.

The QI Program Description supports the QI Department functions, which include:

- A. Implement a multidimensional and multi-disciplinary QI work plan that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
- B. Monitor, evaluate and act on clinical outcomes for members
- C. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members
- D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
 - 1. Drive improvement of quality of care received
 - 2. Coordinate and communicate organizational information, both division and department-specific, and system-wide
- E. Support the maintenance of quality standards across the continuum of care and all lines of business
- F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)
- G. Coordinate and drive improvements with HEDIS compliance and access to preventive care and management of chronic conditions to HEDIS standards
- H. Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program
- I. Support quality processes and effectiveness of continuous quality improvement activities across the organization
- J. Conduct effective oversight of delegated providers

All SCFHP members have timely access to health care that is delivered by qualified practitioners and delivery systems, which meets or exceeds standards determined by the Plan, the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

Objectives

The objectives of the QI Program Description include to:

- A. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
- B. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
- C. Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
- D. Measure the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance
- E. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improve performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
 1. Establishing performance standards
 2. Monitoring performance through regular reporting
 3. Evaluating performance annually
- F. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
 1. Medical record review
 2. Rates of referral to specialists
 3. Hospital discharge summaries in office charts
 4. Communication between referring and referred-to physicians
 5. Analysis of member complaints regarding difficulty obtaining referrals
 6. Identification and follow-up of non-utilizing members
 7. Practice Pattern Profiles of physicians
 8. Rates of referrals per 1000 members
 9. Performance measurement of practice guidelines
- G. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through complaints and grievances collected through the Member Services Department.
- H. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
 1. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
 2. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
- I. Analysis of the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)
- J. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals

- K. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
- L. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and SCFHP employees.

All departments participate in the quality improvement process. The Chief Medical Officer and the Director of Quality Improvement integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

- A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
- B. All activities will reflect the member population in terms of age groups, disease categories and special risk status
- C. The scope of the QI Program includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
 1. Access to Preventive Care (HEDIS)
 2. Behavioral Health Services
 3. Continuity and Coordination of Care
 4. Emergency Services
 5. Grievances
 6. Inpatient Services
 7. Maintenance of Chronic Care Conditions (HEDIS)
 8. Member Experience and Satisfaction
 9. Minor Consent/Sensitive Services
 10. Perinatal Care
 11. Potential Quality of Care Issues
 12. Preventive Services for children and adults
 13. Primary Care
 14. Provider Satisfaction
 15. Quality of Care Reviews
 16. Specialty Care

D. Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:

1. UM Metrics
2. Prior authorization
3. Concurrent review
4. Retrospective review
5. Referral process
6. Medical Necessity Appeals
7. Case Management
8. Complex Case Management
9. Disease Management
10. California Children's Services (CCS)

QI Work Plan

The QI Program guides the development and implementation of an annual QI Work Plan that includes:

- A. Quality of clinical care
- B. Quality of Service
- C. Safety of clinical care
- D. QI Program scope
- E. Yearly objectives
- F. Yearly planned activities
- G. Time frame for each activity's completion
- H. Staff responsible for each activity
- I. Monitoring of previously identified issues
- J. Annual evaluation of the QI Program
- K. Priorities for QI activities based on the specific needs of SCFHP's organizational needs and specific needs of SCFHP's populations for key areas or issues identified as opportunities for improvement
- L. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement
- M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified (PQI)
- N. The Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

There is a separate Utilization Management Work Plan that supports the UM Program Description and the monitoring and evaluation activities conducted for UM related functions.

QI Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- A. Areas for improvement identified through continuous delegated and internal monitoring activities, including, but not limited to, (a) potential quality concern review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- B. Measures required by DHCS for Medi-Cal members such as Performance Improvement Projects (PIPs)
- C. Measures required by the California DMHC, such as access and availability
- D. Measures required by Medicare such as Quality Improvement Activities (QIAs)
- E. Chronic Care Improvement Project (CCIP)

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services

- A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
- B. Case Management
- C. Coordination and continuity of care for Seniors and Persons with Disabilities (in house)
- D. Provisions of chronic and complex care management services
- E. Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- A. Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- C. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- D. Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- E. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

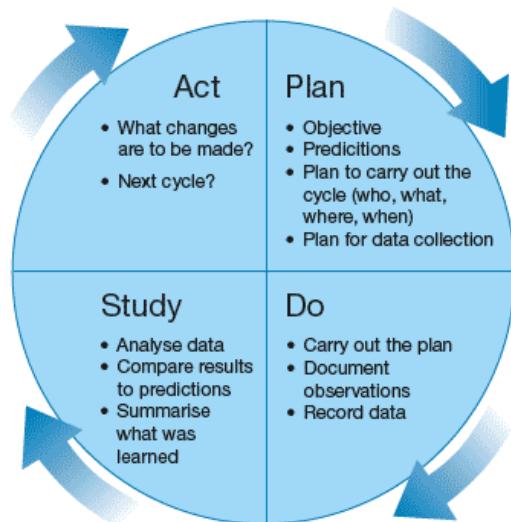
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on SFCHPs' previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

SCFHP uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:



Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 1) Communicate change/plan
2) Implement change plan

Study 1) Review and evaluate result of change
2) Communicate progress

Act 1) Reflect and act on learning
2) Standardize process and celebrate success

QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Sentinel Event monitoring. A sentinel event is defined as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.” The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel events can include:

- A. Potential Quality Issues (PQI)
- B. Potential Quality of Care Concern
- C. Unexpected death during hospitalization
- D. Complications of care (outcomes), inpatient and outpatient
- E. Reportable events for long-term care (LTC) facilities include but are not limited to falls, suspected abuse and/or neglect, medication errors, pressure sores, urinary tract infections, dehydration, pneumonia, and/or preventable hospital admissions from the LTC facilities
- F. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and deaths that occur in the CBAS center and unusual occurrences reportable pursuant to adult day health care licensing requirements.

Sentinel event monitoring includes patient safety monitoring across the entire continuum of SCFHP’s contracted providers, delegated entities, and health care delivery organizations. The presence of a Sentinel event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program’s consumer-complaint-oriented system.

All substantiated medically related cases are reviewed by the Credentialing and Peer Review Committee to determine the appropriate course of action and/or evaluate the actions recommended by delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to delegates for incorporation in their re-credentialing process.

Data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- A. Claims information/activity
- B. Encounter data
- C. Utilization
- D. Case Management
- E. Pharmacy Data
- F. Group Needs Assessments
- G. Results of Risk Stratification
- H. HEDIS Performance
- I. Member and Provider Satisfaction
- J. Quality Improvement Projects (QIPs)
- K. Health Risk Assessment data

An example of identification of risk and quality potential or actual issues include:

- A. Ambulatory setting
 - 1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
 - 2. Annual blood-borne pathogen and hazardous material training
 - 3. Preventative maintenance contracts to promote that equipment is kept in good working order
 - 4. Fire, disaster, and evacuation plan, testing, and annual training
- B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
 - 1. Falls and other prevention programs
 - 2. Identification and corrective action implemented to address post-operative complications
 - 3. Sentinel events identification and appropriate investigation and remedial action

Protocol for Using Quality Monitors Screens

Case Management and Referrals staff apply the quality monitor screens to each case reviewed during pre-certification and concurrent review. Contracted LTC facilities and CBAS centers must report all identified reportable events to the Director of Utilization Management. All potential quality issues are routed to the Quality Department.

When it is decided that medical records are required, the Quality staff contacts the appropriate inpatient facility and ambulatory care site to obtain copies of the medical record. It may be necessary for a Quality staff member to visit the facility/site to review the record.

When a case is identified to have potential quality of care issues, the Quality Improvement RN Clinical Review staff will abstract the records and prepare the documents for review by the CMO or Medical Director. The case is routed back to the Quality staff who initiated the review for closure of the case.

When the Chief Medical Officer agrees that a quality of care problem exists, the CMO reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up or corrective action may include referrals to Child or Adult Protective Services.

In-Home Supportive Services (IHSS) Quality Monitoring

SCFHP will participate in the stakeholder workgroup established by the Department of Health Services, the State Department of Social Services, and the California Department of Aging to develop the universal assessment process, including a universal assessment tool, for home-and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, the county, IHSS, Multipurpose Senior Services Program (MSSP), and CBAS providers, and legislative staff. The universal assessment process will be used for all home-and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

In developing the universal assessment process, a universal assessment tool will be developed that will facilitate the development of plans of care based on the individual needs of the recipient. The workgroup shall consider issues including, but not limited to, how the results of new assessments would be used for the oversight and quality monitoring of home- and community-based services providers.

SCFHP will work closely with the local IHSS Agency to develop an appropriate monitoring and oversight plan to adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

Quality Improvement Activities – Long Term Care Facilities

Monitoring of the quality of care provided to SCFHP members, including those residing in LTC facilities, includes, but is not limited to, the following:

- Member complaint and/or grievance trends.
- Provider complaint and/or grievance trends.
- Case review of potential quality of care issue referrals triggered by quality monitors (sentinel events), or utilization management activities.
- Member satisfaction surveys.
- Focused review of topics, including those specifically related to special needs populations such as members residing in LTC facilities.

Topics for review are identified through the monitoring process. Proposed study indicators shall be reviewed by the QI Committee and approved prior to commencing the study. Initiation of quality improvement projects will be directed to the identified needs of members residing in LTC facilities. Focused quality improvement audits, as necessary, for members residing in LTC facilities are performed by the Concurrent Review Case Managers, or Quality Analysts, during on-site facility visits.

Results of quality improvement activities are presented to the Quality Department for review, analysis and summarizing. LTC facilities are notified if there is a need to execute corrective action plans (CAPs). Follow-up reviews will be conducted at LTC facilities when CAPs are executed. SCFHP assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for SCFHP members in LTC facilities, including the local Regional Center, Licensing and Certification, Medi-Cal Operations Division and the Ombudsman's Office. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

QI Program Activities

The QI Program's scope includes implementation of QI activities or initiatives. The QI Committee and related committee and work groups select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

Prioritization

Certain aspects of clinical care and service data may identify opportunities to maximize the use of quality improvement resources. Priority will be given the following:

- A. The annual analysis of member demographic and epidemiological data
- B. Those aspects of care which occur most frequently or affect large numbers of members
- C. Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated
- D. Those processes involved in the delivery of care or service that, through process improvement interventions, could achieve a higher level of performance

Use of Committee Findings

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient practice. The vast majority of practicing physicians provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Board of Directors and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Clinical Practice Guidelines

SCFHP utilizes evidence-based practice guidelines to establish requirements and measure performance on a minimum of three practice guidelines (chronic and behavioral health) annually to strive to reduce variability in clinical processes. Practice guidelines are developed with representation from the network practitioners. The guidelines are implemented after input from participating practitioners of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

Preventive Health/HEDIS[®] Measures

The Quality Improvement Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually based on product type, i.e. Medi-Cal or Medicare. Initiatives, such as for PAP Smear education and compliance, are put in place to encourage member compliance with preventive care.

Disease Management Programs

The health care services staff, Clinical Quality Improvement Committee and network practitioners identify members with, or at risk for, chronic medical conditions. The Clinical Quality Improvement Committee is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner-patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual UM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

1. Primary care services
2. Behavioral health care services
3. Inpatient hospitalization services
4. Home health services
5. Skilled nursing facility services

The continuity and coordination of care received by members includes medical care in combination with behavioral health care. SCFHP collaborates with behavioral health practitioners to promote the following activities are accomplished:

- A. Information Exchange – Information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely, and confidential manner.
- B. Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral for treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
- C. Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use, and to reduce the incidence of adverse drug reactions.
- D. Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
- E. Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

QI Organizational Structure

The Quality Improvement Department

The Department support and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

- A. Monitor, evaluate and act on clinical outcomes for members
- B. Conduct review and investigations for potential or actual Quality of Care matters
- C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
- D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
 - 1. Drive improvement of quality of care received
 - 2. Minimize rework and costs
 - 3. Minimize the time involved in delivering patient care and service
 - 4. Empower staff to be more effective
 - 5. Coordinate and communicate organizational information, both division and department-specific, and system-wide
- E. Support the maintenance of quality standards across the continuum of care and all lines of business
- F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

Chief Medical Officer (CMO)

The Chief Medical Officer has an active and unrestricted license in the state of California. The CMO serves as the Chairperson for the Quality Improvement Committee and is responsible to report to the Board of Directors at least quarterly on the Quality Improvement program including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QI Program to SCFHP leadership and staff via General Staff meetings, senior management team meetings, and other internal meetings.

Medical Director

The Medical Director(s) has an active unrestricted license in accordance with California state laws and regulations and serves as medical director to oversee and be responsible for the proper provision of core benefits and services to members, the quality management program, the utilization management program, and the grievance system. The Medical Director, reporting to the CMO, is key in the review of potential quality of care cases or potential quality issues.

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions. A Medical Director is the only Plan person authorized to make a clinical denial based on medical necessity. The Plan pharmacist(s) may make a denial based on medical necessity regarding pharmaceuticals.

Director of Quality Improvement

The Director of Quality Improvement is a registered nurse or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of QI reports to the Chief Medical Director and is responsible for directing the activities of the Plan's quality management staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of QI assists the Plan's senior executive staff, both clinical and non-clinical, in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of QI coordinates the Plan's QI Committee proceedings in conjunction with the CMO; report to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; review statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

QI Nurse, RN

The QI Nurse reports to the Corporate Director of QI and oversees the investigations of member grievances, supports HEDIS reviews, investigates and prepares cases for potential quality of care (QOC) reviews and potential quality issues (PQI) for the medical director or CMO review. The QI Nurse also assists with ongoing QI studies and reviews which include but are not limited to Performance Improvement Projects (PIP) and Chronic Care Improvement Projects (CCIP). The QI Nurse is also a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Evaluations (IHEs), and assists with other QI activities at the direction of the Director of QI.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of quality improvement projects. This position is responsible for developing and maintaining processes that enhance the operationalization of QI processes, management of software applications(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

HEDIS Project Manager

The HEDIS Project Manager provides leadership, coordination, and management of HEDIS and HEDIS-related quality improvement projects. This position is responsible for developing and maintaining processes that enhance the operationalization of HEDIS processes, management of software applications(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

QI Health Educator

The Health Educator is responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance to state and federal regulatory requirements concerning health education and cultural and linguistic services. The QI Health Educator works under the general direction of the Quality Improvement Manager and works in cooperation with other departments.

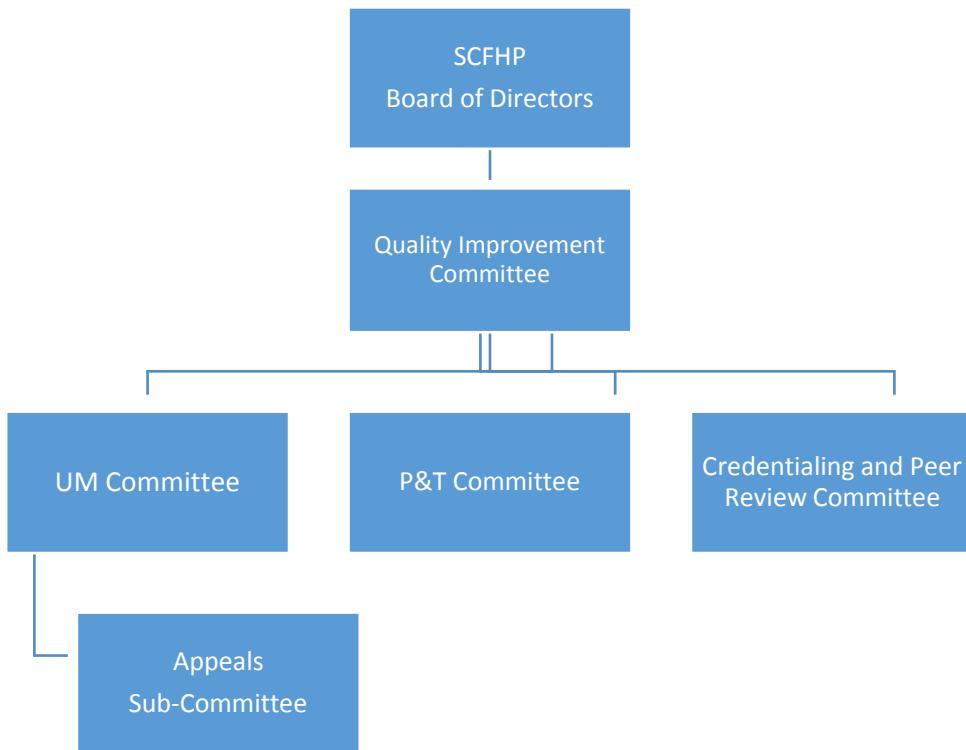
Coordinator, QI

Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management preferred. QI Coordinators report to the Director of QI and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The QI Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews. Committee Structure Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors.

SCFHP involves a contracted network licensed behavioral specialist who is a psychiatrist or Ph.D. level psychologist to serve on the QI Committee and the UM Committee and as an advisor to the QI Program structure and processes. The designated behavioral health practitioner advises the Clinical Quality Improvement Committee to support efforts that goals, objectives and scope of the QI Program are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

Each committee is driven by a Committee Charter which outlines the following;

- A. Voting members
- B. Plan support staff
- C. Quorum
- D. Meeting frequency
- E. Meeting terms
- F. Goals
- G. Objectives



In addition the Grievance/Appeals Committee conducts analysis and intervention and reports to the QI Committee.

Board of Directors

The Board of Directors is responsible to review, act upon and approve the overall QI Program, Work Plan, and annual evaluation. The Board of Directors receives at least quarterly progress and status reports from the QI Committee describing interventions and actions taken, progress in meeting objectives, and improvements achieved. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Quality Improvement is responsible for the coordination and distribution of all quality improvement related data and information. The Quality Improvement Committee reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The Chief Executive or the Chief Medical Officer communicates the QI C activities to the Board. The Board reviews the QI activities and any concerns of the Board are communicated back to the source for clarification or resolution.

Quality Improvement Committee

The QI Committee is the foundation of the QI program. The QI Committee assists the CMO and administration in overseeing, maintaining, and supporting the QI Program and Work Plan activities.

The purpose of the QI Committee is to monitor and assess that all QI activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although Delegation Oversight is overseen by the Plan's Compliance Committee, the QI Committee oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QI Committee includes a participating Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QI Committee provides overall direction for the continuous improvement process and evaluates for activities that are consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach and adequate resources for the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided the highest quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QI Committee.

Providers', practitioners', and contracted groups practice patterns are evaluated, and recommendations are made to promote practices that all members receive medical care that meets SCFHP standards.

The QI Committee shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QI Committee also recommends strategies for dissemination of all study results to SCFHP-contracted providers and practitioners, and contracted groups.

The QI Committee provides overall direction for the continuous improvement process and monitors that activities are consistent with SCFHP's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

Utilization Management Committee

The Utilization Management Committee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM Committee actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's UM Committee is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and UM/QI staff may also attend the UMC as appropriate.

The UM Committee (UMC) monitors the utilization of health care services by SCFHP and through delegated entities to identify areas of under- or over- utilization that may adversely impact member care as well as practice patterns of network practitioners and other QI monitors as defined by the Utilization Management Program and UM Work Plan.

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as adoption of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UMC is also responsible for annual adoption of preventive care guidelines and medical necessity criteria. The Committee meets quarterly and reports to the QIC.

The UMC is responsible for the review and adoption of applicable utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under - or over- utilization which may impact health care services, coordination of care and appropriate use of services and resources, continuity of medical to medical care, continuity and coordination of medical and behavioral health care, as well as member and practitioner satisfaction with the UM process.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program.

In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes practicing physicians and the contracted provider networks. A majority of the members of the P&T Committee are physicians (including both Plan employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties including a Behavioral Health practitioner, in order to adequately represent the needs and interests of all plan members.

The P&T Committee involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacological drugs.

The P&T Committee also involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including,

but not limited to, cost-control measures, therapeutic substitution, and step-therapy.

The Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the QIC.

Credentialing and Peer Review Committee

Peer Review is coordinated through the QI Department and communicated with the Credentialing process. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases will be presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and no further action is required. The QI Department also tracks, monitors, and trends service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the Credentialing and Peer Review Committee at time of re-credentialing. Quality of care case referral to the QI Department is based on referrals to the QI Department originated from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

Role of Participating Practitioners

Participating practitioners serve on the QI Program Committees as necessary to support each committee's function. Through these committees' activities, network practitioners:

- A. Review, evaluate and make recommendations for credentialing and re-credentialing decisions
- B. Review individual cases reflecting actual or potential adverse occurrences
- C. Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures
- D. Review proposed QI study designs
- E. Participate in the development of action plans and interventions to improve levels of care and service
- F. Are involved with policy setting
- G. Participate with the following committees
 - 1. Quality Improvement Committee
 - 2. Pharmacy and Therapeutics Committee
 - 3. Utilization Management Committee
 - 4. Credentialing and Peer Review Committee
 - 5. Additional committees as requested by the Plan

Pharmacy Services

Pharmacy Services are overseen by the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is two-fold, utilizing the Pharmacy Benefit Manager (PBM) national P&T Committee for the Medicare line of business and a Plan Based P&T Committee for the Medi-Cal line of business as well as to oversee QI monitoring of medication management outcomes, and approve applicable programs and policies and procedures. The P&T Committee oversees the development, maintenance, and improvement of SCFHP's formularies. The P&T Committee recommends policy on all matters related to the use of drugs to promote the clinically appropriate use of pharmaceuticals based on sound clinical evidence. The P&T Committee reports organizationally to SCFHP's Quality Improvement Committee. SCFHP has adopted its PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements.

SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state. SCFHP maintains a closed drug formulary for the Medi-Cal (Medicaid) line of business.

The Plan has adopted the PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements. SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state.

Current versions of SCFHP's formularies are posted on the Plan's web site and are accessible to both members and practitioners. SCFHP pharmaceutical management procedures are included within the formulary as well as in the *Member Guide* (Combined Evidence of Coverage and Disclosure Form) and Provider Manual. Members, prescribers, and pharmacies may receive a printed copy of the formulary upon request.

SCFHP develops its own medical exception review criteria and/or adopts its PBM's criteria. The P&T Committee reviews and approves each set of criteria (both Plan developed and PBM-developed criteria) prior to use and performs an annual review of all criteria. When applying the criteria in a review of a request, SCFHP's criteria are applied when they exist. When Plan-developed criteria do not exist, the appropriate clinical references will be applied.

Member safety is integrated into all components of the Plan's QI Program, and is especially applicable to Pharmacy Services who conducts monitoring and evaluation and takes interventions when application while reviewing processes

SCFHP's pharmaceutical quality improvement process includes measures and reporting systems to address the identification and reduction of medication errors and adverse drug interactions. The PBM's utilization review (DUR) edits provide on-line messaging to dispensing pharmacists. The PBM identifies drug-drug interactions based on three severity levels supported by nationally recognized references (e.g., First Data Bank, NDDF Plus, and National Drug Data File). Eight (8) on-line DUR edits are used and send a message to the dispensing pharmacist when "triggered":

- A. Drug Interaction
- B. Drug dosage
- C. Ingredient duplication
- D. Age precaution
- E. Pregnancy precaution
- F. Gender conflict
- G. Therapeutic duplication
- H. Late refill

The PBM identifies and notifies SFHP of members and prescribers affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons. SCFHP uses these reports to notify affected physicians and members within 30 calendar days of the FDA notification. An expedited process is followed for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. When the FDA recalls a drug, the product is immediately removed from SCFHP's formularies and active prior authorizations are terminated.

SCFHP conducts retrospective drug utilization of pharmacy claims and other records, through computerized drug claims processing and information retrieval systems to identify patterns of inappropriate or medically unnecessary care among members or associated with specific drugs or groups of drugs.

SCFHP monitors and implements processes to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:

- A. Compliance programs designated to improve adherence/persistency with appropriate medication regimens
- B. Monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies
- C. Quantity versus time edits
- D. Early refill edits

Behavioral Health Services

SCFHP will monitor and improve the quality of behavioral health care and services provided through and based on applicable contract requirements. The QI program includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our network of practitioners and providers. The quality of Behavioral Health services may be determined through, but not limited to the following:

- A. Access to Care
- B. Availability of practitioners
- C. Coordination of care
- D. Medical record and treatment record documentation
- E. Complaints and grievances
- F. Appeals
- G. Utilization Metrics
 - a. Timeliness
 - b. Application of criteria
 - c. Bed days
 - d. Readmissions
 - e. Emergency Department Utilization
 - f. Inter-rater reliability
- H. Compliance with evidence-based clinical guidelines
- I. Language assistance

Reporting to the CMO, the Clinical Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Clinical Director shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues.

Utilization Management

Utilization Management activities and related UM activities including Case Management, Disease Management, and Model of Care programs and processes as addressed in the Utilization Management Program Description.

The outcomes of UM activities are measured and reported to the UM Committee and are defined in the UM Work Plan.

Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:

- 11. UM Metrics
- 12. Prior authorization
- 13. Concurrent review
- 14. Retrospective review
- 15. Referral process
- 16. Medical Necessity Appeals
- 17. Case Management

18. Complex Case Management
19. Disease Management
20. California Children's Services (CCS)
21. Early and Periodic Screening, Diagnosis and Treatment (ESPDT)

Monitoring Utilization Patterns

To monitor and analyze that appropriate care and service to members, SCFHP's Utilization Management Committee performs an annual assessment of utilization data to identify potential under- and over-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data, pharmacy, dental and vision encounter reporting to identify patterns of potential or actual inappropriate utilization of services. The QI Department works closely with the UM Department, Chief Medical Officer Director of Health Care Services and Plan Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the QI and UM Departments will implement approved actions to improve appropriate utilization of services.

The California DHCS also requires submission of selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, SCFHP adheres to DHCS notification to the Plan of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

Care of Members with Complex Needs

SCFHP is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- A. Standardized mechanisms for member identification through use of data
- B. Documented process to assess the needs of member population
- C. Multiple avenues for referral to case management and disease management programs
- D. Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- E. Ability of member to opt out
- F. Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education
- G. Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

- H. Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
 - I. Coordinating services for members for appropriate levels of care and resources
 - J. Documenting all findings
 - K. Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
 - L. Ongoing assessment of outcomes

The Interdisciplinary Care Teams (ICT) includes three (3) levels of ICTs that reflect the health risk status of members. Each are offered an ICT. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into high, moderate and low risk levels.

The low risk members are managed by the basic ICT at the PCP level. Moderate members may be managed by the primary ICT at the Medical Group level, if delegated. High risk members are managed by the Complex ICT at the Plan level or through a delegation agreement by an NCQA Certified organization.

For high risk members, the ICT includes the member if feasible, Medical Director, PCP/specialist as necessary, Case Management Team, Behavioral Health Specialist, and Social Worker. A treating Specialist may be invited to an ICT meeting if the need is identified. The teams are designed to see that members' needs are identified and managed by an appropriately composed team. Additional disciplines, such as the Clinical Pharmacist, Dietician, and/or Long Term Care Manager, may be included in the ICT based on the member's specific needs.

Interdisciplinary Care Teams process includes:

A. Basic ICT for Low Risk Members:

- 1. Basic CM by PCP in collaboration with the case manager
 - a. Initial Health Assessment (IHA)
 - b. Initial Health Behavioral Assessment (IHEBA)
 - c. Identification of appropriate providers and facilities(such as medical, rehabilitation and support services)
 - d. Direct communication between provider, member and family
 - e. Member and family education
 - f. Coordination of carved out/linked services
 - g. Referral to appropriate community resources/agencies

B. Primary ICT for Moderate Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment of Health History
4. Development of ICP
 - a. Specific to member needs
 - b. Member and PCP input
 - c. Updated at least annually
5. Identification of appropriate providers and facilities (such as medical, rehabilitation and support services) to meet member care needs
6. Direct communication between provider, member/family or caregiver and case manager/care coordinator
7. Member, family and/or caregiver education including healthy lifestyle changes as appropriate
8. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex ICT for High Risk Members:

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

D. Team Composition (As appropriate for identified needs): Member, Caregiver, or Authorized Representative, Medical Group Medical Director, Plan Clinical/Medical Group Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist

1. Roles and responsibilities of this team
2. Consultative for the PCP and Medical Group teams
3. Encourages member engagement and participation in the IDT process
4. Coordinating the management of members with complex transition needs and development of ICP
5. Providing support for implementation of the ICP by the Medical Group
6. Tracks and trends the activities of the IDTs
7. Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
8. Oversight of the activities of all transition activities at all levels of the delivery system
 - a. Meets as often as needed until member's condition is stabilized.

Cultural and Linguistics

SCFHP will monitor that services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

SCFHP is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Identified needs and planned interventions involve member input and are vetted through the Member Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- A. Analysis of significant health care disparities in clinical areas
- B. Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- C. Consider outcomes of member grievances and complaints
- D. Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language specific risks
- E. Identify and reduce a specific health care disparity with culture and race
- F. Provide information, training and tools to staff and practitioners to support culturally competent communication

All individuals providing linguistic services to SCFHP members shall be adequately proficient in the required language to both accurately convey and understand the information being communicated. This policy applies to SCFHP staff, providers, provider staff, and professional translators or interpreters. Monitoring of compliance ability to serve as an interpreter will be maintained by the Plan.

Interpreter services are provided to the member at no charge to the member.

SCFHP offers programs and services that are culturally and linguistically appropriate by:

- A. Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved to reduce health care disparities in clinical areas
- B. Conducting patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity. And language specific risks to improve cultural competency in materials
- C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications
- D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

SCFHP has designated the Director of Quality Improvement to provide oversight for meeting the objectives of service to a culturally and linguistically diverse population through the following:

- A. Translation services
- B. Interpretation services
- C. Proficiency testing for bilingual Spanish staff
- D. Cultural competency trainings such as:
 - 1. Cultural Competency Workshops
- E. Provider newsletter articles on a variety of cultural and linguistic issues
- F. Health education materials in different languages and appropriate reading levels
- G. Provider office signage on the availability of interpretation services

Credentialing Processes

SCFHP conducts a Credentialing process that is in compliance with regulatory and oversight requirements. SCFHP contracts with an NCQA Certified Vendor Organization (CVO). The Plan credentials all new applicants prior to executing a contract to see members and credentials network practitioners at least every 36 months.

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the SCFHP contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to practitioners who work independently including behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and Direct contracts.

Healthcare Delivery Organizations

SCFHP performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and as applicable, accreditation status.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the Re-credentialing process. Should an egregious quality of care issue be identified mid-cycle, the Credentialing and Peer Review Committee may select to review the practitioner between routine re-credentialing cycles.

Monitoring for Sanctions and Complaints

SCFHP has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

SCFHP does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted groups. The Plan does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. SCFHP assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated groups.

SCFHP collaborates with the delegated entities to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 02-02 and SCFHP policies.

Medical records of new providers shall be reviewed within ninety (90) calendar days of the date on which members are first assigned to the provider. An additional extension of ninety (90) calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

SCFHP conducts an additional DHCS-required facility audit for American with Disabilities Act for compliance of Seniors and Persons with Disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

Medical Record Documentation Standards

SCFHP requires that its contracted Groups make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All member data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of the Plan's contracts with CMS and DHCS.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or state law.

Member Safety

The monitoring, assessment, analysis and promotion of Member safety matters are integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part our quality and risk management functions. Our member safety efforts are clearly articulated both internally and externally, and include strategic efforts specific to member safety. The QI Program Description is based on a needs assessment, and includes the areas:

- A. Identification and prioritization of patient safety-related risks for all SCFHP members, regardless of line of business and contracted health care delivery organizations
- B. Operational objectives, roles and responsibilities, and targets based on the risk assessment
- C. Plans to conduct appropriate patient safety training and education are available to members, families, and health care personnel/physicians
- D. Health Education and Promotion
- E. Group Needs Assessment
- F. Over- and under- Utilization monitoring
- G. Medication Management
- H. Case Management and Disease Management outcomes
- I. Operational Aspects of Care and Service

Member Safety prevention, monitoring and evaluation include:

- A. Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- B. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- C. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
- D. Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is identifying and remediate potential and actual safety issues, and to monitor ongoing staff education.

A. Ambulatory setting

1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
2. Annual blood-borne pathogen and hazardous material training
3. Preventative maintenance contracts to promote that equipment is kept in good working order
4. Fire, disaster, and evacuation plan, testing, and annual training

B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings

1. Falls and other prevention programs
2. Identification and corrective action implemented to address post-operative complications
3. Sentinel events identification and appropriate investigation and remedial action
4. Administration of Flu/Pneumonia vaccine

C. Administrative offices

1. Fire, disaster, and evacuation plan, testing, and annual training

Member Experience and Satisfaction

SCFHP supports continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring member and provider complaints, member and provider satisfaction, and member and provider call center performance. The Plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, depending upon the intervention.

SCFHP solicits feedback from members, medical centers, and caregivers to assess satisfaction using a range of approaches, such as NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey, monitoring member complaints and direct feedback from the Member Policy Committee. The Membership Services Department is responsible for coordinating the CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the Quality Improvement Committee with specific recommendations for performance improvement interventions or actions.

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. Plan also uses another approach to obtain more real-time data related to new provider satisfaction. Provider Services

Member Grievances and Provider Complaints

The QI Department investigates and resolves all member quality of care concerns and grievances. All grievances related to quality of care and service are tracked, classified according to severity, reviewed by Plan Medical Directors, categorized by the QI Department, and analyzed and reported on a routine basis to Plan's QI Committee. The QI Committee will recommend specific physician/provider improvement activities.

All administrative member grievances are tracked and resolution is facilitated by the Appeals and Grievance Coordinator. Data is analyzed and reported to the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QI Committee at least quarterly, along with recommendations for QI activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Network Department. Data is reported to and analyzed by the QI Committee on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QI Committee at least quarterly, along with recommendations for QI activities based on results.

Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are reviewed through the Plan's Compliance Committee. The Delegation Committee reports to compliance. The portion of Delegation Oversight specific to the QI Program are the reporting submitted by the delegated entities and the functional operational area overseeing corrective action plans.

Through Delegation Oversight, the Plan monitors include, but are not limited to, the following:

- A. On-going monitoring via quarterly, semi-annual, and annual reports. Focus reviews are conducted when applicable
- B. Annual site visits Annual Review of the delegates' policies and procedures
- C. Annual review, feedback and approval of the delegates' Quality and Utilization Management Program Plans
- D. Annual Review, approval, and feedback to the delegates on QI and utilization management work plans
- E. Review and approval, by Compliance Committee, of sub-delegate's delegation agreement/s prior to implementation of such an agreement for sub-delegation
- F. Sub-delegation reports
- G. Review of case management program and processes Review of quality of care monitoring processes, results of QI Activities, and peer review processes
- H. Review of credentialing and re-credentialing processes Working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
- I. Providing educational sessions
- J. Evaluating and monitoring improvement
 - 1. Monthly and quarterly analysis of reports and utilization benchmarks by with results communicated to delegate, results reported on quarterly basis

The Plans' audit procedures drive the process with the delegates with the following:

- A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services can be delegated and how they can be delegated or not delegated
- B. Providing input into contractual language necessary for delegation
- C. Providing tools and designating appropriate measurement and reporting requirements for monitoring of delegated activities
- D. Providing support in the analysis of data obtained from reporting and other oversight activities
- E. Assisting in the development of corrective action plans and tracking of their effectiveness
- F. Providing structure and methodology in the development and administration of incentives and sanction for delegate's performance.

When a delegate is determined to be deficient in an area or areas, the issue is referred to the Delegation Oversight Committee, which reports to the Compliance Committee, for its review and discussion, with recommendations to the Compliance Department for action.

The Compliance Department presents the issue to the Plan's Compliance Committee for decisions and final recommendations, which could include de-delegation.

Data Integrity

The Clinical Data Warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures, and outcomes measures. SCFHP staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- A. Identify and stratify members with certain disease states
- B. Identify over/under utilization of services
- C. Identify missing preventive care services
- D. Identify members for targeted interventions

Identification and Stratification of Members

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Potential of Over- and Under- Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days. Additional data will be available through UM Metrics such as hospital bed days, length of stays, Emergency Department utilization, readmissions, and UM referrals.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50, or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to SCFHP to fit our unique needs. By using the standard clinical rules and customizing SCFHP specific rules, the database will be the primary conduit for targeting and prioritizing health education, disease management, and HEDIS-related interventions.

By analyzing data that SCFHP currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide SCFHP in not only targeting the members, but also the delegated entities, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals will be utilized. Training for each data element (quality indicator) will be accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be coordinated by the Director of Quality Improvement or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, will be maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- A. Be clearly defined and outlined
- B. Have specific objectives and timelines
- C. Specify responsible departments and individuals
- D. Be evaluated for effectiveness
- E. Be tracked through the QI Program

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring), and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

- A. Demonstrated Improvement
 - Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.
- B. Sustained Compliance with Improvement
 - Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory (CMS, DHCS, DMHC) reporting requirement related to that project. SCFHP may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- A. Project description, including relevance, literature review (as appropriate), source, and overall project goal.
- B. Description of target population
- C. Description of data sources and evaluation of their accuracy and completeness
- D. Description of sampling methodology and methods for obtaining data
- E. List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- F. Baseline data collection and analysis timelines
- G. Data abstraction tools and guidelines
- H. Documentation of training for chart abstraction
- I. Rater to standard validation review results
- J. Measurable objectives for each quality indicator
- K. Description of all interventions including timelines and responsibility

- L. Description of benchmarks
- M. Re-measurement sampling, data sources, data collection, and analysis timelines
- N. Evaluation of re-measurement performance on each quality indicator

Key Business Processes, Functions, Important Aspects of Care and Service

SCFHP provides comprehensive acute and preventive care services, which are based on the philosophy of a medical “home” for each member. The primary care practitioner is this medical “home” for members who previously found it difficult to access services within their community. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the SCFHP model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- A. Access and Availability
- B. Continuity and Coordination of Care
- C. Preventive care, including:
 - 1. Initial Health Risk Assessment
 - 2. Initial Health Education
 - 3. Behavioral Assessment
- D. Patient Diagnosis, Care, and Treatment of acute and chronic conditions
- E. Complex Case Management: SCFHP coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management Department, which details this process in its Utilization Management and Case Management Programs and other related policies and procedures.
- F. Drug Utilization
- G. Health Education and Promotion
- H. Over- and Under- Utilization monitoring
- I. Disease Management Outcomes

Administrative Oversight:

- A. Delegation Oversight
- B. Member Rights and Responsibilities
- C. Organizational Ethics
- D. Effective Utilization of Resources
- E. Management of Information
- F. Financial Management
- G. Management of Human Resources
- H. Regulatory and Contract Compliance
- I. Customer Satisfaction
- J. Fraud and Abuse* as it relates to quality of care

* SCFHP has adopted a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the SCFHP Compliance Program.

Conflict of Interest

Network practitioners serving on any QI Program related Committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues.

All employees and committee participants sign a Conflict of Interest statement on an annual basis.

Fiscal and clinical interests are separated. SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality

SCFHP maintains policies and procedures to protect and promote the proper handling of confidential and privileged member information. Upon employment, all SCFHP employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

In addition, all Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the Quality Improvement Committee and other QI Program related committees, which involve member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act.

All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting.

Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QI Committee quarterly in order to facilitate communication along the continuum of care. The QI Committee reports activities to the Board of Directors, through the CMO or designee, on a quarterly basis. QI Committee participants are responsible for communicating pertinent, non-confidential QI issues to all members of SCFHP staff. Communication of QI trends to SCFHP's contracted entities, members, practitioners and providers is through the following:

- A. Practitioner participation in the QIC and its subcommittees
- B. Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- C. Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on the Plan's website, in addition to the annual article in both practitioner and member newsletter.
- D. The information to be shared with practitioners and members includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service.
- E. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- F. Included in annual practitioner education through Provider Relations and the Provider Manual

Annual Evaluation

The QI Committee conducts an annual written evaluation of the QI Program and makes information about the QI Program available to members and practitioners. Applicable QI related committees contribute to the annual evaluation which is ultimately reviewed and approved by the Board of Directors.

The Plan conducts an annual written evaluation of the QI program and activities that include the following information

- 1. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
- 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
- 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices
- 4. Barrier analysis

The evaluation addresses the overall effectiveness of the QI program, including progress that was made toward influencing network-wide safe clinical practices and includes assessment of:

1. The adequacy of QI Program resources
2. The QI Committee structure
3. Amount of Practitioner participation in the QI Program, policy setting, and review process
4. Leadership involvement in the QI Program and review process
5. Identification of needs to restructure or revise the QI Program for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

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Executive Summary:

A. CLINICAL IMPROVEMENT ACTIVITIES NCQA 2015 Quality HEDIS Measures: (2014 Measurement Year)	
HEDIS Hybrid Measure Key: <ul style="list-style-type: none"> ○ Childhood Immunization Status – CIS (MC & HK) ○ Well Child Visits in First 15 Months – W15 (HK) ○ Well Child Visits 3,4,5,6 – W34 (MC & HK) ○ Cervical Cancer Screening – CCS (MC) ○ Timely Prenatal and Postpartum Care – PPC (MC) ○ Comprehensive Diabetes Care – CDC (MC) ○ Weight Assessment and Counseling –WCC (MC) ○ Immunization for Adolescents – IMA (MC & HK) ○ Controlling High Blood Pressure – CBP (MC) ○ Adolescent Well Care Visits – AWC (HK) 	HEDIS Administrative Measure Key: <ul style="list-style-type: none"> ○ Chlamydia Screening – CHL (HK) ○ All Cause Readmission – ACR (MC) ○ Ambulatory Care – AMB (MC) ○ Cervical Cancer Screening – CCS (MC) ○ Use of Imaging Studies for Low Back Pain –LBP (MC) ○ Appropriate Treatment for Children w/ Upper Respiratory Infection – URI (HK) ○ Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis – AAB (MC) ○ Appropriate Testing for Children w/ Pharyngitis – CWP (HK) ○ Use of Appropriate Medication for People w/ Asthma – ASM (HK) ○ Children’s & Adolescent’s Access to PCPs – CAP (MC & HK) ○ Annual Monitoring for Patients on Persistent Medication – MPM (MC) ○ Annual Dental Visit – ADV (HK) ○ Medication Management for People with Asthma – MMA (MC)
A.1 Goal: <ul style="list-style-type: none"> ○ Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL) ALL Medi-Cal HEDIS Measures. ○ Develop and implement interventions for MMCD Auto-Assignment Measures ○ Increase administrative (claims and encounter) data submissions across Networks. 	
A.2. Interventions: <ul style="list-style-type: none"> ○ Collect and report Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) rates for ALL Product Lines within specified timeframe ○ Facility Site Review Nurse performed on site visits to provider offices regarding accurate coding, preventive well visit schedules, BMI documentation and submissions of PM160 data. Providers where encouraged to submit encounter and claims through electronic submission for accurate and timely data ○ Continued Text4baby program to educate pregnant members and new mothers ○ Facility Site Review Nurse educated providers to follow AAP / SCFHP recommended annual Well-Care Visits and immunization schedule and AGOG recommended Cervical Cancer Screenings ○ HEDIS results and analysis presented to: ○ SCFHP Board of Directors, SCFHP Quality Improvement Committee, Quality Improvement Activities: <ul style="list-style-type: none"> ● Continued immunization reminder postcards to parents with children at 17 months of age to receive recommended immunizations ● launched an offer a Target Gift card as a member incentive for pap smears, especially aimed at new Medi-cal expansion members who the plan does not have records of pap smears. ● Continued education in Quarterly Member Newsletters, for immunizations, well child visits, diabetic care, prenatal and postpartum care and dental care ● Developed reminder letter and incentive program for Healthy Kids members in need of a 	

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dental visit during the year 2015.

A.3. Results:

- Exceeded MMCD Minimum Performance Level (MPL) for all measures
- Three Medi-Cal measures exceeded the HPL, Comprehensive Diabetes Care—Medical Attention for Nephropathy, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent), Use of Imaging Studies for Low Back Pain
- Medi-Cal measures that have improved significantly (>5%) from the prior year; Comprehensive Diabetes Care – HbA1c Poor Control, Comprehensive Diabetes Care—Medical Attention for Nephropathy, Immunizations for Adolescents—Combination 1, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile, Nutrition Counseling, & Physical Activity Counseling, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Medi-Cal measures that decreased significantly (>5%); Cervical Cancer Screening

A.4. Analysis of Findings/Progress:

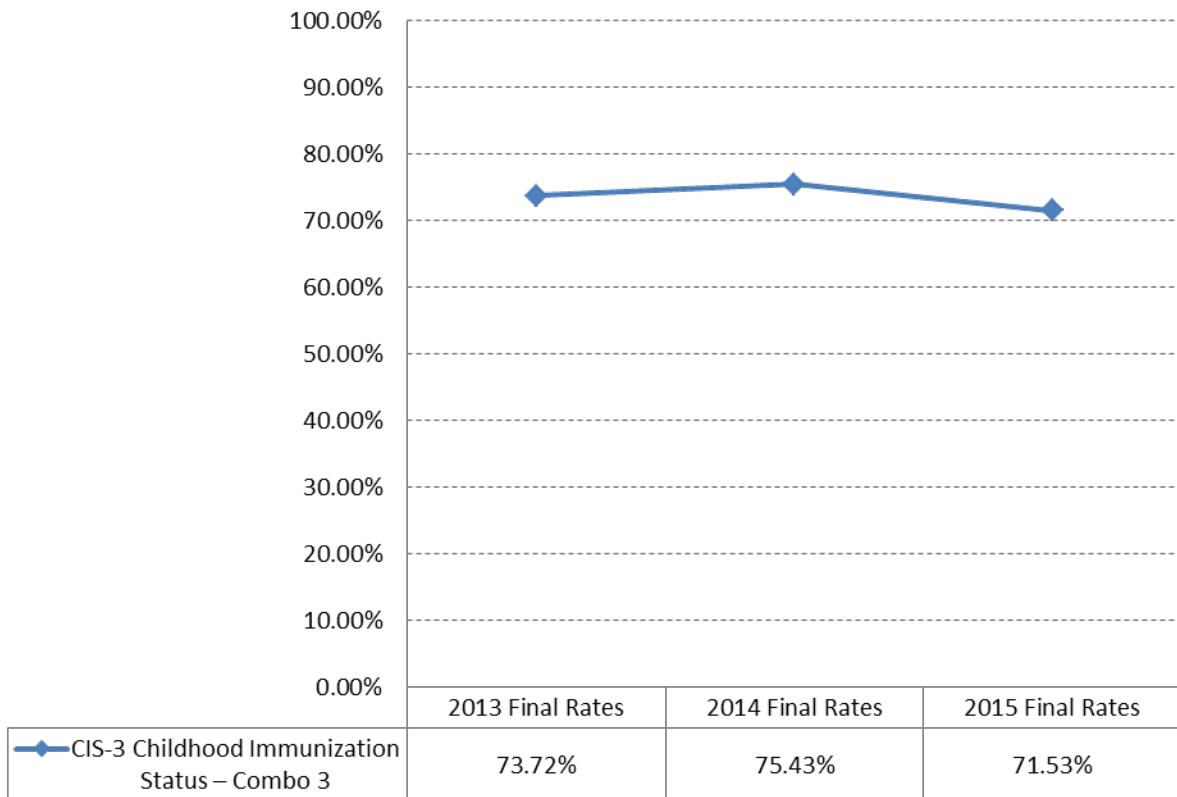
- Due to Administrative Data Volume being flat, continued chart abstraction and Pinpoint chart chase logic is necessary to improve key measures.
- A Provider/Network dashboard for each measure is necessary to define further provider interventions.
- HEDIS Member outreach and incentives is important to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

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Immunization Measures Findings

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

CIS-3 Childhood Immunization Status – Combo 3



Analysis and Findings/Progress:

- Above the MPL of 66.08% and remains below the HPL of 80.86%
- National and state childhood immunization rates are declining
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2 and under

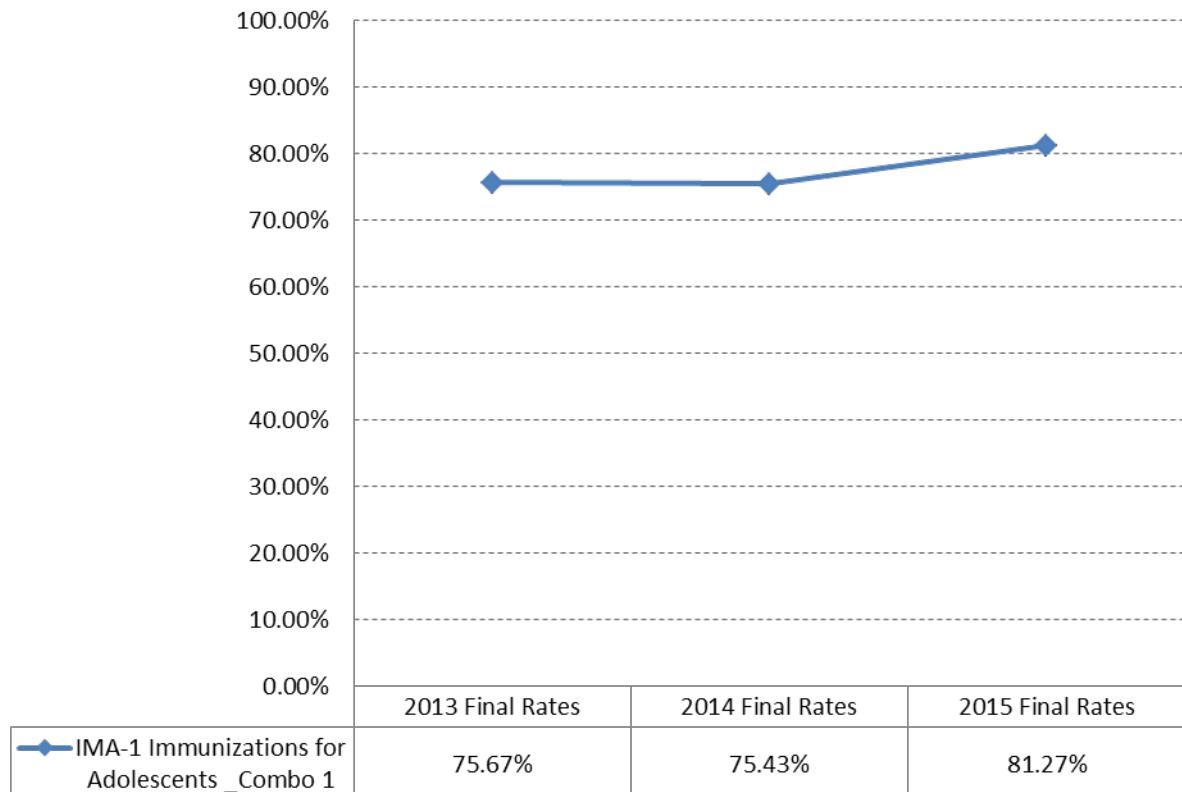
Follow up/Actions:

- Focus ideas on new interventions in 2016 (HEDIS 2017) for providers on immunization schedule
- Focus ideas on new interventions in 2016 for member outreach and incentives
- Utilize CAIR for missing immunization status in claims and/or PCP medical record

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IMA – Immunizations in Adolescents (MC)

IMA-1 Immunizations for Adolescents _ Combo 1



Analysis and Findings/Progress:

- Above the MPL of 58.06% and remains below the HPL of 86.46%
- State of California School requirements of Adolescent immunizations in full effect in 2012, yet measure does not show continuous improvement year to year

Follow up/Actions:

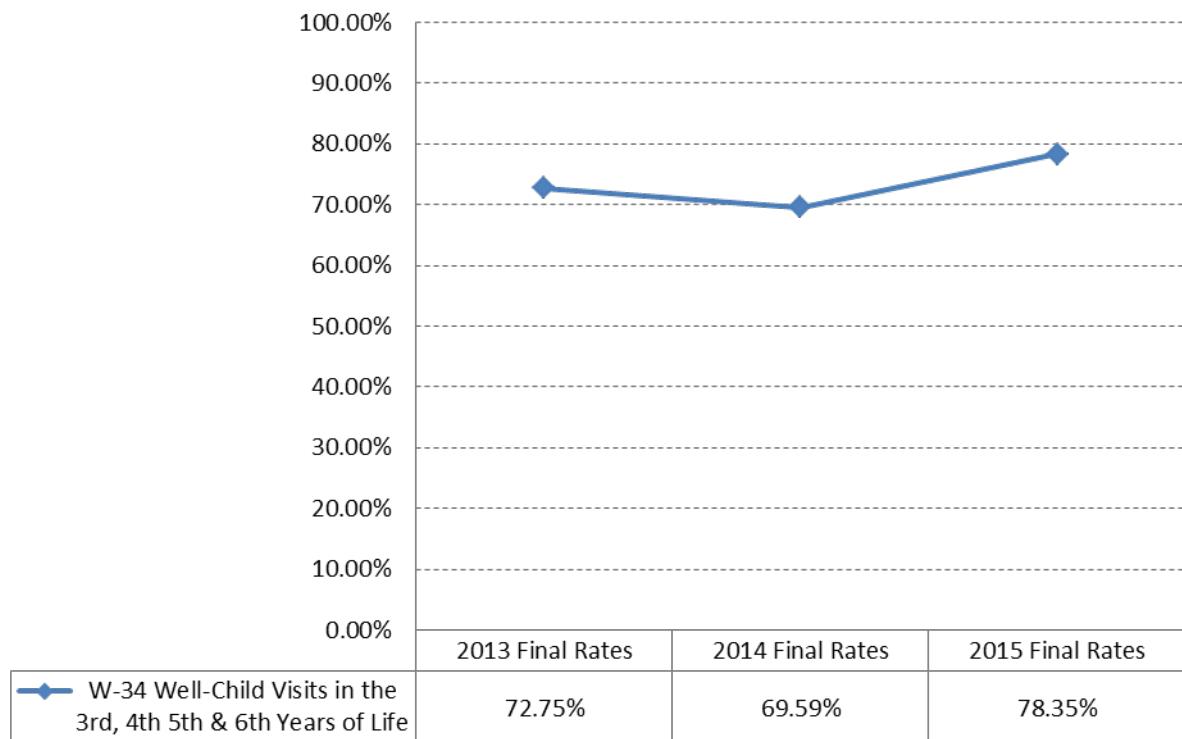
- Focus ideas on interventions in 2016 for member reminders
- Utilize CAIR for missing immunization status in claims and/or PCP medical record

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Well Child Visits Key Findings

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

W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life



Analysis and Findings/Progress:

- Above the MPL of 67.40% and remains below the HPL of 82.69%
- 2015 rates rebounded by almost 9% from HEDIS 2014 to HEDIS 2015, surpassing the rate reported in 2013.

Follow up/Actions:

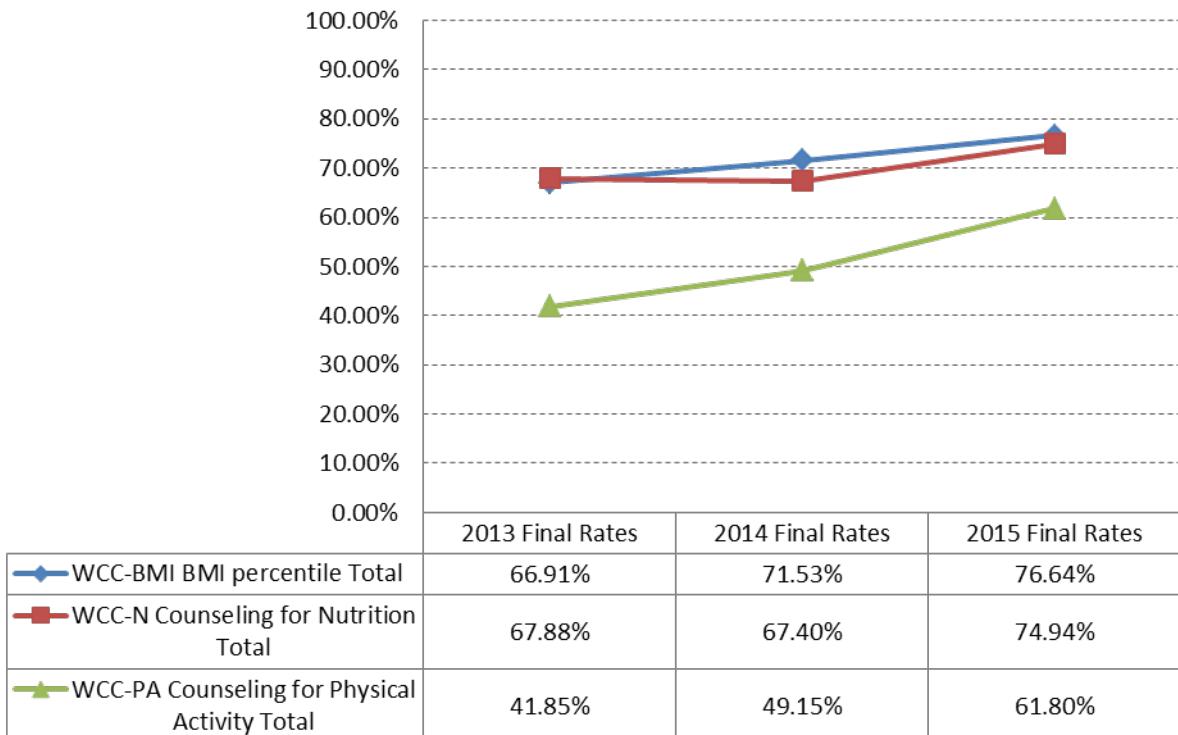
- Focus ideas on new interventions in 2016 for member outreach with incentives
- Focus ideas on new interventions in 2016 for Providers on well child visit schedule
- Pinpoint chart chasing for this measure for 2015 data

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

WCC – Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents (MC)

Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents



Analysis and Findings/Progress:

- Above the MPL for all indicators and remains below the HPL for all indicators
- WCC-PA indicator statistically significant increase of 12.65% from measurement year 2014 to 2015
- WCC- BMI increased 5.11% from measurement year 2014 to 2015
- WCC- Nutrition increased by 7.54% from measurement year 2014-2015

Follow up/Actions:

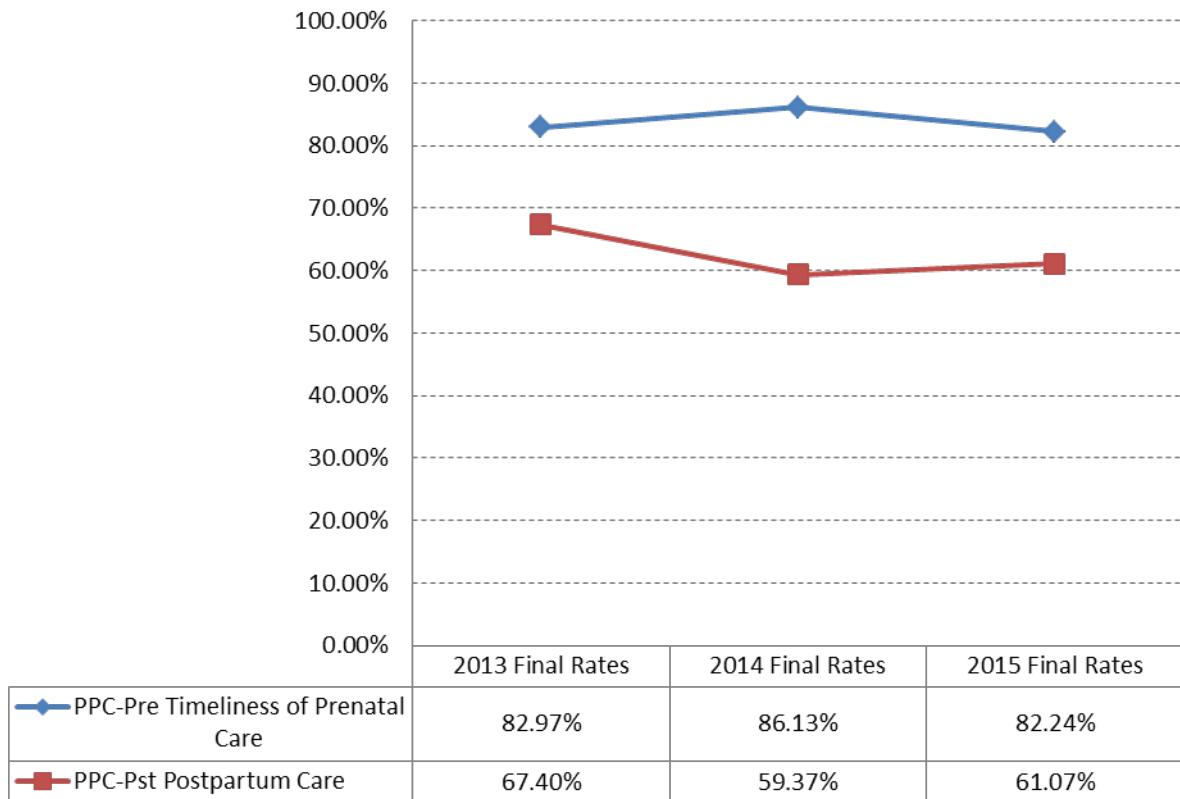
- Focus ideas on new intervention in 2016 for Providers on WCC measure
- Look at maximizing data captured by CHDP forms and encouraging network providers to use CHDP or eCHDP data submission

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Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)

Prenatal & Postpartum Care



Analysis and Findings/Progress:

- Above the MPL's and remains below the HPL's of both indicators
- For Postpartum visits, after a significant decrease from 2013 to 2014, the rates increased by almost 2% from 2014 to 2015.

Follow up/Actions:

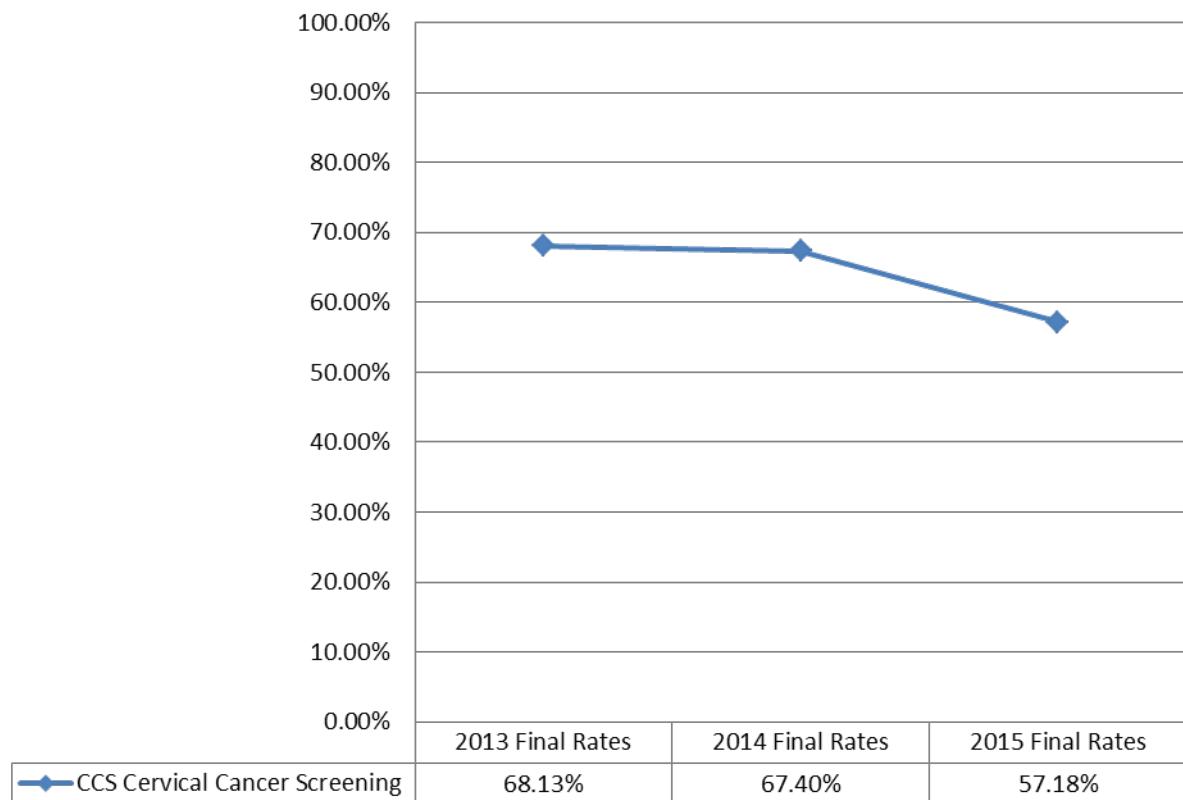
- Focus ideas on new intervention in 2016 for member reminders and outreach, including re-establishing relationship with Text4Baby
- Pinpoint chart chasing for this measure for 2015 data

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Adult Measures: Cervical Cancer Screening and Breast Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)

CCS Cervical Cancer Screening



Analysis and Findings/Progress:

- Above the MPL of 54.50% and remains below the HPL of 75.96%
- The large decrease in rate is attributed to change in specifications, combined with influx of Affordable Care Act members.

Follow up/Actions:

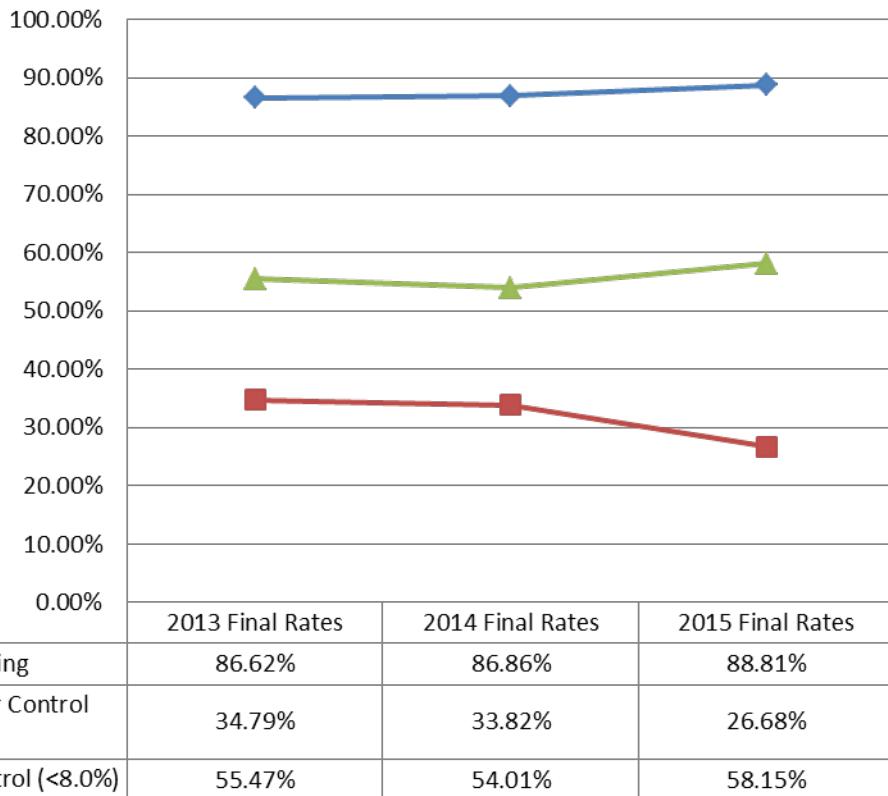
- Focus ideas on new intervention in 2016 for member reminders

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

CDC – Comprehensive Diabetes Care (MC) HbA1c

Comprehensive Diabetes Care - HbA1c



Analysis and Findings/Progress:

- Above the MPL for all indicators and HbA1c poor control exceeded the HPL. Lower is better, the HPL benchmark was 30.28%.
- Overall measure remains relatively flat for HbA1c submeasures

Follow up/Actions:

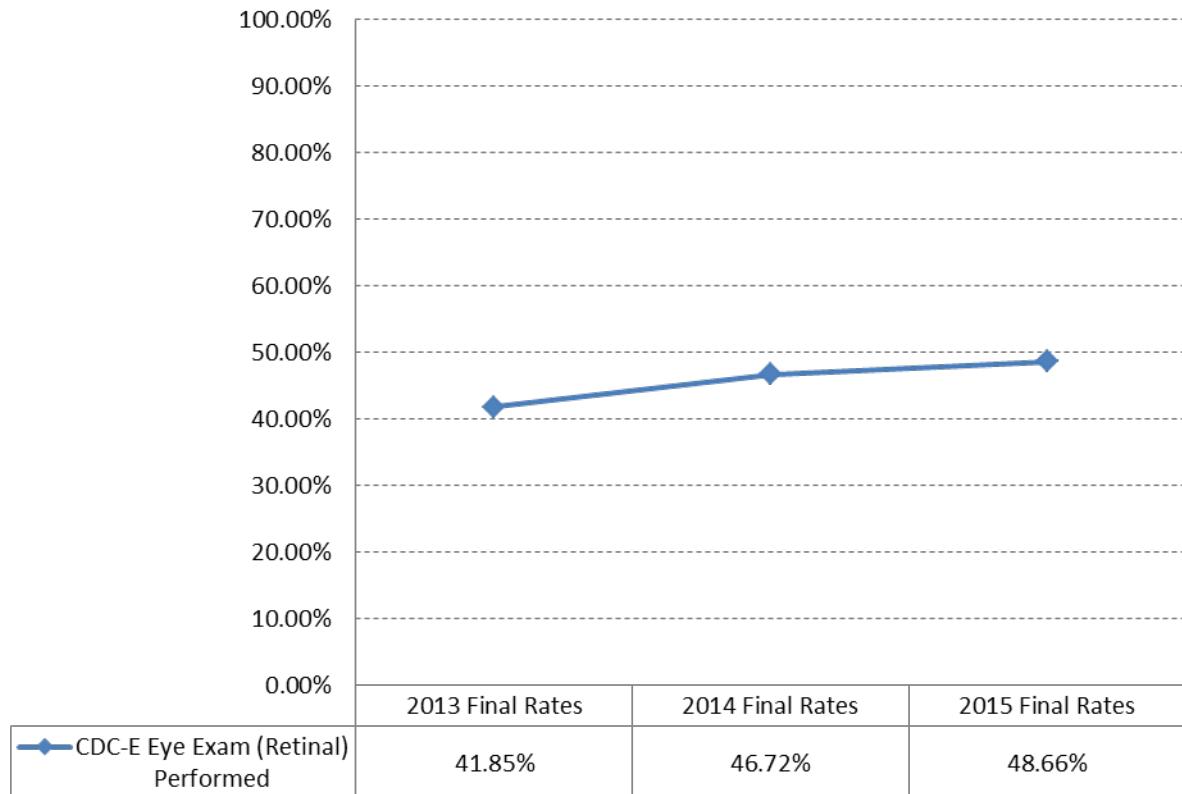
- Focus ideas on new intervention in 2016 for member reminders and outreach

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

CDC – Comprehensive Diabetes Care (MC) Eye Exam

CDC-E Eye Exam (Retinal) Performed



Analysis and Findings/Progress:

- Above the MPL for the Retinal Eye Exam but below the HPL
- Overall measure remains shows slow but sustained improvement

Follow up/Actions:

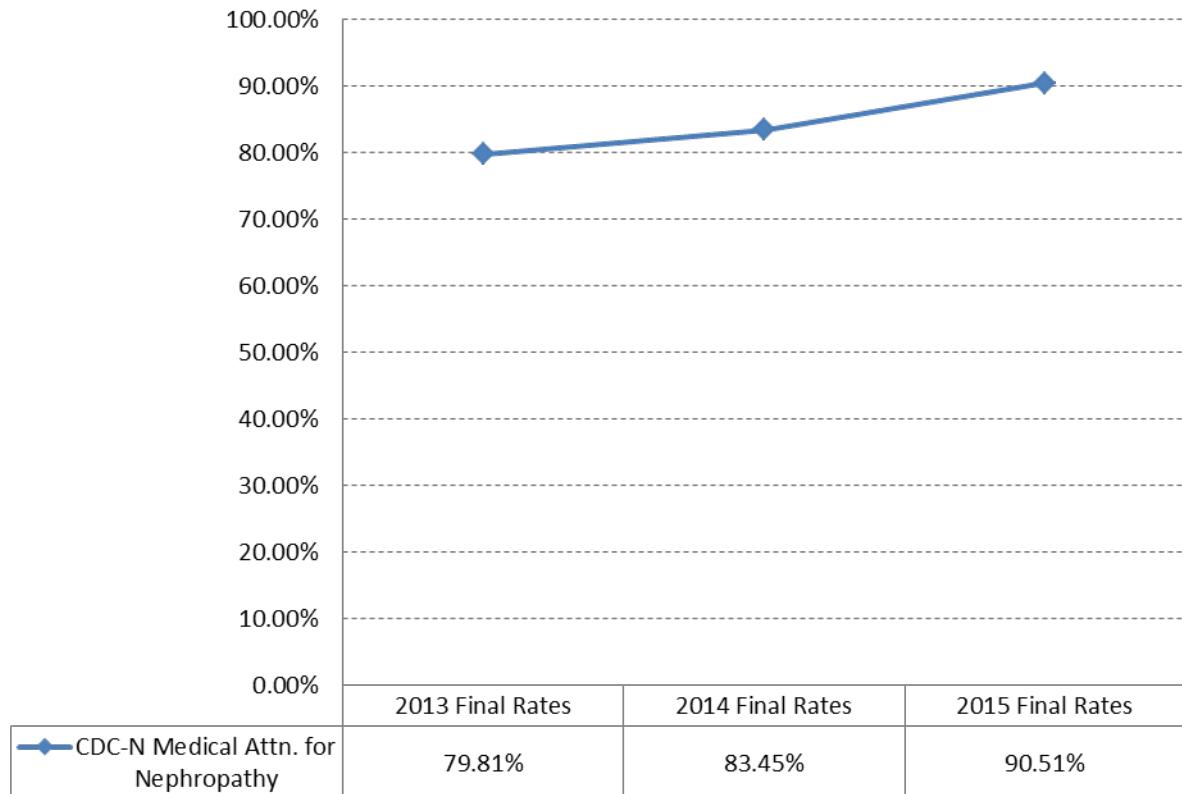
- Focus ideas on new intervention in 2016 for member reminders and outreach

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

CDC – Comprehensive Diabetes Care (MC) Nephropathy Monitoring

CDC-N Medical Attn. for Nephropathy



Analysis and Findings/Progress:

- Above the MPL as well as above the HPL of 86.86%
- Overall measure remains showed an increase of over 7% from 2014 to 2015

Follow up/Actions:

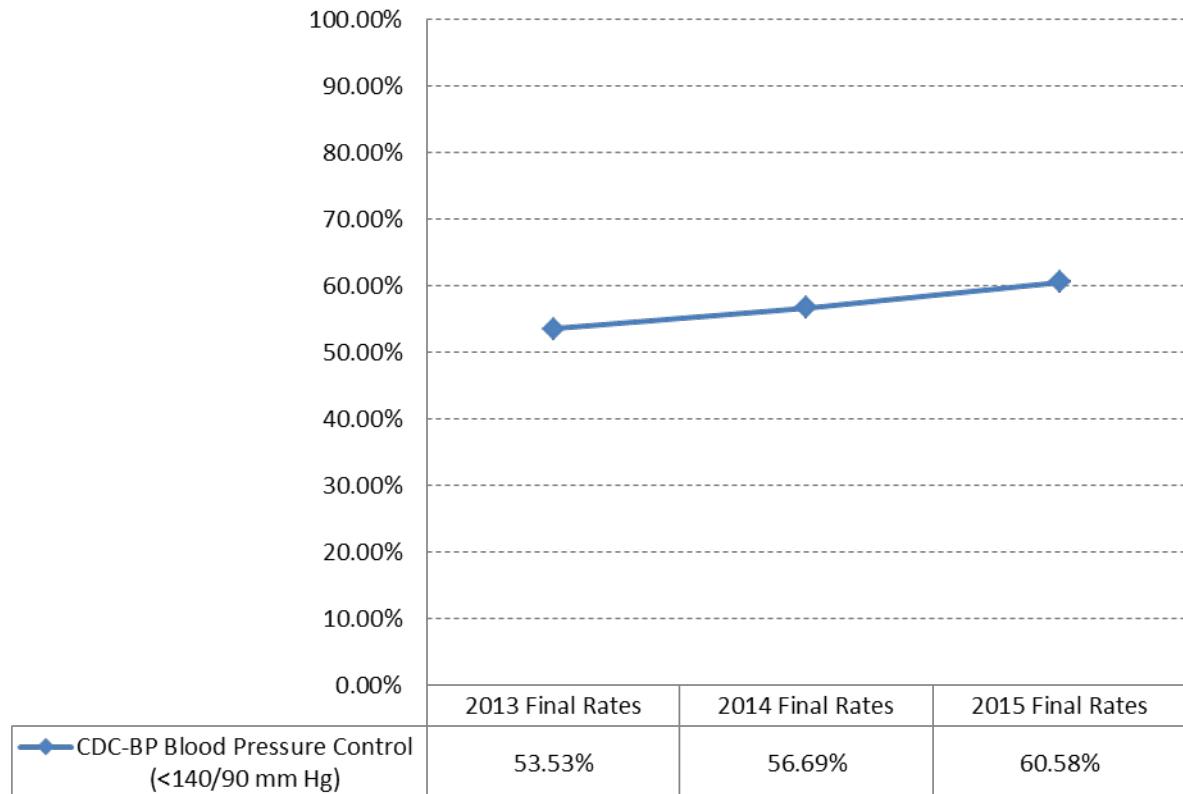
- Focus ideas on new intervention in 2016 for member reminders and outreach

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

CDC – Comprehensive Diabetes Care (MC) Blood Pressure Control

CDC-BP Blood Pressure Control (<140/90 mm Hg)



Analysis and Findings/Progress:

- Above the MPL but remained below the HPL.
- Overall measure remains showed sustained increase over the last three years

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach



The Spirit of Care

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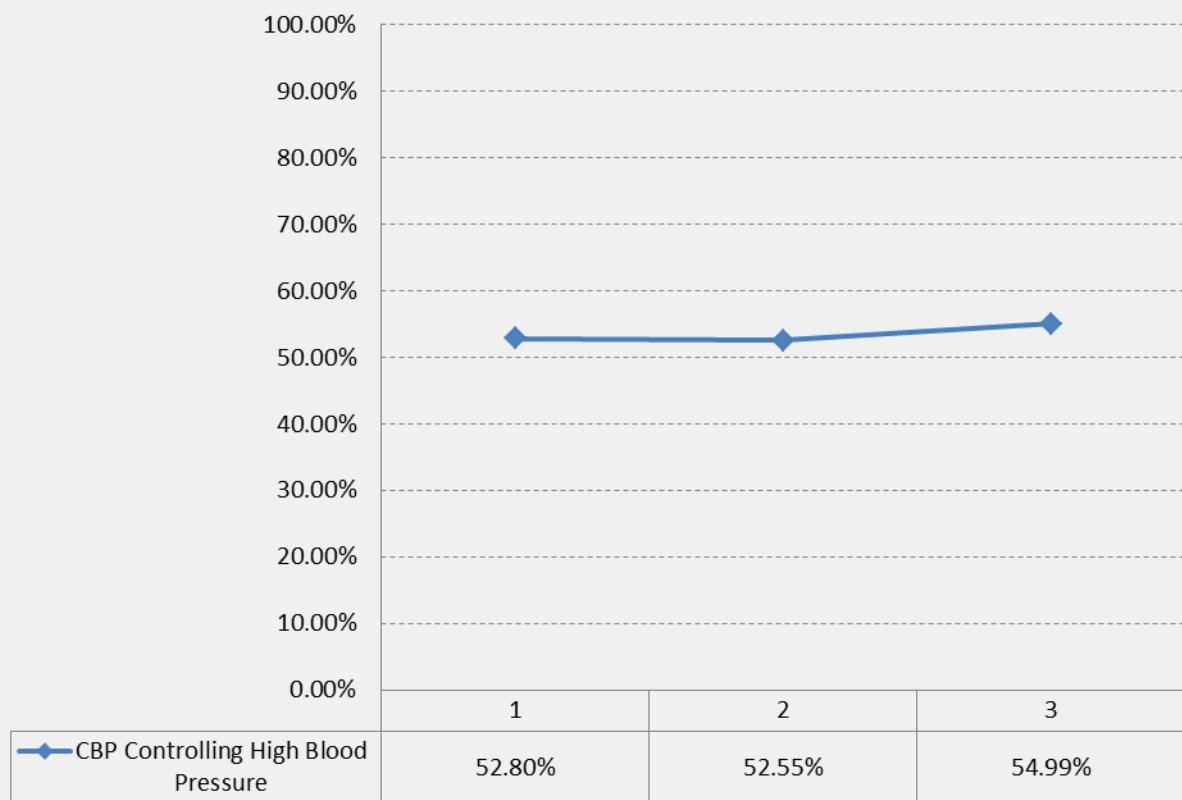
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Controlling High Blood Pressure

CBP Controlling High Blood Pressure



Analysis and Findings/Progress:

- Above the MPL but remained below the HPL.
- Overall measure remains showed sustained increase over the last three years

Follow up/Actions:

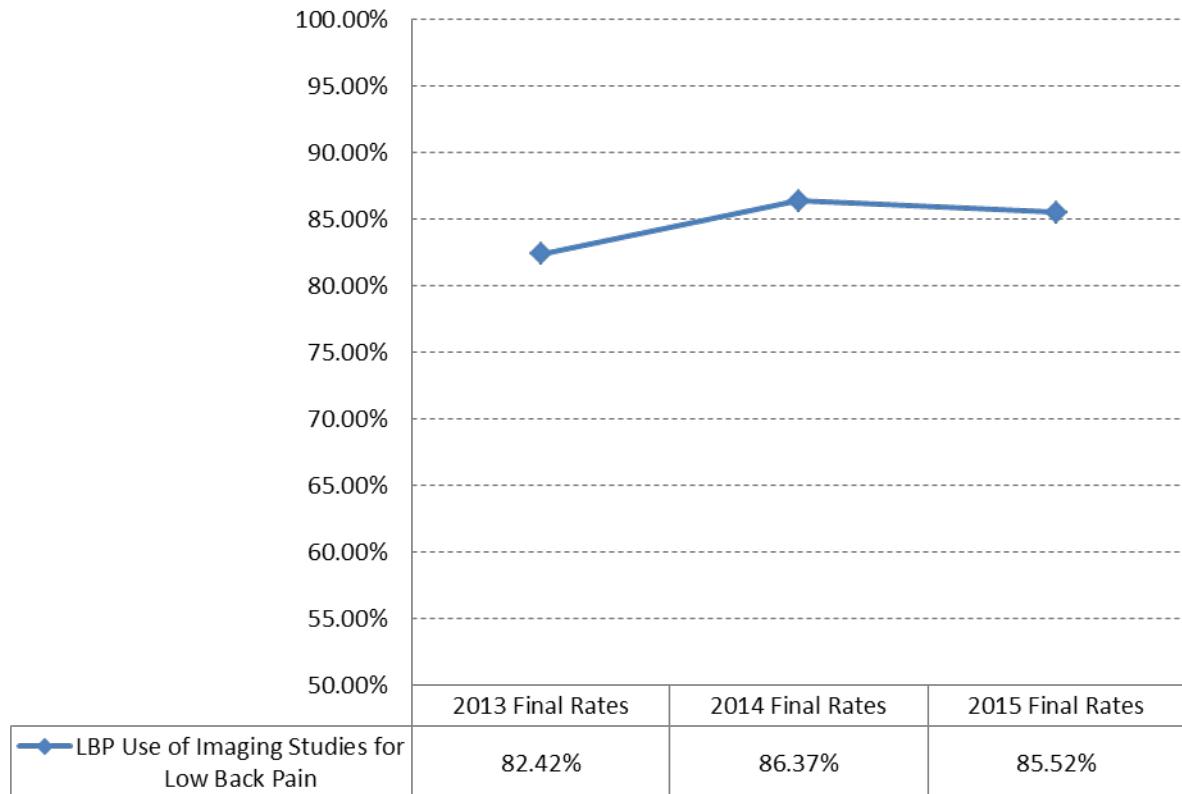
- Focus ideas on new intervention in 2016 for member reminders and outreach

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HEDIS Administrative Measures: Use of Imaging Studies for Low Back Pain

LBP – Use of Imaging Studies for Low Back Pain (MC)

LBP Use of Imaging Studies for Low Back Pain



Analysis and Findings/Progress:

- Above the HPL of 84.03 %
- Decrease of .85% from previous year but second year above the HPL

Follow up/Actions:

- Monitor measure to ensure continued high performance

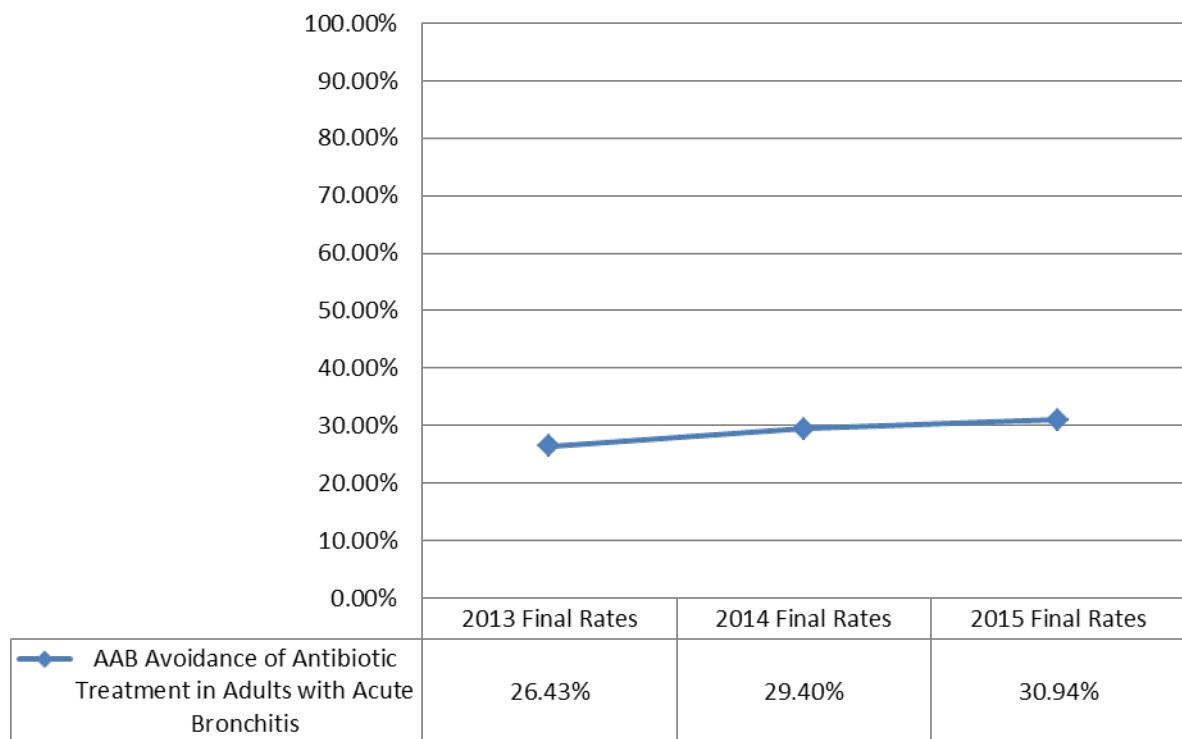
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HEDIS Administrative Measures: Respiratory Conditions

AAB – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (MC)

AAB Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



Analysis and Findings/Progress:

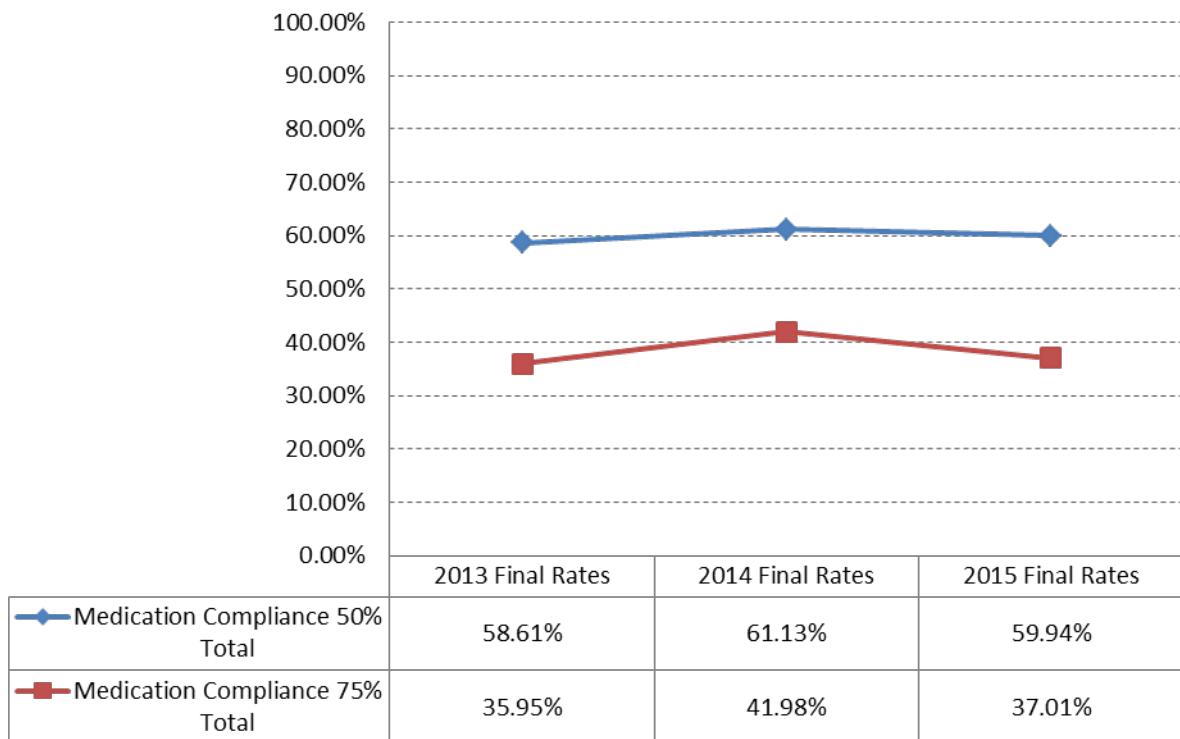
- Above the MPL of 17.92% and remains below the HPL of 38.66%
- Sustained increase over the last three years

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member education
- Focus ideas on new interventions in 2016 with SCFHP Pharmacy Department
- Focus ideas on clinical practice guidelines for providers in 2016
- Promote existing SCFHP health education programs

MMA – Medication Management for People with Asthma (MC)

Medication Management for People with Asthma



Analysis and Findings/Progress:

- Measures showed decreases in both the 50% Compliance and 75% Compliance. Both decreases are less than 5%
- Both measures were above the MPL

Follow up/Actions:

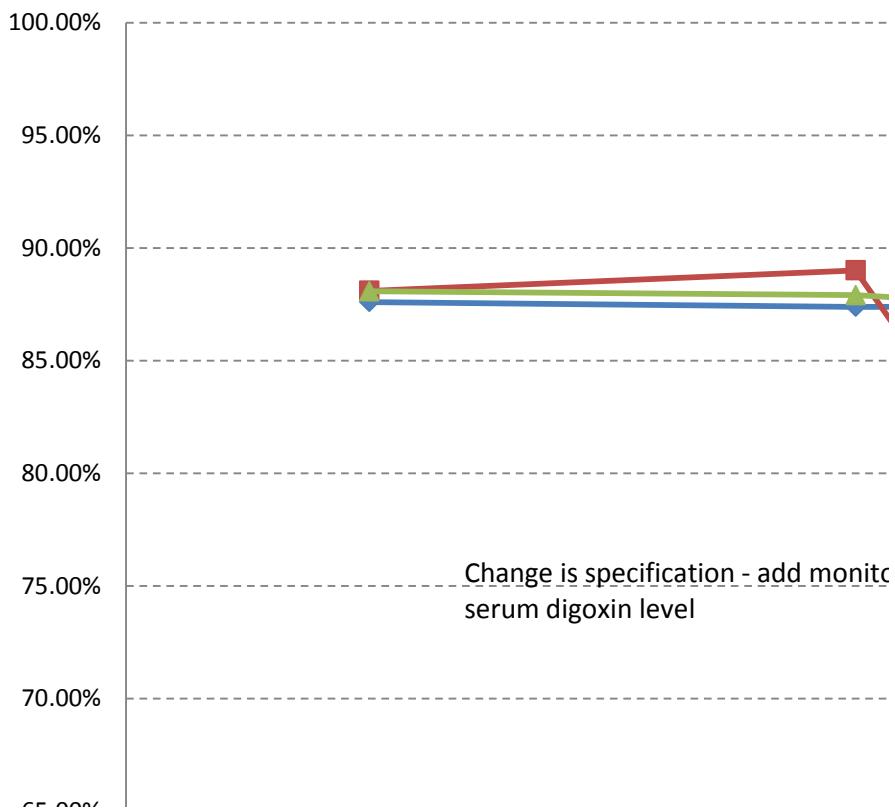
- Focus ideas on new interventions in 2016 with SCFHP Pharmacy Department
- Promote existing SCFHP health education programs

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HEDIS Administrative Measures: Medication Compliance

MPM – Annual Monitoring for Patients on Persistent Medications (MC)

Annual Monitoring for Patients on Persistent Medications (MPM)



Analysis and Findings/Progress:

- All sub measures surpassed the Minimum Performance Levels (MPL)
- The Digoxin sub measure is not held to an MPL due to change in specifications
- Measure continues to remain flat from year to year

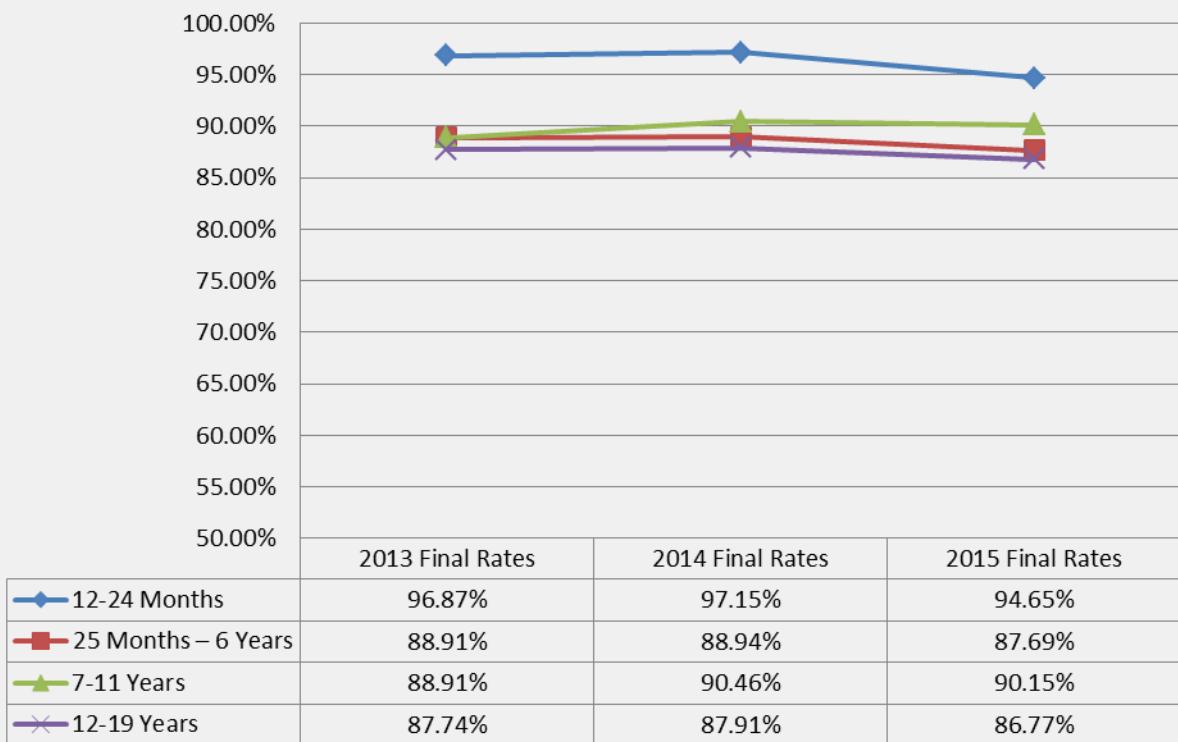
Follow up/Actions:

- Focus ideas on new interventions in 2016 with SCFHP Pharmacy Department
- Focus ideas on clinical practice guidelines for providers in 2016

HEDIS Administrative Measures: Access to Care

CAP – Children’s & Adolescents Access to PCP – (MC)

Children & Adolescents’ Access to Primary Care Practitioners



Analysis and Findings/Progress:

- Measure not held to MPL methodology
- Measure remains consistently flat in range

Follow up/Actions:

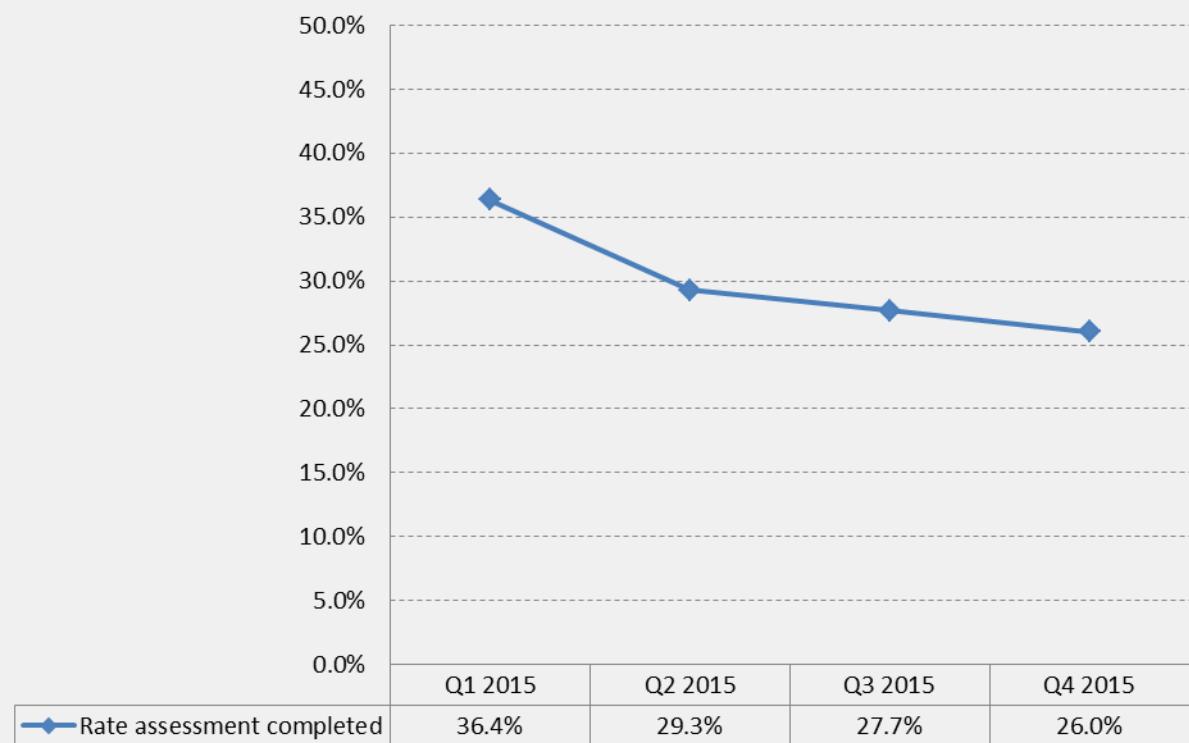
- Focus ideas on new provider interventions in 2016 for continued compliance
- Focus ideas on member appointment reminders and education in 2016

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CMC Health Risk Assessments completed within 90 days of enrollment into the plan

CMC HRA's completed within 90 days of enrollment



All new members to the CMC line of business need an HRA and an Individual Care Plan completed within 90 days of enrollment. The plan has been reporting this on a quarterly basis to CMS and has tried multiple approaches to increasing compliance rates.

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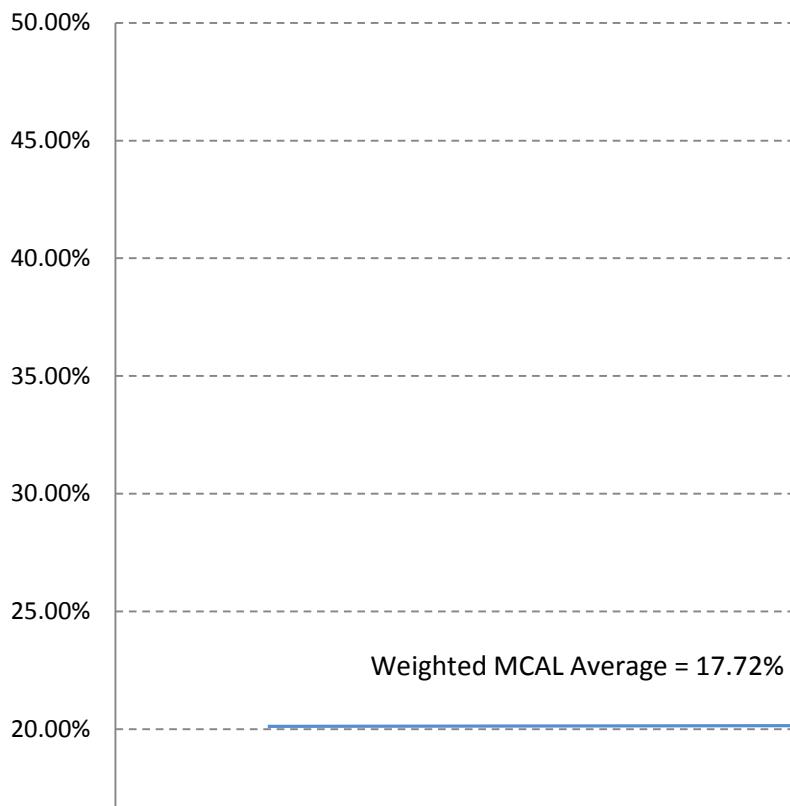
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B. Clinical Improvement Activities

External and Internal QIP's (2015 Measurement Year)

All Cause Readmissions DHCS Quality Improvement Project –

ACR All-Cause Readmissions – Statewide Collaborative



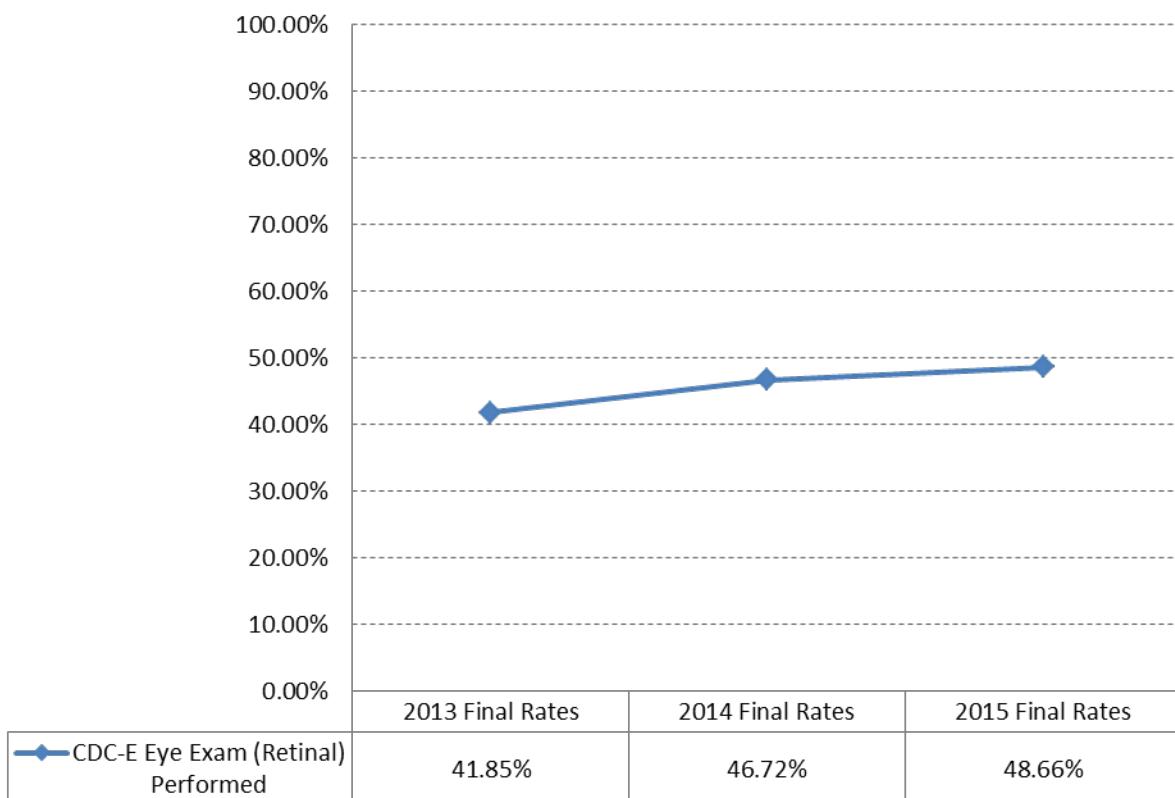
The ACR Statewide Collaborative ended in 2015. SCFHP saw a consistent increase in readmissions through each year of the collaborative.

Diabetic Retinopathy Improvement Plan by Screenings (DRIPS)

2015 QUALITY IMPROVEMENT PROGRAM EVALUATION

Annual Evaluation

CDC-E Eye Exam (Retinal) Performed



The DRIPS internal QIP ended in 2015. While the measure showed sustained improvement, the percent increase did not reach the goal of 5% increase each year.

C. Initial Health Assessment (IHA)

C.1 Goal:

To ensure all SCFHP members completes a Stay Healthy Assessment (SHA) in accordance with the timeframes appropriate by age and that documentation is evidenced in their medical record

C.2 Interventions:

- SCFHP provides information on IHA to the members and providers annually in the Member Newsletter
- SCFHP continues to promote provider education on the IHA with its delegates and Independent network providers
- QI Nurse provides IHA training at every PCP Facility Site Review
- QI Nurse reviews PCP Medical Records for evidence of IHA's at every MRR Review

C.3 Results:

- QI Nurse successfully implemented IHA Training program for PCP sites.

C.4 Analysis of Findings/Progress:

- QI Nurse completed IHA training at 25 PCP Facility Site Review
- QI Nurse reviewed PCP Medical Records for evidence of IHA's at 25 MRR Reviews



The Spirit of Care

2015 QUALITY IMPROVEMENT PROGRAM EVALUATION
 Annual Evaluation

D. Patient Safety: Facility Site / Medical Record Review

2015 QUALITY IMPROVEMENT PROGRAM EVALUATION
 Annual Evaluation

D.1 Goal:

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

D.2 Intervention:

- Complete FSR/MRR Review on all PCP sites that were due for a 3 year review.
- Complete FSR review for all newly contracted sites.
- Transition Part C reviews from Provider Services to Quality Nurse.
- Continue to Collaborate with Anthem Blue Cross.
- Review and update Medical Record Standards

D.3 Results:

- 41 PCP sites completed FSR reviews
- Medical Record Standards Updated
- Two Collaboration meetings held with Anthem Blue Cross to share data.
- Provider Services transitioned completion of FSR Part C reviews to Quality Improvement.

D.4 Analysis of Findings/Progress:

- 20 Corrective Action Plans were issued, monitored, validated and closed

E. Potential Quality of Care Issues Summary

2015 QUALITY IMPROVEMENT PROGRAM EVALUATION

Annual Evaluation

E.1 Goal:

To increase awareness of the PQI process within the health plan

E.2 Intervention:

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

E.3 Results:

- 65 PQI's reported in 2015
- 2 were Level II-Improvement Needed

E.4 Analysis of Findings/Progress:

- Reports need to go to QIC every quarter .



Santa Clara County Health Authority

QUALITY IMPROVEMENT COMMITTEE CHARTER

Purpose

The Quality Improvement Committee (QIC) shall oversee Santa Clara Family Health Plan's Quality Improvement Program, which is an organization-wide commitment to utilize a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

Members

Pursuant to the Bylaws, the Governing Board shall establish a QIC to provide expertise to the Health Plan relative to their professional experience. The QIC shall have a sufficient number of members to provide the necessary expertise and to work effectively as a group. The QIC shall include contracted providers from a range of specialties as well as other representatives from the community, including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All QIC members, including the Chairperson, shall be appointed by the Health Plan's Chief Executive Officer (CEO). All QIC members, including the Chairperson, can serve up to three two-year terms. Additional terms may be appointed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

QIC members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the Committee.

Meetings

Regular meetings of the QIC shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chairperson, the CEO, or a majority of the members of the Committee.

Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an agenda item, as necessary.

Meetings of the QIC shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 et seq.)

The Director of Quality Improvement is responsible for notifying members of the dates and times of meetings and preparing a record of the Committee's meetings.

Responsibilities

The goals and objectives below shall serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The QIC also oversees the Utilization Management Committee, Credentialing and Peer Review Committee, and Pharmacy and Therapeutics Committee. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

Quality improvement Program goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the plan population
- The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risks, and disease profiles for both acute and chronic illnesses, and preventive care
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances

- Compliance with regulatory agencies and accreditation standards
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Design, measure, assess, and improve the quality of the organization's governance, management, and support processes
- Monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
- Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals

SCFHP Q1 2016 Appeals & Grievances

Medi-Cal Q1 2016

Coverage Disputes	Disputes Involving Medical Necessity	Quality of Care	Access to Care	Quality of Service	Other
4	115	2	11	50	28

CMC Q1 2016

Q1 Part C Grievances		Total Number of Grievances	Number of grievances in which timely notification was given
Total Grievances		24	24
Number of Expedited Grievances		0	0
Enrollment/Disenrollment		0	0
Benefit Package Grievances		1	1
Access Grievances		0	0
Marketing Grievances		0	0
Customer Service Grievances		18	18
Organization Determination and Reconsideration Process Grievances		0	0
Quality of Care Grievances		5	5
Grievances Related to "CMS Issues"		0	0
Other Grievances		0	0

Q1 Part C Reconsiderations	Number
Total Number of ODs Made in Reporting Time Period	11
Number Processed Timely	11
Fully Favorable (Services)	8
Fully Favorable (Claims)	0
Partially Favorable (Services)	0
Partially Favorable (Claims)	0
Adverse (Services)	3
Adverse (Claims)	0
Withdrawn	0

Q1 Part D Grievances	Total Number of Grievances	Number of Grievances in which Timely Notification was Given
Total Grievances	0	NA
Number of Expedited Grievances	0	NA
Enrollment/Disenrollment	0	NA
Plan Benefit Grievances	0	NA
Pharmacy Access Grievances	0	NA
Marketing Grievances	0	NA
Customer Service Grievances	0	NA
Redetermination Process Grievances	0	NA
Quality of Care Grievances	0	NA
Grievances Related to "CMS Issues"	0	NA
Other Grievances	0	NA

Q1 Part D Redeterminations	Total Number of Grievances	Number of Grievances in which Timely Notification was Given
Total number of redeterminations	40	37
Number processed timely	37	NA
Number fully favorable	25	24
Number partially favorable	0	NA
Number adverse	10	9
Number withdrawn	5	4
Number dismissed	0	NA

CY 2015 Identification of Health Conditions Impacting MMP Beneficiaries

Tables A and B provide a summary of the demographic profile of SCFHP's CMC membership and the top diagnoses, respectively. SCFHP analyzes and uses this information along with pharmacy data, and claims/encounter data to identify conditions that have an impact on members and their health.

Table A – Demographic Profile of SCFHP's CMC Population – Calendar Year 2015

Age as of CMC enrollment date	Count	Percentage¹
21-64	2,091	23.1%
65-75	3,375	37.2%
76-90	3,224	35.6%
91+	380	4.2%
Language	Count	Percentage
English	3,839	42.3%
Spanish	1,520	16.8%
Vietnamese	1,047	11.5%
Chinese (All)	1,018	11.2%
Unknown	782	8.6%
Tagalog	407	4.5%
Russian	128	1.4%
Farsi	123	1.4%
Korean	49	0.5%
Other (18 languages)	157	1.7%
In Home Health Services (IHSS)	Count	Percentage
No IHSS	4,932	54.4%
IHSS < 20 hours/week	2,284	25.2%
IHSS > 20 hours/week	1,854	20.4%
Aid Code	Count	Percentage
Aged	6,118	67.5%
Disabled	2,725	30.0%
Other	209	2.3%
Family	18	0.2%

Just over seventy-six percent (76.9%) of members are between the ages of

¹¹ Percentages may not total to exactly 100.0% due to rounding.

65 and 90, with over thirty-five percent (35.6%) between 76 and 90 years of age.

The top four language needs of our membership are English, Spanish, Vietnamese and Chinese. Spanish is the language of the greatest percentage of the Plan's non-English proficient members.

The fact that over sixteen percent (16.8%) of SCFHP's CMC membership is Spanish speaking is noteworthy as according to the American Diabetes Association one potential challenge for this subset population is increased prevalence of Type 2 Diabetes and related cardio metabolic abnormalities.

Just over forty-five percent (45.6%) of members receive some level of IHSS.

Just over ninety-seven percent (97.5%) of the membership is identified as being within an aged or disabled aid category.

Thirty percent (30.0%) of members are disabled, and nearly three percent (2.5%) require long-term care.

SCFHP conducts ongoing review of its CMC membership, including regular analysis of enrollment demographics and diagnoses, to determine the conditions that impact members, including the top 20 diagnosis, members with three or more chronic conditions, and members with eight or more prescriptions.

Table B reflects the SCFHP CMC member population by the top 20 diagnoses, again demonstrating the parallels with the Santa Clara County and California State population profiles. Table B is color coded to illustrate the top four diagnostic categories, which include hypertension, diabetes, cardiovascular disease, and behavioral health.

Table B – Top 20 Diagnosis of SCFHP’s CMC Member Population

Diagnosis	Frequency (Number of Members)
HYPERTENSION, ESSENTIAL NOS	13,102
DM, UNCOMPLICATED, TYPE II	9,516
Essential (primary) hypertension	5,843
HYPERLIPIDEMIA NEC/NOS	4,039
Type 2 diabetes mellitus without complications	3,371
FIBRILLATION, ATRIAL	2,972
HYPERTENSION, BENIGN ESSENTIAL	2,501
DM, UNCOMPLICATED, TYPE II, UNCNTRL	2,162
Encounter for immunization	2,022
ROUTINE MEDICAL EXAMINATION	1,981
SYMPTOM, PAIN, CHEST NOS	1,969
DISORDER, DEPRESSIVE NEC	1,812
INFECTION, URINARY TRACT NOS	1,640
SYMPTOM, SHORTNESS OF BREATH	1,630
ALZHEIMER'S DISEASE	1,556
SYMPTOM, COUGH	1,550
FAILURE, CONGESTIVE HEART NOS	1,490
PAIN IN LIMB	1,452
LUMBAGO	1,435
DISORDER, SCHIZOAFFECTIVE, UNSPC	1,421
Legend	
Hypertension	Diabetes
Cardiovascular Disease	Behavioral Health

Again, in concert with the State and County profiles, SCFHP’s 2015 CMC membership profile revealed that of the 9,070 CMC members, 3,860 or forty-three percent (43%) have three or more chronic conditions, and 5,006 or fifty-five percent (55%) receive eight or more prescriptions.

The limitations, barriers, and potential challenges of an enrollment population that includes members with limited English proficiency, are aged and disabled, have multiple chronic conditions, and have socio-economic

issues include:

- a) Decreasing self-care capabilities
- b) Limited health literacy
- c) Caregiver fatigue
- d) Increase in disabilities, including sight and hearing impaired
- e) Increased transportation needs
- f) Diminished social interactions
- g) High prevalence of depression
- h) Inadequate, affordable living quarters
- i) Increased need for assisted living and skilled nursing level of care

Unique Characteristics for the MMP Population Served

The unique characteristics of the SCFHP CMC member population include the limitations, barriers, and potential challenges of a member population that includes members with limited English proficiency, are aged and disabled, have multiple chronic conditions, and have socio-economic issues. These unique challenges are related to:

Decreasing self-care capabilities

Limited education and health literacy

Caregiver fatigue

Increase in disabilities, including sight and hearing impaired

Increased transportation needs

Diminished social interactions

High prevalence of depression

Inadequate, affordable living quarters

Increased need for assisted living and skilled nursing level of care

A higher rate of racial and cultural disparity

Multiple chronic conditions and co-morbidities

Increased vulnerability related to polypharmacy.

SCFHP employs various strategies to respond to these challenges, including:

- a) SCFHP's offices are located and designed to facilitate access for individuals with disabilities.
- b) All SCFHP contracted providers sites are evaluated relative to the Americans with Disabilities Act.
- c) SCFHP provides access for the hearing impaired through the text telephone device (TTY, also known as TDD) number through the California Relay Services.
- d) SCFHP provides access for the visually impaired, as members can obtain important Plan materials in large print, Braille, and computer disk formats by contacting Customer Service.
- e) SCFHP arranges transportation to and from medical services as warranted by the member's medical and physical condition, the urgency of the member's appointment, and the availability of transportation at the time needed.
- f) SCFHP's Customer Service Department, whose staff are fluent in several languages, provides assistance for members with limited English proficiency. If there is not a staff member available that speaks the member's language, SCFHP engages interpreter services available by telephone. Note: Members are informed that they have a right to an interpreter, including a Sign Language interpreter, at no cost to them and available on a 24-hour basis when they receive medical care. Members also have a right to ask for face-to-face or telephone interpreter services, and not to use family members, friends, or minors as interpreters, unless

they request to do so.

- g) SCFHP provides member materials in English, Spanish, Chinese, Tagalog and Vietnamese. Members are encouraged to contact the Customer Service Department to learn if materials are offered in their language.
- h) SCFHP provides licensed healthcare professionals who can assist members, including members with limited education and health literacy, by phone 24 hours a day, 7 days a week through its Nurse Advice line.
- i) SCFHP contracts and partners with community-based providers and resources including: LTSS, housing referral and placement, and maintains a comprehensive network of providers, including behavioral health providers to ensure ready access to care and services.
- j) SCFHP promotes communication with members and providers regarding prescription drugs and potential problems with multiple drugs. SCFHP, in concert with its Pharmacy Benefits Management contractor monitors the volume of outpatient prescription drugs, as well as potential drug interactions and communicates with both members and prescribers.



Santa Clara
Family Health Plan
The Spirit of Care

CMC Dashboard

Q2 QIC

5/11/2016

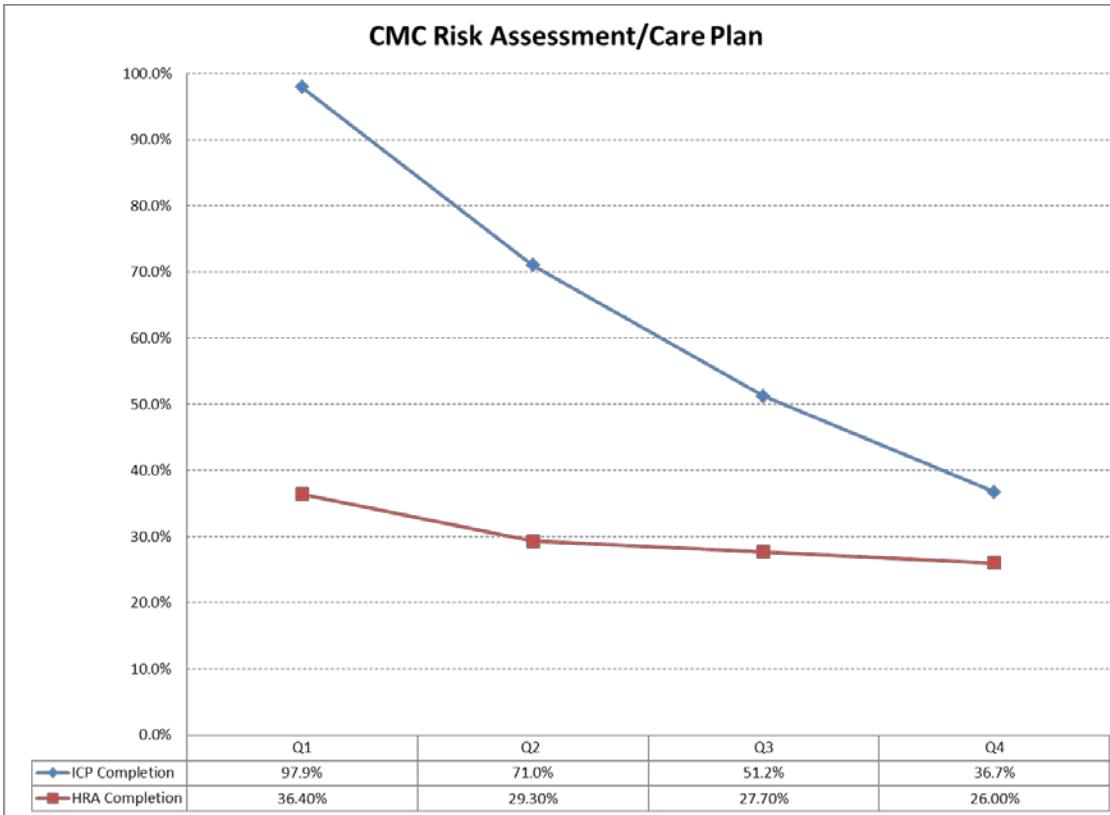


CMC Metrics

- Health Risk Assessments completed within 90 days
- Individual Care Plans completed within 30 working days after HRA completion
- Quality Withhold
- Audited by HSAG



Performance



- Questions?



**QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT**

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

Credentialing Committee April 6, 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	3520	Threshold
Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	22	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialled	12	
Number practitioners recredentialled within 36-month timeline	12	
% recredentialled timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
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	36	43	22	11	18	3
Total # of Recreds	121	40	56	26		7
(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
Pharmaceutical and Therapeutics Committee
December 10, 2015
CONFIDENTIAL**

Committee Member Attendees: Jimmy Lin, MD, Committee Chair, Medical Director (SCFHP); Johanna Liu, PharmD, Pharmacy Director (SCFHP); Jeff Robertson, MD, CMO (SCFHP); Hao Bui, PharmD; Peter Nguyen, MD; Jesse Parashar-Rokicki, MD; Narinder Singh, PharmD

Committee Member Absences: Amara Balakrishnan, MD; Thuong Thuong Nguyen, MD; Minh Thai, MD

SCFHP Staff Attendees: Tami Ogino, PharmD, Clinical Pharmacist; Angelique Tran, Prior Authorization Supervisor, Caroline Alexander, Administrative Assistant

Med Impact (MI) Attendees: Joseph Cherian, PharmD

Item	Discussion	Follow-Up Action
I.	<p>The meeting convened at 6:10 PM.</p> <p>REVIEW, REVISE, AND APPROVE MEETING MINUTES of September 23, 2015.</p> <p>The minutes were reviewed by Committee as submitted.</p>	Upon motion duly made and seconded, the P&T Committee minutes of September 23, 2015 were approved as submitted and will be forwarded to the QI Committee and Board of Directors.
II.	<p>SCFHP UPDATES – Jeff Robertson, MD, CMO Dr. Robertson reported that membership is currently at 280,000 members. Santa Clara Family Health Plan was awarded Outstanding Mid-Sized Health Plan by DHCS. Dr. Jimmy Lin's last day as Associate Medical Director with Santa Clara Family Health Plan was November 20th. Lily Boris, MD, started her role as Medical Director for Santa Clara Family Health Plan on December 7th. Current focus for SCFHP is fostering a culture of compliance and preparing for NCQA accreditation.</p>	
III.	<p>OLD BUSINESS/DISCUSSION ITEMS</p> <ol style="list-style-type: none">Follow up from discussion regarding TB Clinic. Dr. Liu reported that the Priftin BCR is completed and prescribers at the Valley Health Plan TB Clinic can now prescribe Priftin without prior authorization.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 10, 2015
CONFIDENTIAL

Item	Discussion	Follow-Up Action
IV. NEW BUSINESS/ACTION ITEMS	<p>a. Formulary Modifications</p> <ul style="list-style-type: none"> i. Formulary recently reviewed by DHCS and modifications were recommended and made. Formulary approved by DHCS for the year after modifications. ii. Formulary cleanup ongoing due to new print document format. <p>b. MedImpact P&T Minutes</p> <ul style="list-style-type: none"> i. Presented 3Q15 MedImpact minutes for approval ii. Presented Annual MedImpact Medicare Part D P&T Minutes for approval. <p>c. New Drugs</p> <ul style="list-style-type: none"> i. Addyi – presented as informational only <p>d. Class Reviews</p> <ul style="list-style-type: none"> i. Asthma Update- Dr. Cherian presented an update on Asthma treatment medications. <ul style="list-style-type: none"> 1. Formulary addition Requests-Aerospan-two requests to add to formulary 2. Add Spiriva Respimat with step therapy through ipratropium, Combivent or Dulera <p>e. 4Q2015 Drug Trend and Utilization Review</p> <ul style="list-style-type: none"> i. Reviewed 4Q2015 report. <p>f. Medi-Cal Formulary Drug Updates</p> <ul style="list-style-type: none"> i. Remove PA from Uroxatral 	<p>Motioned/Seconded/Approved</p> <p>Upon motion duly made and seconded, the MedImpact minutes were approved as submitted.</p> <p>Motioned/Seconded/Approved</p> <p>Motioned/Seconded/Approved</p> <p>Motioned/Seconded/Approved</p>

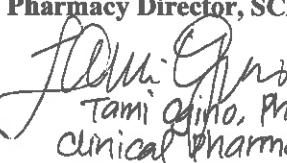
**Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 10, 2015
CONFIDENTIAL**

Item	Discussion	Follow-Up Action
	g. Generic Pipeline – presented as informational only	
V.	REPORTS a. Membership Report – presented by Johanna Liu b. Prior Authorization Report – presented by Johanna Liu	
VI.	ADJOURNMENT The meeting was adjourned at 7:30 PM.	

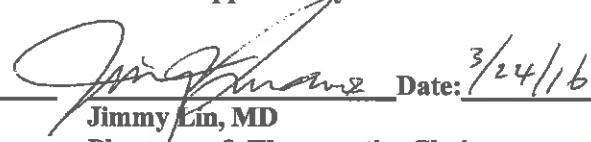
Submitted by:


Caroline Alexander
Administrative Assistant

Internal Approved By:


Johanna Liu, PharmD
Pharmacy Director, SCFHP

External Approved by:


Jimmy Lin, MD
Pharmacy & Therapeutics Chair

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 14, 2015

Committee attendees: Jimmy Lin, MD, Chairperson, Dung Van Cai, MD, Indira Vemuri, MD, Habib Tobbagi, MD

Committee absent: Jeff Robertson, MD, CMO, Ali Alkoraishi, MD, Ngon Hoang Dinh, MD

SCFHP attendees: Christine Tomcala, CEO, Katrina Leestma, Andres Aguirre, Sherry Holm, Caroline Alexander

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	<p>Introduced Katrina Leestma, Medical Management Manager. Announced Sherry Holm has changed job title to Behavioral Health Manager.</p> <p>The minutes of the July 15, 2015 meeting were approved as presented.</p>	
II. Health Plan Update	<p>Ms. Tomcala introduced herself as the new CEO for Santa Clara Family Health Plan. Reported that a Letter of Agreement has been established with O'Connor Hospital effective 10/15/15 for the MediCal population. O'Connor has accepted our proposed rates. Contract will be effective for one year. Reported that membership is over 262,000.</p>	
III. Reports	<p><u>Membership</u> Mr. Aguirre reported that membership is over 262,000. Largest growth was in the MediCal population due to expansion. Gained 11,000 MediCal members since July 2015. Cal MediConnect membership is currently at over 8,000 members.</p> <p><u>UM Reports 2015</u> Mr. Aguirre presented the UM Reports. MediCal Ambulatory Care Outpatient Visit Rate decreased from Q1 2015 to Q2 2015. Also showed a decrease in ER visits in the MediCal population. There was also a decrease in the rate of Outpatient and ER visits for the Seniors and Persons with Disabilities (SPD) population from Q1 2015 to Q2 2015. Total Inpatient Days increased from Q1 2015 to Q2 2015. Increase shown in ALOS. Surgery ALOS decreased, as well as Maternity Total Days inpatient. SPD population showed increase in all areas of Inpatient, but decrease in Surgery Total Days and ALOS. Inpatient Maternity days decreased as well. Reviewed MediCal and SPD Frequency of Selected Procedures. Have seen a change in Bariatric Weight Loss Surgery rates. State has not released the All Plan Comparison grid yet. Will review state numbers when they are released. Currently reviewing against National Measure numbers.</p> <p><u>UM Authorization Reports</u> Ms. Leestma presented the UM Authorization Reports. Reviewed number of Inpatient and Outpatient Authorizations by Line of Business. Started tracking these numbers in July of 2015. Total Inpatient Authorizations for Medical from July to September was 1,177. Total for Cal MediConnect was 1,078.</p>	Report Pharmacy Utilization Data at future meetings (Johanna Liu, Pharm D, Jeff Robertson, CMO)

ITEM	DISCUSSION	ACTION REQUIRED
	<p>UM Authorizations Reports (cont'd)</p> <p>Total Outpatient Authorizations for MediCal, during same reporting period, was 1,791. For CalMediConnect, total Outpatient Authorizations was 817. Turnaround time for all Cal MediConnect authorization times is at 97.7%. Turnaround time for MediCal authorizations is 97% (Turnaround time is under 5 days). Update given on restructure of staffing into areas of focus and line of business. Currently two Concurrent Review nurses, one for Cal MediConnect and one for MediCal. Two Skilled Sub Acute nurses (SNF and LTC), one for Cal MediConnect and one for MediCal. Finally, three nurse case managers and a care coordinator make up the Case Management team.</p> <p><u>Mental Health Update</u></p> <p>Ms. Holm presented the update on Behavioral Health Services. Reported that Santa Clara Family Health Plan covers Mild to Moderate care/Outpatient and that most referrals go through the County Call Center. County Mental Health Department covers all Specialty Mental Health-Outpatient. Currently 1,771 Cal MediConnect members with behavioral health diagnosis, 36 Cal MediConnect Members with substance use diagnosis, and 182 members identified as high risk and with behavioral health diagnosis. Presented the Cal MediConnect goals in Behavioral Health. Effective 9/15/14 health plans are required to cover and coordinate Behavioral Health Treatment for those up to age 21 with Autism Spectrum Disorder. Cases will be transitioning from Regional Center effective 2/1/16. Approximately 3 to 5 referrals a week needing to be matched up with a provider. Working on building a network of providers to include Behavioral Health Treatment, Speech and Occupational Therapy. The goal is to coordinate authorizations and services to ensure that all eligible members are receiving the necessary services. Sherry Holm is the contact to connect members with ABA services. When referring for ABA services, must include evaluation and treatment plan. Currently have 73 ASD members referred. Shared resources available.</p>	Sherry Holm to send list of providers to Dr. Vemuri
VII. Adjournment	Meeting adjourned at 7:35 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, January 16, 2016, 6:00 PM	All: Calendar this event and plan to attend.

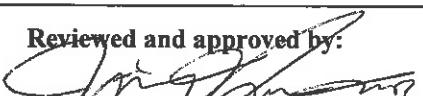
Prepared by:



Caroline Alexander
Administrative Assistant

Date 2/24/16

Reviewed and approved by:



Jimmy Lin, M.D.
Committee Chairperson

Date 2/24/16

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
February 24, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
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	Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Pat McClelland	VP of Medical and Member Operations	N
Lily Boris, MD	Medical Director	Y
Katrina Leestma	Medical Management Manager	Y
Andres Aguirre	Quality Improvement Manager	Y
Sherry Holm	Behavioral Health Manager	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Introduced Lily Boris, MD, as the new Medical Director for Santa Clara Family Health Plan. The minutes of the October 14, 2015 meeting were approved as presented.	
II. CEO Update	Ms. Tomcala presented the update for Santa Clara Family Health Plan. WeiserMazars consultants were onsite to assist Santa Clara Family Health Plan with preparation for the upcoming audit by Department of Managed Health Care and Department of Health Care Services (DMHC/DHCS). Also assist with preparation for National Committee for Quality Assurance (NCQA) Accreditation. Update given on committee structure. Utilization Management Committee will continue to report up to the Quality Improvement Committee. The	

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	Quality Committee will become an official committee of the Board and will report to the Board Committee. Updated policies and procedures will be ready shortly and will be sent out to the Utilization Management Committee members for review. The focus for Santa Clara Family Health Plan is on compliance and audit readiness. DMHC/DHCS joint audit will take place in April during the following dates: April 18 th through 22 nd , and April 25 th through 29 th .	
III. Old Business	No old business to present.	
IV. Action Items	<p>a. Review of Policies and Procedures Dr. Robertson reported that WeiserMazars consultants reviewed policies and procedures for Utilization Management. Reduced number of policies from 51 to a total of 9 policies and revised to be consistent with regulatory requirements. Need to be reviewed, discussed and approved by Utilization Management Committee. Committee members requested ad hoc meeting and the materials in advance for review and editing. SCFHP will schedule and send date.</p> <p>b. Annual UM Guidelines Review and Annual Approval Dr. Boris presented the Hierarchy of Guidelines to the committee. Dr. Lin stated that the Hierarchy is necessary for ensuring uniformity in decision making and process. The committee voted to accept this as the process for every authorization request received.</p> <p>c. UM Program Description 2016 Dr. Boris reported that WeiserMazars consultants are reviewing the UM Program Description.</p> <p>d. UM Workplan 2016 Ms. Leestma reported that WeiserMazars consultants are reviewing the UM Workplan. Workplan is adapted from Technical Assistance Guidelines (TAG's) provided by DMHC.</p>	<p>Schedule Ad Hoc committee meeting for March 23rd. Caroline Alexander to send out invitation to committee. (Those unable to attend in person will attend via WebEx). Present summary of policies to committee.</p> <p>Motioned/Seconded/Approved to accept Utilization Management Hierarchy of Guidelines as written</p> <p>Dr. Boris to present a summary to committee at Ad Hoc meeting on March 23rd</p> <p>Present at March 23rd Ad Hoc committee meeting for review, discussion and approval</p>
V. Reports	<p>a. Membership Dr. Robertson reported membership was 272, 000 in December. Has dropped slightly to 269, 000 due to MediCal having to do a redetermination of eligibility. Cal MediConnect membership dropped from 9,699 to 8, 886. Attribute this to being a program of passive enrollment. At end of December there was no more passive enrollment. Not anticipating</p>	Discuss at next committee meeting getting specialists to contract with Cal MediConnect

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	<p>the same growth that occurred last year. Increase marketing effort to Providers to encourage members to enroll in Cal MediConnect.</p> <p>b. UM Reports 2015</p> <p>i. Over and Under Utilization</p> <p>Mr. Aguirre presented the Cal MediConnect Acute Care Data as well as Frequently Selected Procedures data for Seniors and Persons with Disabilities (SPD) Cal MediConnect (CMC) population. December data not complete as still processing claims.</p> <p>ED visit average: CMC = 43.02/1000 member months SPD = 26.90/1000 member months</p> <p>Average Admits: CMC = 21/1000 member months SPD = 15.29/1000 member months</p> <p>Average Bed Days: CMC = 124.9/1000 member months SPD = 118.29/1000 member months</p> <p>Average Length of Stay: CMC = 5.9 days SPC = 7.74 days</p> <p>The committee requested California specific benchmarks and Medicare Benchmarks. The committee briefly reviewed the MA Plan MCG benchmarks and requested that this information be provided at the next meeting.</p> <p>Reviewed Frequently Selected Procedures for MediCal and SPD Population. In SPD Population, noted that Lumpectomy Procedures per 100 member months in Females age 15 To 44 was low. (Reported at 0.14 as the mean, and at zero for 2nd Quarter 2014 through 3rd Quarter 2015. The committee agreed that the benchmarking and SCFHP data is in line with the averages. Expressed no concerns for over or under -utilization. OB-GYN Dr. Dung Van Cai stated that the guidelines for hysterectomy were changed and that women without symptoms do not routinely get hysterectomies.</p>	<p>Bring California Benchmarks to next meeting for comparison</p> <p>Track lumpectomy rate. (Data issue?)</p>

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	<p>ii. / iii. Turn Around Time and Denial/Approval</p> <p>Ms. Leestma gave an update on Turn Around Times for MediCal authorizations for month of November. (Cal MediConnect data was not available at this time). 870 referrals were processed. Goal is 95% turnaround time in 72 hours or less. Medical rate was at 90%. Addressed this with increasing staffing so average rate for Year to Date is now at 95%. Referral/Authorization Report by Status was presented from March 2014 through February 2016. During this time span: 17, 655 referrals were approved; 1,338 referrals were denied; 121 referrals were pended; 1,024 referrals were cancelled. Committee recommended future numbers be reported as a percentage.</p> <p>c. Behavioral Health Update</p> <p>Dr. Robertson presented an update on the Behavioral Health Program on behalf of Sherry Holm, Behavioral Health Manager. Santa Clara Family Health Plan works directly with Santa Clara County Mental Health Department. There is a large focus on Applied Behavior Analysis (ABA). There are no denials, no appeals, and no grievances to report. In September 2014, ABA was assigned to Managed Care. By July 2016 all cases are to be transitioned from Regional Center. Santa Clara Family Health Plan has hired a Care Coordinator assigned to handle ABA. Santa Clara Family Health Plan is required to report daily on each of these members.</p>	<p>Pharmacy report out referral data at future Utilization Management committee meeting.</p> <p>Sherry Holm to present list of providers that have Psychiatric privileges at hospitals.</p>
VI. Adjournment	Meeting adjourned at 7:25 p.m.	
NEXT MEETING	Ad Hoc meeting is scheduled for Wednesday, March 23, 2016, 6:00 PM The next meeting is scheduled for Wednesday, April 20, 2016, 6:00 PM	All: Calendar this event and plan to attend.

Prepared by:


Caroline Alexander
Administrative Assistant

Date 3/20/16

Reviewed and approved by:


Jimmy Lin, M.D.
Committee Chairperson

Date 3/20/16